

<p>Page 1</p> <p>1 IN THE COURT OF COMMON PLEAS 2 OF SUMMIT COUNTY, OHIO 3 4 KAREN L. ARMOUR, Admin., 5 etc., 6 Plaintiff, 7 vs Case No. 2002-07-4063 8 PATRICK A. RICH, D.O., 9 et al., 10 Defendants. 11 ----- 12 DEPOSITION OF PATRICK A. RICH, D.O. 13 WEDNESDAY, APRIL 2, 2003 14 ----- 15 Deposition of PATRICK A. RICH, D.O., a 16 Witness herein, called by counsel on behalf of 17 the Plaintiff for examination under the statute, 18 taken before me, Lorraine J. Klodnick, a 19 Registered Merit Reporter and Notary Public in 20 and for the State of Ohio, pursuant to notice and 21 stipulations of counsel, at the offices of 22 Reminger & Reminger Co., L.P.A., 80 South Summit 23 Street, Akron, Ohio, commencing at 1:09 p.m., on 24 the day and date above set forth. 25 -----</p>	<p>Page 3</p> <p>1 PATRICK A. RICH, D.O., of lawful age, called 2 for examination, as provided by the Ohio Rules of 3 Civil Procedure, being by me first duly sworn, as 4 hereinafter certified, deposed and said as 5 follows: 6 EXAMINATION OF PATRICK A. RICH, D.O. 7 BY MR. MISHKIND: 8 Q. Would you state your name for the 9 record, please? 10 A. Patrick A. Rich. 11 Q. You are a physician, is that true? 12 A. D.O., yes. Osteopathic physician. 13 Q. Dr. Rich, my name is Howard Mishkind. 14 We were introduced before the deposition started, 15 but I'll officially introduce myself on the 16 record. As I'm sure you know, I'm going to be 17 asking you a series of questions this afternoon 18 concerning your patient and your involvement in 19 her care prior to her death. You understand 20 that, don't you? 21 A. Yes. 22 Q. If I ask you anything that is 23 confusing in any way, tell me you don't 24 understand and I'll scratch my head and try to 25 rephrase it so that it's intelligible. Fair</p>
<p>Page 2</p> <p>1 APPEARANCES: 2 On behalf of the Plaintiff: 3 Becker & Mishkind, by 4 HOWARD MISHKIND, ESQ. 5 660 Skylight Office Tower 6 1660 West 2nd Street 7 Cleveland, Ohio 44113 8 (216) 241-2600 9 On behalf of Defendant Patrick A. Rich, D.O.: 10 Reminger & Reminger Co., L.P.A., by 11 PHILLIP A. KURI, ESQ. 12 200 Courtyard Square 13 80 South Summit Street 14 Akron, Ohio 44308 15 (330) 375-9075 16 On behalf of Defendant Dean P. Rich, D.O.: 17 Bonezzi, Switzer, Murphy & Polito, by 18 JOHN POLITO, ESQ. 19 1400 Leader Building 20 526 Superior Avenue 21 Cleveland, Ohio 44114 22 (216) 875-2767 23 ALSO PRESENT: 24 Maryellen Sansbury, RN/Legal Assistant 25 -----</p>	<p>Page 4</p> <p>1 enough? 2 A. Fair. 3 Q. When you're answering, I'm going to 4 sit quietly and let you finish. I'd ask you to 5 do the same with regard to any questions that I 6 ask, just so we don't have an overlap. Okay? 7 A. All right. 8 Q. Have you had your deposition taken 9 before? 10 A. Yes. 11 Q. I have interrogatory answers that your 12 attorney provided to me and in the 13 interrogatories there's a reference to a claim by 14 Karen West. Was your deposition taken in that 15 case? 16 A. Yes. 17 Q. Is that case still pending? 18 A. No, that was settled. 19 Q. How long ago was that settled, sir? 20 A. About 1995. 21 Q. Do you know who plaintiff's counsel 22 was in that case, do you recall? 23 A. Timothy Scanlon. 24 Q. Mr. Scanlon took your deposition in 25 that case; true?</p>

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

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1 attending physician, then I was involved in that
2 case.
3 The man continued to deteriorate and
4 he ended up passing away at the Cleveland Clinic
5 with other problems, heart and pancreatitis. But
6 the fact he was on isoniazid, he did develop a
7 hepatitis from that.
8 Q. Bruce Hensley also was involved in
9 that case?
10 A. Hensley, he's the one that put him on
11 the isoniazid.
12 Q. That case settled?
13 A. Settled out of court before and
14 between our two companies, insurance companies.
15 Q. Have you ever had your privileges
16 suspended, revoked or called into question?
17 A. No, never.
18 Q. Beside that lawsuit and this lawsuit,
19 have you ever been a party to any other
20 litigation, either as the individual that was
21 bringing a claim or the individual that was
22 having a claim against them?
23 A. No other claims, lawsuits.
24 Q. Do you currently practice?
25 A. Yes.

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1 Q. Where do you practice?
2 A. My office is at 1414 Greensburg Road
3 in Green, Ohio.
4 Q. Do you practice full time?
5 A. Yes.
6 Q. Where did you go to medical school?
7 A. Chicago Osteopathic College.
8 Q. Graduated what year?
9 A. 1958 to 62, graduated in 62.
10 Q. Is there a board certification?
11 A. At that time we graduated as GP,
12 general practitioners. Did a one-year internship
13 at what is now Cuyahoga Falls General Hospital
14 and then I went down and opened an office at my
15 current location in Green.
16 Q. Do you have an area that you
17 specialize in?
18 A. No. I'm just general practice.
19 Q. Have you ever sat to take any type of
20 board certification since finishing your
21 training?
22 A. No.
23 Q. Sometimes people are grandfathered in
24 and become board certified. You're just simply
25 not board certified, period?

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1 A. That's correct.
2 Q. You've not attempted to become board
3 certified and been unsuccessful in any such
4 attempts?
5 A. No.
6 Q. If you wanted to, could you become
7 board certified?
8 A. There was a time when you could have
9 become board certified as family practitioner.
10 When I got out of school, there was no such thing
11 as family practice. It was just general
12 practice. Now it is a three-year specialty
13 family practice.
14 Q. Do you consider yourself a family
15 practice physician or a general practitioner?
16 MR. KURI: Objection. Go ahead and
17 answer.
18 A. What's the difference?
19 Q. If you were an MD, I would equate the
20 difference between a family doctor and an
21 internist; do you follow me on that?
22 A. There's a difference between those,
23 yes.
24 Q. Do you consider yourself more of an
25 internal medicine doctor or more of a family

<p>Page 9</p> <p>1 practice doctor? 2 A. I would be considered family practice. 3 Q. Do you know, you might not know, what 4 the standard of care in terms of working up a 5 patient for congestive heart failure or a 6 pulmonary embolism, whether or not the 7 recognition of the signs and symptoms and then 8 the work-up for congestive heart failure and 9 pulmonary embolism is different for a osteopathic 10 physician as compared to a medical doctor? 11 A. No, there is no difference. 12 Q. Do you know whether the work-up from 13 the standpoint of the recognition of the signs 14 and symptoms and the work-up to rule out or 15 confirm congestive heart failure or pulmonary 16 embolism, whether or not there's any difference 17 in terms of the standard of care between an 18 internal medicine doctor and a family practice 19 doctor? 20 A. No. Should be the same. 21 Q. Okay. Doctor, have you ever applied 22 for privileges at any hospitals and been denied 23 privileges? 24 A. No. 25 Q. I take it you've never been the</p>	<p>Page 11</p> <p>1 was gone, the other would cover. 2 Q. What hospitals do you currently have 3 privileges to admit patients? 4 A. I'm on staff at Barberton Citizens and 5 Akron General. 6 Q. How long have you had privileges at 7 both of those hospitals? 8 A. Well, the first 15 years I was on 9 staff at the Cuyahoga Falls General, then the 10 last 25 I've been on staff at Barberton. And 11 General, I've probably been there 12 years, 12 somewhere around there. 13 Q. Before the deposition started, I asked 14 whether you had a CV and we had a discussion with 15 your attorney and the indication was that you 16 don't have a professional resume; is that true? 17 A. Correct. 18 Q. Just to be fair to you, do you have 19 one back at your office just you don't have one 20 with you? Do you not have one at all? 21 A. I have no printed CV. I could give 22 you that in about two minutes. 23 Q. I understand. We'll probably do that 24 in less than two minutes, but from time to time 25 do you have to submit any type of written</p>
<p>Page 10</p> <p>1 subject of any type of disciplinary action before 2 any state or local medical board; is that true? 3 A. Never, right. 4 Q. Have you ever served as an expert 5 witness -- 6 A. No. 7 Q. -- in connection with any matters? 8 MR. KURI: Let him finish the 9 question. 10 Q. I understand that part of the time 11 that Jean was seeing you and the time right 12 before she died that you were out of town and 13 your son was covering for you -- 14 A. Correct. 15 Q. -- for a period of time? 16 Where is out of town? Is there a 17 particular place you would go to? A vacation? 18 A. I was on vacation. I was in Florida. 19 Q. Did you have a place that you would go 20 to on a regular basis? 21 A. Yes. 22 Q. When you would be out of town for 23 vacation, did you have an arrangement that your 24 son would cover your patients? 25 A. Yes. We covered each other. When one</p>	<p>Page 12</p> <p>1 documentation showing your medical background, 2 your licensure, any professional associations in 3 some type of written format to any of the medical 4 staffs at either Barberton or Akron or anywhere 5 else, for that matter? 6 A. When you initially apply for 7 privileges, but there hasn't been any occasion 8 recently for me to have to supply that 9 information. 10 Q. I take it it's been at least more than 11 five years or so since you've prepared up any 12 type of a professional resume? 13 A. Correct. 14 Q. Even longer than that? 15 A. Even longer than that. 16 Q. More than ten years? 17 A. More than ten years. 18 Q. You have not written anything, 19 correct? 20 A. Correct. 21 Q. Do you do any teaching? 22 MR. KURI: That was an awfully vague 23 question. You have not written anything, you 24 mean in terms of medical articles? 25 MR. MISHKIND: Right.</p>

