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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 DEAN P. RICH, D.O.
13 Wednesday, December 18, 2002
14 -----
15 Deposition of DEAN P. RICH, D.O., a
16 Defendant herein, called by the Plaintiff for
17 examination under the statute, taken before me,
18 Karen M. Patterson, a Registered Merit Reporter
19 and Notary Public in and for the State of Ohio,
20 pursuant to notice of counsel, at the offices of
21 Dean P. Rich, D.O., 2315 Manchester Road, Akron,
22 Ohio, on the day and date set forth above, at
23 9:55 o'clock a.m.
24 -----
25

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1 APPEARANCES:
2 On behalf of the Plaintiff:
3 Becker & Mishkind Co., L.P.A., by
4 JEANNE M. TOSTI, ESQ.
5 Skylight Office Tower
6 1660 W. 2nd Street
7 Cleveland, Ohio 44113
8 (216) 241-2600
9 On behalf of the Defendant Patrick A.
10 Rich, D.O.:
11 Reminger & Reminger Co., L.P.A., by
12 ANDREW JAMISON, ESQ.
13 1400 Midland Building
14 101 Prospect Avenue
15 Cleveland, Ohio 44115
16 (216) 687-1311
17 On behalf of the Defendant Dean P. Rich,
18 D.O.:
19 Bonezzi, Switzer, Murphy & Polito
20 Co., L.P.A., by
21 PATRICK J. MURPHY, ESQ.
22 Suite 1400 Leader Building
23 526 Superior Avenue
24 Cleveland, Ohio 44114
25 (216) 875-2767

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1 DEAN P. RICH, D.O., of lawful age, called
2 for examination, as provided by the Ohio Rules
3 of Civil Procedure, being by me first duly
4 sworn, as hereinafter certified, deposed and
5 said as follows:
6 EXAMINATION OF DEAN P. RICH, D.O.
7 BY MS. TOSTI:
8 Q. Doctor, would you please state your
9 name for us.
10 A. Dean Patrick Rich.
11 Q. What is your home address?
12 A. 787 Meredith Lane, Cuyahoga Falls,
13 Ohio.
14 Q. And your zip code?
15 A. 44223.
16 Q. Is that a single-family home?
17 A. Yes.
18 Q. Your current business address, is
19 that at this establishment?
20 A. Yes.
21 Q. Who is your current employer?
22 A. Self-employed.
23 Q. What is the name of your practice?
24 A. Allenside Family Practice.
25 Q. Are there any other physicians that

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1 work with you in the practice?
2 A. Solo practitioner.
3 Q. In January and February of 2001, was
4 your business as a solo practitioner at
5 Allenside Family Practice?
6 A. Yes.
7 Q. Do you currently render professional
8 services for any other entity besides your solo
9 practice?
10 A. Yes. I cover for my father, Patrick
11 Rich, when he's out of town at his office, and I
12 am also a community preceptor at Barberton
13 Citizens Hospital in the family practice
14 department.
15 Q. What do you do as a community
16 preceptor?
17 A. I review the residents' charts and
18 also help the residents with patient care,
19 questions they have regarding patient care.
20 Q. Have you had your deposition taken
21 before?
22 A. Concerning this case?
23 Q. In any case.
24 A. Yes.
25 Q. How many times?

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1 A. One time.
2 Q. Why was your deposition being taken?
3 Was your deposition being taken as a defendant
4 in a case?
5 A. Yes.
6 Q. Medical malpractice case?
7 A. Yes.
8 Q. That's the only time that you've had
9 a deposition taken?
10 A. Yes. Actually, I apologize. Twice.
11 I've had two depositions.
12 Q. I'm sure that counsel has had an
13 opportunity to talk with you about depositions.
14 I'm going to go over a few of the ground rules.
15 This is a question-and-answer session. It's
16 under oath. It's important that you understand
17 the questions that I ask you. If you don't
18 understand my questions, let me know, and I will
19 be happy to rephrase the question or to repeat
20 the question for you.
21 If at any point in time you would
22 like to refer to medical records that counsel
23 has provided to you, feel free to do so. This
24 isn't a memory test whatsoever.
25 It's also important that you give

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1 all of your answers verbally because our court
2 reporter can't take down head nods or hand
3 motions, and at some point, defense counsel may
4 choose to enter an objection. You are still
5 required to answer my question unless counsel
6 instructs you not to do so. Do you understand
7 those instructions?
8 A. Yes.
9 Q. Now, doctor, you indicated that your
10 deposition had been taken in medical malpractice
11 cases twice as a defendant; is that correct?
12 A. Yes.
13 Q. When was the last time that your
14 deposition was taken?
15 MR. MURPHY: I'll just put a
16 continuing objection on as to prior lawsuits
17 where he was a party. You can go ahead and
18 inquire.
19 A. The last was, I believe, in 1995 or
20 1997.
21 Q. Was there one prior to that?
22 A. There was one in 1992.
23 Q. Where were those cases filed? Were
24 they here in Akron?
25 A. Yes, they were Akron.

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1 Q. What was the plaintiff's name in
2 those two cases?
3 A. The first case, I don't remember the
4 plaintiff's name, and the second case the
5 plaintiff's name was Ivory West.
6 Q. What was the allegation of medical
7 negligence in those two cases? Let's start with
8 the one in 1992.
9 A. I don't remember the allegation.
10 Q. You don't recall why the plaintiff
11 brought that case against you?
12 A. No. I don't remember the exact
13 allegation.
14 Q. Well, in general, what do you recall
15 regarding the allegation?
16 A. Are you asking me what the case
17 entailed?
18 Q. I'm asking you what the negligence
19 was that you were accused of in the 1992 case.
20 A. Again, I don't remember what I was
21 accused of at that point. I remember what the
22 case involved, but I don't remember --
23 Q. Tell me what the case involved.
24 A. It was a young woman who I saw on
25 one occasion while covering for another

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1 physician for an unrelated problem who was
2 subsequently diagnosed with breast cancer.
3 Q. How was that case resolved?
4 A. I was dropped from the case without
5 any judgments against me.
6 Q. In regard to the 1995 case that I
7 think you referred to, the plaintiff was Ivory
8 West; is that correct?
9 A. Yes.
10 Q. What was the allegation of
11 negligence in that case?
12 A. Again, I believe the allegation was
13 failure to diagnose.
14 Q. Diagnose what?
15 A. Hepatitis.
16 Q. Were you the only defendant in that
17 case?
18 A. No.
19 Q. How was that case resolved?
20 A. I was dismissed without any
21 judgments.
22 Q. There was no settlement in either of
23 those two cases that you are aware of?
24 A. There was a settlement in regards to
25 the other physicians.

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1 Q. But not on your behalf?
2 A. No. I was dropped from both cases.
3 Q. Have you ever acted as an expert in
4 a medical/legal proceeding?
5 A. No.
6 Q. Have you ever given testimony in a
7 case involving medical negligence in trial?
8 A. No.
9 Q. Aside from the two depositions that
10 you discussed with me, you have never given a
11 deposition as a witness in a medical negligence
12 case, have you?
13 A. No.
14 Q. Now, doctor, I have a copy of your
15 curriculum vitae. I'm going to mark this as
16 Plaintiff's Exhibit 1.
17 -----
18 (Thereupon, PLAINTIFF'S Deposition
19 Exhibit 1 was marked for purposes
20 of identification.)
21 -----
22 Q. I would just like you to take a look
23 at it and, if you would for the record, identify
24 that document for us.
25 A. This is my curriculum vitae.

