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

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IN THE COURT OF COMMON PLEAS

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SANDRA JOHNSON, ADMINISTRATRIX OF THE ESTATE OF MOSE T. JOHNSON, DECEASED,
Plaintiff,
v.
AKBAR NAEEM, M.D., et al.,
Defendants.
Case No. 97CV118106

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THE DEPOSITION OF JOEL B. ZIVOT, M.D.

THURSDAY, JUNE 1, 2000

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The deposition of JOEL B. ZIVOT, M.D., a witness, called for examination by the Defendants, under the Ohio Rules of Civil Procedure, taken before me, Janis E. Suntheimer, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at the offices of Nurenburg, Plevin, Heller and McCarthy, Co., L.P.A., 1370 Ontario Street, First Floor, Cleveland, Ohio, commencing at 1:45 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff:

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JOEL B. ZIVOT, M.D.

a witness, called for examination by the Defendants, under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS-EXAMINATION

BY MR. FIFNER:

Q. Your full name, please?

A. Joel Bruce Zivot.

Q. Z-I-V-O-T?

A. Right.

Q. Your current residence address?

A. 2953 Winthrop Road, W-I-N-T-H-R-O-P, Shaker Heights, Ohio 44120.

Q. When were you born?

A. I'm sorry?

Q. When were you born?

A. July 17, 1962.

Q. Social Security number?

A. 276-96-0676.

Q. What is your medical specialty?

A. I have two specialties, anesthesiology and critical care medicine.

Q. Board certified in anesthesiology?

A. Yes.

Q. How about critical care?
A. Yes.
Q. When were you boarded in anesthesiology?
A. I'm actually double boarded in anesthesiology from the Royal College of Physicians in Canada, Royal College in Canada in 1993 and the American Board of Anesthesiology in 1995, and critical care medicine from the American Board of Anesthesiology in the same year.
Q. Critical care is a subspecialty of anesthesiology, is it not?
A. Correct.
Q. You are not by training or certification an internist, are you?
A. I have training in internal medicine.
Q. To what extent?
A. Well, anesthesiology -- when I trained in anesthesiology in Canada there's a requirement of two years of internal medicine as part of the general training. General training in internal medicine is three years so I have two years. In addition to that I have two years of critical care medicine, which also covers many aspects of internal medicine.
Q. If you wanted to become board certified in

internal medicine today, could you do it with your training?

A. I don't know the answer to that. It's possible that I would be able to write the exam. They review training and they may allow me to write the exam.

Q. How about as a cardiologist? You don't hold yourself as a cardiologist?

A. I do not hold myself as a specialist in cardiology; however, I do have extensive -- I do not hold myself out as a cardiologist, but I have extensive experience managing patients with cardiac related diseases in my daily practice.

Q. Do you refer to cardiologists?

A. Yes.

Q. So when you manage patients with cardiac problems you refer to a cardiologist for what, the more complicated ones?

A. That would not be correct to say the more complicated ones.

Q. People aren't referring cardiac cases to you for primary management, are they?

A. No.

Q. People aren't referring cases to you for infectious disease management, are they?

A. People refer patients to me who have cardiac and infectious disease problems in the intensive care setting. In that area I give opinion and exercise practice in cardiac or cardiology and infectious disease matters. So in a way they are referred to me or they come to me as my patient.

Q. In an intensive care setting?

A. Correct.

Q. Now, what percentage of cases in the intensive care setting do you consult with either a cardiologist or an infectious disease specialist?

MR. DEMPSEY: And, of course, you mean medical cases?

MR. FIFNER: Yes.

A. Well, I would say, infectious disease I would say maybe 20 percent of the time there is an infectious disease specialist who I will consult with. With respect to cardiology, it's a bit different. I have two different areas of intensive care that I work in presently. I attend in a cardiac intensive care unit, so every single patient has a cardiologist that comes with them when they arrive. So I work very closely with cardiologists all the time.

Q. But in all of those cases there is in fact a

cardiologist on board?

A. Every case has a cardiologist that has been involved in those, but traditionally the cardiologist only acts as a person who follows so when the person travels outside of intensive care therapy can be continued, but they generally don't advise or direct care while it's happening in the intensive care setting.

Q. You don't primarily manage cardiac patients, do you?

A. Well, in the intensive care unit I do.

Q. In the intensive care setting?

A. Yes.

Q. You don't have patients that make appointments to come see you in your office, do you?

A. No.

Q. And have you ever in your career ever run an office where people come into your office to get primary care medicine from you?

A. Yes.

Q. When?

A. During the period of 1989 to 1993 when I was in Toronto, I also had a family practice position in an office.

Q. You did family practice medicine?

A. Yes.
Q. What percentage of your time from 1989 to approximately 1993 was in that office in family practice?
A. I would say that I performed that duty probably one day a week.
Q. And the other four days a week?
MR. DEMPSEY: Do you need to make a call?
THE WITNESS: I think it's okay. I can wait.
MR. DEMPSEY: His pager went off.
BY MR. FIFNER:
Q. The other four days a week you were doing what?
A. Practicing anesthesia.
Q. At what hospital or hospitals?
A. Several hospitals. Anesthesia or family practice, I practiced in an office.
Q. Right.
A. So I practiced in several hospitals in Toronto. Do you want me to list all of the names?
Q. What hospitals did you practice anesthesiology in?

A. Mt. Sinai in Toronto, Toronto Western, Toronto General, St. Michael's, Sunnybrook.

Q. Were you part of a group?

A. This is during my training. I trained at the University of Toronto, the University of Toronto is affiliated with all of those. They are all teaching hospitals in Toronto.

Q. And you were training to be a specialist in the field of anesthesiology?

A. And critical care. The training occurs jointly.

Q. So from 1993 to the present you have not been involved in any office setting managing patients and their illnesses?

A. I am sorry. Actually, there was no circumstance where I had practiced, but I was a volunteer at the Free Clinic in Cleveland and I did that one day a week for a period of a year. People didn't make appointments, they walked in. And that was 1997.

Q. What group are you affiliated with now?

A. I presently work at University Hospitals of Cleveland and I am a member of the department of anesthesiology there. Within that department we have a subgroup, which is critical care medicine,

which I'm also a member of.
Q. How many members of the UH department of medicine are also members of the critical care department?
A. Well, there are actually two groups of doctors who practice critical care independently at University Hospital. The department of medicine has a core group in there of three doctors, and then within the group that I'm in there are six of us and we practice critical care as well. There really are no other -- they're surgeons of different specialties who will admit patients, but once they are admitted they are cared for primarily by us.
Q. What percentage of your time during the course of a week or a month is spent in the active practice of anesthesiology, administering anesthesia in an operating room?
A. Fifty percent.
Q. What percentage of your time is actively managing intensive care patients in the ICU?
A. Fifty percent.
Q. Well, you may have administrative duties or other things. I'm not sure. It's not that obvious.

A. Essentially my administrative duties are very minimal. I have some teaching I do mostly in the clinical setting, so it's commensurate with practice.

Q. How many times have you reviewed medical negligence cases in your career?

A. A few times. I can't exactly say, maybe three or four times.

Q. What is your fee?

A. My fee is $200 an hour.

Q. Do you advertise in any journals or periodicals as being available to review?

A. No.

Q. How does somebody from the Nurenburg law firm know that you are available to review a medical negligence case?

MR. DEMPSEY: Objection.

You can answer if you know.

A. Can you ask me the questions again? How did they find me? Is that your question?

Q. Yes. How does anybody know that you are available to review medical negligence cases?

A. I had an attorney who I knew, not well, who asked me once to review this case and then it eventually found its way to this firm. Initially

it was another attorney I believe.
Q. Was that Mr. Nemeth?
A. Mr. Nemeth was associated with Mr. Powers and I think that Mr. Nemeth was the initial attorney, but this is not his area and so he had handed it over to Mr. Powers.
Q. How did you know Mr. Powers? Was he the one that you knew?
A. No. I knew Mr. Nemeth.
Q. And he asked you to review?
A. He did.
Q. How many cases have you reviewed for the Nurenburg law firm?
A. Including this one?
Q. Yes.
A. One.
Q. This is the only one?
A. Yes.
Q. Who else have you reviewed cases for?
A. I'm sorry. I can't recall the name of the firm. There was a firm. I don't recall the name.
Q. How about any attorneys?
A. No. I can't recall it.
Q. Have you ever reviewed a case and come to the conclusion -- do you keep a file on what you do for

legal persons?

A. I have a file, yes.

Q. At home?

A. At the office.

Q. So you can produce that for us as to what you have done and for whom?

A. Yes, unless it's -- the information is confidential, though, is it not?

Q. No.

A. Okay. I don't know.

MR. DEMPSEY: Well, if a request is made, we will look at it and we will advise accordingly.

Are you asking if he has reviewed for plaintiff or defendant? I'm not sure I understand what you want.

MR. FIFNER: Well, he has a file of whatever he has done as far as medical legal work.

BY MR. FIFNER:

Q. Presumably it has in it if he has ever been deposed, deposition transcripts.

A. I have never been deposed. This is the first time and I have done maybe three other cases and honestly it's been infrequent and I have acted for

both physicians and also for plaintiffs.
Q. Can you tell me the names of any attorneys either on behalf of a physician or on behalf of a patient that you have reviewed a case for?
A. I can't bring it to mind. There is a local law firm and it was on behalf of a physician. It's a large law firm. It's not this firm. I'm sorry. I can't recall it, but I could locate the file in my office and I can get the name of the firm. It's a woman attorney and I can't recall her name.
Q. Have you had an opportunity to review the reports of Dr. Brinkhorn and Dr. Watts?
A. Yes. The ones you have just given me?
Q. Yes.
A. Yes.
Q. Now, you have written some reports in this case as well?
A. Yes.
Q. Do you have retained anywhere any of the correspondence that any of the attorneys have sent to you?
MR. DEMPSEY: Objection. Any correspondence to him would be work product.
MR. FIFNER: Well, I am

not persuaded that it is, but I have a right to know whether that exists and then we will fight later as to whether or not it's work product. So my question stands.

BY MR. FIFNER:

Q. Have you retained anyplace any of the correspondence that was sent to you by any of the attorneys who have ever represented Mose Johnson at any point in time?

A. I think all the correspondence I have are here maybe. I don't -- the letters that I have are -- I don't even recall. I don't think I do. There was nothing in them that was substantial.

Q. I'm not interested right now in what's in them. See, for example, you got sent the EMH chart and there's a cover letter from Mr. Spisak.

A. Right.

Q. Now, when you got the autopsy, did it just magically appear in the mail or was there a cover letter with it explaining what it is?

A. There must have been a cover letter. I don't know where the cover letter is.

Q. I don't see any of these letters. I could understand a couple, one or two, being misplaced, but I see a lot of different information here. Is

it your recollection that all of this information came with cover letters?

MR. DEMPSEY: I can tell you all the depositions came from me and I sent a cover letter with them.

MR. FIFNER: I would have assumed so.

MR. DEMPSEY: Yes, I did. The depos came from me.

BY MR. FIFNER:

Q. You don't have any idea where any of those cover letters or anything went?

A. I can tell you that if there was nothing in them that was more than just "here is the file," I probably would have just thrown it in the garbage.

Q. Did you ever to your recollection get any letters that had any substance to them, any description of what this case was about?

A. No.

Q. Now, you have only done this a couple times?

A. Yes.

Q. How did you know what to do? There was no letter to you explaining what you were supposed to be doing?

A. Well, I had conversations with people where

attorneys asked me, they said, this is exactly the language. This is how the law thinks of this.

Because I am not an attorney and so I am speaking like a physician if I am asked a medical question, so I was instructed on occasion -- or instructed generally with respect to what the law is interested in. Then I was asked, with this instruction are you able to speak on this? And it was something to that effect.

Q. Have you ever generated any other letters to any attorneys involved in this case on behalf of Mose Johnson other than these two letters? One is November 12, '97. The other is May 18th, 2000.

A. Not to my recollection, but I believe not. This has been going on for a little while now so I don't recall, but I don't believe so.

Q. At the time you wrote -- and I'll give you the letters, November 12, 1997 and the other one I have. I will give you those. Take a look at anything you want to look at here. What I want to do is talk about some of your opinions.

A. Sure.

Q. At the time you wrote this letter in November of 1997 had you been asked by the patient's attorneys to review the conduct of either the

emergency room or the hospital?
A. No.
Q. Do you have any kinds of notes when you go through this information? Just how does this letter get generated? Do you generate notes and then dictate from that? Do you just review it all and dictate this letter off the top of your head? How does a letter like this get generated?
A. I review it. And then I may as I'm reviewing it, I may make a few notes to myself on a piece of paper.
Q. Where is that piece of paper with those notes?
A. I don't know. I don't save those. Once I generate this copy, I discard those.
Q. Do you know what information you had available to you to review at the time you wrote this letter of November 12, 1997?
A. This chart here.
Q. The chart of Dr. Naeem?
A. Yes. The chart of Dr. Naeem is what I had.
Q. Anything else?
A. I think I had the autopsy. I think I had the autopsy, the chart of Dr. Naeem, the emergency room record. But as I recall I was only asked to review the chart of Dr. Naeem and that was all that I was

reviewing at the time, and the autopsy record I guess.

Q. When is the first day that you believe that Dr. Naeem's conduct fell beneath accepted standards of care in his treatment of Mose Johnson?

A. On the periodic health examination, which was dated I believe it was November 3rd, but I have to look again.

Q. Okay. Go ahead. Take a look.

A. This one here, November 2nd, 1996.

Q. What is it that you believe fell beneath accepted standards of care with regard to this visit?

A. Two things. Actually, maybe more than two. The first thing is that Mr. Johnson clearly was an individual who was at high risk for coronary artery disease based on his weight, his age, his gender, his family history, his tendency towards hyperglycemia, his smoking history, his obesity if I didn't mention that. These are all strong risk factors and predictors of coronary artery disease.

At the time of the examination he performed an electrocardiogram. I believe that subsequently was found to have abnormalities.

Q. Were those acute or chronic abnormalities?

A. One cannot say because there has to be another electrocardiogram. However, those abnormalities were of a significant nature and highly suggested the presence of active coronary artery disease. The abnormality is the elevated white blood cell count, which was not, as far as I can ascertain from the records, fouled up in any way. It wasn't commented on. It wasn't broken down in any other way.

The temperature wasn't taken at that time, which would have helped determine whether that elevated white blood cell count indicated infection, which I believe that it did.

Q. What was the nexus? Do you see any place on that record that Mr. Johnson had any open area on his body?

A. No.

Q. How did that -- if you believe it constituted infection, how did that infection get in his body?

A. It could have been as trivial as a scratch, which clearly he didn't strip him naked and examine every square inch of his body. So the fact that no open area was seen in this examination in no way rules out that as a possibility.

