IN THE COURT OF COMMON PLEAS

LORAIN COUNTY, OHIO

SANDRA JOHNSON,
Administratrix, et al.,

Plaintiffs,

-vs- CASE NO. 98 CV 122198

AKBAR NAEEM, M.D.,
et al.,

Defendants.

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Deposition of RICHARD W. WATTS, M.D., taken as if upon cross-examination before Leonard R. Gavlen, a Notary Public within and for the State of Ohio, at 3885 Rocky River Drive, Cleveland, Ohio, at 9:30 a.m. on Friday, June 23, 2000, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Defendant
Akbar Naeem, M.D.

RICHARD W. WATTS, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF RICHARD W. WATTS, M.D.

BY MR. DEMSEY:

Q. Okay, Doctor, I'm Richard Demsey. I represent the Estate of Moes Johnson and I will be asking you some questions today, a little about your background, a little about the opinions that you have in this case.

If you don't understand a question that I ask you or Mr. Spisak or Ms. Petrello, please ask us to repeat or rephrase those questions; fair enough?

A. Yes.

Q. As you have done so far, please continue to give your answers out loud and we'll be able to get them down on the record.

Your full name is?

A. Richard Ward Watts.

Q. Have you ever had your deposition taken before?

A. Yes.

Q. All right. Just a couple times?

A. Quite a few.

Q. Quite a few. Okay, how many times would you say you had your deposition taken?
A. No idea.
Q. Would you say it's been hundreds of times?
A. Must be approaching a hundred, anyway.
Q. In legal matters?
A. Yes.
Q. Would that be on behalf of the defense, plaintiff; any idea?
A. Both.
Q. Any idea what the breakdown is?
A. Seventy-five, twenty-five.
Q. More for the defense than for plaintiff?
A. Yes.
Q. Has that always been in malpractice cases?
A. Almost always. One or two personal injury cases.
Q. All right. Would you say the majority of your testimony in malpractice cases has been in defense of the doctor who has been sued for malpractice?
A. Yes.
Q. All right. Have you ever testified in deposition or written a report or testified at trial that in your opinion a doctor committed malpractice?
A. Yes.
Q. When was that?

A. Well, as I said before, twenty-five percent of my work has been for the plaintiff and so, the answer to the above question would be yes at all levels.
Q. Okay. Have you ever testified in a case involving the medical issues in the Johnson case?
A. In deposition, yes.
Q. What would that be?
A. A case of acute pericarditis.
Q. Do you remember the name of the client or patient or the doctor?
A. No to all of the above. I do remember it was in Steubenville, Ohio and I think I know the name of the plaintiff's attorney.
Q. Who is that?
A. Dettwiler I think from Weirton, West Virginia and the defense law firm was Buckingham, Doolittle & Burroughs.
Q. Do you remember what attorney you worked with at Buckingham?
A. No.
Q. Do you remember the opinions that you gave in that case as it pertained to the acute pericarditis?
A. That the rapidity of the disease was such that it would have been impossible even in the best hospital in the country for the outcome to have

been altered.

Q. Do you remember how that patient developed acute pericarditis?

A. She presented on a Saturday night to the emergency department in Steubenville with shortness of breath, was admitted to the hospital with the -- I'm -- now I believe I'm right in the recollection, she was thought to have pneumonia. She was given antibiotics and in about a three hour period she rapidly deteriorated and died. And at autopsy she had an acute bacterial fibrinous pericarditis.

Q. So the essence of that claim, based on what you told me, and I'm working backwards here, I'm not familiar with that case, they didn't make the correct diagnosis. Purportedly had they, this patient could have been saved. And it was your testimony, look, even if they had made a correct diagnosis, with an acute onset of this bacterial pericarditis, even if she walked into the ER that morning wearing a sign saying I have got acute bacterial pericarditis, they couldn't have saved her?

A. That was in essence my testimony.

MR. SPISAK: Excuse me, Doctor. Hand me that briefcase.

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(Thereupon, a discussion was had off the record.)

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Q. And that's why you say, based on the rapidity, meaning the speed with which that ba terial pericarditis developed, there was no saving this patient?

A. That's correct.

a. Patients do recover and can recover from bacterial pericarditis?

A. It is possible but unlikely.

Q. You have saved patients in your career who have had bacterial pericarditis?

A. No.

Q. Let's go off the record for just a moment here.

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(Thereupon, a discussion was had off the record.)

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Q. Back on the record here.

So, Doctor, you said that in this particular case, the rapidity, the speed with which the acute bacterial pericarditis had developed, that patient did not have a chance, in this other case?

A. That's correct.
Q. In this case, Mr. Johnson did have acute bacterial pericarditis?
A. He did.
Q. Am I correct that it's your opinion that he died of a myocardial infarction that was the result of his acute bacterial pericarditis?
A. No.
Q. Did his acute bacterial pericarditis contribute to cause his death?
A. Yes.
Q. In what way?
A. It caused the impairment of cardiac functions and an accumulation of pericardial fluid which compressed the heart within the pericardium so the heart could not fill and therefore could not empty and therefore could not pump enough blood to support the circulation.
Q. What is acute bacterial pericarditis?
A. It's a bacterial infection of the pericardium.
Q. The pericardium is the sac that surrounds the heart and contains the heart and fluid?
A. It is.
Q. How does one develop that?
A. It most commonly comes from a contiguous infection,

an empyema or a pneumonia or surgical procedure. Or it can, as it did in this case, come without any known origin and the bacteria lodged in the pericardium, or in this case may have lodged initially in the myocardium, and then formed an abscess which then ruptured into the pericardium.

Q. You base that based upon your having reviewed the autopsy?

A. Yes.

Q. Anything else?

A. No.

Q. The -- you say it was of unknown origin, this particular bacterial pericarditis?

A. I do.

Q. And you say it can be something that results from another infection, a primary source or primary infection?

A. Yes, I think I just testified along that line.

Q. Right. And what did you mean by that when you said it can but here it was of unknown origin. It can come from another source of infection, here it did not.

First of all, what did you mean by it can come from another source of infection?

A. I think it stands on its own merits, doesn't it?

Q. As a lay person, explain what you mean by that.

You mean if somebody develops another type of infection -- let's say a person gets scratched by a cat, or -- well, they get scratched by a cat and develop an infection. Can any type of infection lead to bacterial pericarditis?

A I'm not sure I know that much about pericarditis. I never heard a cat scratch causing pericarditis. What I was referring to before, and I'll repeat it, is that an infection in a contiguous location may extend into the pericardium, an empyema or bacterial pneumonia, or I didn't mention before but another source would be endocarditis. These would be infections, the origin -- the location of which is evident. The location -- original location is not in the pericardium, but eventually involves the pericardium.

But there are cases such as the lady in Steubenville that I mentioned earlier and Moes Johnson in which the origin of the bacterial entry into the body is not obvious.

Another cause, of course, of pericarditis is a surgical procedure, open heart surgery or something of that type.

Q. It would be a post-surgical complication?

A. Correct.
Q. It's a foreseeable or known risk of that procedure?
A. Yes.
Q. That didn't happen here?
A. No.
Q. Does the bacterial pericarditis always come from some other infection and sometimes we know what it is and sometimes we don't, or can it just come about of its own? Do your best with that?
A. I think I have done my best already.
Q. I'm trying to understand the concepts that you have advanced here. The -- I understand what you mean when you say there can be an infection of a contiguous structure, something at or near, next to essentially the pericardium, if infected or if -- well, if infected, then the pericardium in turn may become infected and if it does, it can lead to --
A. Pericarditis.
Q. The infectious process were talking about here?
A. Yes.
Q. And people don't need a surgical procedure to become infected?
A. Correct.
Q. How do they become infected? What are some of the typical ways that someone can become infected and

it then leads to pericarditis?
A Well, the ways that we know I have already listed. The ways that we don't know, I can't list because we don't know.
Q. The ways that we know, one way would be surgically, post-operatively the site could become infected and then contiguous structure leading to the pericardium and so forth. You have explained that.
What are some other ways that people become infected absent surgery?
A. Bacterial endocarditis.
Q. And that is what?
A. That is an infection by bacteria on one of the heart valves.
Q. How does that come about?
A. It can be intravenous drug use, it can be dental procedure which causes transient bacteremia and the bacteria will settle on an abnormal valve, not apparently on a normal valve. Those are the two most common causes of bacterial endocarditis. Incidentally, he did not have bacterial endocarditis.
Q. Okay. Was there any evidence that he was an intravenous drug user?

A. We don't have any evidence in record.
Q. You are not of the opinion that he was?
A. I have no opinion. I have no evidence that he was and so, in the lack of evidence, I don't have anyway of saying that he was an intravenous drug user.
Q. Are you saying from a single injection, someone can develop bacterial pericarditis?
A. Single intravenous injection of an illicit drug; is that your question?
Q. And let me ask you differently. What if someone just had blood drawn; could that be the site of the infection?
A. Never heard of that happening.
Q. And what if somebody received an injection of medication, either IV or in the hip; could that be the site of the infection?
A. I doubt it very much.
Q. Why do you say that?
A. Because I haven't seen it. I have never seen it, I've never heard it reported.
Q. You say that it is possible that people do recover from bacterial pericarditis. How do you treat people who have bacterial pericarditis that recover?

A. The only sure way of recovery is to do an immediate surgical opening of the pericardial sac and removing part of it, as well as the antibiotics. Antibiotics themselves probably would not cause the patient to survive. So it has to be antibiotics plus surgery.

Q. You are saying if the pericardium becomes infected, antibiotic therapy would be instituted in combination with the removal of the infected portion of the pericardium?

A. At least part of the infected portion. It would be impossible to remove all of the pericardium, but the opening of the pericardium and removing part of it would in effect drain the pus out of the pericardium and also take away the likelihood of cardiac tamponade because of increasing pericardial fluid.

Q. So you are talking about doing a pericardiocentesis?

A. No. That is just draining the pericardium with a needle. You would have to do it surgically.

Q. One could either drain it with a needle bed side, operating suite, or you could actually go into the pericardium and put in a drain. Is that what you are talking about?

