IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

TRACY ANN SMITH, Admin., etc.,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 327823
	)	JUDGE NANCY A.
UNIVERSITY HOSPITALS OF CLEVELAND, et al.,	)	FUERST
	)	
Defendants.	)	

The deposition of STEPHEN DOUGLAS COLLINS, M.D., taken in the above entitled case, before Joyce Fancsalszki, CSR and Notary Public in and for the County of Cook and State of Illinois, on the 16th day of January, 1999, at 2:03 p.m., at O'Hare International Airport, Chicago, Illinois, pursuant to notice.

PRESENT:

BECKER & MISHKIND
By MS. JEANNE M. TOSTI
Skylight Office Tower
1660 West Second Street, Suite 660
Cleveland, Ohio 44113
(216) 241-2600

appeared on behalf of plaintiff;

MAZANEC, RASKIN & RYDER CO., L.P.A.
By MS. COLLEEN H. PETRELLO
100 Franklin's Row
34305 Solon Road
Cleveland, Ohio 44139
(216) 248-7906

appeared on behalf of defendants Stephen Collins, M.D., and Mary Louise Hlavin, M.D.;

PRESENT VIA TELEPHONE:

WESTON, HURD, FALLON, PAISLEY & HOWLEY
By MR. KENNETH A. TORGERSON
Terminal Tower
50 Public Square, Suite 2500
Cleveland, Ohio 44113
(216) 241-6602

appeared on behalf of defendant Lee J. Brooks, M.D.;

MOSCARINO & TREU, L.L.P.
By MS. PATRICIA CUTHBERTSON
The Caxton Building
812 Huron Road, Suite 490
Cleveland, Ohio 44115
(216) 583-1000

appeared on behalf of defendant University Hospitals of Cleveland;

(Cont'd)

PRESENT VIA TELEPHONE (Cont'd):

GALLAGHER, SHARP, FULTON & NORMAN
By MR. JACK O'DONNELL
Bulkley Building
1501 Euclid Avenue, 7th Floor
Cleveland, Ohio 44115
(215) 241-5310

appeared on behalf of defendant Michael Rowane, M.D.

INDEX

WITNESS

Stephen Douglas Collis, M.D.

EXHIBITS

(Documents marked as Plaintiff's Exhibits Nos. 1 through 10 for identification.)

MS. TOSTI: Could I have a stipulation from counsel that Ohio Rules of Civil Procedure will apply and that there is a waiver to any defects in notice or service?

MS. PETRELLO: Yes.

MR. TORGERSON: Right.

MS. TOSTI: Also, could I suggest that any time that you comment during the deposition that you indicate your name so that the court reporter can take it down.

MR. TORGERSON: Surely.

MS. CUTHBERTSON: No objection, Jeanne.

MS. TOSTI: Do we have Jack O'Donnell on the line?

MR. O'DONNELL: Yes, I'm here.

MS. TOSTI: Okay.

MR. O'DONNELL: No problem with that. I'm just trying to make sure I can hear the doctor. I didn't hear him when he was sworn in.

MS. TOSTI: Okay. I think we have the speaker up about as loud as we can get it at this

end. I don't know if you can make an adjustment on your phone.

STEPHEN DOUGLAS COLLINS, M.D.,

having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. TOSTI:

Q Doctor, would you please state your name and spell your last name for us.

A Stephen Douglas Collins, C-o-l-l-i-n-s.

Q And your home address?

A 1543 West Durham, D-u-r-h-a-m, Drive, Inverness, I-n-v-e-r-n-e-s-s, 60067, Illinois.

Q And what is your current business address?

A Abbott Laboratories, 200 Abbott Park Road, Abbott Park, Illinois 60064.

Q Have you ever had your deposition taken before?

A Yes, ma'am.

Q How many times?

A About six.

Q And Doctor, what was the reason that your deposition was taken? And by that I mean, were you a defendant, a treating physician, an expert?

A Expert witness.

Q Each of those six times?

A All of those times.

Q Now, Doctor, I'm sure your counsel has explained to you some of the rules that we work under for deposition. I'm just going to review those for you. This is a question-and-answer session under oath, and it's important that you understand the question that I ask you. And if for any reason you don't understand it, if I phrased a question inartfully, please tell me, I'll be happy to repeat it or to rephrase it, otherwise I'm going to assume that you understood the question that I asked and that you're able to answer it.

If at any point you wish to refer to the medical records that your attorney has brought with her, feel free to do so. This isn't a memory game at all. I would also ask that you provide all of your answers verbally. Our court reporter can't take down head nods or any type of hand motions. And at some point during this deposition, your counsel or one of the other defense counsels may enter an objection, you are still required to answer my question unless your counsel tells you not to do

so.

A 1 understand.

Q Now, at the time that you rendered care to Patricia Smith, were you an employee of a professional medical group?

A Yes, ma'am.

Q What was the name of that group?

A University Neurology Associated, Inc., or University Neurologists Associated, Inc.

Q And how many physicians were in that group?

A I'd guess about 12 to 15 neurologists.

Q And they were all neurologists?

A Yes, ma'am.

Q And who is your current employer?

A Abbott Laboratories, A-b-b-o-t-t.

Q What is your title and position at Abbott Lab?

A I'm an associate medical director. I'm not quite sure how to differentiate title and position.

Q Okay. Your title is associate medical director; is that correct?

A Yes, ma'am.

Q Okay. Is that a full-time position?

A Yes.

Q When did you begin working for Abbott Labs?
A June of 1997.
Q And as an associate medical director at Abbott Laboratories, what are your duties and your responsibilities?
A I supervise, direct, manage development of pharmaceuticals for neurologic disorders and specifically, primarily, epilepsy.
Q And what is the reason that you left your practice in Ohio and moved to Illinois?
A Various reasons. One was it gave me an opportunity to direct development of new medicines for people with epilepsy, which I couldn't really do in academics, and it was a new challenge.
Q And did you relocate at approximately the same time that you took the position with Abbott Lab?
A Yes.
Q Do you currently have a clinical practice where you see patients?
A No, ma'am.
Q And do you currently have hospital privileges anywhere?
A No, ma'am.

Q At the time that you rendered care to Patricia Smith, were you under any type of a mental or physical disability?

A No, ma'am.

Q And other than for Abbott Laboratories, do you currently render professional services for any other entity?

A No.

Q At the time that you cared for Patricia Smith, did you provide professional services for any entity other than your medical group that you previously mentioned?

A No.

Q Have you ever been named as a defendant in a medical negligence case?

A No.

Q Have you ever had your hospital privileges called into question, suspended or revoked?

A No.

Q What states are you currently licensed to practice medicine in?

A Illinois and Ohio.

Q And at the time that you rendered care to Patricia Smith, you were licensed to practice in

Ohio; is that correct?

A That's correct.

Q Have you ever been licensed to practice in any other state besides Illinois or Ohio?

A Yes, California.

Q Has your medical license in any state ever been suspended, revoked or called into question?

A No, ma'am.

Q Now, Doctor, you mentioned previously that you had had your deposition taken as a medical expert six times before, correct?

A Approximately six.

Q Okay. Besides the six times that you had your deposition taken, how many times have you acted as an expert in a medical-legal proceeding?

A 'Would that include reading cases, as opposed to actually being deposed, but records being sent by a lawyer saying, What do you think of this thing?

Q Let me clarify the question then. Do you or have you in the past done medical-legal reviews on a fairly regular basis?

A I guess, yes.

Q Over the course of a year's time, say in

the last year, how many medical-legal reviews have you done?

A I haven't done any in the last year. Prior to that, maybe one or two a year.

Q And over how many years have you done approximately one or two a year?

A I have to do some arithmetic. Ballpark, 10.

Q Do you recall, in the ones that you did most recently, you said not this year but the previous year, do you recall the allegations of negligence in those cases that you reviewed?

A Yes, I think I can remember most of them. I certainly recall what they asked me to do, I mean.

Q If you could tell me what that was?

A Basically, as an epileptologist, they asked me to review whether a diagnosis or an evaluation, a workup, if you will, was done correctly where diagnosis of epilepsy or seizures was made.

Q Have you ever done a medical-legal review involving seizures that occurred during sleep?

A I don't remember because -- I could certainly say that none of them were primarily seizures during sleep. Whether any of the patients

may have had a seizure during sleep is another matter.

Q Did any of the cases that you've acted as a medical-legal expert on involve any questions that dealt with obstructive sleep apnea?

A No.

Q Any deal with any type of a sleep disorder in conjunction with seizures?

A Not that I recall.

Q Have you ever testified in court?

A Yes, ma'am.

Q How many times?

A Twice, I believe.

Q And when were those two times that you testified?

A It was a while ago. I would guess about '95 or '96, maybe '94, '95, '96, in that ballpark.

Q And where did that testimony take place?

A One tools place in Cleveland and one in Florida.

Q And do you recall the allegations of negligence that were made in those two cases?

A The generalities. Do you want to hear them?

Q Yes.

A The one in Florida concerned whether seizures were occurring in a patient and whether any of the diagnoses made and the biopsies and other sort of medical evidence was consistent with a diagnosis of epilepsy. And the other was as to the causality of a head injury and someone's seizures.

Q The one that dealt with the causality of a head injury, was that the Florida case or the Cleveland case?

A That was the Cleveland case.

Q And do you recall who the plaintiff was in that case?

A No, I'm sorry.

Q How about in the Florida case, do you recall the name of the plaintiff?

A No, sorry.

Q Doctor, I've given you what has been marked as Plaintiff's Exhibit 1, which I believe is a copy of your curriculum vitae. And I would like you to please look over it and tell me if it's up to date and if there's any additions that you would like to make to it or any corrections.

A I understand. The home address is

incorrect. That obviously I've already gone over. The home phone is incorrect. My new home phone is (847) 963-8141. My business address is as I've already indicated.

The education section is all the same. The current position is updated with my position at Abbott Labs. My board certification is the same as in neurology. The license section needs to be updated because I now have an Illinois registration, my California I let lapse. I've still been a reviewer for these journals on and off.

The committees, I'm no longer on the American Heart Association, Indiana Chapter Grant Review Committee. I'm no longer on the Epilepsy Foundation, Northeast Ohio Chapter. I am still on the American Association of Neurology Practice Standards Committee. And obviously, the University Hospitals Committees I'm no longer a member of. I am still a reviewer for the National Institutes of Health, Epilepsy Branch.

Clinical research doesn't have much, there's no changes or additions there other than the fact that I run clinical trials now.