Q. What was the WBC?

A. It was 12,900.
Q. What is normal for that lab?
A. Well, normal is between ten-five and eleven. This particular lab I cannot say, but I can't imagine it would exceed eleven.
Q. Now, is 12.9 with an upper limit of normal of eleven, is 12.9 what you would consider to be markedly elevated?
A. Markedly elevated? No. Elevated? Yes.
Q. Well, 11.1 would be elevated as well, wouldn't it?
A. Yes, it would be.
Q. Now, do you see in your review of the records any other possible explanation for his elevated WBC?
A. Other than what?
Q. Infection, which you posit that it is.
A. Do I see any other evidence for something other than --
Q. Is there any other possible explanation for a WBC of 12.9 in Mr. Johnson as of November 2nd, 1996 other than the infection which you believe it shows?
A. Well, if Mr. Johnson did not die of an infectious complication, I would say, yes, there

are other possible explanations.
Q. What are they?
A. Heart disease can elevate the white blood cell count.
Q. Okay. Anything else?
A. Any kind of injury of any variety can elevate a white blood cell count. There are things that can be done that can help discern whether or not this is infection. Those things were not done.
Q. What can be done to discern it?
A. The white blood cell count can be fractionated; that is to say, the components of the white blood cell count can be examined. Certain kinds of white blood cells predominate in certain kinds of conditions which can support or refute a diagnosis of infection. That was not done.
Q. Are you suggesting that every single elevated WBC that an internist or family practitioner gets which is elevated must be fractionated in order to meet accepted standards of care?
A. No, I would not say that.
Q. Okay. Then what about what's going on here? You are the attending doc. A guy comes in and he has a WBC of 12.9. You also know he has coronary artery disease. You also already know he

is status post a recent injury, don't you?
A. With regard to the coronary artery disease, there is nothing here that indicates to me that Mr. Johnson thought he had coronary artery disease. This really doesn't make any mention of it. Dr. Naeem doesn't make any mention of it, so I would discount that. I am saying that, yes, it is possible.
Q. And he had a recent injury, didn't he?
A. Yes, he did.
Q. That could explain it, too, couldn't it?
A. It could, except he doesn't comment on it. Because he doesn't comment --
Q. What do you mean he doesn't?
A. He ordered the test. The test comes back. It's abnormal. It's his responsibility to find out why, to speculate, to decide, to determine the reason for it being elevated. He does no such thing, so I can't know what he was thinking because it's not down here.
Q. Have you had a chance to review his deposition?
A. I have, but he --
Q. Go ahead.
A. I don't recall him specifically, but perhaps

you could show me where he talks about the white blood cell count and breaks it down. But he didn't take a temperature, which would have been a simple enough thing to determine whether this was something at that time. The test was available at the time of this note.

Q. Have you read the wife's deposition, Mrs. Johnson's?

A. I have, but if there's something that's specific you want me to comment on, you will have to remind me.

Q. Do you see any indication in Mrs. Johnson's testimony that Mr. Johnson on or about November 2nd, 1996 was complaining of any cardiac symptoms?

A. His lack of complaint does not in any way exclude the fact that he had coronary artery disease. The reason why I know this to be so is because the autopsy confirmed the presence of extensive coronary artery disease, which could not have happened in three weeks. That was there before.

Q. Do you remember Mrs. Johnson testifying that he had no fever or chills or any other symptoms similar to that?

A. The absence of the fact that she may say that

also does not mean that he does not have a fever. A fever can be raised very slightly and it may be imperceptible if she didn't take a temperature and also fever tends to be periodic. It waxes and wanes in the presence of infection. It may be occurring at night for all we know.

Q. To a reasonable degree of medical probability can you look this jury in the eye and tell them you know had a temperature been done on November 2nd, 1996 it would have been elevated?

A. Because he died of infection I would say that on the balance of probability -- I'm not sure of the word that you used -- it would be my opinion that, yes, it would be elevated.

Q. To a reasonable degree of medical probability had it been done it would have been elevated?

A. Yes.

Q. Now, you wrote an entire report of November 12, 1997, didn't you?

A. Yes.

Q. And you had a chance to review the autopsy at the time you wrote that letter, didn't you?

A. Yes.

Q. You had a chance to review the death certificate, didn't you?

A. Yes.
Q. You never once in that entire letter ever mentioned infection, did you?
A. No.
Q. Never once suggested in that letter that infection was a cause of the death, did you?
A. If the reason why I would have -- I was asked a very specific kind of question, and so the fact that I did not comment on it at the time of the letter does not mean I didn't consider it. It means I wasn't asked to comment on it.
Q. But you don't have any letters to prove that you were asked to comment on it?
A. No.
Q. Nor do you have any notes that suggest that you were asked to comment on it?
A. No, I don't.
Q. All we have is this letter?
A. Yes.
Q. And this letter doesn't suggest in any way that infection played any type of a role in Mr. Johnson's death, does it?
A. No.
Q. And now you are going to try to tell this jury that to a reasonable degree, despite the fact

infection waxes and wanes and despite the fact that sometimes these elevations in temperatures are almost imperceptible, you are going to tell this jury that you can predict to a reasonable degree of medical probability on November 2nd he would have had an elevated temperature at that very moment when Dr. Naeem took his temperature?

A. I don't know when you say -- I think it would have been very likely. So I'm not sure if I'm using the words that you want me to use.

Q. To a greater than 50 percent likelihood?

A. The fact that he died of a very serious infection three weeks later I would say there's a good chance greater than 50 percent that he would have had an infection or would have had a temperature.

And there was another occasion where he saw him, too, a few days later where a temperature also was not taken, so he had another opportunity.

Q. Have you ever been responsible for -- what did Mr. Johnson die from?

A. Mr. Johnson died of coronary artery disease, ischemic heart disease and a complication related to an infection.

Q. What was the immediate cause of death to your

understanding?
A. Well, cardiovascular collapse related to overwhelming infection in a person who had significant decompensated cardiac function.
Q. Are you suggesting that based upon the examination of November 2nd that Mr. Johnson's underlying cardiac status would have been altered by the time of his death?
A. Definitely.
Q. Okay. Now let me ask you this. You have never been primarily involved in the management of a nonintensive care cardiac patient, have you?
A. Well, in the capacity as a family physician I have referred patients to cardiologists. I am not a cardiologist. I have never performed a stress test if that's what you mean. I have never performed an angiogram.
Q. Are you qualified to interpret the results of those stress tests?
A. Angiograms?
Q. Yes. Or do you leave that to the cardiologists?
A. I know how to read them if that's what you are asking me.
Q. You don't get involved in the decision of who

is a surgical candidate and who is not?

A. I do, actually in my capacity I do cardiac anesthesia, and critical care patients may come and need surgery, so I am a person that's involved in the decision of whether or not they will be fit for surgery.

But whether or not surgery is better than medical therapy, sometimes patients are not good surgical candidates and so in that way I may say, well, I don't think that this patient should have surgery, although if they were in another kind of state, then perhaps surgery would be better, and I think we have to do medical therapy at this time because of the -- from the perspective of the operation and they wouldn't have a good outcome.

Q. You have never performed the surgery?

A. No.

Q. You are not a surgeon by training?

A. No.

Q. Do you still consider yourself qualified to tell this jury whether this patient was a candidate for medical management or surgical management?

A. Yes, I do.

Q. And you haven't ever done this surgery?

A. I have never done the surgery.

Q. You've never done anything surgical?
A. But cardiologists have never done surgery and they know when a patient needs surgery or medical therapy. The act of performing the surgery doesn't make a person capable of deciding when surgery needs to be performed.
Q. Do I understand you to be saying that within a period of 10 or 12 or 14 days after November 2nd this patient would have been in, according to your hypothesis, would have been in an operating room having coronary bypass surgery?
A. It would be my opinion that if this person was referred to a cardiologist in a timely fashion and his stress test would have been performed it would have positively led to the presence of a coronary angiogram, which would have revealed extensive coronary artery disease, the treatment of which would be coronary bypass grafting. Had that been done, that would have prevented what I believe to be a myocardial infarction.
Q. And do you believe that if the MI had been prevented that he would not have died from the bacterial pericarditis?
A. I think that is what set him up for the pericarditis.

Q. So you believe that the results of the November 2nd EKG were so dramatic that the standard of care required immediate referral to a cardiologist?

A. Yes.

Q. And at that point in time was he having any cardiac symptomatology?

A. According to Dr. Naeem's record and the way that he records asking the questions, no. However, it depends on how you ask them. It depends on who is asking them. It depends on how often they are asked. Traditionally cardiac symptomatology can present very subtlely. Some patients tend to exclude things they think to be insignificant.

Cardiac pain can be felt as pressure, as fullness, as indigestion, as jaw pain, as arm pain. These are all things that can be cardiac pain.

Q. I am not interested in what might be. I am interested in this case. You tell me where you find evidence to support your proposition that Mr. Johnson had any cardiac symptomatology as of November 2nd, 1996. Show me.

A. He had an electrocardiogram --

Q. Show me where he had any cardiac complaint, cardiac symptomatology as of November 2nd, 1996.

MR. DEMPSEY: Can you let him finish his answer?

MR. FIFNER: Yes.

MR. DEMPSEY: He started to speak.

BY MR. FIFNER:

Q. He had an abnormal EKG?

A. He had positive risk factors for coronary artery disease.

Q. My question is, you show me where in this chart you find any evidence to support your belief he had positive clinical cardiac symptomatology as of November 2nd, 1996, any of those symptoms that you suggested that he might have had.

A. You are going to have to ask me more specifically because the absence of complaining of crushing chest pain does not in any way exclude coronary artery disease.

Q. My question is very simple.

A. He doesn't say anywhere, I have crushing chest pain.

Q. He doesn't say anywhere else anything consistent with cardiac symptomatology, does he?

A. It's not -- you are asking me -- you are framing this in a way that I don't think speaks to

the problem here.

Q. You let me decide what the problem is. Just answer my question.

Is there any place in this record where Mr. Johnson is noted to have any complaints consistent with cardiac symptomatology?

A. Maybe it would help me if you told me that list and then I can tell you yes or no.

Q. It's the very list you just went through, numbness in the arms, problems in the jaw, chest pains, all of the symptoms that you said he might have.

A. I don't see that he asked those questions.

Q. Have you read --

A. He didn't ask them and he didn't volunteer them so I don't know.

Q. Have you read the deposition of Mrs. Johnson?

A. Yes, but I can't remember it so you are going to have to -- if you want me to -- I will have to look at it again if you want me to talk about it.

Q. Do you remember reading in there that she was asked those very questions and she denied that her husband had any of those complaints?

A. I don't recall.

Q. You never got her deposition, did you?

A. Perhaps I didn't because I can't recall it.
Q. Okay. I see Jane May. I see Marion Prince. I see Rose Fenik. I see Dawn Sturgeon and I see Akbar Naeem. You haven't even been sent her deposition, have you?
A. If it is not there, the answer would be, I don't recall it here so I don't think I have it.
If she had said that, as you say, which I'm sure you are recording it accurately, her lack of saying that does not exclude the fact that he had coronary artery disease.
Q. I understand your point. What is it that is so -- what do you believe a reasonable time period would have been between the interpretation of this EKG by Dr. Naeem and this patient showing up in a cardiologist's office to begin the process of evaluation?
A. Well, let me tell you what I would have done.
Q. I'm not interested in what you would have done. I'm interested in what you believe a reasonable physician should have done under this circumstance.
A. Well, then I'll say within a week of this he should be in the office of a cardiologist and perhaps sooner. And the reason why I say that is

because I would ask the questions again. That's what I would do. I would bring him in again and I would say, look I have this abnormal electrocardiogram. Let's go over this now. And I would ask the questions again and if he at that point said, oh, you know what, now that you mention it, there are circumstances where I get pressure, or, there are circumstances where I get these things, then I'd refer him to a cardiologist that day. If the patient is at high risk, I think he should be seen as soon as possible.

Q. But we know from the wife's deposition he didn't have any of those symptoms so there is no valid reason to assume he would have related those on that day, is there?

A. The wife is not a good person to ask. I wouldn't take what she has said as excluding the presence of those symptoms. I don't know the nature of that relationship. I don't know the nature of how they conversed. And typically when I speak to people who are patients, people are not historians and so they don't know how to tell a story. So one of the things as a doctor is the responsibility to teach them how to speak in words and tell a story and it could take more than one

occasion to get the stories right.
Q. Are you assuming for purposes of your testimony -- now, you have told me that it could be within a week or sooner. What if all of this discussion with Mr. Johnson failed to elicit any clinical symptoms of cardiac disease? What then would have been the time frame that would have been appropriate for him to be seen in a cardiologist's office?
A. Well, I can't answer your question that way because if he would have had -- I think it's unlikely that he would have had no symptoms. The reason I say that is his coronary artery disease was extensive. If he would have been asked properly, then he would have -- or what would have happened is this: He would have said, sir, do you exercise? And he would have said perhaps, no, I don't. So he may never get his heart rate up very fast in order to uncover decompensated coronary artery disease. I can't exclude it. Then I would have to say I assume it was there. And I would have to try to get it to happen quickly.
Q. Is there any type of correlation between sudden death among those people who have cardiac symptomatology versus those people who don't have

cardiac symptomatology?
A. Yes, there is a correlation. People can have sudden death.
Q. They can, but don't most people who suffer sudden cardiac death have cardiac symptomatology as well?
A. In fact, people who have angina usually do better with their MI than people who don't, and the reason is because if you have angina and don't have myocardial infarction, usually you have collateral circulation in the people who drop dead and don't get symptomatology. So the absence of symptoms in no way excludes coronary artery disease.
Q. Does it make a difference, though, as to the time frame in which the standard of care requires that they be seen in the cardiologist's office? In other words, if he doesn't have cardiac symptomatology, is it okay for him to be seen in two weeks, in three weeks, in a month, or does everybody have to be seen within one week regardless of whether they have cardiac symptomatology?
A. I would think that -- I think that's a -- I'm sorry. I think it's a hard question to answer because ideally people should be seen as soon as

possible. That's what people will say. So to say it's seven days, eight days, ten days --

Q. You are the one that is telling the jury that my doctor deviated from standard of care. Is there a difference as to the standard of care when a patient should be seen in a cardiologist's office?

A. I would say there's probably two or three ways one could classify this. People who are clearly having symptoms, unstable symptoms, in front of your eyes should be seen immediately. People who have no symptoms at all, you know, probably can wait longer.

Q. How long?

A. I think it would depend upon how suspicious I was. The more suspicious I am, the more quickly I think they should be seen.

Q. How long in this case, assuming that he had no cardiac symptoms, what's the minimum length of time -- what is the maximum length of time that could elapse and meet accepted standards of care before seeing the cardiologist?

A. The reason why I can't answer that exactly as you asked is because the piece of information that's missing is, what are his symptoms.

If he had come back, if he had on the basis of

this electrocardiogram called him back and said, come back, let's talk about this, and in particular do you have this and he was able to get a good story and document it well and he had actually no symptoms whatsoever, then he can probably wait two, three weeks. Okay?

If, on the other hand, if he asked him the -- and only reason why I say that is I appreciate that things get backed up and so on. No one would say that's acceptable per se. That's just what is the difference between what is acceptable and what isn't.