A. I don't want to presume to be a surgeon here because I'm not. Pericardiocentesis will give you the diagnoses and relieve the immediate pressure, but you have to go beyond that. You have to open the pericardium surgically. So rather than getting into the various details you mentioned, it's basically a combined medical surgical treatment.
Q. Are certain patients more likely to survive than others who have bacterial pericarditis?
A. Not that I know of.
Q. Okay. So, let's say a patient with a cardiac risk factor versus a patient without, either one has the same chance of surviving bacterial pericarditis?
A. I would think so.
Q. Doesn't matter that one is more at risk or less at risk?
A. No.
Q. You have been in practice how many years?
A. Forty-eight next week.
Q. Forty-eight years. And have you always practiced in the Cleveland, Ohio area?
A. Kamm's Corners.
Q. You are a cardiologist?
A. Yes.
Q. Are you board certified?

A. I am
Q. And you have kept your board certification -- I'm sorry. You kept your license here, you are still licensed to practice medicine in the State of Ohio?
A. Yes. My CV is in front of you, by the way.
Q. Do you have -- are you currently practicing medicine?
A. As of yesterday evening
Q. What changed today?
A. I haven't seen any patients yet.
Q. I'm exercising as much as I can here, as much patience as I can. Hopefully you have seen some.

Do you -- what percentage of your time is spent practicing medicine?

A. My professional time, probably ninety-five percent.
Q. Your age?
A. Seventy-nine in August.
Q. You look good.
A. Thank you.
Q. Congratulations.
A. Thank you
Q. You know the secret to a healthy heart.

Do you practice as much as you used to?

A. No.
Q. So evidently you have cut back on the time that you

spend seeing patients or practicing?
A. Well, to some extent, but I still am working probably eighty hours a week.
Q. Doing what?
A. First of all, I see patients six days a week. I have office hours five days a week.
Q. From what time to what time?
A. Start at nine and finish at three.
Q. You are here every day?
A. Monday through Friday.
Q. Still make your rounds at the hospital?
A. Yes.
Q. So when you say you have cut back, what is it that you don't do as much as you used to?
A. I used to have office hours until seven o'clock at night and I used to have office hours six days a week.
Q. What are you doing now, playing golf?
A. No.
Q. Have you ever provided expert opinion on behalf of Mr. Fifner before?
A. No.
Q. This is the first time that you have met him or anyone from his law firm?
A. Today is the first time that I have met him

physically and this is the only case I've ever received from that office. I don't know who the other people are in the office.

Q. You have privileges at certain hospitals now?

A. I do.

Q. Where would that be?

A. Fairview, Lakewood. I am an associate physician at the MetroHealth Medical Center. And within the past year, I have resigned from Saint John West Shore and from Lutheran Medical Center.

Q. We are going to talk to an infectious disease specialist this afternoon by the name of Dr. Blinkhorn at Metro. Do you know him?

A. No, never heard of him before I saw his report.

Q. You read his report?

A. I did.

Q. Agree or disagree with it?

A. Agree.

Q. Did you read Dr. Sibits' report?

A. I did.

Q. And his supplemental report?

A. I didn't see the supplemental report. I would assume I didn't see it because it had to do with the emergency department. I gather that from reading his deposition and realizing that I only

had one report.

Q. You read his deposition?

A. I did.

Q. Do you disagree with his opinions?

A. Of course.

Q. In what way?

A. Well, I won't attempt to summarize his opinion. I think my own opinion stands on its own merits. I didn't see anything in his opinion that I thought I could agree with.

Q. One of the opinions was that it would be a deviation from the accepted standard of care for a physician in an emergency room or hospital staff in an emergency room not to take vital signs, blood pressure, temperature.

Do you agree with that or disagree with that?

MS. PETRELLO: Objection.

MR. SPISAK: Same objection.

A. I don't know that I would be in a position to either agree or disagree. That is an emergency room function. I would make the assumption that the emergency room personnel and their procedures were appropriate for the situation.

Q. You would assume that emergency room personnel and

procedures were always appropriate for any situation?

MS. PETRELLO: Objection.

A. I think we are just talking about this case.

Q. Fair enough. I wasn't sure what you meant by that.

Is it your testimony then, do I understand this correctly, whether or not an emergency room physician or staff in an emergency room must take vital signs, whether or not that is a deviation from the accepted standard of care, to fail to take vital signs, you don't know?

A. Correct.

Q. Okay.

MR. FIFNER: For the record, I'm not going to have him talk about the converse either. He is not an emergency room physician. He is not certified. I'm not going to have him come in and say that what the emergency room did was appropriate either.

Q. Okay. But you said that you assumed that what the emergency room did here was appropriate. What's the basis for that statement. I'm talking about the 10th of November, thirteen days before Mr. Johnson's terminal admission on the 23rd?

A. I did not see anything in that very brief examination of that emergency department visit that I would have found any fault with. But that is not, as you know, my main focus in this case.
Q. You don't have expertise in that area?
A. I have already admitted that.
Q. And you don't hold yourself out as someone with expertise in that area?
A. That's correct. I really have no comment to make one way or the other in that area.
Q. So it would be fair that you don't consider yourself competent or qualified to talk about the standard of care for what the emergency room should have done in this particular case with this particular patient?
A. Correct.
Q. As it pertains to Mr. Johnson's -- well, let's just talk generally again about this acute bacterial pericarditis. That is what he had, correct?
A. Correct.
Q. Is there a chronic versus acute?
A. I don't believe there is a chronic bacterial pericarditis. I think that is only in the acute stage. There are other forms of chronic pericarditis that don't have any bearing on this

case.

Q. Why is that?

A. Because they don't apply.

Q. Right. When you say because, I have to explore further. Please don't consider that disrespectful. I do the same thing with my kids and my parents did it to me.

Why don't they apply?

A. Because he didn't have chronic pericarditis.

Q. Ever?

A. Ever.

Q. Okay. How long can acute pericarditis fester or -- maybe fester is the wrong word. From the moment of onset that one has acute pericarditis when they didn't have it before, how long -- what's the longest that you could say someone could have that until they would run out of time for treatment or what's the longest someone would have it? Do you see the concept that I'm getting at. How long can someone live with acute pericarditis?

I'm afraid you're going to say to me, well, do you mean someone who doesn't get treated or someone who does get treated or someone where it's diagnosed or someone where it's not diagnosed. I understand there will be some variables and if you

could help me address them, it might shorten the inquiry a little.

A. The best way I can answer that question is to say I believe that it would be about a twenty-four hour period from onset to fatal outcome. So, obviously it is within that twenty-four hour period and must be perhaps the first twelve hours or the first fifteen hours of the twenty-four hours, it's possible to reverse the process. But the mortality rate from acute bacterial pericarditis is extremely high, even in the modern era of medicine as we know it.

Q. Once someone develops acute bacterial pericarditis, the mortality rate is high?

A. Yes.

Q. What's the mortality rate?

A. The data that I have seen recently is seventy percent.

Q. So if Mr. Johnson's bacterial pericarditis, from the time that he had it was caught early, you are saying that he only had a thirty percent chance at best of survival?

A. Yes.

Q. Are there studies that you are aware of that support that thirty percent figure?

A. Yes. The figure actually comes from Braunwald Fifth Edition 1997.
Q. Spell that?
A. B-R-A-U-N-W-A-L-D.
Q. One word?
A. Yes, that is his name, the name of the senior author. And in the section on pericarditis it refers to the fact that I just gave you that the survival was thirty percent or the mortality is seventy percent.
Q. How about the twenty-four hour -- from onset to survival; you say about twenty-four hours?
A. Did I say twenty-four or twelve?
Q. Twenty-four.
MR. FIFNER: Onset to survival is approximately twelve, if you get to it in that twelve to -- he said if you -- onset to death was twenty-four.
MR. SPISAK: Onset to death was twenty-four.
Q. I said survival. My apologies.
You said onset to death was twenty-four hours if untreated?
A. Right.
Q. Is there authority for that?

A. I presume there is. I can't quote it.
Q. Your testimony is based on your experience?
A. That would be very slender experience. I have only seen two cases.
Q. Tell me about the cases that you have seen. You are talking about your patients as opposed to legal cases?
A. Actually, I think I will have to change that to one case. I saw one case in a four year old girl with H flu pericarditis.
Q. What kind of pericarditis?
A. Hemophilous influenza.
Q. H? The letter H, flu?
A. Yes. She died after operation and that must be thirty years ago.
Q. Is pericarditis a foreseeable infection? In other words, if you have a patient, do you treat them with pericarditis in mind as something that could develop, something that you want to prevent? Would there be certain patients -- I don't know if I'm making this clear enough.

Do you see certain patients, for example, you look at them and say -- is there a patient or type of patient that you would look at in your experience as a cardiologist and say this one is at

risk for pericarditis, I would like to do the following things to make sure we don't get into trouble down the road here?

A. No.

Q. Why not?

A. First of all, it's an extremel rare condition and I don't know of anything that we could invoke to say this person can, in comparison to somebody else, has a better likelihood of pericarditis. We are dealing with a very rare condition.

Q. If someone has an infection in their body -- if you have one of your patients and that patient has an infectious process going on in their body, is it true that one of the potential complications of that infection, albeit rare, is pericarditis?

A. Albeit extremely rare, the possibility exists. But it's virtually never seen. As I said before, this is a very rare event, very rare event.

Q. If you had a patient with an infectious process, would it be a fair statement that you wouldn't treat them -- wouldn't treat the infection or recommend treatment for the infectious process?

A. No.

Q. What would you do?

A. I would treat the infectious process.

Q. And certainly you would agree with me that the infectious process, albeit extremely rare, might lead to acute bacterial pericarditis?
A. It could.
Q. And by treating the infection and bringing an end to the infection, you eliminate that rare chance of the acute bacterial pericarditis coming about?
A. I would hope so.
Q. But that is a correct statement, isn't it?
A. So far as we know. There may be exceptions.
Q. But you are not aware of any?
A. No.
Q. And based on the literature and your experience, treating an infectious process and eliminating the infection in the body eliminates the chance of bacterial pericarditis coming about from that infectious process?
A. Theoretically it should.
Q. And you would hold that opinion to a reasonable degree of medical probability?
A. Yes.
Q. Would it be a deviation from the accepted standards of care not to treat an infectious process?
A. I would think so.
Q. Did Mr. Johnson have an infectious process?

A. No.
Q. He did not?
A. No.
Q. Why do you say that?
A. I see no evidence for it.
Q. Is an elevated white blood count evidence of an infectious process?
A. It's one possibility.
Q. He did have an elevated white blood count?
A. Very mildly.
Q. That could mean a number of things?
A. Yes.
Q. It could have meant that he had inflammation from injury?
A. Possible.
Q. It could have meant that he had infection?
A. Possible.
Q. What else could it have been?
A. There is a variety of things. I don't know that I could call off enough to make a satisfactory catalog. I would point out that the elevation of the white blood count was very mild and in the -- lacking anything to accompany it, it stands on its own merits but doesn't make a diagnosis of anything.