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1 Q. Is it current and up-to-date? Are
2 there any corrections or additions that you
3 would like to make to it?
4 A. No. It's current.
5 Q. Doctor, you are licensed to practice
6 medicine in the State of Ohio; is that correct?
7 A. Yes.
8 Q. Are you licensed in any other
9 states?
10 A. No.
11 Q. Has your license in Ohio or any
12 other state ever been suspended, revoked, or
13 called into question?
14 MR. MURPHY: Objection. You can
15 answer.
16 A. No.
17 Q. Are you board certified in any areas
18 of medicine?
19 A. I'm board certified in family
20 practice.
21 Q. When did you receive that
22 certification?
23 A. Initial certification was in 1990,
24 and then recertification in 1997.
25 Q. Did you pass that certification on

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1 your first attempt?
2 A. Yes.
3 Q. What hospitals do you currently have
4 privileges at?
5 A. I have admitting privileges at Akron
6 General Medical Center and Barberton Citizens
7 Hospital and office privileges at Akron City
8 Hospital, Summa Care.
9 Q. Did you have privileges at those
10 places in January and February of 2001?
11 A. Yes.
12 Q. Have you ever had your hospital
13 privileges called into question, suspended or
14 revoked?
15 MR. MURPHY: Objection.
16 A. No.
17 Q. Have you ever authored or
18 co-authored any medical journal, articles or
19 textbook chapters?
20 A. No.
21 Q. Have you ever taught or given a
22 formal presentation on the subject matter of
23 pulmonary emboli or phlebitis?
24 A. No.
25 Q. Tell me what you've reviewed in

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1 preparation for this deposition.
2 A. I've reviewed my office note from my
3 visit with the patient as well as the hospital
4 chart from Barberton Citizens Hospital and the
5 hospital chart of Akron General Medical Center.
6 Q. Have you reviewed any medical
7 records from Dr. Michael Ginella?
8 A. Yes.
9 Q. So his office records you have seen?
10 A. Yes.
11 Q. Have you referred to any textbook
12 chapters or articles in preparation for this
13 deposition?
14 A. No.
15 MR. MURPHY: Jeanne, are Dr.
16 Ginella's office notes part and parcel with Dr.
17 Murray's notes?
18 MS. TOSTI: Off the top of my head,
19 I can't tell you.
20 Q. Since this case was filed, have you
21 discussed this case with Dr. Patrick Rich?
22 A. Yes.
23 Q. When did you discuss it with him?
24 A. Our initial discussion may have
25 been, I believe, when we received the letter

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1 that a suit was being considered, and I think
2 that was sometime in June of last year.
3 Q. What is it that you discussed with
4 him?
5 A. Just the overall factors involved in
6 the case. I don't remember specifics at this
7 time.
8 Q. Have you discussed this case with
9 him more than once?
10 A. Yes.
11 Q. How many times?
12 A. I don't have an exact number as to
13 how many times I've spoken with him.
14 Q. Approximately.
15 A. Approximately three times.
16 Q. When is the last time you discussed
17 this case with him?
18 A. Last week when I told him I had a
19 deposition.
20 Q. Did you discuss what your testimony
21 would be at this deposition?
22 A. No.
23 Q. What was the content?
24 MR. MURPHY: Let me just object to
25 that.

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1 Q. What was the content of your
2 discussion with Dr. Patrick Rich last week?
3 A. I simply told him I had a deposition
4 concerning the case coming up on the 18th.
5 Q. Did you discuss anything else at
6 that time?
7 A. No.
8 Q. And other than with counsel, have
9 you discussed this case with anyone else?
10 A. No.
11 -----
12 (Thereupon, PLAINTIFF'S Deposition
13 Exhibits 2&3 were marked for
14 purposes of identification.)
15 -----
16 Q. Doctor, I'm going to hand you what I
17 have marked as Plaintiff's Exhibits 2 and 3.
18 Let counsel take a look at it first.
19 Are you able to identify those two
20 documents for us?
21 A. Yes.
22 Q. Would you tell us what those are.
23 A. They are the office notes from my
24 father's practice from February 1st, '01.
25 Q. Are those notes that you wrote?

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1 A. Yes, portions of them are.
2 Q. Can you tell me what portions of
3 Plaintiff's Exhibit 2 or 3 you wrote?
4 A. Would you like me to read my
5 portion?
6 Q. Well, are most of the notes on these
7 two pages yours?
8 A. Yes. The majority of the notes are
9 mine.
10 Q. Would you read which notes are not
11 yours.
12 A. The dating, 2-1-01, the words Jean,
13 C/C S.O.B., and then on the second page --
14 Q. Which is Plaintiff's Exhibit Number
15 3?
16 A. Number 3. Under 2-8-01, cancelled
17 D.F. Then 2-19-01, no show, D.F., those are not
18 my notes.
19 Q. Aside from the notes contained in
20 Plaintiff's Exhibits 2 and 3, do you have any
21 other notes or a personal file on this case?
22 A. No.
23 Q. Have you ever generated any such
24 notes or kept such a file on this case aside
25 from those Plaintiff's 2 and 3?

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1 A. No.
2 Q. Is there a textbook in your field of
3 practice of family medicine that you refer to
4 from time to time for guidance in your practice?
5 A. Yes, there are textbooks.
6 Q. Which textbooks do you utilize?
7 A. There's a textbook called Ambulatory
8 Medicine, and then there's a pediatric textbook,
9 which I believe is just called Clinical
10 Pediatrics.
11 Q. Do you know who the author is on the
12 Ambulatory Medicine text?
13 A. No, I don't.
14 Q. Do you find the information
15 contained in that text to be reliable?
16 A. Yes.
17 Q. Are there any publications, as you
18 sit here today, that you believe have particular
19 relevance to the issues in this case as you
20 understand them? And I am asking if there's
21 something that you are aware of currently.
22 A. Again, I don't understand the
23 question.
24 Q. I'm asking if there is a particular
25 piece of literature that you believe, as you sit

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1 here today, has particular relevance to the
2 issues in this case, as you understand them.
3 A. In regards to what?
4 Q. In regards to the issues of this
5 case.
6 A. I'm sure there are many articles
7 written.
8 Q. My question is merely if there is
9 one that, as you sit here, you currently are
10 aware of. That's all I'm asking you.
11 A. I don't know of any one specific.
12 Q. Have you ever participated in any
13 research dealing with the subject of pulmonary
14 emboli or phlebitis?
15 A. No.
16 Q. In your practice, do you see
17 patients of all ages?
18 A. Yes.
19 Q. Do you also manage patients in the
20 hospital as well as seeing them in an office
21 setting?
22 A. Yes.
23 Q. I'd like you to describe for me in
24 general terms your professional practice
25 schedule as it was in January and February of

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1 2001.
2 A. Are you interested in my daily
3 practice schedule?
4 Q. Yes, just a typical day or week for
5 you in that time period.
6 A. Depending on how many patients I
7 have in the hospital, I would make hospital
8 rounds in the morning before office hours, then
9 come to my office and see patients between
10 scheduled office hours, usually between 9:00 and
11 4:30, and then go back to the hospital to do
12 followup rounds for patients that I had not seen
13 early in the morning.
14 Q. What time would you usually come to
15 the office in the morning after rounds at the
16 hospital?
17 A. I'm usually here by a quarter to
18 9:00.
19 Q. Was that typical Monday through
20 Friday, or seven days a week?
21 A. That's typical Monday, Tuesday,
22 Thursday and Friday when I have office hours
23 here.
24 Q. What type of a weekend schedule did
25 you keep?