Teaching experience, that's all correct.

Professional societies is correct. The invited lecturer section is basically correct, certainly in all those which occurred, and since '97 I've had probably another 20 to 30 invited lectures.

Publications is incorrect because of several publications. Most notable is probably in Neurology this year, which was the position paper of the American Academy of Neurology on diagnosis and evaluation of epilepsy in women, which is the Practice Standards Committee communication on adequate practice standards for diagnosis of epilepsy.

And there's a ton of papers in preparation, but those don't really count much. And then there's some more book chapters.

Q Okay. I have a few more questions in regard to your C.V., so if you'd just keep that in front of you. The date that you have down for your medical school training, I believe, is 1984. Is that the date of completion?

A Yes, ma'am.

Q Do you currently hold any type of a position with Case Western Reserve University?

A No, ma'am.

Q In regard to your board certifications, I believe you have down that you are board certified in neurology; is that correct?

A That's correct.

Q Did you pass that on your first try?

A Yes, ma'am.

Q Under the area of clinical research, these particular studies, did they all involve studies with pharmaceuticals? Or let me rephrase that.

The research that is listed on your C.V., what type of research did that involve?

A There's two general areas. There's basic science and there's clinical. The clinical has to do primarily with epilepsy pharmaceuticals and devices, that is, drugs or devices to stop seizures.

Q And would that be true for the ones that are listed under the Burroughs Welcome as well as the Wallace Pharmaceutical names?

A Yes, ma'am.

Q Do any of the publications that are listed on your C.V. deal with the subject matter of sleep apnea?

A No, ma'am.

Q Do any of them deal specifically with the

subject matter of seizures during sleep?

A No, ma'am.

Q Do any writings that you currently have in progress deal with either of those two subject matters?

A No, ma'am.

Q And have you ever participated in any research at any time dealing with the subject matter of sleep apnea?

A No, ma'am.

Q Have you ever taught or given a formal lecture or a presentation on the subject matter of sleep apnea?

A No.

Q What about just sleep disorders in general?

A No.

Q Would you tell me what you have reviewed for this deposition.

A I read the deposition of Dr. Rowane. And these medical records I went through, particularly mine, whatever you call this, you know, the book of them.

Q And I would like to know specifically what medical records. You reviewed your clinical notes;

is that correct?

A Yes, sorry, there's a list in the front. It's, I guess, labeled 2, Dr. Collins' office chart, and then I glanced through 1, 3, 4, 5, 6, 7.

MS. PETRELLO: She wants to know what these are.

BY MS. TOSTI:

Q I would like to know what those numbers --

A Oh, I'm sorry, you want me to read them out. I'm sorry.

Q Yes.

A Dr. Rowane's office chart is 1, Dr. Collins' office chart is 2, Dr. Hlavin's office chart is 3, Dr. Brooks' office chart is 4, UHOC sleep study records is 5, UHOC records is 6, and autopsy report is 7.

MS. PETRELLO: Just for clarification for everybody, I put this together based on the records that I had, and it was just, since it was together, I sent it to him that way.

MS. TOSTI: Okay. And I would ask to take a look at this at some point when we're done with the deposition.

MS. PETRELLO: Okay. These are my records,

okay. So I've got little Post-its and highlights and so, you know, I'll represent to you that those are the office records, but you're not going to look at my copy.

BY MS. TOSTI:

Q Did you review any films, such as a CT scan or MRI scan, of Patricia Smith?

A No, ma'am.

Q Have you seen the death certificate and autopsy of Patricia Smith?

A I saw the autopsy report. I don't know if the death certificate, if it was in --

MS. PETRELLO: It's not.

A No, I did not.

BY MS. TOSTI:

Q But you have reviewed the autopsy?

A Yes, ma'am.

Q Was that recently?

A The last week or so, within the last week.

Q And contained in those records, you have had an opportunity to look at the polysomnogram results?

A Yes, the reports.

Q Yes.

A Yes.
Q You mentioned that you did read Dr. Rowane's deposition; is that correct?
A Yes, ma'am.
Q Did you review Dr. Hlavin's deposition?
A Deposition? No.
Q What about Dr. Martin's deposition?
A No, ma'am.
Q Have you consulted with any physicians in preparation for this deposition?
A No.
Q Since this case was filed, have you discussed this case with any physicians?
A No.
Q Have you, since this case was filed, discussed it with anyone other than with counsel?
A My wife.
Q Now, the notes that are contained in Ms. Petrello's records, are those the notes from the clinical office visits that Pat Smith had with you?
A Yes.
Q Do you have any personal notes or a personal file on this case?
A No, ma'am.

Q Have you ever generated any personal notes on this case?

A No.

Q Are there any textbooks within your area of expertise that you go to for information from time to time in clinical practice?

A Sure.

Q What would be one of those texts that you would go to to look for information to help you in your clinical practice?

A Well, I don't do clinical practice, but you mean when I was in clinical practice?

Q Correct.

A Textbook of Epilepsy by Elaine Wiley would be a source. And then the three-volume set by Pedley and Engel, which I have chapters in, so of course I go to.

Q You have chapters in the three-volume set?

A Yes, ma'am.

Q Are those listed on your C.V.?

A Probably not. Yes, actually they are. Oh, at this time, the time my C.V. was prepared, it says "To be published Spring of '97." They finally did get them out.

Q Where are you looking at?

A It would be No. 3 and 4, Epilepsy in Pregnancy, Collins, S.D., Yerby, Ramsay, and then the chapter below that, Teratogenesis. And the other would be the chapter in Manual of Obstetrics that I wrote on Neurology of Pregnancy.

Q Do you consider the texts that you just previously mentioned, the Textbook of Epilepsy and the three-volume set of Pedley to be authoritative?

A No. I mean they're references I go to. But I think what you're talking about is, is there one thing I can go to and it's like the bible. No, there isn't any such beast. I wish there was.

Q Doctor, is there any specific professional article or publication that you believe has particular relevance to the issues in this case?

A No, I can't think of one article, if that's what you're saying.

Q What is obstructive sleep apnea?

A Well, I can give you a general definition. I'm not a sleep doctor, so my understanding in that area is thin. But it's presumably a structural mechanical obstruction of airflow during sleep.

Q And to your knowledge, what are the risk

factors for obstructive sleep apnea?

A Obesity, I presume some sort of congenital defect, you know, born with something wrong with the windpipe, larynx, et cetera. That's all I know.

Q Do you know if hypertension is associated with obstructive sleep apnea?

A Yes, I believe with severe sleep apnea hypertension is associated.

Q What about macroglossia, enlarged tongue, is that associated with obstructive sleep apnea?

A I don't know. I mean, anything in the airway which could occlude would presumably be, so I guess I -- it's not my area.

MS. PETRELLO: Doctor, I don't want you to guess. If you know, you know; if you don't, you don't.

A I don't know.

BY MS. TOSTI:

Q And Doctor, what are the signs and symptoms of obstructive sleep apnea in an adult?

A I'm not sure. Again it's not my area. Certainly one that can be is snoring. With severe sleep apnea, you get excessive daytime sleepiness, people who cannot resist falling asleep. I don't

mean drowsiness, I mean absolutely cannot resist falling asleep and have multiple episodes of that. That's what comes to mind at the moment.

Q So if somebody was talking on the phone and they fell asleep while they were on the phone, would that be an example of excessive daytime sleepiness?

A Not necessarily. It would have to be a lot more than that. I've fallen asleep on the phone. I don't have sleep apnea.

Q How is sleep apnea diagnosed?

A By a sleep doctor. A series of tests are run. And that includes electrical tests and some tests of oxygenation and C02 levels, generally, I think.

Q And then based on the results of the test, there is a diagnosis made?

A Yes, I would presume, like everything else.

Q And presuming that there is a diagnosis of severe obstructive sleep apnea, how is that treated?

A I do not know. I know from medical school that --

MS. PETRELLO: That's okay. You've answered the question.

THE WITNESS: Okay.

BY MS. TOSTI:

Q Doctor, have you ever heard of CPAP therapy, continuous positive air pressure therapy?

A Yes.

Q What is that?

A It's a mask placed over the face where there is positive pressure put over the airways.

Q Have you ever heard that as being utilized as a treatment for severe obstructive sleep apnea?

A Yes.

Q Have you ever heard of bi-level positive airway treatment?

A No.

Q How about surgical intervention for the treatment of severe obstructive sleep apnea?

A Yes.

Q Are there any complications that you are aware of associated with severe obstructive sleep apnea in an adult?

A Severe hypertension and, I believe, the risk for cardiomyopathy, that is, thickened heart, enlarged heart.

Q Anything else that you're aware of?

A Well, the excessive daytime sleepiness. I

think they have an increased risk of accidents during the day, i.e., fall asleep in the middle of their driving, stuff like that.

Q Doctor, what is hypoxia?

A Actually I don't know the formal definition, embarrassingly enough. It's a decrease from some normal range of oxygenation of the blood.

Q Can hypoxia in some cases cause seizures?

A Severe hypoxia, normally we would call anoxia, can lead to seizures.

Q Does hypoxia lower the threshold for seizures?

A Severe hypoxia can, yes.

Q If the brain doesn't get enough oxygen, can that cause a seizure to occur in some instances?

A Yes, a generalized seizure.

Q In the course of your practice, have you seen patients who have had seizures caused by hypoxia?

A Severe hypoxia, yes. For example, the patient who is in a car accident and has the ability to breathe stopped, i.e., anoxia, no breathing.

Q Doctor, would you agree that severe obstructive sleep apnea may in some cases cause a

patient to experience episodes of severe hypoxia during sleep?

A I'm sorry, run that one by, I just, I didn't catch it, sorry.

Q Would you agree that severe obstructive sleep apnea may in some cases cause a patient to experience episodes of severe hypoxia --

A Yes.

MR. TORGERSON: Objection.

BY MS. TOSTI:

Q -- during sleep?

A Yes.

MR. TORGERSON: Same objection.

MS. PETRELLO: If you know, go ahead.

A I said, "Yes."

BY MS. TOSTI:

Q And if severe hypoxia occurred during sleep, that could cause a seizure to occur, correct?

MR. TORGERSON: Same objection.

A Very severe hypoxia, protracted, lack of oxygen, could lead, yes.

BY MS. TOSTI:

Q Doctor, do you know whether patients with severe obstructive sleep apnea are at increased risk

for cardiac arrhythmias?

