IN THE COURT OF COMMON PLEAS
OF SUMMIT COUNTY, OHIO

KAREN L. ARMOUR, Admin.,
etc.,
Plaintiff,
vs Case No. 2002-07-4063
PATRICK A. RICH, D.O.,
et al.,
Defendants.

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DEPOSITION OF PATRICK A. RICH, D.O.
WEDNESDAY, APRIL 2, 2003

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Deposition of PATRICK A. RICH, D.O., a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Lorraine J. Klodnick, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Reminger & Reminger Co., L.P.A., 80 South Summit Street, Akron, Ohio, commencing at 1:09 p.m., on the day and date above set forth.

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APPEARANCES:
On behalf of the Plaintiff:
Becker & Mishkind, by
HOWARD MISHKIND, ESQ.
660 Skylight Office Tower
1660 West 2nd Street
Cleveland, Ohio 44113
(216) 241-2600
On behalf of Defendant Patrick A. Rich, D.O.:
Reminger & Reminger Co., L.P.A., by
PHILLIP A. KURI, ESQ.
200 Courtyard Square
80 South Summit Street
Akron, Ohio 44308
(330) 375-9075
On behalf of Defendant Dean P. Rich, D.O.:
Bonezzi, Switzer, Murphy & Polito, by
JOHN POLITO, ESQ.
1400 Leader Building
526 Superior Avenue
Cleveland, Ohio 44114
(216) 875-2767
ALSO PRESENT:
Maryellen Sansbury, RN/Legal Assistant

PATRICK A. RICH, D.O., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF PATRICK A. RICH, D.O.
BY MR. MISHKIND:

Q. Would you state your name for the record, please?
A. Patrick A. Rich.
Q. You are a physician, is that true?
A. D.O., yes. Osteopathic physician.
Q. Dr. Rich, my name is Howard Mishkind. We were introduced before the deposition started, but I'll officially introduce myself on the record. As I'm sure you know, I'm going to be asking you a series of questions this afternoon concerning your patient and your involvement in her care prior to her death. You understand that, don't you?
A. Yes.
Q. If I ask you anything that is confusing in any way, tell me you don't understand and I'll scratch my head and try to rephrase it so that it's intelligible. Fair

enough?
A. Fair.
Q. When you're answering, I'm going to sit quietly and let you finish. I'd ask you to do the same with regard to any questions that I ask, just so we don't have an overlap. Okay?
A. All right.
Q. Have you had your deposition taken before?
A. Yes.
Q. I have interrogatory answers that your attorney provided to me and in the interrogatories there's a reference to a claim by Karen West. Was your deposition taken in that case?
A. Yes.
Q. Is that case still pending?
A. No, that was settled.
Q. How long ago was that settled, sir?
A. About 1995.
Q. Do you know who plaintiff's counsel was in that case, do you recall?
A. Timothy Scanlon.
Q. Mr. Scanlon took your deposition in that case; true?

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A. Yes.
Q. From that time up to now has your deposition ever been taken?
A. No.
Q. So this is now the second time?
A. Second time.
Q. Without going into a lot of detail, just tell me what the subject matter of Karen West's claim was against you as it relates to, apparently, Ivy?
MR. KURI: Hold on. Place an objection in the record regarding past medical lawsuits relating to him, but it's a continuing objection, if that's okay.
MR. MISHKIND: That's fine.
MR. KURI: Thanks.
A. Ivy West was a 50-year-old man who had been sick for about a year. I was the family doctor. He had numerous physicians and surgeons and all looking for a diagnosis. He was referred to an internist who put him in a hospital. He put him on, he and another doctor, infectious disease doctor, put the patient on isoniazid for a positive TB skin test. The man developed isoniazid's toxicity and being that I was the

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attending physician, then I was involved in that case.
The man continued to deteriorate and he ended up passing away at the Cleveland Clinic with other problems, heart and pancreatitis. But the fact he was on isoniazid, he did develop a hepatitis from that.
Q. Bruce Hensley also was involved in that case?
A. Hensley, he's the one that put him on the isoniazid.
Q. That case settled?
A. Settled out of court before and between our two companies, insurance companies.
Q. Have you ever had your privileges suspended, revoked or called into question?
A. No, never.
Q. Beside that lawsuit and this lawsuit, have you ever been a party to any other litigation, either as the individual that was bringing a claim or the individual that was having a claim against them?
A. No other claims, lawsuits.
Q. Do you currently practice?
A. Yes.

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Q. Where do you practice?
A. My office is at 1414 Greensburg Road in Green, Ohio.
Q. Do you practice full time?
A. Yes.
Q. Where did you go to medical school?
A. Chicago Osteopathic College.
Q. Graduated what year?
A. 1958 to 62, graduated in 62.
Q. Is there a board certification?
A. At that time we graduated as GP, general practitioners. Did a one-year internship at what is now Cuyahoga Falls General Hospital and then I went down and opened an office at my current location in Green.
Q. Do you have an area that you specialize in?
A. No. I'm just general practice.
Q. Have you ever sat to take any type of board certification since finishing your training?
A. No.
Q. Sometimes people are grandfathered in and become board certified. You're just simply not board certified, period?

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A. That's correct.
Q. You've not attempted to become board certified and been unsuccessful in any such attempts?
A. No.
Q. If you wanted to, could you become board certified?
A. There was a time when you could have become board certified as family practitioner. When I got out of school, there was no such thing as family practice. It was just general practice. Now it is a three-year specialty family practice.
Q. Do you consider yourself a family practice physician or a general practitioner?
MR. KURI: Objection. Go ahead and answer.
A. What's the difference?
Q. If you were an MD, I would equate the difference between a family doctor and an internist; do you follow me on that?
A. There's a difference between those, yes.
Q. Do you consider yourself more of an internal medicine doctor or more of a family

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practice doctor?
A. I would be considered family practice.
Q. Do you know, you might not know, what the standard of care in terms of working up a patient for congestive heart failure or a pulmonary embolism, whether or not the recognition of the signs and symptoms and then the work-up for congestive heart failure and pulmonary embolism is different for a osteopathic physician as compared to a medical doctor?
A. No, there is no difference.
Q. Do you know whether the work-up from the standpoint of the recognition of the signs and symptoms and the work-up to rule out or confirm congestive heart failure or pulmonary embolism, whether or not there's any difference in terms of the standard of care between an internal medicine doctor and a family practice doctor?
A. No. Should be the same.
Q. Okay. Doctor, have you ever applied for privileges at any hospitals and been denied privileges?
A. No.
Q. I take it you've never been the

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subject of any type of disciplinary action before any state or local medical board; is that true?
A. Never, right.
Q. Have you ever served as an expert witness --
A. No.
Q. -- in connection with any matters?
MR. KURI: Let him finish the question.
Q. I understand that part of the time that Jean was seeing you and the time right before she died that you were out of town and your son was covering for you --
A. Correct.
Q. -- for a period of time?
Where is out of town? Is there a particular place you would go to? A vacation?
A. I was on vacation. I was in Florida.
Q. Did you have a place that you would go to on a regular basis?
A. Yes.
Q. When you would be out of town for vacation, did you have an arrangement that your son would cover your patients?
A. Yes. We covered each other. When one

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was gone, the other would cover.
Q. What hospitals do you currently have privileges to admit patients?
A. I'm on staff at Barberton Citizens and Akron General.
Q. How long have you had privileges at both of those hospitals?
A. Well, the first 15 years I was on staff at the Cuyahoga Falls General, then the last 25 I've been on staff at Barberton. And General, I've probably been there 12 years, somewhere around there.
Q. Before the deposition started, I asked whether you had a CV and we had a discussion with your attorney and the indication was that you don't have a professional resume; is that true?
A. Correct.
Q. Just to be fair to you, do you have one back at your office just you don't have one with you? Do you not have one at all?
A. I have no printed CV. I could give you that in about two minutes.
Q. I understand. We'll probably do that in less than two minutes, but from time to time do you have to submit any type of written

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documentation showing your medical background, your licensure, any professional associations in some type of written format to any of the medical staffs at either Barberton or Akron or anywhere else, for that matter?
A. When you initially apply for privileges, but there hasn't been any occasion recently for me to have to supply that information.
Q. I take it it's been at least more than five years or so since you've prepared up any type of a professional resume?
A. Correct.
Q. Even longer than that?
A. Even longer than that.
Q. More than ten years?
A. More than ten years.
Q. You have not written anything, correct?
A. Correct.
Q. Do you do any teaching?
MR. KURI: That was an awfully vague question. You have not written anything, you mean in terms of medical articles?
MR. MISHKIND: Right.