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1 A. A weekend schedule is hospital
2 rounds and then nursing home rounds.
3 Q. Your nursing home rounds, would they
4 be for your personal patients, or were you
5 fulfilling a position as a medical director for
6 a nursing home?
7 A. Personal patients.
8 Q. Now, Dr. Patrick Rich is your
9 father; is that correct?
10 A. Yes.
11 Q. Have you ever worked in the same
12 medical practice together?
13 A. Yes.
14 Q. When was that?
15 A. When I first came out in private
16 practice in 1991 for approximately a three-month
17 period I worked at his office part time.
18 Q. Then after 1991, did you establish
19 your solo practice?
20 A. Yes, I established this practice in
21 mid 1991.
22 Q. Have you ever shared office space on
23 a regular basis other than the three months that
24 you worked with him?
25 A. No.

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1 Q. In February of 2000, did you have an
2 agreement or an understanding with Dr. Patrick
3 Rich that you would, on occasion, see his
4 patients when he was not available?
5 A. Yes.
6 Q. Can you give me a little bit more
7 detail as to what your agreement was with him as
8 to what responsibilities you would take on in
9 his absence?
10 A. I would cover his office patients
11 while he was out of town and then see any
12 inpatients that were admitted during his
13 absence.
14 Q. When you were seeing inpatients,
15 where would you be seeing those patients?
16 A. Akron General Medical Center and
17 Barberton Citizens Hospital.
18 Q. Did you have any agreement with him
19 to cover on a regular basis so that he could
20 have a day off?
21 A. Not on a regular basis, no.
22 Q. So you didn't take like night call
23 or weekend call for him on a regular basis?
24 A. No.
25 Q. Did he do that for you? Did he

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1 cover your practice in your absences?
2 A. Yes.
3 Q. How often in February of 2001 were
4 you covering for your father, just approximately
5 how often would that occur?
6 A. I would cover for him at his office
7 one-half day, or for half the day Monday,
8 Tuesday and Thursday while he was out of town.
9 Q. How often did he go out of town
10 during the course of a year?
11 A. Two times a year.
12 Q. How long would he be out of town?
13 A. From one to two weeks.
14 Q. How long have you had that agreement
15 with your father to cover his patients in his
16 absence?
17 A. Since I became an attending in 1991.
18 Q. When is the last time that you've
19 filled in for your father?
20 A. I believe it was February of this
21 year.
22 Q. In 2001, when you were filling in
23 for your father and seeing his patients, where
24 would you see those patients?
25 A. At his office.

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1 Q. Where is his office located?
2 A. 1414 Greensburg Road, Uniontown,
3 Ohio.
4 Q. Now, when you would see his patients
5 and fill in for him, would you be providing
6 primary care services to those patients just as
7 if they were your patients?
8 A. Yes.
9 Q. Would you be following up with the
10 plan of care identified by your father in the
11 patient's previous visits?
12 A. That would depend on what the
13 patient was presenting with at the time that I
14 saw them.
15 Q. If it was a continuing problem that
16 the patient had, would you make reference to
17 your father's previous plan of care for that
18 patient?
19 A. If I felt it was significant to my
20 care that day.
21 Q. When you saw Dr. Patrick Rich's
22 patients in his absence, did you communicate to
23 him your assessment, findings and plan of care?
24 A. Not with all the patients, no.
25 Q. Tell me what you did do when you

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1 would see his patients.
2 A. I would evaluate the patient, then
3 write a note, place a note in the chart.
4 Q. Aside from the notes made by you at
5 the patient visits, did you provide Dr. Patrick
6 Rich with any type of a verbal summary of what
7 you did with the patients that you saw?
8 A. I did when the patients were
9 admitted to the hospital.
10 Q. If they were not admitted to the
11 hospital, did you provide him with anything in
12 addition to the clinical note that you wrote
13 when you saw the patient?
14 A. If there was a significant problem
15 with a patient in regards to a workup or a
16 diagnosis where the patient was going to follow
17 up rather quickly after a test, I would tell him
18 about what test I ordered and why. But that was
19 not with every patient.
20 Q. Would it be fair to say that the
21 majority of patients that you saw, you would
22 write a clinical note and that would be your
23 means of communicating with your father?
24 A. Yes.
25 Q. Tell me what deep vein thrombosis

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1 is.
2 A. Deep vein thrombosis is an etiology
3 where there is a clot within the deep vein
4 system of either the upper or lower extremities.
5 Q. And what are the signs and symptoms
6 of DVT?
7 A. Pain in the associated extremity,
8 swelling in the associated extremity. There may
9 be redness associated.
10 Q. In some instances, can deep vein
11 thrombosis be asymptomatic?
12 MR. MURPHY: You say asymptomatic?
13 A. Asymptomatic?
14 Q. Yes.
15 A. Yes.
16 Q. Would you agree that when deep vein
17 thrombosis occurs, in some instances, it may
18 cause the leg to become edematous and the
19 superficial veins to distend?
20 A. It can cause the leg to become
21 edematous, but I'm not aware that it will cause
22 superficial venous distention.
23 Q. What is superficial phlebitis?
24 A. Superficial phlebitis is an
25 inflammation within the walls of the superficial

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1 veins of the upper and lower extremities.
2 Q. If deep vein thrombosis occurs and
3 there's an occlusion of a major vein and backup
4 of blood behind the clot, wouldn't you expect
5 that the superficial veins would also distend as
6 the leg becomes edematous?
7 A. No.
8 Q. Are there instances when superficial
9 venous thrombosis progresses to deep vein
10 thrombosis due to extension of the thrombus?
11 A. Not that I'm aware of.
12 Q. How is DVT diagnosed?
13 A. DVT can be diagnosed with an
14 angiogram of the lower extremity or upper
15 extremity or a venous Doppler ultrasound of the
16 affected extremity.
17 Q. The venous Doppler ultrasound is a
18 noninvasive test; correct?
19 A. Yes.
20 Q. That's the test that's most commonly
21 used to diagnose DVT, isn't it, doctor?
22 A. Initially, yes.
23 Q. Would you agree that imaging studies
24 such as you've just described are necessary to
25 diagnose or rule out suspected DVT?