MR. TORGERSON: Objection.

A I do not know.

BY MS. TOSTI:

Q Okay. Are there any life-threatening complications associated with severe obstructive sleep apnea that you're aware of?

MR. TORGERSON: Objection.

A I would guess with the severe hypertension and with the cardiomyopathy, if that occurs, both could lead to life-threatening. And obviously, if you're in an accident during the day, that's life-threatening.

BY MS. TOSTI:

Q Doctor, if a person had seizures because of severe obstructive sleep apnea, can seizures be life-threatening?

MR. TORGERSON: Objection.

MS. PETRELLO: Objection.

A That's two questions. The occurrence of seizures due to sleep apnea would be unusual, rare. In all my years of practice, I don't remember any time seeing a patient either sent to me by the sleep doctors or me sending somebody because of that

concurrence. But if your postulate was, could it possibly happen and therefore in a seizure could you have bodily damage, the answer would be yes.

BY MS. TOSTI:

Q Doctor, in the course of your practice, have you ever treated adults, an adult patient, with severe obstructive sleep apnea?

A Have I treated them for it or somebody who had it as part of their multiple problems?

Q Well, let's start with, have you ever diagnosed a patient, based on appropriate testing, ever diagnosed them with obstructive sleep apnea?

A No.

Q In the course of treating patients, have you treated patients that have obstructive sleep apnea?

A Yes.

Q Were you the person managing the treatment for the obstructive sleep apnea?

A No.

Q What type of physician would normally be doing that type of treatment for the patient in regard to the sleep apnea?

MR. TORGERSON: Objection.

A A sleep doctor. And to sort of translate that, that means usually a pulmonologist, adult or pediatric, or a neurologist subspecialty trained in sleep medicine.

BY MS. TOSTI:

Q And you have no special training in sleep medicine; is that correct?

A That's correct.

Q Have you ever ordered polysomnograms for any of your patients?

A Never.

Q Doctor, would you agree that an oxyhemoglobin desaturation that falls to 60 percent during sleep in a patient with severe obstructive sleep apnea is alarming?

MR. TORGERSON: Objection.

MS. PETRELLO: Objection. If you know.

A Yes.

BY MS. TOSTI:

Q If a patient's oxyhemoglobin desaturation falls to 60 percent during sleep, could that cause a hypoxic seizure?

A Probably not.

MR. TORGERSON: Objection.

A Probably not. The reason for that is that the number of people with sleep apnea is really large and many of them have desaturations at that range or below and that's not a reason for referral to an epilepsy center, that is to say, you don't see that as a referral pattern, so no.

BY MS. TOSTI:

Q Doctor, if a patient had coronary artery disease in addition to having desaturations to 60 percent, could a patient that develops a ventricular arrhythmia develop seizures from hypoxia to the brain?

MR. TORGERSON: Objection.

MS. CUTHBERTSON: Object to form.

MS. PETRELLO: Objection, again -- if you know -- and form.

A In the first -- it's a multiple-part question. So the first part of it was something about the risk for hypoxia and cardiac disease arrhythmias, and I don't know about that.

The second part of the question was if you have an arrhythmia, can you have a seizure? Yes, if you have a thrombus, a clot, which goes to the brain and you stroke, for example.

BY MS. TOSTI:

Q Doctor, if you have a sustained ventricular arrhythmia, can't that cause a patient to go into a hypoxic seizure?

MR. TORGERSON: Objection.

A No --

MS. PETRELLO: Objection.

A -- because you'd have to have an anoxic condition, that is, relatively low oxygen, for example. And a brief burst of ventricular fibrillation will not, in the normal person, cause a seizure. If it's sustained, if you have ventricular fibrillation going on for 30 seconds, a minute, two minutes, and you have no blood flow, that is, no oxygen and blood flow to the brain, yes, you could have a generalized tonic-clonic seizure and that would be an anoxic seizure.

Q What is your definition of anoxic?

A "A" always means, in medical terms, absence of, complete zero, or 100 percent.

Q Absence of what?

A Anything. You put it in front of any word and it means not there. So here it's anoxic means no oxygen, boom, zero.

Q So you're saying that a person can only have a hypoxic seizure if their PO2 is zero? I want to understand what you're saying here.

A Right. You're positing this hypoxic seizure. And in general, to have a seizure, your oxygen has to go extremely low, like zero. Now, I don't know if it could be at 10 percent or 15 percent because we don't normally measure that. But in general, seizures which occur in the situation of low oxygen occur when breathing stops, so a cardiac arrest or sustained ventricular fibrillation, things like that, not from brief periods of relative drop of oxygen.

Q Okay. And is there a particular time interval that you would say would be the point in time when a person may develop a seizure?

A A window, if you will?

Q Yes.

A I would guess that this would be about a minute. Certainly not seconds. We all hold our breath. You can go underwater for 30 seconds to a minute and you don't have a seizure.

Q Now, when you're saying about a minute, are you saying that a person stops breathing for a

minute, or are you talking about a sustained ventricular rhythm that lasts for about a minute may then cause a person to have a hypoxic seizure? I want to make sure that I understand what you're saying. What does that minute refer to?

A Right. Well, certainly a minute of complete no breathing, one to five minutes is the general area in which you get cerebral damage sufficient for seizures, which is also enough cerebral damage that you can pick it up on neurologic exam. I don't know the period of time that you'd need to have sustained ventricular fibrillation to have a similar anoxia occur. My guess it would be 30 seconds --

MS. PETRELLO: Doctor, I don't want you to guess.

A Okay. So prolonged, a minute say.

BY MS. TOSTI:

Q Have you ever ordered CPAP for a patient?

A No.

Q Have you ever referred a patient for surgery because of sleep apnea?

A No.

Q When an adult patient has a new onset of

seizures, how should that patient be worked up? What's the standard, appropriate way to approach that problem?

A Well, the first thing you do, obviously, is take a history and try to find out if there is an obvious etiology for it. For example, the person just did cocaine. Then you would do a physical exam looking for something that might clue you to a structural lesion, for example, a tumor. Then you do certain lab tests, again looking for, for example, infection or an altered metabolic state, a person with bad diabetes. And then you would do a structural test, like a CT scan or an MRI, and a physiologic test, like an EEG.

Q Why would you try to determine the etiology of the seizure?

A For those patients, for those adults and children that you can determine an etiology, and unfortunately that's in the minority of patients, that may help guide in therapy and certainly help guide your ideas of whether it is going to be a very difficult to treat epilepsy or whether it's going to be an easier to treat epilepsy.

Q Do you have an independent recollection of

Patricia Smith --

A Yes.

Q Let me finish my question.

MS. PETRELLO: Let her finish her question.

A Sorry.

BY MS. TOSTI:

Q -- aside from what you reviewed in the medical records?

A. Yes.

Q Now, you spoke to Dr. Rowane about Patricia Smith when she was seen in the Family Practice Center after her second seizure; is that correct?

MS. PETRELLO: Wait. Just for clarification, is this before he ever saw her?

MS. TOSTI: Yes.

MS. PETRELLO: Put a time reference on this.

THE WITNESS: I see.

BY MS. TOSTI:

Q Prior to the time that you saw her in your office, you spoke to Dr. Rowane about Patricia Smith after she was seen in the Family Practice Center for her second seizure; is that correct?

A I don't think so. I think I spoke with

Dr. Martin first. If I remember correctly, I was called, and my understanding was she was in the ER, or maybe it was the Family Practice Center, after having had this second event, and I spoke with the resident, Dr. Martin, first. In fact, I don't remember if I spoke with Dr. Rowane ever or whether if my conversations were with Dr. Martin.

Q Okay. Doctor, I'm going to hand you what I have marked as Plaintiff's Exhibit 2A, 2B and 2C, and I would like, if you can, for you to identify that particular document for us.

A The 2A is my note when I saw her 11/3/95, I guess, yes.

Q Now, Doctor, about midway through the paragraph under History of Present Illness --

A Yes.

Q -- there is a sentence there that says "She was then sent over to the Family Practice Clinic where Dr. Rowane did some blood work and discussed her care with me."

A You're right. You're right.

Q Okay. Now, did you write this document, Doctor?

A Yes, ma'am.

Q And did you not indicate in this particular document that you discussed her care with Dr. Rowane?

A I guess I did. I thought it was Dr. Martin, but you're right.

Q Doctor, Dr. Rowane's record, I believe, indicates that there was a discussion with you on October 5. Does that date seem appropriate as to when you spoke with him, approximately?

A Probably about right.

Q Now, do you have a recollection of also talking to Dr. Martin?

A Well, it may be that I was confusing the two. Oftentimes when you get the phone calls, they say "Dr. Martin," "Dr. Rowane," so obviously I can't remember which one was which, sorry.

Q But you generated this particular note close to the time that you saw Patricia Smith, correct?

A Yes.

Q And so probably your recollection at that time is better than what your recollection is now?

A Certainly.

Q Now, do you recall receiving a phone call,

or did you talk to one of the doctor's face to face?

A This was a phone call.

Q What was the content of that discussion? What information were you given about Patricia Smith at that point in time?

A All right. They paged me. I was in a local restaurant with my team, actually, and they wanted some advice about where to go with her care. And so they reviewed the history, some portion of which is here. I don't remember exactly what they told me. They certainly mentioned the waking up with the paramedics, et cetera. And they said, did I think she should be started on therapy; and I said yes, because it certainly sounded like she had had seizures.

Q So you recommended that she be started on medication; is that correct?

A Yes.

Q And that was the Dilantin that was ordered?

A Yes, ma'am.

Q Did you make any other recommendations besides that she should be started on medication?

A That she have an EEG. I was trying to see back here if -- yes, and they had already done a CT

scan at another hospital and that was reported as "normal."

Q Was a referral made to you during that conversation? Did they say that they were going to send her to you to take a look at her and evaluate her?

A I don't remember.

Q Now, the family practice records indicate, Dr. Martin wrote a note that says that Patricia Smith was to see you as soon as possible. Did you ever suggest to Dr. Rowane or to Dr. Martin that Patricia Smith should be seen by you as soon as possible?

A I don't believe so. My memory of this was that they just wanted some general guidance on her. I said get the EEG and put her on some medicine.

Q Now, in the family practice notes of October 5 it indicates that she was scheduled to see you on November 3 of 1995. Is that in fact the date that you saw her?

A Yes, the note says 11/3/95.

Q And you're referring to your typewritten clinical notes that are on Exhibit 2A, correct?