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A. I assumed that. I have not written any articles.
Q. You have not published anything in any journals or any textbooks in the area of osteopathic medicine or otherwise; true?
A. Right.
Q. Do you do any teaching to medical students or residents?
A. No, not on a regular basis. I've had medical students in the office from time to time as part of their training for a short period of time, but that's only been once or twice in the years.
Q. Are you a member of any professional associations?
A. No.
Q. Are there state or professional associations that osteopathic physicians --
A. There's the osteopathic state association and there's an AOA association.
Q. You're not members of either?
A. No.
Q. What are --
A. I was at one time. I belonged to those, but over the years I discontinued the

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memberships.
Q. Is there a reason you discontinued the memberships?
A. The main reason was the cost of them.
Q. Fair enough.
A. And I didn't feel any need for it.
Q. Okay. So currently you're not a member of any state or national medical professional associations?
A. Correct.
Q. You've read your son's deposition; true?
A. Yes.
Q. How long ago did you read that? I think it was taken back in December.
A. No. I just skimmed through it last evening.
Q. Did you make any notes at all when you read his deposition?
A. No, I didn't.
Q. Did you dog-ear any of the pages to --
A. No.
Q. -- key you in to anything in particular that was of significance to you?
A. No, I didn't. She can't see me

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shaking my head.
Q. She can, but she can't interpret it. You also have copies of Jean's records, correct?
A. Yes, I do.
Q. And you have, looks like, copies of your office records as well in a separate file?
A. Yes.
Q. Have you reviewed anything else to prepare yourself for this deposition today?
A. No.
Q. At any time since this lawsuit has been filed and you became aware of the lawsuit, have you reviewed any medical literature to familiarize or refamiliarize yourself with regard to anything that would be relevant to your treatment in this case?
A. No.
Q. Do you own any textbooks in the area of family practice medicine?
A. Oh, I have medical books, yeah. In the office, books like the Merck Manual, things that most physicians have.
Q. Do you subscribe to any journals?
A. Yes, a lot of journals.

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Q. Which journals do you get that you consider to be the most reliable, in your mind?
MR. KURI: Objection.
A. There's a Family Practice journal, Medical Economics and even the AOA journal. Numerous magazines come to the office that we don't even subscribe to; they just come.
Q. Your son referenced in his deposition a Principles of Ambulatory Medicine or Ambulatory Medicine. Do you recall seeing that? I think it was at page 16 of his deposition?
A. I recall seeing it.
Q. Is that a publication that you own as well?
A. No.
Q. I think he indicated that that's a publication that he refers to from time to time to obtain what he considers to be reliable information in various areas of medicine.
If you wanted information about a particular topic, let's talk specifically congestive heart failure and pulmonary embolism and the differential for those two conditions, where would you look to for the most reliable source of up-to-date information on signs and

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symptoms of a pulmonary embolism or signs and symptoms of a patient that has congestive heart failure?
MR. KURI: Object to the form of the question. Go ahead, doctor.
A. I'd look at the Merck Manual. There's another book called Current Diagnostics.
Q. Would those be the two that would be the most reliable to you in terms of sources for information on the topic of signs and symptoms of PEs and signs and symptoms of a patient in congestive heart failure?
A. I think so.
Q. And from time to time you refer to both of those -- to Merck as well as Current Diagnostics?
A. Yes.
Q. I take it you own both?
A. Yeah, I have them in my office.
Q. You've just not referred them specifically as it relates to preparing yourself for this case, though, correct? Or have you referred to them?
A. No.
Q. You've not referred to them?

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A. No.
Q. But you own them and you consider them to be generally reliable sources of information in these two areas of medicine; true?
A. Yes.
Q. Besides your son's depo, the records on Jean and your many years of experience as an osteopathic physician, what do you bring with you today that you've either reviewed or that you're applying to be able to answer the questions today? In other words, did you review anything else other than the depo, the records and bring with you your education and training?
A. No.
Q. Poorly worded question and I was trying to be smart with it.
Obviously you've been practicing for many years and I'm sure you've seen patients in your practice that have had signs and symptoms of a PE; true?
A. Yes.
Q. And you've seen patients that have presented with signs and symptoms of congestive heart failure; correct?
A. Yes.

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Q. You understand what the term differential is, don't you?
A. Yes.
Q. So we're talking the same language, what is a differential?
A. Speaking of my differential diagnosis?
Q. Yes.
A. When you speak of your differential diagnosis, you're talking about a list of conditions that you are considering under the case you're working on at the time.
Q. When you look at a patient that presents with acute onset of symptoms and you arrive at a differential, do you try to consider in the differential what may be the most serious potential explanation versus the most benign explanations for those signs and symptoms?
A. Yes, I think you always should start with most serious, rule that out first.
Q. And certainly you recognize that a patient that has signs and symptoms of a PE, that that can be a life-threatening condition; true?
A. Can be.
Q. And it's not something that should be taken lightly if in fact you have reason to

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believe that the patient may have a pulmonary embolism; true?
A. True.
Q. Just a couple other background questions, then we're going to talk specifically about Jean, okay?
Your patient population as an osteopathic doctor, is it from crib to grave, from baby to geriatric?
A. Yes.
Q. That may have been a poor term to use initially, but you treat all-comers?
A. Infants to elderly.
Q. In your practice have you concentrated more in any one area of patient population than the other?
A. No.
Q. I take it you remember Jean?
A. Yes.
Q. Tell me about her. I never met her.
MR. KURI: Objection. Vague question, but what you can recall.
A. Very nice lady. I've seen her over the years, I don't know how far back it went, maybe 60, but then there was periods I didn't see

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her. Then I started to see her again within the last three years ago again. Very pleasant woman. Healthy woman.
Q. Her husband died a year or less before her. Do you remember that?
A. I didn't care for him, so --
Q. Did you ever meet him?
A. I don't want to say I didn't care for him. I didn't treat him, so I'm not familiar with his --
Q. In the physician/patient meaning of that term you didn't care for him?
A. Right.
Q. You had met him from time to time or not?
A. I can't really picture him in my mind.
Q. Do you know what type of relationship Jean had with her husband?
A. No, I can't really speak on that.
Q. Do you know how Jean reacted to the death of her husband?
A. Well, I didn't get into that, really.
Q. Okay. So you have no opinion in terms of whether she was suffering any unusual reaction to the death of her husband?

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A. Let me look at my notes to see if I gave her anything, a nerve pill or something.
Q. Sure. Doctor, as you're looking at that, let me tell you one thing since you've only had your deposition taken twice, when I ask you questions, sometimes I just fire away one question after another. That's not intended to prevent you from looking at your records to answer the question, so don't feel that I'm trying to force you to give me an answer if you feel you need to look at your records, okay?
A. Yeah. I just don't remember her discussing her husband, his death or -- I don't see anything in here where I gave her like a nerve pill or something.
Q. Now, doctor, since your son's deposition has been taken, have you and he talked about this case?
A. Yes.
Q. Tell me in general or specific, whatever is easier for you, what you and he have talked about concerning this case since his deposition was taken.
A. We discussed the case, the problem and then what the patient -- what happened in Akron

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General.
MR. KURI: Doctor, just so you're aware, he's only asking you after this was taken. I want to make sure we're clear.
Q. So you have talked about the case, correct?
A. Yes.
Q. Did you and he sit down and review his deposition testimony together?
A. No, we never sat down. I reviewed that myself.
Q. Did you ever ask him any questions after you read the deposition to get some clarification in terms of what he meant or what he said at any particular page?
A. No, no.
Q. When the two of you talked about Jean, did he express to you any opinions as to what he believed to be Jean's cause of death?
A. You talking about the cause of death?
Q. Yes.
MR. KURI: He's --
A. Yes.
MR. KURI: -- asking what your son told you.

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A. We talked about the cause of death.
Q. And are the two of you, at least as far as you understand, are the two of you essentially in agreement as to what you believe most likely was the cause of death?
A. I think so, yes.
Q. Tell me what that is.
A. Cause of death was a CVA, a stroke.
Q. And have you ever talked to any of the doctors that treated Jean when she was admitted to Akron?
A. No.
Q. Do you have an opinion as to what -- have you and your son talked about what caused the CVA, the stroke?
A. Yes. When you have a stroke, the blood vessel clots up. Hardening of the arteries. She had a massive stroke on one side of her head. The other cause would be a blood clot coming from her heart because she was in atrial fibrillation, irregular heart rate. That will throw off a clot, and that's what happened there.
Q. All right. It's your opinion, she suffered an embolic or thrombotic event leading

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to her CVA?
A. Correct.
Q. And have you seen any evidence in any of the medical records that would support that there was a thrombotic event that caused her CVA?
A. She was in atrial fibrillation when she went in the hospital. That will throw off embolism to the brain. Well, they did a CAT scan and she had a massive stroke on one side, but which one, did it just plug up because of hardening of the arteries or from the embolus, there's no way of knowing that.
Q. Well, when you looked at the records, did you see any evidence that tests were done that would cause you or your son to be able to say that the cause of her stroke was a thrombotic event secondary to complications from her atrial fibrillation?
A. I'm not sure I know how to answer that. You can't tell what happened there. One or the other happened.
Q. Well, patient can have an embolic event?
A. Correct.
Q. Patient can have a thrombotic event,

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correct?
A. Correct.
Q. Patient can also have a hemorrhagic event, correct?
A. Correct.
Q. So there are actually three ways one can have a stroke; true?
A. She did not hemorrhage. They would have seen that on the CAT scan.
Q. Do you have an opinion as to whether there is any causal relationship between her pulmonary embolism that she had and her CVA?
A. No relationship.
Q. On what do you base that?
A. It just doesn't happen. The blood clot to the lung, a PE, does not go to the brain.
Q. And, again, you're assuming that the blood clot that causes the PE, you're assuming that in order to have a stroke secondary to complications from the PE, that there would have to be some continued embolic event from the lungs to the brain?
MR. KURI: Objection.
A. No, that's incorrect.
Q. Okay.

