IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

TRACY ANN SMITH, Admin., etc.	X	
Plaintiff,	)	
v.	)	CASE NO. 327823
UNIVERSITY HOSPITALS OF CLEVELAND, et al.,	)	
Defendants.	)	
	X	

DEPOSITION of STEVEN H. FEINSILVER, MD, held at North Shore University Hospital, 300 Community Drive, Manhasset, New York commencing at 1:52 pm on Monday, January 31, 2000, before Jean Wilm, a Registered Professional Reporter and Notary Public within and for the State of New York.

A P P E A R A N C E S :

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BY: KRIS H. TREU, Esq., of Counsel

Feinsilver

DR. STEVEN H. FEINSILVER, called as a witness, having been first sworn by Jean Wilm, a Notary Public within and for the of New York, was examined and testified as follows:

MS. TOSTI: Let the record show that this deposition is being taken pursuant to Ohio rules of Civil Procedure and that this is a discovery deposition being taken under Ohio Civil Rule 26 for discovery purposes under cross-examination to elicit opinions held by Dr. Feinsilver relative to this case.

This deposition is being taken by agreement of the parties and may I have a stipulation from counsel that any defects in notice of service or the use of a New York court reporter are waived?

MR. TREU: Sure.

EXAMINATION

BY MS. TOSTI:

Q Doctor, would you please state your

full name for us?

A Steven Henry Feinsilver.

Q Your business address?

A 300 Community Drive, Manhasset, New York.

Q And the zip code here?

A 11030.

Q Have you ever had your deposition taken before?

A Yes.

Q How many times approximately?

A I think three times.

Q I want to just go over some of the ground rules for you. This is a question and answer session. It is under oath. It is important that you understand the questions that I ask you. If you don't understand them, if I have phrased them inartfully, just let me know and I will be happy to repeat them or rephrase them. Otherwise, I will assume that you understood my questions and you are able to answer them.

It is important also that you give all of your answers verbally because our court reporter can't take down head nods or hand motions.

At some point defense counsel may choose to enter an objection. You are still required to answer my question unless he instructs you not to do so.

Do you understand those directions?

A Yes.

Q If at any point in time you wish to refer to any portion of your file, feel free to do so.

A Okay.

Q Doctor, I have had an opportunity to briefly look through your file that you have in front of you.

Is that your complete file on this case?

A Yes.

Q Has anything been removed from your file?

A Not as far as I know.

Q In addition to what is in front of you, you have indicated that you also have reviewed the raw data from Patricia Smith's sleep study, correct?

A I have the raw data of the sleep study.

Feinsilver

Q Were you provided with any type of summaries or fact summaries on this case?

A Only the final sleep study report.

Q Are you referring to a document that was prepared at or about the time of Patricia Smith's treatment?

A Yes, that's right.

Q Have you provided any bills for your time to Mr. Treu?

A No.

Q I would like you to tell me about your experience in medical-legal matters.

Have you offered your services as a medical-legal consultant prior to this case?

A Yes. On, I think, two other occasions. Three.

Q When was the first time that you acted as a medical-legal consultant?

A The first time was probably ten years ago on behalf of one of my patients in a disability hearing.

Q Have you acted as a medical-legal consultant in a medical malpractice case prior to this case?

A One. One time prior.

Q What was the subject matter of that case?

A It was involving a sleep laboratory.

Q What was the allegation of negligence?

A It was an allegation of negligence against the director of a sleep laboratory.

Q What was that negligence?

A I'm not sure. Failure to, I guess, get a report of a sleep study to the referring physician and/or arrange treatment.

Q You were providing services on behalf of the plaintiff in that case?

A No, it was on behalf of the defendant.

Q On behalf of the defendant?

A Yes.

Q How was that case resolved?

A I believe they found for the plaintiff.

Q When were you involved with that case?

A Approximately one year ago.

Q Where was that case filed?

A In New York.

Q In the City of New York?

A No. I think it was Poughkeepsie. At least in that general area.

