**In The Matter Of:**

*RIDOLFI v.*
*NEAL CHADWICK, M.D.*

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*Norman Silverman, M.D*
*Vol. I, September 19, 2000*

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IN THE CIRCUIT COURT FOR
CUYAHOGA COUNTY, OHIO

RICHARD RIDOLFI, et al.,

Plaintiffs.

vs Case No. 322843

NEAL CHADWICK, M.D., et al.,

Defendants.

DEPONENT: NORMAN A. SILVERMAN, M.D.
DATE: Tuesday, September 19,2000
TIME: 1:10 p.m.
LOCATION: Henry Ford Hospital
2799 West Grand Boulevard, 14th Floor
Detroit, Michigan
REPORTER: Denise M. Kizy, RPWCSR-2466

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APPEARANCES:

JOSEPH L. COTICCHIA CO., L.P.A.
By: Mr. Joseph L. Coticchia
1370 Ontario Street, Suite 1640
Cleveland, Ohio 44113
(216) 861-6622
Appearing on behalf of the Plaintiff

REMINGER & REMINGER CO., L.P.A.
By: Mr. William Meadows
113 St. Clair Avenue, N.E., 7th floor
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(216) 687-1311
Appearing on behalf of the Defendant,
Robert Paul Van Bergen, M.D.

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EXHIBITS



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Detroit, Michigan
Tuesday, September 19,2000
At about 1:10 p.m.

NORMAN A. SILVERMAN, M.D.
was thereupon called as a witness herein, and after having first been duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

**MR. COTICCHIA:** This is the deposition of Doctor Norman Silverman. The deposition is being taken pursuant to agreement. Is that correct?

**MR. MEADOWS:** Correct.

**EXAMINATION**
**BY MR. COTICCHIA:**

**Q:** Doctor, please state your full name and spell your last name.

**A:** Norman A. Silverman, S I L V E R **M A** N.

**Q:** What **is** your address here at the office?

**A:** Henry Ford Hospital, 2799 West Grand Boulevard, Detroit, ***48202.***

**Q:** What is your residential address?

**A:** 11 Sycamore Lane, S Y C A M **O** R E, Grosse

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Pointe, Michigan, 48230.
Q: And what is your occupation?
A: I'm a cardiac surgeon.
Q: Are you board certified?
A: Yes.
Q: In what area are you board certified?
A: In general surgery and thoracic surgery.
Q: You have a board certification in each one of those *two?*
A: Yes.
Q: Do you have your curriculum vitae?
A: Rightthere.
Q: Okay. Let's mark this Deposition Exhibit 1.
(Marked for identification Deposition Exhibit No. 1.)
Q: Doctor, I'm going to hand you what's been marked Exhibit 1.
Do you recognize that?
A: Yes.
Q: Is that your curriculum vitae?
A: Yes.
Q: When did you get licensed to practice medicine in Michigan?
A: 1989.

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Q: Are you licensed *to* practice medicine anywhere else?
A: No.
Q: So if I add correctly you'llbe *54* on December 19th, this year?
A: Yes.
Q: Did you review records regarding the treatment of the plaintiff, Richard Ridolfi, in this case?
A: Yes.
Q: Tell me what records you reviewed.
A: I reviewed the hospitalizations at — the initial hospitalization, Southwest General Hospital, and subsequent hospital admissions to Fairview General Hospital, and I reviewed numerous depositions of Mrs. Ridolfi, DoctorVan Bergen, Arnold Markowitz, Gary Noskin, and Doctor Gopal as well as an ER report — record of the 4th of September.
Q: September *4,* '95?
A: Yes.
Q: That's an ER record for Richard Ridolfi?
A: At Fairview Hospital.
Q: Yes. All right.
Did you review a deposition

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transcript of Doctor Richard Mayers?
A: Not that I can remember.
Q: Did you review a deposition transcript of a Doctor Edward Levy?
A: No.
Q: Did you review a deposition transcript of Doctor Ralph Lach, L A *C H?*
A: Not that I remember.
Q: Did you review a deposition transcript of Doctor Pamcia Mohoney?
A: Not that I remember.
*Q:* Did you review a deposition transcript of Doctor Bonita Shah, S H A H?
A: Not that I remember.
Q: Did you review a deposition transcript of John Bennett, M.T.?
A: Not that I remember.
Q: Did you review a deposition transcript of Doctor Phillip I. Lerner?
A: Not that I remember.
Q: Doctor, there's no issue here in regard to the success of Richard Ridolfi's coronary artery bypass graft; is there?
MR. MEADOWS: Objection because the way you worded that suggests that the issue is a

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legal matter as to what's in issue for the jury.
I object to form. The question is vague.
Q: (BY MR. COTICCHIA) You may answer.
*A* Could you say the question again?
Q: Do you agree there's no issue here regarding Richard Ridolfi's coronary artery bypass graft?
A: I don't know how to answer that question. It doesn't make any sense to me, sir.
Q: Was there anything inappropriate in the way DoctorVan Bergen performed the *graft* based on your review of the records of Fairview Hospital when he underwent the CABG as you referred to it?
A: I didn't refer to it as CABG.
Q: Or as is referred to, as I referred to it.
A: It seems that the operation was done in an appropriate manner.
Q: I have a copy of your May 21, 1999 letter. I'm going to show it to you, make sure we got the same copy.
That's it?
A: Yes.
Q: Before we go through your letter, I want to ask you a few questions in general.