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A. You don't have an embolic event from the lung to the brain. It had to come from her heart.
Q. Okay. Can you have a PE and have a stroke without having evidence of some thrombotic or embolic event to the brain?
A. I don't understand. Can you have a -- repeat your question.
Q. There's no question that she suffered pulmonary emboli, correct?
A. No, I wouldn't say --
MR. KURI: Talking about at Akron General?
Q. Well, you see evidence -- do you dispute whether this patient experienced a pulmonary emboli?
A. At Akron General she had -- they did a VQ scan and it said high probability.
Q. Okay. So can we agree, and we're going to talk about your treatment in a moment, I'm starting at the end and moving backwards, but can we agree that the VQ scan that showed a high probability of a pulmonary embolism would suggest that the patient does in fact, at least at the time that she was seen at Akron General,

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experience some embolic event that caused a PE?
A. Embolic event of PE had to come from a DVT --
Q. Okay.
A. -- to the lung.
Q. Do you have an opinion as to where the deep vein thrombosis was that caused the embolic event to the lung?
A. They did a Doppler study and it was from -- I don't remember which leg, I can't remember. That went to the lung.
Q. Okay. Now, from a pathophysiology standpoint, is it your testimony, I just want to understand this so I understand your knowledge of medicine, that the occurrence of the PE that was diagnosed in Akron General and her ultimate CVA, which you believe was the cause of her death, is it your opinion that there is no direct causal relationship between the two?
A. Correct.
Q. You don't believe that there is any -- okay. I'll accept that. Do you know Dr. Michael Ginella?
A. No, I don't.
Q. Have you ever seen the death

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certificate for Jean?
A. Yes.
Q. It's in the material that was provided to you, correct?
A. Yes.
Q. You see that he has indicated the cause of her death being respiratory failure due to pulmonary embolism. You see that, don't you?
A. That's wrong.
Q. You disagree with that?
A. I disagree with that.
Q. Okay. Because you believe that the cause of her death was a cerebrovascular accident, correct?
A. That started the downhill course.
Q. The cascade of events?
A. All the problems that evolved from that.
Q. But you don't believe that the pulmonary embolism was a contributing factor to cause the CVA; true?
MR. KURI: Objection. Asked and answered.
A. True.
Q. So it's your opinion that more likely

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than not she would have suffered the cerebrovascular accident irrespective of whether she had a PE or not?
A. Very likely would have happened, yes.
Q. Have you personally, other than with your attorney, but have you personally alone or in conjunction with your son reviewed the medical records with any doctors to arrive at a conclusion that in fact the patient's cause of death was complications from the CVA as opposed to complications from the PE?
A. No. I didn't discuss it with other doctors --
Q. Okay.
A. -- to clarify that.
Q. Your answer was, even though my question may not have been artfully stated, your answer indicated that you at least I think knew what I was asking.
A. Yeah. I didn't review this record with anybody.
Q. Okay. Do you know whether your son has reviewed the case with anyone from the standpoint of whether the CVA was in fact the cause of her death?

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A. No, I don't think he did.
Q. Tell me what are the signs of a DVT?
A. DVT, deep vein thrombosis, usually pain in the leg, usually in the calf area, swelling of the leg.
Q. Is the swelling always symptomatic?
A. Depends on which vessel. Sometimes you'll have a small vessel that it doesn't cause that much blockage and you may not get that much swelling, but most of the time there is going to be swelling of the leg.
Q. Jean did have a history of DVTs, correct?
A. No. She had phlebitis.
Q. She had superficial --
A. Superficial phlebitis.
Q. Is a patient that has superficial phlebitis at increased risk of DVTs?
A. No.
Q. Is it your testimony that that is not supported by the medical literature?
A. That's my opinion.
Q. Okay. Are there instances that you have seen in your practice the patients that have had superficial phlebitis have progressed to

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develop deep vein thrombosis?
A. No.
Q. DVT is diagnosed through what modality? How do you go about diagnosing it?
A. Through a Doppler study.
Q. Anything else?
A. We can do a venogram.
Q. Any other diagnostic modalities that you're familiar with in terms of diagnosing DVT?
A. That should give you your answer.
Q. Can you rule out or confirm the existence of a DVT without doing some type of imaging study?
A. No.
Q. If you determine that a patient has a DVT, how is it treated?
A. With anticoagulants such as heparin and Coumadin.
Q. You mentioned earlier that she had atrial fib, correct?
A. Yes.
Q. Did she have atrial fib from a long-standing perspective?
A. No.
Q. When was she diagnosed with atrial

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fib?
A. Her cardiogram showed when she went in Akron General, her cardiograms upon her admission to Barberton were normal.
Q. Do you have an opinion as to what caused the atrial fib?
A. Frequently it will start with you may have a heart attack. That will throw them into atrial fib. Just plain coronary artery disease, as we get older, hardening of the arteries. Hyperthyroidism, thyrotoxicosis will show up as atrial fib.
Q. In this case do you have an opinion as to what most likely was the cause of her atrial fib?
A. She didn't have a heart attack. They did enzyme studies when she went into General. Just occurred.
Q. I take it then you don't have an opinion to a reasonable degree of medical certainty or probability as to what the mechanism was that caused the atrial fib?
A. Age and coronary artery disease. Atrial fib is quite common as you get older. It's quite common as you get older.

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Q. She never demonstrated any signs and symptoms of atrial fib when you had seen her, correct?
A. Correct.
Q. You had seen her in the hospitalization just a week before her death, correct?
A. Correct.
Q. You didn't obtain any type of a cardiac consult during that hospitalization, did you?
A. She had a normal rhythm cardiogram, so there was no need for a cardiologist.
Q. Certainly you could have consulted with a cardiologist had that been the appropriate thing to do, correct?
A. If she was having --
MR. KURI: Hold on a second. Are you asking if it was the appropriate thing to do or whether he could have just consulted?
Q. If it was the appropriate thing to do under like or similar circumstances, you would have had the ability to consult with a cardiologist, correct?
A. Yes, if she had some cardiac symptoms,

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fibrillation, whatever, yes, you consult a cardiologist.
Q. I take it you believe that your conduct in terms of not consulting with a cardiologist while she was in the hospital was within the standard of care?
A. Yes.
Q. During that hospitalization, though, you did not see any evidence of atrial fib, correct?
A. Correct.
Q. I just want to make sure I understand your testimony. Do you believe that had you done certain studies that weren't ordered when she was in the hospital, that you would have seen evidence of atrial fib, or is it your testimony that she developed atrial fib at some time after the hospitalization and prior to her death?
A. When she was in Barberton, she was not in atrial fib. We have a normal cardiogram showing normal rhythm.
Q. Okay.
A. Atrial fib developed sometime after that.
Q. And can pulmonary emboli cause a

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patient to go into atrial fib?
A. No.
Q. You're certain?
A. Certain.
Q. If the patient had been diagnosed with atrial fib when you had her hospitalized, hypothetically, and you also had a concern about DVT and wanted to treat the patient for a DVT, would there have been any contraindication in terms of providing anticoagulation therapy for the DVT for a patient who also has atrial fib?
A. No.
Q. In fact, the treatment is one in the same, is it not?
A. You could very well anticoagulate them if they're in atrial fib as well.
Q. What are the complications that you see in your practice with a patient that has a DVT that is not properly treated?
A. Well, the most common thing would, of course, be probably a PE and then progressive problems, swelling of the leg.
Q. Let's talk about a PE. The signs and symptoms of a PE are what?
A. They'll vary from just a simple cough,

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shortness of breath, chest pain, coughing up blood, respiratory failure.
Q. Any others?
A. Tachycardia.
Q. Any others?
A. If it's a major one, maybe sweaty, clammy. That's about it.
Q. Can a pulmonary emboli be ruled out on the basis of physical exam alone?
A. No. You could become highly suspicious with your physical exam.
Q. But in order to rule out or confirm the presence of a PE, what's the gold standard?
A. To do a VQ scan or spiral CT scan.
Q. And as a family practice physician, you're familiar with the availability of VQ scans to rule out or confirm the presence of pulmonary embolism, correct?
A. Yes.
Q. And you're familiar with the signs and symptoms that are associated with a patient that has the potential for developing a PE, correct?
A. Yes.
Q. And those signs and symptoms are signs and symptoms that should be recognized equally by

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a medical doctor as well as an osteopathic physician, true?
A. Correct.
Q. Same standard of care?
A. Same standard.
Q. Besides a VQ scan, is a chest x-ray of any assistance or benefit in terms of ruling out or confirming the presence of pulmonary embolism?
A. Unless it's a massive pulmonary embolism, a chest x-ray would be negative.
Q. What about any type of pulmonary angiogram, would that be of any benefit?
A. Yeah, angiogram, pulmonary angiogram would benefit.
Q. I think you said a spiral CT?
A. Spiral CT.
Q. Are there any laboratory tests that you have within your arsenal that are helpful in terms of determining whether a patient has a PE?
A. Blood gases, oxygen levels.
Q. If you have a patient that has a pulmonary embolism, what would you expect to see if you took arterial blood gases?
A. The oxygen level would be decreased.
Q. What would be an abnormal oxygen level

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on an arterial blood gas that would at least cause you to at least consider pulmonary embolism?
A. Your pulse ox gets way down, maybe in the, well, 60s, 70s, even 80s.
Q. Doctor, you would agree, would you not, that if there's suspicion for pulmonary emboli that diagnostic studies should be done promptly to confirm or to rule out the diagnosis?
A. Yes.
Q. And failure to do diagnostic studies, if there is a suspicion for pulmonary emboli, that would be a violation of the standard of care; true?
A. Yes, if you suspect it, you should do it.
Q. Or if you have a high index of suspicion, it would be below the standard of care not to do diagnostic studies to either rule out or confirm it; true?
A. Yes.
Q. And in fact if you have clinical evidence that causes you to have a PE within your differential, not to rule out or confirm the PE by doing those tests would be below the standard