Q. Now, Dr. Naeem does not control how long it takes to get into that cardiologist's office, does he?

MR. DEMPSEY: Objection.

BY MR. FIFNER:

Q. He calls up and the appointment gets made when the appointment gets made, right?

A. Yes and no. Not really because a referring -- I think that the family practitioners are the people that fuel health care. So they call up the cardiologist and say, look, I got this guy I want you to see as soon as possible because of these reasons. The cardiologist just says, okay, I will

fit him in as soon as I can.
Q. What did Mr. Johnson do for a living?
A. I don't recall.
Q. Was he working up to the time -- was he working up to November 2nd, 1996?
A. I believe he may have been at that time not working, but I can't recall.
Q. Why?
A. I think he had an injury that had sidelined him.
Q. The hip injury?
A. I believe so.
Q. And was his job an on-his-feet job or a desk job?
A. I don't think it was strenuous work, but I'm sorry, I just can't recall.
Q. Now, he gets into the cardiologist's office. What do you think is going to happen once he gets into the cardiologist's office?
A. The cardiologist will probably repeat the electrocardiogram, ask him some pointed questions.
Q. Then what?
A. Then he would order some kind of provocative stress testing and there will be a couple of varieties that will occur at that time.

Q. Do you ever order outside stress testing?
A. I refer people to -- I do refer people for those kinds of tests.
Q. Do you ever write the order?
A. I don't understand the question. What do you mean write the order?
Q. Do you ever write the order for a stress test or do you refer them to a cardiologist?
A. I refer them to the cardiologist.
Q. Who then writes the order?
A. Yes.
Q. What is in Lorain, Ohio the average length of time between the writing of an order for a stress test and the actual test?
A. I don't know.
Q. What's an acceptable period of time?
A. In Lorain, Ohio? I don't know. In my opinion what is acceptable would be a very short period of time.
Q. Tell me what.
A. Well, I think it should be less than -- I think it would depend upon the symptomatology. If the symptomatology is great, then the stress test should be immediate. If the symptomatology is absent, then again perhaps a week.

Q. So if Mr. Johnson was absent symptomatology, it could be as long as three weeks before he gets to the cardiologist to begin with and it could be another week before the stress testing gets done?
A. Except we don't know whether Mr. Johnson was absent symptomatology.
Q. Now --
A. And I don't think I said three weeks. I think I said two, or one actually, maybe one week and then another week, so that's two weeks. That still would have been before he died.
Q. Well, the record speaks for itself what you said.
A. Uh-huh.
Q. Now, the stress test comes back. How long does it take? What in your opinion does the stress test show?
A. It will show -- well, as the stress test is being performed it would be reviewed at that time. The stress test, I believe, will show abnormalities. It will show ischemia. I believe it will show ischemia of significant nature. And then it will be reviewed and a recommendation will be made to perform a coronary angiogram.
Q. How long does it then take before you do the

coronary angiogram?

A. It should be done very soon, immediately, within a day, that day or the next day probably. He would have to be fasted, so it should be performed the next day or the day after. However, he might stay in the hospital. If he had a very serious stress test, he might stay in the hospital and be put in the coronary care unit and be monitored.

Q. Can you say to a reasonable degree of medical probability that's what would have happened here?

A. I can't. I can't say that.

Q. So now what's the coronary angiogram going to show?

A. The blockages that he had at the time of his autopsy.

Q. What were those?

A. I would have to review the record again because I can't recall.

Q. Let me ask you this before you take a look at the record. How much time had you spent reviewing these records before your original report in November of '97?

A. You mean hours or --

Q. Yes.

A. A few hours.
Q. Have you generated any fee bills? This has been going on for at least two, three years. Have you generated any fee bills?
A. Maybe on three occasions.
Q. Where are those fee bills among your records?
A. I think that perhaps they are with the attorney.
Q. You don't keep a copy of them?
A. No.
Q. You don't have a copy of the fee bills?
A. No.
Q. How much time have you spent in review of this case?
A. Well, let me say that I thought about this case a lot. But how much time I billed for it, it was probably on the order of maybe nine hours of time.
Q. And how much have you thought about this case?
A. Well, lately I have been thinking about it a lot.
Q. Okay. How much?
A. Well, I have been thinking about it, you know, for the last few weeks coming up to this deposition, probably a little bit every day or

every other day, a few minutes periodically in the day I think about it.

Q. Just give me a total.

A. Let's say 20 minutes a day for the last week.

Q. So that's another four or five hours, 20 minutes a day for the past week?

A. Probably.

Q. It's not that much. It's a couple hours.

Now, prior to today, prior to this moment today have you reviewed any textbooks or literature to assist you in determining what might be the applicable standard of care for Dr. Naeem?

A. Yes.

Q. What textbooks or literature did you review in order to assist you?

A. I looked at Harrison's Internal Medicine, Cecil's. That's a book on internal medicine. I talked with other colleagues.

Q. Who did you speak with?

A. I talked to a cardiologist who I work with.

Q. Who?

A. That was actually back in -- not now. That was back in 1997 and I cannot remember the name that I was --

Q. Why did you consider it necessary to look at

Harrison's and Cecil's and speak with another cardiologist about your review of this case?

A. Because that's the way that doctors think.

Q. Do you consider either Harrison's or Cecil's to be authoritative in the field of internal medicine?

A. Yes. However, textbooks generally are not the most up-to-date depending on the area. It depends upon -- generally these things are considered to be reasonable textbooks.

Q. Do you consider either of them to be authoritative?

A. Generally, yes.

Q. Did you find anything in your review of either Harrison's or Cecil's which assisted you in formulating any of the opinions that you have rendered or will render in this case?

A. Not specifically, not more than -- I guess perhaps I should say nothing that changed my opinion.

Q. Do you hold the underlying belief that Mr. Mose Johnson was a symptomatic patient in terms of coronary artery disease?

A. Well, I think Mr. Johnson was a good patient in that he came to his doctor regularly. He --

Q. Can you answer my question? Do you consider him to have been symptomatic in terms of his coronary artery disease?
A. I believe if he had been asked specifically, that he would have had symptoms.
Q. There certainly are patients who have this degree of coronary artery disease who are symptomless, aren't they?
A. Absolutely.
Q. What allows you to say that Mose Johnson would have been one of those people who had symptoms as opposed to one of those people who did not have symptoms?
A. Because of the extensive degree of his coronary artery disease.
Q. We agreed that people with that degree of coronary artery disease can produce asymptomatic?
A. Yes.
Q. So what allows you to classify him as somebody who was symptomatic?
A. It's my opinion. Beyond that I cannot give you some magic explanation that he has got something in particular that makes it likely. That's my opinion based upon my experience.
Q. So what do we do with the results of the

angiogram?

A. So you are saying now, let's say we have an angiogram that shows coronary artery disease, what is the next recommended therapy?

Q. Yes.

A. It would be bypass.

Q. Was this patient capable of being medically managed?

A. With this degree of coronary artery disease, the indications for bypass would have outweighed the medical. He would have been sent for coronary bypass grafting instead of medical therapy. Medical therapy also would have been initiated.

Q. How soon would this bypass grafting have taken place? What's a reasonable parameter under these circumstances within which to have had the coronary bypass grafting?

A. Well, I can tell you that in my hospital that if someone comes in and has this kind of angiogram, they can be done the next day.

Q. What about in Lorain, Ohio or Elyria, Ohio?

A. I don't know the availability there of coronary artery bypass grafting in 1996 when he died. I can't answer that question.

Q. Do you believe that the groin pain and leg

pain that Mr. Johnson was suffering from in any way related to his pericardial infection?

A. I don't know. The groin and leg pain are puzzling to me, puzzling because he kept complaining of it and therapy, fairly aggressive therapy that would have fixed musculoskeletal pain, did not correct it, and the autopsy did not reveal any obvious abnormality. So I don't know. It's odd to me. But the fact that he kept complaining about it and the fact that therapy wasn't making it any better would have raised a flag in my mind. It would have raised something in my mind that there is something here that is missing.

Q. And we could have done MRIs and CTs until we were blue in the face of this area and it wasn't going to show us anything?

A. Probably not.

Q. Have you ever been involved in managing -- first of all, let me ask you this. Have you ever been involved in the primary diagnosis of bacterial pericarditis?

A. Yes.

Q. Primary diagnosis?

A. Yes.

Q. When?

A. In the intensive care unit.
Q. Have you ever been involved in primarily managing bacterial pericarditis?
A. Yes.
Q. How many times?
A. It's not a common condition so maybe two times.
Q. Were you the primary manager or was an infectious disease consult called?
A. Well, it would have been something that I would have determined and then perhaps I would have had an infectious disease consult because it was unusual, and in teaching hospitals we tend to do that. My practice has been primarily in teaching hospital settings. The information is shared. But when a consultant comes on the case they don't take over the case. They make recommendations. It's still up to me to decide whether to take those recommendations or not.
Q. Now, what are the classic, if you will, symptoms of bacterial pericarditis?
A. Well, I think that there are classic symptoms of pericarditis first of all.
Q. What are they?
A. The classic symptoms of pericarditis are sharp

pain felt in the chest that may be positionally related and exacerbated by deep respiration, which distinguishes it actually from classic angina pain that is not related to position nor is it related to inspiration. The pain might be more stabbing in nature and usually angina pain is not of a stabbing nature.

Q. When is the first time, according to your review of the records, that Mr. Mose Johnson ever presented to anybody with symptoms consistent with pericarditis?

A. The day of his death.

Q. That's the first day?

A. That's the first day that he was there and saw someone, so the day, I guess, when he went to see his family doctor, the day that he died. At least that's when it bothered him enough to say something about it. Whether or not it had been bothering him for several days before that, I don't know.

Q. With the appropriate medical treatment, was Mose Johnson salvageable on the date of his death?

A. No, probably not.

Q. When is the last date that you believe Mose Johnson was capable of being saved with appropriate medical management?

A. Well, certainly the day that he was prepped for the emergency room, and then to his doctor. That would have been the time I believe because at that time there was no evidence of pericarditis that I could determine. Again, those questions weren't asked specifically and he may not have volunteered them.

Q. Why do you believe he was capable of being saved on the date of this last emergency room visit?

A. Because I think he would have, if vital signs had been obtained, I think he again would have had a temperature.

MR. DEMPSEY: By the way, the last emergency room visit was on the day of his death. Do you mean the one prior? Are you talking about the 10th of November?

MR. SPISAK: Would you read the last question and answer?

THE NOTARY: QUESTION: "Why do you believe he was capable of being saved on the date of this last emergency room visit?"

ANSWER: "Because I think he would have, if vital signs

had been obtained, I think he again would have had a temperature."

BY MR. FIFNER:

Q. To a reasonable degree of medical probability what do you believe that temperature would have been?

A. More than normal.

Q. Why did he go to the emergency room?

A. He was complaining of the hip pain.

Q. Can pain cause an elevation of temperature?

A. Some pain can if it's a consequence of something else; pain per se, no.

Q. What was Mr. Johnson's pain a consequence of?

A. I don't know.

Q. What about trauma?

A. I think -- can I just say I think the thing that's unusual about the pain that he had is he received an overdose of the Ketorolac, the Toradol, 60 milligrams, which is twice the recommended dose and which is equivalent to a fairly strong narcotic, although it's not a narcotic itself, and he had no resolution of his symptoms, which is unusual.

MR. DEMPSEY: You are on the second last emergency visit?

THE WITNESS: Yes, not the day of death.

BY MR. FIFNER:

Q. November 10th?

A. Yes. So something was unusual about that pain and I can't explain it.

Q. And neither did the autopsy?

A. The autopsy did not show any abnormality that an autopsy can detect.

Q. So if Dr. Naeem or the emergency room would have come to the same conclusion you did, that there was something abnormal about this pain in the hip, they could have sent him for an MRI and that would have been negative, wouldn't it?

A. I don't know.

Q. Well, the autopsy came up negative, didn't it?

A. Something may have changed at that time. I don't know.

Q. The CT scan would probably have come up negative, wouldn't it?

A. I can't comment because I don't know what the nature of the pain was. It's possible that the pain was being referred from some other place. Pain can originate in some place and be felt in another.

Q. You are not going to say to a reasonable degree of medical probability that what was in his hip was referred pain, are you?
A. Well, I don't know in that there was nothing defined on the examination of the hip, and the pain was severe. So if the pain was in fact from the hip, something should have been there in the hip to see in an x-ray, some inflammation of the skin, something. So I think it's possible that it might have been referred pain, but I don't know from where. I am not going to tell you it's from the heart. I mean, I don't know. I have never heard of heart pain being felt in the hip. That's a new one on me.
Q. So even if the doctors were thinking that there was something abnormal about his hip pain, and even if they got to the next step suggesting that this was perhaps referred pain, they still wouldn't have made the link and said this is now suggestive of cardiac symptomatology?
MR. DEMPSEY: Objection.
You can answer.
BY MR. FIFNER:
Q. Right?
A. Well, there are a lot of ifs there, and the

way people get into the system varies so once a person is in the hospital it becomes fair game, so to speak, what's done. So if they come presenting with a sore toe and upon my examination I uncover significant cardiac disease or cardiac symptomatology, then they get to stay and I get to work that problem out. So I don't know.

I think the fact that he died soon after that of significant coronary artery disease and infection, if they had started to look for some other things depending on the sequence of events, they would have began an investigation and something would have been revealed.

The fact that the Ketorolac did not take his pain away I think even raised the standard or raised the -- should have raised suspicions that something else was going on here.

Q. But that's something else that -- whose index of suspicion is being raised? Coronary artery disease or bacterial pericarditis, those are not two things that you would think would show up as hip pain, would you?

MR. DEMPSEY: Objection.

You can answer.

A. No, not that I have ever seen or heard.

Q. And if somebody would come to you and say, Dr. Zivot, I have a patient that has hip pain that Toradol does not relieve the symptoms, you are not going to tell him to be on the lookout for pericarditis or coronary artery disease?

A. Of course not.

MR. DEMPSEY: Off the record.

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

BY MR. FIFNER:

Q. Now, when a patient has coronary artery disease, does it affect their blood pressure?

A. It may.

Q. Does it affect their pulse?

A. It may.

Q. It may not?

A. It may not.

Q. Does the urgency with which someone is worked up for coronary artery disease in part dependent on the clinical symptomatology that they present with?

A. In part, yes.

Q. In part dependent upon the vital signs that they have?

A. In part.

Q. We have their clinical symptomatology. I can only think of three components. Obviously you have your test results, you have your clinical symptomatology and you have vitals. What other components go into that evaluation of how quickly they get worked up?

A. Well, where are you including electrocardiogram?

Q. Test results.

A. And there were other blood tests that may suggest an ongoing myocardial infarction.

Q. Do you have any reason to believe that Mr. Johnson had an active myocardial infarction at any time between November 2nd and November 10th?