<p>Page 13</p> <p>1 A. I assumed that. I have not written 2 any articles. 3 Q. You have not published anything in any 4 journals or any textbooks in the area of 5 osteopathic medicine or otherwise; true? 6 A. Right. 7 Q. Do you do any teaching to medical 8 students or residents? 9 A. No, not on a regular basis. I've had 10 medical students in the office from time to time 11 as part of their training for a short period of 12 time, but that's only been once or twice in the 13 years. 14 Q. Are you a member of any professional 15 associations? 16 A. No. 17 Q. Are there state or professional 18 associations that osteopathic physicians -- 19 A. There's the osteopathic state 20 association and there's an AOA association. 21 Q. You're not members of either? 22 A. No. 23 Q. What are -- 24 A. I was at one time. I belonged to 25 those, but over the years I discontinued the</p>	<p>Page 15</p> <p>1 shaking my head. 2 Q. She can, but she can't interpret it. 3 You also have copies of Jean's 4 records, correct? 5 A. Yes, I do. 6 Q. And you have, looks like, copies of 7 your office records as well in a separate file? 8 A. Yes. 9 Q. Have you reviewed anything else to 10 prepare yourself for this deposition today? 11 A. No. 12 Q. At any time since this lawsuit has 13 been filed and you became aware of the lawsuit, 14 have you reviewed any medical literature to 15 familiarize or refamiliarize yourself with regard 16 to anything that would be relevant to your 17 treatment in this case? 18 A. No. 19 Q. Do you own any textbooks in the area 20 of family practice medicine? 21 A. Oh, I have medical books, yeah. In 22 the office, books like the Merck Manual, things 23 that most physicians have. 24 Q. Do you subscribe to any journals? 25 A. Yes, a lot of journals.</p>
<p>Page 14</p> <p>1 memberships. 2 Q. Is there a reason you discontinued the 3 memberships? 4 A. The main reason was the cost of them. 5 Q. Fair enough. 6 A. And I didn't feel any need for it. 7 Q. Okay. So currently you're not a 8 member of any state or national medical 9 professional associations? 10 A. Correct. 11 Q. You've read your son's deposition; 12 true? 13 A. Yes. 14 Q. How long ago did you read that? I 15 think it was taken back in December. 16 A. No. I just skimmed through it last 17 evening. 18 Q. Did you make any notes at all when you 19 read his deposition? 20 A. No, I didn't. 21 Q. Did you dog-ear any of the pages to -- 22 A. No. 23 Q. -- key you in to anything in 24 particular that was of significance to you? 25 A. No, I didn't. She can't see me</p>	<p>Page 16</p> <p>1 Q. Which journals do you get that you 2 consider to be the most reliable, in your mind? 3 MR. KURI: Objection. 4 A. There's a Family Practice journal, 5 Medical Economics and even the AOA journal. 6 Numerous magazines come to the office that we 7 don't even subscribe to; they just come. 8 Q. Your son referenced in his deposition 9 a Principles of Ambulatory Medicine or Ambulatory 10 Medicine. Do you recall seeing that? I think it 11 was at page 16 of his deposition? 12 A. I recall seeing it. 13 Q. Is that a publication that you own as 14 well? 15 A. No. 16 Q. I think he indicated that that's a 17 publication that he refers to from time to time 18 to obtain what he considers to be reliable 19 information in various areas of medicine. 20 If you wanted information about a 21 particular topic, let's talk specifically 22 congestive heart failure and pulmonary embolism 23 and the differential for those two conditions, 24 where would you look to for the most reliable 25 source of up-to-date information on signs and</p>

<p>Page 17</p> <p>1 symptoms of a pulmonary embolism or signs and 2 symptoms of a patient that has congestive heart 3 failure? 4 MR. KURI: Object to the form of the 5 question. Go ahead, doctor. 6 A. I'd look at the Merck Manual. There's 7 another book called Current Diagnostics. 8 Q. Would those be the two that would be 9 the most reliable to you in terms of sources for 10 information on the topic of signs and symptoms of 11 PEs and signs and symptoms of a patient in 12 congestive heart failure? 13 A. I think so. 14 Q. And from time to time you refer to 15 both of those -- to Merck as well as Current 16 Diagnostics? 17 A. Yes. 18 Q. I take it you own both? 19 A. Yeah, I have them in my office. 20 Q. You've just not referred them 21 specifically as it relates to preparing yourself 22 for this case, though, correct? Or have you 23 referred to them? 24 A. No. 25 Q. You've not referred to them?</p>	<p>Page 19</p> <p>1 Q. You understand what the term 2 differential is, don't you? 3 A. Yes. 4 Q. So we're talking the same language, 5 what is a differential? 6 A. Speaking of my differential diagnosis? 7 Q. Yes. 8 A. When you speak of your differential 9 diagnosis, you're talking about a list of 10 conditions that you are considering under the 11 case you're working on at the time. 12 Q. When you look at a patient that 13 presents with acute onset of symptoms and you 14 arrive at a differential, do you try to consider 15 in the differential what may be the most serious 16 potential explanation versus the most benign 17 explanations for those signs and symptoms? 18 A. Yes, I think you always should start 19 with most serious, rule that out first. 20 Q. And certainly you recognize that a 21 patient that has signs and symptoms of a PE, that 22 that can be a life-threatening condition; true? 23 A. Can be. 24 Q. And it's not something that should be 25 taken lightly if in fact you have reason to</p>
<p>Page 18</p> <p>1 A. No. 2 Q. But you own them and you consider them 3 to be generally reliable sources of information 4 in these two areas of medicine; true? 5 A. Yes. 6 Q. Besides your son's depo, the records 7 on Jean and your many years of experience as an 8 osteopathic physician, what do you bring with you 9 today that you've either reviewed or that you're 10 applying to be able to answer the questions 11 today? In other words, did you review anything 12 else other than the depo, the records and bring 13 with you your education and training? 14 A. No. 15 Q. Poorly worded question and I was 16 trying to be smart with it. 17 Obviously you've been practicing for 18 many years and I'm sure you've seen patients in 19 your practice that have had signs and symptoms of 20 a PE; true? 21 A. Yes. 22 Q. And you've seen patients that have 23 presented with signs and symptoms of congestive 24 heart failure; correct? 25 A. Yes.</p>	<p>Page 20</p> <p>1 believe that the patient may have a pulmonary 2 embolism; true? 3 A. True. 4 Q. Just a couple other background 5 questions, then we're going to talk specifically 6 about Jean, okay? 7 Your patient population as an 8 osteopathic doctor, is it from crib to grave, 9 from baby to geriatric? 10 A. Yes. 11 Q. That may have been a poor term to use 12 initially, but you treat all-comers? 13 A. Infants to elderly. 14 Q. In your practice have you concentrated 15 more in any one area of patient population than 16 the other? 17 A. No. 18 Q. I take it you remember Jean? 19 A. Yes. 20 Q. Tell me about her. I never met her. 21 MR. KURI: Objection. Vague question, 22 but what you can recall. 23 A. Very nice lady. I've seen her over 24 the years, I don't know how far back it went, 25 maybe 60, but then there was periods I didn't see</p>

<p>Page 21</p> <p>1 her. Then I started to see her again within the 2 last three years ago again. Very pleasant woman. 3 Healthy woman. 4 Q. Her husband died a year or less before 5 her. Do you remember that? 6 A. I didn't care for him, so -- 7 Q. Did you ever meet him? 8 A. I don't want to say I didn't care for 9 him. I didn't treat him, so I'm not familiar 10 with his -- 11 Q. In the physician/patient meaning of 12 that term you didn't care for him? 13 A. Right. 14 Q. You had met him from time to time or 15 not? 16 A. I can't really picture him in my mind. 17 Q. Do you know what type of relationship 18 Jean had with her husband? 19 A. No, I can't really speak on that. 20 Q. Do you know how Jean reacted to the 21 death of her husband? 22 A. Well, I didn't get into that, really. 23 Q. Okay. So you have no opinion in terms 24 of whether she was suffering any unusual reaction 25 to the death of her husband?</p>	<p>Page 23</p> <p>1 General. 2 MR. KURI: Doctor, just so you're 3 aware, he's only asking you after this was taken. 4 I want to make sure we're clear. 5 Q. So you have talked about the case, 6 correct? 7 A. Yes. 8 Q. Did you and he sit down and review his 9 deposition testimony together? 10 A. No, we never sat down. I reviewed 11 that myself. 12 Q. Did you ever ask him any questions 13 after you read the deposition to get some 14 clarification in terms of what he meant or what 15 he said at any particular page? 16 A. No, no. 17 Q. When the two of you talked about Jean, 18 did he express to you any opinions as to what he 19 believed to be Jean's cause of death? 20 A. You talking about the cause of death? 21 Q. Yes. 22 MR. KURI: He's -- 23 A. Yes. 24 MR. KURI: -- asking what your son 25 told you.</p>
<p>Page 22</p> <p>1 A. Let me look at my notes to see if I 2 gave her anything, a nerve pill or something. 3 Q. Sure. Doctor, as you're looking at 4 that, let me tell you one thing since you've only 5 had your deposition taken twice, when I ask you 6 questions, sometimes I just fire away one 7 question after another. That's not intended to 8 prevent you from looking at your records to 9 answer the question, so don't feel that I'm 10 trying to force you to give me an answer if you 11 feel you need to look at your records, okay? 12 A. Yeah. I just don't remember her 13 discussing her husband, his death or -- I don't 14 see anything in here where I gave her like a 15 nerve pill or something. 16 Q. Now, doctor, since your son's 17 deposition has been taken, have you and he talked 18 about this case? 19 A. Yes. 20 Q. Tell me in general or specific, 21 whatever is easier for you, what you and he have 22 talked about concerning this case since his 23 deposition was taken. 24 A. We discussed the case, the problem and 25 then what the patient -- what happened in Akron</p>	<p>Page 24</p> <p>1 A. We talked about the cause of death. 2 Q. And are the two of you, at least as 3 far as you understand, are the two of you 4 essentially in agreement as to what you believe 5 most likely was the cause of death? 6 A. I think so, yes. 7 Q. Tell me what that is. 8 A. Cause of death was a CVA, a stroke. 9 Q. And have you ever talked to any of the 10 doctors that treated Jean when she was admitted 11 to Akron? 12 A. No. 13 Q. Do you have an opinion as to what -- 14 have you and your son talked about what caused 15 the CVA, the stroke? 16 A. Yes. When you have a stroke, the 17 blood vessel clots up. Hardening of the 18 arteries. She had a massive stroke on one side 19 of her head. The other cause would be a blood 20 clot coming from her heart because she was in 21 atrial fibrillation, irregular heart rate. That 22 will throw off a clot, and that's what happened 23 there. 24 Q. All right. It's your opinion, she 25 suffered an embolic or thrombotic event leading</p>

<p>Page 25</p> <p>1 to her CVA? 2 A. Correct. 3 Q. And have you seen any evidence in any 4 of the medical records that would support that 5 there was a thrombotic event that caused her CVA? 6 A. She was in atrial fibrillation when 7 she went in the hospital. That will throw off 8 embolism to the brain. Well, they did a CAT scan 9 and she had a massive stroke on one side, but 10 which one, did it just plug up because of 11 hardening of the arteries or from the embolus, 12 there's no way of knowing that. 13 Q. Well, when you looked at the records, 14 did you see any evidence that tests were done 15 that would cause you or your son to be able to 16 say that the cause of her stroke was a thrombotic 17 event secondary to complications from her atrial 18 fibrillation? 19 A. I'm not sure I know how to answer 20 that. You can't tell what happened there. One 21 or the other happened. 22 Q. Well, patient can have an embolic 23 event? 24 A. Correct. 25 Q. Patient can have a thrombotic event,</p>	<p>Page 27</p> <p>1 A. You don't have an embolic event from 2 the lung to the brain. It had to come from her 3 heart. 4 Q. Okay. Can you have a PE and have a 5 stroke without having evidence of some thrombotic 6 or embolic event to the brain? 7 A. I don't understand. Can you have a -- 8 repeat your question. 9 Q. There's no question that she suffered 10 pulmonary emboli, correct? 11 A. No, I wouldn't say -- 12 MR. KURI: Talking about at Akron 13 General? 14 Q. Well, you see evidence -- do you 15 dispute whether this patient experienced a 16 pulmonary emboli? 17 A. At Akron General she had -- they did a 18 VQ scan and it said high probability. 19 Q. Okay. So can we agree, and we're 20 going to talk about your treatment in a moment, 21 I'm starting at the end and moving backwards, but 22 can we agree that the VQ scan that showed a high 23 probability of a pulmonary embolism would suggest 24 that the patient does in fact, at least at the 25 time that she was seen at Akron General,</p>
<p>Page 26</p> <p>1 correct? 2 A. Correct. 3 Q. Patient can also have a hemorrhagic 4 event, correct? 5 A. Correct. 6 Q. So there are actually three ways one 7 can have a stroke; true? 8 A. She did not hemorrhage. They would 9 have seen that on the CAT scan. 10 Q. Do you have an opinion as to whether 11 there is any causal relationship between her 12 pulmonary embolism that she had and her CVA? 13 A. No relationship. 14 Q. On what do you base that? 15 A. It just doesn't happen. The blood 16 clot to the lung, a PE, does not go to the brain. 17 Q. And, again, you're assuming that the 18 blood clot that causes the PE, you're assuming 19 that in order to have a stroke secondary to 20 complications from the PE, that there would have 21 to be some continued embolic event from the lungs 22 to the brain? 23 MR. KURI: Objection. 24 A. No, that's incorrect. 25 Q. Okay.</p>	<p>Page 28</p> <p>1 experience some embolic event that caused a PE? 2 A. Embolic event of PE had to come from a 3 DVT -- 4 Q. Okay. 5 A. -- to the lung. 6 Q. Do you have an opinion as to where the 7 deep vein thrombosis was that caused the embolic 8 event to the lung? 9 A. They did a Doppler study and it was 10 from -- I don't remember which leg, I can't 11 remember. That went to the lung. 12 Q. Okay. Now, from a pathophysiology 13 standpoint, is it your testimony, I just want to 14 understand this so I understand your knowledge of 15 medicine, that the occurrence of the PE that was 16 diagnosed in Akron General and her ultimate CVA, 17 which you believe was the cause of her death, is 18 it your opinion that there is no direct causal 19 relationship between the two? 20 A. Correct. 21 Q. You don't believe that there is any -- 22 okay. I'll accept that. Do you know Dr. Michael 23 Ginella? 24 A. No, I don't. 25 Q. Have you ever seen the death</p>

