IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

JUNE M. HAYES, et al.,
Plaintiffs,
vs.
JUDSON RETIREMENT COMMUNITY, et al.,
Defendants.

CASE NO.: 383210
JUDGE ANTHONY O. CALABRESE, JR.

The deposition of NEAL WAYNE PERSKY, M.D., M.P.H., taken pursuant to Notice in the above-entitled cause, at 623 West Huron, in the City of Ann Arbor, Michigan, on Wednesday, October 4, 2000, commencing at or about 2:02 p.m., before Vicki L. Rodriguez, B.S., M.Ed., CSR, a Notary Public in and for the County of Washtenaw, Michigan.

APPEARANCES:

BECKER & MISHKIND, CO., L.P.A.
By: Jeanne M. Tosti
Skylight Office Tower
1660 West 2nd Street, Suite 660
Cleveland, Ohio 44113
(216) 241-2600

Appearing on behalf of the Plaintiffs.

(Appearances continued on page 2.)

APPEARANCES (Continued):

DAVIS & **YOUNG,** L.P.A.
By: Jan L. Roller
1700 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115-1027
(216) 348-1700

Appearing on behalf of the Defendant Larry Irvin, M.D.

SLATER & ZURZ, L.P.A.
By: Bruce S. Goldstein
One Cascade Plaza, Suite 2210
Akron, Ohio 44308-1135
(330) 762-0700

Appearing on behalf of the Defendant Judson Retirement Community.

I N D E X

WITNESS	PAGE
NEAL WAYNE PERSKY, M.D., M.P.H.	
Examination by Ms. Roller.	4
Examination by Mr. Goldstein	72
Re-Examination by Ms. Roller	101

E X H I B I T S

	MARKED
Deposition Exhibit. A . . . . . (Curricu1um Vitae)	5
Deposition Exhibit B . . . . . (Letter Dated 5-23-00 to Jeanne Tosti)	5
Deposition Exhibit C . . . . . (Vital Statistics of the United States 1993)	54
Deposition Exhibit D . . . . . (Dr. Persky's Handwritten Notes)	102

Ann Arbor, Michigan

Wednesday, October 4, 2000

At or about 2:02 p.m.

- - -

NEAL WAYNE PERSKY, M.D., M.P.H.,

a Witness herein, was first duly sworn by the Notary Public to tell the truth, the whole truth and nothing but the truth, testified as follows:

MS. ROLLER: Dr. Persky, my name is Jan Roller. I represent one of the Defendants in this case, Dr. Larry Irvin.

We're here to take your discovery deposition for the case that the Hayes family has brought.

EXAMINATION

BY MS. ROLLER:

Q. First let me get some basic information down. Would you state your full name.

A. Neal Wayne Persky.

Q. And Neal is N-E-A-L?

A. Correct.

Q. What is your date of birth?

A. 04-05-56.

Q. And where do you live?

A. In Ann Arbor, Michigan.

Q. What is your current -- what is your occupation?

A. I'm a physician in geriatric medicine and internal medicine at the University of Michigan.

Q. And how long have you been at the University of Michigan?

A. About fifteen years.

MS. ROLLER: You were kind enough to produce a Curriculum Vitae for us. I'd like that marked as Exhibit A. And while we're marking I'll have your report marked as Exhibit B.

(Whereupon Deposition Exhibits A and B were marked for identification by the Notary Public and are attached.)

BY MS. ROLLER, CONTINUING:

Q. Dr. Persky, as you can see, we've marked the copy of your Curriculum Vitae as Exhibit A, correct?

A. Yes.

Q. You have a copy of it in front of you?

A. Correct.

Q. I want to just briefly walk through it. You received your medical degree from what institution?

A. University of Illinois.

Q. And in what year? I'm not finding it.

MR. GOLDSTEIN: 1981.

THE WITNESS: Yes, in 1981.

BY MS. ROLLER, CONTINUING:

Q. Okay. I see. All right. And then you spent some time

in Colorado.

A. Correct.

Q. Your residency and internships were spent there. And you did a clinical fellowship in geriatric medicine here at the University of Michigan from '84 to '86; is that right?

A. Correct.

Q. And I guess that does account for fifteen years at that period of time.

You have academic appointments as well as I can see here on your Curriculum Vitae, but can you just describe for me currently what your academic appointment is?

A. Sure. I'm a clinical instructor in the Department of Internal Medicine at the University of Michigan. Do you want an outline of my responsibilities?

Q. Yes, why don't you.

A. I'm Medical Director of the Turner Geriatric Clinic. I'm Associate Director of the University of Michigan Geriatric Center. I'm an attending physician at several of our health care facilities. And I have teaching and administrative and research responsibilities related to those roles.

Q. Can you maybe describe for me the percentage of your time that's spent in those various roles: teaching, clinical,

time with patients, research, et cetera?

A. Sure. I spend a little more than half of my time in clinical activities, probably three-quarters of the remainder in administrative capacities, and the other remainder in research and teaching and miscellaneous kinds of things.

It's hard to separate some of these activities from the others, because they sometimes come together. For example, clinical teaching is often done at the bedside or in the outpatient clinics and things like that.

Q. Do you have actual classroom time that you spend?

A. I do.

Q. Currently what is that?

A. My classroom time is probably around an hour a week.

Q. And what are you teaching?

A. I teach a variety of topics depending on the circumstance. But some of the things I teach have to do with interdisciplinary assessment and treatment of older patients, long-term care, case management. Some of the teaching is related to specific geriatric types of problems such as dementia, bedsores, preventive health care, congestive heart failure, hypertension, hyperlipidemia testing, diabetes, et cetera.

Q. You have done some writing as indicated on your C.V. Is

this current with respect to any publications you have?

A. Probably so. I see here that the copy of my Curriculum Vitae that was provided is more than a year old. And there may be some limited additions to this, but I think it's substantially current.

Q. Is there anything with respect to yours writings that you feel is particularly relevant to the issues presented in this case?

A. Well that's a broad question. But if I understand the nature of it, certainly the aspect related to coordination of care and interdisciplinary practice would be relevant.

Q. Which item is that that you're referring to?

A. Oh, there are a couple I suppose. I was just looking at the Abstract number ten which related to interdisciplinary training.

Q. And what do you mean by that?

A. By interdisciplinary training?

Q. Yes.

A. Well it refers to defining the role of different disciplines in assessing and treating older patients and coordinating the team over time.

Q. And how do you see that issue as relevant to this case?

A. As I say, I was thinking of your question in broad terms. But coordination of different disciplines in a nursing

home is important so that things don't fall through the cracks for example.

Q. And is it your thought that that's what occurred here?

A. Well that's certainly a relevant issue I'm sure we'll talk about. For example, if a test is ordered and different personnel are involved in carrying out that order or making sure that it did and didn't happen and so forth, that is an issue of coordination of care, communication, and team management.

Q. Mr. Hayes, William Hayes, was not a patient of yours at any time, correct?

A. Correct.

Q. And you were asked to review this matter for medicolegal purposes, correct?

A. Yes.

Q. And who is it that contacted you for that purpose?

A. I believe it was Miss Tosti or someone in her office.

Q. And do you have a file that you brought with you today regarding this case?

A. Yes.

Q. Could I see that, please?

A. (Indicating.)

Q. All right,. You're showing me a black binder; is that correct?

A. Yeah.

Q. And can you just tell me what's contained in here? I see that it is labeled. Is it basically medical records and some deposition transcripts?

A. That's correct.

Q. Do you also have a folder with any correspondence?

A. I have some loose correspondence --

Q. Okay.

A. -- that is all from Miss Tosti.

Q. Could I take a look at that also?

A. It's okay with me.

Q. And I'm sure if it's not with Jeanne we'll hear about that.

What you handed me, Dr. Persky, are basically four letters from Ms. Tosti dated January 14th, 2000, Play 3rd, 2000, August 30th, 2000, and September 6th, 2000, correct?

A. I believe you.

Q. The material that you've reviewed for your knowledge of this particular case, is it all contained in this binder that's here on the table?

A. All the medical records and depositions that I've reviewed are here, and that's the basis for the opinions that I'll have to offer.

Q. Did you review anything else for purposes of preparing your opinions in this matter?

A. Well, no, not for preparing my opinion, but there were some materials that had been provided to me that had been described as attorney work product that Miss Tosti has I believe.

Q. That you looked at?

A. Yes.

Q. And when did you look at that material?

A. I looked at them in the course of my review.

MS. TOSTI: He may be referring to questions that I posed to him that I asked for answers to specific issues that I wanted to discuss with him. Those types of things. He hasn't been provided any additional --

MS. ROLLER: Medical records.

MS. TOSTI: -- medical records or materials.

BY MS. ROLLER, CONTINUING:

Q. The format of the questions that Miss Tosti just referred to, what was the format? Was it in a letter, a piece of paper, was it written down?

A. Yes.

Q. And do *you* have a copy of that?

A. I don't. I brought them with me.

MS. TOSTI: I will volunteer I have removed that from his file as attorney work product.

BY MS. ROLLER, CONTINUING:

Q. This piece of paper -- first of all, how many pieces of

paper are we talking about?

A. I don't know the exact number. It was more than one, and there were probably several pieces of paper.

Q. And this is information that you looked at prior to the preparation of your report which is dated May 23rd, 2000?

A. Yes.

Q. And just so that we can identify your report for the record it's been marked Exhibit B; is that correct?

A. Yeah.

Q. It's a two-page report.

MS. ROLLER: I would ask to see that work product, the documents you're calling work product.

MS. TUSTI: I will not produce them as I believe they go to my theory of the case, but you may ask the Doctor any questions regarding the issues he was asked to address in this case.

BY MS. ROLLER, CONTINUING:

Q. Let's go back for- a moment. The materials that you have reviewed, first of all, did you review them all before you prepared your report?

A. I believe so. I can't recall exactly when I received each of the depositions. But I have in preparing for today's deposition reviewed all the medical records and all the depositions entailed in conjunction with that review, my report, and am comfortable that the report

opinions are still ones that I would offer to you.

Q. The letter of January 14th, 2000, that Miss Tosti sent you lists eight items that she is sending to you. Do you see that there?

A. I do.

Q. And did you review each of those?

A. Yes. I believe all of these are contained and tabbed in that black folder that you have.

Q. Great. And just if I can read it into the record rather than going through each of these. That means that you reviewed the records of Dr. Hissa, the records from the Meridian Hillcrest Hospital admission of 11-20-97 to 11-27-97, the records from the Judson Retirement Community admission 11-23-97 to 11-27-97, the Cleveland EMS report of 11-27-97, the Cleveland Clinic's emergency department records of 11-27-97, the Cleveland Clinic outpatient records of 1-97 through 10-97, the Cleveland Clinic Foundation autopsy report, and the Death Certificate, correct?

A. Correct

Q. You also have some deposition transcripts here. And first am I correct that you received the transcripts of Nurse Thill and Nurse Hayes with this letter of May 3rd, 2000, from Jeanne Tosti?

A. Yes.

Q. And did you review those transcripts before you wrote your report of August 23rd, 2000?
A. I believe so.
Q. Now I see also among the documents that you have is a deposition transcript of Larry Irvin, M.D., and Elizabeth O'Toole, M.D.; is that correct?
A. Yes, that's correct.
Q. Have you reviewed --
MS. TOSTI: (Indicating.)
BY MS. ROLLER, CONTINUING:
Q. And Lisa Ann Atkinson, M.D. You have those in your possession as well.
A. That's correct.
Q. Have you reviewed each of those depositions?
A. I have.
Q. And when did *you* review them?
A. I reviewed them soon after getting them and then again for my deposition preparation today.
Q. When did you receive those three transcripts of Doctors Atkinson, Irvin, and O'Toole?
A. I'm not sure, but it might be mentioned in one of the cover letters.
Q. Okay. Let's see.
MS. TOSTI: I will volunteer that after we received them he probably got them within a week or two

of receipt from our office. That's the normal procedure. I don't know. We usually just send out a single cover letter and please find the depositions.