Q. If you saw an elevated white blood count in a patient like this -- let me back up.

Mr. Johnson had numerous cardiac risk factors; isn't that correct?

A. It is.

Q. He had a fifteen-year history of hypertension?

A. Yes.

Q. And he was obese?

A. Yes. He was quite tall and did weigh two hundred and forty pounds.

Q. He was -- I'm trying to think of the other cardiac risk factors. He was essentially sedentary as far as exercise is concerned?

A. I don't know about that.

Q. Let's assume that he was. Would that be an additional cardiac risk factor in a patient like this?

A. Yes.

Q. And smoked a half pack of cigarettes a day?

A. Yes.

Q. Was he diabetic?

A. No.

Q. Any other cardiac risk factors that Mr. Johnson had?

A. No.

Q. If that is your patient, same age, same physical makeup as we have described and he has an elevated white blood count, elevated as it's seen here, would it be a fair statement you would leave that alone, you wouldn't work it up, you would do nothing?

A. There isn't anything to work up. He had nothing that that white blood count would tie in. And, as we all know, that white blood count is in the setting of a complete physical examination and nothing was discovered in either the history, review of symptoms or the physical examination that would lead to the white blood count being taken at anymore than an unsupported laboratory abnormality.

Q. If you have an unsupported laboratory abnormality such as that white blood count, what does the standard of care require you to do?

A. Once you have done what Dr. Naeem did, which is all the things I just enumerated, I don't think -- the standard of care would not obligate you to do anything beyond that point.

Q. You wouldn't repeat the white blood count to see if it was up, down, normal or abnormal or just a variance by the lab?

A. I wouldn't do it on a short term basis.

Q. When would you do it?
A. Some time in the future, but I wouldn't have a great urgency to do it because it did not pertain to any of the evidence that I had in front of me. And this was not just a brief office encounter, that was a full examination.
Q. A full examination is an opportunity for the physician to essentially find out everything that is going on with the patient within the confines of that complete physical, right?
A. Yes.
Q. Okay. It's not like Mr. Johnson was coming in because he had a fever or sinus problems and somebody would miss something in another system of his body, correct?
A. That's right.
Q. This is a complete system review essentially?
A. Yes.
Q. That is the purpose of the physical?
A. It is.
Q. Okay. When would you do something in follow-up to the abnormal white blood count? You say you wouldn't do it urgently, which means I wouldn't repeat it right then and there. I wouldn't repeat it the next day necessarily. When would you do

something to see if maybe there is an infectious process going on?

A. First of all, I would doubt very much there is an infectious process if that is the only evidence for it. But at some point when he had laboratory testing done again, it would be wise to repeat the white blood count.

Q. So it could be if he was someone who came in for a yearly physical, you'd repeat it a year later?

A. Yes.

Q. You don't see any reason to repeat it any sooner or within any specified time frame?

A. No.

Q. What about Mr. Johnson's EKG. Did he have an EKG on the date of this physical; I believe it was November 2?

A. Yes.

Q. Did he have an EKG?

A. Yes.

Q. What were the results of the EKG? And obviously you are a cardiologist; you can read these, right?

A. Yes.

Q. Maybe what I should ask you first and foremost, I understand there was an interpretation and that is -- and that interpretation **I** understand to be

computer generated. Am I correct about that?
A. Yes.
Q. All right. Do you agree with the computer generated interpretation of the EKG, based on your actual reading of the EKG as you are doing right now and have done before?
A. I don't agree with the computer interpretation in the words possibly due to myocardial ischemia. I don't see evidence for myocardial ischemia here, but the electrocardiogram is abnormal.
Q. How so?
A. In the frontal plane the T-waves are quite small. That is an abnormality. The T-wave is inverted in lead V-six. That is an abnormality and there is one ventricular premature complex.
Q. Let's go through each one of those. The first abnormality that you see is where, can you hold up the EKG and show me?
A. Well, I talked first about the frontal plane and you can barely see T-waves here. This is one thing computers are good at and that is the axis in the frontal plane. And as you see axis, P-wave -- we are not talking about the P-wave but the QRS complex has an axis of three degrees, the T-wave has an axis of eighty-five degrees. Normally these

should be within thirty degrees of each other. So obviously they are more than eighty degrees apart. That is an abnormality.

Q. What does that mean?

A. It's not specific.

Q. So it could mean a number of things?

A. A great number.

Q. Give me things that you think it could mean?

A. In this case?

Q. Well, this case is now after the fact. What are the things that it could mean generally or do we have to go through the others and take them together and then talk about what's going on?

A. That might be helpful.

Q. Okay. Talk about the next abnormality. The first abnormality is the variance of eighty-two degrees on the axis. That's A-X-E-S?

A. No, A-X-I-S.

Q. It says A-X-E-S on there?

A. That is plural.

Q. Axes?

A. On the axes, yes.

Q. There's a variance of eighty-two degrees. And what would the next abnormality on this EKG of November 2 be?

A. T-wave is inverted in V-6.
Q. The T-wave is inverted in V-6, is one of the leads?
A. Yes, where my finger is.
Q. And where would that be -- what does that mean? What's the significance of that?
A. I don't know.
Q. Physically, to a lay person, explain what this V-6 means. Is this something connected on his leg, his chest, his toes, what. How do we get this reading?
A. The V-6 is recorded on the left side of the chest.
Q. Left side of the chest. One of the leads is placed on the left side of his chest?
A. Right.
Q. And it's showing an abnormality at V-6. What is the abnormality that you see and what should it be?
A. T-wave is down, it should be up.
a. The T-wave is down?
A. Yes.
Q. Okay. What's the next abnormality?
A. Ventricular premature complex.
Q. Is that the same thing as premature ventricular contractions?
A. It is.
Q. Where do you see that on the EKG?
A. Where my finger is pointing.

Q. At V-6 where it drops below the center line?
A. Do you see the difference in configuration -- three leads are recorded simultaneously, so what you have at V-6 you have at the same time in V-5 and in V-4.
Q. V-4 and V-5 appear essentially the same?
A. Similar.
Q. Similar. V-6, on the other hand, has -- what would you call it, inverted T-waves?
A. Well, I think we are getting a little confused here. The T-wave in all of the leads of V-6 are inverted and now we have moved onto the ventricular premature complex. That is seen in V-4, 5 and 6, somewhat different configuration but recorded simultaneously.
Q. I see what you mean. Where you were pointing, that is where that would be, that abnormality.
What do those mean when taken together? Were there any other abnormalities? I think you just said three. Was there anything else?
A. I think I have covered them.
Q. Okay.
A. I don't think we can make much of a diagnosis other than to say it is not normal, but we can't say it is specifically abnormal.
Q. It is abnormal but not specifically abnormal?

A. Correct. In other words, electrocardiograms can be normal, abnormal, nonspecifically or specifically abnormal. This is a nonspecific abnormality.
Q. Is there a computer generated print-out for nonspecific abnormality versus abnormality?
A. I think they are implying that here. They are saying abnormal changes possibly due to myocardial ischemia. So the computer is not being definitive about this. It is only just raising that as a possibility, sort of as a hint to the doctor.
Q. And they are implying nonspecific or they are implying specific?
A. They are saying it's nonspecific, but they are saying possibly due to. If the computer were dogmatic, it wouldn't have said possibly. It would have said myocardial ischemia.
Q. And what is myocardial ischemia?
A. Impaired circulation to the heart as reflected by the electrical activity of the heart.
Q. And that can cause a myocardial infarction?
A. It can lead to it, but usually it is a brief event that then subsides and circulation is restored.
Q. Is myocardial ischemia something that Mr. Johnson had at any time?
A. No.

Q. And why do you say that?
A. I don't have any evidence for it.
Q. Sinus tachycardia, did he have sinus tachycardia?
A. Yes. On this, his heart rate is one hundred three beats per minute.
Q. And what does sinus tachycardia mean and is it an abnormality?
A. We look upon it as an abnormality in that the resting heart rate should be somewhere between seventy -- or between sixty and eighty. I'm not certain how important it is here. We are dealing with a big man, so he may have well had to have a higher heart rate than a smaller person.
Q. So you are saying in him it may be normal?
A. Yes. It may be.
Q. And it may be abnormal as well in him?
A. Yes.
Q. What's the best way to find that out or do you not care? Does a physician not care if they find that condition?
A. Well, I personally would not be impressed by a heart rate of a hundred and three in a man of this size who is without any particular cardiac or other symptoms.
Q. What about a cardiac history or cardiac risk

factors; would that be impressive?
A. No more than already has been discussed.
Q. Premature ventricular contractions, did he have that?
A. One.
Q. And where?
A. V-4, 5, 6.
Q. Is that where you pointed out the difference in the T-wave?
A. It is.
Q. What does that mean, a premature ventricular contraction. Is that the right ventricle?
A. Both ventricles. The right ventricle is the source of it here.
Q. The right ventricle is the source and it is contracting prematurely?
A. Yes.
Q. Why?
A. I don't know.
Q. Is that an abnormality?
A. Yes.
Q. What does that mean?
A. Usually nothing. We all have them.
Q. Okay. If you saw this EKG and this man with this cardiac risk factor history, what would the

standard of care require you to do?
A. Nothing in particular. As we all know, Dr. Naeem suggested a stress test.
Q. I don't know that Dr. Naeem suggested a stress test?
A. It is in his notes.
Q. When did he suggest the stress test?
A. When he wrote his notes on November 2, '96.
Q. How does one suggest a stress test?
A. Recommend it to the patient.
Q. How does a patient go about getting a stress test?
A. Well, first he has to agree to having the stress test and then the patient is referred to somebody who does the stress test.
Q. Who was Mr. Johnson referred to?
A. I'm not sure that he agreed to the test.
Q. You are not sure that he didn't?
A. Seems to me in Dr. Naeem's deposition he said that Mr. Johnson was reluctant to do the stress at the time. But the other factor that came up was about that time Mr. Johnson's right hip became painful and that would make walking on a treadmill difficult.
Q. That is the only way one could have a stress test. You have to walk on a treadmill. There is no other

way that one could have a stress test?
A. In 1996, in this community I think we were just beginning to do the Persantine stress test.
Q. Spell?
A. P-E-R-S-A-N-T-I-N-E stress test.
Q. That a person's name?
A. No. It is the name of a compound, a drug.
Q. All right. A drug called Persantine is administered to the patient and what kind of a stress test is that?
A. We call it a chemical stress test because it opens up the blood vessels throughout the body and if there is a blood vessel in the heart that can't open, that may cause symptoms, may cause changes on the electrocardiogram, but most importantly would cause a change in the radioactive picture of the heart muscle. But I'm not sure we were doing that in '96.
Q. Hypothetically, a Vietnam veteran lost his legs and he's in a cardiologist's office. He has cardiac risk factors, he's got sinus tachycardia and premature ventricle contractions, abnormal changes like Mr. Johnson had and the physician wants to give him a stress test and it is 1989. What do they do?