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of care?
A. Yes.
Q. Okay. I think you told me before in your practice you treated patients that have had PEs?
A. Yes.
Q. Have you admitted them to the hospital?
A. Yes.
Q. And then have you followed them on an outpatient basis?
A. Yes.
Q. They've been on Coumadin or some type of anticoagulation therapy?
A. Yes.
Q. Are they typically on that for the rest of their lives or does it depend upon the extent of the embolic event?
A. It depends. There was a time when we would keep them on an anticoagulant for six months. Now the tendency is sometimes to keep on for the rest of their lives.
Q. If you diagnose in your practice a patient with pulmonary emboli, it has confirmed by diagnostic studies and been treated in the

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hospital, do you on occasion refer the patient to a specialist for ongoing management of that condition?
A. Yes.
Q. And if you were to refer a patient to a specialist for ongoing management of a pulmonary embolus, what area of medicine would that be?
A. I would call in a pulmonologist.
Q. I take it you'd agree that prompt treatment of a pulmonary emboli increases the chances for survival?
A. Yes.
Q. If you can treat a patient that has emboli or embolic events going on from a deep vein thrombosis before the patient's hemodynamic status deteriorates, the likelihood of a good outcome is increased, true?
A. Yes.
Q. One of the goals of treatment of a pulmonary embolus is to stop the deep vein thrombosis from increasing in size; true?
A. Right.
Q. And you give the anticoagulant heparin or if there's any sensitivity, one or the other

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anticoagulants --
A. Start with heparin.
Q. Once the clot caused by the DVT is treated, does the body then have its own mechanism that it dissolves the clots?
A. No. That clot will remain. There's some theory that that vein may open up a little bit, but generally that clot is going to stay there.
Q. Does the body have any type of process whereby the clot is autolyzed, if you will, or broken up over time through any mechanism the body produces?
A. Does that clot maybe shrink over a period of time? Get smaller? I imagine it can. I don't know.
Q. Does the risk for embolization from a DVT decrease the longer the patient is on anticoagulants?
A. I would think so.
Q. If the patient presents with reports of leg swelling and new complaints of shortness of breath, should pulmonary embolism be within the differential diagnosis?
A. Yes.

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Q. I asked you before about Jean; you said she was a nice woman. I think you also said that she was relatively healthy, correct?
A. For her age she was.
Q. Was she compliant with your medical management of her over the years?
A. Yes. What little I treated her, she was compliant.
Q. Sometimes doctors will say, the patient never followed my advice or never did this or that. That's not the case with Jean, correct?
A. She didn't seek that much medical assistance.
Q. What she did, was she appropriate and reasonable in terms of her understanding of what you had to say to her?
A. Yes.
Q. And also in term of responding to any recommendations that you made relative to her medical management?
A. Yes.
Q. So you would not describe her as a noncompliant patient; true?
A. True.

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Q. You saw her back in October of 1986 for the first time, correct?
A. Somewhere back there.
Q. As I told you before, I'll keep to my promise, I'm not going to go through each and every one of the visits, but suffice it to say from 1986 up to the time of her death, before she went in to Akron General where she ultimately died, you were her physician, correct?
A. Yes.
Q. She didn't have any underlying cardiac or pulmonary problems that you were aware of prior to January of 1999, did she?
A. No.
Q. Did she have a history of hypertension?
A. No, she was not hypertensive.
Q. She didn't have any risk factors for heart disease, to your knowledge, did she?
A. Correct.
Q. You might want to keep your records available because I'm going to ask you some specific questions about the office visits now.
The paragraph before January 25, 2001, you had last seen her in -- I'm sorry, in looks

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like January of 2000, correct?
A. 2000.
Q. January 6, 2000?
A. January 6.
Q. And at that time she had some dizziness; true?
A. Yes.
Q. When nose runs, she -- I can't read that.
A. When nose runs, she doesn't seem as dizzy. That was written by the office personnel when she came in.
Q. The blood pressure, was that taken by an office person or was that taken by you?
A. No, that's taken by me.
Q. Are the notes then to the right of the blood pressure, are all of those notes yours?
A. Yes.
Q. Did you diagnose her with vertigo?
A. Yes, that was my impression.
Q. What was causing the vertigo?
A. Vertigo can be caused by numerous problems. Very commonly if you have a little sinus infection, that will trigger it off. Also, consider hypertension, consider carotid artery

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disease where she didn't have any bruits there, as I wrote. That's the little noise you hear when you're plugged up. She was worse with motion like motion sickness, such as being on a boat. That will make you dizzy. My impression, this was just a standard vertigo probably brought on by her sinus.
Q. What other conditions can cause vertigo?
A. Well, like I stated, hypertension, blockage of the carotid arteries.
Q. When she would come in for examinations, would you always look to see whether there was any evidence of JVD?
A. Look for DVT?
Q. JVD.
A. What am I missing here?
Q. Do you know what JVD is?
A. No.
Q. Have you ever heard of jugular venous distention?
A. Oh, yeah. No. I would recognize that especially when I examined for the carotids.
Q. Of what significance would jugular venous distention have to you if you detected it?

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A. You're getting some back pressure, cardiac or lung.
Q. In the lower right-hand corner on January 6th, doctor, you have a note. Can you read what that says?
A. Yeah. If her dizziness persists, then I would do a carotid artery study.
Q. So within your differential at that point, you obviously were at least concerned about there being some potential pathology that might explain the vertigo?
A. Yes.
Q. And the testing that you would have done, had you followed this through, would have been to refer her to someone or would you have done testing?
MR. KURI: Objection. He didn't say if he would have followed it through.
A. No. I would have worked her up and I did. I did a carotid artery study.
Q. When did you do the carotid artery study?
A. Well, it was scheduled for January 25th at Akron General.
Q. That's January 25th of 01?

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A. No, no, 2000. The next page. The secretary scheduled --
Q. Got it.
A. If she had some other neurological symptoms, you may want to do a CAT scan. At that time I did the carotid artery, the Doppler study.
Q. Okay. Then you saw her. Was the Doppler study normal?
A. I'm sure it was. I was looking through it -- I don't know if you have it over there -- I know she had -- here is -- yes, here it is.
Q. What's the date of that?
A. 1-25-2000. And normal carotid studies.
Q. You saw her again then on April 3, 2000, correct?
A. Yes. She came in for another reason.
Q. She had a pulled muscle in her back?
A. Uh-huh.
Q. That's a yes?
A. Yes.
Q. Her dizziness had gone away, that's a good sign, isn't it?
A. Yes.

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Q. What was your diagnosis as of April 3, 2000?
A. That she just had a tendonitis, bursitis.
Q. You treated it with what type of medication?
A. I gave her an antiinflammatory and I injected her along her right side of her scapula area.
Q. She then returned on November 2nd, 2000, true?
A. She came in for a flu shot.
Q. Then the next time you would have seen her would have been January 25, 01, correct?
A. Correct.
Q. Do you recall having any contact with Jean in 2000 and early 2001 other than what's recorded in your office notes?
A. No, no contact.
Q. January 25, 2001, Jean came in and was complaining of swollen left leg the week before the visit to you; true?
A. That's what she said.
Q. In fact, you have down, had swelling left leg last week, correct?

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A. Last week.
Q. And she had also developed shortness of breath, especially when walking three days before this visit on January 25, right?
A. Correct.
Q. She also told you during that visit that at nighttime she had to use an extra pillow to breathe better, correct?
A. Yes. She woke up at 4 a.m., had to prop herself up on an extra pillow.
Q. What does that suggest to you for a patient that has to use an extra pillow to breathe better?
A. Congestive heart failure.
Q. Anything else that is within your differential where a patient also presents with a history of swelling in the leg, shortness of breath, especially with walking, what else is within your differential?
A. That was my primary concern. I also included rule out a PE.
Q. On January 25, 2001, were you able to determine from your history and your examination of the patient what was causing her shortness of breath?

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A. No.
MR. KURI: That question was in the office?
MR. MISHKIND: Right.
Q. I mean, based upon the history that she gave you and the physical exam, you couldn't determine what was causing her shortness of breath, correct?
A. Correct.
Q. Now, she had had, I'm not going to go through all the records, but her superficial phlebitis that she had had, I noted it in 87, in 89 and in 97. You don't need to necessarily go back to your records, but in reviewing your records do you recall that she had had two or three episodes of superficial phlebitis?
A. I probably at that time looked through her record.
Q. But is it your testimony that she was not at risk for a PE due to her history of phlebitis?
A. Correct.
Q. She was also tachycardic on January 25, 2001, correct?
A. Yes.

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Q. In the past did Jean have a tendency of being tachycardic?
A. No.
Q. What was causing her tachycardia on January 25, 2001?
A. That's why I put her in the hospital that day.
Q. You weren't able to determine what was causing it, correct?
A. Right.
Q. So you knew you had a patient with shortness of breath; true?
A. True.
Q. You knew you had a patient that was tachycardic; true?
A. True.
Q. You knew you had a patient that presented with some difficulty breathing requiring another pillow at 4 a.m. that morning before she came to see you; true?
A. True.
Q. A history that week of swelling in her left leg; true?
A. True.
Q. And also shortness of breath

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especially with walking and that was a history of having shortness of breath with walking for three days; true?
A. That's what she stated.
Q. And you had no reason to suspect that that history was inaccurate, do you?
A. No, that was true.
Q. Now, your examination, tell me what you detected relative to her breathing during your exam.
A. She was not in any respiratory distress. Her symptoms were very mild. This is why the picture was confusing. She had no cough. She had no respiratory symptoms like a cold. She had no chest pain. She had no leg swelling. She had no PTE, pretibial edema as swelling of the leg, although she said her leg had swollen previously, obviously it went down.
Her lungs were clear and the only finding was a tachycardia. And for that reason not because she was that short of breath, she was quite comfortable in her breathing, we -- she decided, I suggested she go in the hospital and she was very cooperative. I admitted her that day.

