Doc. 18

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

IN THE COURT OF COMMON PLEAS

FRANCES SMITH, Administratrix of the Estate of Alvester Smith, Sr., Deceased,

Plaintiff,

v.

ST. LUKE'S HOSPITAL, et al.,

Defendants.

Case No. 100877

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Deposition of RONALD J. BACIK, M.D., a witness herein, taken by the Plaintiff as if upon cross-examination before Marguerite A. Sandly, RPR/CM and Notary Public within and for the State of Ohio, at Chest Disease Associates, Inc., Deaconess Professional Centre, Suite 311, 4269 Pearl Road, Cleveland, Ohio, on Thursday, the 3rd day of December, 1987, commencing at 7:00 a.m., pursuant to notice and agreement of counsel.

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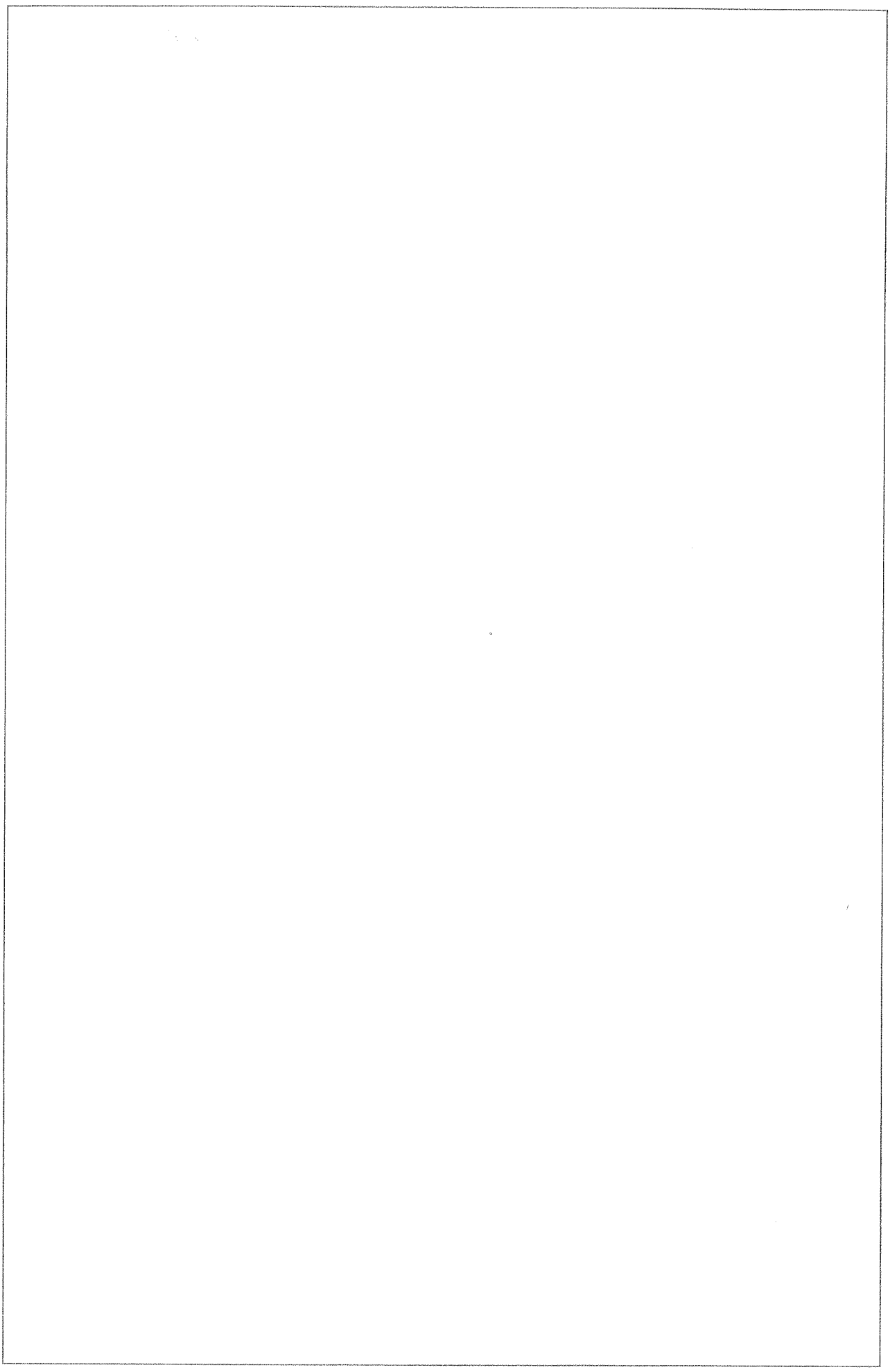

APPEARANCES:

Char es Kampinski Co., L.P.A.,
By: Charles Kampinski, Esq.,
and
Christopher M. Mellino, Esq.,

On behalf of the Plaintiff.

Reminger & Reminger Co., L.P.A.,
By: Marc W. Groedel, Esq.,

On behalf of Defendants
Timothy L. Stephens, Jr., M.D.
and Curtis W. Smith, M.D.