A. Can't do it.
Q. They can't give him a stress test?
A. No.
Q. And what do they do?
A. Either nothing or if they have a strong suspicion of coronary disease, the heart catheterization would be the only alternative.
Q. Would you agree with me that based upon Mr. Johnson's past medical history up through and including November 2 of '96, he presented as someone with coronary artery disease?
A. No.
a. Why not?
A. No evidence for it. He is someone who could have coronary disease but there is no evidence that he does have coronary disease.
Q. Does he -- why do you say he could have coronary disease?
A. Anybody could have coronary disease.
Q. Are some people more at risk than others?
A. Yes.
Q. Who?
A. People who have risk factors.
Q. So Mr. Johnson would have been more at risk for coronary disease than someone without risk factors?

A. Yes.
Q. You are telling me that you don't believe that Mr. Johnson should have had -- do you believe that Mr. Johnson needed a stress test?
A. I thought it was an appropriate recommendation on the part of Dr. Naeem.
Q. Is that because there was an abnormal EKG?
A. Well, the abnormal EKG and, of course, the risk factors that you referred to.
Q. Okay. If Dr. Naeem did not recommend a stress test, would that have been a deviation from the accepted standards of care?
A. It probably would be, I think taking the whole thing in context. I'm not sure I could be dogmatic about that. As I said before, he was a completely asymptomatic person. I think it would have been prudent some time in his mid-40's to do a stress test. I'm not sure there was an urgency to do it. The abnormal electrocardiogram, without any -- anything being specific about its abnormality increases the desire of that to some extent.
Q. You have reviewed Mr. Johnson's chart?
A. I have.
Q. Based upon that chart, does Mr. Johnson -- you would agree with me he appears to be a compliant

patient?
A. Pretty well. A few times he ran out of antihypertensive medication and didn't get it refilled very timely. In fact, on one occasion his blood pressure was quite high because he had been off the medication for a period of time.
Q. And what was it then, about one eighty? Regardless, for the most part, he did take his hypertensive medication?
A. Apparently so.
Q. And in spite of his hypertensive medication, his blood pressure was still a little elevated, even on November 2?
A. Well, I'm not sure I can agree with your statement. I have got a one fifty over seventy in 1995 and I have a one forty-four over eighty later in 1995.
Q. Which statement don't you agree with?
A. Well, you were implying that his blood pressure had not been well controlled before and I was working my way up to your second question which I also had an answer, and that was the blood pressure wasn't well controlled on November 2nd.
2. I don't think I said wasn't well controlled. What I said was, in spite of taking his hypertensive medication and doing a reasonably good job, he

still presented with a slightly elevated BP?
A. Why don't we talk about the numbers.
Q. And whether or not they are elevated or not?
A. Let's talk about the numbers first.
Q. *Go* ahead?
A. One forty-four over eighty.
Q. Is?
A. I don't think it's -- I wouldn't call it slightly elevated. That is what he had on November 2nd.
Q. That is normal blood pressure?
A. Well, you look at one forty over ninety and we were talking about one forty-four over eighty, I would call that within a normal range.
Q. It is slightly -- it's high end normal; is that what you would say?
A. Yes. I think the JCN Six definition would be high normal.
Q. He is taking his hypertensive medication and his blood pressure is high normal but not abnormal or not -- what would the word be if it's beyond high normal, abnormal?
A. Slightly elevated.
Q. Okay. He is high normal, okay.

Is it a deviation from the accepted standards of care not to take a person's temperature during a

physical?
A. No.
Q. If a person has an elevated white blood count, infection being one of the possible causes, do you think that the physician should follow up and take a temperature?
A. No.
Q. Why not?
A. I think the -- we have already talked about how the elevated white blood count is just barely above normal and the patient is completely asymptomatic. I don't see any deviation from standard care not to take a temperature in that circumstance.
Q. The acute bacterial pericarditis came from something, some other infectious source, but you don't know what it was?
A. Correct.
Q. One does not just get acute bacterial pericarditis; it starts somewhere else?
A. Fair enough.
Q. That is a correct statement?
A. Well, within the context of this case. I have already explained it quite often comes from a contiguous source.
Q. What else can it come from?

A. It can be something that is transiently in the bloodstream and lodges in the myocardium and pericardium.
Q. Do you know Dr. Naeem?
A. No.
Q. Have you ever reviewed any case that he has been involved in?
A. No.
Q. Other than this one, of course.
This is the only one?
A. This is the only one.
Q. Okay. What was he taking, Procardia?
A. Yes.
Q. Was that appropriate?
A. Yes.
Q. Was the dose appropriate?
A. Yes. Good result too.
Q. And brought it down to?
A. One forty-four over eighty.
a. High normal is what it brought it down to?
A. It did.
Q. What would it have been without the --
A. We found out on -- he found out on February 16, 1996 that his blood pressure, after being of€ medication for one week, was one eighty over a

hundred.
Q. Had -- was Mr. Johnson working or off work at the time of his periodic health exam on November 2?
A. I don't know. It was on a Saturday so, apparently he wasn't working that day.
Q. I meant generally?
A. I don't know.
MR. FIFNER: That is one thing we are going to have to clear up. I think understandably so, but I think his wife was kind of both ways on that.
Q. And I have documents from the employer and I'll send them to you.
MR. FIFNER: I think at one point in time during her deposition, she suggested he might have been off. I think another point in time she suggested he was working through the 15th or so.
Q. The impression from the November 2, 1996 exam was hypertension, family history of diabetes. So while he didn't have diabetes, that was a down the road risk factor; is that what means?
A. It is.
Q. Poor pedal pulses. What does that mean?
A. He had trouble finding the pulses at the -- below

the ankle.
Q. Finding the what?
A. Pulses.
Q. What does that mean?
A. It implies there is poor circulation in the blood vessels leading to the ankles.
Q. Is that somehow related to the cardiac risk factors in this patient? Certainly it's another risk factor or evidence of some ongoing circulatory problems in this individual?
A. I don't know what to make out of it. I don't know what Dr. Naeem means by poor pulses. This is a big man. I would have guessed that they would have been better pulses with the one forty-four over eighty, so you have a sixty-four millimeter pulse pressure.

But, as I said, he is a big man and it might be difficult to locate the pulses in a man with large ankles and so forth. He put it down so he was impressed by it. I think it stands on its own merits.
Q. But in a man with various cardiac risk factors, certainly it is another significant finding related to those other cardiac risk factors?
A. I wouldn't consider it very significant. I'm not

sure what I can do with that factor.
Q. We won't call it significant then. You will agree it is part of the picture that relates to this man's cardiovascular makeup on November 2 of '96?
A. In a vague sort of way, yes, it does.
Q. In a vague sort of way?
A. He apparently didn't have any symptoms from that.
Q. It means that he may have poor circulation?
A. Yes.
Q. It may mean that the heart -- poor circulation -- may mean that the heart is not pumping sufficiently to get blood to that part of his body?
A. I wouldn't agree with that.
Q. What does it mean?
A. Means that the blood supply to that -- basically what it means is that the pulsatile flow of the blood at the level of the ankle is somewhat less than the examiner expected it to be. I don't think it tells us anything about the heart.
Q. If it was a heart related condition, what would it be?
A. I can't imagine a heart related condition that would have that as a manifestation.
Q. Anything to do with a person's cardiovascular makeup that in any way, shape or form relates to

poor pedal pulses?
A. Only an impairment of circulation from the knees down.
Q. And caused by?
A. A narrowing of the arteries.
Q. Which would be a -- same thing as coronary artery disease?
A. No.
Q. Could be?
A. No.
Q. Narrowing of the arteries where?
A. In the leg.
Q. If a person had severe coronary artery disease, could they have poor pedal pulses?
A. They would be separate anatomic abnormalities. They may coexist.
Q. Okay. What would cause the narrowing of the arteries in that portion of the anatomy from the knees down?
A. Arteriosclerosis would be by far the most likely.
Q. What is arteriosclerosis?
A. Narrowing of the artery.
Q. Due to or resulting from what?
A. Either constriction of the media of the arterial wall or deposition of cholesterol under the intima

of the arterial wall.

Q. Would that most likely explanation, arteriosclerosis, be consistent with this patient's cardiac history and cardiac risk factors?

A. Yes. His cigarette smoking may have played a role.

Q. By the way, when we are talking about him being a compliant patient, you said fairly compliant because it appeared sometimes he didn't take his medication, are you referring to the February 16, 1996 visit where it says blood pressure -- ran out of blood pressure medication one week ago?

A. I am.

Q. You don't know if he tried to get an appointment right away or how it came about that he was in there just a week after he ran out of medication?

A. No. I don't know how it came about.

Q. But we do know within a week he is back in the doctor's office and it appears just for the purpose of getting new blood pressure medication. Doesn't appear to be for anything else. Certainly he has a callous on his right foot, but that doesn't appear to be the reason he is there.

My question is, on February 16, 1996, you would agree the reason that he is there is to get blood pressure medicine?

A. Yes, that seems to be at least one of the reasons.
Q. Then on July 1, 1996, he ran out of meds, it looks like three days before, on June 28. So within three days he is right back in the doctor's office to get his prescription; is that correct?
A. Yes.
Q. And again it appears that the reason that he is there is to get the blood pressure medication?
A. Apparently his legs were bothering him too.
Q. He's got pain in his left calf on walking, right?
A. That left or right?
Q. I'm looking at the typed note?
A. You are, okay.
Q. That might be a little better?
A. I didn't have that.
Q. He also has poor pedal pulses on that day, on July 1st of '96, correct?
A. Correct.
Q. Any idea why an EKG was never done earlier with this patient?
A. No.
Q. Would you have recommended one?
A. I would because I'm a cardiologist.
Q. Why would you have recommended that test, the EKG, for this patient?