A. I think that his electrocardiogram when he was in on his second was abnormal and he could have a myocardial infarction between that period of time. Yes, the fact that he had elevated blood sugar may have been associated with a diagnosis of diabetes. Diabetes can mask the presentation of coronary artery disease and make symptoms less felt. I don't think -- I wouldn't say he had out of control diabetes, but it is possible.

Q. To a reasonable degree of medical probability can you time the ischemic event which caused the

November 2nd EKG to be abnormal?

A. When did it occur?

Q. Yes. Was it something that happened within the two weeks previous, two years previous or 20 years previous?

A. May I look at the electrocardiogram again?

Q. Take a look at whatever you want. It's in Dr. Naeem's records. It should be at the back of his deposition.

A. This is the one on the 2nd here?

Q. Yes.

A. You asked me when do I think this happened?

Q. Yes.

A. Well, what he does not have here are pathological Q waves. Now, Q waves would suggest that he was infarcted right through his entire myocardial wall. So there are a couple possibilities. One is that he had a myocardial infarction that wasn't all the way through, so he has a nontransmural infarction, and I would look at it differently.

Another possibility that is happening I think -- look at this electrocardiogram. There's no way he had an infarction of ten percent at this time. So sometime between November 2nd and the day

of his death he lost a lot of function, a significant amount of function. So all I can say is that something was happening here and it might have been ongoing. It may take several days to complete or it may be a series of small nibbles.

Q. When you look at the autopsy, are the autopsy findings consistent with your interpretation of that November 2nd --

A. Yes.

Q. -- EKG?

A. What specifically are you referring to, the presence of coronary artery disease?

Q. No. The presence of any prior acute MIs and how they may have occurred.

A. Let me look again at the finding here. Well, he has blockage in the main vessels that supply his heart and he has an electrocardiogram. This electrocardiogram seems to point more towards the distribution of the right coronary artery, but he has blockage in all three. So it does not mean that -- all that means is that at the time that may just not have been revealed as much, but I think that certainly I can connect the findings of coronary artery disease, I guess, if the pattern of injury here happened to be in a place where there

was no coronary artery disease, I would say it does not correlate or does not correlate easily, but his entire heart blood supply was compromised. Anywhere that you see abnormality here can be correlated with what we know to be his corollary anatomy.

Q. When you look at the heart on the autopsy, are the findings on the autopsy of the heart consistent with somebody who had, as you say, an ongoing MI back on November 2nd, 1996 and has a series of MIs thereafter?

A. Well, there's not a -- it doesn't comment on whether there's a period of like an aneurism, which could be a consequence of an infarction.

I am just going to read the summary again.

"The sections of the heart that include the pericardium show fibrinous material on the surface with, in most of the sections, a heavy infiltration of inflammatory cells."

I would interpret that as indicating pericarditis as a consequence of a myocardial infarction. There is a condition called Dressler's syndrome, which occurs three weeks after a myocardial infarction with an autoimmune disease characterized by inflammation of the pericardium.

That could very well have been what happened to him. I believe to a -- how do you put it -- to a degree of medical certainty that he had pericarditis as a consequence of a myocardial infarction.

Q. Which occurred when?

A. Well, it occurred sometime between -- on or around the 2nd of November.

Q. And then how long after this MI does it take for the pericarditis to manifest itself?

A. It takes up to the time of his -- of the day of his death.

Q. So it takes about three weeks to manifest itself?

A. Well, manifest in what way? As symptoms or --

Q. Yes.

A. Well, it may be that it's happening, but it's not felt. It's happening, but not felt. It may take three weeks before he would feel it.

Q. And this is called Dressler's syndrome?

A. Dressler's syndrome, yes.

Q. I just want to make sure I understand what you think happened here. You think that on or about November 2nd this guy was having an MI?

A. Yes.

Q. And we got very lucky that we happened to get an EKG demonstrating the MI going on?
A. Obviously unlucky.
Q. And you think that that MI, although it was going on November 2nd, didn't cause any cardiac symptomatology consistent with pericarditis until 21 days later?
A. Yes, possibly. They don't -- if that's -- that's a way of putting that together that's logical to me.
Q. Now, how does he get bacterial pericarditis from this?
A. Because he has an abnormal pericardium; therefore, it sets him up for any kind of trivial bloodstream infection. It could be something as innocuous as brushing his teeth.
Q. What organism was ultimately cultured here?
A. Staph aureus.
Q. Was it an aggressive form of staph or not?
A. He died. I think that's aggressive if that's what you mean.
Q. Is it possible to have abnormalities of pericardium with its resultant swelling, et cetera, and not have symptomatology?
A. Is it possible?

Q. Yes.
A. Sure.
Q. Is it likely?
A. No.
Q. Isn't it more likely that he had and was having an MI on November 23rd, the morning of his death --
A. I think --
Q. -- which is what then allowed him on that day to have symptoms consistent with pericarditis?
MR. DEMPSEY: Wait. Before you answer, he started to say something. You have got to pause a moment.
Do you have any of those words in there?
THE NOTARY: ANSWER: "I think."
MR. DEMPSEY: Clarify the "I think," if you would, so you are not addressing a portion of that sentence.
A. You are going to have to remind me what you asked. I don't remember what the "I think" was related to.
MR. DEMPSEY: You weren't answering a question. You were starting -- it

was an interruption, so wait until he finishes the question.

A. Perhaps you could ask the question again, please.

Q. Okay.

MR. DEMPSEY: Sorry.

BY MR. FIFNER:

Q. Is it also possible that what happened here was that Mr. Johnson began to have an MI on the 18th -- or on the 23rd of November, which MI caused inflammation of his pericardium and that is what caused him to have his symptomatology on the 23rd?

MR. DEMPSEY: Objection.

You can answer.

A. I think it's possible that he had another MI on the day that he died, but I think that that may have been the 2nd or more than the 2nd. I think to inflame the pericardium that acutely with a myocardial infarction is not typical.

Q. Can bacterial pericarditis present asymptomatically?

A. I can't -- I would say generally not.

Q. Can it?

A. Anything is possible.

Q. Okay. When do you believe he developed

bacterial pericarditis in this case?
A. Bacterial pericarditis I think he developed very close to the day of his death, maybe in 24 hours. I think that he had an infection that may have been there, that was there prior to that.
Q. What infection? Where?
A. In his body. I can't --
Q. In his pericardium or in his body?
A. No, not in his pericardium. I don't think so, at least I think it began -- these things take more than five minutes to develop, so I think these things take time to develop.
Q. So you think he had an infection in his body as of when?
A. Well, I think it could have been -- I think it was back to the 2nd of November.
Q. And what was the organism?
A. I don't know, maybe staph, but I don't know.
Q. What are some signs and symptoms consistent with infection?
A. Well, infection, it depends whether -- it can be something like pain in a local area. It can be fever, chills, fast heart rate, fast respiration, sweating, a feeling of being hot or a feeling of being cold.

Q. Tell me one place in the record where you see evidence Mr. Johnson had any of these symptoms prior to November 23rd.

A. Well, Mr. Johnson had pain which may have been related to infection, although I can't say because he didn't have any of those things documented, but he never had a temperature taken so I don't know.

Q. Well, whether or not the temperature was ever taken, he didn't have documented fever, chills, increased respiration?

A. Well, he didn't have it documented. If it wasn't taken, you can't document it.

Q. There's no place in the record that discusses he had any of those complaints?

A. Well, there's nothing in the record that suggests that they were asked about.

Q. Is that the kind of thing that if somebody has fever, chills, hot flashes, cold flashes, is that the kind of thing a loving spouse would know about?

A. I don't know. It depends.

Q. Are you married?

A. Yes.

Q. Okay. When you get sick and feel hot flashes or cold flashes, do you tell your wife that you are experiencing those?

A. Sometimes.
Q. Are you assuming that he had any of those symptoms in your analysis of this case?
A. I think he -- I think -- yes, I think he had some of these symptoms.
Q. And it is your understanding which one of these do you think he had?
A. Well, in him it may have been something as nonspecific as general malaise, generally not feeling well. He may have had fever. He may have had chills. I really don't know. None of those in particular can clinch the diagnosis or even speaks to whether it's mild, moderate or severe. None of those things in isolation relate to the severity of the infection.
Q. So you think he had an infection in his body and that's the explanation for the 12.9 WBC 11-02-96, right?
A. I think that is likely based on the fact that he died of an infectious complication.
Q. You are not looking retrospectively. Are you evaluating the conclusion of Dr. Naeem retrospectively or prospectively?
MR. DEMPSEY: Objection.
Do you understand the question?

A. Yes. But both I guess.
Q. Prospective?
A. Certainly.
Q. You tell me what in the record as of November 2, 1996 you think it is that tells you that this gentleman is going to die in three weeks.
A. Nothing in three weeks. Nothing. I mean, I am not clairvoyant, but I think that he has an illness that ultimately resulted in his death. And if the illness had been intervened, if there had been intervention, that intervention would have prevented his untimely death.
Q. Well, he had infection in his body according to your analysis as early as November 2nd. Is that infection in his body a contraindication to the proposed bypass surgery?
A. That infection would -- if a diagnosis had been made, it depends. It depends on how sick he is. Not necessarily. Sometimes things have to happen sometimes.
Q. But you understand the dichotomy here?
A. I absolutely do.
Q. If he is well enough to go ahead and undergo this coronary bypass surgery and he is well enough to do it in the presence of this infection, then

that lengthens the period of time within which it's appropriate to do the workup, right?

A. Say that again.

Q. If he is well enough to undergo the surgery even in the presence of an infection --

A. Uh-huh.

Q. -- then that would give acceptability to a longer period of time to do the workup?

A. Why would you do that? Why would you delay it? I don't understand what you are saying. Because the infection is mild, that we can wait?

Q. No. What's the average length of time in your experience between diagnosis of coronary artery disease and bypass surgery?

A. It depends on the nature of the coronary artery disease. It could be as short as 48 hours.

Q. And as long as?

A. Well, never, because sometimes people don't need surgery. They need medical therapy.

Q. Is this a usual presentation for bacterial endocarditis -- or pericarditis?

A. At the time of death, yes.

Q. As of November 23th?

A. I think that this is -- I think that as unusual as this is, it's a presentation of it. But

at the time of death, you know, when people begin to die, it all looks the same. So how it got there, I don't know.

Q. Based upon everything you know, was there any reason to believe as of November 22nd, 1996 that this patient was going to be dead in 24 hours?

A. On November 22nd?

Q. Yes.

A. When he presented?

Q. Looking prospectively the last time -- we'll move it up a little bit, from November 2nd. The last time he presented to Dr. Naeem's office was when?

A. The day that he died or the day before he died, the 22nd. I believe he died on the 23rd.

Q. Do you have any reason to believe as of the last time he presented to Dr. Naeem's office that this was going to be a patient who was going to be dead on November 23rd based upon the findings of Dr. Naeem?

A. At that moment?

Q. Yes.

A. No.

Q. So looking prospectively when Dr. Naeem had this guy in his office the very last time, not

including the date of his death?
A. I think he did the right thing. On that day he said, go to the hospital.
Q. No, no, no. Look at Dr. Naeem's records. Look at the 2nd of November. You have got them right in front of you. The patient then goes to the emergency on the 10th and the emergency does a workup.
A. Yes.
Q. When does he next see Dr. Naeem?
A. He sees him I think the day after or the day after that.
Q. The 11th?
A. Yes, because he was still complaining of the pain.
Q. Does he see him again before the date of death?
A. On the 18th.
Q. Take a look at the records on the 18th. Take a look at that record.
A. He gives him Relafen and a sitz bath and he does not comment there on the previous findings that he uncovered.
Q. What previous findings?
A. Electrocardiogram, the white count. So what

do you want me to comment on?
Q. Look at that record and look at the emergency room record of the 10th and Dr. Naeem's record of the 11th.
A. Yes.
Q. Any reason to believe this patient is going to be dead on the 23rd?
A. I don't know where you are going with this because I guess people can walk up the street and be hit by a car. There's nothing in there in those two lines that make me think that he thinks he was going to be dead.
Q. Have you read anything in the deposition that gives you reason to believe that this is a man who left untreated is going to be dead on the 23rd of November?
A. Well, I don't think so because if they thought that, they would have done something about it. I am sure that they would have wanted to prevent his death. So the fact that they didn't suggests to me that they didn't think that.
Q. Based upon your interpretation of this EKG November 2nd, is this the classic EKG of a patient who is going to be dead in three weeks?
A. That's an impossible question to answer. I

think this is a classic presentation of a person who is a candidate for coronary artery disease and should be seen in a timely fashion.

Q. Do you believe that the bacterial pericarditis played any role in this patient's -- I want to make sure I understand the timing. The MI that you believe was occurring November 2, was that caused by bacterial pericarditis?

A. No. Bacteria can't cause a myocardial infarction generally.

Q. Do you believe that there was another MI caused or there was another MI on the 23rd?

A. Possibly.

Q. Not probably?

A. Probably.

Q. What was the cause of that MI?

A. Coronary artery disease.

Q. So to your analysis the bacterial pericarditis really played no role in anything here?

A. No. I don't think the bacterial pericarditis caused him to have a myocardial infarction. I think the myocardial infarction sets him up to have pericarditis which sets him up to have bacterial pericarditis

Q. Does he develop pericarditis as a result of

the 11-02 MI that you think happened?
A. Yes.
Q. Does he develop pericarditis as a result of the 11-02 MI regardless of how quickly he goes to the cardiologist's office?
A. No.
Q. How long does one have to wait after -- and in fact it was your interpretation of that EKG that it is an active, ongoing MI?
A. I think that it's a -- I think that that's probable.
Q. Was that EKG overread by anybody?
A. No, but that doesn't mean anything. It was not overread. We know this technology is actually superior to a human generally.
Q. Are you talking about it being computer read?
A. Yeah.
Q. Does that computer interpretation say that there is an active MI?
A. It says abnormal change possibly due to myocardial ischemia, abnormal unconfirmed analysis. It says also premature ventricular contractions, which can also be part of ischemia.
Q. But it doesn't say that there is an active MI going on? It does not say active myocardial

infarction?
A. It says myocardial ischemia.
Q. Right. And myocardial ischemia is a by-product perhaps of long-term coronary artery disease when it was decompensated?
A. Yes.
Q. Do you think that's what happened here?
A. Well, I think that something was going on here. And I think that if you had brought him in the next day and had done another electrocardiogram maybe that electrocardiogram would have said myocardial infarction. And the reason I say that is the nature of the sequence of events.
Q. There's nothing in that EKG interpretation that suggests a repeat study to be done the next day or at any point in the future, does it?
A. The computer does not make that call.
Q. Do you know whether a cardiologist from the hospital overread that?
A. I don't have any record of that.
Q. Have you ever been sued for malpractice before?
A. No. Actually, you know, I'm involved -- that's not true. I'm named in a case that is going on right now.