Arter & Hadden,
By: Michael Zellers, Esq.,

On behalf of Defendan
St. Luke's Hospital.

Jacobson, Maynard, Tuschman
& Kalur Co., L.P.A.,
By: William Bonezzi, Esq.,

On behalf of Defendant
Song Joon Lee, M.D.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Marguerite A. Sandly; that her stenotype notes may be subsequently transcribed in the absence of the witness; and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taking this deposition are waived.

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RONALD J. BACIK, M.D.,

a witness herein, called by the Plaintiff for the purpose of cross-examination as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your full name, please.

A. Ronald John Bacik.

Q. And you are a physician here in Cleveland, right?

A. That's correct.

Q. Do you have a CV, Doctor, that we can look at?

MR. ZELLERS: It was in our arbitration packet. I have got one here that you can look at.

MR. KAMPINSKI: Okay. Thank you.

Q. (BY MR. KAMPINSKI) Have you ever been associated with St. Luke's Hospital, Doctor?

A. No, I haven't.

Q. You were retained by Mr. Zellers to render an opinion in this case; is that right?

A. That's correct.

Q. All right. What materials did you review to provide him with an opinion originally?

A. The hospital record and then the depositions as they became available.

I believe I have most of the depositions except for one expert witness; is that correct?

MR. ZELLERS: You may.

A. I can tell you what I have here.

Q. Okay.

A. Howard Nearman's, Edgar Jackson's, Edward Lin, Al Oliver, Agnes Sims, Song Lee. That's it.

Q. Okay. You didn't get Dr. Van Poznak's then?

A. I did not.

Q. Okay. Your report which was dated October 19th, '87, is that the only report that you prepared in this case, Doctor?

A. I believe it is.

Q. Okay. What were you asked to do initially that led to your preparing this report?

A. Mr. Zellers wanted me to comment on the most likely cause of death, given the possibility of aspiration-pneumonia or acute myocardial infarct.

A. And having reviewed the hospital records, the letters of Dr. Rogers, I think that was the only expert letter that I had at that time, and the depositions of Nurse Sims and Dr. Lee, I believe.

Q. Okay. How about Dr. Nearman, his report?

A. Not at that time. I did not have that deposition.

Okay. You don't agree with Dr. Nearman's conclusions in terms of his belief, hi conclusion that is?

. I think aspiration-pneumonia i possibly leading cause of death, but I don't thin it was by any means a likely possibility.

Q. Did you render any other opinions at the time of your making this report that aren't set forth in the report?

MR. ZELLERS: Objection.

A. I am not sure I understand the question. Did I write something down or --

Q. No, no. Did you tell Mr. Zellers that you had any other opinions with respect to the case that just aren't contained in the report?

A. I told him that I thought there were

other possibilities as to the cause of death that were not included with those two options.

Q. Okay. Did you indicate to him that you had any opinions whatsoever on the intended or proposed likelihood of the life expectancy of Mr. Smith had he survived this incident?

MR. ZELLERS: Objection.

A. At that time, no.

Q. Have you since then rendered such an opinion?

A. I think I have an idea, rough idea of what his life expectancy would have been.

Q. Let's go slow, first of all.

There are tables, are there not, Doctor, that physicians such as yourself use for purposes of determining statistically how long somebody will survive, life expectancy tables set forth by the government, by life insurance companies, things of that nature?

A. Yes, they are.

Q. All right. And those take into account the entire population of sick people as well as well people, do they not?

A. Yes.

Q. So statistically that would be an

average for any given person; would that be correct?

MR. ZELLERS: Objection.

A. It's an average that relates to an average person, someone with an average amount of illness, it's only that. Simply an average.

Q. Right. But it's an average of sick people as well as well people?

A. Yes, it is.

Q. You don't, I take it, profess that you have any great insight into the ability to forecast the day or the year or the month in which somebody will die?

A. Obviously not.

Q. All right. Given that, why don't you tell me what your opinion is, Doctor?

A. Well, obviously no one has a crystal ball and you cannot predict, as you just stated, with any kind of certainty what the time of death or the date of death of anyone is going to be even given a pretty good insight into their medical history. However, we know beyond the tables that you alluded to, that primarily do not come from the medical profession, they come from insurance companies, the actuarial tables are from the

government, they're not based on medical information, per se, from the medical field.

We do know that certain diseases do shorten life span. Perhaps the best identified tables have to do with the life expectancy in patients with cancer. That does not apply here, but those tables are fairly worked out by tumor registries. I think it's fairly well known that certain major medical problems can shorten life expectancy and are responsible for major deaths relating to medical problems, and that being heart disease and lung disease.

This patient exhibited a strong history of at least one and possibly two types of heart disease, that being hypertension and coronary artery disease, and also had a history of chronic obstructive lung disease.

Q. Where do you see a history of coronary artery disease?

A. This is referred to in some of the depositions, I believe in some of the records from previous institutions, this is by inference and by the statements that other physicians have made.

There is very little in the hospital record from St. Luke's Hospital to document any

degree of coronary artery disease, but he did carry that diagnosis.