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Q. And certainly she again complied with your medical management?
A. Yes.
Q. She was relying on you, correct?
A. Yes.
Q. To do the tests that were necessary to determine what was causing her symptoms, correct?
A. Correct.
Q. Because this was a recent onset of symptoms that this patient had not experienced before; true?
A. True.
Q. And you had a duty and a responsibility to safely and appropriately evaluate these symptoms, evaluating that differential that we talked about, correct?
A. Right.
Q. And within your differential was rule out CHF and rule out PE, correct?
A. Correct.
Q. At the very bottom, is that treatment?
A. Yeah, treatment. I suggested we needed a chest x-ray and further studies. And I admitted her that day as see congestive heart failure.

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Q. You were the attending during her hospitalization?
A. Yes.
Q. She was obviously a private patient?
A. Yes.
Q. You didn't -- other than the endocrinology consult, you didn't seek any other consultation, did you?
A. No.
Q. You did seek an endocrinology consult; true?
A. Yes.
Q. We'll talk about that in a moment. You didn't seek a cardiac consult; true?
A. True. There was no indication for anything else.
Q. You ordered an echo?
A. Ordered an echo.
Q. Did you interpret that echo yourself?
A. Yes.
Q. Was the echo, in your opinion, normal?
A. The echo --
MR. KURI: You can take a look at it if it's easier.
A. It's in here.

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Q. Do you have the echo in front of you now?
A. Yes.
Q. Did you consider this to be a normal echo?
A. Partially normal, normal ventricle and ejection fraction, but she showed significant pulmonary hypertension of the pulmonary artery pressure.
Q. She had significant pulmonary hypertension with peak pulmonary artery pressure estimated at 55 to 60, correct?
A. Yes.
Q. First, what is pulmonary hypertension?
A. Excessive pressure on the lungs.
Q. What's the difference between primary and secondary pulmonary hypertension?
A. Primary and secondary, what the cause is.
Q. What causes primary pulmonary hypertension?
A. There are many reasons for primary pulmonary hypertension. Congestive heart failure, PE, COPD, liver problems, cirrhosis.
Q. What about secondary pulmonary

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hypertension?
A. I would think secondary is a result of one of these other factors.
Q. You said liver disease, cirrhosis?
A. Cirrhosis.
Q. There was no evidence of cirrhosis in Jean, was there?
A. No.
Q. In your progress notes in the hospital you noted that the echo was normal. Do you recall that?
A. Yes.
Q. That's not quite an accurate statement, is it?
MR. KURI: Do you want to look at your notes?
A. What I wrote there, I'm sure, was ejection fraction.
Q. January 27th, does it say echo normal?
A. Yes, echo is normal. Do I have the ejection fraction there?
Q. Where is the ejection fraction?
A. That's over here.
Q. But on your note can we agree that you just marked down echo normal?

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A. Normal.
Q. You don't say anything about the ejection fraction?
A. No, I didn't write anything down.
Q. The only thing that was normal about the echo was her ejection fraction, correct?
A. Correct.
Q. And that caused you to rule out congestive heart failure, correct?
A. Yes. My --
Q. Is that an accurate statement?
A. Yeah.
Q. You didn't consult with any cardiologist to discuss the results of the pulmonary hypertension in this case while she was in the hospital?
A. No, I didn't.
Q. Even though you ruled out congestive heart failure, were you able to rule out pulmonary embolism?
A. Her clinical symptoms did not lead me that way.
Q. What clinical symptoms would you have needed to have seen -- strike that.
First, we can agree she was admitted

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to the hospital for rule out CHF and rule out PE, correct?
A. That was part of my differential.
Q. And when she was admitted to the hospital, we can agree that you did not do any tests to rule out PE, correct?
A. Correct.
Q. And if PE was still within your differential when she was admitted that same day, there are tests you should have done to rule out the PE, correct?
A. Clinically she didn't present that to me, so I didn't do it. I just did the echo.
Q. What changed between the office visit and the same day when you admitted her such that you no longer had a concern about the patient having a PE?
A. I was focused on the congestive heart failure.
Q. I understand that very clearly, but what was it about the patient in terms of her symptoms that caused you to feel as a reasonable and prudent doctor that you could overlook ruling out the PE and just focus in on the CHF?
A. She wasn't that dyspneic. She wasn't

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short of breath and neither did she have any leg swelling at that time.
Q. When she was seen in the hospital, the nurses took an admission history from the patient. That's pretty standard, isn't it?
A. Yeah.
Q. In the history, you would expect that if the patient is complaining of shortness of breath, that that's something that she would tell the nurses, correct?
A. Yes.
Q. And if the patient has shortness of breath and if the patient has swelling of the lower extremity upon admission, then certainly you as a reasonable physician should continue to be ruling out the existence of a PE, correct?
A. Correct.
Q. Is it your testimony that during the hospitalization she did not continue to have shortness of breath?
A. She was not complaining of shortness of breath. She was quite comfortable. Her legs weren't swollen. She was examined by house physicians and there was no mention, no mention of her shortness of breath.

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Q. She's also seen by nurses, correct?
A. Yeah.
Q. And nurses really are sort of your eyes and ears?
A. Correct.
Q. And when you come in to see a patient, you have a duty, do you not, to take a look and see what the nurses have recorded as it relates to the patient's symptomatology?
A. Sometimes, yes.
Q. Especially if a patient's admitted with rule out PE, you want to look to see whether or not the patient has shown any signs of edema or any signs of shortness of breath during the hospitalization; true?
A. Yeah.
Q. And if the patient on repeated days was showing signs of edema and shortness of breath in the hospital, that would be significant to you, correct?
A. Yes.
Q. That would mean that you as a reasonable and prudent physician should be ruling out the possibility of pulmonary embolism; true?
A. True.

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Q. And failure to do that would be a violation of the standard of care, correct?
A. Correct.
Q. What's nonpitting edema?
A. That's a swelling of your legs usually. It swells up.
Q. When you --
A. When you press on it, it makes a little pit. That's pitting edema.
Q. Is nonpitting edema of any concern to you on a patient that has been admitted to the hospital with the history that she had where you had rule out CHF and rule out PE?
A. If they have a large, swollen leg.
Q. If they have edema, you certainly want to be aware of that, correct?
A. Yes.
Q. Whether it's one plus or nonpitting, it's something that you should be aware of, correct?
A. Yes.
Q. If the patient is complaining of shortness of breath on exertion, that's something that you should be aware of, correct?
A. Yes.

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Q. And something that if it's documented in the records, you have a duty to be aware of, correct?
A. Yes.
Q. Those symptoms of shortness of breath on exertion as well as edema in the legs, noted in the hospital records, would cause a reasonable and prudent doctor that has ruled out CHF to evaluate the patient for the other condition, and that is PE, correct?
A. If I see those symptoms, yes.
Q. You certainly, in addition to looking at the records, you have an opportunity to talk to the nurses, correct?
A. If I feel there's some question, yeah.
Q. And you certainly in addition to seeing the records and talking to nurses, you have an opportunity to do an examination on your own, correct?
A. Yes.
Q. She was discharged from the hospital on what day?
A. 28th?
MR. KURI: Talking about Barberton?
MR. MISHKIND: Yes.

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A. She was admitted on the 25th, discharged on the 28th.
Q. Was she discharged on the morning of the 28th?
A. Usually the doctors come in and make their rounds in the morning and write the discharge and then the patient will leave sometime before noon, sometimes after noon.
Q. So on the 27th, if the records reflect that the patient in the afternoon had shortness of breath at 3:45 in the afternoon as well as edema in the left leg, I'll sort of save you time --
MR. KURI: I got it right here.
MR. MISHKIND: Okay.
Q. I've got it highlighted. I think that's the 27th. Do you see the two areas where I have highlighted?
MR. POLITO: Is that at 3:45?
MR. MISHKIND: Right, 1545.
A. This is a nurse's note.
Q. The nurse's note with regard to the shortness of breath, what does that say?
A. Looks like shortness of breath with, I don't know what you got there, exertion or

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something.
MR. KURI: Exertion.
Q. Would you have already --
A. I would have already been there. I make my rounds in the morning.
Q. So then before she was discharged on the 28th, then you would have made your rounds and then okayed her discharge on the 28th; true?
A. True.
Q. And then would have had this information available to you that the patient the day before discharge was complaining of shortness of breath on exertion, correct?
A. Depends how much trouble she's having, how much shortness of breath.
Q. Certainly that information would have been available to you --
A. That was down here, yes.
Q. And then if you just stay with that page, also on that same page at 1345 she had complaints of, I'm sorry, there was the nurse noted edema of the lower extremity, correct?
A. It says trace.
Q. Right. But nonetheless, there is edema noted, correct?