Q. What's the name of that case?
A. I think the name of the plaintiff is Siegel.
Q. Who is your attorney?
A. Don't know. It was the group.
Q. So what's the longer period of time that can go by after this presumed MI of November 2nd before pericarditis commences?
A. The longer period of time it would take for pericarditis to occur?
Q. Yes.
A. The longer period?
Q. Yes.
A. Well, if it's what I am talking about, then classically that takes about three weeks to set up, okay? It could also be sooner; it could be later.
Q. If it takes three weeks for the pericarditis to be set up, then wouldn't the initiation and commencement of the bacterial pericarditis have been one day in duration?
A. Bacterial pericarditis, yes; the infection, no.
Q. The infection where?
A. In his body.
Q. But we don't care about the infection in his body until it reaches the pericardium, do we?

A. That wouldn't be so. I think if he has an infection in his body we would like to know about it.

Q. I understand.

A. And we would treat it especially in any person who is overweight, diabetic, has hypertension and coronary artery disease.

Q. But that infection ultimately, according to your analysis, played no role in the ultimate outcome?

A. No. I think the infection was contributory to his death.

Q. How?

A. Because the pericarditis was part of his myocardial decompensation and the pericarditis as well is part of a global infectious process that's just a cardiac manifestation, but the active severe infection results in a release of compounds that cause inflammation and can make the blood pressure unstable, can affect the heart, directly affect the performance of the heart even in the absence of myocardial infarction, can affect the ability to bring oxygen to the blood.

Q. Do you have any reason to believe that as of the emergency room visit of November 10th that any

of that was going on?

A. No, but --

Q. How about the November 11th visit to Dr. Naeem?

A. With any of the severe things going on at the time that I described?

Q. Yes.

A. Absolutely not.

Q. How about November 18th when he last saw Dr. Naeem before his death?

A. Not of a severe nature, no. I think that there was opportunity at that point to intervene.

Q. So when is the latest -- if he goes to the latest, what you think the ER should have done November 10th?

A. Should have taken his vital signs as part of his workup.

Q. Now, if we have the vital signs, what's it going to show?

A. A temperature.

Q. An elevated temperature?

A. Yes.

Q. How could we get from an elevated temperature to a coronary artery bypass lab?

A. Well, we get from an elevated temperature to a

workup of infection. And we get from a workup of infection, a workup of his general state of health.
Q. How would you have worked up this infection?
A. I would have searched for the cause of infection with a history and then a physical examination. I would have looked at his body, listened to his chest or had a chest x-ray, sampled his urine, blood.
Q. Are you assuming after this date November 10th that this patient would have had an elevated temperature?
A. Yes.
Q. What are you assuming this elevated temperature would have been?
A. You mean the number?
Q. Yes.
A. Well, elevated is defined as greater than 37.5, so greater than 37.5.
Q. So if it was 37.6 in a patient who had a complaint of hip pain, would you have done this workup for infection?
A. Well, then I would have been concerned when one would not connect hip pain and fever. It could have been an infected joint. That would have been a concern. I think there was some evidence they

were wondering something of that nature.

The temperature, I could speculate the temperature wasn't obtained and it wasn't commented on directly and they didn't feel a need that antibiotics were necessary. So I think they discounted infection as an explanation for his hip pain.

Q. Can we assume he didn't look clinically sick on that day?

A. I can't assume that. I don't know. I don't know. I can't tell you that. All I can tell you is how I practice. I can't tell you how other people -- how it looks to other people's eyes.

Q. Do you feel that you are qualified to render opinions as to what another reasonably prudent physician in the same or similar circumstances would do?

A. Yes, I do.

Q. Do you understand the difference between what you would do personally and what represents the standard of care?

A. Yes, I do, but when you ask me how I think it would look to this other doctor's eyes, all I can do is speculate. I cannot know what this person was thinking.

Q. And all you can do is speculate as to what the temperature might have been on or about November 10th?

A. Yes.

THE WITNESS: I'm sorry. I need to get this I think.

MR. FIFNER: Go ahead.

(Thereupon, there was a brief recess.)

BY MR. FIFNER:

Q. Now, we talked about your assumptions regarding the temperature had it been taken November 10th, and you indicated whatever number you come up with would be speculative?

A. Absolutely.

Q. Same thing on November 11th when sees Dr. Naeem?

A. Uh-huh.

Q. Same thing November 12th when he sees Dr. Naeem?

A. Uh-huh.

MR. DEMPSEY: Those were yeses?

THE WITNESS: Yes.

BY MR. FIFNER:

Q. I asked you this earlier and you told me, but

I want to make sure I understand. What do you think was the actual mechanism of this man's death? What did he die from? How did it happen?

A. I think on or around the 2nd of November he had a heart attack and that set him up to develop pericarditis, commensurate in that time he had an infection. I don't know where it began.

Q. Do you know when it began?

A. It may have begun on the 2nd of November, but it may have begun later. I don't know. Your point is well taken with respect to other signs of infection. I don't know. They hadn't asked. They weren't documented. They may have or may not have been there, but the fact is he had a serious infection that takes longer than a few hours to set up.

Q. What serious infection?

A. The staphylococcal infection he had in his pericardium.

Q. Do you have any opinion to a reasonable degree of medical probability how long that infection was present?

A. The infection that was in the pericardium I think was not there for a long period of time, maybe a few days.

Q. Okay. And when the infection got in his body --
A. Yes.
Q. To a reasonable degree of medical probability can you tell me when that infection got in his body before it got to the pericardium?
A. It's conceivable -- but that's probably not the word you want me to say.
Q. No. I want you to tell me then to a greater than 50 percent likelihood when can you tell me that organism entered the body?
A. Sometime between the 2nd and the day of his death.
Q. Okay. Now, I keep interrupting you, but I want to make sure you have the general major question in front of you.
A. You are fine.
Q. What's the mechanism? How did this guy die?
A. He died of a combination of decompensated myocardial function as a consequence of coronary artery disease, and in the presence of a commensurate infectious pericarditis of a severe nature.
Q. Assuming he never had infectious pericarditis of a severe nature, could he have survived the MI

of November 2nd?
A. Possibly, but I think that the pericarditis began to very rapidly complicate the area of his myocardial infarction. All I can say is that people have pericardial infarction that have infractions of ten percent and survive. And in him, I don't know.
Q. Can you tell me what his infraction would probably have been, not speculatively, but probably would have been taken any time after November 2nd and before November 23rd?
A. I don't think that it was that severe. I think it was probably -- I mean, there are different grading systems to grade it. It really would be a three-point system. One is normal. Three is very severe and two is in between. And I should say it in quotations because that's really my own thought. There are other classifications, but I would say his was somewhere in between. The reason I say that is because if he had had that profound myocardial infarction that resulted in the fracture of ten percent, then he would have more symptomatology. The absence of symptoms indicated he didn't have the killer infarction until the day he died on or about the date he died.

Q. Can you state to a reasonable degree of medical probability that had he begun getting worked up for the WBC of 12.9, that a diagnosis of bacterial endocarditis or bacterial pericarditis would have been made?
A. Absolutely not.
Q. Okay.
A. When, like on the 2nd?
Q. No. At any point in time within the next two, three weeks.
A. Well, I think that the infection would have eventually revealed or eventually resulted in the pericarditis, so they are related. But, now, I can't make the 12.9 on that day -- clearly on that day, there was not bacterial pericarditis there, no question.
Q. Why do you say that?
A. Because he wasn't that sick.
Q. There is an alternate explanation for the 12.9. That the muscle pain he was having, wasn't it?
A. Well, as we talked about before, there are alternative explanations.
Q. One of them is the muscle pain he was having?
A. Yes.

Q. Wasn't it then reasonable for Dr. Naeem in the presence of that 12.9 WBC and a patient with a history of muscle pain to conclude that the most likely explanation for that 12.9 WBC was in fact the muscle pain and not an ongoing infection?
A. It was not stated in his records so I can't know what his conclusions were.
Q. Assuming that was his conclusion, wouldn't that have been a reasonable conclusion for him?
A. If he had said so, then, yes. But I still think that he should have done a few more simple things to confirm or refute that, which he did not do.
Q. So which killed him, the bacterial pericarditis or the MI?
A. They worked together.
Q. In and of itself, was the MI on or around November 23rd, which you believe happened, sufficient to kill him?
A. Yes.
Q. In and of itself, was bacterial pericarditis sufficient to kill him?
A. Yes.
Q. So in order for Mr. Johnson's life to have been saved, both the bacterial pericarditis and the

coronary artery disease resulting in diagnosis testing and ultimate bypass grafting, would all have had to have been accomplished before November 23rd, right?

A. No, because if he had been in the system he may also have had medical therapy that would have extended his time when he may have got to the bypass therapy. I think the bypass grafting is important in the long-term and in the short-term sometimes, too, but he could have had other intervention in the short-term which would have bought him more time.

Q. If they had done that, he had the bacterial pericarditis setup that was going to kill him even if he didn't have an MI?

A. I wouldn't say that that's necessarily so. If he is in the system, he might have been seen and the infection that might have been smoldering might have been detected and may have been prevented from progressing.

Q. Isn't an infection only going to be diagnosable if it's systemic and not a local infection?

A. We don't know that because he wasn't in the system very long and very extensively. So, yes, I

think what you say is true, except in the case of him. I think there were some signs of infection albeit subtle, but they were not acted upon at all. So we don't know what would have been the natural history of that infection had it been interpreted.

Q. We don't worry about it infecting the pericardium unless it becomes a systemic infection, do we?

A. No, I don't think that's true. People have local infections confined to the throat, confined to the kidneys that still warrant therapy.

Q. Did you in your review of the autopsy find any evidence that this man had a local infection anyplace?

A. Well, there was no collection that I could see. An abscess is what you are talking about. But you don't have to have an abscess to have a systemic infection.

Q. I understand. But is there any place on that autopsy that you can point to to say this is evidence or suggest that this person had a local infection anyplace in his body?

A. Other than the pericardium?

Q. Other than the pericardium.

A. There was no abscess that was commented on

other than the pericardium.
Q. Any evidence anywhere?
A. There's -- tell me what you are looking for; like a collection of some sort, a cut?
Q. Anything. Is there anything noted on the autopsy report that he had a cut on his foot? That he had --
A. No. Those things are not.
Q. -- an infection in his throat?
A. They are not commented on.
Q. Okay. What evidence is there in any of these records that this patient had a systemic infection prior to November 23rd?
A. So what you are talking about is on the day that he saw doctors, because that's the only days we can speak about. Because the days he didn't see doctors obviously there is no documentation because he didn't see anybody.
Q. Okay.
A. So on the day that he saw doctors a white count of 12.9 may be an indication of a systemic infection, that is to say that it's part of the body. Now, I am not going to suggest to you that this is a severe infection. Obviously it's not. On the day that he saw doctors in the emergency

department and his family doctor, again, is there evidence of severe systemic infection? I don't know because a temperature wasn't taken at that time. Those questions were not addressed and we don't know. There are no more blood tests. That's as specifically as I can answer your question.

Q. Isn't your assumption that he had some sort of infection on November 2nd resulting in the increased WBC speculation as well?

A. Tell me what you mean when you say speculation and I'll answer the question. It's all like I can't --

Q. You have no proof from any of the records that the explanation for the 12.9 WBC was an infection either locally or systemically in that man's body?

A. The tests were not taken so the lack of test evidence does not exclude my interpretation of the evidence, the scant evidence that I see.

Q. Do you have any kids?

A. Yes.

Q. Is your wife a doc?

A. No.

Q. Is she able to tell when your kids get up in the morning whether they are sick or not?

A. Sometimes.

Q. And that can sometimes be done just by looking at them, can't it?
A. Sometimes.
Q. It can be done just by looking at people, even people who aren't trained medical persons; is that correct?
A. Absolutely.
Q. Trained medical people are better at just looking at people and ascertaining whether or not they are sick, right?
A. Yes.
Q. Okay. Is there any indication in any of these records that any of the trained medical or nursing people who ever saw Mose Johnson ever saw any evidence of infection or clinical manifestation of coronary artery disease?
MR. DEMPSEY: Objection to what somebody else saw.
A. It's not stated so I don't know.
Q. And for you to suggest that it was present would be speculation on your part, wouldn't it?
MR. DEMPSEY: Objection. You can answer.
A. It's my opinion.
Q. And isn't that opinion pure speculation?

A. It's speculation because there is no evidence that refutes it.
Q. But there's no evidence that supports it, is there?
A. Well, what supports it is the elevated white blood cell count and the death related to infection and unusual pain.
Q. When?
A. On the times that he was complaining of hip pain.
Q. But that unusual pain, I thought we agreed earlier, in no way is suggestive of either an infection in the pericardium --
A. I don't know how to sort out the unusual pain. I don't know how that fits in here. It fits in somehow.
Q. Why do you mention it?
A. Because it's something that's unusual.
Q. I agree, but it is not proof that your theory is correct, is it?
A. What I'm telling you is my opinion based on the evidence as I see it.
Q. Do you have any further criticisms of the care and treatment rendered to Dr. Naeem other than what's contained in your two reports and what we

have talked about here today?

A. No.

Q. Do you have any further reasons for your criticisms of Dr. Naeem other than what's contained in your two reports and we have talked about here today?

A. No.

MR. FIFNER: Well, with that I am done. All I ask is that if for any reason you have any further criticisms or reasons for your opinions that you let counsel know and then he will let me know so we can talk about those.

MS. PETRELLO: Before we start, Les and I meant to put this on the record before we started but we forgot.

Mr. Spisak and I are participating in this deposition in questioning Dr. Zivot, plaintiff's expert as a result of the court's order and approval of our participation in this deposition despite the fact that neither Mr. Spisak nor I, representing Drs. Carroll and Prince, have identified our experts to the plaintiff. And according to Lorain County's Local Rules that has to be done prior to

taking the discovery deposition of the opponent expert. However, as a result of that pretrial, the judge had deemed that we had good cause --

MR. DEMPSEY: Colleen, I don't have an objection to you doing the deposition.

MR. SPISAK: We are not waiving anything as far as our expert by virtue of our participating in this deposition.

MS. PETRELLO: That was going to be my --

MR. DEMPSEY: You are going to send a report over. I have no objection to you coupling it in with this order.

THE WITNESS: I didn't understand that.

MR. DEMPSEY: Your report came before your deposition and they haven't given a report of their expert before they took your deposition, but I don't have a problem with it.

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BY MS. PETRELLO:

Q. Doctor, again, we were introduced a few hours ago. I'm Colleen Petrello. I am here representing Drs. Prince and Carroll, who were the two emergency room physicians involved in Mr. Johnson's care.

I am going to try not to go over any of the things that Mr. Fifner did. I apologize in advance if I do repeat a question.

I want to start sort of in the beginning and talk a little bit about your background. I was provided an affidavit as well as a supplemental report from you. Do you recall signing an affidavit?

A. Yes.

Q. And in that affidavit you made reference to your experience working in an emergency room?

A. Yes.

Q. And what I would like to do is talk about that a little bit.

First of all, in medical school, did you have experience working in an emergency room as an emergency room physician?