Q. From whom?

A. Well, it was in a University Hospital record from 1983. I believe Dr. Jackson alluded to it in his deposition that he had, he had heart disease. And that would not be --

Q. Well, coronary heart disease?

A. I believe so, if I am not mistaken.

Q. Yes.

A. And it would not be uncommon for a patient with a degree of hypertensive heart disease, that this gentleman exhibited, to have additional ischemic or coronary artery disease as well.

Q. Well, let's take that. Coronary artery disease, I take it, is treatable, is it not, by by-pass?

A. I'm sorry. By?

Q. By-pass.

A. Well, that's one form of getting at coronary artery disease, is bypass surgery.

Q. Medically it can be treated?

A. Medically you can extend life expectancy with treatment.

Q. Exercise?

A. Exercise would help.

Q. Diet?

A. Obviously.

Q. Okay. So there are treatments for coronary artery disease which I take it could affect someone's life expectancy?

A. Exactly. There are treatments that could extend how long the patient would live. There are no cures, per se, for coronary artery disease.

Q. And there is absolutely no documentation I take it anywhere that would reflect the extent of any coronary artery disease if, in fact, it existed in Mr. Smith?

A. That's exactly correct.

Q. Okay. As far as hypertension, are you suggesting, Doctor, that Mr. Smith would have lived less than 19 years from the date of his death because of his hypertension?

A. I think he would have.

Q. 18 years, 17, 16 and a half, 14?

A. This is obviously getting into the area of --

Q. Well, in your experience.

A. -- speculation. But I think if we were going to state a time period at which he probably would no longer be alive, based on the severity documented in the chart, it was hypertension and the risks that that entails, added to the fact that he had chronic obstructive lung disease, and let's at least say possibly at least coronary artery disease. I think that a good estimate would be that he probably would not have survived more than ten years or half his expected life, his life expectancy at that point.

Q. Okay. What kind of medication was he on for his hypertension, Doctor?

A. He was on Lopressor and a diuretic, if I am not mistaken.

Q. At the time of his hospitalization?

A. I believe he was. He was on Lasix and Lopressor.

Q. Did you read Dr. Jackson's deposition or just the summary that Mr. --

A. I read most of his deposition.

Q. Did you see where he indicated that his blood pressure was fairly well controlled?

MR. ZELLERS: Objection.

Q. Do you recall that testimony, sir?

MR. ZELLERS: Objection.

A. No. I don't.

Q. (BY MR. KAMPINSKI) Would that change your opinion if, in fact, that was his testimony?

MR. ZELLERS: Objection.

A. No, not really. You're evaluating a patient at one point in time when you are taking care of him in the office that might be no more frequently than three or four times a year. With him in the hospital here, under relatively stable conditions, certainly you can have an elevated blood pressure due to the anxiety of being in the hospital, but that doesn't persist for 24 hours a day.

In general, I think that his hypertension is documented by numerous blood pressures in the hospital. It was poorly controlled on the same medication that wa supposed to be controlling him as an out-patient

Q. Are you suggesting that there weren't reasons in this hospitalization for an elevated blood pressure, Doctor?

A. I just said there were. The point is, that doesn't cause a sustained high blood pressur 24 hours a day. And by and large his readings

were elevated.

Q. How many times did you see Mr. Smith, Dr. Bacik?

A. How many times did I see him?

Q. Sure.

A. Not at all.

Q. Then wouldn't the doctor who did see him have a better idea of whether his blood pressure was controlled or not controlled?

A. Blood pressure control is related to a blood pressure reading on the cuff. You don't have to see the patient to see whether the blood pressure is controlled or not.

Q. Was it controlled in your opinion?

A. No.

Q. Okay. How about before he entered the hospital, was it controlled sufficient for him to undergo the surgery?

A. That would be something I would have to defer to the attending physician at that time, because I only have, I don't think I have any exact records stating a blood pressure. I may in Dr. Jackson's office records.

Q. You mean there is no admitting blood pressure when he came to the hospital on the 13th?

A. Oh, yes, there was, but that, you know, by the same argument you are using before, may be a spurious blood pressure. I would expect that to be a little bit off and not very valid because of the anxiety of being admitted to the hospital.

That first blood pressure is not one that you are going to be hanging a lot of information on.

Q. Well, if it was uncontrolled, should he have gotten the surgery?

MR. ZELLERS: Objection.

A. Well, we're talking not between controlled and uncontrolled. It's a gradient, it's how well controlled was the blood pressure. I think that he had moderately severe hypertension. Not all hypertension can be controlled as well as we would like to have it controlled.

I think that in this situation, judging from the records, that at best the control was only fair. And if I might expand on that, the fact that the patient had cardiomegaly, or an enlarged heart, would speak to the fact that the blood pressure was elevated for a substantial length of time.

Q. What's athlete's heart, Doctor?

A. Athlete's heart?

Q. Yes, athlete's heart.

A. That is a layman's term.

Q. I am a laymen.

A. And probably a laymen's diagnosis.

I think some people in the past have felt that an enlarged heart can be related to -- how should I state this -- a patient who has exceptional physical conditioning. They may have an enlarged heart that is there because of his physical conditioning and not because of any type of medical abnormality. I personally have never seen that situation and I think it's debatable whether it exists or not.