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As a surgeon in your experience how many coronary artery bypass grafts have you performed?
A: Four or 5,000.
Q: And is that as the attending or primary physician?
A: Yes.
Q: Since your board certification?
A: A few of them were done before then because you don't get certified the first year that you're out, so since I finished the residency and — since I finished the residency, that's about four or 5,000.
Q: So that would be, tell me, because I don't have it right now, when were you board certified as a thoracic surgeon?
A: Maybe '92. No, no, '82. '81 or '82. I finished the residency in 1980 and then I got my boards in general surgery before you can get your boards in thoracic surgery and then I got my boards in thoracic surgery. By the time you went through the four stages to get to my boards was probably '92 by the time I was certified.
MR. MEADOWS: '82 or '92?
THE WITNESS: '82, *sorry,* '82, but I

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was an attending on the faculty of the University of Illinois, so for two years I did cardiac surgery and I don't know how many of those were.
Q: (BY MR. COTICCHIA) So approximately *4,000* to 5,000 since about generally speaking the time you were board certified in '82?
A: Yes.
Q: Is that fair?
A: Yeah. We won't quibble over the other part of it.
Okay. Yes.
Q: Does coronary artery bypass surgery involve the risk of infection?
A: Yes.
Q: And is that risk in the area of the sternal incision?
A: That is one of the risks.
Q: Okay. As a sign of infection is drainage from the incision, I'm talking about the sternal area, is drainage from the incision, can that be a sign of infection?
A: There are — in association with many other presenting syndromes, symptomatology, it can be but not necessarily always associated.
Q: Can a low grade temperature be a sign of

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an infection?
A: It's such a nondescript symptom that very little credulity could be placed on the diagnostic veracity of a low grade fever.
Q: Let's say fourth day postoperatively which is Richard Ridolfi's situation, can that be a sign of a fever?
A: That's a very very very weak dicriminator of infection in that circumstance.
Q: Is it something we take into consideration with all the other elements if you're trying to determine the presence of an infection?
A: It's not very helpful. Low grade fever, no. No, I don't put much credence on that.
Q: Is a high white cell count a sign of infection, can it be?
A: It has to be again taken with all the other clinical circumstances. In isolation, it's meaningless.
Q: Let's take it collectively,
Assuming that there's existence of incision drainage and a low grade temperature.
Is a high white cell count a sign of infection?
MR. MEADOWS: Objection to form.

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THE WITNESS: Well, again it has to be — taken in isolation those three things are not — they can suggest that there may be an infection, but they're not very diagnostic.
Q: (BY MR. COTICCHIA) Is dehiscence of the sternal wound a sign of infection?
A: Again, taken in isolation, a sternal wound, if it is dehisced, can be infected but it may well not be infected just as often.
Q: Is an unstable sternum following discharge after a CABG?
A: I just answered this question.
Q: I'm not talking about a dehiscence now. I'm talking about an unstable sternum.
A: Well, if it's unstable that means the sternal closure is dehisced.
Q: Is incisional pain fourth day postoperative surgery?
A: That's an absolutely worthless indicator of the degree of healing of a sternal wound on the fourth postoperative day.
Q: Is agitation a sign of infection?
A: No, not necessarily.
Q: Have you had occasion when you have treated patients that you've performed coronary

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artery surgery, to have a patient contract a sternal wound infection?
A: Yes.
Q: Have you had occasion where in the treatment of that infection you will call in an infectious disease doctor?
A: Yes.
Q: Do you have occasion before you discharge a patient following coronary artery surgery to take a sternal wound culture?
A: No.
Q: Why not?
A: You have to culture something. The concept of culturing a sternal wound implies that the wound is all separated and open, so you didn't mention that. So we wouldn't discharge a patient whose wound is separated and open.
Q: I said prior. Well, let me repeat it.
Prior to discharge.
When you perform a coronary artery bypass graft, before you close, do you do a wound culture.
A: No.
Q: When have you done, if at all, a wound culture of a patient following or during coronary

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artery bypass surgery?
A: Those are two questions. You want to separate them'
MR. COTICCHIA: Would you read the question back, please.
(Record repeated by Court Reporter.)
THE WITNESS: That's two questions. The during is never, the answer to during is never.
The answer to following if the clinical circumstances warrant it.
Q: (BY MR. COTICCHIA) What clinical circumstances warrant a culture?
A: If you suspect clinically that the patient has an infection and you take him to the operating room, we usually — we do intraoperatively on exploring wounds culture various levels of the wound.
Q: And what are the aspects or the bases upon which you would suspect an infection?
A: There are numerous factors with an infection and you'd have to see the patient's clinical symptomatology and his physical examination and his laboratory evaluation.
Q: Tell me what you look for in the clinical symptomatology.

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A: Mostly it's a disrupted dehisced wound that is draining purulent material associated with redness usually in a patient who has a high fever and a marked elevation of their white count.
Q: What percentage of your patients following coronary artery surgery contract a sternal wound infection?
A: Probably somewhere between — somewhat less than one and a half percent probably would be, one year maybe two percent, another year maybe half a percent, but less than one and a half percent I would say would be an average.
Q: Doctor, let's talk a little bit about your report.
Do you have copy of it in front of you?
A: Yes.
Q: Do you have the home-going records in front of you now?
A: I don't know what you mean — I don't know what a home-going record is here.
Q: Well, you said Fairview home care records.
Where are those?
A: I don't know where those are. I don't have all — some records may be at home. I do not

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have here in front of me the home care record.
Q: Was there anything in the home care records that you used as a basis of your opinion in this letter?
A: I don't have an independent recollection right now of what the home care records were, so I can't answer that question.
I would suspect since I wrote that I reviewed them that I made my judgments on what I reviewed.
Q: Did you make any notes in regard to the home care records?
A: No, sir.
Q: Do you have your notes here today regarding — first of all, did you prepare notes before you wrote this letter?
A: No.
Q: Did you underline anything before you wrote the letter?
A: No.
Q: Is it your testimony that you prepared this letter simply by reading the records and not making a note?
A: I guarantee it.
Q: Did you make an outline?