A. Well, in medical school I wasn't a physician.

Q. Correct. All right. That's a good point. How about let's start with your internship.

A. I worked in an emergency department. I was assigned to work in the emergency department during my internship, yes.
Q. Your internship was one year?
A. One year.
Q. And out of that year how many weeks or months did you spend in the emergency room?
A. Well, my involvement with the emergency room was in different capacities. I had a two month period of time assigned only to the emergency room. And then throughout various rotations I would be called to the emergency room to see patients.
Q. I'm only talking about working in an emergency room as an emergency room physician as opposed to being consulted to come to the emergency room for some other service you may have been rotated to.
A. Two months.
Q. Two months. Then your internship was from 1988 to 1989?
A. Yes.
Q. You went in from your internship, according to your CV here, you went into anesthesiologist residency in Toronto?
A. Yes.
Q. That went from '89 to '93?

A. Yes.
Q. During your anesthesia residency --
A. Yes.
Q. I haven't finished my question.
A. Oh, I'm sorry.
Q. During your anesthesia residency, during that residency period, were you assigned to work in the emergency room as an emergency room physician?
A. No.
Q. From there you went to another anesthesiology residency and critical care fellowship at the Cleveland Clinic?
A. Yes.
Q. And that was from '93 to '95?
A. Yes.
Q. I'm just going by the dates of your CV here. And during that postgraduate training experience, did you have the opportunity to work in the emergency room as an emergency room physician?
A. No. You know, I can truncate this and say that I have not worked as an emergency room physician other than the time I told you.
Q. So the only emergency room experience that you have functioning as an emergency room physician was between 1988 and 1989 for two months?

A. Yes. Except that I -- well, except that I have been in emergency as a physician on multiple occasions and --

Q. I understand.

MR. DEMPSEY: Can he finish?

A. -- in other capacities where I review emergency room records and I discuss them with the emergency room physicians, so I feel that I'm able to comment on this particular aspect.

MS. PETRELLO: Move to strike.

BY MS. PETRELLO:

Q. Doctor, the answer to my question was, yes, that your only experience as an emergency room physician was for two months between 1988 and 1989 where you were the emergency room physician?

A. You are correct.

Q. Thank you.

Your internship was at Mt. Sinai Hospital in Toronto, Canada?

A. Yes.

Q. Is that where you did the emergency room experience, at that particular hospital?

A. Yes.

Q. Can you describe -- I don't know anything about this hospital. Can you describe for me the type of emergency room that they had at Mt. Sinai Hospital?

A. It was the -- Mt. Sinai Hospital is a hospital of about maybe at the time maybe four hundred beds. It had an emergency room department that had, depending upon the time of day, one or two or three emergency room physicians assigned, plus house staff. There was a triage nurse who saw patients as they came in and sorted them appropriately. The hospital handled -- I cannot remember how many visits, but it was a busy downtown hospital that handled a variety of cases from the sublime to the ridiculous 24 hours a day, seven days a week.

Q. Was there just one emergency room?

A. Yeah. Well, it was a large area.

Q. Well, that was a poor question.

In this particular case, are you aware that on November 10th when Dr. Prince saw Mr. Johnson, that Mr. Johnson was seen in a section of Elyria Memorial Hospital's emergency room which was called the Med Express as opposed to the regular emergency room?

A. I'm aware of that.

Q. Did the hospital, Mt. Sinai Hospital, have such a section with the emergency room divided into acute and less acute sections?

A. Yes. There was an acute and less acute section.

Q. What was the less acute section called?

A. The less acute section.

Q. Is that the name?

A. I don't remember if it had a specific name, but it was -- people were triaged. I can't recall the names of the location. There was an area that was clearly designed as the resuscitation or critically ill. There was something in between and something minor -- they may have called it the minor side. I can't recall exactly.

Q. But you recall a side of the emergency room as opposed to maybe just one particular cubical, if you will?

A. No. There was several spaces where people could go which was of a less acute nature.

Q. Okay. And in your experience the one to three doctors that worked in the emergency room, did they cover all of the areas?

A. Yes.

Q. Okay. So those one to three doctors would not

only see patients in the less acute, for lack of better word, but also the resuscitation unit versus the emergency room?

A. It may have been that during the day one person would be assigned to the major side and one person was assigned to the minor side, and that's the way that they divided the manpower. And at night when there was low census, when there was less people, I think one person would handle everything.

Q. What about the nurses, did they work the entire emergency room?

A. No. It was the same thing. They would be assigned to a location generally.

Q. And when you did your two months, do you recall were those consecutive months?

A. Yes.

Q. And did you work the entire emergency room?

A. Yes.

Q. You were involved with patients that were in the less acute section?

A. Yes.

Q. Do you recall being assigned -- well, let me ask you, how did that work? You were there for two months. Were you assigned like a week in the less

acute section, a week in the regular E.R., a week in the resuscitation section?

A. I'm sorry. I can't exactly recall. It may have actually changed from day-to-day and even from morning to afternoon. It may have been a few hours in one section and a few hours in the other. I think also if things came up that were particularly interesting, then, you know, you might be informed to go and see something that's particularly interesting that was not in the place where I may have been normally.

Q. Do you recall at what part of your internship that this two-month rotation occurred?

A. In the middle, I believe in the middle.

Q. So you had probably been out of medical school for about six months or so when you had that experience?

A. That would be yes.

Q. And I don't see anything on your CV, so why can I make the assumption that throughout the course of your career you have never, quote, moonlighted, if you will, as an emergency room physician in any --

A. No.

Q. -- facility?

And you are not board certified in emergency room medicine?

A. No.

Q. You have never done a residency or fellowship?

A. In emergency room medicine?

Q. Yes.

A. No.

Q. You are not eligible to take the boards in emergency room medicine?

A. I don't know if I am or not. Sometimes they overlap. If you ask, you can.

Q. But as you sit here today you don't know whether or not --

A. I don't know.

Q. -- you would be eligible?

A. I don't know.

Q. Doctor, I'm a little confused about your file here and what you received and what you haven't received and when you received it and from who, so I want to sort this out as fast as I can.

A. Sure.

Q. You have various different things here. Does this represent your entire file?

A. Yes.

Q. Okay. Is there anything that you have at home

or at your office that is not on this table here today?

A. No.

Q. When were you asked to bring this file to the deposition?

A. Today.

Q. Okay. Was that as a result of a phone call from Mr. Dempsey?

A. Actually, he didn't ask me because I think he couldn't get ahold of me, but I assumed it would be required.

MR. DEMPSEY: I tried to tell him that you had issued that notice, but I didn't reach him.

A. I didn't get it, but I brought it because I thought you might need it.

Q. Did anyone tell you or suggest to you or instruct you not to bring any correspondence from Mr. Nemeth, or, for that matter, any other lawyer that has been associated with this case?

A. No.

Q. To the best of your knowledge, as you sit here today you do not have any other correspondence other than this Reminger letter that's attached to some records?

MR. DEMPSEY: I just handed him that today.

A. Yes. I'm sorry. The correspondence I told you are -- I know that there were cover letters. I don't have them because I think they were of a very nonspecific and trivial nature, so I just chucked them.

Q. Okay. Now, as I understand this, you were asked by Mr. Nemeth to take a look at this case?

A. Yes.

Q. And you had some sort of personal relationship with him; you knew him?

A. Yes. I knew him, uh-huh.

Q. Okay. But he didn't really do this kind of work?

A. Right.

Q. So he referred it then to a Mr. Powers?

A. Yes.

Q. When you were first asked -- and Mr. Nemeth is the person that asked you to look at this case?

A. Yes.

Q. When he asked you to look at this case, did he give you any materials in this case?

A. No.

Q. When he flipped it then to Mr. Powers --

A. Uh-huh.
Q. -- did Mr. Powers give you material to review in this case?
A. I don't remember. No, I don't think so. This is the file that I had for Mr. Powers at the time when Mr. Powers was involved. That's the whole thing.
Q. Okay. Because your first letter, which is dated November 12th, is in fact addressed to Mr. Powers?
A. Uh-huh.
Q. And in this letter you make reference to the autopsy?
A. Uh-huh.
Q. Okay. And you believe --
A. The autopsy is in here.
Q. This manila folder, which is just a manila folder, and all it says is "medical records" is all that you received at the time Mr. Powers asked you to take a look at this case?
A. I believe so, but --
Q. Fair enough.
A. -- I can't tell you exactly.
Q. Okay.
(Thereupon, there was a discussion off

the record.)

BY MS. PETRELLO:

Q. And at the time when Mr. Powers asked you in conjunction with Mr. Nemeth to look at this case, you were specifically focused on -- was it Dr. Naeem?

A. Yes.

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

Q. At some point in time, Mr. Dempsey became involved in this case?

A. Yes.

Q. Do you recall when that was?

A. No.

Q. Do you recall what year that was?

A. No.

Q. Okay. You have had conversations obviously with Mr. Dempsey?

A. Uh-huh.

Q. And I don't want to know what those entailed, all right? When is the first time you recall speaking with Mr. Dempsey about this case?

A. I can't exactly remember, a year ago, maybe a year and a half ago.

Q. Okay.

A. There haven't been -- go ahead.
Q. Go ahead.
A. There haven't been many conversations about this. There have been a few conversations.
MS. PETRELLO: And I just want the record to reflect that this manila folder that he initially received when he was asked to review this case, and it's just entitled medical records, does in fact contain the emergency room visit of November 10th.
BY MS. PETRELLO:
Q. All right. Getting back to these questions here. You haven't had very many conversations with Mr. Dempsey?
A. No.
Q. Do you recall what records, if any, that you received next? You had already received these records in the manila folder?
A. It may have been these ones actually.
Q. Okay. Is this something that you received or --
A. This is a copy.
MR. DEMPSEY: This is mine. It was a little more organized for the depo.

BY MS. PETRELLO:

Q. Okay. That's fine.

So you had the depositions of Dr. Naeem, Dawn Sturgeon, Rose Fenik, Marion Prince, Jane May, and you believe that this is the next bit of material that you received?

A. I believe so.

Q. Okay. Do you recall when you received this?

A. It would have been around the 18th of May when I wrote this letter, before that. I guess it had to have been before that.

Q. Do you recall how much before, a week, a day?

A. A few days, a day, a few days I think, yeah.

MR. DEMPSEY: Did I send you some of these earlier?

THE WITNESS: You may have.

MS. PETRELLO: Excuse me, I think he answered the question.

MR. DEMPSEY: You want completeness. I thought I sent this earlier.

MS. PETRELLO: We certainly don't have any letters to be able to establish that.

Q. In any event, do you recall at some point

when, well, Mr. Dempsey asked you to look at this case in terms of the care provided by the emergency room physicians and perhaps Elyria Memorial Hospital?

A. Yes. At some point he asked me to do that.

Q. When was that?

A. On a very early conversation with Mr. Dempsey.

Q. Okay. And you didn't receive any additional records, correct?

A. Just what I had.

Q. And you already had the emergency room records, correct?

A. Uh-huh, yes.

Q. In between the time when Mr. Dempsey asked you to look at the care rendered by some other people and the time that you received these deposition transcripts, did you have any conversations about what your opinions were with Mr. Dempsey relative to the care that Drs. Prince or Carroll or the hospital provided?

A. Yes.

Q. Okay. And what were those opinions?

A. I was concerned that the vital signs weren't obtained at the time that Mr. Johnson presented. That was my concern.

Q. Was that on the November 10th emergency room visit?
A. Yes.
Q. Did you at any time -- well, these are the only two reports that you have authored, correct?
A. Yes.
Q. Did you ask to see the transcripts of any of these individuals?
A. They were forwarded to me before I asked, but they were given to me.
Q. Did you in fact read these deposition transcripts?
A. Yeah, I did, yeah.
Q. When did you read these?
A. When I got them.
Q. Did it help your opinions in any way or change your opinions?
A. Not really, no.
Q. Why did you issue another report?
A. I was asked to because there was some confusion about the five year point that I was asked to comment on in the initial letter and also to include my concern about the emergency room visit, which wasn't in the first letter.
Q. Well, when were you asked to do that?

A. Which now, this letter?
Q. To write the second letter, which --
A. Just before I wrote it.
Q. Okay. When you wrote your first letter, did you have concerns about the care provided in the emergency room?
A. I would have to say yes, but I have no record. And I was asked a very specific kind of question and that's why the letter is of that form. I was not asked to comment on the emergency care and I wrote that letter because that was the advice of the attorney of what he was interested in. That's all that I commented on.
Q. Did you discuss your concerns with this other lawyer at the time?
A. I believe so, but I can't recall.
Q. When Mr. Dempsey discussed this case with you, what were you asked specifically to do as it relates to the emergency room visits?
A. To comment on what I thought was the quality of the care there.
Q. Your report, supplemental report, is dated May 18th and is timed at 9:47 p.m. along with your CV.
A. I faxed it from my home.
Q. That's what I was going to ask you.

A. Yeah.
Q. When you do medical legal reviews, do you do this generally from your home?
A. Well, generally would mean that I do this a lot. So in this particular case I did it at work, but I faxed it from home.
Q. Doctor, can Tylenol reduce or take away a fever?
A. Yes.
Q. I want to talk about, first of all, right out of the box, do you have criticisms of Dr. Carroll?
A. You know, I'm sorry, I can't remember the names of the doctors, okay?
Q. Dr. Carroll was the second emergency room physician who treated Mr. Johnson on November 23rd, the date of his death.
A. No.

MR. DEMPSEY: I told you we were going to dismiss Dr. Carroll.

MS. PETRELLO: I just wanted to make sure.

BY MS. PETRELLO:
Q. Dr. Prince, another emergency room physician, cared for Mr. Johnson in the emergency room visit on 11-10 when he came in because of the pain.

A. Uh-huh.
Q. Okay. And since you don't have any criticisms of Dr. Carroll, that will make it really easy because we are only going to be talking about Dr. Prince now.
A. Got it.
Q. Now, as I understand your previous testimony, your first report dated -- what's the date of your first report -- November 12, 1997 does not contain any criticisms?
A. That's not the one you are holding up.
Q. I understand. It does not contain any criticisms of Dr. Prince?
A. I'm having trouble hearing.
MR. DEMPSEY: Doug, we can't hear.
(Thereupon, there was a discussion off the record.)
Q. Your first report --
A. Yes.
Q. -- dated November 12, 1997 did not contain any criticisms of Dr. Prince?
A. Right, correct.
Q. Your second supplemental report dated May 18th, 2000, as I understand, contains all of your

criticisms that you have against Dr. Prince; is that correct?

A. Yes.

Q. And that criticism is the fact that on the emergency room visit on 11-10-96 there was a failure to take vital signs, specifically temperature?

A. Actually, none actually are recorded, but the temperature --

Q. But the temperature is the one you are most concerned with?

A. Yes.

Q. And that had a temperature been taken it would have been elevated and a diagnosis of infection would have been made, it would have been treated and Mr. Johnson wouldn't have died. Is that your criticism?

A. Yes.

Q. And do you believe that Dr. Prince should have taken the temperature?

A. She or one of the nurses should have taken the temperature, yes. It's not required that she herself take a temperature.