Q. It's documented in the medical literature, is it not?

A. I don't know whether it's documented in the medical literature. If it is, there is not a large amount of articles on it. It's not a big thing.

Q. What was the nature of his congestive, I'm sorry, of his pulmonary disease?

A. Again, he carried a diagnosis of chronic obstructive lung disease and he was a smoker. And I assume that was the basis for his diagnosis.

There are very, there is very little information in the chart to document the extent of his chronic lung disease.

Q. Well then, what conclusions do you reach from whatever is available in terms of the nature and extent of it?

A. Unfortunately there have been no blood gases done as a base line. All I have is Dr. Jackson's previous records, records from previous admissions documenting chronic obstructive lung disease and the history that he was a smoker.

He also was admitted the first time for the surgery and was discharged, as you know, because of a pulmonary problem. Dr. Jackson felt that it was unsafe with the pulmonary condition to go through, what he felt was a chronic bronchitis. Based on that information, you can surmise that he had some degree of chronic obstructive lung disease. For me to tell you how severe that actually was, I would actually need pulmonary function studies or at minimal arterial blood gases done at ambient air.

Q. And without any of those studies, Doctor, are you just guessing then as to the extent of his

lung disease?

MR. ZELLERS: Objection.

A. I think it would have to be an assumption. It's not anything concrete. I do think that he had chronic lung disese.

Q. Perhaps mild?

MR. ZELLERS: Objection.

A. Judging from Dr. Jackson's concern about his pulmonary situation and that he canceled surgery, I would say probably more in a moderate degree, which results in an, on functions studies, which equate to about a one/third reduction to close to one/half reduction in his lung function.

Q. (BY MR. KAMPINSKI) And if he stopped smoking, could that improve?

A. It might. It might improve a bit. I think cessation of smoking improves anyone's lung function. The degree to which improvement takes place is individual, and again based or judged by functional studies.

Q. So there is treatment for that then also?

A. Yes, there was treatment for that.

Q. And do you have any statistical studies that you can rely on, Doctor, that you are aware of that support or detract from your opinion?

A. No, I don't.

Q. Have you ever testified -- I'm sorry. take it that -- Have you ever been retained by Mr. Zellers or any members of his firm to testify before?

A. No, I don't believe I have.

Q. How is it that he retained you in this particular case?

A. I am not sure how Mr. Zellers got my name.

Q. Have you ever testified before, Doctor?

A. Yes, I have.

Q. All right. For whom?

A. Let's see. I testified for Kitchen, Messner & Deery in two cases.

Q. Well, what were they?

A. One was a patient, the patient's name was a Michael Opalko, and I was retained to defend, help defend Dr. Mersol in that case.

Q. And he was what kind of doctor?

Ear, nose and throat.

. Okay. Who was the attorney at Kitchen, Messner & Deery?

A. Steve Albert.

Q. All right. Go [illegible].

A. And there was another one for Kitchen Messner with Barbara Jean White, and I don't recall, but it was versus a hospital, and I don't recall the hospital right offhand.

Q. Was that for Steve Albert also?

A. Yes, it was.

Q. And did both of these go to court?

A. Neither one of them went to court.

Q. You testified at deposition?

A. Right. Exactly right.

Q. All right. Any other cases?

A. There is a case for Reminger & Reminger for Mr. Marvinney.

Q. I'm sorry, Mr. Who?

A. Marvinney, Craig Marvinney.

Q. Okay. What was the nature of that case?

A. It was against, I believe, Mt. Sinai Hospital. And I don't remember the name unfortunately of the plaintiff.

Q. What was the nature of the case?

A. It was a case of a patient who was found dead in bed and the hospital was being sued for negligence.

Q. And who were you retained on behalf of, the hospital or the doctor or both?

A. The hospital.

Q. What kind of an opinion testimony did you give in that case; what did it relate to?

A. It related to the probable cause of death and the outcome, if indeed the etiology of the situation was such, what would be the patient's chances of survival had it been adequately diagnosed or treated at that point in time.

Q. I'm sorry. What was the nature of the Barbara Jean White matter?

A. That was a post-operative surgical problem in a patient with multiple medical complications who went on to die from pulmonary cause.

Q. And the nature of your testimony in tha case was what?

A. Having to do with essentially the diagnosing of her medical problem at that time post-operatively and was it adequately treated or not; could death have been prevented, in other words.

Q. And the nature of your testimony in Opalko?

A. This was a strange case of a youngster

who was admitted to the hospital with severe brain damage following an accident involving his bike and a park vehicle. He was admitted, I think it was, to Marymount Hospital for several months under the care of, the pulmonary status under the care of Dr. Mersol. He was then transferred, he improved, survived for another six years and then was found dead one morning by his mother. And they were alleging that Dr. Mersol's care six years hence, previous, had caused his ultimate demise.

Q. Any other cases? And the nature of your testimony was what?

A. That Dr. Mersol's -- the evaluation of Dr. Mersol's care of the patient at Marymount Hospital.

Q. Any other cases that you have been retained by anybody to assist in?

A. There have been some cases that I have looked at records and rendered an opinion either over the phone or by letter, but nothing that went even as far as a deposition, to my knowledge.