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1 A. Yes.
2 Q. How is DVT treated?
3 A. It's treated with anti-coagulation
4 therapy.
5 Q. If anti-coagulation is
6 contraindicated, filtering devices can be
7 inserted into the vena cava; correct?
8 A. Yes.
9 Q. Are there complications associated
10 with DVT?
11 A. Yes.
12 Q. What are those?
13 A. One complication is a pulmonary
14 embolism. Another complication, if a patient
15 has recurrent DVTs, would be chronic venous
16 stasis of the affected extremity.
17 Q. Would one of the things that you
18 would see with chronic venous stasis be leg
19 swelling?
20 A. There could be leg swelling, yes.
21 Q. What is a pulmonary emboli?
22 A. Pulmonary embolism is a blood clot
23 within the pulmonary artery system.
24 Q. You would agree that DVT, a deep
25 vein thrombosis, that becomes dislodged can

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1 travel through the venous system to the
2 pulmonary system and cause pulmonary emboli;
3 correct?
4 A. Yes.
5 Q. What would be the signs or symptoms
6 for pulmonary emboli?
7 A. There may be shortness of breath,
8 tachypnea, tachycardia, pleuritic type chest
9 pain. Some people get a feeling of anxiety or
10 apprehension with it, decreased oxygen level.
11 Q. Can hypotension and cardiac arrest
12 occur from pulmonary emboli?
13 A. Yes.
14 Q. From the signs and symptoms that you
15 just described, do all of those have to be
16 present in order to arrive at a diagnosis or a
17 suspicion for pulmonary emboli?
18 A. No.
19 Q. Would you agree that deep vein
20 thrombosis is the most common cause of pulmonary
21 emboli?
22 A. Probably, yes.
23 Q. In fact, doesn't deep vein
24 thrombosis cause the majority of pulmonary
25 emboli?

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1 A. I would think so, yes.
2 Q. Are there any complications
3 associated with pulmonary emboli?
4 A. Hypoxemia, respiratory failure,
5 pulmonary infarction, subsequent pneumonia, and
6 if it's a massive pulmonary embolism, you could
7 have cardiopulmonary arrest.
8 Q. You would agree that pulmonary
9 emboli can be life-threatening; correct?
10 A. Yes.
11 Q. How is pulmonary emboli diagnosed?
12 A. It's diagnosed -- one test is a V/Q
13 scan. Another test would be a pulmonary
14 angiogram, and then we can do a spiral CT of the
15 chest with pulmonary artery protocol.
16 Q. Would you agree that pulmonary
17 emboli cannot be ruled out on the basis of
18 physical exam alone?
19 A. On the basis of physical exam alone,
20 yes.
21 Q. Doctor, if there's suspicion of
22 pulmonary emboli, would you agree that
23 diagnostic studies should be done promptly to
24 confirm or rule out the diagnosis?
25 A. That would depend on the patient's

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1 clinical presentation, and that would also
2 include some basic testing could be done at the
3 time of admission.
4 Q. What type of basic tests?
5 A. One would be a simple chest x-ray to
6 rule out other causes, and then a pulse oximeter
7 reading or an arterial blood gas to look for
8 hypoxemia. Then that would be combined with the
9 patient's clinical presentation.
10 Q. After doing whatever you consider to
11 be an appropriate assessment, if you still have
12 a suspicion for pulmonary emboli, would you
13 agree that one of the diagnostic studies that
14 you previously described should be done to rule
15 it out?
16 A. Yes.
17 Q. So, doctor, you indicated a variety
18 of tests that might be done initially in order
19 to come to the decision to move forward to
20 doing, say, a V/Q scan. What would be the
21 clinical indicators that would indicate to you
22 that you should proceed with a V/Q scan to
23 assist and evaluate a patient for pulmonary
24 emboli?
25 A. If the patient had an initial

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1 clinical presentation in regards to history and
2 physical, and if initial oxygen determination by
3 blood gas or pulse oximeter reading was low and
4 indicated hypoxemia, then I would proceed.
5 Q. What is the treatment for pulmonary
6 emboli?
7 A. Initial treatment is
8 anti-coagulation therapy, and depending on if
9 there's hypoxemia involved, oxygen therapy.
10 Q. Initially, when you say
11 anti-coagulation, are you speaking of heparin?
12 A. Heparin is one medication we can
13 use, yes.
14 Q. Can thrombolytics and embolectomy
15 also be alternative treatments in the right
16 patients?
17 A. Yes.
18 Q. How often in your practice do you
19 see patients with suspected pulmonary emboli?
20 A. In the last year, I've had five to
21 six patients with emboli.
22 Q. Have you personally diagnosed the
23 patient with pulmonary emboli?
24 A. Yes.
25 Q. When is the last time you did that?

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1 A. Approximately a month ago.
2 Q. Have you ever referred a patient to
3 another physician such as a pulmonologist with a
4 diagnosis of suspected pulmonary emboli?
5 A. Yes.
6 Q. When is the last time you did that?
7 A. I can't remember the last time I
8 referred for a suspected emboli.
9 Q. Would you agree, in general, prompt
10 treatment of pulmonary emboli increases the
11 chances for survival?
12 A. Yes.
13 Q. Is one of the main goals of
14 treatment in pulmonary emboli to stop deep vein
15 thrombosis from increasing in size, like giving
16 anti-coagulants such as heparin?
17 A. No. Heparin simply stops further
18 new clots from forming.
19 Q. So it stops the clot from extending
20 or increasing in size; correct?
21 A. Through stopping new clot formation.
22 Q. Correct. Once a clot is no longer
23 increasing in size, adding to it, the body then
24 begins to act to break down the clot; correct?
25 A. Yes.

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1 Q. Would you agree that, in general,
2 the risk for embolization from DVT decreases the
3 longer the patient is on the anti-coagulants?
4 A. Are you asking for the chance of a
5 new DVT, or --
6 A. No. From the --
7 Q. No. Let me rephrase the question.
8 In a patient that has an identified deep vein
9 thrombosis, the longer the patient is on
10 anti-coagulation, the less likely it is that
11 particular thrombosis is going to cause
12 embolization? Would that be fair to say?
13 A. I would say yes.
14 Q. Would you agree that pulmonary
15 embolism should be within the differential
16 diagnosis when a patient reports leg swelling
17 and new complaints of shortness of breath?
18 A. Yes.
19 Q. Now, if one of your patients is
20 diagnosed with pulmonary embolism, would you as
21 the family practice physician manage the care
22 and treatment for that patient?
23 A. Initially I would have a
24 pulmonologist help with the care, but, yes, I
25 would also manage the care.