Q. And you believe that that was the standard of care in the Med Express to take a patient's

temperature?
A. Yes.
Q. Now, you believe that it would have been elevated?
A. Yes.
Q. All right. Are there any other symptoms associated with an elevated temperature or signs?
A. What are you referring to specifically?
Q. Well, for example, chills?
A. Other than what we have discussed you mean?
Q. Yes.
A. Well, yes, there are things that may be associated with elevated temperature. It depends on whether the person's temperature is going up or going down as to how they feel.
Q. Let's say it's going up.
A. Then they should feel cold. Generally they may feel cold.
Q. They feel cold?
A. Yes.
Q. And if it's coming down?
A. Then they should feel hot.
Q. Is that in every case?
A. Well, depending on how quickly it's going up and going down, sometimes it goes up very slowly

and they are not particularly attuned to that, they may not be able to express that, so it depends on their ability -- the rate of rise and their ability to be perceptive about what's happening to them.

Q. Are there any other symptoms or signs?

A. With an elevated temperature?

Q. Yes.

A. When a person -- if we are saying the temperature is elevated because they have an infection, then they may have general feelings of malaise. They may have pain in the area where -- at the source of the temperature. They may have, depending upon if it's very, very severe, they may have difficulty with concentrating. They may have a headache. They may have a lot of very nonspecific kinds of things, fast heart rate, fast respiration, fast breathing, if it was severe, or it may be a number of those things.

Q. I believe you testified earlier that while you believe that his temperature would have been elevated, anything beyond 98.6 would be speculation on your part as to what his actual temperature may have been?

A. I can't know exactly what his temperature would have been. It's impossible to know.

Q. I think you were asked a question, at what point do you believe in terms of being an elevated above-normal temperature an evaluation should have taken place?

A. When you say evaluation, what do you mean by that?

Q. Well, you have opined that the temperature should have been taken and it would have been elevated and then he would have been worked up for the infection.

A. Yes.

Q. All right. So at what point if a normal temperature is 98.6 --

A. Can we speak in centigrade? I am more familiar with that.

Q. All right, fine. Centigrade is what?

A. 37.

Q. So at 37.1 are you saying that a workup for infection should occur?

A. No.

Q. That's what I want to get at. At what point above 37, which is normal, would you believe that the infection workup should begin; 38, 39, 40?

A. Well, I think it depends on the workup. I think a temperature above the 38.5 usually is the

cutoff where people begin to suspect a serious generalized infection. Temperatures lower than that can also be indicators of infection and the workup -- when you say workup, it just might be different.

Q. Okay, well --

A. A sampling of a workup for infection would include again a history, physical examination, a sampling of certain blood and body fluids depending upon where the history and physical points you.

Q. A history was done in this case, correct?

A. Yes.

Q. And the physical was done in this case, correct?

A. In the area of the hip.

Q. That was his presenting complaint, correct?

A. Correct.

Q. I guess I am confused here. I want to know, you criticized Dr. Prince and the emergency room and I want to know at what point was Dr. Prince to do the next step, which we are going to talk about, but is it 37.1, 2, 3, 4, 5? I mean, where?

A. I think they would have taken a temperature. They would have taken a heart rate, respiratory rate and blood pressure, which are also vital signs

which they did not take. And those things may have also been elevated or rather they may have been abnormal. And so in that circumstance, depending upon how far away from normal they were, different kinds of workups would have been done. They didn't take an electrocardiogram, but they didn't feel the need to do it. If they had, on the other hand, taken his blood pressure and taken -- his blood pressure was 220 over 110. They may have taken an electrocardiogram because they would have that. It was odd. And maybe he has something else going on here. The hip pain wouldn't go away with Ketorolac and it's odd. People come in the emergency room with complaints and something else is uncovered in the process. That's the nature of that business.

Q. But, Doctor, see, here is my confusion. I mean, so much of this is just speculation on your part, all right? You are saying they could have done this and they could have done that, this would have been elevated and then they could have done this. Based upon the record you have, you have a gentleman who comes in with a history of falling off some sort of cart injury. I forgot how you described it, all right, with hip pain, and it's the Med Express part of the ER. They do an x-ray.

He has some pain medication. They give him an anti-inflammatory. They tell him to follow up the next day with his family physician. And you are speculating that they could have done all these things, all these tests, and they would have discovered this, that and that. What did you expect Dr. Prince to do when she saw this gentleman with this history and this complaint?

MR. DEMPSEY: Objection. And before he answers, Colleen, I just object to your characterization of Dr. Zivot's earlier testimony and speculation because he testified to a reasonable degree of medical certainty before. You can ask him the question.

MS. PETRELLO: Go ahead.

MR. DEMPSEY: You gave a long statement and then put a question at the end of it.

BY MS. PETRELLO:

Q. I am so confused here, but go ahead.

A. I expect she or the nurse should have taken vital signs and depending on what occurred in those vital signs would necessitate the different kinds of investigations. I am not saying -- when you say

many, many things, I don't know what you are referring to.

Q. Vital signs, let's just take the vital signs.

A. Uh-huh.

Q. Tell me to a reasonable degree of medical probability what would his blood pressure have been?

A. Elevated.

Q. What?

A. More than 120 over 80.

Q. Now, at what point should she have embarked on some sort of path to work this up?

A. Well, I'm not -- I think that -- I'm not going to go through each individual thing like this does not make sense to me. It's part of what I see would be a part of what I think would be. And based upon the fact that he died of infection, that's why I am saying -- or died of complications related to his infection as related to his heart disease, that's what I'm speculating. If he was living and fine, I wouldn't feel this way. But I feel this way because he died and that's why I feel that. So that's my opinion as to why I say that.

Q. Doctor, despite the fact that you testified that with this type of infection, the fever would

wax and wane --

A. Yes.

Q. -- despite the fact that Mr. Johnson had Tylenol --

A. Yes.

Q. -- despite the fact that there's been --

A. Mr. Johnson had Tylenol? When did that occur?

Q. I don't remember. You tell me.

A. I don't remember. You brought it up. I don't remember because --

Q. Do you note that in the emergency room record?

A. Can we look at it now?

Q. Sure. And, please, if you have any question, feel free to look at that.

A. You are saying the Tylenol lowered his temperature?

Q. No. I'm not saying that.

A. Why did you ask me if Tylenol lowered his temperature?

MR. DEMPSEY: You asked him that about five minutes ago.

MS. PETRELLO: Right. And he said it can and that's all I need to say.

MR. DEMPSEY: Let's go off the record.

(Thereupon, there was a brief recess.)

MR. GORDON: I'm Harlan Gordon sitting in for Mr. Dempsey from this point forward.

BY MS. PETRELLO:

Q. Doctor, jumping back a minute or two, you said you spend 50 percent of your time in anesthesia versus 50 percent of your time in critical care medicine with a little bit of administrative stuff in between that. How does that work out? Do you spend a month in anesthesia, then a month on critical care or --

A. It varies. Usually it's a week at a time, but there's a lot of overlap because of the nature of my operating room practice. Many of the patients that I care for in the operating room get admitted to the ICU, so we do a lot of -- I am in the intensive care unit every single day. Sometimes I am only in the intensive care unit and sometimes in the operating room and the intensive care unit.

Q. The patients that you put to sleep from the anesthesia point --

A. Yes.

Q. -- and end up in ICU --

A. Yes.

Q. -- that you see daily, are those patients that you are seeing because they simply are in the critical care unit, or are those patients that you are seeing as follow up both as anesthesia --
A. Both. There are times where my assignment is attending in the intensive care unit and then I see them in that capacity and I have not given them an anesthetic. There are other times --
Q. Yes, I understand that. I guess what I am trying to understand is say today is Monday and you give anesthesia all day in the OR?
A. Uh-huh.
Q. On that particular day you also would not be an attending in the critical care unit, would you?
A. No.
Q. And if you happen to then go to the critical care unit that would be in follow up to the anesthesia that you may have given to a patient?
A. In addition to other things because in our group our block times are a week duration, generally one or two weeks when we are attending. But because the periods of time are small we always are discussing the cases, so when the people who are chronic when they return we are right up to date on what is going on with them.

Q. I understand you are discussing the cases, but you are not wearing two hats at the same time, that being the attending responsible for the care in critical care and --

A. No.

MR. GORDON: Let her finish the question.

BY MS. PETRELLO:

Q. It's just easier for the court reporter. -- assigned to deliver anesthesia in the operating room?

A. You are correct.

Q. And your critical care unit, how is that divided? Is it a med-surg unit combined or is it just medicine versus surgery?

A. I divide my critical care experience between two distinct units. I attend in the cardiothoracic intensive care unit when the people, patients, have had that surgery or a complication of that surgery, and I also work in the general surgical intensive care unit that occupies shared space with the general medical intensive care unit, and so they are two separate teams. There is a medical team and there is a surgical team within one large room and so we generally have our own patients, but we

normally consult each other during the day and during the time that we are there as well.

Q. When you were talking about your assignments, anesthesia versus critical care, is the critical care experience then subdivided between a week in the cardiothoracic section?

A. Yes.

Q. Okay. So, for example, let's just take a month, four weeks. You would have maybe one week anesthesia OR, one week cardiothoracic ICU, and one week -- what was the other one?

A. General surgery.

Q. General surgery ICU?

A. Yes.

Q. And it would go back again?

A. Yes. It comes out on average 50 percent, but it was probably a little more critical care than anesthesia, so like I saw it was one-third of anesthesia and two-thirds of critical care.

Q. As far as your anesthesia experience, do you have any subspecialty? In other words, do you only give anesthesia in certain cases?

A. Generally, yes. I give cases in cardiac and thoracic cases, but I do a smattering of everything. But the majority, I would say more

than 50 percent of the time it was a cardiac or a thoracic case.

Q. Do you do any pain management?

A. I do, well, as part of other things, but I don't exclusively do pain management alone.

Q. Okay. I understand that there's pain management in the care of patients. But as I understand, there is a subspecialty?

A. There is a subspecialty of pain management that can be divided into acute and chronic. Acute management is something that I do a fair amount of in the intensive care unit.

Q. Now, as I understand it, you believe that somewhere around November 2nd up through just shortly before November 23rd Mr. Johnson developed an infection in his body?

A. Yes.

Q. Okay. And as I recall you characterized it as not severe on November 10th when he was seen in the emergency room?

A. Yes.

Q. You think to a reasonable degree of medical certainty that on November 10th he did in fact have an infection?

A. Yes.

Q. What do you base that on?
A. Based on the fact that he was -- he had evidence of an infection prior to that date and no therapy had been initiated and that he subsequently died of something related to infection.
Q. When you say he had evidence of that prior to that, the only evidence that you are basing that on is the elevated white count?
A. Yes, and generally feeling unwell or complaining of different periods of feeling unwell.
Q. Point to me in whatever medical records that you reviewed where he had complaints of not feeling well.
A. I'd have to look back.
Q. Sure. Take your time, Doctor.
A. I guess I should say that he didn't say or was never quoted as saying, Doctor, I feel unwell. He was quoted as saying, I have pain here and I have pain there. And he had therapy that did not fix it and he came back on a couple of occasions between the 2nd and the date that he died to try to get some help.
Q. Okay. I just want you to be a little bit more specific when you said he had pain there and pain there.

A. Well, pain in his hip, I guess, primarily pain in his hip.
Q. What date was that?
A. Well, the emergency room visit, and then it didn't go away and so he went to see his doctor, his family doctor, and he had pain in his groin, too, and pain in his buttocks,
Q. Okay. So you believe that on November 10th, 1996 when he was seen by Dr. Prince that the complaint of hip pain, which he stated, and he died shortly after he got up off of the bed, was due to the infection?
A. I think that they -- I can't make that connection to a degree of absolute -- how do you put it?
Q. Medical certainty.
A. I can't say that.
Q. Okay. Fair enough.
A. That complaint of hip pain.
Q. So, as I understand it, you don't fault Dr. Prince for believing that this was a strain in his right hip based upon the exam and history as presented on November 10th?
A. I don't fault her on the way that she looked at his hip. I think she looked at his hip

thoroughly. What I fault her on is the inability or the lack of vital signs. That's what I fault her on. I think she did a reasonable workup of the hip.

Q. And I would assume that you have no criticisms of Dr. Prince for instructing or advising Mr. Johnson to follow up with his family physician?

A. No. I think that's -- based on what she did, I think that's sound advice.

Q. And you can't say when Mr. Johnson developed this underlying body infection?

A. Well, I believe that it happened somewhere between the 2nd and the day of his death, but I think it was -- it happened -- there was evidence to my mind that it happened before the 10th.

Q. And the underlying body infection led to the pericarditis?

A. Yes.

Q. And you don't know what kind of body infection he had, correct?

A. No.

Q. I'm just about done here.

A. Did you want to talk about the Tylenol thing or no? Remember we were talking about that before?

Q. Right. I remember. Thanks for bringing it

up, but I don't think I want to ask you that. I am sure you are all prepared to answer it.

You may have been asked this question and I apologize if you were.

A. I accept your apology.

Q. Thank you.

Fever has many sources. Would you agree with that statement?

A. Yes.

Q. Of which infection is just one, correct?

A. A common one.

Q. Elevated white count, many explanations for?

A. Define many.

Q. More than five.

A. It would depend upon the circumstance whether something would be more or less likely.

Q. I didn't ask you that. For an elevated white count there could be a number of possibilities why a white count is elevated?

A. There are common possibilities and uncommon.

Q. I'm not talking about common or uncommon. I am just asking --

A. Then yes.

Q. I am just asking there are a lot of different reasons?

A. Yes.
Q. And you would agree that based upon the records available, Mr. Johnson didn't have any signs or symptoms of any cardiac disease on November 10th?
A. They didn't look for them.
Q. What's the basis of that statement?
A. There's nothing in the record that suggests that they looked for them.
Q. Was there any reason to look for them based upon the history and the presenting complaint?
A. Vital signs should have been taken. If vital signs would have been taken, they would have found something abnormal and that would have initiated an investigation.
Q. But you can't state to a reasonable degree of probability that his vital signs, including his blood pressure plus respiration and pulse, would have been elevated?
A. Specifically, no, but I think I can state that they were abnormal.
Q. But based upon his history and what is documented in the chart, did he have any symptoms that required a cardiac workup?
A. No.

Q. Did he have any symptoms of a cardiac problem?
A. They didn't ask, so, I mean, he didn't have symptoms of many things that they didn't ask about. They wouldn't know unless they asked.
Q. Do you know what they asked him?
A. All I know is what is written down here.
MS. PETRELLO: I don't have any further questions.
- - -
BY MR. SPISAK:
Q. My name is Les Spisak and I just have a few questions for you. I have been sitting here for almost four hours now and --
MR. GORDON: Four hours?
MR. SPISAK: Close to it. Three hours, more like four, three and a half give or take.
Q. In any event, as I'm hearing you -- and it helps me to sort of repeat it to make sure I understand, and you tell me if I am correct or not. What I think I am hearing you say is that it is your belief that everybody who comes to an emergency room with the kinds of complaints that Mr. Johnson came to the emergency room with should have vitals taken.