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A. That was her interpretation.
Q. But you don't have any notes -- you might want to keep that page open because I'm not done.
When you came in to approve the discharge as to whether or not this patient was safe to be discharged, this information would have been available in the hospital record for you, correct?
A. Yes, this would be in the record.
Q. And certainly if the patient was having shortness of breath and swelling in the leg, those are two symptoms that would be consistent with your prehospital admission diagnosis of rule out PE, correct?
A. Yes.
Q. Okay. And to the extent that you were aware that the patient the day before discharge was having shortness of breath on exertion and swelling, would you -- you have to wait until I'm done before you answer -- would you agree that the patient should have been worked up for a PE before being discharged?
A. The patient was not, in my clinical judgment, when I saw the patient in the morning,

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she was not having these problems.
Q. What did you mark down on the 28th that indicated she wasn't having these problems at the time you discharged her?
A. I think I wrote down she was stable.
MR. KURI: Why don't you wait to get it first so you don't have to say think.
A. She was in sinus rhythm. Her heart was not going fast. I said will dismiss today, will follow in the office.
Q. Do you have any note at all about examining her lower extremities?
A. No.
Q. Do you have any indication that the lower extremity edema that was noted the day before was gone?
A. I'm sure I looked at her and checked her --
Q. That's not my question.
A. No, I didn't mark it down.
Q. Do you have any indication that the patient, the shortness of breath that she had on exertion the day before, had resolved that morning?
A. She apparently wasn't having any

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problem when I checked her.
Q. You do not note anything about no shortness of breath?
A. I would have noted it.
Q. If you were acting in a reasonable and prudent manner, you would certainly be aware of the fact that she had shortness of breath and swelling in the leg the day before as well; true?
MR. KURI: Let me just object in that you're characterizing what the nurse -- the objection is I think you're mischaracterizing exactly what the nurse said, but that's fine. Go ahead.
A. So back to the question?
Q. Sure. You don't remember your exam the day that she was discharged, do you? I mean, physically, do you remember being there and seeing her before you sent her home?
A. Yes. I always see them and I have to write the dismissal. At that time she was in no distress.
Q. I understand that. Can you picture -- strike that.
Are you relying on your note or are you able to tell me, I remember being there on

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January 28th, 2000, seeing this patient and discharging her on that date?
A. I made no note of it, but I remember being there, discharging her and I remember she was in no distress.
Q. Who was present?
MR. KURI: That's 2001, by the way.
Q. Who was present at the time that you saw her and discharged her?
A. No one. I visited the patient myself. Usually don't have anyone with you.
Q. Tell me what else you discussed with Jean during that visit, that you remember, that's not recorded in the record.
A. I can't remember what I discussed with her at that time, at the bedside.
Q. I want you to tell me everything that you remember that's not recorded in the record.
A. I can't remember anything that far back.
Q. That's what I mean.
A. Other than we were going to follow up. I would see her in the office. Usually like in a week. And also she was to follow up with the endocrinologist.

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Q. We're going to talk about that in a moment. You said you can't remember that far back?
A. Oh, specifically.
Q. So that's why you make a note in terms of what you've noted, correct?
A. Right.
Q. Do you physically remember being in the room and seeing Jean?
A. Yes.
Q. You do. Okay.
A. If I didn't see her, there wouldn't be a note for that day.
Q. I understand that. Are you able to recreate in your mind being there and talking with her and examining her or are you relying on the note as being the proof that you were there?
A. No, I know I was there.
Q. Because of the note?
A. Yes.
Q. But it's been --
A. I saw her every day. She was only in for a few days. I took care of her those few days. I happened to be there on that day. I had to dismiss her and discuss her after-hospital

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care.
Q. Tell me what you discussed with her about her after-hospital care.
A. My brief note was that I would follow up in the office, usually within a week is what we do, and that she was also to see Dr. -- this endocrinologist, the specialist.
Q. We talked about the 27th when she had shortness of breath and edema in the leg. On the 26th, the record also shows that she had shortness of breath with exertion, according to the nurse's notes, as well as edema in the lower extremity. I presume you would have seen her on the 27th?
A. Yes, I saw her the 27th.
Q. And do your records reflect any examination of her lower extremities on that date?
A. No, there's nothing on the 27th.
Q. Do your notes on the 27th indicate any discussion with her or with the nurses about the shortness of breath that she had upon exertion during the evening of the 26th?
A. No. Usually when you see the patient in the morning, you generally write down the

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negative problems she's complaining of at the time such as I'm short of breath or nauseated or something. So on the 27th I didn't write any complaints like that, nor did I write she had any swelling.
Q. But -- I'm sorry, go ahead.
A. In my interpretation, she apparently did not.
Q. Yet we can agree, can we not, that the nurses on the 26th and on the 27th note shortness of breath as well as edema in the lower extremity, yet when you saw the patient as her physician the following morning on both of those days, you make no notation about examining her legs and seeing that the swelling has gone away; true?
MR. KURI: Let me go to the 26th while you're looking at it. Can you show me? Would you like the question read back to you?
(Record read.)
MR. KURI: This is the 26th. And the 27th. Make sure you take a look at these so we're all clear --
A. I made no notation because it apparently was not a problem to me at that time.

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Q. I understand that. I understand what --
A. And what the nurse is writing here, this trace, I don't know how much she interpreted.
Q. I understand that.
A. Trace is minimal. She could have swelling. Same thing with shortness of breath. What did she do to have shortness of breath? When I'm in the room talking to her, she's not short of breath.
Q. So she was just having these --
A. What this -- she told the nurse, she could have been sitting there, I get short of breath when I climb the steps.
Q. I hear what you're saying, doctor, but in all fairness, you admitted this patient for two primary conditions to rule out, one was CHF and one was pulmonary embolism, correct?
A. Correct.
Q. And you never ruled out pulmonary embolism during this hospitalization, did you?
A. As her clinical symptoms when she's in the hospital there were not of the embolus and I was focusing on her congestive failure and then

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her thyroid problems, when the thyroid problems poked up, that's when I called the endocrinologist --
Q. I understand that, doctor.
A. Because she was tachy. She was a little bit tachy.
Q. I'm going back to my question. You never ruled out pulmonary embolism during this hospitalization; true?
A. I didn't feel it was necessary at that time.
Q. You didn't rule it out, did you?
A. I didn't rule it out.
Q. Tachycardia can be caused by pulmonary embolism, correct?
A. Correct.
Q. You never ruled out pulmonary embolism, even though on three different occasions, we can go back and I can talk to you further about the 25th where the patient also has shortness of breath on exertion and the patient also has edema in the lower extremity. And we can agree that on three separate occasions, on three different dates, the nurses have entries of shortness of breath, of edema in the lower

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extremity, but you, as the physician that admitted the patient to rule out PE, did not consider those apparently to be significant enough to want to rule out PE by the time she left the hospital; true?
MR. KURI: Object to the form of the question.
A. At that time she wasn't presenting me with those symptoms, correct, nor would she present it to the house physician or the endocrinologist.
Q. So the three nurses that saw these symptoms, they should be disregarded in terms of the analysis?
MR. KURI: Objection.
A. I don't know what they saw or what she told them.
Q. Are you critical of the nurses --
A. I'm not being critical. Just that I can't tell you what the patient told them.
Q. You --
A. And how much shortness of breath, what they're judging as shortness of breath.
Q. You have a duty and a responsibility as this patient's physician to evaluate her

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symptoms not only when you're seeing the patient at bedside, but also to evaluate how the patient has been doing over the last 24 hours since you've last seen the patient, correct?
A. Yes.
Q. And you take into account what is told to you by the patient as well as information that's available to you in the hospital chart, correct?
A. Yes.
Q. And if there's sufficient information from one or both of those sources, from the patient and from the hospital chart, that at least continues to keep PE within the differential, then ruling out PE should be done before this patient goes home, true?
A. True, that's true.
Q. The patient was given Tenormin, correct?
A. Right.
Q. What is Tenormin?
A. Beta blocker. Slows the heart rate down.
Q. And in your opinion, did that lead to the conclusion that the patient most likely did

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not have congestive heart failure?
MR. KURI: The fact that you gave them the beta blocker?
A. No, that didn't --
Q. Of what significance was the Tenormin?
A. Tenormin, the endocrinologist suggested that to slow the heart rate down.
Q. Did Tenormin assist you in determining whether or not the patient had a PE?
A. No, that has no relationship to the PE.
Q. Who ultimately had the responsibility to decide whether to do diagnostic studies for a PE, you or the endocrinologist?
A. Well, I think that's, you know, both are responsible.
Q. Did the endocrinologist tell you it was unnecessary to work the patient up for a PE?
A. No.
Q. The final --
A. She obviously didn't find any indication for it.
Q. Pardon me?
A. She obviously didn't find any indication for it in her examination and she just

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worked up the thyroid.
Q. Tell me about the thyroid. What's your understanding as to the significance of the patient's thyroid disease?
A. Her tests were abnormal, which indicated that she may have been hyperthyroid. Hyperthyroid will cause tachycardia.
Q. Her levels, her thyroid levels, were they significant or were they --
A. No, they were mild. And the endocrinologist suggested some other studies.
Q. Certainly one can have a mild case of thyroid disease and still be experiencing a pulmonary embolus, correct?
A. Yeah, you can, yes.
Q. So the fact that she had some findings to the endocrinologist, that would be consistent with the thyroid disease. That doesn't mean that you as the physician treating the patient in the hospital no longer needed to work the patient up for a PE if her signs and symptoms were still consistent with a PE; true?
A. You have to -- you take the consultant's opinions and recommendations.
Q. You didn't consult with her to