A Yes, ma'am.

Q Doctor, in a patient with a new onset of seizures such as Patricia Smith had, where the cause is unknown, is it usual to wait a month before evaluation by a neurologist, is that typical?

A Where there's no mass lesion, where a CT scan has been done and there is no mass lesion, and where an EEG is scheduled appropriately, that is within a week or so, I would say it would be usual to see the patient within one to three months by the neurologist.

Q Now, the visit of November 3 of 1995, was that the first visit that you had with her?

A Yes, ma'am.

Q Doctor, now, these notes were generated after you saw her, correct?

A Correct.

Q I believe at the top of the page there is a date of November 16, 1995 on Exhibit 2A?

A Yes.

Q And this visit was actually November 3 of 1995; is that correct?

A Correct.

Q Can you tell me why these particular notes are dated almost two weeks after this visit

occurred?

A Yes, it was the sort of typical time to get a dictation corrected, et cetera. And that's why I believe I say in here that I called Dr. Rowane. So yes, in my plan on the third page, that day, "I have called Dr. Rowane and discussed her case."

Q And you're referring to Plaintiff's Exhibit 2C there, correct?

A Yes, ma'am.

Q So were these notes dictated at or about the time of the clinical visit on the 3rd?

A Immediately after seeing the patient.

Q Okay. And then you just have a typing lag time for the dictation to then be transcribed?

A Yes.

Q And that was fairly typical as to what occurred when you had patient visits in regard to getting the typewritten copy completed?

A Yes. But I always called the doctor. There were two standing orders. One is that when I saw a patient that the nurses would make sure that I wasn't getting another patient immediately so I'd always call a doctor. And the other standing order was any time a doctor called, I was to be paged

immediately. My pager was on seven days a week, 24 hours a day.

Q When you would see a patient, did you generate any handwritten notes in addition to the ones that you dictated?

A Yes.

Q And in Patricia Smith's case, did you do handwritten notes?

A Yes.

Q Where are those handwritten notes?

A Back in the files of the University Neurology Associated, Inc. They would be exactly this.

MS. TOSTI: We had made a production of documents for all records, so I will --

MS. PETRELLO: I didn't know about it.

MS. TOSTI: -- I will at this time make a formal request for the handwritten notes of Dr. Collins.

MS. PETRELLO: Let me just go off the record for a minute here.

(Discussion off the record.)

MS. TOSTI: Back on the record.

Q Now, how is it that Patricia Smith came

under your care then? You don't recall a direct referral at the time that you spoke with Dr. Rowane or Dr. Martin, so how is it that she came to you?

A Well, she wasn't under my care, I was consulting. My guess is that when the conversation occurred, I usually would end by saying, you know, if I can help you any further, and they decided to send her over to me. The issue that comes up in here is in that first paragraph on Plaintiff's Exhibit 2A, it says she took one 300 milligram dose, did not take a second or third, somehow or other spoke with Dr. Rowane who started her again, and she had a bunch of questions. So my guess would be that they said, "Well, look, we'll send you to the epilepsy clinic and have somebody see you there."

Q You don't have any recollection of that though specifically?

A No.

Q And you did not receive a referral note on this patient; is that correct?

A No, ma'am.

Q And you don't recall any additional phone call from Dr. Rowane or Dr. Martin other than that initial one when there was discussion about whether

she should be started on treatment?

A No, ma'am.

Q And what was your understanding as to why Patricia Smith came to you that particular day, on November 3 of '95?

A My memory is that she was upset, like everyone is when they hear they have epilepsy, that she had not taken the Dilantin religiously, and she wanted to be able to talk with an expert and also wanted some help with forms for her work.

Q Was it your impression she was confused about the way she was supposed to take this medication?

A No. People, when they get a diagnosis of epilepsy, are, as you can expect, just unbelievably upset, because their whole life changes. They can't drive, oftentimes their employers will fire them or not keep them on, their family mistreats them, on and on.

Q How many times did you see Patricia Smith?

A I believe twice. Is there another? I saw her on 11/3/95 and 2/8/96.

Q And did anyone accompany her to either of those two visits?

A I don't believe so. It's possible that she had a daughter or something or some family member the second time, but I don't remember. Normally, had someone, I would have, up at the top of my office note, it would have said, you know, Patricia Smith and her daughter Belinda, or whatever, you know.

Q Now, in regard to the 11/3/935 visit, what was the clinical history that you received from Patricia Smith at that visit?

A It was a 42-year-old woman who had no early risk factors for seizures, that is, cerebral palsy, something like that. And she had had an event a couple months prior, after some alcohol and a cough medicine, when she had a loss of consciousness and came to with the family surrounding her. She had had urinary incontinence. And for some reason or other that was not further evaluated. She or the family didn't take her to a hospital.

Then the second seizure happened a month later, that would be, say, October, this time without the Champale, without the alcohol or the sleeping medicine, and she was sleeping with her daughter in the bed and the mother awoke with

activity, which was presumably generalized tonic-clonic, that is, a generalized seizure, with sort of typical signs and symptoms, foaming and urinary incontinence, then came to, was taken to St. Luke's hospital, a CT scan was performed, and then sent over to see Dr. Rowane, I guess that morning. They did some blood work and at that time they, that is, the family practitioners, called me -- that would be the history -- for the proximate situations.

My history of her was, is that she also had what sounded like simple partial seizures over perhaps the year or so, which were quite frequent and during the day.

Q And when you describe simple partial seizures, what are you speaking of?

A The seizures can be thought of as focal or generalized. So basically the analogy I would give you is that the brain has many, many millions of radio stations; and in general, they work just fine. They all talk to each other. And just like driving around, you can hear one station and drive away, you hear another. If you think back to the old analog radios, where you twist the dial slightly, you get

static. And if you twist it a little bit more, you get more static. And finally, you can't hear the station.

Epilepsy, or I should say a seizure, is when a small area of the brain has a dysfunction and all the cells there start firing away, kind of like having a million radio stations all going at once in one place. Now, if that area is a very tiny area, it probably won't upset much. If it's a little bigger area, because the brain is mapped out so that one portion of the brain regulates another part of the body, for example, the left side of the brain runs the right side of the body, you get a small area of cortex, that outer rind of the brain, which was seizing, then you might have jerking, for example, of the right hand. If it gets a little larger, then you might have an inability to communicate, a complex partial seizure. A person would be apparently incommunicado, if you will, and not be aroused during that time. If it spreads more, you have a generalized seizure, a generalized tonic-clonic seizure.

And in her case, she was describing episodes which sounded like a small area, a focal

area of the brain, was discharging, leading to the "sensations," which came on rapidly, lasted a few seconds, happened up to daily, and then went away. And so that would be a simple or a focal seizure.

When I went on, I couldn't find any other signs or symptoms for any other types of simple partial or complex partial seizures other than those episodes.

Q Now, Doctor, the head rush that she described, were you able to determine that that wasn't something such as menopausal symptoms?

A That would not be characteristic of menopausal symptoms.

Q Like a heat flash?

A Right. That would not be typical for what women would describe as a menopausal symptom.

Q When she described a head rush, what exactly -- was that her term?

A Yes. And that's actually the classic description people with epilepsy have, is they say, "Oh, I have a head rush." It's the aura. It's the beginning of that simple partial seizure. Very hard to characterize. There is a differential for it certainly, it could be panic attacks, et cetera, but

it's very classic. It's upsetting to people because it comes on rapidly, they have no control, and then it goes away.

Q And in her case were you able to rule out that this was not an anxiety attack?

A No. That is I was not able to rule out. Sorry.

Q Now, both of the episodes that she described that were seizure-like in description occurred when she was asleep, or in her sleep, correct?

A That sounds right.

Q Is that correct according to your notes?

A Yes. I'm presuming in the first episode in September she was asleep. It was not clear. I couldn't clarify that. The second one was clearly asleep. The first is that she had the alcohol, she took some cough medicine, and then she came to and she couldn't tell me the scenario right before that.

Q Doctor, I'd like you to take a look at Plaintiff's Exhibit 2C, and under the area of Assessment in No. 1, it says "Clinical"?

A Yes.

Q And doesn't the sentence there say that

"The patient had two generalized tonic-clonic seizures in sleep, without a clear precipitant'!?

A That's right.

Q So Doctor, the description that she gave to you and the information that you had was that these both occurred in her sleep; is that correct?

MS. PETRELLO: That's not what he said.

A I think they were. That is in my assessment I presumed, I went ahead and made the leap of logic that they were probably in sleep. But you'd asked me, Did I know they were in sleep? No, I didn't know the first one was.

BY MS. TOSTI:

Q Well, obviously, you weren't there for them, Doctor, but the information that you had at the time that you wrote your note, you did not mention that it was a presumption, did you?

A No, but in notes oftentimes you don't. I think they were probably in sleep.

Q Now, when you were told that both the episodes occurred during sleep, did it raise a concern that the seizures may be caused by a sleep disorder?

A No.

Q And what was the basis for your opinion that these were not caused by a sleep disorder?

A Generally sleep and seizures, that correspondence, comes with the inherited or generalized epilepsies. And they usually occur with large numbers of other warning flags. So, for example, juvenile myoclonic epilepsy of Janz, the seizures occur within 15 minutes of waking up. Or people who have the childhood epilepsies may have seizures occur on the onset of sleep, that is, the first 10-15 minutes as you're going from drowsy into sleep. But it is not uncommon at all for many people to have their seizures during the middle of the night without any association of a sleep architecture problem.

Q So when you saw her, after the description that both of these occurred during sleep, it didn't raise a suspicion that a sleep disorder was involved as an etiology to the seizures; is that correct?

A That's correct. It would be extraordinarily unusual to have that conjuncture of things occur.

Q Was any history you were given at that visit of November 3 consistent with obstructive

sleep apnea?

MS. PETRELLO: If you know.

A One piece was. At the end of the visit, literally as she was going out the door, she said, and this is under Exhibit 2C, she said that her daughter said she snores. And so my memory of this was that I asked her, like, "How much snoring?" And she said, "Snoring." And I said, "Well, do you have other problems?" And I asked her about excessive daytime sleepiness sorts of affairs, falling asleep driving is the classic.

BY MS. TOSTI:

Q And how did she respond to those questions that you asked?

A In the negative.

Q That she did not have excessive daytime sleepiness, is that what she told you?

A Correct.

THE WITNESS: Is it okay to call a break for a men's room for a couple seconds here?

MS. TOSTI: Yes. We're going to take a 5- or 10-minute break right now.