Q. And for whom would that have been?

A. I think there were one or two others for Kitchen, Messner & Deery.

Q. Okay.

A. I believe there were a couple for Reminger & Reminger. These go back quite a ways.

Q. Okay. Any other firms that you can recall, Arter & Hadden?

A. I think this is the only one with Arter & Hadden.

Q. Jacobson Maynard?

A. No.

Q. Any other firms that you can think of?

A. Not offhand.

Q. Did you review the depositions for the purpose of determining whether or not appropriate care was given by any of the doctors or the institution involved?

A. Yes, I have.

Q. Did you put that in any report?

A. No.

Q. What is your opinion with respect to the care provided Mr. Smith by the doctors; let's start with Dr. Lee?

MR. ZELLERS: Objection.

Q. There are a few things that I think that I would have done or would have expected to have seen done in the immediate post-operative period

in this case that I think Dr. Lee didn't do.

Whether that would have made a difference in the final outcome or not is another question. However, I would have certainly felt more comfortable with more data earlier on to know exactly where the patient stood with regard mainly to his cardiac and pulmonary status.

I looked at it obviously with interest from the point of the nurses in the hospital, since this was the reason why Arter & Hadden is involved in the case, and I really could find no evidence of any negligence on the part of the nursing staff.

In fact, I thought the nurses did an incredible job. I am a bit confused as to the responsibility of some of the physicians involved, some of the house-based physicians and also Dr. Oliver, I think, who is the, at least he was at that time the doctor who was in charge of the surgical intensive care unit and what his relationship is to both the hospital and to the attending physicians in the manner of taking care of their patient.

That is a very individual thing hospital to hospital. Some institutions have the patients

transferred to the intensive care unit and become under the primary care of the intensivist. I think that's a very uncommon situation in the United States today, but it does occur in certain institutions.

If the relationship is such that he is there to assist, if needed, the attending physician, that changes, of course, the whole complexity and his legal responsibilities and medical/ethical responsibility, as far as I see it, to the patient. And I am not sure that I fully understand exactly the relationship between Dr. Oliver, the hospital, and the physicians.

Q. Well, let me ask you some specific questions, Doctor. The failure, I take it, of the residents or of Dr. Oliver or Dr. Lee or Dr. Smith to properly care for this patient who you believe had some serious physical problems when he entered the hospital certainly would result in the high degree of risk of dying to this patient, wouldn't you agree with that?

A. I think inappropriate care in a situation of this, in this situation would result in, could result in serious medical problems or death.

Q. Yes. And I take it any institution should be aware of whether or not the doctors they put in charge of part of the hospital such as a recovery room should be aware of the competence of that individual, should they not, sir?

MR. ZELLERS: Objection.

A. Why I think that's the whole process of credentialling and the reason for applications and the process of adjoining medical staff.

Q. You would agree with me, would you not, that the failure of that process to work adequately, and that is to allow an incompetent physician to be in charge of, let's say, a recovery room, could result in a high degree of risk to a patient requiring care of a competent physician in that recovery room; would you agree with that, Doctor?

MR. ZELLERS: Objection.

MR. BONEZZI: Objection.

A. We're dealing with an assumption that an incompetent physician is in charge of an area and that the hospital knows that this physician --

Q. Or should know.

A. Well --

Q. And I will grant you that those are both

assumptions, and I will ask you to assume that.

A. I think that would be negligence, yes.

Q. Wouldn't it be more than that, Doctor?

MR. ZELLERS: Objection.

Q. Well, I am not -- that's not fair, because whether it's negligence or whether it's far more than that is not for you or me to decide, it's for the jury.

A. Fine.

Q. Let's talk about the conduct and then we'll talk about the degree of culpability attributed to that kind of conduct. Fair?

A. All right.

Q. Were you aware of the requirements of the hospital to have Board-certified physicians as level three anesthesiologists?

MR. ZELLERS: Objection.

Q. (BY MR. KAMPINSKI) Were you aware of that requirement, sir?

A. The hospital is required to have Board-certified physicians?

Q. The hospital required its level three anesthesiologists to be Board-certified; were you aware of that, sir?

A. No, I wasn't.

Q. Mr. Zellers didn't tell you that?

A. No.

Q. Were you told at all of Dr. Lee's testimony in this case?

MR. ZELLERS: Other than his deposition?

Q. Yes. What he testified to Monday morning, or Tuesday at trial.

A. No.

Q. You are not aware of that at all?

A. No. I was only told that he was going to admit some degree of negligence in the case, but that was the sum total. I did not know what he testified to.

Q. Or what Dr. Smith testified to?

A. No, I don't know that at all.

Q. Should Dr. Lee and Dr. Smith have been aware of the CPK and the Mb fraction of two percent?

A. I think they both probably should have been aware of it as for starters. Whether they would have done anything about it beyond that point is another issue, but I think Dr. Oliver was the doctor who ordered the study, I believe.