<p>Page 29</p> <p>1 certificate for Jean? 2 A. Yes. 3 Q. It's in the material that was provided 4 to you, correct? 5 A. Yes. 6 Q. You see that he has indicated the 7 cause of her death being respiratory failure due 8 to pulmonary embolism. You see that, don't you? 9 A. That's wrong. 10 Q. You disagree with that? 11 A. I disagree with that. 12 Q. Okay. Because you believe that the 13 cause of her death was a cerebrovascular 14 accident, correct? 15 A. That started the downhill course. 16 Q. The cascade of events? 17 A. All the problems that evolved from 18 that. 19 Q. But you don't believe that the 20 pulmonary embolism was a contributing factor to 21 cause the CVA; true? 22 MR. KURI: Objection. Asked and 23 answered. 24 A. True. 25 Q. So it's your opinion that more likely</p>	<p>Page 31</p> <p>1 A. No, I don't think he did. 2 Q. Tell me what are the signs of a DVT? 3 A. DVT, deep vein thrombosis, usually 4 pain in the leg, usually in the calf area, 5 swelling of the leg. 6 Q. Is the swelling always symptomatic? 7 A. Depends on which vessel. Sometimes 8 you'll have a small vessel that it doesn't cause 9 that much blockage and you may not get that much 10 swelling, but most of the time there is going to 11 be swelling of the leg. 12 Q. Jean did have a history of DVTs, 13 correct? 14 A. No. She had phlebitis. 15 Q. She had superficial -- 16 A. Superficial phlebitis. 17 Q. Is a patient that has superficial 18 phlebitis at increased risk of DVTs? 19 A. No. 20 Q. Is it your testimony that that is not 21 supported by the medical literature? 22 A. That's my opinion. 23 Q. Okay. Are there instances that you 24 have seen in your practice the patients that have 25 had superficial phlebitis have progressed to</p>
<p>Page 30</p> <p>1 than not she would have suffered the 2 cerebrovascular accident irrespective of whether 3 she had a PE or not? 4 A. Very likely would have happened, yes. 5 Q. Have you personally, other than with 6 your attorney, but have you personally alone or 7 in conjunction with your son reviewed the medical 8 records with any doctors to arrive at a 9 conclusion that in fact the patient's cause of 10 death was complications from the CVA as opposed 11 to complications from the PE? 12 A. No. I didn't discuss it with other 13 doctors -- 14 Q. Okay. 15 A. -- to clarify that. 16 Q. Your answer was, even though my 17 question may not have been artfully stated, your 18 answer indicated that you at least I think knew 19 what I was asking. 20 A. Yeah. I didn't review this record 21 with anybody. 22 Q. Okay. Do you know whether your son 23 has reviewed the case with anyone from the 24 standpoint of whether the CVA was in fact the 25 cause of her death?</p>	<p>Page 32</p> <p>1 develop deep vein thrombosis? 2 A. No. 3 Q. DVT is diagnosed through what 4 modality? How do you go about diagnosing it? 5 A. Through a Doppler study. 6 Q. Anything else? 7 A. We can do a venogram. 8 Q. Any other diagnostic modalities that 9 you're familiar with in terms of diagnosing DVT? 10 A. That should give you your answer. 11 Q. Can you rule out or confirm the 12 existence of a DVT without doing some type of 13 imaging study? 14 A. No. 15 Q. If you determine that a patient has a 16 DVT, how is it treated? 17 A. With anticoagulants such as heparin 18 and Coumadin. 19 Q. You mentioned earlier that she had 20 atrial fib, correct? 21 A. Yes. 22 Q. Did she have atrial fib from a 23 long-standing perspective? 24 A. No. 25 Q. When was she diagnosed with atrial</p>

<p>Page 33</p> <p>1 fib?</p> <p>2 A. Her cardiogram showed when she went in</p> <p>3 Akron General, her cardiograms upon her admission</p> <p>4 to Barberton were normal.</p> <p>5 Q. Do you have an opinion as to what</p> <p>6 caused the atrial fib?</p> <p>7 A. Frequently it will start with you may</p> <p>8 have a heart attack. That will throw them into</p> <p>9 atrial fib. Just plain coronary artery disease,</p> <p>10 as we get older, hardening of the arteries.</p> <p>11 Hyperthyroidism, thyrotoxicosis will show up as</p> <p>12 atrial fib.</p> <p>13 Q. In this case do you have an opinion as</p> <p>14 to what most likely was the cause of her atrial</p> <p>15 fib?</p> <p>16 A. She didn't have a heart attack. They</p> <p>17 did enzyme studies when she went into General.</p> <p>18 Just occurred.</p> <p>19 Q. I take it then you don't have an</p> <p>20 opinion to a reasonable degree of medical</p> <p>21 certainty or probability as to what the mechanism</p> <p>22 was that caused the atrial fib?</p> <p>23 A. Age and coronary artery disease.</p> <p>24 Atrial fib is quite common as you get older.</p> <p>25 It's quite common as you get older.</p>	<p>Page 35</p> <p>1 fibrillation, whatever, yes, you consult a</p> <p>2 cardiologist.</p> <p>3 Q. I take it you believe that your</p> <p>4 conduct in terms of not consulting with a</p> <p>5 cardiologist while she was in the hospital was</p> <p>6 within the standard of care?</p> <p>7 A. Yes.</p> <p>8 Q. During that hospitalization, though,</p> <p>9 you did not see any evidence of atrial fib,</p> <p>10 correct?</p> <p>11 A. Correct.</p> <p>12 Q. I just want to make sure I understand</p> <p>13 your testimony. Do you believe that had you done</p> <p>14 certain studies that weren't ordered when she was</p> <p>15 in the hospital, that you would have seen</p> <p>16 evidence of atrial fib, or is it your testimony</p> <p>17 that she developed atrial fib at some time after</p> <p>18 the hospitalization and prior to her death?</p> <p>19 A. When she was in Barberton, she was not</p> <p>20 in atrial fib. We have a normal cardiogram</p> <p>21 showing normal rhythm.</p> <p>22 Q. Okay.</p> <p>23 A. Atrial fib developed sometime after</p> <p>24 that.</p> <p>25 Q. And can pulmonary emboli cause a</p>
<p>Page 34</p> <p>1 Q. She never demonstrated any signs and</p> <p>2 symptoms of atrial fib when you had seen her,</p> <p>3 correct?</p> <p>4 A. Correct.</p> <p>5 Q. You had seen her in the</p> <p>6 hospitalization just a week before her death,</p> <p>7 correct?</p> <p>8 A. Correct.</p> <p>9 Q. You didn't obtain any type of a</p> <p>10 cardiac consult during that hospitalization, did</p> <p>11 you?</p> <p>12 A. She had a normal rhythm cardiogram, so</p> <p>13 there was no need for a cardiologist.</p> <p>14 Q. Certainly you could have consulted</p> <p>15 with a cardiologist had that been the appropriate</p> <p>16 thing to do, correct?</p> <p>17 A. If she was having --</p> <p>18 MR. KURI: Hold on a second. Are you</p> <p>19 asking if it was the appropriate thing to do or</p> <p>20 whether he could have just consulted?</p> <p>21 Q. If it was the appropriate thing to do</p> <p>22 under like or similar circumstances, you would</p> <p>23 have had the ability to consult with a</p> <p>24 cardiologist, correct?</p> <p>25 A. Yes, if she had some cardiac symptoms,</p>	<p>Page 36</p> <p>1 patient to go into atrial fib?</p> <p>2 A. No.</p> <p>3 Q. You're certain?</p> <p>4 A. Certain.</p> <p>5 Q. If the patient had been diagnosed with</p> <p>6 atrial fib when you had her hospitalized,</p> <p>7 hypothetically, and you also had a concern about</p> <p>8 DVT and wanted to treat the patient for a DVT,</p> <p>9 would there have been any contraindication in</p> <p>10 terms of providing anticoagulation therapy for</p> <p>11 the DVT for a patient who also has atrial fib?</p> <p>12 A. No.</p> <p>13 Q. In fact, the treatment is one in the</p> <p>14 same, is it not?</p> <p>15 A. You could very well anticoagulate them</p> <p>16 if they're in atrial fib as well.</p> <p>17 Q. What are the complications that you</p> <p>18 see in your practice with a patient that has a</p> <p>19 DVT that is not properly treated?</p> <p>20 A. Well, the most common thing would, of</p> <p>21 course, be probably a PE and then progressive</p> <p>22 problems, swelling of the leg.</p> <p>23 Q. Let's talk about a PE. The signs and</p> <p>24 symptoms of a PE are what?</p> <p>25 A. They'll vary from just a simple cough,</p>