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A: No, I dictated this off the top of my head.
Q: Did you put any tabs, sticky tabs on any pages?
A: There was no pages. It was dictated with a Dictaphone.
Q: I'm talking about pages in the records you reviewed.
A: The only sticky tabs on the pages are what came with the pages.
Q: Okay. Did you fold the comers over on any records that you thought —
A: I made no marks in these, sir, either by physically distorting the pages or inserting markers or putting in cardboard or underlining things in yellow or writing in pencil or any other way. There is no physical notation in the records that were sent to me.
Q: Why do you not make notes or mark pages?
A: Because then I have to just go find them again. I just don't do that.
Q: When you're reading a record do you have your portable dictator with you?
A: No. I do not make verbal notes either, but no — it is with me because it's on the desk.

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If I read them here it's on the desk. If I read them at home then it's not near me.
I want to be sure I tell the truth.
Q: So it's my understanding you get the records and you read them?
A: Correct.
Q: You don't take a note?
A: Correct.
Q: You don't mark anything either by pencil, pen or sticky tab of anything that you think is significant?
A: Correct.
Q: And after you've read all the records — how many times would you read the records? How many times did you read these records?
A: In toto probably once. Probably scanning some parts, two or three times.
Q: All right. And independent of all the things we just talked about, you do not make oral records on your portable dictator when you're reviewing the records?
A: No, sir.
Q: All right. What records do you recall reading more than once?
A: Those would be the operative notes that

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were done, and I believe I've looked at this ER sheet a couple of times, and the depositions of Markowitz, Noskin, and Van Bergen I believe I've read twice.
Q: In the first paragraph you state that there are notes in the chart stating the wound is dry, no drainage. The patient was afebrile and the last white count taken two days prior to his discharge was not inappropriately elevated.
I want to talk to you about the words "was not inappropriately elevated."
Are you saying there that the white count was elevated?
A: No. No, elevated is a relative word. His white count upon discharge was somewhere around 12,000.
I take that back. His white count was about 12,000 a few days prior to his discharge. That is not elevated for someone who has had recent cardiac surgery, so I do not believe that it was elevated at all.
Q: But you're saying that this is —
A: It depends upon —
Q: — fourth day postoperatively: right?
A: I believe he was discharged on the fourth

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postoperative day. He was in the hospital.
Q: What was the white count?
A: 12,000 something; wasn't it —
MR. MEADOWS: When?
MR. COTICCHIA: I'm talking about the statement here that he's saying —
THE WITNESS: Can I clarify it in the answer?
Q: (BY MR. COTICCHIA) Yeah, please.
A: The white count that I'm talking about was the last white count taken during his hospitalization when he was discharged on the 25th of August in 1995, and the last notarization on the routine hematology report shows that the white count was 12.6 thousand and that was on the 23rd.
Q: Can I see that, please?
That was the 23rd, correct, 12.6; correct?
A: Yeah, that's what I just said.
Q: And it says H after it; doesn't it?
A: Yes.
Q: That means high; doesn't it?
A: No.
Q: So you're disagreeing with the symbol used at the Fairview Hospital hematology lab when they

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put an H after it?
A: That's not the purpose of that. The purpose of that — that is a meaningless H in my opinion because that would group all patients at all times in all circumstances, and they have a range of values.
The appropriate grouping of patients would be someone who had recent major or cardiac surgery. So I do not feel that that white count deserves an H and I would disregard it as being abnormal. That is my opinion.
Q: Would you disregard the notations of the letters L as well for the same reason?
A: I don't know what circumstance you're talking about.
MR. MEADOWS: L for what?
Q: (BY MR. COTICCHIA) On the same hematology report we're talking about here.
A: Where is L?
Q: There are Ls following hemoglobin.
A: That's individually the L following hemoglobin and hematocrit and platelet count, those Ls are not abnormal for a patient being discharged postoperatively, and I would consider that a routine assessment or quantitation of the blood count, the

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white count and the platelet count in someone being discharged after cardiac surgery.
Q: So it's your testimony in regard to the hematology of August 23rd that the indications H which we can assume mean high and the indications L which you can assume mean low, in your opinion as a cardiothoracic surgeon are not relevant?
A: Your question is not completely stated.
In a patient who is being discharged after cardiac surgery, I do not think they're inappropriate. If you add the last little caveat to that then I would say yes.
Q: As a matter of fact, as I recall before you closed the file there were no hematology reports for the 24th or the 25th; were there?
A: I think that's appropriate.
Q: I'm not asking you if it's appropriate. I'm just asking did you see any in there?
A: No.
Q: Did you review the admission of Richard Ridolfi on the 26th of September?
A: Yes.
MR. MEADOWS: You said September. Do you mean to say September?

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MR. COTICCHIA: I apologize.
Q: (BY MR. COTICCHIA) August.
A: Yes.
Q: Now would you refer to those records, please. I'll give it back to you.
A: Okay.
Q: Will you turn to the graphic — well, do you have a copy of the graphic flow sheet for August 29th — I'm sorry, August 26th through 29th?
A: Graphic of what?
Q: Temperature.
A: Yes.
Q: Doctor, do you agree that indicated on this chart is a line, next to the line is 98.6 for Fahrenheit and 37 for Centigrade; do you see that?
A: Yes.
Q: Do you agree that that represents a normal level?
A: No.
Q: What was Richard Ridolfi's temperature on the morning of August 29th?
A: It looks like about 37.6.
Q: And what does that represent in Fahrenheit?
A: 99.

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Q: Is that a low grade fever?
A: Not necessarily, no.
Q: Will you please turn back to the graphic flow records for his previous admission when he underwent the bypass surgery which would be August 20 to August 25.
MR. MEADOWS: You want him to look at the graphics for that?
MR. COTICCHIA: Yeah, I want to look at the temperature graphics.
THE WITNESS: I have it, sir.
Q: (BY MR. COTICCHIA) You have it here?
A: Yes.
Q: Will you tell me what his temperature was on the last temperature taken on August 24, '95?
MR. MEADOWS: August 24th or 25th?
THE WITNESS: You said the 24th. Is that what you want?
MR. COTICCHIA: I said the 24th.
MR. MEADOWS: Okay.
THE WITNESS: That looks to me like 37.6 or something. There's a little flag on it. I can't tell whether that's one or two readings.
Q: (BY MR. COTICCHLA) Well, it looks like two readings because one is above the other.