BY MS. ROLLER, CONTINUING:

Q. So that means with respect to Dr. Irvin's testimony when would you have received that? It's stated that the deposition was January 21st, 2000.

A. Well I believe I got it before preparing my report. But since my report is probably something we'll talk about and knowing that I've reviewed this in detail just now I would be happy to go through each opinion in the report and elaborate on them.

Q. So it's your testimony that to the best of your recollection you received Dr. Irvin's deposition transcript before you prepared your report of May 23rd, 2000.

A. Yes, I believe that's correct.

Q. So other than the deposition transcripts that we've talked about and the records that we listed that you received as indicated in Miss Tosti's letter to you of January 14th, 2000, have you reviewed anything else regarding this case?

A. I have reviewed the materials I mentioned that Miss Tosti has retained due to legal considerations that you understand better than I do.

Q. And so that I understand what that was to the best of my ability to do so it was basically questions posed to you, or was it also information given to you?

A. There were several items some of which were correspondence that included questions related to the clinical care and so forth.

And there was a chronology of selected events that I used as an index or table of contents to help me efficiently look through the medical records. But as far as I recall, that included no -- nothing other than references to specific places in the medical records.

And I guess it's also important for- you to note that my opinions are based on the medical records and the transcripts rather than anything else.

Q. I'm sorry if I asked you this question before, The information that you just referred to that you reviewed with Ms. Tosti which has been described here as work product, did you review that before you prepared your report on May 23rd, 2000?

A. You know, I don't know exactly when I got each item or even the total inventory of what those items were, but I believe so. I would expect that a chronology would be provided prior to my review to help me efficiently do that review.

Q. Have you ever reviewed a case -- and by "a case" I mean a

medicolegal case potentially in litigation. Have you ever done that for the law firm of Becker and Mishkind before this case?

A. Not to my recollection.

Q. How about since then? Any other case?

A. Not to my recollection.

Q. So this is the only case that you're aware of that you've reviewed for that law firm?

A. I believe so.

Q. Or any member of that law firm; is that right?

A. Correct.

Q. Do you know how it is that you were called or how they received your name?

A. I don't.

(Whereupon a discussion was held off the record.)

BY MS. ROLLER, CONTINUING:

Q. How frequently do you review a case where the individual involved was not your patient for medicolegal purposes?

A. Probably about once a month.

Q. And you understood my question to be review a case, not that you ---

A. Act as a consultant working with an attorney --

Q. Yes.

A. -- to offer medical perspectives on a medical record.

Q. So you say about once a month you will have a case come into your office for review?
A. Right.
Q. And of those cases how many do you author written opinions on?
A. That I would guess would occur a couple times a year.
Q. And "a couple" is what?
A. Well "a couple" is usually two, but I'm sure it would vary from year to year. Reports aren't commonly requested in my limited experience.
Q. Then how about of the cases that come in approximately once a month how many of those have you been deposed on in a year? And by that I mean a deposition, not a trial but just a deposition.
A. I'm guessing and would put it at maybe a quarter of them.
Q. Does that mean three times a year?
A. Something like khat.
Q. And I guess I should be more specific. You said about twelve cases a year you look at. How many of them do you get involved with? In other words, I'm sure you say yea or nay I will be involved with you. I will work on the matter with you giving an opinion that supports the position of the attorney who's requested it. How many times does that occur out of those twelve? Do you understand what I'm asking you?

A. I guess I don't.
Q. Well when a case comes into the office for you to review, I take it you will give your opinion to that attorney about any medicolegal consequences involved.
A. Correct.
Q. And sometimes it's --
A. Sometimes they like what I have to say and sometimes they don't.
Q. And how many times do they like what you say out of the twelve that come in?
A. I don't know. I don't assess that. I'm given a case to review, and I'm told what the issues and questions are. I'll review it and offer my opinions.

And then if they have further need of my review or have other questions, I'll respond to that. And if they tell me the case is closed or they no longer need any further review on my part, then khat's fine.

Q. Well then how frequently do you find yourself being involved in more than just an initial review is what I'm trying to understand from you.
A. Well it seems like often there will be a file that I'll review, and it may or may not come with depositions. And then some of the time it ends there, and some of the time I'll be sent depositions to review in conjunction with the medical records to see if, you know, that sheds

additional light on the questions the attorneys want me to comment on.

Are you asking me how often do I get depositions in addition to medical records to review?

Q. No. Let me try to get at it a different way. If I asked you how often are you associated with a case until it's resolved one way or the other, whether it be settlement or trial, how frequently does that occur?

A. I don't always know when a case goes to trial or is settled. I suppose if somebody wrote me a letter and said that the matter was settled -- I mean I suppose they could send me a letter like that if they were really trying to say that they didn't like my opinions and they wanted to drop the case or seek another medical expert. I really don't know what's happening at the attorney's end of the process.

Q. I know you're not trying to be difficult here, but we're not communicating. What I'm trying to understand is of the twelve cases that come in in a year how frequently with respect tu those twelve cases --

A. Yes.

Q. -- are you the retained expert on the case whether the case is tried eventually, whether it's settled eventually, whether it comes to a conclusion and there's no --

A. If I understand, maybe I can answer your question in my own terms, and maybe that will do for you.

Q. Please do.

A. If an attorney sends me a file and I review it and offer my opinion, I don't recall saying "I don't want to be associated with this file" but rather would let the attorneys determine what they need. My opinions are what my opinions are. And they can like them or not like them, and then we go from there.

Now I do as a matter of course make sure there's no conflict of interest for me with respect to my role at the University of Michigan. So that might be the kind of thing you're talking about whe-e someone might contact me about a case.

I would usually have a brief and formal discussion with the attorney or whoever in the office was contacting me to make sure the clinical issues were within my area of expertise. And if they were, I would then deter-mine whether there was any conflict of interest for me with respect to the University of Michigan and my role here.

And assuming that those two things were okay then they would presumably send me the file for review, and I would give some preliminary opinions. And from that point forward the attorney would determine whether

or not to send me additional materials or at that point in time to tell me to throw them away.

Q. And of the twelve that come in a year how many go beyond that point?

A. You mean to a deposition?

Q. Right, right.

A. I said maybe a quarter of them.

MS. TOSTI: Objection, asked and answered. He told you he's been deposed about three times a year.

BY MS. ROLLER, CONTINUING:

Q. Have you ever appeared live in court to testify?

A. I did I believe one time.

Q. And have you ever had your videotaped testimony taken for use at trial?

A. I think I had that happen once also in the ten or fifteen years I've been doing this.

Q. And in this matter do you realize that your testimony is being offered in support of -- your report is being offered in support of a plaintiff, a person who is bringing a lawsuit? You understand that?

A. Yes, I do.

Q. And of the matters where you have given approximately three depositions a year, let's take that group, what percentage of the time is your testimony being offered for a plaintiff as opposed to a defendant?

A. Right. I don't know that I can really divide them for the ones that had depositions and didn't. But in terms of my review of files I would estimate that about three-quarters of them are for defense attorneys that are contacting me, and the remainder are either for plaintiff attorneys or ones I can't characterize.

Q. That's the cases you're asked to review, correct?

A. That's right.

Q. But with respect to when your testimony is offered for trial, whether it be via videotape or the one time you appeared live, do you know whether the testimony is being offered for the plaintiff or the defense?

A. It's hard for me to separate those out specifically. I can recall one circumstance where I gave trial testimony for a plaintiff's attorney and one time where I gave testimony at the request of a defense attorney.

Q. Were those the one live appearance at trial?

A. Actually what I'm now remembering is that the one live --

Q. Appearance.

A. -- the one live trial appearance that I can remember was at the request of a defense attorney. But there was one where I gave a telephone deposition which I believe was for trial purposes at the request of a plaintiff's attorney.

Q. How long is it that *you* have been reviewing one case a

month for medicolegal purposes?

A. Ten to fifteen years.

Q. Now I take it, Dr. Persky, that you have not reviewed or seen the pathology slides taken from any tissue in Mr. Hayes' lungs.

A. That's correct.

Q. And the appropriate specialist to evaluate that material would be a pathologist?

A. Most commonly.

Q. If you wanted information about what was on lung tissue, you would refer it to a pathologist for review?

A. It would depend on the question, but that would be one common way to do it.

Q. For the age and character of an emboli is that the appropriate professional?

A. That would be one appropriate professional.

Q. Who else would you consider?

A. Often a pulmonary physician with an interest in the area most commonly might be able to comment as well, and probably a hematologist who would also be familiar with the clotting system and so forth.

Q. What were you asked to do in this case?

A. I was asked to review the materials including the medical records and depositions and comment on the standard of care and life expectancy of the patient, and there were

various questions that Miss Tosti had about the case that she wanted expert review of.

Q. And the opinions that you hold in this case, are they contained in your report of May 23rd, 2000?

A. Some of them aren't.

Q. Well our local rules require that all of your opinions be contained in your report.

A. I see.

Q. Were you aware of that?

A. It's my understanding that this report would be useful to the attorneys in the case. And my opinions do include statements in that report, but it seems to me that it depends on what questions you want to ask me.

Q. Well let me ask you this. After you authored your report, did attorney Tosti ask you at any time to prepare a supplemental report?

A. No.

Q. And if you had opinions regarding the subject matter, you would have done so I take it?

A. If I had opinions that I thought were directly relevant to the issues in the case, I would have most likely added them to the report. I'm just trying to say khat I could offer you additional opinions if you had other questions.

Q. But with respect to what you felt were the relevant, significant questions regarding the standard of care and

whether or not it had been breached in the matter involving William Hayes, those opinions you put in your report of May 23rd, 2000; is that correct?

A. I put in the ones that I thought were most relevant to the case, and I'll be happy to answer any other questions you have.

Q. I understand you'll be happy to answer any questions I have within reason, but I want to know what your opinions are. And as I understand it, when you were asked to review this case and to indicate what your opinions are regarding the standard of care and whether or not it had been breached to Mr. Hayes, you gave your opinion as stated in your report of May 23rd, 2000; is that correct?

A. I'm going to look at the specific opinions --

Q. Please do.

A. -- and see if there are other important items that we don't get to here.

So I'm not trying to be difficult, but maybe you could help to clarify your question for me. So, for example, related to opinion number seven --

Q. Yes.

A. -- where I describe my opinion that "Failure of the Judson Retirement Community personnel to schedule the DVT study as ordered, and to follow-up to ensure its completion, was below the standard of care." You could

break that down into, you know, different personnel and how should it have happened, but there would be a variety of opinions related to that topic.

So is it fair to assume that you're not wanting me to describe every nuance of the opinions that are highlighted here on paper?

Q. Who are the Judson Retirement Community personnel that you're referring to?

A. Well to use this as an example --

Q. That's the question, sir.

A. -- to use this as an example, they have an obligation to have staff who will schedule the study that was ordered by the doctor, and since that didn't happen then there's a problem at Judson Retirement Community.

Now if we discuss who did what and then we could pinpoint perhaps that it was this person or that person, I don't have all that kind of stuff down on paper, and I wouldn't expect to.

Q. So, Dr. Persky, that's my question for you. With respect to item seven on Exhibit B which is your report of May 23rd, 2000 --

A. Yes.

Q. -- would you please identify for me the people who you feel failed at the Judson Retirement Center to schedule the DVT --

A. Right.
Q. -- and who, therefore, acted below the standard of care?
A. Sure. Well, first of all, the facility has an obligation to ensure that there is a mechanism for the doctor's orders to be taken off and followed through on.

The facility as an entity has a responsibility to ensure that there are safeguards to make sure that that is happening reliably to fulfill the standard of care for the facility and professionals there, and they have some flexibility perhaps as to how they do that. So the facility could make those assignments to a nurse or a clerk and could have the double-checking that everything was happening also assigned to a nurse or clerk. They can divide up the work in a variety of ways in order to achieve the standard of care, and that could vary from facility to facility.