<p>Page 37</p> <p>1 shortness of breath, chest pain, coughing up 2 blood, respiratory failure. 3 Q. Any others? 4 A. Tachycardia. 5 Q. Any others? 6 A. If it's a major one, maybe sweaty, 7 clammy. That's about it. 8 Q. Can a pulmonary emboli be ruled out on 9 the basis of physical exam alone? 10 A. No. You could become highly 11 suspicious with your physical exam. 12 Q. But in order to rule out or confirm 13 the presence of a PE, what's the gold standard? 14 A. To do a VQ scan or spiral CT scan. 15 Q. And as a family practice physician, 16 you're familiar with the availability of VQ scans 17 to rule out or confirm the presence of pulmonary 18 embolism, correct? 19 A. Yes. 20 Q. And you're familiar with the signs and 21 symptoms that are associated with a patient that 22 has the potential for developing a PE, correct? 23 A. Yes. 24 Q. And those signs and symptoms are signs 25 and symptoms that should be recognized equally by</p>	<p>Page 39</p> <p>1 on an arterial blood gas that would at least 2 cause you to at least consider pulmonary 3 embolism? 4 A. Your pulse ox gets way down, maybe in 5 the, well, 60s, 70s, even 80s. 6 Q. Doctor, you would agree, would you 7 not, that if there's suspicion for pulmonary 8 emboli that diagnostic studies should be done 9 promptly to confirm or to rule out the diagnosis? 10 A. Yes. 11 Q. And failure to do diagnostic studies, 12 if there is a suspicion for pulmonary emboli, 13 that would be a violation of the standard of 14 care; true? 15 A. Yes, if you suspect it, you should do 16 it. 17 Q. Or if you have a high index of 18 suspicion, it would be below the standard of care 19 not to do diagnostic studies to either rule out 20 or confirm it; true? 21 A. Yes. 22 Q. And in fact if you have clinical 23 evidence that causes you to have a PE within your 24 differential, not to rule out or confirm the PE 25 by doing those tests would be below the standard</p>
<p>Page 38</p> <p>1 a medical doctor as well as an osteopathic 2 physician, true? 3 A. Correct. 4 Q. Same standard of care? 5 A. Same standard. 6 Q. Besides a VQ scan, is a chest x-ray of 7 any assistance or benefit in terms of ruling out 8 or confirming the presence of pulmonary embolism? 9 A. Unless it's a massive pulmonary 10 embolism, a chest x-ray would be negative. 11 Q. What about any type of pulmonary 12 angiogram, would that be of any benefit? 13 A. Yeah, angiogram, pulmonary angiogram 14 would benefit. 15 Q. I think you said a spiral CT? 16 A. Spiral CT. 17 Q. Are there any laboratory tests that 18 you have within your arsenal that are helpful in 19 terms of determining whether a patient has a PE? 20 A. Blood gases, oxygen levels. 21 Q. If you have a patient that has a 22 pulmonary embolism, what would you expect to see 23 if you took arterial blood gases? 24 A. The oxygen level would be decreased. 25 Q. What would be an abnormal oxygen level</p>	<p>Page 40</p> <p>1 of care? 2 A. Yes. 3 Q. Okay. I think you told me before in 4 your practice you treated patients that have had 5 PEs? 6 A. Yes. 7 Q. Have you admitted them to the 8 hospital? 9 A. Yes. 10 Q. And then have you followed them on an 11 outpatient basis? 12 A. Yes. 13 Q. They've been on Coumadin or some type 14 of anticoagulation therapy? 15 A. Yes. 16 Q. Are they typically on that for the 17 rest of their lives or does it depend upon the 18 extent of the embolic event? 19 A. It depends. There was a time when we 20 would keep them on an anticoagulant for six 21 months. Now the tendency is sometimes to keep on 22 for the rest of their lives. 23 Q. If you diagnose in your practice a 24 patient with pulmonary emboli, it has confirmed 25 by diagnostic studies and been treated in the</p>

<p>Page 41</p> <p>1 hospital, do you on occasion refer the patient to 2 a specialist for ongoing management of that 3 condition? 4 A. Yes. 5 Q. And if you were to refer a patient to 6 a specialist for ongoing management of a 7 pulmonary embolus, what area of medicine would 8 that be? 9 A. I would call in a pulmonologist. 10 Q. I take it you'd agree that prompt 11 treatment of a pulmonary emboli increases the 12 chances for survival? 13 A. Yes. 14 Q. If you can treat a patient that has 15 emboli or embolic events going on from a deep 16 vein thrombosis before the patient's hemodynamic 17 status deteriorates, the likelihood of a good 18 outcome is increased, true? 19 A. Yes. 20 Q. One of the goals of treatment of a 21 pulmonary embolus is to stop the deep vein 22 thrombosis from increasing in size; true? 23 A. Right. 24 Q. And you give the anticoagulant heparin 25 or if there's any sensitivity, one or the other</p>	<p>Page 43</p> <p>1 Q. I asked you before about Jean; you 2 said she was a nice woman. I think you also said 3 that she was relatively healthy, correct? 4 A. For her age she was. 5 Q. Was she compliant with your medical 6 management of her over the years? 7 A. Yes. What little I treated her, she 8 was compliant. 9 Q. Sometimes doctors will say, the 10 patient never followed my advice or never did 11 this or that. That's not the case with Jean, 12 correct? 13 A. She didn't seek that much medical 14 assistance. 15 Q. What she did, was she appropriate and 16 reasonable in terms of her understanding of what 17 you had to say to her? 18 A. Yes. 19 Q. And also in term of responding to any 20 recommendations that you made relative to her 21 medical management? 22 A. Yes. 23 Q. So you would not describe her as a 24 noncompliant patient; true? 25 A. True.</p>
<p>Page 42</p> <p>1 anticoagulants -- 2 A. Start with heparin. 3 Q. Once the clot caused by the DVT is 4 treated, does the body then have its own 5 mechanism that it dissolves the clots? 6 A. No. That clot will remain. There's 7 some theory that that vein may open up a little 8 bit, but generally that clot is going to stay 9 there. 10 Q. Does the body have any type of process 11 whereby the clot is autolyzed, if you will, or 12 broken up over time through any mechanism the 13 body produces? 14 A. Does that clot maybe shrink over a 15 period of time? Get smaller? I imagine it can. 16 I don't know. 17 Q. Does the risk for embolization from a 18 DVT decrease the longer the patient is on 19 anticoagulants? 20 A. I would think so. 21 Q. If the patient presents with reports 22 of leg swelling and new complaints of shortness 23 of breath, should pulmonary embolism be within 24 the differential diagnosis? 25 A. Yes.</p>	<p>Page 44</p> <p>1 Q. You saw her back in October of 1986 2 for the first time, correct? 3 A. Somewhere back there. 4 Q. As I told you before, I'll keep to my 5 promise, I'm not going to go through each and 6 every one of the visits, but suffice it to say 7 from 1986 up to the time of her death, before she 8 went in to Akron General where she ultimately 9 died, you were her physician, correct? 10 A. Yes. 11 Q. She didn't have any underlying cardiac 12 or pulmonary problems that you were aware of 13 prior to January of 1999, did she? 14 A. No. 15 Q. Did she have a history of 16 hypertension? 17 A. No, she was not hypertensive. 18 Q. She didn't have any risk factors for 19 heart disease, to your knowledge, did she? 20 A. Correct. 21 Q. You might want to keep your records 22 available because I'm going to ask you some 23 specific questions about the office visits now. 24 The paragraph before January 25, 2001, 25 you had last seen her in -- I'm sorry, in looks</p>

<p>Page 45</p> <p>1 like January of 2000, correct?</p> <p>2 A. 2000.</p> <p>3 Q. January 6, 2000?</p> <p>4 A. January 6.</p> <p>5 Q. And at that time she had some</p> <p>6 dizziness; true?</p> <p>7 A. Yes.</p> <p>8 Q. When nose runs, she -- I can't read</p> <p>9 that.</p> <p>10 A. When nose runs, she doesn't seem as</p> <p>11 dizzy. That was written by the office personnel</p> <p>12 when she came in.</p> <p>13 Q. The blood pressure, was that taken by</p> <p>14 an office person or was that taken by you?</p> <p>15 A. No, that's taken by me.</p> <p>16 Q. Are the notes then to the right of the</p> <p>17 blood pressure, are all of those notes yours?</p> <p>18 A. Yes.</p> <p>19 Q. Did you diagnose her with vertigo?</p> <p>20 A. Yes, that was my impression.</p> <p>21 Q. What was causing the vertigo?</p> <p>22 A. Vertigo can be caused by numerous</p> <p>23 problems. Very commonly if you have a little</p> <p>24 sinus infection, that will trigger it off. Also,</p> <p>25 consider hypertension, consider carotid artery</p>	<p>Page 47</p> <p>1 A. You're getting some back pressure,</p> <p>2 cardiac or lung.</p> <p>3 Q. In the lower right-hand corner on</p> <p>4 January 6th, doctor, you have a note. Can you</p> <p>5 read what that says?</p> <p>6 A. Yeah. If her dizziness persists, then</p> <p>7 I would do a carotid artery study.</p> <p>8 Q. So within your differential at that</p> <p>9 point, you obviously were at least concerned</p> <p>10 about there being some potential pathology that</p> <p>11 might explain the vertigo?</p> <p>12 A. Yes.</p> <p>13 Q. And the testing that you would have</p> <p>14 done, had you followed this through, would have</p> <p>15 been to refer her to someone or would you have</p> <p>16 done testing?</p> <p>17 MR. KURI: Objection. He didn't say</p> <p>18 if he would have followed it through.</p> <p>19 A. No. I would have worked her up and I</p> <p>20 did. I did a carotid artery study.</p> <p>21 Q. When did you do the carotid artery</p> <p>22 study?</p> <p>23 A. Well, it was scheduled for January</p> <p>24 25th at Akron General.</p> <p>25 Q. That's January 25th of 01?</p>
<p>Page 46</p> <p>1 disease where she didn't have any bruits there,</p> <p>2 as I wrote. That's the little noise you hear</p> <p>3 when you're plugged up. She was worse with</p> <p>4 motion like motion sickness, such as being on a</p> <p>5 boat. That will make you dizzy. My impression,</p> <p>6 this was just a standard vertigo probably brought</p> <p>7 on by her sinus.</p> <p>8 Q. What other conditions can cause</p> <p>9 vertigo?</p> <p>10 A. Well, like I stated, hypertension,</p> <p>11 blockage of the carotid arteries.</p> <p>12 Q. When she would come in for</p> <p>13 examinations, would you always look to see</p> <p>14 whether there was any evidence of JVD?</p> <p>15 A. Look for DVT?</p> <p>16 Q. JVD.</p> <p>17 A. What am I missing here?</p> <p>18 Q. Do you know what JVD is?</p> <p>19 A. No.</p> <p>20 Q. Have you ever heard of jugular venous</p> <p>21 distention?</p> <p>22 A. Oh, yeah. No. I would recognize that</p> <p>23 especially when I examined for the carotids.</p> <p>24 Q. Of what significance would jugular</p> <p>25 venous distention have to you if you detected it?</p>	<p>Page 48</p> <p>1 A. No, no, 2000. The next page. The</p> <p>2 secretary scheduled --</p> <p>3 Q. Got it.</p> <p>4 A. If she had some other neurological</p> <p>5 symptoms, you may want to do a CAT scan. At that</p> <p>6 time I did the carotid artery, the Doppler study.</p> <p>7 Q. Okay. Then you saw her. Was the</p> <p>8 Doppler study normal?</p> <p>9 A. I'm sure it was. I was looking</p> <p>10 through it -- I don't know if you have it over</p> <p>11 there -- I know she had -- here is -- yes, here</p> <p>12 it is.</p> <p>13 Q. What's the date of that?</p> <p>14 A. 1-25-2000. And normal carotid</p> <p>15 studies.</p> <p>16 Q. You saw her again then on April 3,</p> <p>17 2000, correct?</p> <p>18 A. Yes. She came in for another reason.</p> <p>19 Q. She had a pulled muscle in her back?</p> <p>20 A. Uh-huh.</p> <p>21 Q. That's a yes?</p> <p>22 A. Yes.</p> <p>23 Q. Her dizziness had gone away, that's a</p> <p>24 good sign, isn't it?</p> <p>25 A. Yes.</p>

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1 Q. What was your diagnosis as of April 3,
2 2000?
3 A. That she just had a tendonitis,
4 bursitis.
5 Q. You treated it with what type of
6 medication?
7 A. I gave her an antiinflammatory and I
8 injected her along her right side of her scapula
9 area.
10 Q. She then returned on November 2nd,
11 2000, true?
12 A. She came in for a flu shot.
13 Q. Then the next time you would have seen
14 her would have been January 25, 01, correct?
15 A. Correct.
16 Q. Do you recall having any contact with
17 Jean in 2000 and early 2001 other than what's
18 recorded in your office notes?
19 A. No, no contact.
20 Q. January 25, 2001, Jean came in and was
21 complaining of swollen left leg the week before
22 the visit to you; true?
23 A. That's what she said.
24 Q. In fact, you have down, had swelling
25 left leg last week, correct?