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A: Well, one is a circle and one is a heart.
Q: One is a dot and one is a circle; right?
A: Right.
Q: Let's refer to the dot. It's a slightly higher elevation.
What's the temperature in Fahrenheit?
A: 99 something. 99.3 or something, 5. I can't tell,
Q: All right. Doesn't that indicate to you —
A: No, actually it would be difficult to ascertain. The spacing is not quite right.
Q: Well, we can agree it's somewhere between 99 and 100; would you agree with that?
A: Most likely.
Q: All right. Now my question is as a cardiothoracic surgeon, isn't it a concern if you want to diagnose or rule out an infection in this patient, he's basically got the same temperature levels on his discharge — he's discharged on the 25th, by the way. There's no temperature at all; is there?
MR. MEADOWS: That's not true. Objection.
THE WITNESS: If you looked at the

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chart, I guess maybe you did or didn't, he's got a temperature of 37.1 on the morning of the 25th.
Q: (BY MR. COTICCHIA) All right. My question is as a cardiothoracic surgeon if you're going to rule out infection in this patient, isn't it something you want to take in consideration when he's got a temperature on the 24th or the 25th for that matter —
A: He doesn't have a temperature on the 25th, sir. He doesn't have a fever. Everyone has a temperature. He doesn't have a fever on the 25th.
Q: Even though the finding is above 37 or above 98.6, you don't consider that a fever or low grade fever?
A: No.
Q: And he's got similar readings, does he not, the last two days that he's discharged following the surgery for the dehiscence on the 28th and the 29th?
MR. MEADOWS: Objection to form. What do you mean by similar, similar to what?
MR. COTICCHIA: On the 28th and 29th, similar to the 24th and 25th.
MR. MEADOWS: Objection to form.
I don't know how you can answer that,

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but if you can, go ahead.
THE WITNESS: I don't know what you're talking about, sir. I really don't. Are you saying that —
Q: (BY MR. COTICCHIA) You don't understand my question; is that what you're saying?
A: Yes, yes, sir.
Q: Well, I can't form it any better because I'm not a doctor.
A: It has nothing to do with a physician. It has to do with — his name was the same too. He doesn't have a temperature spike. That is a normal temperature curve for someone following surgery.
Since he seemed to have an uneventful convalescence from his first surgery, an uneventful convalescence from his second surgery, I suspect that his vital signs would be similar, his weight would be similar, his name would be similar, his BUN and creatinine would be similar.
So I think that since there was no evidence that he was infected when he left the first time and there was no evidence he was infected when he left the second time, that his charts would look similar.
Q: So you're saying his discharge with this

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temperature elevation on the 25th —
A: I didn't say it was a temperature elevation, sir.
Q: Well, I'm referring to it. I'm using that word, okay.
A: Well, then don't —
MR. MEADOWS: He just told you it's not.
MR. COTICCHIA: Well, I'm going to ask him again since he didn't understand my question.
Q: (BY MR. COTICCHIA) Is it your testimony that the temperature on the 24th and the 25th which are approximately 99.3 and 99, as well as Richard Ridolfi's discharge on the 28th and the 29th which vary in range from 98.8 to 99, are not significant and of no indication of an infection?
MR. MEADOWS: Objection to form. Go ahead and answer if you can.
THE WITNESS: Well, there's more than objection to form. You didn't present all the — if you want to enumerate what all the data points are, then you could have said what all the data points are.
You specifically or purposely, I

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don't know what, excluded two of the temperatures which were below what are perceived normal of 37, 98.6 on the 28th, one of which showed that his temperature was actually 36, and the last discharge temperature was 37.2 or 1 or something like that or 37, those you ignored to mention.

Do you want me to answer the question?

Q: (BY MR. COTICCHIA) Sure.

A: Well, I can't answer the question because all you did was give me two points on either side.

Do you want me to answer the question that all the data points that you wanted to have, the 24th and the 25th, there are six temperatures on this patient on August 24th and 25th, and the last two days, August 28th and 29th, there's one, two, three, four, five, six, seven, there are eight data points there and I think those data points are comparable and normal.

That is my testimony.

Q: You earlier testified regarding temperatures of a patient referring to a spike; correct? Did you use that word?

A: I don't remember. If you want to read back the question. I don't know the context where I

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used it.

MR. COTICCHIA: Do you want to go back and see if you can find it? It's several questions back.

(Brief delay.)

(Record repeated by Court Reporter.)

Q: (BY MR. COTICCHIA) Doctor, are you satisfied that you used the word spike?

A: Yes.

Q: All right. My question to you is what is a spike when we talk about a patient's temperature?

A: It would be a graphic representation — usually it comes from the graphic representation of his vital signs and if he has an abnormally high temperature and that it subsequently comes down.

Q: Calling your attention to the graphic flow records for August 26 through 29, is the spike — or is the increase in temperature from 36 it looks like .1 or .2 to a little over 37.5, is that a spike?

A: No.

Q: Is that an indication of a fever?

A: No.

Q: Now let's go on with your report, Doctor.

Your next paragraph states, I quote:

The drainage noted on the following day was after a

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severe coughing spell and he return to the hospital and had prompt operative intervention. At this time he underwent a weave to reconstruct the sternal fragments and then these were wired back together. This is an alternative and acceptable form of therapy for what was felt to be a sternal dehiscence.

What do you mean by an alternative and acceptable form of therapy?

A: It is one acceptable way of dealing with a surgical problem.

Q: What are the other alternative ways to deal with this dehiscence?

A: To do a flap reconstruction of his sternum.

Q: Flap reconstruction of the sternum, what do you mean?