(Recess taken.)

MS. TOSTI: Okay. We're ready to go back

on the record. Is everybody there?

MS. CUTHBERTSON: We're here. Cuthbertson is here.

MR. TORGERSON: Yes.

BY MS. TOSTI:

Q Doctor, the two episodes of generalized seizures that were described to you by Patricia Smith, would it be correct to describe those as a grand mal. type seizure?

A Yes. The modern term is generalized tonic-clonic, but in parlance it would be grand mal, certainly.

Q And at the time that you saw her on November 3 of '95, what diagnostic test results did you have available?

A I speak on 2A about some labs. And I'm guessing those were electrolytes and the CBC, the cell blood count. I'm know sure if we have a copy of what I had then or not with me.

MS. PETRELLO: That's what I'm looking for. I don't.

BY MS. TOSTI:

Q So you think you had some blood work?

A Yes, ma'am.

Q What else?
A They had verbally told me about the CT scan before, but I didn't have the report. And I want to see about the EEG. I probably had a verbal on the EEG report, but I don't have the actual chart chart with me, so it's a little hard to tell.
Q And in regard to the information that you had on those --
A Sorry, could I just --
Q Sure, go ahead.
A I probably did have the EEG report which was performed 10/10/95.
Q In regard to the EEG report, what was the results of the EEG?
A The impression was "This EEG is within normal limits for a person of this age in the awake, drowsy and light sleep state."
Q Nothing abnormal that you are aware of in regard to that EEG?
A No.
Q And in regard to the information that you were given about the CT scan --
A Yes.
Q -- anything abnormal about the CT scan that

you're aware of? And I understand you didn't have the report.

A It was discussed with me as normal. Right, on Exhibit 2C, Anatomic, "As above, CT scan was said to be normal."

Q Now, during this visit of November 3, you did a physical examination of Patricia Smith; is that correct?

A Yes, ma'am.

Q And what were your findings on the physical exam?

A I didn't weigh her, but she told me she weighed 220 pounds, and from inspection that was pretty clear. And I did not have a blood pressure cuff large enough for her arm. Her neurologic exam revealed an abnormality, and that is to say that she had a focal decrease in fast finger movements on the right, indicating to me a potential structural lesion, focal lesion, on the left side of the brain.

Q Now, the notation that you have under Physical Exam, there was nothing remarkable; is that correct?

A You mean the general physical?

Q Just the general physical.

A Well, she was massively obese. She was 5 foot 1, so she was very large. I didn't have a blood pressure cuff big enough for her.

Q But the notation that you made on this particular set of notes was the general exam was unremarkable, correct?

A I understand, yes, I'm sorry.

Q That's okay. Did she have any physical characteristics that would be consistent with a diagnosis of obstructive sleep apnea?

A Obesity.

Q And when you were told her, as she was leaving, that you would speak with Dr. Rowane to determine if it would be useful to do a further sleep evaluation, did you tell her anything else about sleep problems or the type of sleep problems she may have?

A No. I left that for the sleep doctor.

Q So there was no discussion of what a sleep study might show or anything like that?

A I was pretty specific about not going into that because I never order them. I let the sleep doctor figure out if one was necessary and which ones and all that.

Q Doctor, grand mal or generalized clonic-tonic type seizures can be life-threatening; is that correct?

A Absolutely.

Q And you would agree, I believe earlier you said that hypoxia can decrease the threshold for seizures; is that correct?

A Severe hypoxia can, correct.

Q And in Patricia Smith's case, if she indeed had a type of epilepsy, you, as a neurologist, would consider episodes of hypoxia to place her at increased risk for seizures, correct?

A No. In fact, that was a two-part question. The first one I'm trying to remember.

MS. PETRELLO: Well, why don't you let her ask the question again.

THE WITNESS: Okay.

BY MS. TOSTI:

Q Doctor, you felt that Patricia Smith had some type of an epilepsy; is that correct?

A By definition she had epilepsy. The definition is two seizures, so she had epilepsy.

Q And previously you stated that hypoxia can decrease the threshold for seizures, correct?

A Severe hypoxia can.

Q And in Patricia Smith's case, wouldn't you agree that if she became hypoxic at night when she slept that that would place her at increased risk for seizures?

A I understand --

MR. TORGERSON: Objection.

A I understand your question now. No, I do not.

BY MS. TOSTI:

Q And why not?

A If she had this condition, the severe sleep apnea, and that went on for some time, because presumably it doesn't just happen instantaneously, then I would have expected a protracted history of nighttime seizures. And in fact what she was telling me was daytime events, which I took to be simple partial seizures, and then two nighttime events, one of which potentially had the precipitant of alcohol and cough medicine. And sort of unspoken there is some of the ingredients in cough medicines can drop the seizure threshold. Many, many, many people have sleep apnea. 1 don't know how many, but it's enough to run a lot of sleep centers around.

And those people don't go to epilepsy centers, they're not seen by epileptologists with some discordant amount of seizures. So putting those two things together, the daytime episodes, simple partial seizures, and these two generalized seizures, and a physical exam which demonstrated an abnormality, which then later was shown on MRI to be there as a focal lesion, consistent with a reason for epilepsy, I don't believe that her sleep apnea was a contributing factor to those.

Q And you don't believe that if she had epilepsy that hypoxia at night would have any effect on lowering her threshold for seizures during sleep?

A In her situation you're asking?

Q Correct.

A Yes, I believe that did not.

Q A 50 percent oxyhemoglobin desaturation would have no effect as to her seizure threshold; is that correct?

A To a medical certitude, no, I do not. Because if it would, then she would have had lots of them.

Q Well, Doctor, doesn't everyone have to have a starting point when they develop seizures?

A Once you get it going, unfortunately, seizures beget seizures. And once you have a risk, for example, alcohol, unfortunately, then that tends to recreate the situation. If she had had large numbers of seizures at night that would be consistent. But again, the daytime seizures don't go for that, they don't argue for that. She's having simple partial seizures during the day, presumably she has a mass lesion, and that fits, excuse the expression, all in a package.

Q My question, Doctor, though, was assuming she has some type of epilepsy --

A Right.

Q -- and she's suffering from oxyhemoglobin desaturations down to 60 percent at night, it's your opinion that that would not increase the risk for seizures?

A It would not considerably increase the risk, that's correct.

Q Would it increase it at all?

MR. TORGERSON: Objection.

A It might increase it some. But in my experience of many years of epilepsy, I don't remember ever having seen, of the thousands of

patients I've seen, that scenario.

BY MS. TOSTI:

Q Well, Doctor, how many of those patients had sleep apnea associated with their epilepsy?

A Now, you're asking a different question. You're saying, Can hypoxia cause it?

Q I'd like you to answer the question. Of the patients that you have treated with epilepsy over the course of years, what percentage, just a ballpark, of those patients had obstructive sleep apnea?

A Well, I'd have to guess. I was the head of epilepsy at the V.A., and most of my patients were male, obese and elderly, so they're at increased risk for sleep apnea. So I guess probably 20 percent of my patients had sleep apnea.

Q They were diagnosed with sleep apnea?

A Well, I don't know about that. But I'm saying risk factors for.

Q No, Doctor, I'm saying that were diagnosed with sleep apnea, that you knew had sleep apnea.

A I'm not sure what that number would be. It's so low from one perspective that, of course, I didn't send them for the evaluations.

Q Okay. Then, Doctor, how can you say that sleep apnea and oxygen desaturations during sleep have no effect when you have nothing to base it on as to whether there is an increase in seizures of patients that have epilepsy and sleep apnea?

MR. TORGERSON: Objection.

MS. PETRELLO: Objection. He has a lot to base it on. And I think he's already answered this question. But go ahead, Doctor.

A Well, first of all, there are lots of patients who have epilepsy who get relative hypoxia and they don't get seizures necessarily when they have decreased oxygenation that is temporary. And what's unstated here is that this woman does not have a 60 percent desat all the time. She goes down into that and comes back up. So all sorts of children and adults who have reasons to have hypoxia, relative hypoxia, don't necessarily seize all the time.

Second of all, as I'd stated, in my practice, and it was pretty extensive, those two didn't come together. Nor am I aware in epilepsy of any correlation. Epileptologists don't call sleep doctors all the time saying, please, see this

patient for sleep apnea because I think it's causing seizures. It just doesn't happen. Could it happen? Of course, anything can happen. But it is not usual, it's not frequent. And a lot of patients have severe sleep apnea. I saw patients at the V.A. who were on CPAP ordered by the doctors in my epilepsy clinic. And how many? A few. But clearly there were a lot of sleep patients, because the clinic was next to us, and they didn't get sent over. There was no barrier. There was literally 3 feet between the clinics, and they weren't sending a lot of patients over.

BY MS. TOSTI:

Q Why were they on CPAP?

A Presumably for their sleep apnea.

Q And what was the CPAP supposed to do for them?

A It increases the oxygen and decreases the C02. And actually, I'd forgotten, there's a couple other reasons why it's a relative thing. Maybe I have to go back to the biology. In her EEG, they did something very typical in all EEGs, they had her hyperventilate. The way that you get somebody *to* seize is to hyperventilate as opposed to

hypoventilate. And so they did that with her. They had her breathe rapidly for three minutes. And that decreases, that clears the C02. And the reason that's important is when C02 goes down, that is the obverse of 02, oxygen, when carbon dioxide goes down, that decreases the threshold for people to seize. Actually, rising C02 is probably the body's defense to stop a seizure. And so, for example, when you see a person with a grand mal seizure and they turn "blue," that's the body's defense to stop the seizure. So high C02, which you get in somebody with severe sleep apnea -- when the 02 goes down, obviously the C02 has to go up -- could be argued to be protective in fact.

In her EEG, they hyperventilate her, that doesn't cause a seizure. And furthermore they went through light sleep. And so those sleep situations I talked about early, the early stages of sleep, the drowsiness did not elucidate a seizure. So her EEG was normal. It is typical for adults, and it is in fact usual, for adults who have new onset epilepsy to have normal EEGs, not the contrary.

Q Correct me if I'm wrong, but I thought I heard just now that it is protective against

seizures to have low oxygen levels and --

A No.

Q -- high C02 levels?

A What I said was it's protective to have high C02. So that's why when you do an EEG, you hyperventilate, you blow off the C02, you lower the C02. That, if someone has a tendency toward seizures, may precipitate a seizure.

Q But when you hyperventilate, you are not reducing the oxygen levels, correct?