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1 Q. So, in most cases, would you be
2 co-managing the patient with the pulmonologist?
3 A. Yes.
4 Q. Do you have an independent
5 recollection of Jean Speicher, as you sit here
6 today? Do you recall her?
7 A. Yes, I do have a vague recollection
8 of our meeting.
9 Q. When is the first time that Jean
10 Speicher came under your care?
11 A. February 1st, '01.
12 Q. Where did you see her?
13 A. At my father's office in Greensburg.
14 Q. Is the visit on February 1st, 2001
15 the only time that you saw Jean Speicher?
16 A. Yes, to my knowledge.
17 Q. Now, how did it happen that you saw
18 her on February 1st, 2001 at your father's
19 office? What were the circumstances that put
20 you there to see her?
21 A. My father was out of town, and I was
22 covering his practice.
23 Q. Where was your father at the time?
24 A. I believe he was in Florida.
25 Q. How long were you providing coverage

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1 for him at that point in time?
2 A. I believe one to two weeks.
3 Q. Was Jean Speicher accompanied by
4 anyone at that February 1st, 2001 visit?
5 A. Not to my memory, no.
6 Q. Now, before you saw her on February
7 1st, did you have any conversations with your
8 father about her condition?
9 A. No.
10 Q. Did you speak to any other physician
11 about her before seeing her on February 1st?
12 A. No.
13 Q. Now, generally, when you were
14 covering for your father and you saw patients at
15 his office, when the patient would come into the
16 office, would the patient be seen by a nurse or
17 a medical assistant first?
18 A. Yes.
19 Q. Was it a nurse or a medical
20 assistant?
21 A. It was a medical assistant.
22 Q. What would the medical assistant do
23 in regard to the patient prior to the time you
24 would see the patient?
25 A. Medical assistants would place the

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1 patient in the room, and on most occasions would
2 take a short history, and then sometimes vital
3 signs.
4 Q. Would the medical assistant record a
5 chief complaint that brought the patient to the
6 office? You have to answer verbally.
7 A. Yes.
8 Q. And would the medical assistant
9 advise you of the information that he or she
10 collected from the patient?
11 A. Not verbally.
12 Q. They would provide you with a
13 written note on the clinical sheets?
14 A. Yes.
15 Q. Now, on February 1st of 2001, what
16 did you understand to be the reason that Jean
17 Speicher came to see you?
18 A. She presented with a chief complaint
19 of a cough and symptoms of depression.
20 Q. Now, doctor, on Plaintiff's Exhibits
21 2 and 3, those are copies of your clinical notes
22 from that office visit; is that correct?
23 A. Yes.
24 Q. Would you tell us, under the first
25 line with the patient's name Jean, there's a

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1 C/C. That stands for chief complaint; correct?
2 A. Yes.
3 Q. That first line, I think you
4 indicated previously, was written by the medical
5 assistant?
6 A. Yes.
7 Q. Read for us what she has recorded as
8 the chief complaint that brought the patient to
9 the office that date.
10 A. S.O.B.
11 Q. That stands for shortness of breath;
12 correct?
13 A. Yes.
14 Q. Now, doctor, Jean Speicher had been
15 in the hospital just a couple of days before you
16 saw her. I think she was hospitalized from
17 January 25th through January 28th, 2001. Was
18 this a followup visit for that hospitalization?
19 A. I believe, per my history, that she
20 was presenting with new complaints.
21 Q. So this was not a scheduled
22 appointment?
23 A. I don't know if it was scheduled or
24 not.
25 Q. When you saw her on February 1st,

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1 did you have access to Dr. Patrick Rich's office
2 chart?
3 A. Yes.
4 Q. Did you have the information in that
5 chart from her previous visit of January 25th,
6 2001?
7 A. Yes.
8 Q. When she presented, did you read
9 through the previous office notes from your
10 father for the January 25th, 2001 visit?
11 A. No.
12 -----
13 (Thereupon, PLAINTIFF'S Deposition
14 Exhibit 4 was marked for purposes
15 of identification.)
16 -----
17 Q. I'm going to hand you what's been
18 marked as Plaintiff's Exhibit 4. I believe
19 these are the office notes of January 25th, 2001
20 prior to Jean Speicher's admission to the
21 hospital. Now, I want you to assume these were
22 contained in your father's office chart. These
23 would have been available for you to review if
24 they were in his office chart; correct?
25 A. Yes.

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1 Q. If you were seeing a patient just a
2 couple of days after discharge from the
3 hospital, wouldn't it be important for you to
4 review what put her into the hospital, your
5 father's impressions?
6 A. Not if she was able to give a
7 history, an adequate history, verbally as to why
8 she was in the hospital and it was done during
9 that hospital course and what her treatments
10 were subsequent to that.
11 Q. Did she do that in this instance?
12 A. Yes.
13 Q. What did she tell you occurred in
14 regards to her hospitalization?
15 A. She stated she was hospitalized
16 January 25th through the 28th for shortness of
17 breath, that she was diagnosed with
18 hyperthyroidism, and she listed the medications
19 that she was on at the time of our visit. And
20 she also stated that her shortness of breath had
21 resolved, that she had two new complaints, one
22 of a cough and the other one, again, of
23 depression.
24 Q. Now, doctor, according to the
25 January 25th, 2001 notes, it indicates near the

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1 top of the page that Jean Speicher had swelling
2 in her left leg last week and then developed
3 shortness of breath. Do you see that?
4 A. Yes.
5 Q. When you saw her, did you discuss
6 the swelling in her left leg?
7 A. No.
8 Q. Did you assess her left leg?
9 A. Yes.
10 Q. How do you know that you did that?
11 A. Because on Exhibit 3, under
12 extremities, which is Ext, I noted no clubbing,
13 cyanosis or edema, no CCE.
14 Q. You were aware that she developed
15 shortness of breath, especially when walking,
16 prior to the time that she went in the hospital.
17 That was one of the reasons why she went into
18 the hospital; is that correct?
19 A. I didn't know that, no.
20 Q. Well, it's recorded in your notes
21 that she went to the hospital because of
22 shortness of breath; correct?
23 A. Right. But I had no knowledge at
24 that time it was with walking, as you stated.
25 Q. Wouldn't that be something that

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1 would be important for you to know when you're
2 seeing this patient?
3 A. Yes, if she was still having
4 persistent shortness of breath when I saw her.
5 Q. The chief complaint recorded by the
6 medical assistant states that she is there for
7 shortness of breath. That would have been
8 information that the patient provided to the
9 medical assistant; correct?
10 A. I can't say if she was there with
11 shortness of breath at that time because there
12 was no documentation after that in regards to
13 what she told the medical assistant. She may
14 have stated that she was there for followup to
15 her previous mentioned shortness of breath, but,
16 again, without any further documentation from
17 the medical assistants, I don't know exactly
18 what her chief complaint was in regards to.
19 Q. Now doctor, in your father's note of
20 January 25th, under his impressions, he has
21 indicated rule out congestive heart failure,
22 rule out pulmonary emboli; correct?
23 A. Yes.
24 Q. You would agree that those two
25 diagnoses were within your father's differential

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1 at the time that he saw her; correct?
2 A. Yes.
3 Q. Other than what the patient told you
4 at the February 1st, 2001 visit, were you aware
5 of what your father's reasons were for
6 hospitalizing her?
7 A. No.
8 Q. What was your understanding of the
9 admitting diagnosis for the January 25th
10 Barberton hospitalization?
11 A. For the patient's history of
12 shortness of breath.
13 Q. That's a symptom, doctor. That's
14 not a diagnosis; correct?
15 A. Right.
16 Q. So I'm asking what your
17 understanding was of the diagnosis.
18 A. Diagnosis.
19 Q. The admitting diagnosis.
20 A. I don't know what the admitting
21 diagnosis was. I know the discharge diagnosis,
22 but not the admitting.
23 Q. Do you know whether any evidence of
24 congestive heart failure was found during her
25 January 25th hospitalization at Barberton