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determine whether or not the patient should be worked up for a PE, did you?
A. You consult -- when you have a problem, you consult the appropriate specialist.
Q. Right. But --
A. That specialist should give you their opinion as to what's going on, whether it's in their field or not their field. If it's not their field, you better do something else.
Q. Again, I asked you about PEs, who you would consult with. You said you'd consult with a pulmonary specialist?
A. Pulmonary specialist.
Q. Not an endocrinologist, correct?
A. Correct.
Q. So we can agree that in terms of your work-up of this patient, in terms of whether it was necessary for you to do diagnostic studies to rule out or confirm a PE, you wouldn't rely on a consultation by an endocrinologist to make that decision; true?
A. Right. Correct.
Q. That's your decision --
A. Right.
Q. -- ultimately? And if you had

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sufficient clinical information that should have caused you to work the patient up for a PE, you can't say, well, I relied on the endocrinologist, that's why I didn't do the work-up?
A. No, correct.
Q. That would be bad medicine, right?
A. No. It would be up to me to consult a pulmonologist if I felt it necessary.
Q. You discharged Jean from the hospital and she did not have a work-up done that would meet the standard of care for a patient to rule out pulmonary embolism; true?
A. I worked it up. Did what I felt was necessary considering her symptoms at the time.
Q. But to rule out pulmonary embolism, you'd have to do a VQ scan?
A. You'd have to do a VQ scan.
Q. You didn't do a VQ scan, correct?
A. No, I didn't do a VQ scan.
Q. So she was discharged from the hospital without having the standard tests done to rule out a PE, correct?
A. If that's what you're looking at.
Q. Isn't that a fact, that she was admitted, rule out PE, that you discharged her

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from the hospital without doing the diagnostic study that one would do to rule out a PE?
A. Yeah, I didn't do it, no. But until my opinion and my clinical judgment changed, and I didn't do it.
Q. Did you at any time in the record indicate that you no longer considered this patient to be a rule out PE?
A. No, no notation.
Q. Did you ever note anywhere in the record or tell the patient that you no longer considered her to be a risk for a pulmonary embolism?
A. No, I didn't. It's not in the record.
Q. Did you discuss this patient with your son before you left for vacation?
A. No.
Q. So when he saw her in the office, was this a regularly scheduled visit or was this an unscheduled visit?
A. When I dismissed her on the 28th, I said, we'll follow in the office and probably told her, you know, we'll see you in the office usually within a week and she showed up then. I was gone at that time.

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Q. At the time of discharge, what do your discharge instructions say in terms of how many days she should make the appointment for?
A. I probably said within a week.
Q. Is that what the note says?
A. I didn't even see there anything, but I think in my note I said will follow in office. My practice is to see them within a week or two.
Q. She's discharged on the 28th and she's seen by your son on February 1, correct?
A. When I saw her? Yeah. So that was only like three days.
Q. Her follow-up in the office would have been consistent within this period of time of when you wanted her to come in to see you?
A. Yes.
Q. In other words, when you sent her home, you didn't tell her there was any urgency in terms of her returning to the office, correct?
A. Correct.
Q. You didn't indicate to her that she was still at risk for a pulmonary embolus, correct?
A. Correct.
Q. In fact, in your mind you felt that

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you had ruled out pulmonary embolism, correct?
A. In my mind I was comfortable with the thyroid problem, diagnosis.
Q. That was explaining all of her symptoms, in your opinion?
A. Her tachycardia, even the shortness of breath, tachycardia you get short of breath.
Q. What about pulmonary hypertension and the echo?
A. That could be due to even the chronic lung. The congestive heart failure we ruled out and she was in a medium range there, so we didn't go any further than that.
Q. You said chronic lung. Did she have a history of chronic obstructive lung disease?
A. Just the age alone, your pulmonary fibrosis, toughening of the lungs.
Q. I'm sorry, I didn't mean to interrupt you. Pulmonary hypertension, that would not be inconsistent with her thyroid problem that she had; true?
A. Yeah, the thyroid probably shouldn't necessarily cause that much.
Q. So is it fair to say when she was discharged from the hospital with the abnormal

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findings with regards to pulmonary hypertension, you didn't have a handle on what was causing her pulmonary hypertension at that time; true?
A. At that time, yeah.
Q. And certainly you had a duty and a responsibility to determine what was causing her pulmonary hypertension; true?
A. That could have been worked up later on, too.
Q. You didn't have any plan to work her up further for pulmonary hypertension, did you?
A. I didn't express any there, no.
Q. There's nothing noted in the hospital record, will work her up by doing A, B and C for her pulmonary hypertension at any time in the future, correct?
A. Correct.
Q. Do you know whether your son had access to the hospital records from Barberton when he saw Jean on February 1?
A. No, he wouldn't have the hospital records.
Q. What would he have had?
A. He would have had maybe some lab tests because those are sent to the office.

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Q. Might he have had the echo?
MR. POLITO: Objection.
A. He may not have had the echo. I don't know if they were in the records at that time.
Q. Would you agree that your son, when he saw Jean on February 1, 2001 after the hospitalization, the hospitalization to rule out congestive heart failure and to rule out pulmonary embolism, had a duty to be aware of the findings from the diagnostic work-up that had just been done in the hospital?
MR. POLITO: Objection.
MR. KURI: Objection.
A. When she came into the office, he asked what's the problem at that time. According to his notes he thought the shortness of breath was a resolved problem, so he went no further than that.
Q. Her chief complaint was shortness of breath when she appeared on February 1, 2001, correct?
A. Is that what the secretary -- the secretary writes that over there.
Q. They ask why are you here, right?
A. Yeah.

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Q. They mark down chief complaint, shortness of breath, correct?
A. He said that she had a cough for a couple of days. He felt it was probably just bronchitis at that time.
Q. All right.
A. Treated her for that. But he also wrote down here, her shortness of breath was resolved. She was in the hospital the 28th, felt the shortness of breath was resolved. She apparently wasn't having that much. Just writing shortness of breath does not mean the person is gasping for air. She wasn't in any distress at that time.
Q. Do you need to be gasping for air to be concerned about whether or not the patient is showering emboli?
A. No.
Q. You can have shortness of breath and not be gasping for breath and still be experiencing pulmonary emboli?
A. You can have very mild shortness of breath even if you're having emboli.
Q. Going back to my question, which I don't think you answered, that is when your son

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saw Jean on February 1 and got the history that she had been in the hospital, can we agree that he had a duty to be aware of what the findings were from the diagnostic work-up that had been done in the hospital just four or five days earlier?
MR. POLITO: Wait a minute.
MR. KURI: Objection.
MR. POLITO: That question has been asked and answered. I want you, if you would, to go back and read his previous answer to that same question. I'm allowed under the rules to make an objection whether it's already been asked and answered.
MR. MISHKIND: Right. But I don't want you to make an objection asked and answered and then start telling us what he said. You've asked the court reporter to read it back.
MR. POLITO: Fair enough.
MR. MISHKIND: In fairness to you, I have no problem with her doing that.
(Record read.)
MR. POLITO: He's answered it.
MR. MISHKIND: He hasn't.
BY MR. MISHKIND:

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Q. Doctor, I'll ask you specifically whether or not your son had a duty to be aware of the findings from the diagnostic work-up that had been done in the hospitalization, yes or no?
MR. KURI: Objection.
MR. POLITO: Wait a minute, it's not yes or no. You can't demand that a witness answer yes or no.
MR. MISHKIND: Yes, I can. I most certainly can. What school did you go to that said I can't ask the witness to ask whether your son had a duty --
MR. POLITO: You can ask that. You can't demand he give you yes or no answer.
BY MR. MISHKIND:
Q. Doctor, did your son have a duty to be aware of the results of a diagnostic work-up that had been done in the hospital?
MR. KURI: Objection.
MR. POLITO: Objection.
A. Depends what the patient came in for.
Q. Patient comes in with shortness of breath and --
MR. KURI: I'm going to object to your characterization to what actually was going on

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when she came in there.
A. He apparently was not impressed with the shortness of breath. He felt that was resolved.
Q. Okay. Can we agree, doctor, that your son was covering for you?
A. Yeah.
Q. Can we agree that covering for you he would have had access, if necessary and appropriate, to the same information that you would have had access to on February 1, 2001?
MR. POLITO: Objection.
A. He could go to the hospital and get those records, yes.
Q. Or pick up the phone and call and say, I've got one of my father's patients that was here that was hospitalized and I want certain information, if he felt it necessary he would have been able to do that without going over to the hospital; true?
A. True. He wrote in there she was hospitalized from the 25th to the 28th. Her shortness of breath was resolved. He assumed the diagnosis of thyroid problem was correct, or that was the diagnosis that she gave to him, and he

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found no reason to go any further. She had no swelling of her legs or her lungs were clear, so he had no reason to go back or go further or anything else.
Q. Okay. He would have had access to your note of January 25, correct?
A. That's in the chart, yeah.
Q. And your note of January 25 would have indicated that she was being admitted and it was rule out CHF and rule out PE, right?
A. Right.
Q. Without him getting ahold of people at the hospital, how would he have known whether or not you ruled out a PE during the hospitalization?
A. You say there he went by her, what she told him, thyroid?
Q. So he would have been able to determine on February 1 that you had ruled out a PE because of what she told him concerning the thyroid, is that --
MR. KURI: Let me place an objection. Your questions are getting speculative. You're asking him to assume things the other doctor was doing and what she was thinking at the same time.