A. For this patient?
Q. Yes?
A. I think the risk factors we talked about, hypertension and the poor pedal pulses.
Q. All right. And if you received the same EKG, the abnormal EKG, you would have followed up and recommended a stress test?
A. Yes.
Q. Okay. Do you have any way to know that Mr. Johnson's EKG on November 1 would have been any different back in July of 1996 -- I'm sorry, on November 2 of 1996, would he have been any different than on July 1, 1996 when he had the weak pedal pulses?
A. Of course not.
Q. Could have been the same?
A. Sure. I have no idea.
Q. And he could have been carrying that for sometime?
A. Sure.
Q. A person who carries an abnormal EKG -- this abnormal EKG with these risk factors is a greater risk for a cardiac event than someone who is healthy and has a normal EKG, no risk factors?
A. I am a little confused by the question.
Q. Sure.

This abnormal EKG of November 2 of 1996, you have just agreed with me may well have been the same with Mr. Johnson as far back as July 1 of 1996, the day he had the abnormal pedal pulses, could have been. How long could a person carry that same abnormal EKG -- how long could Mr. Johnson have presented with that?

A. Obviously, I have no factual answer to the question.

Q. It's the same kind of -- let me clarify. It's the same kind of question when I say how long could somebody have bacterial pericarditis and you said twenty-four hours is about as long as I expect them to have it before they're going to crash and die. Same thing with the EKG as you saw it on November 2 of 1996.

That EKG, is that the kind of EKG that you would say I think that that is what **I** would have expected Mr. Johnson to have been born with and carried with him for forty some years, or about as long as I would expect somebody to have that with his risk factor would only be a year or ten years or only -- certainly, you have agreed it could have been there on July 1 of 1996, but earlier?

A. I don't have an answer for you. I don't know the

answer.
Q. Could it have been there for years?
A. Yes.
Q. Would you agree with me that a person with that abnormal EKG and these risk factors presenting as Mr. Johnson does is at greater risk for a myocardial infarction than a person who is without those risk factors and with an -- and with a normal EKG?
A. Yes.
Q. And why is that?
A. Well, having risk factors are exactly what they are. They are increasing the risk of premature coronary disease and the electrocardiogram being abnormal would suggest that at least there has been some change in the electrical activity of the myocardium, but not in a specific manner.
Q. Okay. People who are having any kind of cardiac event, do they have physical pain symptoms?
A. Well, I'm not sure what you mean by any kind of. Are we talking symptoms or just the existence?
Q. Well, I think you had indicated there were no symptoms, no other symptoms. For example, shortness of breath would be a symptom?
A. Could be.

Q. The ones that you hear about all the time, that lay people hear about, would be a crushing pain in the chest, like an elephant standing on your chest?
A. Yes.
Q. Jaw pain. Where would the jaw pain be?
A. Lower jaw.
Q. And where? Can you point?
A. Left side.
Q. Left side next to your mouth?
A. Could be the entire left side of the jaw.
Q. And how about under the neck?
A. Well, that would be not jaw pain but neck pain.
Q. Could there be neck pain?
A. Yes, there could.
Q. Left side?
A. More likely central. We have to realize that we are dealing with a tremendous number of individuals and everybody is different in their makeup and the symptoms may vary from one person to another.
Q. Could it be right sided jaw pain?
A. Yes, it could.
Q. And should I keep going?
MR. SPISAK: Go ahead.
Q. Neck pain could be right or left?
A. Could be.

Q. And arm pain?
A. More likely left, but could be right.
Q. And shoulder pain?
A. Either one, but more likely left.
Q. What do those symptoms mean to you as a doctor when you hear that a patient with cardiac risk factor has one or more of these symptoms?
A. Means we must rule out myocardial ischemia or myocardial infarction.
Q. And those are serious life threatening conditions?
A. Indeed.
Q. And not to rule it out would be a deviation from the accepted standards of care?
A. It would.
Q. And how do you go about ruling it out?
A. Electrocardiogram.
Q. And if the electrocardiogram is abnormal and you have one or more of these symptoms, what do you do next?
A. Either stress test or cardiac catheterization, depends on the setting of the symptoms.
Q. All right. And if you couldn't do the stress test because of hip pain, would you want to do the cardiac cath?
A. Again, depending on the symptoms I would think a

cardiac cath is about the only alternative.
Q. And how quickly would you want to schedule it?
A. Depends on the individual presentation.
Q. Well, if Mr. Johnson presented with one or more of these symptoms?

MR. FIFNER: Object. Do you have any evidence he had one or more of these symptoms?

Q. I'm asking hypothetically if he presented, how quickly -- with one or more of these symptoms -- obviously, if he had the crushing chest pain and sweating, you would want to do it faster. But if he had one of the other pain symptoms that we talked about, right versus left and so forth, how quickly would you want to schedule the stress test or cardiac cath?

MR. FIFNER: Before you answer, let me make it clear it is entirely hypothetical and has nothing to do with Moes Johnson. If you believe Mr. Johnson had any of these symptoms that we have discussed, point them out to the doctor and show him what they were.

Q. And I'm just asking if a patient hypothetically who presents like Mr. Johnson does, as you understand

his presentation, has one or more of these pain symptoms?

MR. FIFNER: Don't use Mr. Johnson's name in this hypothetical because Mr. Johnson did not have any of these symptoms and if you believe he did, please show the doctor where you think he did so that he could incorporate that into the hypothetical and in his answer.

Q. And your objection is noted on the record.

My question is, how quickly would you schedule?

A. Hard to answer.

Q. And why is that?

A. It depends, you know, you have got so many variables in your question that we have to -- for us to live in the real world have to take each patient individually and judge each symptom and put it all into context to decide whether the patient goes immediately to the coronary care unit, whether they are given a prescription of nitroglycerin, stress test, whether they get a cardiac cath. You have so many variables in your question that I can't give you a finite answer.

Q. And how quickly could you get one of your patients

in for a stress test?
A. Twenty-four hours.
Q. Okay. Do you have any reason to believe it's any different in Lorain County?
A. I don't know about Lorain County.
Q. Have you ever seen it take more than twenty-four hours in some communities?
A. Sure.
Q. And have you ever seen it take more than forty-eight hours?
A. Yes.
MR. FIFNER: Under what circumstances?
Q. Just -- he wants to get a stress test. How long does it typically take?
MR. FIFNER: I think what he tried to tell you is whether you get a stress test today or you get a stress test two months from today depends on a number of different factors.
Q. You are really not allowed to testify.
MR. FIFNER: I am not. I'm telling you what he already told you.
Q. And all you are allowed to say under the rules is objection. That is what the Ohio Supreme Court has

said and that is technically all you're allowed to say.

MR. FIFNER: I am objecting to the form of your question and I'm telling you what's wrong with the form of your question.

Q. And Dr. Watts is a cardiologist and if he doesn't understand the question, he is going to ask me to repeat or rephrase it, true?

A. True.

Q. Absolutely. And if you think I'm asking you hypothetically, please just say is this a hypothetical or Mr. Johnson.

And if I am referring specifically to Mr. Johnson, Doug, I'll do my best to say this is Mr. Johnson right now.

If I'm asking you generally how long does it take to get a patient in, I'll ask it that way as well. Fair enough?

A. Fair enough.

Q. Also I do understand, and Doug's point is well taken, if somebody comes in with crushing chest pain or sweating, much like Mr. Johnson did on the 23rd of November, you get that patient right over to the emergency room or the cath lab or get them

to the hospital stat, correct?
A. Right.
Q. So the question here is -- simply, it's a general question. How long can you -- how long does -- strike that.
How quickly can you get somebody to the stress test and you said twenty-four hours. That was your answer?
A. Yes.
Q. How quickly can you get someone into a cath lab?
A. It could be up to twenty-four hours.
Q. The kind of pain that you were talking about that could be in the jaw, if it is cardiac related, is it going to be constant or off and on?
A. Off and on.
Q. If a person has that pain in one of their arms, left or right, and it's cardiac related will it be constant or will it be off and on?
A. Off and on.
Q. And if a person has pain in their shoulder and it's cardiac related, will it be constant or off and on?
A. Off and on.
Q. If a person is having the crushing chest pain of an immediate MI, myocardial infarction, will it be constant or off and on?

A. Constant.
Q. The diaphoresis, the sweating, will that be constant or off and on if it is due to a myocardial infarction?
A. It can vary, but it is more likely to be constant.
Q. As it is getting worse and the myocardial infarction is increasing in severity?
A. Yes.
Q. Mr. Johnson had numbness and tingling in his left foot. Is that of unknown origin?
A. Yes, I believe it was unknown to Dr. Naeem, and I wouldn't have known what it meant either.
Q. Is there any possible cardiac explanation for that or circulatory explanation for that?
A. No.
Q. That would be ortho or neuro, in all likelihood?
A. In all likelihood it would be.
Q. Could be a lumbar disk or sciatica, something along those lines?
A. Yes.
Q. He later gets pain in the right buttock radiating down the back of the right leg to the knee, which was worse on weight bearing. Again, could there be any cardiac explanation for that or would you say more likely -- or would you say -- any cardiac

explanation for that?
A. No.
Q. Can infection cause pain?
A. Yes.
Q. Can it cause pain in a joint?
A. Yes.
Q. Can it cause pain in one's back?
A. Yes. Fortunately not very often, but it could.
Q. It can cause pain that radiates?
A. Yes.
Q. Cause pain that radiates down the back of the right leg to the knee?
A. It is possible. It's obviously not a very common cause.
Q. Is there a cardiac explanation for right groin pain or left groin pain?
A. No. None that I know of.
Q. What are some of the explanations for groin pain absent trauma?
A. I would think it would be musculoskeletal.
Q. Mr. Johnson, of course, with his -- now I'm specifically talking about Mr. Johnson -- he came in on the 18th. Take a look at the note of the 18th there and you will see it's a follow-up from the November 11 follow-up where he had the pain in

the right buttock radiating down the back of the right leg to the knee and the impression on the 11th was radicular pain of the right leg. On the 18th, the pain in the back of the right leg is better and he is now complaining of right groin. And he had tender medial abductor tendons and muscles. So my question is, did he have -- I think you would say that that is more likely than not orthopedic in nature?

A. Yes.

Q. Or musculoskeletal, I should say. That could be ortho or neuro?

A. Yes.

Q. Is there any conceivable cardiac explanation for that right groin pain?

A. I can't think of any.

Q. I don't have that much more.

What did Mr. Johnson die from?

Actually before you answer that, let me back up.