So there is an obligation to make sure those things happen. That there are personnel in place to do that. That there are double-checks to do that. That there is ongoing training and education and in-service orientation so that people can do their job and so forth.

Q. Okay. From your review of this case --
A. Yes.
Q. -- other than saying that the facility as an entity has responsibility to do khat, have you identified who in

your opinion had the direct responsibility to do that, to make sure that the DVT study was done?

A. From the depositions it's my understanding that the nurse verified and transcribed the orders and provided written indication of that to the unit clerk on Sunday and that the process fell through at that point.

So I guess depending on how broadly you think about that process certainly the unit clerk who, you know, failed to do that and/or failed to communicate with the physician and/or clinical personnel in order to alert them to that and perhaps schedule it somewhere else or get on the phone and say, "Well we really need this done, and it needs to be done in this time frame."

So those were lapses of care. Violations of the standard of care I guess is the term.

Q. So you are clearly identifying the facility as an entity which had that responsibility and then can delegate it to whomever it delegated that responsibility to, but the bottom line is that the facility had the responsibility.

A. That is my first comment.

Q. I'm asking after that who else are you identifying specifically as having the responsibility. You identified the unit clerk whose responsibility it was to schedule it after receiving the order from the nurse.

A. Right.

Q. Anyone else?

A. Typically there will be -- it will depend on the policies and procedures of the given facility, and I don't know all the policies and procedures of Judson. But typically there will be a clinical person such as a Director of Nursing who will be responsible for making sure that all the staff know the steps to take in order to carry out the order, the steps to take to deal with situations such as not being able to schedule the test as ordered, and there will be someone responsible for communicating with the clinicians as I described earlier.

So there's a failure to perform the scheduling; there's a failure to seek alternative ways to do it; a failure to communicate with the staff; a failure to provide adequate training and supervision and quality assurance in terms of making sure that the staff are prepared, that the test was scheduled, and that the double-checking that the test was scheduled actually was in place and operating effectively.

Q. That double-checking, what do you see as a mechanism that you would describe as double-checking to make sure that a test like that would happen and wouldn't be missed?

A. We've talked about the procedures whereby a unit clerk would schedule the test as ordered and the response that they or affiliated personnel should have if they can't

schedule a test.

In addition to that it would be likely that they would have policies and procedures to check that ordered test did happen. That would be the responsibility of clinical personnel rather than the unit clerk.

Q. And the clinical personnel that you've given --

A. Like a nurse or the Director of Nursing ultimately.

Q. Like a checklist. Is that what you're referring to?

A. It could be a checklist. For example, transcribing the physician's order to have the DVT test. could well trigger putting that on a treatment sheet which would have the correct date indicated. And then if that didn't happen on the day it was supposed to, then that would be in someone's face who could then query as to why it didn't happen.

Q. You've identified the facility itself and then specifically a unit clerk, a clinical person at the facility such as a Director of Nursing. Anybody else specifically?

A. And probably the charge nurse on the unit would have a responsibility for that double-checking that the test happened as well as orienting, training the unit clerk, and ensuring that quality assurance things were happening locally at the unit.

Of course, that person would report to the Director of Nursing, and the Director of Nursing would have broader responsibilities even than those.

Q. Anyone else?

A. I think that should cover it with respect to the scheduling of the test as we had talked about.

Q. Doctor, let me switch gears here for a minute. What diagnostic tools are available if there's a concern that a patient might develop a DVT?

A. In general?

Q. Yes, in general.

A. Well there are lots of them but --

Q. Maybe if you could take it from the top, the best, the most specific testing, and others.

A. Sure. Well the gold standard is commonly considered to be contrast venography where dye is injected into the veins and pictures are taken to see whether the flow is good.

And another available test would be tagged fibrinogen scanning which is a nuclear study that highlights places of clot formation.

And another commonly used test is ultrasound testing which can be done in several different ways. Duplex scanning is one, and plethysmography is a related technique, and Doppler color flow is another.

Q. What was the middle word there?
A. Plethysmography? P-L-E-T-H-Y-S-M-0 --
MR. GOLDSTEIN: Slower.
THE WITNESS: -- G-R-A-P-H-Y.
MR. GOLDSTEIN: Do it one more time, please.
BY MS. ROLLER, CONTINUING:
Q. P-L-E-T-H-Y-S --
A. -- mography.
Q. So that's three general types of testing: the contrast venography, the tagged fibrinogen test or imaging, and then the ultrasound testing.
A. And then tha color Doppler flow is a related but separate technique.
Q. That's a separate technique?
A. Yeah. Sometimes they're done in conjunction to get the greatest sensitivity and specificity.
Q. Anything else?
A. There are other tests, but those cover the main ones.
Q. The DVT study that was ordered, is that one of these four?
A. It would be the ultrasound.
Q. The duplex?
a. The noninvasive DVT scan, yes, would be the ultrasound and likely with color duplex.
Q. Of these tests is there one that's done more often than

1 another, and what is that?
2 A. In clinical practice the noninvasive testing is the most
3 commonly performed --
4 Q. The DVT?
5 A. -- as a screening test.
6 Q. And that's the DVT test?
7 A. Yes.
8 Q. The venography would be invasive, because you have to put
9 dye in the vein. Is that right?
10 A. Correct.
11 Q. And then is it a tagged fibrinogen?
12 A. Correct.
13 Q How is that performed?
14 A. In that test something is injected by vein. It
15 circulates through the blood, and the radioactive
16 material is deposited in areas of clot formation.
17 Q. And what would dictate ordering one of these tests over
18 the other? I mean is it cost?
19 A. The clinical circumstance. The location that you
20 suspected DVT to have occurred in. For example, they can
21 occur in arms as well as legs. (Indicating.) They can
22 occur in the abdominal cavity. You can have clot
23 formation that you might need to diagnose and so forth.
24 Q. For someone who had a bilateral knee replacement what
25 would be the best test?

A. Noninvasive testing would be the best screening test in most circumstances.

Q. The best in what fashion? The best in that it would be the most diagnostic, or that it's the least invasive, or it's the least expensive? By "best" what are you referring to?

A. You've raised a variety of good points. So let me ask you to restate your question.

Q. By "best" I mean the best imaging. What's the best imaging if someone has a bilateral knee replacement?

A. To put it in clinical terms?

Q. Yes.

A. It sounds like you're asking what would be the most sensitive in terms of diagnosing clots if they exist regardless of whether they're big or small or clinically significant or clinically insignificant.

Q. Much better put.

A. And as I mentioned before, the contrast venography is commonly considered the gold standard for diagnosing any and all venous clots.

Q. And why would an ultrasound, a DVT study, be ordered as opposed to the gold standard contrast venography?

A. Because of a variety of reasons some of which you mentioned in your earlier comment. First of all, what we're looking for typically in a situation like that are

clinically significant clots, not just any clot no matter how small or insignificant they might be.

And we're looking for information that will help us determine what is the best clinical test intervention treatment to provide to the patient, and for that purpose the noninvasive test would be the appropriate first step.

Sometimes the gold standard test like contrast venography which involves more risk to the patient because of contrast and radiation exposure would be a necessary follow-up if for example the noninvasive testing was equivocal and we were afraid to fully anticoagulate the patient and for some reason you didn't have the ability to put in a Greenfield filter or other inferior vena cava filter to reduce the risk of significant pulmonary emboli.

So sometimes we use these tests in a sequence so that we only proceed to the more risky procedure when it is clinically necessary.

Q. How do you define a clinically significant clot?

A. Well it depends on the circumstance again. But since we're talking in general terms --

Q. And let me define a little bit better in this circumstance with a patient like Mr. Hayes, his clinical presentation, his age, the fact that he had bilateral

knee surgery, what would be a clinically significant clot?

A. I'll assume that we're going to just talk about venous clots rather than arterial clots or hematomas and things like that.

Q. Let me ask you before we go on. The DVT study would only have shown a venous clot, wouldn't it?

A. It would have shown primarily venous clots. It would not show arterial clots, and it may or may not show hematomas of significance around the total knee arthroplasty.

Q. So if you could define clinically significant clot in that sense.

MS. TOSTI: From the perspective of an internal medicine physician, correct?

MS. ROLLER: Yes. Thank you.

THE WITNESS: A clinically significant clot would be one that could develop to a clinically significant complication. And most commonly we think in terms of venous propagation where there's extension of the clot through the leg which can result in what's commonly called phlebitis or postphlebitic syndrome, varicose veins, lymphedema, and local complications such as that.

And the other even more significant complication that we want to try to avoid by identifying

clots early when they exist are pulmonary emboli and other sorts of complications resulting from pieces of clot breaking off and migrating through the circulatory system.

BY MS. ROLLER, CONTINUING:

Q. Can you quantify that in any way? When referring to a clinically significant clot under these circumstances, can you quantify it by dimension or size?

A. You're asking how big of a clot is clinically significant?

Q. Exactly.

A. It depends on the location and clinical circumstances. So, for example, it's well-recognized and I think discussed in some of the other depositions that I read that clots that form at or above the level of the knee are of greater risk to the patient because of the significantly greater risk of pulmonary emboli. Whereas, those that are restricted to below the knee are of less consequence although they provide a focus or nidus of clot which leads to propagation of clotting to these other more dangerous types that are at or above the knee.

Q. You talked about sensitivity before with respect to these four various tests. How sensitive is the DVT test? In other words, how large does a clot have to be so that it's detected on a DVT?

A. In a patient such as Mr. Hayes it's 95 percent sensitive in most circumstances for detecting a clot at or above the knee.

Q. In this case do we know that the clots that eventuated in the pulmonary emboli which led to his death, do we know where they began?

A. It's probable that they developed at or below the level of the knee replacements and propagated into the thigh proximally from there.

Q. I want to make sure I understand what you're saying. Before when you talked about 95 percent sensitivity that was for predicting clots where?

A. At or above the knee.

Q. At or above. And it's your testimony that you believe that the clots/clot which eventuated in the pulmonary emboli in this case started at or below the knee?

MS. TOSTI: And propagated to the thighs.

BY MS. ROLLER, CONTINUING:

Q. Is that your testimony?

A. I'm not sure if that exactly characterizes the circumstance. But to go over my opinions about that, the total knee arthroplasty by itself and related to the surgical trauma and then the swelling of the tissue around the knee that's a natural consequence of the surgery will impair venous return from the calf and

contribute to stasis or slowing of the blood flow below the knee and around the area as an immediate consequence of the surgery. So the clot is likely to at the very beginning start right around the knee or just below the knee --

Q. I see.

A. -- and then to extend. Or there may be multiple areas in the affected part of the limb where a clot will form, and then they may coalesce into a large massive clot and then propagate proximally, meaning towards the bellybutton, and develop into a more expensive clot in larger diameter veins with a greater potential to break off and migrate to other areas such as the lungs.

Q. This DVT study that was ordered, it was a DVT study of what part of his anatomy?

A. I believe the lower extremities, but we can look at the order.

Q. Yes. Why don't we.

(Whereupon a discussion was held off the record.)

BY MS. ROLLER, CONTINUING:

Q. I'm looking at the order sheet that says under miscellaneous orders --

A Yes.