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Q. Doctor, I'm not trying to be difficult. I'm just trying to ask you whether or not without calling over to the hospital, would he have had sufficient information from the patient on February 1, from what you know from talking with your son and by looking at his note, to be able to determine that PE had been ruled out during the hospitalization?
MR. KURI: Objection.
MR. POLITO: Objection.
MR. KURI: Asked and answered.
Q. Go ahead, doctor.
A. He obviously had no hospital records there.
Q. Okay.
A. He was going by his clinical impression at the time and what she told him and there is no indication to him there that she had an ongoing PE.
Q. That's now your reading his mind, right?
MR. KURI: No, it's from the note.
A. She says no swelling.
MR. KURI: That's enough. Let him ask a question.

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Q. Doctor, you would agree, would you not, unexplained right ventricular volume or pressure load on echocardiogram should heighten one's concern for pulmonary emboli?
A. Yes.
MR. KURI: Can you read the question back?
Q. Unexplained right ventricular volume or pressure load on an echocardiogram should heighten the concern for pulmonary emboli, and your answer is yes, correct?
A. Yes.
Q. From your son's note on February 1, 2001, did he indicate, from what you can tell, that Jean was given any instructions regarding any signs or symptoms to watch for that would warrant contacting a doctor sooner than one week?
A. No.
MR. KURI: Why don't you get the note just so everyone is clear.
A. He wrote here return to the office for a check in one week.
Q. But he didn't indicate what signs or symptoms she should look for that should cause her to come back sooner than one week, correct?

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MR. KURI: Do you want us to read to you?
MR. MISHKIND: No, he's answered the question.
Q. Doctor, you said --
A. You can't write down everything you say.
Q. I understand that, doctor.
A. He did tell her to come back in a week.
Q. I think you told me before that with significant pulmonary hypertension on an echocardiogram, that that would warrant further work-up?
A. I think you asked that before.
Q. And you agreed with that, correct?
A. Yes.
Q. And when did you plan on doing that further work-up?
A. I had no plan in mind when I dismissed her because she was stable at that time.
Q. So your plan could have been a week, a month, whenever?
A. When I saw her again in the office or at this time he saw her, my son saw her.

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Q. And do you have an opinion, doctor, whether the pulmonary hypertension that was identified on echocardiogram on January 26th, whether or not that was caused by undiagnosed pulmonary emboli?
MR. KURI: Objection.
A. I don't know, I don't know, because --
MR. KURI: You answered the question.
Q. Because of what, doctor?
A. I don't know she had a PE. Obviously she didn't.
Q. Obviously she didn't; is that what you said?
A. Yeah.
Q. You mean on January 26th?
A. Where are we? Right. Correct.
Q. So is it fair to say, though, that it's certainly possible that the pulmonary hypertension that Jean had on echocardiogram on January 26th was caused by an undiagnosed pulmonary emboli?
MR. POLITO: Objection as to form.
MR. KURI: Objection.
A. I don't know.
Q. You can't rule it out, correct?

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A. I can't rule it out.
Q. Did you speak to Jean's family after her death?
A. No.
Q. When did you learn about Jean's death?
MR. KURI: I'm sorry, you said what did you learn?
MR. MISHKIND: When did he learn about the death.
A. I don't remember because I had no -- I didn't even know she was in the hospital. They called this other doctor. I don't know if we saw it in the newspaper or where. I can't remember.
Q. When she was admitted to the hospital they did -- at Akron they did a VQ scan, it showed the high probability of a PE, correct?
A. Yes.
Q. Do you have an opinion as to how long prior to her admission, given -- you've taken a look at the Akron records, correct?
A. Yes.
Q. Do you have an opinion as to how long prior to her admission to Akron General she had been showering emboli prior to that date?
MR. KURI: Objection.

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A. No, I would have no way of knowing.
Q. Can you state to a certainty that she wasn't showering emboli from the DVT going back to the time that she was in Barberton Hospital?
MR. POLITO: Objection.
MR. KURI: Same objection.
A. In my opinion she wasn't showering them then. She would have had more clinical symptoms.
Q. What would you have needed to have seen to be able to say she was probably having a PE back when she was at Barberton?
A. Large swollen leg, being in the calf, shortness of breath to some degree, coughing.
Q. If you had done a VQ scan in the hospital at Barberton, is it your opinion that it would have been negative or low probability?
A. If it's a small PE, could very well have been negative.
Q. Can you state to a probability that it would have been negative?
A. In all probability, it probably would have been negative because of her very mild symptoms.
Q. You told me that Jean was relatively

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healthy before all of this occurred, correct?
A. Correct.
Q. Do you have an opinion as to what Jean's life expectancy would have been had she not suffered the PE and had she not suffered the cerebrovascular accident?
A. She could have had that cerebral -- CVA regardless of anything prior to that.
Q. That wasn't my question. If she had not suffered the CVA and had not suffered the PE, would --
A. There's no way of knowing. She's already exceeded the average length of -- she was how old?
Q. How old was your patient?
A. 74 or 77?
Q. You think she exceeded what?
A. Average length of life expectancy, what is it, around 74 or so?
Q. In your opinion --
A. I have no way of knowing how long she would have lived.
Q. You just said she already exceeded her life expectancy?
A. She reached the median age,

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apparently.
Q. Is it your testimony that she had exceeded her life expectancy at that time at 74 or 77?
A. She reached a median life expectancy. How many more years she could have lived without these, I have no way of knowing that. These things can happen at any time.
Q. I understand that. But absent a CVA, caused by whatever it was caused by, absent the PE, caused by whatever it was caused by, if she didn't have those events happen, do you have an opinion as to how long -- how much longer she would have lived?
MR. KURI: Objection.
A. No.
MR. KURI: He said it twice already.
Q. I take it you don't blame Jean in terms of failing to do anything that caused any of these complications?
A. Oh, no, I don't blame her.
MR. MISHKIND: Give me just a few minutes to look at my notes and also to talk to Maryellen.
(Recess had.)

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BY MR. MISHKIND:
Q. Doctor, if you had clinical reasons to suspect that this patient was having a PE in the hospital at Barberton, would you have anticoagulated her?
A. If I had a positive VQ scan or spiral?
Q. Would you have anticoagulated her before doing either a spiral CT or VQ scan?
A. No.
Q. If you had done a spiral CT or a VQ scan and had a positive -- a high probability VQ or positive CT scan, you then would have anticoagulated the patient, correct?
A. Yes.
Q. And if she had been anticoagulated at that time with a positive VQ scan, would that have minimized, again, this is a hypothetical, you understand, but would that have minimized the likelihood of her continuing to shower emboli in the foreseeable future?
MR. KURI: Objection.
MR. POLITO: Objection.
A. Yes and no. That's -- they still happen. More clots develop in the leg. But that's the purpose of anticoagulation, is to try

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to prevent those things, but it doesn't always happen.
Q. You would then, if you have a patient with DVT with emboli, you have to be more aggressive with your treatment of the patient, correct?
A. Then you would put a filter in.
Q. Greenfield filter?
A. Greenfield filter.
Q. And then you would consider perhaps referral to a pulmonologist for further consultation, correct?
A. Correct.
Q. All things being done, because untreated properly, a PE has a high likelihood of causing death, correct?
A. Not all PEs lead to death.
Q. But they have a high likelihood if they're untreated of causing death?
A. The risk is greater, yes.
Q. And do you know from the hemodynamic standpoint what happens to a patient in terms of their blood pressure when they suffer a PE? Do they have a tendency of becoming hypotensive, hypertensive? What happens?

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A. If you have a massive PE, yes, you're going to drop pressure, respirations.
Q. So --
A. It would have to be a massive one.
Q. You never talked to the doctors at Akron. We discussed that about an hour and a half ago, correct?
MR. KURI: At Akron General.
A. No, I have no knowledge of her there or discussed with anyone there.
Q. You have not had any discussion with them since this case?
A. Correct, no discussion.
Q. In terms of your treatment at Barberton and your -- in terms of your treatment at Barberton and what you did, have we discussed everything that you remember?
MR. KURI: I'm going to object. It's extremely vague.
Q. I've asked you a lot of questions.
A. I think so, yeah. Is there something else you want me to --
Q. I want to know whether there's anything else that you recall about what you did and why you did certain things other than what

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we've already talked about?
MR. KURI: Again, I object.
A. I have no other --
Q. You have no what?
A. I have no other comment.
Q. And the reasons for the admission to the hospital when you saw her on January 25, what you remember about her visit, have you told me everything that you can remember concerning her condition that caused you to admit her to the hospital on January 25?
A. Yes.
Q. You had no contact with her after your son saw her on February 1 and before you learned of her death; true?
A. True.
MR. MISHKIND: No further questions. Thank you, doctor.
MR. POLITO: I have no questions.
MR. KURI: He'll read it.
MR. POLITO: I'll have Pat call you.
MR. MISHKIND: Do you want 28 days?
MR. KURI: Yes, if you would.
(Deposition concluded at 3:26 p.m.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 102 and note the following corrections:

PAGE/LINE REQUESTED CHANGE

_____
PATRICK A. RICH, D.O.

Subscribed and sworn to before me this _____ day of 2003.

Notary Public

My commission expires _____.

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CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

I, Lorraine J. Klodnick, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named PATRICK A. RICH, D.O. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 10th of April, 2003.

Lorraine J. Klodnick, Notary Public
Within and for the State of Ohio
My commission expires July 20, 2007.

97 51:13