Q. Sure.

A. Am I correct?

Q. That was an hour after he returned to the intensive care unit after surgery; isn't that correct?

A. Yes.

Q. Isn't it true that you would expect that to rise if additional tests would have been taken, additional enzymes would have been drawn?

A. This two percent Mb fraction has disturbed me, because it's not something you run across very often. It's a very low percentage. I have talked to some people in pathology here at this hospital who state that they really can't make much out of a two percent fraction. As a matter of fact, they felt that at least in their institution it's probably insignificant.

Q. Well, what troubles me is that I can't talk to them. They're not here, Doctor.

A. I am giving you my opinion based on what I would do in the same situation, how I would handle this situation.

Q. Sure.

A. And whether I would consider it significant, whether I would consider it significant or not.

Q. Yes.

A. The fact that the total CPK was minimally elevated, I believe if I am not mistaken, 339, and the upper limits would be 300 in their laboratory, and the fact that he just went through major hip surgery, which he would be expected to raise the total CPK, not the Mb fraction, but the total CPK, that that two percent, if we expected the increase to be from a cardiac source, would have been much higher.

Q. Would it be much higher within an hour of the damage occurring or does it take a number of hours, sir, for it to register?

A. It generally takes a while for the CPK to go up. What I am not sure about and what my feelings are on the issue is that it's not a slow gradual rise over a period of several hours to a peak. I think the peak is fairly sharp. The decay portion might be a little bit slower.

Q. Once again, you haven't read the deposition of Dr. Van Poznak; is that right --

A. No, I have not.

Q. -- the other physician retained by the hospital as an expert, you haven't read that?

A. No.

Q. And is your concern as to whether or not they would have done anything about it based upon your belief that it may not have been significant or their inability to understand what it meant if they did see it?

A. I think it may not have been significant.

Q. I see. Did you read Dr. Lee's testimony that he did not know what the Mb fraction was; did you read that, sir?

A. If I did -- I have read Dr. Lee's deposition a while back. I don't recall that particular incident.

Q. Okay.

A. I do recall that, I believe you are referring to it in another deposition I read mor recently, but I didn't go back to read Dr. Lee's deposition to confirm that.

Q. Should Dr. Lee have known about the black qualac positive emesis that had occurred with Mr. Smith?

A. I think Dr. Lee should have been aware of the falling hamatocrit and hemoglobin, which one --

Q. There were a number of emeses between

the 14th and the 17th.

A. But I think only one was tested for guaiac.

Q. I think that's probably right.

But he should have been aware of it, whether only one was tested or not, shouldn't he? He should have read the record to have become aware of it, shouldn't he?

A. I think it had some significance in the situation.

Q. And you've read his testimony, although a while ago, where he's indicated that if he knew the values, he probably wouldn't have authorized surgery at that time; are you aware of that, too?

A. Yes.

Q. You don't disagree with that, do you?

MR. ZELLERS: Objection.

A. Whether or not a patient goes to surgery is often a value judgment that has to be made at the time. There is almost, in my mind, no type of patient that cannot undergo surgery. In other words, it's the balance of risks versus the benefit of the surgery, and there are very little absolute contraindications to surgery.

I think what we would have to do is

collect all the data available and then make a decision based on the risks versus the benefits or the need for the surgery, whether or not you would proceed with that.

Q. Okay. And take the appropriate cares to monitor the patient and provide care based upon the risks that are present, right?

A. That's correct.

Q. But to do that you need the information as to his condition, don't you?

A. Yes.

Q. Okay. And Dr. Lee did not have that, did he?

A. I don't think he had all of it, no.

Q. And Dr. Smith didn't give it to him either, did he, because he didn't have it, did he?

MR. GROEDEL: Objection.

A. I don't think Dr. Smith gave Dr. Lee any information.

Q. What was Mr. Smith's condition when he got to the recovery room?

A. Are you talking about the second surgery?

Q. Yes, sir.

A. Well, he appeared to have tachypnea and tachycardia, which by itself is not terribly

unusual. He had a limited surgical procedure under spinal anesthetic. And even given the problems that he did have, his heart disease, lung disease, the fact that his hematocrit had dropped, I think that immediately post-operatively he came through the initial part of the surgery, the surgical event in pretty good shape.

Q. He was in pretty good shape?

A. I think for a post-operative patient at that point in time, I think he was okay. I would not be terribly concerned about the information I have relating to his case immediately post-op.

Q. How did he do later on?

A. Well, that's where you would have some concerns.

Q. I see.

A. He, throughout the period of time in the recovery room, developed increasing respiratory distress, he developed myocardial irritability, he became more confused, and it was obvious that something was going on in a progressive fashion. And I think by the time we get to, roughly, 10:00 or so, 9:55, and from that point forward things began to get rather serious.

Q. Did he receive appropriate care up until

that time by Dr. Lee?

MR. ZELLERS: Objection.

Q. The best that I can tell, with the way the notes say, I think that up until that time supportive care, which was essentially what Dr. Lee was giving, could not be faulted to any great extent. From that point forward I think there were more things that could have been done. And in retrospect, things that probably should have been done earlier on in the recovery room stay, but looking at the events moment by moment as the patient is progressing from the end of surgery up until his demise, I think that, in all probability, people, anyone taking care of him should have been significantly concerned in that time period between nine and ten o'clock.