Q. -- DVT study 11-25 to rule out DVT.

A. Yes.
Q. But I'm not aware of it any more specifically defined.
MS. TOSTI: Deep vein is the title of the test.
MS. ROLLER: Thank you.
THE WITNESS: That would be interpreted as a bilateral lower extremity study especially in the context of having bilateral total knee arthroplasties.
BY MS. ROLLER, CONTINUING:
Q. Now if the result of a DVT study is concerning, what is the appropriate therapy?
A, It depends on the patient. But in a patient such as Mr. Hayes the appropriate response would, of course, be to contact the physician with the result immediately so that they could make a determination.
What would be the common course of action would be to evaluate whether he was a candidate for either thrombolytics, anticoagulation, or a filter placement in the inferior vena cava which is basically a wire mesh net that is lodged into the very large central veins where the pieces of clot might break off and flow through to prevent them from getting into the lungs.
Q. Now does a DVT study -- tell me what you'd see. Is it a film like an x-ray? What is the study? What does it produce?
A. Well it depends on which one of the studies. So, for

example, the color duplex study would look at the blood vessel, in this case a vein, and the Doppler color study would show different colors depending on the velocity of the blood flowing through it, for example, to show whether it was patent or not and how much of it was patent, and you could compare. And you could get ultrasound which would be basically a black and white and gray monochromatic picture.

Q. Is it a film like a CAT scan, an MRI film, an x-ray? I mean is it a film?

A. It's more like a movie which is recorded, and then standard pictures may be taken for review.

Q. I've never seen it.

A. They're cool.

Q. It sounds like it.

And is it in various locations of the lower extremity, or is it the entire vein?

A. Well they would study it at different levels.

Q. And on this movie?

A. Right.

Q. You said you'd contact the physician and then consider thrombolytics or anticoagulants. They're two different things?

MS. TOSTI: Or filter placement.

MS. ROLLER: Yes, or filter placement.

BY MS. ROLLER, CONTINUING:

Q. But I'm asking about the thrombolytics or anticoagulants. Are those two different things?

A. They are.

Q. Could you tell me what each of them are?

A. Sure. Well anticoagulation is something which simply inhibits the clot formation process which would primarily be intended to stop the clot from enlarging and hopefully give the patient time to solidify the clot. Because the natural process is for the clot to harden, contract, become endotheliolized, recanalized, reabsorbed, and secured so that it's not as likely to break loose and go off.

Q. And heparin and lovenox are both anticoagulants?

A. They are as is coumadin or warfarin.

Q. Any other anticoagulants that are used for this purpose?

A. Well enoxaparin and other low molecular weight and medium molecular weight forms of heparin. But functionally they do much the same. They're just easier to administer and monitor.

Q. How is that different than thrombolytics?

A. Thrombolytics actually dissolve the clot and can mitigate the risk of it breaking off by actually dissolving it. So it's more like Draino for blood clots.

Q. And what is an example? What kind of medication?

A. Streptokinase, urokinase, TPA.

Q. Can you tell me under what conditions that you would order a filter placed as opposed to treating the patient with either thrombolytics or anticoagulants or both of those? Under what circumstances would you place a filter?

A. In a patient that was at an unacceptably high risk of complications related to the other forms of treatment and/or at immediate risk of big clots breaking off.

Q. Because that's an invasive procedure I take it.

A. Minimally invasive but it is invasive.

Q. How long does it take to obtain results from a DVT once the study has been done?

A. Usually the tech reads it, and it's available immediately. I'll often get a phone call right away.

Q. And who in this case would have been the appropriate person to call if the DVT study had shown results of concern?

A. You mean for the DVT technician to call?

Q. Excuse me. Yes.

A. They could call the attending physician and/or the facility.

Q. And then how long does it take -- once a physician has determined the appropriate therapy to begin or medication how long does it take for it to become effective?

A. Well, for example, if Mr. Hayes had gone to the hospital to have the DVT scan as it had been ordered, it's my opinion that that DVT scan would have been positive or abnormal and that it would have been clear immediately so that the technician would page the attending physician or responsible party while Mr. Hayes was still in the DVT office at which point he would probably have gone to the emergency room.

Or if they're set up with a vascular lab where he could have been treated immediately, he probably would have had a filter placed within an hour or so, two hours, but certainly the same day.

Q. What is the basis of your opinion that the DVT study on November 25th would have revealed the presence of thrombolytic material'?

A. Thrombolytic material would be like the TPA or the streptokinase. It's my opinion that the DVT study would have shown a clot based on my review of the clinical records and understanding of the pathophysiology and my clinical training and expertise.

Q. Well it's certainly possible, is it not, that the thrombus could have developed after November 25th, 1997?

A. In my opinion that's extremely unlikely.

Q. Why is that?

A. What appears to be probable in my opinion is that the

time course of the postoperative edema and stasis in the venous system was such that he was at very high risk for DVT starting immediately postoperatively and that it would take a certain amount of time for that clot to develop and propagate.

It's very unlikely that the test would have been normal on the 25th and develop to such a degree between then and the 27th so as to cause this problem.

Q. Can you give me some time frame on how long in your opinion it takes to develop from a thrombus to the condition of a pulmonary emboly so as to cause death?

A. It varies with the circumstance, but the circumstance that put Mr. Hayes at a high predisposition for forming thrombus was the knee surgery. And there was not a substantial change in his clinical circumstance between the period of the 25th and the 27th as to put him at substantially higher risk than between the 23rd and the 25th.

And just the natural history and epidemiology of when these things occur in relation to the surgery is such that it is most likely that it was developing from relatively soon after surgery. It may or may not have reached clinical significance, you know, within a couple of days, but that probably had become established at least in the calf and around the knees around the time of

his first day or so there and would very, very likely have been readily detected on noninvasive testing on the 23rd -- or rather on the date of the 25th which is when the DVT study was ordered.

Q. I take it though that there is a variability in the rate of development of a thrombus to grow in size, to become dislodged, the rate of its movement. I take it that all of those issues are variable from patient to patient.

A. All biological parameters have some variability, hut this is not a surprising circumstance. It would be extremely unlikely for the patient to have not had clinically detectable thrombus at the time the test was ordered on the 25th and then to suddenly develop fatal pulmonary emboli thereafter. Because it is known that these things most commonly develop in the three to five days thereafter just in a general circumstance, and that's presumably why the attending physician ordered the DVT study to be done on postoperative day five.

Q. You've reviewed the autopsy report?

A. Correct.

Q. And it indicates that with respect to the lungs that -- (Indicating.) I recall seeing reference to a shower of thromboemboli, and I forget where that reference of a shower was.

But in the lungs it does say on page four and

then to the top of page five there are multiple thromboemboli present in the small and medium-size branches of the pulmonary artery. The emboli are present in all lobes of both lungs. Parenchyma of the lungs is unremarkable.

What significance do you take from that finding with respect to the development of the thrombus from the deep veins if any that that was the finding in the lungs?

A. I relate the multiple pulmonary emboli shown at autopsy to the most likely source being the lower extremities, an area around the total knee arthroplasties.

Q. But is the configuration of what you see here, does it give you any clue as to whether it's one clot that develops and moves up or whether it's a multiple maybe smaller thrombus that then emerge as if on a sudden burst? Does it tell *you* anything with respect to this is the presentation at autopsy?

A. That's a good question. What I think we can infer from this is that there were multiple emboli. But it's hard to say a lot with respect to the size, because a large embolus can break up into pieces.

And, of course, just thinking about it in terms of plumbing, a large clot will become stopped as the narrow of the blood vessels tapers to that same diameter. However, because the body has its own process to dissolve

clots and try to protect vital organs like the lungs there is a process to dissolve that clot to the extent the body is able to.

And the clots can also be broken up because of mechanical forces; and, therefore, it could have been a large clot that breaks up into multiple pieces.

I infer though from the diffuse nature that there were probably multiple emboli reflecting an extensive venous clot in the lower extremities, and whether some of them were quite large and then broke up to fit into the small and medium branches of the pulmonary artery is something I can't comment on.

Q. Let's move on to something else. You in your report, I think it's paragraph ten, state that in your opinion Mr. Hayes had a life expectancy of at least four years on November 23rd, 1997, correct?

A. Yes.

Q. First let me just ask you how you determined that, your basis for that statement.

A. Sure. Well it's based primarily on my clinical training and background in conjunction with a detailed review of his medical records.

Q. it's fair to say that there are written studies or charts that give you life expectancy if you plug in certain factors. Did you use any source material in reaching

that opinion?

A. Well the way I would typically do that and did in this case would be to try to determine life expectancy using several different approaches and hoping that they converge which in this case they do.

So, for example, certainly looking at a life table and seeing what the average life expectancy for someone of this sex and age would be is one point of reference.

Q. And do you know what the life table states about Mr. Hayes?

A. It depends on what life tables you look at. Some do general population; some do by sex, by race; some do by health conditions and so forth. But the average life expectancy for a black male of his age would be between nine and ten years.

Q. Are you referring to any particular life table in reference to that?

A. One I recall is a 1993 life table that is a general national frame of reference that is put out by the United States government. (Indicating.) And I might have something. As I mentioned, it's only a point of reference, but it is one.

Q. Now I didn't know those were part of your notes. Is there any reference to a life chart in those notes?

A. Well I had hoped it was in this stack of materials, but it is certainly a standard sort of an item that I could either produce one of or similar.

Q. Where did you obtain it?

A. The 1553 tables?

Q. Yes.

A. I probably have it in my office, and I think you may have it as well.

MS. TOSTI: We discussed it at some point I remember.

MS. ROLLER: Is this part of the documents that you have?

THE WITNESS: What you have I don't know.

MS. TOSTI: I have a copy of it.

MS. ROLLER: Well I'd like to see it, because he said he made reference to it. Do you have it with you, Jeanne, or any other life table information?

MS. TOSTI: Let me see here.

THE WITNESS: Should I continue with my answer as she's looking for that?

MS. ROLLER: Is that all right, Jeanne?

MS. TOSTI: Go ahead.

THE WITNESS: So life table information would be one point of reference. And to the extent it might be available, multidecrement life table information might

also be useful if the medical conditions in those multidecrement life tables relate to the patient's condition.

BY MS. ROLLER, CONTINUING:

Q. Multidecrement? That's a new word for me.

A. I'm sorry.

Q. D-E-C-R-E-M-E-N-T?

A. Yes.

Q. What does that mean?

A. I suppose we didn't talk about my research fellowship, but one of the areas of interest I had was in terms of determining how different health conditions affect life expectancy for patients.

But a multidecrement life table is similar to the general life tables that I suspect you're familiar with that give life expectancies, but then they break down how a given condition, let's say diabetes or strokes or cancer, affect the mortality.

So if you, for example, take a thousand people and chart out for every year for the next hundred years how many of them are surviving, you would see a decline in the number, because none of us live to a thousand years. And it would break down how many of those die due to the different causes; and, therefore, you get some indication of how much of that mortality or attrition in

the population is related to those different conditions.

So, for example, we know that the five leading causes of mortality in people in his age group would be things like, you know, heart disease and stroke and COPD and diabetes and cancer. And so if we have some detailed information on how much of the attrition in the population is duo to each of those causes and I can clinically determine his risk either compared to average or absolute for each of those conditions, I can fine-tune that information in terms of determining his life expectancy and use that as another point of reference in conjunction with my clinical judgment and review of the records and fine-tuning what his life expectancy is.

Q. Thank you very much for that, because we'll get back to it in one second.

MS. ROLLER: Jeanne?

MS. TOSTI: I have a copy of the 1993 Vital Statistics of the United States Life Tables. This is my copy and not in his file. So for reference that you've requested it from me you can look at it.

MS. ROLLER: If I can maybe ask Dr. Persky --

MS. TOSTI: Whether that's one he looked at I can't say.

BY MS. ROLLER, CONTINUING:

Q. That's the question, whether or not the document you're

looking at right now is the same as the life table you referred to earlier being from the U.S. government.

A. Yes.

MS. ROLLER: Can we make a copy of that, Jeanne, since he looked at it? Let's just mark that as Exhibit C.

MS. TOSTI: As long as it shows that this is my copy and not anything with his notations on it.

MS. ROLLER: That's fine.

(Whereupon Deposition Exhibit C was marked for identification by the Notary Public and is attached.)

(Recess held at or about 3:30 p.m.)