The 10th, the emergency room visit of the 10th, he complained of right hip pain for six days. He thought it began to be painful with getting up from a cart during a physical the prior week and denied any back pain and said he gets some relief

from Tylenol. You are aware of that?
A. Yes.
Q. They gave him sixty milligrams, a shot of Toradol. What's Toradol?
A. It is an analgesic.
Q. Dr. Sibits was of the opinion that sixty milligrams constituted an overdose, almost twice the dosage that you would give someone under those conditions. Do you know one way or the other whether or not it's an overdose?
A. No, I don't.
Q. Mr. Johnson did not respond to the Toradol. It did not relieve the right hip pain. Do you know why?
A. No, I don't.
Q. Is it conceivable that if someone was having pain due to infection in a hip for example or a related anatomical structure just generally in that area, would you agree with me that it's conceivable to you that someone might not respond to an analgesic such as Toradol?
A. No. I don't know that the cause of the pain has anything to do with whether you respond to it or not. I would think that whatever its cause -- well, I guess I have already said it. I don't know that the relief or lack of relief from an analgesic

is specifically related to why the person has the pain in the first place.

Q. Okay. Your CV is current?

A. Yes, it is. It has this year's date on it.

Q. I know you said you were practicing medicine as of last night so you sound like somebody who may have some interesting changes.

You reviewed in this case the office records of Dr. Naeem for Mr. Johnson from 9-22-94 to 11-23-96 and the lab reports of November 2 and 7, 1996?

A. Right.

Q. You reviewed the emergency room department exam of November 10, 1996 with the pelvis and right hip x-ray. That is what you wrote in the report?

A. It is.

Q. Did you review the interpretation of those x-rays or the x-rays themselves?

A. Interpretation only.

Q. You reviewed the Elyria Memorial Hospital Emergency Department admission of November 23, '96 with the chest x-ray?

A. I did.

Q. Again, the interpretation?

A. Yes.

Q. You looked at the autopsy report of November 26, '96?
A. I did.
Q. He had a large heart you say?
A. Yes.
Q. That is based on what the coroner found?
A. It is.
Q. What do you mean by a large heart?
A. Same thing the coroner meant.
Q. Well, put that in lay terms. What is a large heart, because he is a big man he has a big heart or did you mean that as an abnormality?
A. I think it is an abnormality. It is a little hard to know exactly what the normal weight of a heart should be for a man who was seventy-three inches tall and weighs two hundred and forty pounds.
Q. But there is an average normal?
A. We don't have an awful lot of people who are of that size. Probably the best way to know what the normal weight of the heart is is based only on heights, but it might be based on weight or it might be based on high end weight which would be body surface area. The data I've seen suggests that height is probably the best. After we boil all of that down I think it is safe to say his

heart is larger than we would have expected it to be.
Q. And what is cardiomegaly?
A. Large heart.
Q. Did he have cardiomegaly?
A. He had a large heart.
Q. And is cardiomegaly a condition that could develop in someone, in other words, the heart can enlarge at some point?
A. Yes.
Q. And do you believe Mr. Johnson's heart was larger than normal or that due to the disease processes or illnesses -- and I'll ask you when all this happened.

To the best of your ability, do you believe that he developed a large heart or he came with one from his maker?
A. I have no idea.
Q. Okay. So whether or not the large heart was an abnormality related to any of the disease processes or medical conditions that led to his death, you don't know?
A. I would expect that his cardiac enlargement had to do with his size and high blood pressure.
Q. How long would you have expected him to have had an

enlarged heart?
A. I have no idea.
Q. Do you think it is something that just occurred over the last couple of weeks before his death or do you think that he had that for years and years'?
A. Well, I don't think it was a couple weeks but how many years and years, I don't know.
Q. But a matter of years, not weeks?
A. More likely.
Q. Okay. You also say he had severe coronary arteriosclerosis. Is that your opinion, coroner's opinion or something that is agreed upon.

What I'm getting at is, what do you mean by that, where did you get it and explain?
A. I got it from the diagnosis by system in the autopsy report. Looking at page one of eleven pages, the forth line from the bottom that says coronary arteriosclerosis, comma, severe.
Q. Did it get into the extent of the severity?
A. Not as complete as it would on an arteriogram, but one of the arteries was judged to be seventy-five percent narrowed and one of the other -- let's not guess. Let's take a look.
Q. The question is going to be, on a scale of severity -- or questions, and I'll give you a two-part

question.

How severe is severe on the scale of severity, if you can tell me, and how long would you estimate Mr. Johnson had been suffering from severe coronary arteriosclerosis? Then I will let you direct your attention back to the gross anatomic description.

A. Well, in the description of the gross anatomy, this is page six, left anterior descending coronary artery shows severe atherosclerotic changes with thickening of the intima with a reduction of the lumina to the vessel to about half of its normal caliber.

The same is said farther down in that paragraph about the right coronary artery and in the microscopic -- at the bottom of page nine, in some of these vessels, the lumina is reduced to seventy-five percent.

Q. Seventy-five percent blockage or twenty-five percent blockage?

A. I believe the way he means is seventy-five narrowing or twenty-five percent remaining of the original diameter.

Q. Reduced to seventy-five percent?

A. It is -- it could be interpreted either way.

Q. So we are seeing vessels blocked anywhere from fifty percent to seventy five percent?
A. Yes. I think in the context I would have -- you are right that it could be interpreted either way. In the context, I would think that he means seventy-five percent stenosed, but it could be interpreted either way.
Q. And because twenty-five percent stenosed would not be severe coronary artery disease, if it was that alone, or severe arteriosclerosis or atherosclerosis, twenty-five percent would not be severe?
A. Is that a question?
Q. Would it be or wouldn't it be? I'm wondering if in light of another interpretation we could still call it a severe blockage, severe coronary arteriosclerosis?
A. I wasn't sure you were asking a question.
Q. Right. I was.
A. Okay. Could you ask it again?
Q. If we interpret it the other way to mean only twenty-five percent blocked, would you call that severe or would you think more likely than not the other way, a seventy-five percent blockage means that it is severe?

MR. FIFNER: I think what's he is asking you is, do you think it is twenty-five percent blocked or seventy-five percent blocked.

Q. I think he told me it is seventy-five. He told me that he thinks it is seventy-five percent stenosed. It could be interpreted the other way and I'm saying that if you do interpret it the other way, that is not likely because you probably wouldn't call it severe. That is all I was getting at.

Do we agree with that?

A. We do.

Q. But you believe it was seventy-five percent stenosed more likely than not and that would be consistent with a severe coronary arteriosclerosis, right?

A. Right.

Q. How long would you say Mr. Johnson suffered from this blockage, this severe coronary arteriosclerosis?

A. I have no idea.

Q. Would you say in all likelihood, more likely than not, it was only a couple of weeks that he was blocked like this?

A. It's possible.
Q. He could have gone from no blockage to seventy-five percent stenosed in a matter of weeks?
A. In a matter of minutes.
Q. How is that?
A. Because that is the way things happen.
Q. To a reasonable degree of medical probability, simply means more likely than not. Do you have an opinion as to whether or not Mr. Johnson suffered from coronary arteriosclerosis on and before November 2 of 1996?
A. He wasn't suffering from anything at that point.
Q. Do you believe Mr. Johnson -- to a reasonable degree of medical probability, do you believe Mr. Johnson had within his body coronary arteriosclerosis on and before November 2, 1996?
A. I do.
Q. Why do you believe that?
A. Well, the evidence that we had twenty-one days later of the kind of disease we have just talked about must have had some presentation before November 2nd. However, the presentation could have been just minor irregularities of the coronary arteries and not the more advanced stage that we saw three weeks later.

Q. More likely than not, again to a reasonable degree of medical probability, what do you believe the extent of the blockage was on November 2 of 1996?
A. I have no idea.
Q. Could have been seventy-five percent, seventy-four percent, even less?
A. Could have been five percent.
Q. You don't know one way or the other?
A. No, I don't.
Q. You believe he had coronary arteriosclerosis but the percentage you cannot say?
A. Correct.
Q. Okay. Do you have the EKG? I want to ask you another question about the EKG.

Maybe I can state it for you. The computer came up with the diagnosis abnormal changes possibly due to myocardial ischemia. Do you recall that?
A. I do.
Q. And tell me again, what's myocardial ischemia?
A. Impaired circulation to the myocardium.
Q. What does that mean in lay terms, impaired circulation to the myocardium?
A. That is in lay terms, isn't it?
Q. Well, break it down a little more. You are talking

to a sixth grade class here. Impaired circulation to the myocardium, what does that mean?

A. The myocardium depends upon blood to deliver the oxygen to help it function as a muscle and if there isn't enough blood delivered to the myocardium, that reduces to some extent its function, but also changes its electrical activity. And it's the change in the electrical activity that the electrocardiogram detects.

Q. And it's because of that lack of blood flow to the myocardium that a person is at greater risk for a heart attack?

A. Yes.

Q. Do you believe that Mr. Johnson was suffering from myocardial ischemia?

MR. FIFNER: Objection.

A. No. I didn't agree with that.

Q. Why is that?

A. Because it doesn't look like myocardial ischemia to me.

Q. Why do you say it doesn't look like myocardial ischemia?

A. The classic changes of myocardial ischemia are not seen in my view.

Q. What are the classic changes that you would have

expected if it were due to myocardial ischemia?
A. What we see on a treadmill all the time, ST segment depression.
Q. Is there any ST segment depression here?
A. No.
Q. Where is the ST segment depression? Where would it be shown?
A. Between the R-wave and the T-wave.
Q. And show me on the EKG where you would have expected that?
A. It should be right there. It's not there.
Q. That is an elevation?
A. It is? No, I would say it's isoelectric.
Q. Explain what you mean by that?
A. It's at the baseline.
Q. Isoelectric means that the result seen is at baseline?
A. Yes. Isoelectric means that there is no electrical activity being detected by the galvanometer which is recording the electrocardiogram.
Q. It would be a normal finding with respect to that aspect of the EKG?
A. It would.
Q. And we're talking about Mr. Johnson's EKG. As you say, that was a normal finding?

A. Yes.
Q. Why would the computer generate that, possibly due to myocardial ischemia, phrase?
A. It was programmed to do that.
Q. By?
A. The programmer.
MR. FIFNER: Hewlett Packard.
Q. I'm not familiar with Dr. Packard. Is he a cardiologist?
A. He is not even a doctor.
MR. FIFNER: Off the record
- - - -
(Thereupon, a discussion was had off the record.)
- - - -
Q. Is myocardial ischemia a serious condition?
A. It is.
Q. And if you saw myocardial ischemia, what would you do?
A. Treat the patient.
Q. How?
A. Lot of things that can be done. I'm not sure they are germane to this conversation.
Q. Well, if you had Mr. Johnson on November 2 of 1996, and your interpretation or your understanding was

that he had myocardial ischemia, given his height, weight, risk factors and an EKG that showed you that he -- convinced you that he had myocardial ischemia or led you to believe that he had myocardial ischemia, what should be done to treat him?