Prior to that we certainly couldn't fault someone for being concerned. I think, though, from that point forward it was somewhat mandatory that further steps be taken.

Q. Well, how did they do after that?

A. Well, I think that the studies that I would have liked to have seen done were not performed.

Q. How about the medication that he was

provided, was that pretty good treatment?

A. Medications specifically for what?

Q. How about sodium pentothal, was that a good drug to use on Mr. Smith?

A. Sodium pentothal was given just prior to intubation, if I am not mistaken.

Q. You are not mistaken.

A. Well, that's not my choice as a medication for intubation, but it's an acceptable one.

Q. Is it?

A. (Witness indicating.)

Q. How did it affect Mr. Smith's heart?

A. How did it affect Mr. Smith's heart?

Q. Yes, sir. You are a chest disease doctor.

A. I don't know that it affected his heart in any significant fashion.

Q. Is it a cardiac depressant?

A. So is Lidocaine, for that matter. But it needed to be given at that point.

Q. So sodium pentothal was needed?

A. I think if he was going to be intubated and he required something for sedation to intubate him, he was at this time confused and, as I

understand it, somewhat combative.

Q. Where do you understand that from, sir?

A. Either from the depositions or from the record itself, which said that he became progressively more confused and disoriented.

Q. Why don't you find that for me.

A. Patient remains agitated.

Q. What time?

A. 10:05. Let's see if I can find any other references. Patient restless, 10:25. Those are the two.

Q. Well, the term you used, sir, is "combative," and I would only ask you where you came up with that?

A. Well, I will retract combative. The picture that I am gaining here is that the patient is becoming more and more excitable based on his worsening pulmonary status and difficulty in breathing.

Q. I get the picture, Doctor.

A. And I think in a situation like that, it's hard to put a plastic tube into the patient's throat when he's upset.

Q. Sure, I understand. Any other opinions that you are going to render today, sir?

MR. BONEZZI: Objection. He doesn't know unless he is asked.

A. I guess that's the best way to answer. I don't know of any.

Q. (BY MR. KAMPINSKI) Well, do you hold any other opinions with respect to the care and treatment given by anybody in this case or the prospects of survival of Mr. Smith at any point in time that evening or anything else regarding your review of this case?

A. We can discuss all those --

Q. Well, let's discuss those.

A. -- those points.

Q. What would you like to discuss? How about prospects of survival, do you think given appropriate care he would have survived that evening?

A. That would have been based on knowing exactly what the cause of death was. And I will explain that for you. If the patient had a massive myocardial infarct, even with appropriate care you cannot correct the damage that has already been done to the heart. Supportive care beyond that point can only be given, and that may not have been enough to help him survive. If the

patient had a massive pulmonary embolism, again, once that occurs you can only support the patient.

Now, whether supportive therapy with oxygen and anti-arrhythmics for his heart would have been enough to pull him through, again, one can only surmise. I don't have enough information based on arterial blood gases, arterial blood gases during this time period when he was worsening, a full developed 12-lead EKG to tel you exactly what was going on in severity of the problem, to be able to fully state whether or not with any likelihood he would have been abl to survive had appropriate care been given.

Q. Does that mean you don't have an opinion based on the lack of information in the chart?

A. It means that I cannot give an estimate or give you my ideas without any degree of probability whether or not he would have survived

Q. That's fine. That's what I am here to find out. Any other opinions with respect to the care that he had been given that night? You told me about the nurses. Anything additional about Dr. Lee or Dr. Smith that you feel needs to be said?

A. I don' think so

Q. Okay. Anything additional with respect to his likelihood of surviving 10 years, 20 years, 80 years, whatever?

A. No. As I said, and this is just an assumption, but I do feel in all probability, given the extent of his medical problems predating his admission for surgery, that in all probability his life expectancy could have been another ten years or so.

Q. Or so?

A. Right.

Q. All right. Are there any other factors regarding his health that leads you to that conclusion?

A. Just the ones we discussed.

Q. Did you review his EKGs, by the way?

A. Yes.

Q. Did you review them from prior to this hospitalization?

A. I think we did have an EKG from --

Q. 1980?

A. -- '83.

Q. '83? Is there one from '80 also?

A. There might be. I am not sure I've seen that one.

Q. Were there any changes between the EKG, any of the prior EKGs and the one taken November, let's see, 14th was it? Or was there one before that?

A. November 14th, 1983.

Q. Was there one before that?

A. Not that I have out here. These are all from that admission.

Q. Were there prior EKG changes? I mean, were there changes from that EKG from the prior ones?

A. I think the only difference is now, his present admission, the one we're discussing here now in '84, there was a diagnosis made of a right bundle-branch. Prior to that, the diagnosis was intraventricular conduction delay, which at that time seems appropriate, but --

Q. It could be the same thing, couldn't it?

A. It could be, maybe just a slight worsening or a slight increase slowing of the conduction through the right bundle now making it a more proximate right bundle-branch block. He did have conduction abnormalities.