(Back on the record at or about 3:34 p.m.)

BY MS. ROLLER, CONTINUING:

Q. You have defined for us this multidecrement table. Is it actually a table?

A. Yes.

Q. And you made reference to some work you did as, what was it, a fellow?

A. Part of my research fellowship was working with multidecrement life tables.

Q. Did you publish anything on that?

A. I don't think so.

Q. Now where would one find the multidecrement life table?

A. For example, the public health library at the University of Michigan, or I would expect in many of the same places where you could find life tables similar to the one we've just had copies made of.

Q. And if you could just explain one aspect of those tables. You mentioned, for example, five different conditions that contribute to one's earlier demise than if they didn't have those conditions. How does a multidecrement life table take into account if a person has perhaps two of those conditions or three of those conditions?

And I guess what I'm specifically asking is is there a multiplier effect? In other words, it's not just you add on the same amount of reduction in the life, or is there a multiplier effect?

A. Boy, those are great questions, and those are fundamentally research questions. But if you want, I could answer those.

Q. Well let's just review with respect to Mr. Hayes' conditions that would show up on a multidecrement life table, because it's fair to say that he had a number of conditions that challenged his life expectancy. Is that fair to say?

A. A number can read from zero to infinity.

Q. He had more than one.

A. He had health conditions that would affect his quality of

life and survival. And normally in determining life expectancy we would want to do our best to determine what clinical conditions that we knew about might affect his life expectancy a5 well as whether there might have been preclinical conditions that would likely become evident in the future to the extent we can determine that based on clinical judgment and the tools available to us.

Q. What conditions did you consider for Mr. Hayes?

(Whereupon a discussion was held off the record.)

THE WITNESS: Well I looked at his medical records and, you know, determined his different medical conditions of significance and also looked at the autopsy to try to identify the severity of the conditions we knew about as well as whether or not there might have been other conditions that would have been important to identify preclinically, or their absence also would be important. So are you looking for an enumeration?

BY MS. ROLLER, CONTINUING:

Q. Yes, I am, please, at this point.

A. Well let me go through some of the highlights and also mention that just as you're asking about how do all these different things add up and is there a multiplicative effect and added effect and so forth, statistical methods will never replace clinical judgment in looking at this

kind of thing comprehensively and offering an expert opinion.

But some of the things I felt were clinically relevant when I reviewed his record with both quality of life and life expectancy had to do with mild COPD which showed up as causing shortness of breath with exertion. He had high blood pressure. At one time he had aortic stenosis which had been treated successfully with a prosthetic or artificial valve which resulted I recall in a resolution of I think a left hypertrophy which is thickening of the left ventricle as a result of blockage of the left aortic valve.

Q. I'm sort-y to interrupt, but on that point did you then eliminate that as a contributing factor to lowering his life expectancy? In other words, aortic stenosis was remedied by aortic valve replacement. That's what you felt?

A. Yes. Although we would have to factor in the life expectancy of the prosthetic valve and whether there was any potential risk of needing subsequent surgery and things like that which based on the autopsy as well as the clinical history did not seem to be a problem. They particularly mention how nice the valves looked and so forth.

He had some rare confusion episodes that had

been mentioned. And although the circumstances aren't defined in the references that I saw, I did note that. But there were also some episodes of delirium in the hospital which I don't make particular significance of, because it's so common among older people with and without cognitive impairments.

I notice the fact that he had osteoarthritis which was largely responsible for his gait problem and need for bilateral knee replacement, but I expected that would have been taken care of by and large with the knee surgery had he survived the recuperative period.

And he had nocturia, meaning urinating at night, and a history of a prostate condition requiring treatment.

Q. Was that cancerous at any point?

A. There was not a significant prostate cancer. And I'm not aware as to whether there might have been microscopic specks of things when enlarged prostate tissue is removed surgically. But as far as I'm aware, he did not have a clinical significant problem with prostate cancer.

And he had a history of congestive heart failure mentioned in the past, but I believe that was related to the aortic stenosis which again was taken care of with the surgery. And he was clinically fine with that.

And so those are the main conditions that I considered. He was a little bit overweight. And so those are the factors that might negatively affect either his quality of life or life expectancy.

And, of course, there are certain things that stand out as being very positive in terms of his life expectancy. Partially the absence of many of the either fatal conditions or disabling conditions that people experience. We talked about some of the ones that we consider.

Q. Such as diabetes?

A. "Such as diabetes."

Q. Anything else that you can think of?

A. Sure. Well he didn't have clinically significant COPD from what I see.

And with respect to the question of whether he did or didn't have a stroke, I only saw reference to that without knowing the basis. But I do also see that there was autopsy information that indicated that, you know, both on CT and pathologic examination that there was no significant stroke damage done to the brain. So I'm not at all clear as to whether he did or didn't have a stroke in '95 and if so of what if any significance that was.

But other factors that I was getting to was also the fact that he lived with his wife and, therefore,

had good social support. He was well-nourished. He had a good quality of life, activities and so forth, and there was reasonable expectation of that continuing for many years.

And then the family support being local and so forth, other social and psychological factors, and absence of things that affect quality of life like depression or, you know, major life traumas as well as the absence of some of the medical conditions or the mild nature of some of the medical conditions that he had.

Q. So you've provided us with a list of what you factored in for Mr. Hayes with respect to determining his life expectancy.

A. I identified the main clinical factors that I considered.

Q. With respect to his hypertension, how did you rate that? Was his hypertension, his Glood pressure, controlled, poorly controlled?

A. Well there are a couple ways to think about that clinically. One way is looking at his blood pressure. Another is by looking at the end organs which are commonly affected by blood pressure which would include the retina in the eye, the kidney a5 shown by serum creatinine primarily as well as urinalysis, looking for protein in the urine.

And 1eft ventricular hypertrophy is something

that can happen to the heart if it's straining such as could occur in controlled hypertension And aortic stenosis and so forth.

So from the perspective of looking at blood pressures and seeing how he was doing, there were times when it was marginally controlled and other times when it was well-controlled. And I didn't look to see why it was not optimally controlled at all points in time, but there were times that it was well-controlled and times that it was not as well-controlled.

Q. I guess I'm just asking with respect to what factor his blood pressure -- did you factor it as a severe problem, moderate problem?

A. I wouldn't necessarily use that categorization, but I weighed in the relative lack of end organ disease and the generally adequate control but not uniformly optimal control.

Q. He did have cardiac disease with left ventricular hypertrophy.

A. Prior to '95 and the aortic valve replacement. I'm not aware of him having it subsequent to that time. And we also have the pathology from the autopsy that did not describe left ventricular hypertrophy.

Q. Did you note that he had a stenotic liver?

A. I did not note -- he did not have a stenotic liver let me

say, but he had fatty infiltration of the liver to some degree which is not a clinically critical thing.

Q. Are you aware that the final anatomic diagnosis lists -- well it says S-T-E-A-T-O-S-I-S of the liver.

A. Steatosis.

Q. Okay. What is steatosis?

A. Fatty infiltration.

Q. And what is that condition?

A. It's not typically of clinical significance. If he had cirrhosis of the liver, that would be of clinical significance or a variety of others things.

Q. Could you show me the particular reference?

A. Page one under final anatomic diagnosis.

MS. TOSTI: (Indicating.)

THE WITNESS: Steatosis as we had described.

BY MS. ROLLER, CONTINUING:

Q. What is severe ulcerating athrosclerosis abdominal aorta?

A. That is hardening of the arteries in the aorta which is the main blood vessel that supplies the legs.

Q. Is that a significant factor here to determine his life expectancy?

A. Hardening of the arteries is certainly an important consideration, and the severe ulcerating athrosclerosis in the abdominal aorta is certainly something I would consider and would need to consider along with the other

evidence for and against vascular disease.

Q. Should we add that to your list then? I didn't hear you mention it earlier, did you?

A. Well I talked about vascular disease. And I didn't mention that particular aspect of it, but certainly that was considered. I'm sorry I didn't note vascular disease. We were talking about the risk of stroke and so forth.

Now something like this could cause peripheral vascular disease depending on the circumstance. But more commonly if little plaques break off of the atheromas in the abdominal aorta they're going into the legs at that point, and they're not usually clinically significant. But it could be a mark of associated disease in the lower extremities which was not identified on the autopsy.

Q. Let me just ask you about one other area. With respect to his condition, you made reference to that he had a rare confusion episode and a note of delirium in the hospital. What do you attribute that to?

A. As I think I mentioned briefly at the time, those are separate events. And there was a reference to rare confusional episodes which are a little hard to interpret, because I don't know the circumstances and whether it was a reference to things that happened, for example, when he went in for his aortic valve replacement

or whether they were things that happened at home, whether he was having, for example, a urinary tract infection or other metabolic-like condition that might cause such a thing without being of any significance.

But I take that to, you know, suggest that he had some sensitivity with respect to his cognitive functioning to metabolic insults.

Q. Enough that it is mentioned in his history.

A. Yes.

Q. That is it's not just a one-time incident. It's happened on more than one occasion.

A. When they say "rare confusional episodes," I would guess that they're referring to one or two times over a decade or something in that neighborhood.

Q. He also has been noted in his history to have a right occipital CVA cerebral accident.

A. A history of.

Q. I'm reading it as H/O history.

A. Yes. H/O would mean history of.

Q. And what I was trying to clarify is whether you saw any diagnostic test that identified that from perhaps some medical records that I don't have.

A. But I did see a reference which I did mention as I was going through my list of a possible stroke in 1995. And in conjunction with interpreting that I also looked at

the CAT scan autopsy information done after his death that didn't show such a problem.

Q. Putting all that together then how is it that you came up with that life expectancy for him of four years?

A. Well considering his clinical history and medical records as well as the life table information and so forth 1 think that -- just to touch back on five major causes of death that we discussed earlier, his COPD was mild and not likely to be a significant cause of either morbidity or mortality certainly in the next five years and probably longer.

With respect to heart disease, we have both clinical tests and pathology information to suggest that he didn't have significant coronary artery disease.

With respect to cerebral vascular disease, we have a clinical suggestion of an event in 1995 without any confirmation or recurrence up to the time of hi5 autopsy and no significant damage based on the autopsy CAT scan and metroscopic exam.

He did not have diabetes. He had normal kidney function based on serum creatinine and other tests that were done. And he had no clinical history of significant malignancy nor did the autopsy identify any preclinical malignancy all of which I think would give him I think in a lot of respects a good life expectancy in relation to

the norm.

And on my report I put that I would estimate it to be at least four years, because I wanted tu be conservative and not finalize my estimation of life expectancy. But at this point based on more extensive review I would place it upwards from four years and put him somewhere in the middle of his age and race distribution.

Q. Meaning specifically what?

A. Meaning at least eight years would be his life expectancy with a reasonable degree of medical certainty certainly.

MS. ROLLER: Did we mark this?

MR. GOLDSTEIN: We did. It was Exhibit C. That's my copy.

MS. ROLLER: Could I look at it?

MR. GOLDSTEIN: Sure. You can look at it.

BY MS. ROLLER, CONTINUING:

Q. The life table from the United States Vital Statistics 1993 that you mentioned earlier that we marked as Exhibit C for a 72-year-old black male is 9.9 years.

A. Right.

Q. And you're saying that you believe now that his life expectancy is eight years?

A. I'm trying to be conservative in saying that it would be at least eight years, because on balance of the nature of

the clinical conditions and his anticipated recovery from the total knee arthroplasties I would expect him to have recovery and average life expectancy for his age and sex.

Q. And the fact that he does have COPD, albeit mild, he does have a blood pressure/hypertension issue which at times has been noted to be uncontrolled -- you do agree with me that it was noted in his records?

A. Yes.

Q. That he has aortic valve replacement and has had some suggestion of a vascular episode in the past --

A. Right.

Q. -- with episodes of confusion, osteoarthritis, congestive heart failure. All of those factors exist in this man, and you are now stating that his life expectancy you think is eight years as opposed to the four years stated in your report?