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1 Hospital?
2 A. No evidence of congestive heart
3 failure found.
4 Q. So it was ruled out during that
5 hospitalization; is that correct?
6 A. Yes.
7 Q. Was pulmonary emboli ever ruled out
8 during that hospitalization?
9 A. No.
10 Q. Doctor, would you agree that when
11 you're seeing a patient in followup after
12 hospitalization to rule out congestive heart
13 failure and pulmonary emboli, you have a duty to
14 be aware of the findings of the diagnostic
15 workup in the hospital?
16 MR. MURPHY: Object to that
17 question. It's in the form of a hypothetical
18 and I don't think it's borne out by this
19 evidence.
20 MR. JAMISON: Objection.
21 MR. MURPHY: You can answer it if
22 you still remember it.
23 A. I don't remember it now.
24 (Record read.)
25 A. No. That would depend on what her

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1 presentation was to me at the time of our visit.
2 Q. You previously told me that, with
3 pulmonary emboli, you can't rule that out on
4 physical examination alone; correct?
5 A. That's correct.
6 Q. Aside from your physical
7 examination, you didn't do any other diagnostic
8 studies at the office visit on February 1st of
9 2001, correct?
10 A. Correct.
11 Q. Now, you've had an opportunity to
12 review Jean Speicher's Barberton Hospital
13 admission records; correct?
14 A. Yes.
15 Q. Doctor, would you agree that
16 unexplained right ventricular volume or pressure
17 load on an echocardiogram should heighten the
18 concern for pulmonary emboli?
19 A. It may, given the clinical
20 presentation.
21 Q. What type of clinical presentation
22 factors would heighten the concern with those
23 findings on echo?
24 A. Those would be symptoms of a
25 possible PE.

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1 Q. And would that include leg swelling
2 and shortness of breath?
3 A. Yes.
4 Q. Now, you indicated that at the
5 February 1st, 2001 visit you obtained a history
6 from Jean Speicher and she told you that she had
7 a cough for two days; correct?
8 A. Yes.
9 Q. And that she had also been
10 hospitalized?
11 A. Yes.
12 Q. Was it your understanding that Jean
13 Speicher had a thyroid problem?
14 A. Yes, by her own admission.
15 Q. Now, you've had an opportunity to
16 review the Barberton Hospital records. Did you
17 review the endocrinologist's evaluation of Jean
18 Speicher during that hospital stay?
19 A. Yes.
20 Q. Would you agree that the
21 endocrinologist found that she did not have
22 evidence of overt hypothyroidism?
23 A. I believe she said she had evidence
24 of early hyperthyroidism.
25 Q. I believe it was hyperthyroidism; is

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1 that correct?
2 A. Hyperthyroidism, yes.
3 Q. When you reviewed the medical
4 records, was it your impression that the
5 endocrinologist felt that she had early
6 hyperthyroidism?
7 A. Yes.
8 Q. Now, you also did a physical exam at
9 the February 1st office visit; correct?
10 A. Yes.
11 Q. Did you find any deviations from
12 normal that you felt were significant on your
13 physical examination?
14 A. She was tearful at the time of our
15 examination, and in regards to her pulmonary
16 examination, she had a few rhonchi in her
17 bilateral upper lobe areas without any wheezing.
18 Q. What was your conclusion regarding
19 her condition after evaluation?
20 A. My assessment at that time was
21 bronchitis, depression, and hyperthyroidism.
22 Q. Was there anything else within your
23 differential diagnosis at the time that you saw
24 her?
25 A. No.

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1 Q. Do you know whether Dr. Patrick Rich
2 thought the etiology of her shortness of breath
3 during hospitalization was related to congestive
4 heart failure or pulmonary emboli?
5 A. Again, I don't understand the
6 question.
7 Q. Did you ever discuss with your
8 father what the etiology of her shortness of
9 breath was on admission to the hospital on
10 January 25th, 2001?
11 A. Did I discuss with him at that time
12 when I saw the patient?
13 Q. At any point in time.
14 A. Since that time, yes, I have.
15 Q. What did you discuss in regard to
16 that etiology of the shortness of breath on
17 admission to the hospital?
18 A. Just specifically what tests were
19 done during the hospital course.
20 Q. Did he indicate to you what he
21 thought the etiology of her shortness of breath
22 was?
23 A. I believe that he felt that it was
24 related to her hyperthyroidism and transient
25 tachycardia that can be associated with that.

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1 Q. Would you expect to see transient
2 tachycardia and shortness of breath with
3 hypothyroidism?
4 A. No.
5 Q. Doctor, what was the basis for your
6 diagnosis of bronchitis?
7 A. It was based on her history and my
8 clinical findings on exam.
9 Q. Tell me specifically what points in
10 the history and what points in your clinical
11 findings.
12 A. Her complaint of a cough without any
13 other associated pulmonary problems, and then on
14 examination, the fact that I heard rhonchi in
15 her upper lobe regions.
16 Q. Can you get cough and rhonchi with
17 pulmonary emboli?
18 A. Cough can be a presenting factor,
19 but to my knowledge, not rhonchi.
20 Q. If the pulmonary emboli is present
21 for a while, can you get rhonchi?
22 A. Again, not to my knowledge.
23 Q. What was your plan of care for her
24 when you saw her on February 1st?
25 A. I asked her to stop the

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1 ciprofloxacin that she was on. I started her on
2 a Z-Pak. I also started her on Paxil for her
3 depression. And she was asked to follow up in
4 one week for a check.
5 Q. Why did you want to see her back in
6 one week?
7 A. That's routine followup care in
8 regards to my practice; if somebody comes in
9 with any acute problems, I like to make sure the
10 presenting symptoms have resolved, and I would
11 also like to see how they're doing on the new
12 medication I started.
13 Q. The Z-Pak, is that an antibiotic?
14 A. Yes.
15 Q. You changed her from Cipro to
16 another antibiotic; correct?
17 A. Yes.
18 Q. Why did you make that change?
19 A. I thought the Z-Pak was more
20 appropriate in regards to my diagnosis of
21 depression, and it was evidence that Cipro was
22 not working because she developed this cough
23 while on --
24 MR. MURPHY: The Z-Pak was related
25 to her depression? Did you misspeak?

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1 A. It's an antibiotic.
 2 Q. You indicated to me Z-Pak was an
 3 antibiotic; correct?
 4 A. Yes.
 5 Q. You mentioned it was more
 6 appropriate considering her depression?
 7 A. I apologize, more appropriate in
 8 regards to her bronchitis.
 9 Q. When was she placed on the Cipro?
 10 A. I would assume during her hospital
 11 course, because she presented to me on the
 12 Cipro.
 13 Q. And do you know why the Cipro was
 14 ordered for her?
 15 A. I believe due to suspected urinary
 16 tract infection.
 17 Q. Doctor, I've had a little bit of
 18 difficulty with some of your handwriting. If
 19 you could just read through on Plaintiff's
 20 Exhibit 2 the part that begins with "Diagnosed
 21 with" just so that we can get down what you have
 22 written there.
 23 A. Okay. Diagnosed -- this?
 24 Q. Yes, about halfway down the page.
 25 A. Diagnosed with hyperthyroidism.