A: The sternal wound. To use — to not wire him back together, but to move some muscle flaps or omental flaps to reconstruct his chest wall rather than reclosing it primarily.

Q: Which method do you use?

MR. MEADOWS: Under what circumstance?

Objection to form. I don't think

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it's complete.

Q: (BY MR. COTICCHIA) Which method do you use, Doctor?

MR. MEADOWS: Under what circumstance?

MR. COTICCHIA: I'm talking about this situation right here.

Don't interrupt. He did not have a question about my question. You don't have to coach the witness. We're three days from trial, Bill, and I accommodated you to postpone this twice, so I appreciate your not interfering with this deposition.

MR. MEADOWS: Are you done?

MR. COTICCHIA: I'm done and I hope you're done.

MR. MEADOWS: Are you done?

Under the rules I'm obligated to tell you the basis for my objection when it is to the form of the question.

MR. COTICCHIA: Then object.

MR. MEADOWS: I'm obligated to tell you the basis of my objection when it is to the form of the question.

Frankly, many of your questions, the

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way you have formed them, lead to valid objections.
I apologize that that's necessary,
but it's your fault.
Go ahead, try it again.
**THE WITNESS:** Do you want to ask the
question again?
Q: (BY MR. COTICCHIA) Under these
circumstances of a dehiscence.
**A:** Which circumstances, the circumstances —
Q: The one you're writing about here.
**A:** Okay.
**Q:** Have you wired a sternal dehiscence in
this manner in your experience?
**A:** Yes.
**Q:** Have you used as you said sternal flaps?
**A:** No, I didn't say sternal flaps. I said
reconstruct the chest wall with various kinds of
flaps, and we have done it that way too, yes.
Q: Do you do that or do you call in a plastic
surgeon to do that?
**A:** We have the plastic surgeons do it, but
it's usually an intraoperative decision.
Q: Is there an incidence of infection that's
tracked just for statistical purpose of whether the
wiring of a sternal dehiscence in this manner is

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greater or less than the muscle flap you're talking
about to repair a sternal dehiscence?
**A:** Is your question is the incidence — if
it's not infected and you have a sterile sternal
dehiscence, if it's reconstructed by primary
rewiring versus flap reconstruction, is the
infection — is infection secondary to
reconstruction of the initial sterile dehiscence
higher with one or the other, is that the question
you're asking?
Q: Yes.
**A:** Then I have no idea. I have no data to
support or refute that.
Q: Which method do you use more frequently?
**MR. MEADOWS:** Objection.
***Q:*** (BY MR. COTICCHIA) Which of these two
methods?
**MR. MEADOWS:** Vague and ambiguous.
**THE WITNESS:** That actually is not —
that's not an answerable question either. It's not
prolonged. If there's sufficient bone that we feel
is good bone to put the chest wall back together
then we will do that. If we do not think that the
sternum is good, and depending upon the clinical
circumstances of other associated diseases that the

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patient has, then we'll do a chest wall
reconstruction, but they're not all alternatives.
They're applied in different
circumstances depending upon the character of the
wound and the character of the patient, so they're
noncomparable.
Q: (BY MR. COTICCHIA) When you said chest
wall reconstruction, is that what Doctor Van Bergen
did here?
**A:** Doctor Van Bergen generically
reconstructed his chest wall by closing it primarily
as opposed to using flaps to reconstruct his chest
wall.
Q: All right. Now earlier you said you used
the — let's see if we're on the same page here.
When you say chest wall
reconstruction, you're talking about wiring the
sternum?
**A:** Okay. No.
You have a wound, you have to close
it. You can close it primarily, so I won't use the
term chest wall reconstruction anymore, you can
close the wound primarily or you can close the wound
using various flaps.
Q: Okay. And I think you said if the chest

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wasn't good you would use chest wall reconstruction?
**A:** I probably used that and I will redefine
that term so that there's no more confusion with it.
Q: Well, I want to ask you a question first.
**A:** Well, you asked me a question.
**MR. MEADOWS:** Let him answer your
question.
**THE WITNESS:** You already asked me a
question. You want me to not answer that question?
Q: (BY MR. COTICCHIA) No, I don't want you
answer that question.
**MR. MEADOWS:** Are you withdrawing the
question?
**MR. COTICCHIA:** I'm withdrawing the
question, yeah.
Q: (BY MR. COTICCHIA) My question is when
you say depending on if the chest wall is not
good —
**A:** That's not what I said.
Q: What is a good and not good chest wall in
your opinion?
**MR. MEADOWS:** Objection. That's not
what he said.
**THE WITNESS:** That's not what I said,
sir. What I said was it was the character of the

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sternum that needed — the character of the sternal bone that needed to be reapproximated is what I said. I think I'm right on that.
Q: (BY MR. COTICCHIA) And I still have the same question.
When you said good or not good —
**A:** So your question is what determines whether a sternum is sufficient that it could be reclosed primarily versus closed using an alternative flap technique; is that the question you want to ask me?
Q: Yeah, but you used the word good, and I'll be happy to have this capable court reporter go back. You said it's not good and I want to know what you mean when you say it's not good.
What are the factors that you take into consideration when you determine it's not good?
**A:** The thickness of the sternal remnant, whether there is good marrow there, whether the wound was opened initially in the middle, whether a mammary artery was used to dissect it, whether it bleeds satisfactorily upon debridement, whether the patient has other associated diseases that would impair wound healing such as diabetes or chronic obstructive pulmonary disease, how sick the patient

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is, and the need for multiple operations versus one single operation.
There's a lot of things that go into it.
Q: **All** right. Now I have another question.
You talk about he recovered promptly from this surgery and it is noted in the chart that there was contact with the pathology lab in regards to the intraoperative cultures.
Where in the record is there contact with the pathology lab that you made that statement — upon which you made that statement?
**A:** It was in the progress notes that the residents wrote.
Q: I think I have what you're referring to.
Hold on a second.
**A:** It says cultures negative so far. The progress note on 8-29, 6:45 post update No. **3,** it says doing well, ***chest*** tube dislodged yesterday, accidently chest **x-ray** obtained without pneumo. CAT pi1 something. Something without seepage that is post doing well, will get — actually that's arterial blood gas, cultures negative so far.
Q: **All** right. Nowhere in that statement by the resident, whose name is Doctor Mayers by the