MR. FIFNER: Objection to the hypothetical.

MS. PETRELLO: Join as well.

A. Well, first of all, we are dealing with a man who doesn't have any symptoms, which means that it is not right to the hospital sort of thing. So we are treating -- the definition here would be silent myocardial ischemia. And the easiest way to treat that would be to have him on a long-acting nitroglycerin compound and recommend a stress test.

Q. How soon would you want that stress test. If you believed that he had silent myocardial ischemia, how soon would you want the stress test? You would put him on nitro right away, long-acting, and you would want a stress test how soon?

A. Within the next couple of weeks. This could have been going on for a long time and, as I said before, you would have to take the patient as he is. He has no symptoms.

Q. What if he had a symptom such as jaw pain or arm pain or shoulder pain without the crushing, get him to a hospital pain. Now it's not silent?

MR. FIFNER: Objection to the hypothetical.

Q. Go ahead. What would you do?

A. First of all, we know that is not the case. That is a hypothetical. Put him in the hospital. That would be acute coronary syndrome.

Q. And if he had one of those symptoms, that would be acute coronary syndrome and you would put him in the hospital right away, to do what?

A. Preferably a cardiac catheterization, but depending on the timing, if we are taking Mr. Johnson on November 2nd, Saturday at noon, probably neither stress test nor cardiac catheterization is going to be available for forty-eight hours.

Q. So by Monday you would expect?

A. Yes.

Q. You would have had the stress test and/or the cardiac catheterization done?

A. Yes. This is set, of course, with my acknowledging that I have never been in Elyria Hospital. I have no idea how things work there. All I can tell you is how they work here.

Q. Fair enough.

Would you -- assuming that the cardiac cath revealed -- well, what would you see in someone like Mr. Johnson -- if the EKG was correct and there was indeed myocardial ischemia, what would the stress test reveal and what would the cardiac cath, if you did it, what would you expect it more likely than not to have revealed?

A. Which test are we doing?

Q. Do the stress test first. Let's say there is myocardial ischemia, the EKG is correct?

A. Well, in that setting I would conjecture. I think that you have probably about a fifty-fifty chance of having a true positive or a false positive.

Q. On the stress test?

A. I'm sorry, a true positive or false negative. This is going to fall in a gray area where the stress test may very well miss the fact that the man does have ischemia or it may suggest that there is ischemia there, but there isn't.

Q. The best way to rule that out would be the cardiac cath?

A. Yes. That would be more definitive.

Q. That's what you would do?

A. Preferentially, yes.

Q. And if the cardiac cath was performed and cardiac ischemia was there, nuts and bolts, mechanically, technically, how does the cardiac cath show myocardial ischemia?
A. Anatomically it shows the substrate for ischemia by the fact that there is a significant narrowing of one or more of the major coronary arteries.
Q. And how is it treated?
A. A variety of ways. Long-acting nitroglycerin, beta blockers. Of course, control, better control of the blood pressure, although it's pretty well controlled. Weight reduction, cholesterol control, going to interventional cardiology. Of course, balloon angioplasty, with or without stint, or going into the operating room for coronary bypass graft surgery. It depends on the results of the cardiac catheterization.
Q. And myocardial ischemia you said is lack of blood flow to the myocardium?
A. Insufficient blood flow, not a lack of blood flow.
Q. And lack of -- you are interpreting to mean a total deprivation, but a decreased blood flow to the myocardium, to the heart tissue?
A. Correct.
Q. Do you agree with me that if heart tissue is

receiving less blood flow due to ischemia, it is prone to infection?

A. No, no, no, no.

Q. Why not?

A. I have never seen it.

Q. If you were performing a cardiac cath, the purpose is to increase -- and you found myocardial ischemia, the treatment that you are talking about is all designed to restore normal or as much blood flow as possible to the myocardium. That is the goal?

A. It is.

Q. And to restore what you would like to see, and that is normal heart function?

A. Yes.

Q. If the patient during the -- let's say the patient was suffering from an infection of the pericardium, during the cardiac catheterization would you discover that?

A. Well, if it was of the degree that he had during the last six hours or so of his life, I think the answer is yes, you would probably see there is pericardial fluid there. You are looking primarily at the arteries and secondarily at the left ventricle chamber. But the left ventricle chamber

would have been reduced by the fact that there is pericardium fluid compressing the heart. It's kind of an indirect way to make the diagnosis.

Q. Okay. And depending upon the amount of the fluid, what, the severity of infection would be picked up? How does that work? Let me try to rephrase.

If on cardiac catheterization Mr. Johnson was as infected as he was in the last six hours of his life, the acute bacterial pericarditis, that you would have expected to see, correct?

A. Yes.

Q. What about a milder form of infection? Was there anyway to discover that, any other infection of the pericardium during cardiac cath or stress test?

A. I'm having a hard time with your question because, as you know, in my view this was a rapidly progressing process and when he presented to the emergency department on November 23, he was acutely and severely ill and was judged to be having a myocardial infarction.

Q. You agree with that?

A. I think that was the correct decision, given the circumstances they were presented with.

MR. FIFNER: The question is, do you agree it was a myocardial

infarction?
A. Not with all the data I have in front of me. We know he was not dealing with a myocardial infarction.
Q. He was dealing with an acute pericardial abscess?
A. Exactly.
Q. That was responsible for the even greater decreased blood flow to the heart?
A. Yes.
Q. It was the pressure, fluid, in the pericardium pressing on the myocardium, on the heart?
A. Yes. And he also had a one point three centimeter abscessed cavity which had broken into the pericardium, so he had lost that much myocardium at that point.
Q. And that is what, an infection of the myocardium?
A. Yes.
Q. And how long had that been brewing?
A. I have no idea
Q. How long could it have been brewing?
A. I don't know. Maybe a day.
Q. All right. Now, let's assume hypothetically that infection was brewing for a couple of weeks and you performed your cardiac cath, say on November 5 or 6 or thereabouts. You would agree that you would

find that infection at that point in time?
A. I don't know whether you would or not. I have never seen a myocardial abscess.
Q. And is it treatable?
A. Treatable like any abscess, you drain the pus.
Q. And if you catch it, the person has a chance of surviving?
A. It would increase the chance.
Q. And what that chance is you don't know?
A. No.
Q. You can't say one way or the other?
A. No, because I have never seen a myocardial abscess.
Q. You don't hold an opinion to a reasonable degree of medical probability one way on another what a person's chances of survival are if infection of the myocardium is found during a cardiac cath two weeks before approximately in a patient like Mr. Johnson; you don't know?
A. I don't know if you could even find a myocardial abscess. We know three weeks later it is one point three centimeters. What it was on November 2nd, 3rd, 4th or 5th, I have no idea. Obviously it was a lot smaller.
Q. If a person has ischemic myo -- or cardiac myopathy -- what is the phrase again on the EKG, I'm sorry?

A. Possible myocardial ischemia.
Q. Right. Of two weeks duration, if it's caught earlier, would you agree that they have a greater than fifty percent chance of not having a heart attack?
A. Are we back to silent ischemia?
Q. Does it matter if it's silent or if there is just one of those symptoms, would that change it?
A. Yes.
Q. And how?
A. Silent myocardial ischemia, since it is not causing any symptoms, is presumably a less severe form of ischemia than when you have symptoms. We see that all the time on the treadmill. We see changes on the electrocardiogram about two minutes before the patient has any chest discomfort. So obviously the presence of chest discomfort is a more advanced stage of ischemia.
Q. And if it is not silent?
A. That is what I'm talking about. Silent means you don't have symptoms and not silent means you have typical anginal symptoms.
Q. So if you have an anginal symptom such as -- even one of them, that would not be silent?
A. Correct.

Q. That could be the jaw pain, the shoulder pain, the arm pain; one of those?
A. Right.
Q. That is non-silent ischemia?
A. Right.
Q. And if the person nas that ischemia and it is caught timely, what are the chances of survival?
A. Quite good, fortunately.
Q. What's ischemic cardiomyopathy?
A. That is not what Mr. Johnson had. Do you still want an answer?
Q. Yes.
A. Ischemic cardiomyopathy is a person with ischemic heart disease who's had multiple episodes of infarction or at least severe impairment of myocardial function because of repeated episodes of ischemia which has caused small scars, not large enough perhaps to be diagnosed on the electrocardiogram. But the net result is to cause the myocardium to fail to do its job and therefore, the patient goes into congestive failure because of the inability of the heart to circulate enough blood to support the circulation of the body.
Q. And can that congestive failure be over an extended period of time?

A. *Of* course.
Q. Can infection set in under those circumstances?
A. No.
Q. Why not?
A. I don't know. It just never does.
Q. Ischemic cardi myopathy, is that som thing that you would be able to diagnose with a cardiac catheterization?
A. Yes.
Q. Again, is that something that could be silent or not silent?
A. Well, it is not silent because the patient has congestive failure. They are not having chest pain, but they are impaired, short of breath and so forth.
Q. Could they have one of the symptoms, jaw pain or shoulder pain or arm pain?
A. Sure.
Q. That could be some evidence of an ischemic cardiomyopathy?
A. That is the evidence for the ischemia. They may not have a cardiomyopathy because *of* it.
Q. Okay. Cardiomyopathy is a diagnosis that would be made pursuant to either a stress test or cardiac catheterization?

A. Well, ischemic cardiomyopathy implies an advanced stage of ischemic heart disease. I think we better be clear about that.
Q. And why do you say Mr. Johnson did not have ischemic cardiomyopathy?
A. Didn't have any evidence of it.
Q. Based on what?
A. Everything that I have in the record.
Q. What's staph aureus -- what's staph aureus?
A. Bacteria.
Q. How does it enter the body?
A. Multiple ways.
Q. And give me some examples?
A. Well, usually comes through the skin since staph aureus is a common bacterium on the skin, so any break in the skin can cause it to come in.
Q. Mr. Johnson had -- there is an anatomic finding that he had staph aureus?
A. At the autopsy, yes, and also when they did the pericardiocentesis and got pus.
Q. While he was still alive, they found that he had some staph aureus in the pericardium?
A. Right.
Q. That is the fluid surrounding the heart?
A. Correct.