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1 Complaint of depression times three months.
 2 Positive crying spells. Positive mood swings.
 3 Husband passed away in 9 of 2000. Sleep okay.
 4 Appetite poor. Denies suicidal/homicidal
 5 ideations. Urine culture negative. Continue?
 6 Q. Yes.
 7 A. O, which is objective, 130 over 80.
 8 76 per minute. 18 per minute. Tearful, NAD,
 9 which is no acute distress. Weight, 180 pounds.
 10 HEENT, WNL, within normal limits. Lungs, few
 11 rhonchi bilateral upper lobes without wheezing.
 12 Heart, regular without S3/S4. Abdomen, soft.
 13 Extremities, no CCE. No calf tenderness.
 14 Assessment, number one, bronchitis;
 15 number two, depression; number three,
 16 hyperthyroidism.
 17 Plan: DC Cipro. Z-Pak number 1, no
 18 refills. Paxil, 20 milligrams Q day, number 30,
 19 one refill. Use discussed. Followup one week
 20 for check.
 21 Q. Under extremities, you mentioned
 22 CCE. What does that stand for?
 23 A. Clubbing, cyanosis, edema.
 24 Q. Now, when you instructed that she
 25 was to follow up in one week, would that

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1 followup have been with you or with your father
 2 at that point in time?
 3 A. That would have been with my father.
 4 Q. Did you give her any instructions
 5 regarding signs or symptoms to watch for that
 6 would warrant contacting the doctor sooner than
 7 the one week?
 8 A. Routinely, I do ask them to present
 9 sooner if problems arise. But in this case, I
 10 don't have an independent memory of saying that.
 11 -----
 12 (Thereupon, PLAINTIFF'S Deposition
 13 Exhibit 5 was marked for purposes
 14 of identification.)
 15 -----
 16 Q. Doctor, I'm going to give you a copy
 17 of the echo Doppler that was done on January
 18 26th, 2001, during Jean Speicher's Barberton
 19 Hospital hospitalization.
 20 MR. MURPHY: Is that 5?
 21 Q. It's a two-page report from that
 22 examination. Under the conclusions, under item
 23 number one, it says, normal left ventricular
 24 size, thickness and function. The estimated
 25 ejection fraction is 65 to 70 percent. No

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1 regional wall motion abnormalities. Do you see
 2 that?
 3 A. Yes.
 4 Q. Would you agree those findings would
 5 argue against left-sided heart failure?
 6 A. Yes.
 7 Q. Now, under the conclusions, it
 8 further states that there is, under item number
 9 2, mild right-sided chamber enlargement,
 10 significant pulmonary hypertension with a peak
 11 pulmonary artery pressure estimated at 55 to 60
 12 millimeters of mercury. Do you see that?
 13 A. Yes.
 14 Q. Would you agree that right
 15 ventricular systolic pressures of 55 to 60
 16 millimeters of mercury in a person reporting
 17 recent history of leg swelling and new onset of
 18 shortness of breath should heighten the concern
 19 for pulmonary embolism?
 20 A. That is one of the diagnoses for
 21 this presentation.
 22 Q. Would you agree that in Jean
 23 Speicher's case, with her history of leg
 24 swelling and new onset of shortness of breath
 25 and echo findings of significant pulmonary

Page 53

1 hypertension, it would have been prudent to do a
2 followup V/Q scan to rule out pulmonary emboli
3 as a cause of her symptoms?
4 A. That would have depended on her
5 other clinical presentation, any other workup
6 that was done.
7 Q. Well, you had an opportunity to
8 review the Barberton records. Do you feel, in
9 her case, that a V/Q scan was indicated?
10 A. Not given her other clinical
11 presentation and physical findings.
12 Q. Why not?
13 A. Well, she was -- on admission, she
14 was neither tachycardic nor tachypneic. She had
15 a room air pulse oximeter reading of 96 percent,
16 which is normal and not indicative of any
17 hypoxemia. During her hospital course, she
18 remained stable without any deterioration, and
19 at the time of discharge, she was asymptomatic.
20 Q. Do you know whether Jean Speicher
21 had any type of followup specifically for the
22 significant pulmonary hypertension identified on
23 her January 26th, 2001 echocardiogram?
24 A. No, I don't.
25 Q. Would you agree that significant

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1 pulmonary hypertension on an echocardiogram
2 would warrant a pulmonology consult or referral
3 to a pulmonologist for evaluation?
4 A. Pulmonologist or cardiologist, if it
5 was a new finding.
6 Q. Was that done in this case?
7 A. No.
8 Q. Should it have been done in this
9 case?
10 A. Are you asking by me or by the
11 treating physician in the hospital?
12 Q. The treating physician.
13 A. No, I don't think necessarily a
14 referral needed to be done at the time of her
15 hospitalization.
16 Q. When do you think it needed to be
17 done?
18 A. That could have been done in
19 followup.
20 Q. And you did not do that when you saw
21 her on February 1st of 2001; correct?
22 A. I did not have this echocardiogram
23 result at that time.
24 Q. Do you have an opinion as to whether
25 the pulmonary hypertension identified on Jean

Page 55

1 Speicher's echocardiogram on January 26 was
2 caused by undiagnosed pulmonary emboli?
3 A. No.
4 Q. Now, after you saw her on February
5 1st and did your evaluation, did you discuss
6 your findings with Dr. Patrick Rich at any time?
7 A. Other than just more recently, I did
8 not discuss with him at the time of my visit or
9 shortly after that.
10 Q. Do you have an opinion as to the
11 cause of her prior left leg swelling?
12 A. No.
13 Q. I am referring to the leg swelling
14 that she had on the January 25th office visit.
15 Would you agree that if a patient with a history
16 of phlebitis reports a new onset of swelling in
17 one leg and shortness of breath, a reasonably
18 prudent physician should move to rule out deep
19 vein thrombosis and pulmonary emboli?
20 A. In regards to phlebitis, would that
21 be superficial phlebitis that you're asking?
22 Q. Superficial phlebitis or deep vein
23 phlebitis. When a patient reports a new onset
24 of swelling in one leg and shortness of breath,
25 would a reasonably prudent physician move to

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1 rule out deep vein thrombosis and pulmonary
2 emboli?
3 A. If there was a concern with a deep
4 vein thrombosis, but not necessarily if there
5 was just a concern for the superficial
6 thrombophlebitis.
7 Q. Wouldn't the coincidence of leg
8 swelling and shortness of breath heighten the
9 concern for pulmonary emboli?
10 A. Yes.
11 Q. Is it sometimes difficult to
12 differentiate between superficial phlebitis
13 swelling and deep vein thrombosis swelling in a
14 leg?
15 A. No. Usually superficial
16 thrombophlebitis is fairly clear with distended
17 superficial veins, tenderness over the
18 superficial veins.
19 Q. If you have leg swelling with it,
20 does it raise the concern that it might be deep
21 vein thrombosis?
22 A. That can be, yes.
23 Q. Do you normally get leg swelling
24 with superficial phlebitis?
25 A. Not of the entire area; just of the