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way, does it state that he contacted the lab; does it?
**A:** There is testimony in Doctor Van Bergen's deposition about his communication with the resident and calling the laboratory.
Q: Who called the lab, Doctor Van Bergen or the resident?
**A:** I would have to find it in the deposition transcript.
***Q:*** Doctor, I'm going to quote for you page ***22*** of Doctor Mayers' deposition, line 18.
**A:** I haven't got it.
Q: **As** I recall you did not read that deposition; did you?
**A:** Not that I remember.
Q: Question: Let me rephrase the question. **As** a resident at Fairview Hospital, was it the practice for the lab to call either you or Doctor Van Bergen when the culture came back of this nature?
**Answer:** I cannot answer that exactly because I do not recall how they did things back in Fairview.
Then up above, line 13: My question is independent of what you saw in the culture did

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you call the lab before you signed the discharge to get an update?
**Answer:** That I can't recall. I'd like to think I would have, but I don't remember.
So my question to you, Doctor, is where in the records do you base that statement?
**A:** I base it —
**MR. MEADOWS:** Objection; asked and answered.
You can answer it again.
Q: (BY MR. COTICCHIA) Independent of Doctor Van Bergen's deposition or independent of Doctor Mayers' deposition, where in the records does it show that there was contact with the lab, the pathology lab, in regard to the intraoperative cultures?
**A:** If the cultures were — if he states the cultures were negative he had to get that information from the pathology laboratory. The pathology laboratory issues those statements that they're negative. There's no other place he can get them from. It's not a revelation.
Q: It doesn't say where he got that information; does it?
**A:** That's where the information is generated,

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in the pathology laboratory. It has to be communicated from the pathology laboratory.
Q: Right.
**A:** So if the cultures are negative from now and he's checked the cultures, they're negative from now, he says the cultures are negative, okay, then that communication has to come through the pathology laboratory. They're the ones who determine that they're negative. He doesn't make it up.
Q: No, I'm not saying he made it up.
My point is that entry does not state where he got that information; does it?
**A:** It doesn't matter where he got the information from. The information came from the pathology laboratory. Whether it was put on a computer or whether he called them or whether it was printed out in the chart, the information came from the pathology laboratory. They do the examination.
Q: Right.
Because it comes from the pathology lab doesn't mean it came directly from the lab to Doctor Mayers; does it?
**MR. MEADOWS:** Objection.
**THE WITNESS:** What difference does that make? That's ridiculous.

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Q: *(BY* MR. COTICCHIA) Well, the difference is this:
It says culture negative so far; doesn't it?
**A:** Correct.
Q: It doesn't say final; does it?
**A:** It doesn't make any difference. The cultures were three days out by then. By the time he was discharged the cultures were three days out. That is — anything after that would either be spurious or have to be explained some other way.
Q: What happened the next day, what was the culture the next day?
**A:** I have no idea what the culture was the next day.
No, no, I'll answer that question even better than you think I believe.
**An** inappropriate culture came back, something that would be almost impossible to interpret.
Q: He had a positive culture for rare Serratia; didn't he?
**MR. MEADOWS:** The next day you're asking?
**MR. COTICCHIA:** The next day, August

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30th.
**THE WITNESS:** I know, but that particular report is —
Q: (BY MR. COTICCHIA) Well, that's an easy question. Here, let me show you the culture. All right. That's an easy question. Here.
In **the** middle of the page it says August 26th, culture. Tell me what the culture reading was on the date for the Serratia.
**MR. MEADOWS:** You want him to explain the whole context in which that was taken?
**Q:** (BY MR. COTICCHIA) I'm handing you what was marked Exhibit 1.
**A:** I wouldn't pay any attention to that.
**Q:** I'm not asking you whether you paid attention.
**A:** It's the wrong culture, sir.
**Q:** I'm asking you what the record says.
**A:** The record is uninterpretable.
**Q:** You cannot interpret it?
**A:** No.
**Q:** Okay. Thank you.
I went you to assume that Richard Ridolfi was not discharged on August 29th, and based on the culture of August 30th that says rare

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Serratia, and since you can't interpret it, you called in an infectious disease specialist and that specialist suggests that you prescribe — I don't know how to pronounce this — Piperacillin because of the presence, even though it's rare, of Serratia.
All right. Can you assume that for me for a moment?
**A:** No, sir. That is an untenable position.
Q: Do you agree that if that Serratia had been treated with an antibiotic to which Serratia is sensitive on the 30th of August, the infection would not have grown and the debridement would not have been necessary?
**MR. MEADOWS:** Objection to form.
**THE WITNESS:** No, I strongly disagree with that.
Q: (BY MR. COTICCHIA) What's your reason for disagreeing?
**A:** His subsequent infection, wound infection, was not due to Serratia.
His Serratia that was reported couldn't possibly have been of clinical significance from that operative culture that was taken when he was rewired. It's of no significance and is uninterpretable.

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Q: Why is it insignificant or of no significance?
A: First, it was reported on the fourth postoperative day so there must have been a minuscule inoculum.
Secondly, the subsequent wound infection was due to a strep that was cultured from the wound. Truly a strep infection. Never had Serratia cultured from the medius on the wound before. Serratia, that's a laboratory growth of what doesn't represent an infection. It is not the clinical circumstance in which you'd find Serratia grown, and, lastly, Serratia can't grow in an anaerobic culture report because it's not an anaerobe.
Q: Doctor, do you agree that the culture taken by Doctor Van Bergen was a wound culture on the admission of August 26th?
A: Yes.
Q: All right. You don't have any problem with that?
A: It was a culture taken in the operating room of the wound, yes.
Q: And do you know where it came from?
A: Yes.