Q. Staph aureus can only come in through the skin, or that is the most common way?
A. Most common.
Q. If he had blood drawn, that would create an opening in the skin for -- that would be capable of allowing staph aureus to get in?
A. No.
Q. Why not?
A. It doesn't as far as I know.
Q. Opening in the skin could be, what, a scratch?
A. Possible. I would think it would be more than that.
Q. And why do you say that?
A. Observation.
Q. Do you know -- what is staph aureus pericarditis? Is that essentially staph aureus bacterium in the pericardium?
A. Yes, it is.
Q. And calling it pericarditis -- staph aureus pericarditis means what, just what I said?
A. Yes.
Q. Okay. And how does one develop staph aureus pericarditis?
A. I don't know.
Q. How long can one live with staph aureus

pericarditis?
A. I think we said twenty-four hours the last time that you asked that question.
Q. Well, you called it bacterial pericarditis, but we didn't narrow it down to staph aureus. So when you were referring to bacterial pericarditis, the bacterium or the bacteria to which you were referring was staph aureus?
A. Yes.
Q. Because that is what he had?
A. Yes.
Q. If you find staph aureus pericarditis -- again, what's the treatment? What did you say the treatment was should you find it in a timely fashion, how do you treat it?
A. Two ways. One, more important way to relieve the pericardium of its fluid and to open up the pericardium so the pus that will reform will not be compressing the heart and, of course, to give the appropriate antibiotic.
Q. If you performed a cardiac cath and a person had staph aureus pericarditis, would you see it?
A. I think we just covered that.
Q. What's your answer?
A. Same as last time, you may or may not.

Q. I'm just about done. I'm going to let Les ask -- as a matter of fact, if you want to ask questions, I'll page through my notes. If you don't have any, I reserve the right to just go through my notes.

MR. SPISAK: I just have one question, or at least I think I just have one question.

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CROSS-EXAMINATION OF DR. RICHARD WATTS

BY MR. SPISAK:

Q. Doctor, you mentioned in your report, the very last sentence, cause of death was a rare condition which could not have been successfully treated. Can you explain that briefly?

A. Well, the natural history of bacterial pericarditis is exactly that, the mortality is seventy percent and one would have to know the condition at a time that intervention could help to prevent death. And in this case, of course, the treating personnel had only at the best about four hours, and first of all they had to make the diagnosis. And second of all, they had to do something about it, and by that time in his case it was too late.

Q. Doctor, do you have any reason to think that the condition which caused Mr. Johnson's death was

either -- well, whether that condition existed in a diagnosable fashion, let's say, within the last week of his life?

A. It did not.

Q. Why do you say that?

A. As I read particularly his widow's deposition, she didn't seem to notice anything different about Mr. Johnson until the morning of the day of his death. And admitting, of course, we are now over three years beyond that sad event and relying on her memory, nothing seems to stand out in her memory that he appeared ill even up to within twenty-four hours of his death. So I think the ability to diagnose the condition therefore would have been completely impossible.

Q. All right. I said one question and I'm violating my own comment, but I have one or two more.

Assume, for the sake of this question, that a patient such as Mr. Johnson had a fever of unknown origin, say within the last -- or at a point in time approximately ten to twelve to thirteen days before his death. How would you treat the fever of unknown origin?

A. Well, that could be treated with antibiotics then.

Q. And at that point, I trust you would treat him with

a broad spectrum antibiotic?

A. Yes. Of course, you get all the appropriate laboratory data, the urine culture, the blood culture and chest x-rays and, of course, a complete physical examination before you come anywhere near using an antibiotic.

Q. Do you have any reason to think that treating a patient, treating Mr. Johnson let's say, with a broad spectrum antibiotic ten days to two weeks before his death would have affected the ultimate course of events here?

A. No.

MS. PETRELLO: I'm sorry, what was his answer?

A. No.

Q. And the reason being?

A. Well, I -- in my opinion, this all occurred over a twenty-four hour period before his death. So whatever you did ten days to two weeks before that would not have been treating the condition which ultimately caused his death.

MR. SPISAK: Thanks, Doctor, I have nothing further. Colleen?

MS. PETRELLO: No questions

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FURTHER CROSS-EXAMINATION OF DR. RICHARD WATTS

BY MR. DEMPSEY:

Q. Doctor, the question was asked of you whether the -- whether treating with broad spectrum antibiotics would have made a difference and you said I don't think so. Do I understand that if you did find a fever in Mr. Johnson, you would have done something else, there would be some workup, what did you say, lab and what were all the things you just listed?

A. Urine culture, blood culture, chest x-ray, complete physical examination.

Q. So if Dr. Naeem had found a fever on the day of the physical, those things should be done and assuming that they revealed infection, then you would treat that infection as opposed to using some broad based antibiotic?

A. Depends what the infection is.

Q. Let's say it showed a staph aureus infection?

A. Well, then you would get sensitivities to the organism and use the appropriate antibiotic.

Q. Is staph aureus a treatable infection?

A. Sometimes it is but sometimes it isn't. That is one of the big problems in hospitals. We get staph aureus that is resistant to the usual

antibiotics.
Q. Mr. Johnson had staph aureus?
A. In the pericardium.
Q. And that staph aureus started somewhere else in his body?
A. Yes, I believe so.
Q. And it would have started in his body and ultimately moved to the pericardium?
A. Yes.
Q. Is it more treatable or less treatable if it is not in the pericardium? And that will get to my next related question, is it more life threatening or non-life threatening if it is not in the pericardium?
A. So this is pericardium or anywhere else in the body?
Q. Correct?
A. Hard to answer.
Q. More likely than not, fifty-one percent over forty-nine percent, where do you believe -- and I know you can't tell me with certainty or precisely, but more likely than not, where do you believe the staph aureus was before it went to the pericardium?
A. I have no idea.
Q. Was it more treatable via antibiotic before it got

to the pericardium?
A. Best guess is yes. I don't know.
Q. Certainly you would agree with me there is a greater chance of survival before it gets to the pericardium?
A. Probably.
Q. You would hold that opinion to a reasonable degree of medical probability?
A. Yes.
Q. If Mr. Johnson did have a fever on November 2 of '96, and of course, it is not documented, but if he did, and it was worked up as staph aureus as an infection -- well, first of all, it could have been staph aureus as the infection, you would agree with that?
A. We are assuming that he had a fever on November 2nd?
Q. Assuming that he had a fever on November 2nd or on November 10th at the ER?
A. Which way are we assuming now?
Q. Will it change -- I'm going to ask you if he had a fever on November 2nd, would you agree that it could have been staph aureus that was responsible for it?
MS. PETRELLG: Objection.

A. Yes, it could.
Q. And if he had a fever on November loth, would you agree that it could have been staph aureus?
MS. PETRELLO: Objection.
a. It could.
Q. And would you agree on November 2nd the staph aureus was not in his pericardium?
A. I don't believe it was.
Q. Would you believe -- I'm sorry. Would you agree that if he had a fever on November 10th at the ER and it was staph aureus, it was not in the pericardium?
A. That is a little closer to the date of death but it is still thirteen days away, so I don't know.
Q. More likely than not?
A. Probable more likely than not.
Q. It was or was not?
A. Was not.
Q. In the pericardium?
A. Right.
Q. And would you agree with me that if it was treated, recognized and treated on November 2nd, more likely than not it would not have gone to the pericardium?
A. We are now assuming that he was febrile on November 2nd, which he wasn't.

Q. Assuming that he had a fever on November 2, that it was staph aureus and he was treated, you would agree with me more likely than not it would not have gone to the pericardium?
A. Yes. I think I said that before.
Q. And you would agree?
A. Yes.
Q. Same answer if he had a fever on November 10th and it was staph aureus, that was the infection hadn't yet gone to the pericardium and he was treated, more likely than not it would not have gone to the pericardium?
A. Okay.
Q. Correct?
A. Right.
Q. And the cause of his death, in your opinion and to a reasonable degree of medical probability, was staph aureus infection in the pericardium?
A. Yes.
Q. Just so I'm clear, if you could summarize for me, how would your opinion change -- well, no. Strike that.

Let me look at one more note here, then I think I'm done.

Have you practiced internal medicine?

A. Yes.
Q. So you feel qualified to talk about the standards of care for an internal medicine specialist such as Dr. Naeem?
A. Yes.
Q. I trust that when you have given your opinions relative to standard of care, if it's been what a cardiologist should do, throughout the deposition you've told me. Otherwise, it would be whether or not Dr. Naeem's conduct was appropriate?
A. Yes.
Q. Does a physician such as Dr. Naeem have a duty to exclude coronary artery disease in Mr. Johnson as of that November 2 physical or as his treating physician?
A. Yes.
Q. Is it true that the only way to have high blood pressure and weak pedal pulses is due to blocked blood vessels?
A. Yes.
Q. Thank you, Doctor Watts.

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FURTHER CROSS-EXAMINATION OF DR. RICHARD WATTS
BY MR. SPISAK:
Q. One follow-up question. If I understand everything

that has been said here, the fact that Mr. Naeem -- I'm sorry, Mr. Johnson had a staph aureus infection on autopsy does not necessarily mean that that staph infection existed anywhere in his body two weeks or ten days prior to that time, does it?

A. That's correct.

Q. Okay. Thank you.

MR. DEMSEY: All set, Colleen?

MS. PETRELLO: All set.

MR. DEMSEY: We'll call you when we get to the doctor's office.

(Deposition Concluded.)

PAGE	LINE	NOTATION

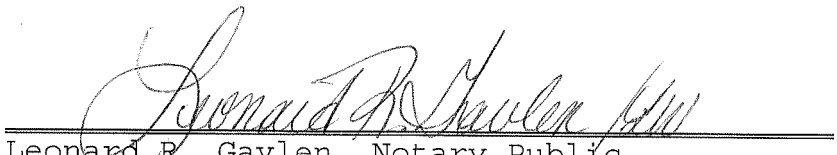
Richard W. Watts, M.D.

CERTIFICATE

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

I, Leonard R. Gavlen, Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named RICHARD W. WATTS, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of computer aided transcript under my direction, and is a true record of the testimony given by the witness; that said deposition was taken on the 23rd day of June, A.D. 2000 in the City of Cleveland, State of Ohio, and County of Cuyahoga and was completed without adjournment; that I am not a relative or attorney or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office this 13th day of July, 2000.



Leonard R. Gavlen, Notary Public
My commission expires August 10, 2000