Q. And they weren't serious enough to require a pacemaker, were they?

A. No.

Q. And were they basically the same in '84 as they were before, from what you can see on the EKGs?

A. I think the EKG from '83 is very similar to the one done in '84.

Q. You said you may have had one from before, from 1980?

A. I haven't seen it, but I may have it here in the University Hospital record.

The ones I have pulled here are all from '83.

Q. Why don't you take a look and see.

MR. ZELLERS: Do you want him to look at the one in '80?

MR. KAMPINSKI: I think that's the one you showed --

MR. ZELLERS: I haven't showed anybody anything.

MR. KAMPINSKI: -- Downs.

Well, it was Mr. Charms.

MR. ZELLERS: 108 to 113, I think.

A. Well, there are several different changes. In '80 the QRS complex, QRS duration was .115, and now in '83 it's up to .129. This is

significant only in that .120 or above would indicate a complete bundle-branch block if that pattern were present.

But even in '83 this is not really a classical right bundle-branch pattern. It seems to develop more of that in 1984. So that was in the process of lessening that QRS complex. That means the conduction certainly is slower.

Q. Right.

A. Second of all, he had a left axis deviation. Well, the frontal plane axis is changed. I would have called this a left anterior hemiblock back in '80. They did not. They just called it -- They didn't call it anything, as a matter of fact.

The left anterior hemiblock, I think, was present in '80 and in '83. That's really not a significant difference. The degree of left ventricular hypertrophy, if we can use voltage as a criteria, is more significant in '83 than it was in 1980. And I am looking at that with only the EKG. I would have to wonder about an increased wall of thickness in the left ventricular consistent with a greater degree of hypertrophy.

Q. But that certainly doesn't define the

extent of the sickness or if it's even there, is it, you can only make summation?

A. It's only one piece of information. You would have to correlate that with other studies.

Q. Which weren't done?

A. A chest x-ray would be a start. And I believe a cardiac echo was performed at one point in time, too. I remember seeing a report about that.

Q. In 1980?

A. I think it was '83.

Q. Okay.

A. Not in '80.

Q. Did you review any of the x-rays, by the way?

A. The x-rays themselves?

Q. Yes.

A. No.

Q. Okay. Go ahead. You were looking --

A. That's really the only difference. There looks like there might be more left ventricular hypertrophy there, a greater degree that you can measure on an EKG. The QRS complex was lessening, which would suggest a worsening of his conduction abnormalities. But beyond that

there's little change.

Q. Okay. Anything else, Doctor, that you believe is significant in terms of his health?

A. No, not off the top of my head.

Q. Would it be important at all for you to know how he was outwardly to people who knew him day by day, whether he had complaints relating to the heart or anything of that nature; would that be important to you?

A. As far as his survival

Q. Yes.

No don' really think so

Q. How about as far as his condition at the time that he entered the hospital?

A. With regard to his --

Q. Cardiac status or pulmonary status, whether he was wheezing, whether he was short of breath, whether he couldn't climb stairs, whether he complained of angina, you know, anything of that nature?

A. Well, I think that would be helpful. I don't think it's necessary to make a diagnosis of significant cardiac problems due to his hypertension, certainly, and maybe even also to his chronic lung disease. Hypertension is known

as the silent killer. You don't need a lot of symptoms to have a significant amount of problems with that.

Q. Are there people with hypertension who live to age 80, 90, do you know of any?

A. With hypertension?

Q. Sure.

A. It depends on the degree of your hypertension and your degree of treatment.

Q. So I take it that there are then?

A. There are.

Q. Okay.

A. I don't think it's common that someone with diastolics consistently running above 100 and 110 would live that long without significant complications, heart disease, renal disease, even retinal disease, just because the time with the blood pressure that elevated is going to cause some end organ disease.

. Okay. Thank you very much.

MR. KAMPINSKI: Do you guys have any questions?

MR. BONEZZI: No.

MR. GROEDEL: No questions.
MR. KAMPINSKI: See you later.
(Deposition concluded at 8:00 a.m.)

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I have read the foregoing transcript from page 1 to page 45 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

Ronald J. Bacik, M.D.

Subscribed and sworn to before me this day of , 1987.

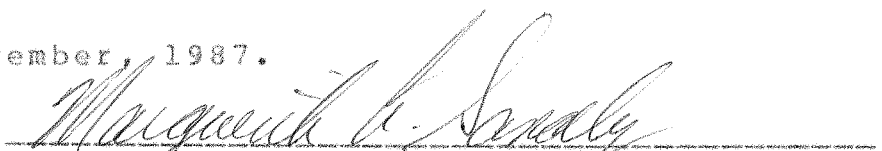
Notary Public

My Commission Expires:

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

I, Marguerite A. Sandly, RPR/CM and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that RONALD J. BACIK, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotype and was subsequently transcribed into typewriting by means of computer-aided transcription under my direction; that said deposition was taken at the time and place aforesaid pursuant to notice and be agreement of counsel; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 3rd day of November, 1987.



Marguerite A. Sandly, RPR/CM and Notary Public within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: October 30, 1989.