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Q: You read his deposition; right?
A: Yes.
Q: He described he went below the sternum and he took a swab somewhere around the pericardium; do you remember that?
A: Yes.
Q: So he's gone deep enough to go below the bone; correct?
A: Yes.
Q: All right. That culture grew rare Serratia; didn't it?
A: I have no idea, sir. I don't know whether that culture grew Serratia.
Q: Okay. So this culture which we marked Exhibit 1, organism No. 1, you don't understand or you can't interpret; is that it?
A: Yes.
Q: Okay. Your last sentence in the second last paragraph, or I should just say second paragraph: The fact that later on Serratia was grown from that, when you say "that," I assume you're saying that culture. What do you mean by "that?"
A: Yes.
Q: Okay. You say: I feel reflects a

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contaminant; correct?
A: Yes.
Q: And then you go on to say: Serratia is an opportunistic nosocomial infection.
What do you mean by opportunistic?
A: Usually occurs not as a primary invader. It has to have a compromised host or the person who is having the infection has to be compromised in some way, and Serratia overgrows — there's an overgrowth of Serratia usually in the absence of the other microbes that are commonly present in the body, normally present. You alter the microbial environment, in that way Serratia would be able to become an infection. In the normal microbial environment of the body it can't become invasive and infectious.
Q: What do you mean by nosocomial?
A: Hospital acquired.
Q: And you say: The infection usually occurring in patients having had prolonged antibiotic therapy or an intensive care unit setting; correct?
A: Yes.
Q: All right. When Richard Ridolfi was discharged on the 25th he was discharged following

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bypass surgery; correct?
A: Yes.
Q: He was in the intensive care unit, I believe it was cardiac intensive care; correct?
MR. MEADOWS: At what point?
MR. COTICCHIA: His initial surgery.
MR. MEADOWS: Up until his discharge you're asking?
MR. COTICCHIA: Yeah.
THE WITNESS: I don't think he was discharged from the ward, not from the intensive care unit.
Q: (BY MR. COTICCHIA) When he left the surgery room where did they place him?
A: That's not the question you asked. Are you asking when he went home or —
Q: No, I said — you said intensive care.
A: Okay. Time out.?
He was in the intensive care unit during the hospitalization for his coronary revascularization, okay. He wasn't discharged from there. He was in it before he went home, yes, in some bizarre twist of nature, but he was only in it for a short period of time. He was only in the hospital for a short period of time. His intensive

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care unit —
Q: Wait a minute.
**A:** That's the question you asked me.
Q: I have a separate question. You just answered my question.
I want to know following his coronary artery bypass *graft* surgery was he in intensive care?
**MR. MEADOWS:** Ever?
**Q:** (BY MR. COTICCHIA) Do you understand the question, on that admission?
**A:** Was he ever in the intensive care unit?
Q: Yes.
**A:** Yes.
Q: Okay. So he fits that category?
**A:** No, he does not in any way, shape or form.
Q: Okay. I got another question.
**MR. MEADOWS:** You can try to trick witnesses and play your word games. It's not going to work.
**MR. COTICCHIA:** He's too smart. I can't trick him. He knows more about medicine than me.
**MR. MEADOWS:** I'd appreciate it if you didn't try.

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**MR. COTICCHIA:** I'm not even trying. I'm trying to find out what he means by intensive care unit setting.
**MR. MEADOWS:** No, you're not.
**THE WITNESS:** The word is prolonged. The adjective goes with both of them, okay.
Q: (BY MR. COTICCHIA) What's the purpose of —
**A:** Well, that's the purpose of it; otherwise, we're going to sit here screwing around for hours doing diddlysquat.
You want to get discovery, you want to get information, or do you want to play games?
Q: Was he given antibiotic therapy?
**A:** Not prolonged antibiotic therapy. My statement holds. This patient did not receive either prolonged —
Q: Wait. My question is — let me put it this way.
Just like you have disagreements about high and low, some people who are experts may have disagreements about what's prolonged and what's not or whether even prolonged is necessary.
My question is real simple. Was he given antibiotics in his first admission?

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**MR. MEADOWS:** I move to strike.
**THE WITNESS:** He was given prophylactic antibiotics appropriate for the coronary revascularization which is the antithesis of prolonged antibiotic therapy.
Q: **(BY** MR. COTICCHIA) And I assume at some point you agree that Mr. Ridolfi in fact had a Serratia infection?
**A:** No.
**Q:** He never had a Serratia infection?
**A:** Not of his sternal wound, no.
Q: No?
**A:** No.
**Q:** Did he have a Serratia infection?
**A:** He had Serratia cultured. The primary source of the Serratia, I do not know where that was from, on a subsequent admission, not these two, but his wound was never infected, the surgical wound, the sternal wound was never infected with Serratia.
Q: Did you review x-rays of Richard Ridolfi in regard to any of these admissions?
**A:** No, sir.
Q: Do you know any of the doctors who treated Richard Ridolfi in this case?
**A:** No, sir.