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1 A. No.
2 MR. KURI: That question was in the
3 office?
4 MR. MISHKIND: Right.
5 Q. I mean, based upon the history that
6 she gave you and the physical exam, you couldn't
7 determine what was causing her shortness of
8 breath, correct?
9 A. Correct.
10 Q. Now, she had had, I'm not going to go
11 through all the records, but her superficial
12 phlebitis that she had had, I noted it in 87, in
13 89 and in 97. You don't need to necessarily go
14 back to your records, but in reviewing your
15 records do you recall that she had had two or
16 three episodes of superficial phlebitis?
17 A. I probably at that time looked through
18 her record.
19 Q. But is it your testimony that she was
20 not at risk for a PE due to her history of
21 phlebitis?
22 A. Correct.
23 Q. She was also tachycardic on January
24 25, 2001, correct?
25 A. Yes.

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

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1 Q. In the past did Jean have a tendency
2 of being tachycardic?
3 A. No.
4 Q. What was causing her tachycardia on
5 January 25, 2001?
6 A. That's why I put her in the hospital
7 that day.
8 Q. You weren't able to determine what was
9 causing it, correct?
10 A. Right.
11 Q. So you knew you had a patient with
12 shortness of breath; true?
13 A. True.
14 Q. You knew you had a patient that was
15 tachycardic; true?
16 A. True.
17 Q. You knew you had a patient that
18 presented with some difficulty breathing
19 requiring another pillow at 4 a.m. that morning
20 before she came to see you; true?
21 A. True.
22 Q. A history that week of swelling in her
23 left leg; true?
24 A. True.
25 Q. And also shortness of breath

<p>Page 53</p> <p>1 especially with walking and that was a history of 2 having shortness of breath with walking for three 3 days; true? 4 A. That's what she stated. 5 Q. And you had no reason to suspect that 6 that history was inaccurate, do you? 7 A. No, that was true. 8 Q. Now, your examination, tell me what 9 you detected relative to her breathing during 10 your exam. 11 A. She was not in any respiratory 12 distress. Her symptoms were very mild. This is 13 why the picture was confusing. She had no cough. 14 She had no respiratory symptoms like a cold. She 15 had no chest pain. She had no leg swelling. She 16 had no PTE, pretibial edema as swelling of the 17 leg, although she said her leg had swollen 18 previously, obviously it went down. 19 Her lungs were clear and the only 20 finding was a tachycardia. And for that reason 21 not because she was that short of breath, she was 22 quite comfortable in her breathing, we -- she 23 decided, I suggested she go in the hospital and 24 she was very cooperative. I admitted her that 25 day.</p>	<p>Page 55</p> <p>1 Q. You were the attending during her 2 hospitalization? 3 A. Yes. 4 Q. She was obviously a private patient? 5 A. Yes. 6 Q. You didn't -- other than the 7 endocrinology consult, you didn't seek any other 8 consultation, did you? 9 A. No. 10 Q. You did seek an endocrinology consult; 11 true? 12 A. Yes. 13 Q. We'll talk about that in a moment. 14 You didn't seek a cardiac consult; true? 15 A. True. There was no indication for 16 anything else. 17 Q. You ordered an echo? 18 A. Ordered an echo. 19 Q. Did you interpret that echo yourself? 20 A. Yes. 21 Q. Was the echo, in your opinion, normal? 22 A. The echo -- 23 MR. KURI: You can take a look at it 24 if it's easier. 25 A. It's in here.</p>
<p>Page 54</p> <p>1 Q. And certainly she again complied with 2 your medical management? 3 A. Yes. 4 Q. She was relying on you, correct? 5 A. Yes. 6 Q. To do the tests that were necessary to 7 determine what was causing her symptoms, correct? 8 A. Correct. 9 Q. Because this was a recent onset of 10 symptoms that this patient had not experienced 11 before; true? 12 A. True. 13 Q. And you had a duty and a 14 responsibility to safely and appropriately 15 evaluate these symptoms, evaluating that 16 differential that we talked about, correct? 17 A. Right. 18 Q. And within your differential was rule 19 out CHF and rule out PE, correct? 20 A. Correct. 21 Q. At the very bottom, is that treatment? 22 A. Yeah, treatment. I suggested we 23 needed a chest x-ray and further studies. And I 24 admitted her that day as see congestive heart 25 failure.</p>	<p>Page 56</p> <p>1 Q. Do you have the echo in front of you 2 now? 3 A. Yes. 4 Q. Did you consider this to be a normal 5 echo? 6 A. Partially normal, normal ventricle and 7 ejection fraction, but she showed significant 8 pulmonary hypertension of the pulmonary artery 9 pressure. 10 Q. She had significant pulmonary 11 hypertension with peak pulmonary artery pressure 12 estimated at 55 to 60, correct? 13 A. Yes. 14 Q. First, what is pulmonary hypertension? 15 A. Excessive pressure on the lungs. 16 Q. What's the difference between primary 17 and secondary pulmonary hypertension? 18 A. Primary and secondary, what the cause 19 is. 20 Q. What causes primary pulmonary 21 hypertension? 22 A. There are many reasons for primary 23 pulmonary hypertension. Congestive heart 24 failure, PE, COPD, liver problems, cirrhosis. 25 Q. What about secondary pulmonary</p>

<p>Page 57</p> <p>1 hypertension? 2 A. I would think secondary is a result of 3 one of these other factors. 4 Q. You said liver disease, cirrhosis? 5 A. Cirrhosis. 6 Q. There was no evidence of cirrhosis in 7 Jean, was there? 8 A. No. 9 Q. In your progress notes in the hospital 10 you noted that the echo was normal. Do you 11 recall that? 12 A. Yes. 13 Q. That's not quite an accurate 14 statement, is it? 15 MR. KURI: Do you want to look at your 16 notes? 17 A. What I wrote there, I'm sure, was 18 ejection fraction. 19 Q. January 27th, does it say echo normal? 20 A. Yes, echo is normal. Do I have the 21 ejection fraction there? 22 Q. Where is the ejection fraction? 23 A. That's over here. 24 Q. But on your note can we agree that you 25 just marked down echo normal?</p>	<p>Page 59</p> <p>1 to the hospital for rule out CHF and rule out PE, 2 correct? 3 A. That was part of my differential. 4 Q. And when she was admitted to the 5 hospital, we can agree that you did not do any 6 tests to rule out PE, correct? 7 A. Correct. 8 Q. And if PE was still within your 9 differential when she was admitted that same day, 10 there are tests you should have done to rule out 11 the PE, correct? 12 A. Clinically she didn't present that to 13 me, so I didn't do it. I just did the echo. 14 Q. What changed between the office visit 15 and the same day when you admitted her such that 16 you no longer had a concern about the patient 17 having a PE? 18 A. I was focused on the congestive heart 19 failure. 20 Q. I understand that very clearly, but 21 what was it about the patient in terms of her 22 symptoms that caused you to feel as a reasonable 23 and prudent doctor that you could overlook ruling 24 out the PE and just focus in on the CHF? 25 A. She wasn't that dyspneic. She wasn't</p>
<p>Page 58</p> <p>1 A. Normal. 2 Q. You don't say anything about the 3 ejection fraction? 4 A. No, I didn't write anything down. 5 Q. The only thing that was normal about 6 the echo was her ejection fraction, correct? 7 A. Correct. 8 Q. And that caused you to rule out 9 congestive heart failure, correct? 10 A. Yes. My -- 11 Q. Is that an accurate statement? 12 A. Yeah. 13 Q. You didn't consult with any 14 cardiologist to discuss the results of the 15 pulmonary hypertension in this case while she was 16 in the hospital? 17 A. No, I didn't. 18 Q. Even though you ruled out congestive 19 heart failure, were you able to rule out 20 pulmonary embolism? 21 A. Her clinical symptoms did not lead me 22 that way. 23 Q. What clinical symptoms would you have 24 needed to have seen -- strike that. 25 First, we can agree she was admitted</p>	<p>Page 60</p> <p>1 short of breath and neither did she have any leg 2 swelling at that time. 3 Q. When she was seen in the hospital, the 4 nurses took an admission history from the 5 patient. That's pretty standard, isn't it? 6 A. Yeah. 7 Q. In the history, you would expect that 8 if the patient is complaining of shortness of 9 breath, that that's something that she would tell 10 the nurses, correct? 11 A. Yes. 12 Q. And if the patient has shortness of 13 breath and if the patient has swelling of the 14 lower extremity upon admission, then certainly 15 you as a reasonable physician should continue to 16 be ruling out the existence of a PE, correct? 17 A. Correct. 18 Q. Is it your testimony that during the 19 hospitalization she did not continue to have 20 shortness of breath? 21 A. She was not complaining of shortness 22 of breath. She was quite comfortable. Her legs 23 weren't swollen. She was examined by house 24 physicians and there was no mention, no mention 25 of her shortness of breath.</p>

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1 Q. She's also seen by nurses, correct?
2 A. Yeah.
3 Q. And nurses really are sort of your
4 eyes and ears?
5 A. Correct.
6 Q. And when you come in to see a patient,
7 you have a duty, do you not, to take a look and
8 see what the nurses have recorded as it relates
9 to the patient's symptomatology?
10 A. Sometimes, yes.
11 Q. Especially if a patient's admitted
12 with rule out PE, you want to look to see whether
13 or not the patient has shown any signs of edema
14 or any signs of shortness of breath during the
15 hospitalization; true?
16 A. Yeah.
17 Q. And if the patient on repeated days
18 was showing signs of edema and shortness of
19 breath in the hospital, that would be significant
20 to you, correct?
21 A. Yes.
22 Q. That would mean that you as a
23 reasonable and prudent physician should be ruling
24 out the possibility of pulmonary embolism; true?
25 A. True.

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1 Q. And something that if it's documented
2 in the records, you have a duty to be aware of,
3 correct?
4 A. Yes.
5 Q. Those symptoms of shortness of breath
6 on exertion as well as edema in the legs, noted
7 in the hospital records, would cause a reasonable
8 and prudent doctor that has ruled out CHF to
9 evaluate the patient for the other condition, and
10 that is PE, correct?
11 A. If I see those symptoms, yes.
12 Q. You certainly, in addition to looking
13 at the records, you have an opportunity to talk
14 to the nurses, correct?
15 A. If I feel there's some question, yeah.
16 Q. And you certainly in addition to
17 seeing the records and talking to nurses, you
18 have an opportunity to do an examination on your
19 own, correct?
20 A. Yes.
21 Q. She was discharged from the hospital
22 on what day?
23 A. 28th?
24 MR. KURI: Talking about Barberton?
25 MR. MISHKIND: Yes.