A. I believe that was intended as a question.

Q. That's a question.

A. And we have to separate out things that would affect survival from things that would affect function, and in my report what I stated is that it would be at least four years, I didn't say that it would be four years. Let me please be clear about that.

And based on further review I can now tell you that it is my opinion that his life expectancy is fairly

close to the average for his age and sex because of some of the factors we've talked about; for example, the relative absence of the common fatal conditions or the mild nature of them and the fact that older people commonly have chronic diseases in varying levels of severity.

So we're not comparing him to, you know, healthy 40-year-olds who don't have a disease burden. So that the norm for a 72-year-old gentleman is to have some disease burden. So we have to look at the nature of the problems, the severity of them, and the likelihood that they would affect survival.

Now based on further review I can state and it's my opinion that his likely survival would be more than four years and would be between the mean stated as the fiftieth percentile in the life tables and the four-year figure.

Q. The mean, is that 9.9 or half of 9.9?

A. That's a good question. If you look at different life tables, they will vary between nine and ten. So I guess I would state that I'm comfortable offering the opinion that it would be close to eight years. That his life expentancy would be close to eight years.

And, you know, if you want me to try to pinpoint it between six and ten by the six months, I

guess I'd have to go and, you know, sharpen my pencil and try to come up with a precise mean for you. I guess you do need that though.

Q. Well is it fair for us to understand that your opinion is that his life expectancy is somewhere between four and eight years?

MS. TOSTI: I think he just said six to ten.

MS. ROLLER: No. I'm not sure what he said. That's why I'm asking the question.

THE WITNESS: It's a fair question. I'm certainly comfortable offering the opinion that it's more than six years.

BY MS. ROLLER, CONTINUING:

Q. Can you be any more specific than that? Do you have an opinion that is more specific than that?

(Interruption.)

THE WITNESS: I believe the question was what's his life expectancy with as much specificity as I can give you, and based on further review I can offer you my conservative opinion that his life expectancy was at least six years and no greater than ten.

And I suppose if you want the most precise average of those two then we could split it down the middle and call it eight. But I'm certainly comfortable stating that his likely life expectancy was at least six

years, and my best guess --

MS. TOSTI: We don't want you to guess.

THE WITNESS: -- is something you don't want.

BY MS. ROLLER, CONTINUING:

Q. The notebook over there with your handwriting in it, what is that?

A. These are some preliminary notes I made in going through the depositions and medical records.

Q. I would like to make a copy of that and take it with me.

A. Okay.

Q. Make it two copies. And let me just go back for one moment, and that's all it's going to be.

I had previously asked you questions about your report and specifically in reference to paragraph seven where you identified that in your opinion it was a failure of the Judson Retirement Community personnel to schedule the DVT study as ordered and to follow-up to ensure its completion and that that was below the standard of care.

That paragraph in your report makes reference to the scheduling of the DVT as well as to follow-up to ensure its completion, does it not?

A. Correct..

Q. And I asked you to identify for me the individuals you felt at Judson should have ensured that not only it was

scheduled but that it was completed and that the DVT study was done, and you identified I think not by name but by --

A. Role.

Q. -- role three types of individuals: the unit clerk, the clinical person, and then a charge nurse on the unit, correct?

A. Something along those lines. I think we talked about the person who was supposed to do the scheduling, the person who was supposed to clinically supervise them to make sure they were doing their job, that they were trained and prepared to do their job, as well as the person who I would expect would be the Director of Nursing. Someone who would hire appropriate personnel, train them appropriately, and also put in place a mechanism to make sure that they were doing their job, that the test had been scheduled. So that not only a mechanism was in place to get it scheduled and double-checked but to ensure that this was being done with a reasonable degree of reliability.

Q. Is it your testimony that anybody who came into contact with Mr. Hayes had responsibility to make sure that test was done?

A. No.

MS. ROLLER: I have nothing further. Thank

you.

MR. GOLDSTEIN: I'm going to ask you some questions at this time, Doctor, but I want. to afford you the opportunity to stretch your legs or take a short break and our Court Reporter, of course.

THE WITNESS: No. I think we're fine.

MR. GOLDSTEIN: Doctor, I'm attorney Bruce Goldstein. I represent Judson Retirement Community.

EXAMINATION

BY MR. GOLDSTEIN:

Q. I sat here through the questions of you by attorney Roller, and she has fortunately for all of us asked many of the questions I had designated and prepared to ask you. So I'm going to try to eliminate virtually all of the questions I think have been asked of you and attempt to avoid any duplication of questions that have been asked and answered. Okay?

A. Okay.

Q. I may fail in that regard, but I'm certainly going to exercise some caution to avoid it.

If I ask you a question and my question is unclear to you, (A) forgive me. And (B) let me know, and I'll try to clarify it. Okay?

A. Okay.

Q. We'll be reasonably brief given the fact that most of these questions have been asked.

Do you have a private practice of medicine?

A. It depends on how you define private practice? but I do see patients privately or individually without trainees, nurse practitioners, or others involved such as are commonly found in the teaching situation.

Q. It's my understanding from your testimony that you are an internal medicine physician, and you have a subspecialty in geriatrics.

A. That is correct.

Q. If I lived in the Ann Arbor area and fell within the age group of patients that you would see, I could come to you a5 a patient?

A. That's correct.

Q. Do you have any understanding as to how attorney Tosti's office located you?

A. I don't know.

Q. You never made an inquiry a5 to, "Hey, how did you find me?"

A. I might have asked about that in an initial phone contact but don't recall.

Q. Fair enough.

Do you register yourself with any services that identify experts in particular areas of medicine?

A. No.
Q. We have previously identified the records that you were given here today, correct?
A. Correct.
Q. And as you've testified here today and up to this point, is there or are there any additional information which you've received that you've omitted to tell us about?
A. I believe we've covered it all.
Q. Fair enough. Sometimes you may have forgotten a thing or two and recall it as we pressed through. I wanted to afford you the opportunity to think back for a moment.
A. Thank you.
Q. You're welcome.

Did you go outside of the materials provided to you by attorney Tosti to help formulate any opinions you've expressed in this case? You mentioned the life tables.

MS. TOSTI: Aside from the materials he's already mentioned?

MR. GOLDSTEIN: Yes.

BY MR. GOLDSTEIN, CONTINUING:

Q. Outside of the materials provided you and if there's any materials like the life table which was not provided to you.
A. As a basis for my opinions?

Q. Yes, sir.
A. No.
Q. Or as for any reference to support an opinion.
A. No.
Q. All right. And you have looked at the depositions of Dr. Atkinson, Dr. O'Toole, Nurse Thill, Nurse Hayes. Any others? Did you look at Nurse Soukup's deposition testimony?
A. I did not. I don't think you mentioned Dr. Irvin.
Q. And, thank you, Dr. Irvin.
A. Those were all that I reviewed.
Q. Doctor, you indicated and Miss Tosti confirmed that certain items have been removed from the file, matters which Miss Tosti contends are work product. I don't know that they are, and I don't want to go into that particularly here.

But I do want to ask *you* this specific question. Were you asked to form an opinion or to offer an opinion as to the potential culpability of any doctors in this case?

A. I don't recall. I was asked to evaluate the case generally and identify violations of the standard of care if any were found, but I don't recall her naming any particular individuals.
Q. And since I don't know because the items have been

removed -- I don't know what the charge was that was given to you in this matter specifically. Okay. And I'd like to know what that charge was specifically, but at this moment I'm going to have to rely solely on your memory unless Counsel wants tu produce a letter which would identify what you were charged with in this case.

MS. TOSTI: You have the letter he was given as to what he was charged with in this case.

MR. GOLDSTEIN: Actually if you'd hand it to me, that would help.

MS. TOSTI: (Indicating.)

MR. GOLDSTEIN: Thank you.

BY MR. GOLDSTEIN, CONTINUING:

Q. I'm going to read the letter just *so* -- I don't think it tells me what you were charged with doing. It's dated January 14th, 2000, addressed to Dr. Persky, and it states in relevant part: Thank you for agreeing to review the medical record of the decedent, William H. Hayes, and for agreeing to reach an expert medical opinion should you find an adequate basis to do so.

After you have had an opportunity to review the enclosed materials, I would like to speak with you by phone in our Cleveland office to discuss your findings. Please do not write a report at this time.

And the letter concluded by identifying what is enclosed for you to review and then stating: I look forward to speaking with you with regard to your findings. Should you have any questions or need additional information, please do not hesitate to contact me. Thank you, et cetera, Jeanne Tosti.

That doesn't tell me what you were asked to do other than to render an opinion. So I don't know if you were asked to render an opinion as to the standard of nursing care in this case, the medical care provided in this case, or the conduct of any individuals in this case, and that is my question to you. Were you asked to provide an opinion as to the medical care provided, the nursing care provided, or the conduct of any individuals?

A. What I recall as being the content of my telephone conversations with Miss Tosti as well as any written communication was to review the files and depositions and identify any potential problems which related to the care he received. And because of my background and training I would naturally look at both the facility and clinical personnel involved.

So although I can't tell you for sure what I was specifically asked to address at any particular time, I can tell you that. I did look at the care provided by the various staff that were in contact with him.

Q. Including the doctors?

A. Including the doctors and the nursing personnel. And I feel comfortable in offering the opinions that I have with respect to those.

Q. Do you have an opinion as to whether Dr. Larry Irvin was negligent in this case?

A. I do.

Q. What is your opinion?

MS. ROLLER: Objection. And we'll move to strike it and any use at trial as well. Go ahead. It was not previously stated in the report or any supplemental information thereafter. Go ahead.

THE WITNESS: I didn't identify any violation of the standard of care with respect to Dr. Irvin, his practice.

(Whereupon a discussion was held off the record.)

BY MR. GOLDSTEIN, CONTINUING:

Q. And the reason --

MS. ROLLER: Withdraw the objection.

BY MR. GOLDSTEIN, CONTINUING:

Q. The reason I am asking you the question is because of your comment to number seven, failure of Judson Retirement personnel to schedule the DVT study as ordered and follow-up to ensure its completion.

Doctor, have you been in situations in your practice where a test was ordered for a patient under your care by perhaps a cophysician in the case?

A. Can you repeat the question?

Q. I could rephrase it perhaps.

A. Because I work with faculty colleagues as well as supervising fellows and residents as well as a whole team of people in an outpatient clinic or long-term care setting.

Q. Afford me to make the question more specific to Mr. Hayes' case. That might be more appropriate to address.

In this case Dr. Hissa was the surgeon who did the bilateral knee replacement surgery, correct?

A. Correct.

Q. Dr. Hissa ordered that the DVT study be done on November 25th, 1997, correct?

A. He wrote an order to that effect.

Q. I assume the answer to my question is yes then.

A. Okay.

Q. You agree with it. I want to make sure we're on the same page.

MS. TOSTI: He was one of the persons. Is that what you're saying?

MR. GOLDSTEIN: I don't know who else could

have ordered the study.

MS. TOSTI: Well, take a look at the orders, and see who wrote the orders and signed them. I will object to that if you're implying that Dr. Hissa was the only person that ordered that particular DVT study.

MR. GOLDSTEIN: I'm just looking to get it right.

BY MR. GOLDSTEIN, CONTINUING:

Q. Who all ordered a DVT study be done on November 25th, 1997?

MS. TOSTI: If you'd like to look at the medical records --

MR. GOLDSTEIN: Absolutely.

MS. TOSTI: -- go right ahead.

THE WITNESS: I don't need to for purposes of this question I don't think. But I believe that Dr. Hissa and colleagues perhaps initiated an order for a DVT study on postoperative day five.

BY MR. GOLDSTEIN, CONTINUING:

Q. And when you say "colleagues" --

A. Well, for example, there may have been a resident or either a colleague or someone under his supervision at the hospital with authority to initiate that from the hospital to be done in the skilled nursing facility.