A That's right.

Q The oxygen levels actually stay up and may even increase somewhat, correct, when you hyperventilate?

A They would not increase significantly, no; but they stay normal.

Q They stay normal?

A Right.

Q Doctor, when you saw Patricia Smith on November 11, were you able to determine the cause of her seizures?

A No.

Q What was within your differential diagnosis?

A Leading it was a mass lesion, as I indicated from the clinical and anatomic sections. Second of all would be so-called cryptogenic, which means that no etiology can be found. The reason for that is the majority of adults who come in to see a physician, who have had two seizures, i.e., who have epilepsy, no etiology can be found, neither EEG nor structural.

Q And you did not think that at any time, either on the first visit or the second visit, that oxyhemoglobin desaturation during sleep may be causing her seizures?

A I did not.

Q Now, did you in fact discuss, after the November 3 visit, the sleep problems with Dr. Rowane?

A No. Other than what was captured by the telephone call where I told him that she was snoring and I thought she should see a sleep doctor.

Q When did you talk with Dr. Rowane?

A I believe it was immediately after I saw her because, first of all, that was my pattern of practice and, second of all, I always dictated right afterwards, because if I didn't, then it was too

much of a backup. And as I say, in Plan, I've called Dr. Rowane and discussed her case.

Q So it's likely that you discussed the sleep evaluation with Dr. Rowane on November 3 sometime, correct?

A Yes, ma'am.

Q Did you ever suggest to Dr. Rowane that her seizures may be caused by oxyhemoglobin desaturation during sleep?

A I don't believe so. I don't -- no, I don't remember that at all. What I remember was being worried about having a mass lesion and she should get an MRI.

Q Did you advise him to refer her for a sleep study to see if she was having oxyhemoglobin desaturations during sleep?

A No. I referred, I recommended she be seen by a sleep doctor.

Q Doctor, I'm going to hand you what has been marked as Plaintiff's Exhibit No. 5, which I believe is the referral from the University Family Medicine Foundation for the sleep study?

A Yes, ma'am.

Q And I'd like you to take a look at the

middle of the page where it says "Diagnosis."

A Yes.

Q And I believe Dr. Rowane has testified he filled out this form.

A Yes.

Q And he writes "No. 1, seizure disorder; No. 2, rule out nocturnal hypoxia," and then there's a reason for the referral, and he wrote "This patient has been recently diagnosed with seizure disorder. Request evaluation for sleep study, as concerns patient may desaturate as etiology for seizure disorder. Workup requested. Dr. Steven Collins." Do you see that?

A I do.

Q Do you know of any reason why Dr. Rowane would put this information on a referral form for a sleep study stating you were requesting a workup?

A Because I think in parlance I had recommended sleep evaluation, and he took that to mean a sleep study. He also puts on here the specialist that he must have worked with, Dr. Rosenberg, who was the sleep doctor in neurology at University Hospitals.

Q And in regard to concern patient may

desaturate as etiology for seizure disorder, is that something that you told him?

A I do not believe so.

Q And do you know of any reason why he would put that particular information on this form?

A I presume he linked the snoring and the need for sleep evaluation with the seizures.

Q So you believe, it's your understanding this information had to have come from him, it didn't come from you?

A That's correct.

Q Do you know Dr. Carl Rosenberg?

A Yes.

Q Did you ever discuss Patricia Smith's case with Dr. Rosenberg?

A No.

Q Do you know if he works with the sleep center at University Hospital?

A Yes, I believe he's the director now actually.

Q Did you ever tell Dr. Rowane to refer Patricia Smith to Dr. Rosenberg?

A I don't believe so. It's possible that I said, "Why don't you get a sleep evaluation by

Dr. Rosenberg," or I could have said, "Why don't you get a sleep evaluation because she's snoring," but I don't formally remember.

Q And you never talked to Dr. Rosenberg about Patricia Smith?

A No, ma'am.

Q Did you ever talk to Dr. Brooks about Patricia Smith?

A No, ma'am.

Q Did you advise Dr. Rowane to get a sleep study?

A No, ma'am. I recommended he get a sleep evaluation. And the first I knew about it was after I was contacted about this case and I saw that there was a sleep study performed and it was abnormal.

Q So you were not aware that she even was going to have a sleep study done?

A No, in my second note, I believe I knew that she had gotten one. Yes, on my February 8, 1996 note, I said, "She had multiple questions as well as problems with sleep. That has been evaluated by Dr. Rowane in the Sleep Lab here and I am not aware of those results." And then in the letter to him, I may have -- no, I didn't say

anything about sleep. In the letter basically I said that I fixed the problem I can fix and she's discharged from my care, i.e., her seizures are controlled.

Q When you spoke with Dr. Rowane in regard to Patricia Smith's sleep problem and you suggested a sleep evaluation, did you ever discuss who would follow up on those results?

A No, I wouldn't need to. He was the primary doctor. He had referred her for me to see her for epilepsy for a couple of visits. It was not within my domain. I don't know how to treat people for sleep.

Q Now, you advised Dr. Rowane that she should be placed on Dilantin to control her seizures; is that correct?

A Yes, ma'am.

Q And you did that when you talked with him on the phone when she was being seen in the Family Practice Center, correct?

A Yes.

Q And then when you saw her on November 3, did you reevaluate as to whether or not this Dilantin was being prescribed effectively for her?

A Yes.

Q And you did a Dilantin level on her or had at least some information of a Dilantin level?

A Right, two things. She had had some drawn with a serum level of 4.4 to 4.9. There are a number of people who are adequately controlled at that level. But since she was a slight -- she had the possibility of being a so-called hypermetabolizer, that is, to run through it quickly, so I sent her down to check to see if it was in the same ballpark.

Q And you had another blood study done; is that correct?

A Yes. Well, I asked her to do it. As my note says, if that doesn't actually happen, it should happen when Dr. Rowane sees her next.

We are looking to see if there's a lab from that day. Yes, here we go. Yes, she went down and had a phenytoin in the same range that she had had before.

Q And in regard to being within a therapeutic range, was she within what's considered a therapeutic range?

A Yes.

Q Now, if you take a look at the sheet that you are referring to, what is the date of that particular blood work that was drawn?

A 11/3/95.

Q If you look at the range that's given on that sheet, does she fall within the range given on the sheet?

A She falls within the reference -- does she fall within the reference value?

Q On the sheet.

A Right. No, she does not fall in the reference value area. That's different than therapeutic.

Q Okay. Now, in regard to the therapeutic level, what would be the appropriate therapeutic level for her?

A Whatever level she maintained in steady state in the absence of seizures. It is a clinical definition.

Q So at the time that you saw her on November 3, because she had not had any new seizures, it was your opinion that she was being controlled at the level of medication that she was on?

A I believe so, but let me just check to see. You know what, this is not stated in here. But in my letter of February 8, 1996, it says "Since her serum levels were fairly low, as I remember in the 3 or 4 range, we would recommend that she be increased in dose to 200 twice a day." So it probably wasn't very well noted by me, but my guess is in that telephone conversation of 11/3/95 I recommended they go to twice a day. Oh, I'm sorry, I did. It's underlined. "I asked her to increase her Dilantin dose to two by mouth, p.o., b.i.d."

Q And that was on the visit that was made on February 8 of '96?

A No, actually that was the 11/3/95. It's in the Plan section, sorry.

Q Okay. Now, when you then saw her on February 8, did you have another Dilantin level to look at to determine whether she was at a level that you were happy with?

A No, apparently not.

Q And from the perspective of managing a patient, how often should you be doing those Dilantin levels?

A It's extremely variable. If a patient is

not seizing and they're not showing any signs of toxicity, a range would be anywhere from once a year to once every few years. If a patient is seizing, that would be a reason to follow up on it.

Q So on February 8 when you saw her, I believe that was the date --

A Yes.

Q -- you were happy with the level of medication that she was on and didn't make any recommendations to increase that since she hadn't had any additional seizures that you were aware of?

A Correct. And because she wasn't having any toxic symptoms, so she was in a therapeutic range.

Q Doctor, will Dilantin have any effect in controlling seizures caused by hypoxia?

A Dilantin can treat anoxic seizures. Poorly, but it can. No drug works well.

Q So it can reduce --

A The likelihood.

Q -- the risk for seizures?

A Correct. They're very, very difficult to treat. Classically, people are on very high doses of multiple medications.

Q Would it be appropriate to say that it

raises the threshold for seizures?

A Correct.

Q Now, Doctor, I just want to clarify something which I think you may have already. You indicate in your notes of February 8, I believe -- let me make sure I have the right one here. On one of your notes you had indicated that you wanted to increase -- oh, here we go. On Plaintiff's Exhibit 2C --

A Yes.

Q -- the underlined sentence on that particular page says "I asked her to increase her Dilantin dose to two, p.o., b.i.d., if she has toxic symptoms." Is that a typographical error?

A That is a typographical error. It should be if she does not have toxic symptoms.

Q Okay. Now, what was the reason that you saw her on February 8?

A That was a follow-up. I believe the recommendation, or the referral, was for one to two or maybe three visits. And so that was the second visit, at which time her seizures were controlled, I had nothing else to offer in her care.

Q So it was specifically for follow-up on the

seizures?

A Yes. I guess it was by recommendation from Dr. Hlavin, who January 5 says, "I am checking the Dilantin level today and have instructed patient she should schedule follow-up with Dr. Collins in epilepsy clinic."

Q Now, your note indicates on Plaintiff's Exhibit 3, which is the office notes from February 8, which -- have I given you a Plaintiff's Exhibit 3?

MS. PETRELLO: He can look at mine.

It's all right, we've got it right here.

BY MS. TOSTI:

Q That you spent 45 minutes with her discussing multiple questions, correct?

A Correct.

Q What questions was she asking you at that visit?

A I may not remember all of them. A lot of them had to do with epilepsy and with having seizures and her driving.

Q Okay. Now, the note also indicates that you talked to her about problems with sleep, correct?

A Correct.

Q What specifically did you discuss with her regarding the problems with sleep?

A I believe it was that she was saying she was having difficulty getting to sleep or snoring, but I can't quite remember, sorry.

Q And did you make any recommendations to her regarding those problems?

A No, ma'am. I was presuming Dr. Rowane would follow up on it.

Q Did she give you any other information other than the fact that she was snoring at night?

A As I say, I don't remember if it was snoring that she was complaining about or difficulty getting to sleep because she was upset.