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1 Q. And failure to do that would be a
2 violation of the standard of care, correct?
3 A. Correct.
4 Q. What's nonpitting edema?
5 A. That's a swelling of your legs
6 usually. It swells up.
7 Q. When you --
8 A. When you press on it, it makes a
9 little pit. That's pitting edema.
10 Q. Is nonpitting edema of any concern to
11 you on a patient that has been admitted to the
12 hospital with the history that she had where you
13 had rule out CHF and rule out PE?
14 A. If they have a large, swollen leg.
15 Q. If they have edema, you certainly want
16 to be aware of that, correct?
17 A. Yes.
18 Q. Whether it's one plus or nonpitting,
19 it's something that you should be aware of,
20 correct?
21 A. Yes.
22 Q. If the patient is complaining of
23 shortness of breath on exertion, that's something
24 that you should be aware of, correct?
25 A. Yes.

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

16 (Pages 61 to 64)

<p>Page 65</p> <p>1 something. 2 MR. KURI: Exertion. 3 Q. Would you have already -- 4 A. I would have already been there. I 5 make my rounds in the morning. 6 Q. So then before she was discharged on 7 the 28th, then you would have made your rounds 8 and then okayed her discharge on the 28th; true? 9 A. True. 10 Q. And then would have had this 11 information available to you that the patient the 12 day before discharge was complaining of shortness 13 of breath on exertion, correct? 14 A. Depends how much trouble she's having, 15 how much shortness of breath. 16 Q. Certainly that information would have 17 been available to you -- 18 A. That was down here, yes. 19 Q. And then if you just stay with that 20 page, also on that same page at 1345 she had 21 complaints of, I'm sorry, there was the nurse 22 noted edema of the lower extremity, correct? 23 A. It says trace. 24 Q. Right. But nonetheless, there is 25 edema noted, correct?</p>	<p>Page 67</p> <p>1 she was not having these problems. 2 Q. What did you mark down on the 28th 3 that indicated she wasn't having these problems 4 at the time you discharged her? 5 A. I think I wrote down she was stable. 6 MR. KURI: Why don't you wait to get 7 it first so you don't have to say think. 8 A. She was in sinus rhythm. Her heart 9 was not going fast. I said will dismiss today, 10 will follow in the office. 11 Q. Do you have any note at all about 12 examining her lower extremities? 13 A. No. 14 Q. Do you have any indication that the 15 lower extremity edema that was noted the day 16 before was gone? 17 A. I'm sure I looked at her and checked 18 her -- 19 Q. That's not my question. 20 A. No, I didn't mark it down. 21 Q. Do you have any indication that the 22 patient, the shortness of breath that she had on 23 exertion the day before, had resolved that 24 morning? 25 A. She apparently wasn't having any</p>
<p>Page 66</p> <p>1 A. That was her interpretation. 2 Q. But you don't have any notes -- you 3 might want to keep that page open because I'm not 4 done. 5 When you came in to approve the 6 discharge as to whether or not this patient was 7 safe to be discharged, this information would 8 have been available in the hospital record for 9 you, correct? 10 A. Yes, this would be in the record. 11 Q. And certainly if the patient was 12 having shortness of breath and swelling in the 13 leg, those are two symptoms that would be 14 consistent with your prehospital admission 15 diagnosis of rule out PE, correct? 16 A. Yes. 17 Q. Okay. And to the extent that you were 18 aware that the patient the day before discharge 19 was having shortness of breath on exertion and 20 swelling, would you -- you have to wait until I'm 21 done before you answer -- would you agree that 22 the patient should have been worked up for a PE 23 before being discharged? 24 A. The patient was not, in my clinical 25 judgment, when I saw the patient in the morning,</p>	<p>Page 68</p> <p>1 problem when I checked her. 2 Q. You do not note anything about no 3 shortness of breath? 4 A. I would have noted it. 5 Q. If you were acting in a reasonable and 6 prudent manner, you would certainly be aware of 7 the fact that she had shortness of breath and 8 swelling in the leg the day before as well; true? 9 MR. KURI: Let me just object in that 10 you're characterizing what the nurse -- the 11 objection is I think you're mischaracterizing 12 exactly what the nurse said, but that's fine. Go 13 ahead. 14 A. So back to the question? 15 Q. Sure. You don't remember your exam 16 the day that she was discharged, do you? I mean, 17 physically, do you remember being there and 18 seeing her before you sent her home? 19 A. Yes. I always see them and I have to 20 write the dismissal. At that time she was in no 21 distress. 22 Q. I understand that. Can you picture -- 23 strike that. 24 Are you relying on your note or are 25 you able to tell me, I remember being there on</p>

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1 January 28th, 2000, seeing this patient and
2 discharging her on that date?
3 A. I made no note of it, but I remember
4 being there, discharging her and I remember she
5 was in no distress.
6 Q. Who was present?
7 MR. KURI: That's 2001, by the way.
8 Q. Who was present at the time that you
9 saw her and discharged her?
10 A. No one. I visited the patient myself.
11 Usually don't have anyone with you.
12 Q. Tell me what else you discussed with
13 Jean during that visit, that you remember, that's
14 not recorded in the record.
15 A. I can't remember what I discussed with
16 her at that time, at the bedside.
17 Q. I want you to tell me everything that
18 you remember that's not recorded in the record.
19 A. I can't remember anything that far
20 back.
21 Q. That's what I mean.
22 A. Other than we were going to follow up.
23 I would see her in the office. Usually like in a
24 week. And also she was to follow up with the
25 endocrinologist.

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1 Q. We're going to talk about that in a
2 moment. You said you can't remember that far
3 back?
4 A. Oh, specifically.
5 Q. So that's why you make a note in terms
6 of what you've noted, correct?
7 A. Right.
8 Q. Do you physically remember being in
9 the room and seeing Jean?
10 A. Yes.
11 Q. You do. Okay.
12 A. If I didn't see her, there wouldn't be
13 a note for that day.
14 Q. I understand that. Are you able to
15 recreate in your mind being there and talking
16 with her and examining her or are you relying on
17 the note as being the proof that you were there?
18 A. No, I know I was there.
19 Q. Because of the note?
20 A. Yes.
21 Q. But it's been --
22 A. I saw her every day. She was only in
23 for a few days. I took care of her those few
24 days. I happened to be there on that day. I had
25 to dismiss her and discuss her after-hospital

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1 care.
2 Q. Tell me what you discussed with her
3 about her after-hospital care.
4 A. My brief note was that I would follow
5 up in the office, usually within a week is what
6 we do, and that she was also to see Dr. -- this
7 endocrinologist, the specialist.
8 Q. We talked about the 27th when she had
9 shortness of breath and edema in the leg. On the
10 26th, the record also shows that she had
11 shortness of breath with exertion, according to
12 the nurse's notes, as well as edema in the lower
13 extremity. I presume you would have seen her on
14 the 27th?
15 A. Yes, I saw her the 27th.
16 Q. And do your records reflect any
17 examination of her lower extremities on that
18 date?
19 A. No, there's nothing on the 27th.
20 Q. Do your notes on the 27th indicate any
21 discussion with her or with the nurses about the
22 shortness of breath that she had upon exertion
23 during the evening of the 26th?
24 A. No. Usually when you see the patient
25 in the morning, you generally write down the

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1 negative problems she's complaining of at the
2 time such as I'm short of breath or nauseated or
3 something. So on the 27th I didn't write any
4 complaints like that, nor did I write she had any
5 swelling.
6 Q. But -- I'm sorry, go ahead.
7 A. In my interpretation, she apparently
8 did not.
9 Q. Yet we can agree, can we not, that the
10 nurses on the 26th and on the 27th note shortness
11 of breath as well as edema in the lower
12 extremity, yet when you saw the patient as her
13 physician the following morning on both of those
14 days, you make no notation about examining her
15 legs and seeing that the swelling has gone away;
16 true?
17 MR. KURI: Let me go to the 26th while
18 you're looking at it. Can you show me? Would
19 you like the question read back to you?
20 (Record read.)
21 MR. KURI: This is the 26th. And the
22 27th. Make sure you take a look at these so
23 we're all clear --
24 A. I made no notation because it
25 apparently was not a problem to me at that time.

18 (Pages 69 to 72)

<p>Page 73</p> <p>1 Q. I understand that. I understand 2 what -- 3 A. And what the nurse is writing here, 4 this trace, I don't know how much she 5 interpreted. 6 Q. I understand that. 7 A. Trace is minimal. She could have 8 swelling. Same thing with shortness of breath. 9 What did she do to have shortness of breath? 10 When I'm in the room talking to her, she's not 11 short of breath. 12 Q. So she was just having these -- 13 A. What this -- she told the nurse, she 14 could have been sitting there, I get short of 15 breath when I climb the steps. 16 Q. I hear what you're saying, doctor, but 17 in all fairness, you admitted this patient for 18 two primary conditions to rule out, one was CHF 19 and one was pulmonary embolism, correct? 20 A. Correct. 21 Q. And you never ruled out pulmonary 22 embolism during this hospitalization, did you? 23 A. As her clinical symptoms when she's in 24 the hospital there were not of the embolus and I 25 was focusing on her congestive failure and then</p>	<p>Page 75</p> <p>1 extremity, but you, as the physician that 2 admitted the patient to rule out PE, did not 3 consider those apparently to be significant 4 enough to want to rule out PE by the time she 5 left the hospital; true? 6 MR. KURI: Object to the form of the 7 question. 8 A. At that time she wasn't presenting me 9 with those symptoms, correct, nor would she 10 present it to the house physician or the 11 endocrinologist. 12 Q. So the three nurses that saw these 13 symptoms, they should be disregarded in terms of 14 the analysis? 15 MR. KURI: Objection. 16 A. I don't know what they saw or what she 17 told them. 18 Q. Are you critical of the nurses -- 19 A. I'm not being critical. Just that I 20 can't tell you what the patient told them. 21 Q. You -- 22 A. And how much shortness of breath, what 23 they're judging as shortness of breath. 24 Q. You have a duty and a responsibility 25 as this patient's physician to evaluate her</p>
<p>Page 74</p> <p>1 her thyroid problems, when the thyroid problems 2 poked up, that's when I called the 3 endocrinologist -- 4 Q. I understand that, doctor. 5 A. Because she was tachy. She was a 6 little bit tachy. 7 Q. I'm going back to my question. You 8 never ruled out pulmonary embolism during this 9 hospitalization; true? 10 A. I didn't feel it was necessary at that 11 time. 12 Q. You didn't rule it out, did you? 13 A. I didn't rule it out. 14 Q. Tachycardia can be caused by pulmonary 15 embolism, correct? 16 A. Correct. 17 Q. You never ruled out pulmonary 18 embolism, even though on three different 19 occasions, we can go back and I can talk to you 20 further about the 25th where the patient also has 21 shortness of breath on exertion and the patient 22 also has edema in the lower extremity. And we 23 can agree that on three separate occasions, on 24 three different dates, the nurses have entries of 25 shortness of breath, of edema in the lower</p>	<p>Page 76</p> <p>1 symptoms not only when you're seeing the patient 2 at bedside, but also to evaluate how the patient 3 has been doing over the last 24 hours since 4 you've last seen the patient, correct? 5 A. Yes. 6 Q. And you take into account what is told 7 to you by the patient as well as information 8 that's available to you in the hospital chart, 9 correct? 10 A. Yes. 11 Q. And if there's sufficient information 12 from one or both of those sources, from the 13 patient and from the hospital chart, that at 14 least continues to keep PE within the 15 differential, then ruling out PE should be done 16 before this patient goes home, true? 17 A. True, that's true. 18 Q. The patient was given Tenormin, 19 correct? 20 A. Right. 21 Q. What is Tenormin? 22 A. Beta blocker. Slows the heart rate 23 down. 24 Q. And in your opinion, did that lead to 25 the conclusion that the patient most likely did</p>