Q. Okay.

A. And that would be communicated in a combination of ways: written discharge order, possibly verbally as well and so forth.

But if I understand the nature of the question, I don't believe that -- well let me start that statement again. I don't know that Dr. Hissa has attending privileges --

Q. At Judson.

A. -- at the long-term care facility. Judson in this case.

Q. Let me then lead into the next part of my question for you. Dr. Hissa and/or colleagues at Meridian Hillcrest Hospital ordered a DVT study to he done on November 25th, 1997, correct?

A. Correct.

Q. Mr. Hayes was then transferred to Judson Retirement Community on or about November 23rd, 1997, correct?

A. Correct.

Q. While at Judson Retirement Community Mr. Hayes came under the care of other doctors, correct?

A. Correct.

Q. Dr. Atkinson for example; is that correct?

A. Yes.

Q. Do *you* recall who Dr. Atkinson was?

A. Dr. O'Toole I believe was the Medical Director at Judson --

Q. Correct.
A. -- who had an administrative role at the facility. And Dr. Atkinson as I recall was the attending physician for Mr. Hayes once he was transferred to Judson.
Q. Are you able to tell me what the role of an attending physician is particularly as it relates to Mr. Hayes in this case?
A. Sure. And it will depend on the particular facility and organization in terms of specific responsibilities.
Q. But generally.
A. Generally an attending physician is the physician responsible for providing medical assessment and care and participating in team assessment and care of a patient.
Q. All right. And in addition to the attending physician there would be other physicians who had a role in the patient's care, correct?
A. Absolutely.
Q. In this case, for example, Dr. Irvin?
A. Correct.
Q. Dr. Irvin was a fellow at Judson.
A. He was a fellow at the University on a geriatric fellowship with an assignment at Judson.
Q. Thanks for being more clear on that.
A. All right.
Q. So the question that I'm attempting to get to by working

through this with you is you have the doctors at Judson who have a responsibility to carry out orders from the doctors at Hillcrest, correct?

A. Well, no. Most commonly I would expect that the staff at Judson have a responsibility to carry out the orders as placed in the Judson medical records by the doctors with privileges at Judson.

Q. Would the doctors who have privileges at Judson have any responsibility towards following up on the execution of those orders?

A. It depends on the nature of the order and circumstance.

Q. How about a DVT study on November 25th?

A. Can you repeat the question?

Q. How about to have a DVT study on November 25th?

A. I'm sorry. I want to make sure who you're talking about with regard to the DVT study and what they're doing.

Q. Any of the doctors at Judson.

A. So if I understand your question, it's whether doctors at Judson --

Q. Who are attending to Mr. Hayes.

A. -- who are attending to Mr. Hayes have a responsibility to follow-up.

(Interruption.)

MS. TOSTI: Why don't you reask your question.

BY MR. GOLDSTEIN, CONTINUING:

Q. Did tho doctors at Judson have a responsibility in your opinion to follow-up to ensure that the DVT study which was ordered for November 25, 1997, was in fact done as ordered on November 25th, 1997?

MS. ROLLER: Objection. Go ahead.

THE WITNESS: No.

BY MR. GOLDSTEIN, **CONTINUING:**

Q. Would your opinion change if a physician has reviewed the chart, been aware that a DVT study was to be done on that day, then met with the patient on the day following November 25th?

A. Not based on my review of the medical record. There might be circumstances where the clinical history and exam might identify this as a clinically urgent problem which the standard of care would require them to perform some sort of follow-up or even send a patient to the emergency room to have the study done, but I didn't identify any such extenuating circumstance in the medical record.

Q. You would agree that Mr. Hayes was at high risk for DVTs following bilateral knee replacement surgery.

A. Absolutely.

Q. And you would expect that the doctors caring €or Mr. Hayes would know that.

A. I would.

Q. You would agree that the DVT study was an important diagnostic tool in determining whether or not Mr. Hayes was at risk of having a thrombus.

A. Yes, recognizing that there might be other clinically relevant reasons to get the DVT study as well.

Q. And notwithstanding those realizations you don't feel that any of the doctors at Judson had an obligation to follow-up to make sure that DVT study was done?

A. Correct. Because --

Q. Why?

A. --- as I've thought about this, physicians order tests all the time, CAT scans, DVT scans, blood tests, x-rays, and it is the standard of care and the implicit assumption that when those orders are written and clearly communicated that the facility will act on them and/or communicate if there's a problem in carrying them out as ordered. And the physicians would have to spend all their time double-checking to make sure that the clerks and nurses were doing their jobs and having no time to act as physicians if that were required of them.

So it clearly is not their job even though we may try to monitor some of those things. It is not the responsibility of the physician to do so.

Q. You have indicated to us the medical conditions that you were aware of which Mr. Hayes had at the time of his

admission to Judson, correct?
A. Correct.
Q. Now incidentally you're offering an opinion in this case as to the standard of nursing care at Judson Retirement Community.
A. That may well be.
Q. You are not a Registered Nurse, correct?
A. That's correct.
Q. You have never gone to nursing school; is that correct?
A. That's correct.
Q. And you are not aware of the standard of the State of Ohio as to who may offer an opinion as to the negligence of nurses in a nursing negligence case, are you, sir?
A. No. But there probably are some relevant qualifications that you might want to know about with regard to nursing practicing standards.
Q. In the State of Ohio?
A. Generally as well as in the State of Ohio.
Q. Okay.
a. And just in terms of my background, my training and administrative and clinical responsibilities lead me to participate in interdisciplinary teaching with nursing colleagues, to be responsible for teaching nursing students, clinical nurse practitioner students, in both clinical and didactic formats as well as supervising

their practice in a variety of settings including long-term care settings, community settings, outpatient practice and inpatient practice.

So I just mention that in terms of describing some background related to being involved in teaching, clinical supervision, clinical training of nurses at different levels as well a5 an emphasis on interdisciplinary practice and training as well as administrative responsibility of people in different disciplines including nurses in a variety of settings.

Q. You're not a medical director of a nursing home, are you, sir?

A. I'm not. I am --

Q. I'm sorry.

A. I am Associate Director for the Geriatric Center with responsibility for clinical programs which does give me administrative responsibility for long-term care settings among others.

Q. You don't have any ownership interest in any nursing homes here in Michigan, do you?

A. No.

Q. Or anywhere else?

a. No. Ohio or anywhere else.

Q. In reviewing the medical record of Mr. Hayes did you see any contraindication for him having bilateral knee

replacement surgery?

A. I didn't see an absolute contraindication. There's always risks as well as benefits to be weighed.

I recall he was evaluated for preoperative clearance and had some cardiology and testing done and was given clearance for the surgery which he went through fine in terms of the inpatient portion.

Q. I noted from a review of the records, Dr. Persky, that Mr. Hayes was expectorating some brown sputum at Hillcrest. Are you aware of that?

A. I am.

Q. What if any significance do you attach to that at the point when it was discovered at Hillcrest?

A. Well it certainly is an interesting and potentially important clinical finding in terms of the conclusion I believe Dr. Atkinson drew that it reflected bronchitis. But it also in retrospect raises the possibility that it may have been hemoptysis related to pulmonary emboli.

Q. I sensed -- and I don't want to put any words in your mouth or draw an erroneous conclusion. I sensed you may not have agreed with Dr. Atkinson's conclusion about bronchitis.

A. I think it was a reasonable conclusion based on the information available to her at the time. For example, as I recall, in addition to the brown sputum there was a

low-grade temperature, he was coughing, and there were no compelling signs of phlebitis at that time. So bronchitis was not an unreasonable conclusion for her to draw at least as a preliminary diagnosis.

Q. Do you see any indication as to whether or not Dr. Hissa was made aware of the existence of the brown sputum?

A. I don't recall that.

Q. Do you think he should have been made aware of it?

A. I'd need to look at the particular references in the medical record to comment --

Q. Okay.

A. -- at Judson.

(Whereupon a discussion was held off the record.)

BY MR. GOLDSTEIN, CONTINUING:

Q. The question is whether or not you saw any records from Hillcrest indicating the presence of the brown sputum.

MS. TOSTI: Oh, at Hillcrest.

MR. GOLDSTEIN: Yes.

THE WITNESS: And I'm not recalling those. So if you can refer me to any particular reference.

BY MR. GOLDSTEIN, CONTINUING:

Q. I looked through the Hillcrest records, and I couldn't find any reference. Perhaps the only question is whether or not the brown sputum originated while Mr. Hayes was a

patient at Judson, and I don't know if you can comment on that or not.

MS. TOSTI: Do you have another reference you want him to look at?

MR. GOLDSTEIN: I don't, Jeanne.

THE WITNESS: I don't recall brown sputum production in the hospital. But if that had been reported to the attending physician in the hospital, it is entirely possible that they would have concluded as Dr. Atkinson did that bronchitis is the likelihood. I don't know.

BY MR. GOLDSTEIN, CONTINUING:

Q. Are there other tests that can be done to verify if that was or was not bronchitis?

A. There are not any great tests to diagnose bronchitis. It's a clinical diagnosis and clinical treatment.

And if one had a strong clinical suspicion of pulmonary embolus in association with brown sputum, then there are tests that you can do to diagnose either DVT or pulmonary emboli if khat was clinically indicated.

Q. What tests could be done?

A. Well I described a series of ones that could be done to evaluate the possibility of DVT.

One can also look at the lungs with a test called a ventilation profusion scan which is sometimes

done or if necessary a pulmonary angiogram with contrast and x-ray picture.

Q. Doctor, based on your review of the Hillcrest Hospital records did you see any sign or symptoms of a deep vein thrombosis while Mr. Hayes was at Hillcrest?

A. None of a compelling nature.

Q. There was a notation in the supplemental nursing notes that a nurse was unable to dopple an OD pulse on the right foot. First off what's OD?

A. Can you show me the reference?

Q. I can actually. Doctor, I'm going to hand you the supplemental nurse's note from Hillcrest Hospital. It's not easily identifiable by page or description, but you're welcome to look at it. About halfway down the page you'll see the entry unable to dopple OD pulse.

A. Yes. And pulses are in the arteries --

Q. Yes.

A. -- and aren't related to phlebitis or DVTs. They wouldn't be affected one way or the other by that.

Q. Because the DVTs are in the veins.

A. That's right. And the soft tissue. And so I wouldn't take the lack or presence of a pulse as directly relevant.

Q. You indicated in response to my prior question about any signs or symptoms of a DVT at the hospital that there

were none that you felt were significant. What were present that you felt were insignificant?

A. I didn't say that there were. So I would need you to --

Q. You're not aware of anything?

A. I'm not recalling anything.

Q. Is a positive Homans' sign an indication of a DVT?

A. Not a reliable indicator. It's not sensitive or specific. We commonly teach people not to do it since there is not much point.

Q. Was Mr. Hayes on coumadin or heparin therapy at the time he was admitted to Judson Retirement Community?

(Whereupon a discussion was held off the record.)

THE WITNESS: Are you specifically referring to the time of transfer meaning the medicines he was receiving from the hospital, or are you referring to the medicines that were ordered and presumably administered to him at Judson?

BY MR. GOLDSTEIN, CONTINUING:

Q. I am asking you specifically was he on heparin or coumadin while a patient at Hillcrest Hospital.

MS. TOSTI: At Hillcrest?

MR. GOLDSTEIN: Yes.

THE WITNESS: I thought you said something about Judson.

BY MR. GOLDSTEIN, CONTINUING:

Q. I'm clarifying it. It's getting late. I may have blown the question, but it's clear now.

A. I don't have a specific recollection of his being on either at least in anticoagulant doses, but we could certainly review.

MS. TOSTI: (Indicating.) There should be a section on medications in here that you would be able to look at in these sheets. Are we in the Hillcrest records? Go to the front, Doctor.