Q Did she tell you that she had undergone a sleep study the day before?

A I believe that's the reason I say in there "That has been evaluated by Dr. Rowane in the Sleep Lab here."

MS. PETRELLO: And just for the record, so it's clear. This note doesn't say that he was aware that she had a sleep study, it's just that she was evaluated at a sleep lab.

BY MS. TOSTI:

Q And I asked if she had told you that she had had a sleep study?

A I believe what she said was she was seen by the sleep docs. But I don't know, I don't remember exactly what she said.

Q And you didn't have any results from the sleep study that was done from her at the time that you saw her on February 8?

A No, ma'am. Nor ever.

Q Now, you had a conversation with Dr. Hlavin, according to your February 8 note; is that correct?

A That's correct.

Q And what did Dr. Hlavin tell you about Patricia Smith?

A That there was a lesion consistent with a meningioma on the frontal skull base and that she was just going to follow up on it because it was fairly small.

Q And did you discuss any concerns with Dr. Hlavin about Patricia Smith having desaturations of her oxyhemoglobin while she slept at night?

A I don't remember that.

Q Did Dr. Hlavin raise any issues that the fact that she was having oxyhemoglobin desaturations during sleep as a possible source of her seizures?

MS. PETRELLO: Objection. That assumes that somebody knew she was having them.

MS. TOSTI: I asked if she raised that in a conversation, he can answer yes or no.

A No, not to my memory.

Q Now, are you aware of the fact that neither the radiologist nor Dr. Hlavin was able to rule out that there may be an exostosis, or an overgrowth of bone, that was showing up on the x-ray rather than any type of a calcified tumor?

A Correct.

Q You were aware that that was a possibility?

MS. PETRELLO: When? When? Wait.

BY MS. TOSTI:

Q At the time that you talked to Dr. Hlavin, were you aware that that was a possibility?

A I don't remember. I don't remember the conversation well enough, if she got into differential. I doubt she did. But probably the discussion was that she probably has a meningioma there, it's so small that the operative risk is

greater than doing anything, we'll just follow up on a regular basis with CT scans.

Q And at some point in time did you learn that neither Dr. Hlavin nor the radiologist was able to rule out that this was an overgrowth of bone and not a calcified meningioma?

A In the MRI report I think it said that there was a differential. I don't know that I ever got the MRI. I think it was sent straight to Dr. Hlavin and they never called me back.

MS. PETRELLO: She's not talking about what I told you.

THE WITNESS: Right.

A I don't think I ever got the MRI until it came in this package.

BY MS. TOSTI:

Q Okay. So do you know whether or not you had that information at any point when you were seeing Patricia Smith?

A I believe I didn't.

Q Doctor, you said that you have reviewed the autopsy of Patricia Smith, correct?

A Yes, ma'am.

Q And you are aware that on autopsy there was

no tumor found, no calcified meningioma on autopsy of the brain; is that correct?

A That's correct. That's not unusual. They usually do not necessarily go through every millimeter of the meninges. Unfortunately, when you take the top of the skull off, the meninges are damaged.

Q But, Doctor, you agree that there is nothing on that autopsy that says that they found any type of a meningioma?

A Certainly.

Q Doctor, did you have any additional clinical findings on Patricia Smith when you saw her on February 8, in addition to what you had previously told us about from the November 3 visit, anything new or different?

A No.

Q And at that point in time on February 8 what was your plan of care for Patricia Smith?

A I had discharged her from my clinic.

Q And at the point on February 8 of '96, when you saw her, what was within your differential diagnosis for her?

A Leading was a frontal lesion, structural

lesion. Second would be cryptogenic epilepsy.

Q And did you give Dr. Rowane any guidelines as to how he should continue to manage her?

A I don't remember, other than the recommendations that she should stay on the Dilantin. And the recommendations that Dr. Hlavin had made, which were not mine, of course.

Q And the continued management on Dilantin, this would not fall to you to do --

A That's correct.

Q -- this would go back to Dr. Rowane in the Family Practice Center?

A That's correct.

Q Did you anticipate that he would be in consult with you any further after you saw her on February 8?

A No, ma'am.

Q And you had no plans to see her unless they sent her back to you; is that correct --

A That's correct.

Q -- after February 8? Now, at any time after you saw her on February 8 and prior to the filing of this case, did you receive the results of Patricia Smith's sleep study?

A No, ma'am.
Q You never received the printed copy of the final report on the sleep study?
A No, ma'am.
Q When is the first time that you saw the final printed report?
A When these medical records were sent to me.
Q And that was provided by counsel?
A Yes.
MS. PETRELLO: Yes.
While she's looking for whatever she's looking for, I just want to ask the other lawyers, are you going to have any questions? The reason why I'm asking is it's about 4 o'clock Chicago time, and Jeanne and I have a 5:10 flight. We're just curious here, do you guys have a lot of questions?
MR. TORGERSON: I don't have any questions.
MS. PETRELLO: I'm sorry?
MR. TORGERSON: I don't anticipate asking any questions.
MS. TOSTI: I'm going to be done probably in another 10 minutes or so.
MS. CUTHBERTSON: I just might ask one or

two things.

MR. O'DONNELL: I may have one or two.

MS. PETRELLO: Okay, thanks.

BY MS. TOSTI:

Q Doctor, I'm handing you what has been marked as Plaintiff's Exhibit No. 7, which I believe is the overnight polysomnogram report. If you look at the area that is marked on the Referred By line, it indicates, I believe, Dr. Rowane and Dr. Collins. Do you see that?

A I do.

Q Your name is down as a referring physician. Doctor, wouldn't you expect if you were a referring physician that you would receive a report from this study?

MR. TORGERSON: Objection.

A I would.

BY MS. TOSTI:

Q And it's your testimony that you never received a report from this study, correct?

A No. Sorry, no, I did not receive a report. If anyone, Dr. Rosenberg would have gotten one because the referral had his name as the referring neurologist.

Q Now, Doctor, I'd like you to take a look at the summary at the bottom of the page and just read through that. You've had an opportunity to review these records, but I'd like you to take a look at the summary at the bottom of the polysomnogram report for a second.

A Yes.

Q Doctor, would you agree that based on this report Patricia Smith should have been offered treatment for severe obstructive sleep apnea?

MS. PETRELLO: Objection. If you know.

MS. CUTHBERTSON: Objection.

MR. TORGERSON: Same here.

A It's not my area of practice. Certainly it says severe and that looks bad.

BY MS. TOSTI:

Q And Doctor, if you received a report like this on one of your patients, what would you do?

A I would call the physician who did it and say, What does this mean and what do you do and how soon do you do it?

Q And would you refer the patient to someone else, then, to do whatever needed to be done for this patient?

A Yes.

Q Now, Doctor, I'm going to hand you what has been marked as Plaintiff's Exhibit 8, which has a title on it, "School Employees Retirement System." It's a two-page document. I believe the original may have been a double-sided document.

A Yes.

Q And I'd like you to take a look at it and tell me if you've seen that document before?

A Sure have.

Q And the title on this says "Attending Physician's Report," correct?

A Yes.

Q And on the second page, did you fill out that information?

A Yes.

Q And did you sign this report as an attending physician?

A Yes.

Q Now, at the time that you saw Patricia Smith, you told her that she could no longer drive her school bus -- that was her employment was driver of a school bus -- and one of the things that you told her was that because of her seizure disorder

she should not be driving a school bus anymore; is that correct?

A That's correct.

Q Did you anticipate at any time in the future she would be able to continue to drive?

A Probably not.

Q So it's unlikely that she would ever be able to continue with that career option?

A That's correct.

Q Now, Doctor, I'm going to hand you what has been marked as Plaintiff's Exhibit 9, which is a copy of a page from the Family Practice Center, and you've had an opportunity to look at those earlier with your counsel.

MS. PETRELLO: Objection. I don't think he said he reviewed it, he said he skimmed his records. So why don't you take a minute and look at it.

BY MS. TOSTI:

Q I'm providing you with a copy now. And I would like you to look at the entry marked with the No. 2 that's just below the middle of the page. We're looking at a page of the Family Practice Center notes that has a date at the top of 3/25/96.

A Right.

Q And I believe Dr. Rowane indicates in his note that he called your office and that you were to call back to discuss the results of Patricia Smith's severe obstructive sleep apnea. Do you see where I'm referring to?

A I do.

Q Now, does your office keep a copy of phone messages when they come into the office?

A Transiently they do. They're not permanent. It's not like a telephone record, you know, computerized and filed and all that stuff.

Q Do they have a logbook that has like a carbonizing sheet where you receive one message off the top and then there's a carbonized sheet that remains in the book?

A Usually it's the pink slips and -- first of all, this is not actually my particular -- that's the general neurology number. And the standard was that the physician would call in and ask for me, or whomever, and they would send the call back to my secretary who would write out on a pink sheet the name of the doctor, et cetera, et cetera. And as I said earlier, the standing order was that I was

paged. Now, if I wasn't in town -- and I don't know if I was in town, nor do I have calendars back that far -- but if I was in town, I was paged instantly. And if the doctor couldn't hold on, then a number was obtained to call them back. If I wasn't in town, then one of the other physicians in the group, Dr. Wirtz, Dr. Rosenberg, doctor whomever, would be asked to handle the call

Q Is Dr. Rosenberg an associate of yours?

A Yes.

Q He was in the same practice with you?

A He's in the same practice.

Q To your knowledge, did Dr. Rosenberg see Patricia Smith?

A I don't know.

Q Did you ever receive a phone message on March 25 of '96 asking you to call Dr. Rowane to discuss the test results?

A I don't believe so.

Q And you never called Dr. Rowane to discuss Patricia Smith's sleep study results; is that correct?

A No. I don't know why I would. I mean had someone called me like this and said, you know,

there's this bad report, I would have said, boy, that's too bad, talk to one of the sleep docs, I don't know what to do about it.

Q Doctor, I'm handing you what has been marked as Plaintiff's Exhibit No. 10, which I believe is another page from the Family Practice records. The date at the top is April 1 of '96. And I'd like you to look at the very top of it where I believe Dr. Rowane has written "Called Dr. Collins office again" -- and he has recorded a number of 43192 -- "regarding sleep study with severe obstructive sleep apnea, arousal and oxyhemoglobin as low as 60 percent. Dr. Collins given my beeper number and will call back." Do you see that?

A I do.

Q Did you receive a message from Dr. Rowane on April 1 of 1996?