Q Do you recall the plaintiff's name in that case?

A No, I don't. I would have to look it up.

Q Do you recall the plaintiff's attorney's name?

A No.

Q In that particular case was there no report that was provided?

A I provided a report to --

Q In regard to the facts of the case, was there not a report provided by the defendant in the case?

A I'm not sure what you mean by "report."

Q You said that the allegation of negligence in that case was a failure to get a report of a sleep study to a physician. I am asking --

A No. The facts of that case, as I

could tell, was that the technician from the sleep laboratory called the referring physician in the morning to say that the test was abnormal and it was, in fact, very abnormal and the referring physician did not get the patient treated very quickly in any case.

I believe a number of physicians actually were sued but my only involvement was the physician who was the medical director of the sleep laboratory.

Q Did the patient die in that case?

A Yes.

Q What was the cause of death?

A Actually, it's very unclear. She was found, sudden death at home.

Q Was one of the allegations in the case that the patient died as a result of sleep apnea?

A Yes.

Q Were recommendations for treatment made by the sleep specialists?

A I believe so.

Q Aside from that one case that you served as a medical-legal expert, that is the only medical malpractice case other than this one that you

have served as an expert on?

A Yes.

Q Now, Doctor, you said that you had your deposition taken three times.

A I believe so.

Q What were the other two times? Once, I assume, was in the medical malpractice case that we just --

A Once was a suit against me personally, having nothing to do with medical. Having to do with my dog. Actually, I'm not sure the last case whether I was officially deposed. Perhaps I was just a witness.

Q Have you ever testified at trial?

A Yes.

Q Was it in the medical malpractice case that we just discussed?

A No. It was actually a few months ago. It's a complicated case that you may not wish to know about. It was a matter where I was being asked as an expert witness to discuss a patient's sleep disorder in a suit that the patient was involved in.

Q Was it a medical malpractice case?

A No, actually it was a paternity suit.

Q Were you a treating physician in that case?

A Yes.

Q What is your charge for consultation on legal matters?

A I usually charge a flat rate of $250 an hour.

Q Is that the same for deposition testimony?

A I think so.

Q What about your charge for trial testimony?

A I've never charged for trial testimony so far. I assume it would be about the same per hour.

Q Have you ever provided your name to a professional service or medical-legal consultant firm indicating that you were available to do medical-legal reviews?

A No.

Q Other than this case, have you ever been consulted by Mr. Treu's firm on a medical-legal matter?

A No.

Q Now, Doctor, you were originally engaged to act as a medical expert on behalf of Dr. Brooks; is that correct?

A Yes.

Q How did it happen that you are now acting as an expert for University Hospitals of Cleveland?

A I was contacted by Mr. Treu's office.

Q When were you contacted?

A I will guess it was perhaps three months ago.

MR. TREU: If you don't know, don't guess.

Q Do you recall when Mr. Torgerson on behalf of Dr. Brooks contacted you originally?

A That must have been about a year ago.

Q Now, when you were contacted by Mr. Treu or Mr. Treu's office, what assignment were you given in regard to this case?

A I'm not sure I understand what you mean.

Q When you were first contacted by Mr. Torgerson, I'm sure that he gave you some idea as to

what he was asking you to do.

My question is: When Mr. Treu contacted you, what did he ask you to do in regard to this case?

A Well, he asked if I would be available as an expert witness to review this case knowing that I have already reviewed that, made it somewhat simpler. I'm not sure I understand the question beyond that.

Q Did he give you any specific directions as to certain issues or questions he wished you to address?

A No, I don't think so. Perhaps because I'm already aware of the issues.

Q But you were looking at the issues from the perspective of Dr. Brooks when you initially reviewed the case.

A That's true.

Q My question is: Did you do anything different now that you are representing -- you are going to be providing testimony as an expert on behalf of University Hospitals?

A No, I don't think it would change my opinion.

Q Since the time that you agreed to act as an expert on behalf of University Hospitals, have you reviewed any additional materials?