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1 immediate area around the vein.
2 Q. If a V/Q scan had been done on
3 admission to Barberton Hospital on January 25th,
4 2001, do you have an opinion whether it would
5 have shown a high probability for pulmonary
6 emboli?
7 A. Given her clinical presentation, I
8 would have to say that I feel it probably would
9 not show a high probability.
10 Q. If a deep vein ultrasound study of
11 the lower extremities had been done during the
12 Barberton hospitalization, do you have an
13 opinion as to whether it would have been
14 positive for deep vein thrombosis?
15 A. Given the admission history and
16 physical on her presentation, I don't feel it
17 would have been positive.
18 Q. Do you have an opinion as to whether
19 it was appropriate to discharge her to home from
20 Barberton on January 28th, 2001?
21 A. Given the fact that she was stable
22 and asymptomatic, I do feel it was appropriate
23 to discharge her at that time.
24 Q. What is your understanding as to
25 what happened to Jean Speicher after you saw her

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1 on February 1st, 2001?
2 A. She presented to Akron General
3 Medical Center on February 5th with shortness of
4 breath, tachypnea, and respiratory failure and
5 was subsequently diagnosed with a pulmonary
6 embolism and admitted for treatment.
7 Q. Were you ever contacted by any of
8 her subsequent medical providers after the
9 February 1st, 2001 visit?
10 A. I don't remember ever being
11 contacted, no.
12 Q. You are aware from your review of
13 the Akron General Medical Center records that a
14 V/Q scan done after admission showed a high
15 probability of pulmonary emboli; correct?
16 A. Yes.
17 Q. After reviewing that report, do you
18 believe that your diagnosis of bronchitis on
19 February 11 of 2001 was accurate?
20 A. Yes.
21 Q. Would you agree that the sooner a
22 patient is treated for deep vein thrombosis and
23 pulmonary emboli the greater the chance there is
24 for avoiding lethal complications?
25 A. Yes.

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1 Q. You would agree that most patients
2 treated for deep vein thrombosis do not die from
3 pulmonary emboli; correct?
4 A. Can you rephrase the question.
5 Q. Patients that are diagnosed with
6 deep vein thrombosis, when they receive
7 treatment, most of those patients do not die
8 from pulmonary emboli; correct?
9 A. Correct.
10 Q. When did you learn of Jean
11 Speicher's death?
12 A. I really can't remember what date,
13 what time of the year I learned of her passing.
14 Q. Was it close to the time that she
15 passed away?
16 A. It may have been, but, again, I
17 can't remember.
18 Q. Do you recall if it was before this
19 lawsuit was filed?
20 A. No, I can't recall when I initially
21 learned of her passing.
22 Q. You don't recall your father ever
23 discussing it with you since you had seen her
24 just a few days before her last admission saying
25 this woman that you saw in the office passed

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1 away?
2 A. Not to my memory, no.
3 Q. Did you ever speak to any of Jean
4 Speicher's family at any time?
5 A. No, I don't believe so.
6 Q. Do you have an opinion as to whether
7 her death was preventable?
8 A. I don't think it was.
9 Q. Why not?
10 A. Because she presented to the -- when
11 she presented to Akron General Medical Center
12 they made a diagnosis, they initiated treatment,
13 and she had a recurrent PE while being treated.
14 Then she had subsequent other problems including
15 a massive stroke.
16 Q. Do you have an opinion as to what
17 caused her stroke?
18 A. No, I do not.
19 Q. Do you have an opinion as to what
20 point in time her condition was irreversible?
21 A. I believe it was probably at the
22 time when she suffered the stroke.
23 Q. Do you have an opinion as to what
24 caused her death?
25 A. I think it was cardiopulmonary

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1 arrest, and I believe it was due to a massive
2 stroke.
3 Q. Do you have an opinion as to when
4 Jean Speicher first suffered pulmonary emboli?
5 A. No, other than the time when the
6 diagnosis was made.
7 Q. I believe you told me you did not
8 speak to anyone, but you never discussed Jean
9 Speicher's case with any of the physicians that
10 treated her at Akron General Medical Center
11 while she was a patient there; is that correct?
12 A. That's correct, I don't believe I
13 spoke to any of those physicians because she was
14 under the care of another physician.
15 Q. To the best of your recollection.
16 A. To my memory, I didn't.
17 Q. If Jean Speicher had not suffered a
18 catastrophic stroke after her admission, do you
19 have an opinion as to what her reasonable life
20 expectancy would have been?
21 A. Well, she may have come through the
22 pulmonary embolism, but she also had many other
23 medical problems at that time. She had acute
24 renal failure that at least, according to the
25 notes, looked like she might need dialysis. She

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1 had an acute GI bleed. She had anoxic
2 encephalopathy. So she had many other medical
3 problems that needed to be considered in regards
4 to her overall outcome.
5 Q. Had she received successful
6 treatment for pulmonary emboli and was
7 discharged from the hospital, do you have an
8 opinion as to what her life expectancy would
9 have been?
10 MR. MURPHY: You're assuming that
11 there was no stroke, just for clarification?
12 Q. Had she not suffered a catastrophic
13 stroke and its sequell, do you have an opinion
14 as to what her reasonable life expectancy would
15 have been if she had gotten out of the hospital?
16 A. Are you asking specifically of just
17 pulmonary embolism or the other things, the GI
18 bleed or acute renal failure that went on?
19 Q. Well, let me ask you this: On the
20 date that you saw her, February 1st of 2001, had
21 she not suffered pulmonary embolism, what do you
22 feel her reasonable life expectancy would have
23 been?
24 A. Without a pulmonary embolism?
25 Q. Correct.

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1 A. I can't really quantify how long she
2 would have lived. She may have lived to be an
3 average age.
4 Q. That's what I'm asking, if you have
5 an opinion. If you don't, doctor, just tell me
6 that.
7 A. I can't have an opinion. I don't.
8 Q. Do you have any criticisms of Dr.
9 Patrick Rich in regard to his care of Jean
10 Speicher?
11 A. No.
12 Q. Do you blame Jean Speicher in any
13 way for the complications that she suffered?
14 A. No.
15 MS. TOSTI: Doctor, I don't have any
16 further questions for you.
17 MR. JAMISON: I don't have any
18 questions for you.
19 MR. MURPHY: If it's written up,
20 Jeanne, we would like to read it, and I presume
21 we waive the seven-day requirement. I'm going
22 out of town.
23 MS. TOSTI: I thank you. We're all
24 finished.
25 (Deposition concluded at 11:15 o'clock a.m.)
(Signature not waived.)

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1 AFFIDAVIT
2 I have read the foregoing transcript from
3 page 1 through 63 and note the following
4 corrections:
5 PAGE LINE REQUESTED CHANGE
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17
18 DEAN P. RICH, D.O.
19
20 Subscribed and sworn to before me this
21 _____ day of _____, 2002.
22
23
24 Notary Public
25 My commission expires _____.

CERTIFICATE

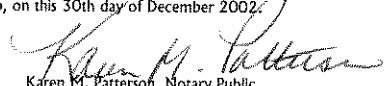
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State of Ohio,)
) SS:
County of Cuyahoga.)

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 30th day of December 2002.



Karen M. Patterson, Notary Public
Within and for the State of Ohio
My commission expires October 7, 2004.

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|---|--|--|--|--|
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