<p style="text-align: right;">Page 77</p> <p>1 not have congestive heart failure? 2 MR. KURI: The fact that you gave them 3 the beta blocker? 4 A. No, that didn't -- 5 Q. Of what significance was the Tenormin? 6 A. Tenormin, the endocrinologist 7 suggested that to slow the heart rate down. 8 Q. Did Tenormin assist you in determining 9 whether or not the patient had a PE? 10 A. No, that has no relationship to the 11 PE. 12 Q. Who ultimately had the responsibility 13 to decide whether to do diagnostic studies for a 14 PE, you or the endocrinologist? 15 A. Well, I think that's, you know, both 16 are responsible. 17 Q. Did the endocrinologist tell you it 18 was unnecessary to work the patient up for a PE? 19 A. No. 20 Q. The final -- 21 A. She obviously didn't find any 22 indication for it. 23 Q. Pardon me? 24 A. She obviously didn't find any 25 indication for it in her examination and she just</p>	<p style="text-align: right;">Page 79</p> <p>1 determine whether or not the patient should be 2 worked up for a PE, did you? 3 A. You consult -- when you have a 4 problem, you consult the appropriate specialist. 5 Q. Right. But -- 6 A. That specialist should give you their 7 opinion as to what's going on, whether it's in 8 their field or not their field. If it's not 9 their field, you better do something else. 10 Q. Again, I asked you about PEs, who you 11 would consult with. You said you'd consult with 12 a pulmonary specialist? 13 A. Pulmonary specialist. 14 Q. Not an endocrinologist, correct? 15 A. Correct. 16 Q. So we can agree that in terms of your 17 work-up of this patient, in terms of whether it 18 was necessary for you to do diagnostic studies to 19 rule out or confirm a PE, you wouldn't rely on a 20 consultation by an endocrinologist to make that 21 decision; true? 22 A. Right. Correct. 23 Q. That's your decision -- 24 A. Right. 25 Q. -- ultimately? And if you had</p>
<p style="text-align: right;">Page 78</p> <p>1 worked up the thyroid. 2 Q. Tell me about the thyroid. What's 3 your understanding as to the significance of the 4 patient's thyroid disease? 5 A. Her tests were abnormal, which 6 indicated that she may have been hyperthyroid. 7 Hyperthyroid will cause tachycardia. 8 Q. Her levels, her thyroid levels, were 9 they significant or were they -- 10 A. No, they were mild. And the 11 endocrinologist suggested some other studies. 12 Q. Certainly one can have a mild case of 13 thyroid disease and still be experiencing a 14 pulmonary embolus, correct? 15 A. Yeah, you can, yes. 16 Q. So the fact that she had some findings 17 to the endocrinologist, that would be consistent 18 with the thyroid disease. That doesn't mean that 19 you as the physician treating the patient in the 20 hospital no longer needed to work the patient up 21 for a PE if her signs and symptoms were still 22 consistent with a PE; true? 23 A. You have to -- you take the 24 consultant's opinions and recommendations. 25 Q. You didn't consult with her to</p>	<p style="text-align: right;">Page 80</p> <p>1 sufficient clinical information that should have 2 caused you to work the patient up for a PE, you 3 can't say, well, I relied on the endocrinologist, 4 that's why I didn't do the work-up? 5 A. No, correct. 6 Q. That would be bad medicine, right? 7 A. No. It would be up to me to consult a 8 pulmonologist if I felt it necessary. 9 Q. You discharged Jean from the hospital 10 and she did not have a work-up done that would 11 meet the standard of care for a patient to rule 12 out pulmonary embolism; true? 13 A. I worked it up. Did what I felt was 14 necessary considering her symptoms at the time. 15 Q. But to rule out pulmonary embolism, 16 you'd have to do a VQ scan? 17 A. You'd have to do a VQ scan. 18 Q. You didn't do a VQ scan, correct? 19 A. No, I didn't do a VQ scan. 20 Q. So she was discharged from the 21 hospital without having the standard tests done 22 to rule out a PE, correct? 23 A. If that's what you're looking at. 24 Q. Isn't that a fact, that she was 25 admitted, rule out PE, that you discharged her</p>

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

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

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

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

21 (Pages 81 to 84)

<p style="text-align: right;">Page 85</p> <p>1 Q. Might he have had the echo? 2 MR. POLITO: Objection. 3 A. He may not have had the echo. I don't 4 know if they were in the records at that time. 5 Q. Would you agree that your son, when he 6 saw Jean on February 1, 2001 after the 7 hospitalization, the hospitalization to rule out 8 congestive heart failure and to rule out 9 pulmonary embolism, had a duty to be aware of the 10 findings from the diagnostic work-up that had 11 just been done in the hospital? 12 MR. POLITO: Objection. 13 MR. KURI: Objection. 14 A. When she came into the office, he 15 asked what's the problem at that time. According 16 to his notes he thought the shortness of breath 17 was a resolved problem, so he went no further 18 than that. 19 Q. Her chief complaint was shortness of 20 breath when she appeared on February 1, 2001, 21 correct? 22 A. Is that what the secretary -- the 23 secretary writes that over there. 24 Q. They ask why are you here, right? 25 A. Yeah.</p>	<p style="text-align: right;">Page 87</p> <p>1 saw Jean on February 1 and got the history that 2 she had been in the hospital, can we agree that 3 he had a duty to be aware of what the findings 4 were from the diagnostic work-up that had been 5 done in the hospital just four or five days 6 earlier? 7 MR. POLITO: Wait a minute. 8 MR. KURI: Objection. 9 MR. POLITO: That question has been 10 asked and answered. I want you, if you would, to 11 go back and read his previous answer to that same 12 question. I'm allowed under the rules to make an 13 objection whether it's already been asked and 14 answered. 15 MR. MISHKIND: Right. But I don't 16 want you to make an objection asked and answered 17 and then start telling us what he said. You've 18 asked the court reporter to read it back. 19 MR. POLITO: Fair enough. 20 MR. MISHKIND: In fairness to you, I 21 have no problem with her doing that. 22 (Record read.) 23 MR. POLITO: He's answered it. 24 MR. MISHKIND: He hasn't. 25 BY MR. MISHKIND:</p>
<p style="text-align: right;">Page 86</p> <p>1 Q. They mark down chief complaint, 2 shortness of breath, correct? 3 A. He said that she had a cough for a 4 couple of days. He felt it was probably just 5 bronchitis at that time. 6 Q. All right. 7 A. Treated her for that. But he also 8 wrote down here, her shortness of breath was 9 resolved. She was in the hospital the 28th, felt 10 the shortness of breath was resolved. She 11 apparently wasn't having that much. Just writing 12 shortness of breath does not mean the person is 13 gasping for air. She wasn't in any distress at 14 that time. 15 Q. Do you need to be gasping for air to 16 be concerned about whether or not the patient is 17 showering emboli? 18 A. No. 19 Q. You can have shortness of breath and 20 not be gasping for breath and still be 21 experiencing pulmonary emboli? 22 A. You can have very mild shortness of 23 breath even if you're having emboli. 24 Q. Going back to my question, which I 25 don't think you answered, that is when your son</p>	<p style="text-align: right;">Page 88</p> <p>1 Q. Doctor, I'll ask you specifically 2 whether or not your son had a duty to be aware of 3 the findings from the diagnostic work-up that had 4 been done in the hospitalization, yes or no? 5 MR. KURI: Objection. 6 MR. POLITO: Wait a minute, it's not 7 yes or no. You can't demand that a witness 8 answer yes or no. 9 MR. MISHKIND: Yes, I can. I most 10 certainly can. What school did you go to that 11 said I can't ask the witness to ask whether your 12 son had a duty -- 13 MR. POLITO: You can ask that. You 14 can't demand he give you yes or no answer. 15 BY MR. MISHKIND: 16 Q. Doctor, did your son have a duty to be 17 aware of the results of a diagnostic work-up that 18 had been done in the hospital? 19 MR. KURI: Objection. 20 MR. POLITO: Objection. 21 A. Depends what the patient came in for. 22 Q. Patient comes in with shortness of 23 breath and -- 24 MR. KURI: I'm going to object to your 25 characterization to what actually was going on</p>

<p>Page 89</p> <p>1 when she came in there. 2 A. He apparently was not impressed with 3 the shortness of breath. He felt that was 4 resolved. 5 Q. Okay. Can we agree, doctor, that your 6 son was covering for you? 7 A. Yeah. 8 Q. Can we agree that covering for you he 9 would have had access, if necessary and 10 appropriate, to the same information that you 11 would have had access to on February 1, 2001? 12 MR. POLITO: Objection. 13 A. He could go to the hospital and get 14 those records, yes. 15 Q. Or pick up the phone and call and say, 16 I've got one of my father's patients that was 17 here that was hospitalized and I want certain 18 information, if he felt it necessary he would 19 have been able to do that without going over to 20 the hospital; true? 21 A. True. He wrote in there she was 22 hospitalized from the 25th to the 28th. Her 23 shortness of breath was resolved. He assumed the 24 diagnosis of thyroid problem was correct, or that 25 was the diagnosis that she gave to him, and he</p>	<p>Page 91</p> <p>1 Q. Doctor, I'm not trying to be 2 difficult. I'm just trying to ask you whether or 3 not without calling over to the hospital, would 4 he have had sufficient information from the 5 patient on February 1, from what you know from 6 talking with your son and by looking at his note, 7 to be able to determine that PE had been ruled 8 out during the hospitalization? 9 MR. KURI: Objection. 10 MR. POLITO: Objection. 11 MR. KURI: Asked and answered. 12 Q. Go ahead, doctor. 13 A. He obviously had no hospital records 14 there. 15 Q. Okay. 16 A. He was going by his clinical 17 impression at the time and what she told him and 18 there is no indication to him there that she had 19 an ongoing PE. 20 Q. That's now your reading his mind, 21 right? 22 MR. KURI: No, it's from the note. 23 A. She says no swelling. 24 MR. KURI: That's enough. Let him ask 25 a question.</p>
<p>Page 90</p> <p>1 found no reason to go any further. She had no 2 swelling of her legs or her lungs were clear, so 3 he had no reason to go back or go further or 4 anything else. 5 Q. Okay. He would have had access to 6 your note of January 25, correct? 7 A. That's in the chart, yeah. 8 Q. And your note of January 25 would have 9 indicated that she was being admitted and it was 10 rule out CHF and rule out PE, right? 11 A. Right. 12 Q. Without him getting ahold of people at 13 the hospital, how would he have known whether or 14 not you ruled out a PE during the 15 hospitalization? 16 A. You say there he went by her, what she 17 told him, thyroid? 18 Q. So he would have been able to 19 determine on February 1 that you had ruled out a 20 PE because of what she told him concerning the 21 thyroid, is that -- 22 MR. KURI: Let me place an objection. 23 Your questions are getting speculative. You're 24 asking him to assume things the other doctor was 25 doing and what she was thinking at the same time.</p>	<p>Page 92</p> <p>1 Q. Doctor, you would agree, would you 2 not, unexplained right ventricular volume or 3 pressure load on echocardiogram should heighten 4 one's concern for pulmonary emboli? 5 A. Yes. 6 MR. KURI: Can you read the question 7 back? 8 Q. Unexplained right ventricular volume 9 or pressure load on an echocardiogram should 10 heighten the concern for pulmonary emboli, and 11 your answer is yes, correct? 12 A. Yes. 13 Q. From your son's note on February 1, 14 2001, did he indicate, from what you can tell, 15 that Jean was given any instructions regarding 16 any signs or symptoms to watch for that would 17 warrant contacting a doctor sooner than one week? 18 A. No. 19 MR. KURI: Why don't you get the note 20 just so everyone is clear. 21 A. He wrote here return to the office for 22 a check in one week. 23 Q. But he didn't indicate what signs or 24 symptoms she should look for that should cause 25 her to come back sooner than one week, correct?</p>