A I don't believe so. In fact, I believe the American Academy of Neurology meeting was going on at that time, which was not in Cleveland.

Q Now, do you know of any reason why a phone message from Dr. Rowane would not have been passed on to you?

A None. If I wasn't there, obviously. In

which case it would absolutely go to whoever was available, so-called on-call, which, going backwards in time, I wasn't on-call. The reason they called me was as an epileptologist, not because I was just a random on-call. But we always had an attending physician on-call. And when physicians called particularly, we got back to them. Somebody got back to them.

Q Who was taking phone messages at this number?

MS. PETRELLO: If you know.

A I don't remember her name, I'm sorry. That's the general neurology number. It starts with an S.

MS. PETRELLO: That's all right if you don't remember.

THE WITNESS: As long as she doesn't know that I don't remember her name.

BY MS. TOSTI:

Q Is this individual an employee of University Neurologists Associates?

A Yes.

Q And she would be an employee of your medical group at that time?

A Yes.

Q And the policy regarding phone messages that came in to that particular number, if you would review that again, that person would take the message and then what would happen?

A Actually, normally what would happen, if it went in to 43192, which was not my number per se, they would call my secretary who would decide whether it's a patient or whether it was a physician, whomever. And then if it was a physician, I was to be paged instantly.

Q And if you were not available?

A Whomever covered for me. And we always had coverage. In an epilepsy clinic you cannot not have coverage. Sorry about the double negative.

Q Would you agree that if an employee failed to pass on a message to a physician that that would be improper and could cause harm to a patient?

MS. PETRELLO: Objection.

MS. CUTHBERTSON: Object.

A Certainly.

BY MS. TOSTI:

Q If Dr. Rowane had been able to get through to you, is there anything that you would have told

him in regard to Patricia Smith's sleep study?

MS. CUTHBERTSON: Object to form.

MS. PETRELLO: Objection.

A I would have recommended he call Dr. Brooks or Dr. Rosenberg.

BY MS. TOSTI:

Q So you would have recommended a referral to someone else?

A Correct.

Q When did you learn that Patricia Smith had died?

A I don't know the exact date. It was from counsel.

Q So it was after this case was filed?

A Yes, ma'am.

Q Do you know whether her death occurred during sleep?

A No.

Q After she died, did you speak at any time to any of the family members?

A No, ma'am.

Q Did you talk to Dr. Rowane, Dr. Hlavin, Dr. Brooks or Dr. Martin about Patricia Smith's death at any time?

A No.

Q Do you think the fact that Patricia Smith was known to have had two seizures during sleep and also found to have oxyhemoglobin desaturations to 60 percent during sleep contributed in any way to her death?

MR. TORGERSON: Objection.

MS. PETRELLO: Objection. If you know.

A Based on my reading the autopsy report, is that what you're asking me?

BY MS. TOSTI:

Q I'm just looking to note whether you have any opinions on that. And if you don't, you can tell me you don't.

A There's this difficult thing of how much I'm guessing here, and I'm trying to figure --

MS. PETRELLO: Well, we don't want you to guess, not at all. So you don't know.

A Then no.

BY MS. TOSTI:

Q Do you have an opinion as to whether Patricia Smith received appropriate follow-up for her severe obstructive sleep apnea?

MR. TORGERSON: Objection.

MS. CUTHBERTSON: Objection.

MR. O'DONNELL: Note an objection here.

MS. PETRELLO: Objection. If you know.

A The answer is no, I don't know.

BY MS. TOSTI:

Q Do you find any fault with the fact that her sleep study was done on February 7 of '96 and she received no treatment for severe obstructive sleep apnea with oxyhemoglobin desaturations to 60 percent through the time of her death on April 8 of '96?

MR. TORGERSON: Objection.

MS. CUTHBERTSON: Objection.

MS. PETRELLO: And I'm going to make an objection because he's already testified that the first time he ever saw this stuff was when I showed it to him, which was just a couple months ago. He's already testified that he's not a sleep doctor. So to the extent that you can answer that question, go ahead.

MR. O'DONNELL: I'm going to object.

A I've lost the question somewhat.

MS. TOSTI: Do you want to read it back, please.

(Question read.)

A No.

BY MS. TOSTI:

Q Do you have an opinion as to what the likely cause of Patricia Smith's death was?

MS. PETRELLO: Same objection. To the extent that you know.

A I'm going to say no, because it's in areas that I'm not expert in.

MS. CUTHBERTSON: I didn't hear that answer.

A I apologize. I'm going to say no, because it involves conjecture in areas that I'm not an expert in.

MS. CUTHBERTSON: Thanks, Doctor.

BY MS. TOSTI:

Q Do you blame Patricia Smith in any way for her own death?

A Blame? No.

Q And Doctor, you'd agree that Patricia Smith was entitled to standard and appropriate care regardless of whether she was fat or thin, correct?

A Yes, ma'am.

MS. PETRELLO: Objection.

A Yes.

BY MS. TOSTI:

Q Are you critical of the care rendered to Patricia Smith by any other health care provider?

A No.

Q Doctor, do you intend to return to Cleveland for the trial of this matter?

A Do I want to?

Q No, I asked you, Doctor, my question was, do you intend to return to Cleveland for the trial of this matter?

MS. PETRELLO: We've not even discussed that.

A I don't see why I should be going. I'm not a sleep doctor and none of this was within my purview. Are you asking is it legally possible to make me go? I don't know.

BY MS. TOSTI:

Q I asked if it was your intention to return.

MS. PETRELLO: We haven't even discussed this.

A I don't want to.

BY MS. TOSTI:

Q In regard to the trial, do you intend to

express any opinions at trial beyond those that we've discussed today?

MR. TORGERSON: Objection.

MS. PETRELLO: Objection. I'm not even going to let him answer that because he's not here as an expert. We haven't had any expert reports. If you produce an expert report that criticizes him, then he will have opinions, okay. And he's not here --

BY MS. TOSTI:

a My question was, at the present time, do you have an intention to express any opinions at trial beyond those discussed today?

MR. TORGERSON: Objection.

MS. PETRELLO: Objection. Same objection. He can't even answer that question because he doesn't even understand the legal significance. So you have my objection. And he's not going to answer it.

MS. TOSTI: You're instructing him not to answer?

MS. PETRELLO: Right. Because I don't know what your intentions are. And he may very well have opinions. And you're asking an obscure

question that he can't possibly answer.

MS. TOSTI: You're saying in the future, I'm saying right now.

Q Doctor, do you have any additional opinions that you intend to express at trial that we haven't discussed?

MS. PETRELLO: And again, he's not an expert, he's not answering the question, move on.

MR. TORGERSON: Objection.

MS. TOSTI: I have no further questions, and I will defer to other counsel at this point.

MR. TORGERSON: This is Torgerson on behalf of Dr. Brooks. I have no questions and reserve my rights at some future point.

EXAMINATION

BY MS. CUTHBERTSON:

Q Dr. Collins, I represent University Hospitals of Cleveland. You mentioned that you talked to Dr. Martin on one occasion. Did we refresh your recollection that your conversation with Dr. Martin on that day, I think it's October 5, was actually with --

A I may have been wrong.

Q -- Dr. Rowane?

A I apologize, I thought it was Martin. But I don't know these guys, you know, that is to say they're not like my bosom buddies, so I couldn't differentiate that well.

a Have we covered your entire memory of that October 5 conversation?

A Yes, ma'am.

Q Do you recall any other conversations with Dr. Martin?

A No, I do not.

Q Okay. And I take it you didn't talk with any other residents other than Dr. Martin that you can recall about Patricia Smith's care?

A No, I did not.

Q And one thing I wanted to ask just for clarification. I couldn't tell whether you were expressing an opinion or were saying that you had no opinion regarding the question as to whether you thought that the fact that Patricia Smith had two seizures during sleep and desaturations contributed to her death. Did you have an opinion about that, or was your opinion that no, those things were not related?

MS. PETRELLO: Do you remember the question?

A Yes, I sort of remember the question. And it's hanging on such a thin thread of how many angels on a pin, I'm having a hard time remembering the -- I do not believe that her death was related to the hypoxia. I think that's what you're asking me, right?

Q Yes, I think that's exactly Jeanne's question.

A Yes, right. No.

Q Is your answer again you don't think that --

A As far as I know, they were not related.

MS. CUTHBERTSON: Thanks a lot, Doctor, that's it for me.

THE WITNESS: Thank you.

MR. O'DONNELL: Dr. Collins, this is Jack O'Donnell in Cleveland for Dr. Rowane. I don't have any questions specifically for you, but I just want to take one second to ask whoever can answer this, I think I'm missing Exhibits 3, 4, and 6.

MS. PETRELLO: Could you speak just a tad

louder, we're having a real hard time hearing you.

MS. TOSTI: Let me answer that. I premarked exhibits and I didn't use all of the ones that I had, so it may very well be that some of the numbers are not sequential. And we'll make sure that whatever we actually used will be attached to the deposition and you'll get a copy of them.

MR. O'DONNELL: Okay. Thank you. I'm sorry to waste the doctor's time in asking that particular question. No questions.

MS. TOSTI: I have no more questions. I'm done.

MS. CUTHBERTSON: Are you going to have this typed up, Jeanne?

MS. TOSTI: Yes.

MS. PETRELLO: All right, Doctor, you have the right to read this. He will read it.

(WITNESS EXCUSED.)

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

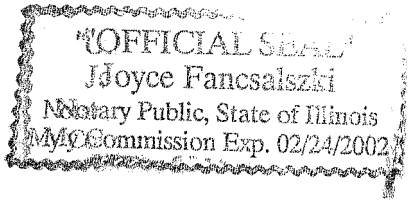
I, JOYCE FANCSALSZKI, CSR and Notary Public in and for the County of Cook and State of Illinois, do hereby certify that on the 16th of January, 1999, at 2:03 p.m., at O'Hare International Airport, Chicago, Illinois, the deponent STEPHEN DOUGLAS COLLINS, M.D., personally appeared before me.

I further certify that the said Stephen Douglas Collins, M.D., was by me first duly sworn to testify and that the foregoing is a true record of the testimony given by the witness.

I further certify that the deposition was terminated at 4:30 p.m.

I further certify that I am not counsel for nor related to any of the parties herein, nor am I interested in the outcome hereof.

In witness whereof, I have hereunto set my hand and seal of office this 29th of January, 1999.



Joyce Fancsalszki
Notary Public

CSR No. 084-003068 - Expiration Date: May 31, 1999.