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Q: Do you know Robert Van Bergen?
**A:** He was one of the doctors. No, sir, I just said that.
***Q:*** Do you know of him?
**A:** No, I never heard of him before this.
Q: How were you contacted to review this case?
**A:** Mr. Meadows called me.
Q: When he called you did he describe the case to you?
**A:** I have no independent recollection of what the initial conversation was.
Q: How were the records transported to you; mail, FedEx, UPS?
**A:** I don't know, sir.
Q: Was there a cover letter?
**A:** I suspect there was. I don't remember it.
Q: Did you remove any letters or correspondence before today's deposition?
**A:** No.
***Q:*** I don't see any cover letter there.
**A:** I did not remove any before today's deposition.
Q: Where is the cover letter, sir?
**A:** I have no idea. I wouldn't keep the cover

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letter. The cover letter generically usually states that, you know, enclosed is such.
Q: So you would have not kept it?
A: Yes.
Q: That means you would throw it away?
A: Yes.
Q: Is there any other correspondence that is not with these records that you're aware of?
A: No, sir. I probably sent him a bill. I don't keep a record of those, but I probably sent him a bill.
Q: Did Mr. Meadows or anybody from Reminger and Reminger send you any kind of correspondence; enclosed is a deposition transcript, there are questions here we'd like you to review, anything like that?
A: It wasn't led that way. The first part of the letters, we usually like that: Enclosed, please find deposition transcripts.
Q: Where are those letters?
A: That's the same as the letters of these. I threw them out.
Q: Why did you throw them out?
A: I have no reason to keep them.

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Q: Were you instructed by Mr. Meadows to throw them out?
A: No, sir.
Q: Have you reviewed cases for any other attorneys in the office of Reminger and Reminger?
A: I believe I have.
Q: Who are the other attorneys?
A: I don't remember their names, sir.
Q: Are you related to any lawyers at Reminger and Reminger either by marriage or by blood?
A: No, sir.
Q: Is your wife related to any attorneys at Reminger and Reminger, either by marriage or by blood?
A: No, sir.
Q: When you say you don't remember who the other lawyers were, are you currently reviewing any other cases for attorneys at Reminger and Reminger?
A: I believe there's another case that I'm reviewing for them
Q: For who, for Mr. Meadows?
A: No, not for Mr. Meadows.
Q: Do you remember who the other lawyer is?
A: No, sir.
Q: You don't remember the name of the lawyer?

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A: No, sir, I do not remember.
Q: How did Mr. Meadows get your name?
A: I have no idea. You'd have to ask Mr. Meadows.
Q: What percentage of your time do you spend in the clinical practice of medicine?
A: About 98.
Q: How many cases in the last five years, medical malpractice cases, have you reviewed?
A: 50 to 75.
Q: So that would be approximately 10 to 15 cases per year?
A: Yes, sir.
Q: On the basis of a hundred percent, have you reviewed cases — on the basis of a hundred percent, what percentage have you reviewed cases for the patient/plaintiff?
A: Probably less than 10 percent.
Q: How much are you charging for your time today in this deposition?
A: $500 an hour.
Q: When you reviewed the records for this case that were sent to you by Mr. Meadows did you charge $500 per hour?
A: No, I charged 5350 an hour because I

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changed in January of this year. I had the same amount for 10 years.
Q: When Mr. Meadows was sitting here with you before we started the deposition, and I'm not going to ask you what was talked about, but I'm assuming you discussed this case; correct?
A: Yes.
Q: Do you charge Mr. Meadows $500 an hour?
A: Yes.
MR. COTICCHIA: Okay. This can be off the record.
(Discussion held off the record.)
MR. COTICCHIA: I don't have any more questions.
Ms. Kizy, I would Like a copy of this quickly, rush, whatever you want to call it, and I don't care whether you waive signature or not.
MR. MEADOWS: We'll have him read it.
(Deposition concluded at about 2:20 p.m.)

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SIGNATURE PAGE

NORMAN A. SILVERMAN, M.D.

DATE

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State of Michigan)
County of Oakland)
Certificate of Notary Public

I do hereby certify that the witness, whose attached testimony was taken in the above-entiled matter, was first duly sworn to tell the truth; the testimony contained herein was reduced to writing in the presence of the witness by means of stenography: afterwards transcribed; and is a true and complete transcript of the testimony given by the witness.

I further certify that I am not connected by blood or marriage with any of the parties; their attorneys or agents; and that I am not interested, directly or indirectly, in the matter of controversy.

In witness whereof, I have hereunto set my hand at Beverly Hills, Michigan, County of Oakland, State of Michigan.

Denise M. Kizy, RPWCSR-2466
Registered Professional Reporter
Certified Shorthand Reporter
Notary Public, Oakland, Michigan
My Commission Expires: 7-28-03

## D



## E



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## S

## T



## U



## V



## W



## X



## Y

FAIRVIEW GENERAL HOSPITAL
DEPARTMENT OF PATHOLOGY
LABORATORY SUMMARY REPORT

RIDOLFI, RICHARD
AGE: 54Y
SS#: 284-34-5392
HOSP: 1691895

SOON: 225-1
VANBERGEN ROBERT D
ADM DATE: 08/26/95
DSC DATE: 08/29/95

## WOUND MICROBIOLOGY

08/26/95 WOUND CULTURE
* 1230 ACC. NO.: S78527 FNL 08/29/95
SPECIMEN DESCRIPTION: WOUND CHEST
SPECIAL REQUESTS: NONE

GRAM STAIN: OBS #1 MANY RBC'S SEEN
OBS #2 RARE WBC'S SEEN
OBS #3 NO ORGANISMS SEEN

CULTURE: ORG #1 NO GROWTH 3 DAYS

08/26/95 WOUND CULTURE
* 1350 ACC. NO.: S78578 FNL 13/29/95
SPECIMEN DESCRIPTION: WOUND CHEST CAVITY
SPECIAL REQUESTS: SURGICAL SPECIMEN

GRAM STAIN: OBS #1 FEW RBC'S SEEN
OBS #2 NO ORGANISMS SEEN

CULTURE: ORG #1 NO GROWTH 3 DAYS

08/26/95 ANAEROBIC CULTURE
* 1350 ACC. NO. S78579 FNL 18/30/95
SPECIMEN DESCRIPTION: WOUND CHEST CAVITY
SPECIAL REQUESTS: SURGICAL SPECIMEN

GRAM STAIN: OBS #1 MODERATE RBC'S SEEN
OBS #2 NO ORGANISMS SEEN

CULTURE: ORG #1 RARE SERRATIA MARCESCENS
ORG #2 NO ANAEROBES CULTURED

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