<p style="text-align: right;">Page 93</p> <p>1 MR. KURI: Do you want us to read to 2 you? 3 MR. MISHKIND: No, he's answered the 4 question. 5 Q. Doctor, you said -- 6 A. You can't write down everything you 7 say. 8 Q. I understand that, doctor. 9 A. He did tell her to come back in a 10 week. 11 Q. I think you told me before that with 12 significant pulmonary hypertension on an 13 echocardiogram, that that would warrant further 14 work-up? 15 A. I think you asked that before. 16 Q. And you agreed with that, correct? 17 A. Yes. 18 Q. And when did you plan on doing that 19 further work-up? 20 A. I had no plan in mind when I dismissed 21 her because she was stable at that time. 22 Q. So your plan could have been a week, a 23 month, whenever? 24 A. When I saw her again in the office or 25 at this time he saw her, my son saw her.</p>	<p style="text-align: right;">Page 95</p> <p>1 A. I can't rule it out. 2 Q. Did you speak to Jean's family after 3 her death? 4 A. No. 5 Q. When did you learn about Jean's death? 6 MR. KURI: I'm sorry, you said what 7 did you learn? 8 MR. MISHKIND: When did he learn about 9 the death. 10 A. I don't remember because I had no -- I 11 didn't even know she was in the hospital. They 12 called this other doctor. I don't know if we saw 13 it in the newspaper or where. I can't remember. 14 Q. When she was admitted to the hospital 15 they did -- at Akron they did a VQ scan, it 16 showed the high probability of a PE, correct? 17 A. Yes. 18 Q. Do you have an opinion as to how long 19 prior to her admission, given -- you've taken a 20 look at the Akron records, correct? 21 A. Yes. 22 Q. Do you have an opinion as to how long 23 prior to her admission to Akron General she had 24 been showering emboli prior to that date? 25 MR. KURI: Objection.</p>
<p style="text-align: right;">Page 94</p> <p>1 Q. And do you have an opinion, doctor, 2 whether the pulmonary hypertension that was 3 identified on echocardiogram on January 26th, 4 whether or not that was caused by undiagnosed 5 pulmonary emboli? 6 MR. KURI: Objection. 7 A. I don't know, I don't know, because -- 8 MR. KURI: You answered the question. 9 Q. Because of what, doctor? 10 A. I don't know she had a PE. Obviously 11 she didn't. 12 Q. Obviously she didn't; is that what you 13 said? 14 A. Yeah. 15 Q. You mean on January 26th? 16 A. Where are we? Right. Correct. 17 Q. So is it fair to say, though, that 18 it's certainly possible that the pulmonary 19 hypertension that Jean had on echocardiogram on 20 January 26th was caused by an undiagnosed 21 pulmonary emboli? 22 MR. POLITO: Objection as to form. 23 MR. KURI: Objection. 24 A. I don't know. 25 Q. You can't rule it out, correct?</p>	<p style="text-align: right;">Page 96</p> <p>1 A. No, I would have no way of knowing. 2 Q. Can you state to a certainty that she 3 wasn't showering emboli from the DVT going back 4 to the time that she was in Barberton Hospital? 5 MR. POLITO: Objection. 6 MR. KURI: Same objection. 7 A. In my opinion she wasn't showering 8 them then. She would have had more clinical 9 symptoms. 10 Q. What would you have needed to have 11 seen to be able to say she was probably having a 12 PE back when she was at Barberton? 13 A. Large swollen leg, being in the calf, 14 shortness of breath to some degree, coughing. 15 Q. If you had done a VQ scan in the 16 hospital at Barberton, is it your opinion that it 17 would have been negative or low probability? 18 A. If it's a small PE, could very well 19 have been negative. 20 Q. Can you state to a probability that it 21 would have been negative? 22 A. In all probability, it probably would 23 have been negative because of her very mild 24 symptoms. 25 Q. You told me that Jean was relatively</p>

<p>Page 97</p> <p>1 healthy before all of this occurred, correct? 2 A. Correct. 3 Q. Do you have an opinion as to what 4 Jean's life expectancy would have been had she 5 not suffered the PE and had she not suffered the 6 cerebrovascular accident? 7 A. She could have had that cerebral -- 8 CVA regardless of anything prior to that. 9 Q. That wasn't my question. If she had 10 not suffered the CVA and had not suffered the PE, 11 would -- 12 A. There's no way of knowing. She's 13 already exceeded the average length of -- she was 14 how old? 15 Q. How old was your patient? 16 A. 74 or 77? 17 Q. You think she exceeded what? 18 A. Average length of life expectancy, 19 what is it, around 74 or so? 20 Q. In your opinion -- 21 A. I have no way of knowing how long she 22 would have lived. 23 Q. You just said she already exceeded her 24 life expectancy? 25 A. She reached the median age,</p>	<p>Page 99</p> <p>1 BY MR. MISHKIND: 2 Q. Doctor, if you had clinical reasons to 3 suspect that this patient was having a PE in the 4 hospital at Barberton, would you have 5 anticoagulated her? 6 A. If I had a positive VQ scan or spiral? 7 Q. Would you have anticoagulated her 8 before doing either a spiral CT or VQ scan? 9 A. No. 10 Q. If you had done a spiral CT or a VQ 11 scan and had a positive -- a high probability VQ 12 or positive CT scan, you then would have 13 anticoagulated the patient, correct? 14 A. Yes. 15 Q. And if she had been anticoagulated at 16 that time with a positive VQ scan, would that 17 have minimized, again, this is a hypothetical, 18 you understand, but would that have minimized the 19 likelihood of her continuing to shower emboli in 20 the foreseeable future? 21 MR. KURI: Objection. 22 MR. POLITO: Objection. 23 A. Yes and no. That's -- they still 24 happen. More clots develop in the leg. But 25 that's the purpose of anticoagulation, is to try</p>
<p>Page 98</p> <p>1 apparently. 2 Q. Is it your testimony that she had 3 exceeded her life expectancy at that time at 74 4 or 77? 5 A. She reached a median life expectancy. 6 How many more years she could have lived without 7 these, I have no way of knowing that. These 8 things can happen at any time. 9 Q. I understand that. But absent a CVA, 10 caused by whatever it was caused by, absent the 11 PE, caused by whatever it was caused by, if she 12 didn't have those events happen, do you have an 13 opinion as to how long -- how much longer she 14 would have lived? 15 MR. KURI: Objection. 16 A. No. 17 MR. KURI: He said it twice already. 18 Q. I take it you don't blame Jean in 19 terms of failing to do anything that caused any 20 of these complications? 21 A. Oh, no, I don't blame her. 22 MR. MISHKIND: Give me just a few 23 minutes to look at my notes and also to talk to 24 Maryellen. 25 (Recess had.)</p>	<p>Page 100</p> <p>1 to prevent those things, but it doesn't always 2 happen. 3 Q. You would then, if you have a patient 4 with DVT with emboli, you have to be more 5 aggressive with your treatment of the patient, 6 correct? 7 A. Then you would put a filter in. 8 Q. Greenfield filter? 9 A. Greenfield filter. 10 Q. And then you would consider perhaps 11 referral to a pulmonologist for further 12 consultation, correct? 13 A. Correct. 14 Q. All things being done, because 15 untreated properly, a PE has a high likelihood of 16 causing death, correct? 17 A. Not all PEs lead to death. 18 Q. But they have a high likelihood if 19 they're untreated of causing death? 20 A. The risk is greater, yes. 21 Q. And do you know from the hemodynamic 22 standpoint what happens to a patient in terms of 23 their blood pressure when they suffer a PE? Do 24 they have a tendency of becoming hypotensive, 25 hypertensive? What happens?</p>

<p style="text-align: right;">Page 101</p> <p>1 A. If you have a massive PE, yes, you're 2 going to drop pressure, respirations. 3 Q. So -- 4 A. It would have to be a massive one. 5 Q. You never talked to the doctors at 6 Akron. We discussed that about an hour and a 7 half ago, correct? 8 MR. KURI: At Akron General. 9 A. No, I have no knowledge of her there 10 or discussed with anyone there. 11 Q. You have not had any discussion with 12 them since this case? 13 A. Correct, no discussion. 14 Q. In terms of your treatment at 15 Barberton and your -- in terms of your treatment 16 at Barberton and what you did, have we discussed 17 everything that you remember? 18 MR. KURI: I'm going to object. It's 19 extremely vague. 20 Q. I've asked you a lot of questions. 21 A. I think so, yeah. Is there something 22 else you want me to -- 23 Q. I want to know whether there's 24 anything else that you recall about what you did 25 and why you did certain things other than what</p>	<p style="text-align: right;">Page 103</p> <p>1 AFFIDAVIT 2 I have read the foregoing transcript from 3 page 1 through 102 and note the following 4 corrections: 5 PAGE/LINE REQUESTED CHANGE 6 7 8 9 10 11 12 13 14 15 16 17 18 PATRICK A. RICH, D.O. 19 20 Subscribed and sworn to before me this 21 day of 2003. 22 Notary Public 23 My commission expires _____ 24 25</p>
<p style="text-align: right;">Page 102</p> <p>1 we've already talked about? 2 MR. KURI: Again, I object. 3 A. I have no other -- 4 Q. You have no what? 5 A. I have no other comment. 6 Q. And the reasons for the admission to 7 the hospital when you saw her on January 25, what 8 you remember about her visit, have you told me 9 everything that you can remember concerning her 10 condition that caused you to admit her to the 11 hospital on January 25? 12 A. Yes. 13 Q. You had no contact with her after your 14 son saw her on February 1 and before you learned 15 of her death; true? 16 A. True. 17 MR. MISHKIND: No further questions. 18 Thank you, doctor. 19 MR. POLITO: I have no questions. 20 MR. KURI: He'll read it. 21 MR. POLITO: I'll have Pat call you. 22 MR. MISHKIND: Do you want 28 days? 23 MR. KURI: Yes, if you would. 24 (Deposition concluded at 3:26 p.m.) 25</p>	<p style="text-align: right;">Page 104</p> <p>1 CERTIFICATE 2 3 State of Ohio, 4 SS: 5 County of Cuyahoga. 6 7 8 I, Lorraine J. Klodnick, a Notary Public 9 within and for the State of Ohio, duly 10 commissioned and qualified, do hereby certify 11 that the within named PATRICK A. RICH, D.O. was 12 by me first duly sworn to testify to the truth, 13 the whole truth and nothing but the truth in the 14 cause aforesaid; that the testimony as above set 15 forth was by me reduced to stenotypy, afterwards 16 transcribed, and that the foregoing is a true and 17 correct transcription of the testimony. 18 19 I do further certify that this deposition 20 was taken at the time and place specified and was 21 completed without adjournment; that I am not a 22 relative or attorney for either party or 23 otherwise interested in the event of this action. 24 I am not, nor is the court reporting firm with 25 which I am affiliated, under a contract as 26 defined in Civil Rule 28 (D). 27 IN WITNESS WHEREOF, I have hereunto set my 28 hand and affixed my seal of office at Cleveland, 29 Ohio, on this 10th of April, 2003. 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 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