Is that a fair statement?
A. Yes.
Q. And is it your belief that that is what emergency room staff and emergency room physicians do?
A. Yes.
Q. All right. Now, again, I am sort of stating it my way to make sure I understand. If that had been done in this case, it is then your belief that based on some elevation in the temperature that this person then being put into the system they would have stumbled onto that infection, correct?
MR. GORDON: Objection.
Go ahead and answer.
A. I wouldn't use the word stumbled.
Q. All right. What word would you use?
A. Found.
Q. Found, okay. But it would have been essentially a serendipitous finding, would it not?
MR. GORDON: Objection.
Go ahead and answer.
A. I wouldn't use the word serendipitous.
Q. All right. Let me ask you this. They wouldn't have -- the taking of the temperature, for example, would have been a routine matter. They

wouldn't have been taking the temperature with the thought that there was an infection at that point in time?

A. I can't know what they were thinking.

Q. Well, let me say it this way. This man didn't present with signs or symptoms of infection, clinical signs of infection, did he?

A. Not that they elucidated in their questioning.

Q. Okay. Stated another way, there is nothing in the record to that effect, correct?

A. There is nothing in the record that indicates that they asked questions that would indicate a concern about infection.

Q. There is also nothing in the record that would indicate that this gentleman came to the hospital complaining of anything that was indicative of infection, was there?

A. You are correct.

Q. Okay. All right. Now, to that extent had a temperature been taken, even though they weren't looking for infection, they would have, as you explained to us, found that?

A. Yes.

Q. Without looking for it per se? Fair statement?

A. Yes.
Q. Okay. Doctor, do you have any experience with establishing, with writing, with being involved in creating nursing policies and procedures in emergency room settings?
A. In emergency room settings, no.
Q. Okay. And I would assume, Doctor, that you are not here telling us that you are an expert or that you are holding yourself out as an expert in nursing room policies and procedures in emergency room settings as such?
A. When you say as such or when you say all policies, no.
Q. I didn't say all policies by the way.
A. Or policy.
Q. And procedures?
A. I would say, no, except --
Q. Okay.
A. -- all I'm commenting on is something specific, which are the vital signs.
Q. You are commenting on something that you believe they should have done?
A. Yes.
Q. Okay. Fair enough.
But you did say that you are not an expert in

nursing policies and procedures per se?
A. No.
Q. Okay. Do you know what the nursing policies and procedures were at this hospital, at Elyria Memorial Hospital, on November 10, 1996 as it relates to the taking of vitals for this particular patient?
A. If the policy there was not --
Q. Excuse me. That's not my question. The question is, do you know what the policies were; yes or no?
A. I believe that I know.
Q. Tell me what you believe they were and how you know that.
A. I believe that they take -- that people who go to the emergency room have vital signs taken as a matter of routine. I say that based upon my experience as a physician for 12 years working in multiple hospitals in multiple settings.
Q. That is what your belief is?
A. That's my belief.
Q. But you are not able to point specifically to policies and procedures --
A. A document?
Q. -- at this particular hospital or testimony or

anything to the effect of what the policies or procedures were --

A. No.

Q. -- in anything you reviewed?

A. I did base it on the fact that they have a form that has that as a blank, so the fact that it's on their form, on the preprinted form, suggests to me it's something valuable, that it was something they should be doing, yes.

Q. Because it was on the form, it was something you think they should be doing?

A. Right. It's right on top.

Q. My question is, because it was on the form, it was something that should be done in every single occasion no matter what the complaints are?

A. Yes.

Q. Okay. Fair enough.

I trust, Doctor, you and I can agree that nurses in an emergency room setting can and should follow what the policies and procedures are that are established by the hospital?

A. Yes.

Q. And that in doing so, in other words, in following the policies and procedures that are established by a hospital that would in general

constitute compliance with the standard of care for nurses?

MR. GORDON: Objection.

BY MR. SPISAK:

Q. You are shaking your head. What is your answer?

A. Can you ask it again, please?

Q. Yes.

MR. SPISAK: Would you read it back for us?

THE NOTARY: QUESTION: "And that in doing so, in other words, in following the policies and procedures that are established by a hospital that would in general constitute compliance with the standard of care for nurses?"

A. Well, then I guess for -- I'm sorry. I don't think I understand the question. Because I think that --

Q. Since Mr. Gordon objected, you don't understand it?

A. I guess I don't.

Q. You are shaking your head.

MR. GORDON: That's very unfair.

MR. SPISAK: It's not.

MR. GORDON: Because I object and --

MR. SPISAK: I am just making the comment.

BY MR. SPISAK:

Q. You tell me what part of that question you don't understand.

A. You made some statement something at the end about some kind of general standard of nursing practice.

Q. All I'm saying is, Doctor, it's real simple, if nurses are given certain policies and procedures to be followed and they follow them, in general that would be in compliance with the standard of care, would it not?

MR. GORDON: Objection. Go ahead and answer.

A. Yes.

Q. Now, in this case, for example, there is an emergency room physician in the hospital and if the emergency room physician thinks that a nurse should have done something or that something was appropriate to be done, that physician can then order that it be done if it's not done, correct?

A. Yes.
Q. And that would not be an inappropriate thing, correct?
A. Yes.
Q. Just a final point and that is, the scenario that you have outlined here, and I don't want to rehash the whole thing, but temperature should have been taken. You believe if it had been taken, it would have been elevated. If it was elevated, that would have triggered certain other things to be done, perhaps some additional tests, perhaps some additional lab studies, et cetera, those types of things, correct?
A. Yes.
Q. So those would be things that would have to be ordered by a physician, correct?
A. Yes.
Q. Not by a nurse?
A. Yes.

MR. SPISAK: That's all I have. Thank you.

- - -

BY MS. PETRELLO:
Q. I just have a couple questions. Based upon Mr. Johnson's history and the records as we have it

from a medical standpoint, is there anything to suggest that Dr. Prince should have thought that that man had an elevated temperature?

A. Based upon the questions that she asked?

Q. Yeah. The record, the presenting complaint, the reason why he was there.

A. Well, people who have a sore hip one explanation might be infection and so, yes, it would be reasonable to also look for a temperature as an explanation of a sore hip.

Q. With the history that was given by Mr. Johnson?

A. Absolutely.

Q. All right. If hypothetically the temperature had been taken on November 10th and it was normal, would you have any other criticisms of Dr. Prince?

MR. GORDON: Objection.

I thought he was talking about vital signs.

Temperature is one of the vital signs.

A. Temperature, not just temperature alone.

Q. Let's start with temperature. If the temperature was normal --

A. Well, if the temperature was normal and the other vital signs were normal, then no, but then this would have been someone else, wouldn't it have

been?
Q. You wouldn't have any other criticisms if the temperature was normal?
A. If the vital signs were all normal including temperature -- well, I think she gave too much Ketorolac.
Q. Toradol?
A. Toradol.
Q. What did that cause in this case?
A. Well, Toradol can cause renal failure in excessive doses.
Q. Is there any evidence that Mr. Johnson had renal failure?
A. Not until he died. No, you know, no. I think if the vital signs are all normal, then this is a reasonable workup for a sore hip.
Q. Okay. Doctor, a few minutes ago you told me that your report contained all of your criticisms you had in this case. Your report is critical of the fact that there was no temperature taken, all right? The report does not indicate anything about the Toradol.
A. I withdraw it then.
Q. I just want to make sure that I understand all your criticisms that you intend to offer at

trial --
A. Uh-huh.
Q. -- in this matter --
A. Fair enough.
Q. -- relative to Dr. Prince.
A. I withdraw the Toradol statement.
Q. And it relates to the vital signs you have shown on the temperature according to your report; is that not correct?
MR. GORDON: Objection.
A. Yes.
Q. And my question to you is, had the temperature been taken hypothetically, we know it wasn't, and it was normal, then everything else that was done in the emergency room on November 10th you would not have a problem with?
A. I need to change that statement then.
Q. Go ahead.
A. I would have to say my concerns about the vital signs as well the lack of vital signs, not the temperature alone.
Q. Is there any other vital signs other than the temperature that is of more concern to you than others, respiration, pulse, blood pressure?
A. They all go together. They should be taken at

once. They are all together.
Q. And you believe that all of them would have been elevated or been abnormal?
A. I believe that the blood pressure probably -- let me withdraw the word probably -- that the blood pressure and the temperature would have been elevated to a reasonable degree of medical certainty. The precise nature of that I cannot say, but they would have been elevated.
Q. And you are aware he had a history of hypertension?
A. I'm aware of that.
Q. And in terms of the pulse, can you give a range of what you thought that would have been?
A. No. Well, the pulse I am less certain of.
Q. Okay. Would you agree with the statement that a pulse is elevated for many reasons?
A. Yes.
Q. Is pulse elevated because of pain?
A. Sometimes that's a reason.
Q. Is pulse elevated because of anxiety?
A. That's a reason.
Q. And are you aware that he had a history of hypertension?
A. I'm aware of that.

Q. And he was on medication for his hypertension?
A. I am aware of that.
MS. PETRELLO: I don't have any other questions.
MR. GORDON: The doctor will read the deposition.
- - -
BY MR. FIFNER:
Q. Doctor, you have given an opinion that had everything been done the way you wanted it to be done that this patient would have had a near normal life expectancy?
A. He would have survived this episode.
Q. Had he survived this episode, given his underlying coronary artery disease, obesity, diabetes, which you indicated, all his other medical problems --
A. Yes.
Q. -- do you have an opinion how long he would have survived had he survived these incidents of November 23rd?
A. I think that hypertension, obesity, coronary artery disease, these things are treatable diseases. Diabetes is treatable. He struck me, as much as I can say, as a person who was motivated to

get well because he kept going to the doctor. So if he had been given advice and followed advice, I think that the conditions that he had he may have turned around, and so I think he could have lived a reasonable life expectancy. I cannot say exactly what, but it would have been more than three weeks and could have been probably 20 years. I don't know.

Q. Did he suddenly get religion or did it occur to him only after November 2nd?

MR. GORDON: Objection.

Go ahead and answer.

A. I don't know what you mean.

Q. Well, was he not notified to do well and do what the doctor said and follow all of his treatment regimens before November 2nd?

A. I don't know what was said between the two of them. I can't comment.

Q. But we know by the time November 2nd rolled around -- and he was in his what, mid 40s?

A. Forty-four.

Q. He had big time coronary artery disease by the age of 44?

MR. GORDON: Objection.

If you can understand the term "big time."

A. He had significant coronary artery disease. Yes, he did.

Q. Enough coronary artery disease that left untreated he is going to be dead in three weeks per your testimony, right?

A. Yes.

Q. Now, God didn't make his coronary arteries as good as he made other people's, did he?

A. I don't know what you mean.

Q. They sure failed him earlier than a lot of other people's.

MR. GORDON: Objection.

A. I don't know what you mean. I can't answer that.

Q. What happened in his life to get his coronary arteries to the point where he is three weeks from death in November 1996? What is it? Was it the product of his lifestyle or was it the protoplasm he was given at birth?

MR. GORDON: Objection.

A. I think it was some of all of that.

Q. Why do you think any of that is going to change over the next 20 years?

A. Because frankly when people have an event that is disturbing or frightening to them with

relationship to their health, they frequently turn themselves around.

Q. You are assuming that he would have somehow gotten religion after November 23rd and turned himself around and lived a different lifestyle than he had lived up until then?

MR. GORDON: Objection. Objection to the word religion.

Go ahead and answer.

A. I know what you are saying. I know you are speaking colloquially. I assume he could turn himself around, yes.

Q. And that's part of your hypothesis that he was going to live another 20 years after this?

A. Yes.

Q. Can you state to a reasonable degree of medical probability that he stood a greater than 50 percent chance of living more than ten years?

A. Yes.

Q. Do you have --

A. Assuming that he has care, has therapy, assuming he has therapy and accepts therapy.

Q. Wasn't he taking antihypertension medication before that?

A. He was taking one. He may have needed more

than that.
Q. But that didn't solve the problem, did it?
MR. GORDON: Objection.
Go ahead and answer.
A. No, it didn't.
Q. Do you now assume that whatever antihypertension medication he was going to be given in the future he is going to take and it is going to be effective?
A. Yes.
Q. What caused his coronary arteries to occlude? Was it his lifestyle or was it the protoplasm he was given?
A. I don't know.
Q. Was the protoplasm he was given the same protoplasm that is going to be in the graft as it is in the original vessel, isn't it?
MR. GORDON: Objection.
A. I can't comment on that. I don't know.
Q. Why not?
A. Because I don't know.
Q. Isn't that important to your decision as to how long he is going to live?
A. Well, you are suggesting that his protoplasm is what set him up for coronary artery disease and

that's the major reason why he had obstruction in his coronary arteries. I would suggest that's not the case. He smoked. He had hypertension. He was obese. Those are the things that are material that he could turn around and that could reverse those processes. Those processes can be reversed.

Q. And you are assuming that he would?

A. Yes.

Q. If he does not reverse those processes, and we have a 44 year history that he hasn't done it yet, right?

MR. GORDON: Objection.

Go ahead and answer.

A. I don't know when it began. I don't know when he began to do that or why he began to do it.

Q. What if he doesn't? What if he doesn't turn those things around?

A. Then he's dead in three weeks.

Q. Well, what if he has the coronary artery bypass graft and does not turn those things around? How long does he live?

A. It depends on what they use as grafts, first of all. If he has bilaterally lina and rima bypasses, that five year patency rate of these grafts is 90 percent, which is pretty good.

Q. What about ten years?
A. That's not so well known because people don't usually angiogram people that far, but --
Q. Do they generally live that long?
A. Yes, they generally do. I see people who have a second bypass to give them another five or ten years. Many people have bypass surgery and live 20 years or more than that.
Q. And those are people who change their lifestyles?
A. Some do; some don't.
Q. What happens to this man if he doesn't change his lifestyle?
A. I don't know.
Q. Can you say to a reasonable degree of medical probability that if he doesn't change his lifestyle that he is even going to live another five years?
MR. GORDON: Objection.
Go ahead.
A. If he doesn't -- I'm sorry -- if he doesn't get care?
Q. If he does get the care. If he gets the graft but does not change his lifestyle.
A. Then how long will he live?
Q. Yes.

A. It depends on how much he does, what he does to himself is all I can say.
Q. The same amount he did before the graft.
A. It does not work like that. It's not linear like that necessarily. I don't know.
Q. Okay. That's fine. You don't know.
A. Yeah.

MR. FIFNER: I am done.

MR. GORDON: He'll read the deposition.

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(DEPOSITION CONCLUDED.)

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JOHN B. ZIVOT, M.D. DATE

STATE OF OHIO,)
)
COUNTY OF CUYAHOGA.) SS:

CERTIFICATE

I, Janis E. Suntheimer, Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the witness, JOHN B. ZIVOT, M.D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony then given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the events of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 9th day of June 2000.

Janis E. Suntheimer, Registered Professional Reporter and Notary Public in and for the State of Ohio.
My Commission Expires 08-31-02.