BY MR. GOLDSTEIN, CONTINUING:

Q. (Indicating.) I'll represent to you those are Hillcrest, Doctor. And if you see a mistake, feel free to point it out to me.

MS. TOSTI: Doctor, here are the medication sheets, and here's the section, the first page, and the records right there.

THE WITNESS: And in addition to not recalling him being on those medications I don't identify either heparin or coumadin on the medication records from the hospital that you just. showed me.

BY MR. GOLDSTEIN, CONTINUING:

Q. Let me broaden the question, because I've only identified two of the anticoagulant drugs which you identified early in your deposition. To your knowledge was he on any

anticoagulant therapy while a patient at Hillcrest?

A. That wasn't a specific focus of my review, and I don't recall him being on anticoagulants. I recall in the preop he had been off of aspirin for some time. I don't recall for sure whether they had given him subcu heparin, but we should be able to determine that.

Q. That would be in the operative note?

A. Medication orders and medication records would be the places I would look for that.

Q. Would you please take a minute to do that?

MS. TOSTI: (Indicating.) These are the IV sheets and medications right there.

THE WITNESS: These are what we've just looked at. This is my copy of the records you've seen. And I can look up the doctor's order as well.

BY MR. GOLDSTEIN, CONTINUING:

Q. Whatever will help you answer that question I'm grateful for your assistance.

A. Sure, sure. I see no orders for heparin or coumadin. Just to be completely accurate I note the IV flush was ordered, and sometimes that is a heparinized solution but not enough to be of significance as an anticoagulant.

Q. Doctor, in a situation where a patient receives bilateral knee replacement surgery, and understanding based on your testimony in part that the risk of a DVT is greater in

those patients and in particular with Mr. Hayes, is there any reason that the prophylactic administration of an anticoagulant would not be indicated?

A. Yes.

Q. In Mr. Hayes' case was there any reason why he should not have received prophylactic anticoagulant therapy?

A. Well there are a lot of different strategies to reduce various postoperative and perioperative complications, and generally I would leave that in the hands of the orthopedist doing a bilateral total knee replacement.

But from the perspective of an internist in geriatrics I can talk to you about various strategies that have been tried at different times to reduce the risk of postoperative DVTs and pulmonary emboli.

Q. What strategies were employed with regard to Mr. Hayes?

A. With regard to Mr. Hayes as I recall he was given both TED hose and sequential compression stockings which are felt to be a very good prophylactic measure to reduce the risk of DVTs and pulmonary emboli.

Q. Are you done answering?

A. I can be. I don't know how much of a clinical background you want regarding different strategies that have been tried as enoxaparin, coumadin, and then doing DVT scans, heparinization. There's a lot of different protocols that have been used and the risks and benefits evaluated

in different subgroups of patients.

Q. With regard to Mr. Hayes, do you feel based on your education, training, and experience that he should have had additional steps taken in his care to reduce the chance of having an embolism or a thrombus?

A. Yes. First and foremost I think the DVT study should have been done on postoperative day five as ordered.

Q. Right.

A. And from my understanding of these issues that could have been sufficient to uphold the standard of care.

Q. All right. So you don't have a problem from the standpoint of a doctor reviewing this case that he was not given prophylactic coumadin or heparin or some other anticoagulant?

A. No, I didn't.

Q. You're comfortable with the fact that he was given stockings to wear?

A. Yes.

Q. And then the DVT study was ordered for post-op day five.

A. Correct.

Q. Doctor, with respect to the report that you authored in this case, were there any drafts of that report. which preceded the one that was submitted to us in this case?

A. I believe that I did on my computer prepare a draft as I was finalizing my review at that point, and so there may

have been one other version that I saved that would have been very similar. Maybe I broke one point into two or something like that. But that's as much of a variation as I would expect, one point of difference.

Q. Would you have sent any of those prior drafts to Plaintiff's counsel in this case?

A. I may have, and she could probably answer whether I did in fact do that or not.

Q. Although it's inappropriate for me to Cross-Examine her. So I'm asking you did you do so.

A. You know, when I was looking through my computer files, I did print out my report so that I could review that in conjunction with the medical records. And I'm pretty sure that I had saved another version of it, and I took the latter one which I knew was on the basis of my further review.

Q. Were you asked to make any changes in the report that you had submitted originally to Plaintiff's counsel in this case?

A. I don't expect I would have been asked to change any opinion, but there's a possibility that I was asked to clarify a point or address a point, whatever my opinion would have been.

Q. I take it you don't have a copy of that draft here with you today?

A. I don't. But if my recollection is correct that I have both versions on my computer at home, I could easily print one and provide it.

Q. I'd ask that you do it and give it to Miss Tosti, mail it to her or whatever, and she'll forward it to me.

A. Fine.

Q. Thank you, sir.

The opinions that you're going to offer in this case are set forth in your report, correct?

A. As we discussed earlier, I continue to endorse the opinions in the report and can elaborate on those as needed or if you have other questions. But I think we've covered the opinions I think of as being particularly important both in my report and our discussion today.

Q. I appreciate that.

In the autopsy of Mr. Hayes there's a finding that he had T-U-R-P. Could you tell me what TURP is?

A. Transurethral resection of the prostate. That was the prostate surgery that he had had in 1995. That was the prostate surgery that he had I believe it was in 1995.

MS. TOSTI: I believe it was later that than.

MS. ROLLER: Ninety-seven.

THE WITNESS: Okay.

MR. GOLDSTEIN: Thank you for correcting me.

BY MR. GOLDSTEIN, CONTINUING:

Q. Doctor I assume there's some charge for your time here today?
A. Correct.
Q. Would you share with me, please, and MS. Roller what that charge is?
A. Sure. I'm charging $400 an hour for deposition time.
MS. ROLLER: It's always best we agree upon how much time you've spent.
BY MR. GOLDSTEIN, CONTINUING:
Q. We started at 2 o'clock today. It's ten to 5:00.
A. Okay.
Q. I'm about done.
A. Good.
MS. ROLLER: Two to five; is that fair?
MS. TOSTI: Three hours.
THE WITNESS: If we conclude by that.
BY MR. GOLDSTEIN, CONTINUING:
Q. And I am just about done. Give me a second to review my notes.
A. I wouldn't charge you for travel time to my family in Chicago.
Q. Thank you.
I guess I want to then finish with one question. And I don't want to beat a dead horse, because Miss Roller questioned you about life expectancy.

Perhaps as we conclude you can clarify that.

My question is, Doctor, when you prepared your report and you offered the opinion that his life expectancy was at least four years, you had at your disposal all of the materials that you have before you today, correct?

A. I believe so.

Q. That's your testimony so far today.

MS. TOSTI: Except for -- never mind.

BY MR. GOLDSTEIN, CONTINUING:

Q. Thank you. Without having reviewed any additional materials your opinion changed as to the life expectancy, or is that a misrepresentation of your testimony? I don't want to misrepresent anything. I want to make sure I understand. I perceived there was a change in your opinion. That you gave a greater opinion as to the life expectancy than you originally did.

And my question to you and I guess stated differently is without any additional items why did your opinion change?

A. My opinion didn't change. And we only touched on this briefly, Gut I intended to do a focused review and to limit the amount of time and charges related to my review as needed and, therefore, when asked to address the issue of life expectancy put into the report a figure that I

was completely confident of and was confident that would not be inaccurate.

Based on further review as we came to the current date in preparation for my deposition I did a more detailed review of certain aspects and addressed things that I identified as being of interest to this matter based on the depositions and further consideration and, therefore, looked more closely at some of the more detailed things that we described.

I don't feel in any way that I changed my opinion. At least four years means it could be anywhere upward from there. I'm sorry if that was misunderstood as pinpointing it at that level.

Q. But you've now offered the opinion that it was somewhere between six and ten years.

A. That is correct.

MS. ROLLER: I just want to follow-up on that particular point.

RE-EXAMINATION

BY MS. ROLLER:

Q. I just want to know if there was any handwriting. Did you do any calculation, any analysis to come to a different stated position than was in your report?

A. Not anything written.

(Whereupon a discussion was held off the

record.)

MR. GOLDSTEIN: Doctor, I don't have anything else to ask you at this time. I would reiterate the request of Counsel to have the Doctor's notes copied so that we may take them with us and ask you to produce your second draft or your first draft to Miss Tosti for forwarding to Counsel.

With that I would conclude my questioning of you, and thank you for your time.

MS. ROLLER: I have no other questions either.

MR. GOLDSTEIN: To make sure that the record is clear we're going to ask that the Reporter mark the notes of Doctor Persky as Exhibit D to the deposition. And I don't believe there are any other exhibits which require marking for our purposes here today.

MS. TOSTI: And the Doctor would like to read and sign his deposition.

(The deposition adjourned at or about 5:03 p.m.)

(Whereupon Deposition Exhibit D was marked for identification by the Notary Public and is attached.)

STATE OF MICHIGAN)
) SS.
COUNTY OF WASHTENAW)

CERTIFICATE OF NOTARY PUBLIC

I certify that this transcript is a complete, true and correct record of the testimony of the deponent to the best of my ability taken on October 4, 2000.

I also certify that prior to taking this deposition the witness was duly sworn by me to tell the truth.

I also certify that I am not a relative or employee of a party, or a relative or employee of an attorney for a party, have a contract with a party, or am financially interested in the action.

Vicki L. Rodriguez

Vicki L. Rodriguez, B.S., M.Ed., CSR-3303
Notary Public, Washtenaw County
State of Michigan
Commission expires October 15, 2001

Huron Reporting Services
623 West Huron
Ann Arbor, MI 48103

October 11, 2000

Neal W. Persky, M.D., M.P.H.
University of Michigan Hospital
Department of Internal Medicine
Division of Geriatric Medicine
1439 East Park Place
Ann Arbor, MI 48104

RE: June M. Hayes, et al., vs Judson Retirement Community, et al.

Dear Dr. Persky:

Enclosed is a complimentary copy of the transcript of your deposition testimony taken on Wednesday, October 4, 2000, in the above-captioned case for you to read and sign.

Please note any corrections on the enclosed errata sheets and return them to our office along with the enclosed signature sheet. There is a self-addressed envelope enclosed for you to return them in, Any corrections will be forwarded to the other attorneys in the case,

If you have any questions regarding this transcript, you may call our office between the hours of 8 a.m. and 5 p.m. Monday through Friday. Our phone number is 734-761-5328.

Sincerely,

Vicki L. Rodriguez
B.S., M.Ed., CSR

cc: Ms. Jeanne Tosti
Ms. Jan Roller
Mr. Bruce Goldstein

Enclosures

RE ***June M. Hayes, Etc. vs. Judson Retirement Community, et al.***
Cuyahoga County Court of Common Pleas Case No.: 383210

ERRATA SHEET

1 1/2 cy

I, Neal W. Persky, have read the entire transcript of my deposition taken on the 4th day of October, 2000; or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the signature page and authorize you to attach the same to the original transcript.

PAGE	LINE	CORRECTION OR CHANGE AND REASON THEREFORE
9	17	"Ms." not "Miss"
11	3	"
13	2	"
15	23	"
9	25	"Yes" not "Yeah"
12	9	"
9	7	"or" not "and"
21	15	"informal" not "and formal"
25	12	"the statements" not "statements"
27	15	"when" not "then"
31	4	"tests" not "test"
40	11	extensive not expensive
57	12	"the aortic" not "the left aortic"
63	6	"peripheral vascular" not "vascular"
66	4	"had not finalized" not "not finalize"
67	3	"and an average" not "and average"
91	2	"pictures" not "picture"
94	5	"subq" not "subcu"
95	23	"tried such as" not "tried as"

11/9/00
Date

Neal Persky
Neal W. ~~Perksy~~ Persky, M.D.
"persky" not "Perksy"

F:\karen\MSOFFICE\FORMS\ERRATA.SHT