A Yes, I believe the two most recent depositions.

Q Those would be which ones?

A Dr. Landis and I believe Dr. Sutherland also was a deposition I only received since. I do not honestly remember whether 1 saw Dr. Pelayo's deposition before or since, before agreeing to work with Mr. Treu or not.

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

A I think so. I have to answer that in that way because the hospital here has been named in something which I may or may not be a party to mostly as one of the directors of the intensive care unit. I'm not sure whether I have been personally named yet.

Q Do you know what the allegation of negligence in that case is?

A It's an incident that happened in the intensive care unit where the patient died after a procedure was done.

Q Were you a treating physician in that case?

A Yes.

Q What was the procedure?

A Pulmonary artery catheterization.

Q Have you ever had your deposition taken in that case?

A No.

Q Has your medical license ever been suspended or revoked or called into question?

A No.

Q Doctor, where do you have hospital privileges?

A Only here. North Shore University Hospital.

Q Has your hospital privileges ever been suspended or revoked?

A No.

Q And the privileges that you have here at North Shore, are those admitting privileges?

A Yes.

Q Is there a particular textbook that you consider to be the leading text in the field of sleep disorders?

A There are several. I don't think that any of them are definitive.

Q Any of those that you consider to be the best?

A The best is probably Principles and Practices of Sleep Medicine that Kreiger wrote. It's up here somewhere. It's somewhat imperfect.

Q You have before you your file on this case. I would like for you to just go through the various records that you reviewed in preparing your report on this case.

A Okay.

Q Start, if you want, with whatever you have on top will be fine.

A No particular order, I guess. I have what looks to me to be the clinic records or the outpatient records from University Hospitals of Cleveland, Dr. Rowane, mostly I think. I have some records from the department of neurology, Dr. Collins.

Do you want me to go through the reviews and things too?

Q Yes, just naming if you have a report and who it is from.

A I have a report from Dr. Stephen Meister, medical-legal review. I have a letter from Dr. Sutherland reviewing the case, a letter from Dr. Pelayo reviewing the case. I have the final sleep study report. I have the autopsy report.

I have -- I'm not sure what this is. Responses and Objections of University Hospitals of Cleveland to Plaintiff's First Request for Production of Documents. Some sort of documents here.

I have the answer of the defendants Rowane, Collins, University Neurologists, et al.

I have the summons in the case.

Q That's with the complaint attached; is that correct?

A Yes, I guess that is the summons and complaint.

This may be duplicate records from Dr. Collins and Hlavin.

I have the deposition of Dr. Rowane. I have a deposition from Dr. -- actually the Answer to the First Set of Interrogatories, Dr. Brooks. I have another copy of the polysomnogram.

I have Dr. Brooks' deposition, Dr. Landis' deposition, Dr. Sutherland's deposition, and

Dr. Pelayo's deposition. I believe that's all.

Q Doctor, you had the autopsy, I believe, also as part of your record.

A Yes, I mentioned that I think.

Q Have you reviewed the depositions of Dr. Collins, Dr. Hlavin?

A I do not believe I reviewed anything that I haven't mentioned.

Q I will mention a couple of others.

Dr. Martin or Dr. Whiting?

A No, that doesn't sound familiar.

Q Have you reviewed depositions of Tracy Smith or Geneva Smith?

A No, I don't think so.

Q Or the deposition of David Savagio?

A No.

Q You have not reviewed Dr. Meister's deposition, if I am correct, from what you said?

A Yes, I believe I have a letter from him, but I have not seen the deposition.

Q Since you agreed to provide expert testimony on behalf of University Hospitals, did you request that you be forwarded any additional materials?

A No.

Q In formulating your opinions in this case, did you review any medical literature, journal articles or textbooks in preparation?

A No, not specifically.

Q How about in preparation for this deposition, did you refer to anything other than your file in this case?

A No.

Q Are there any publications that you believe have particular significance to your opinions in this case?

A No.

Q Did you consult with any physicians at any time regarding this case?

A No.

Q Prior to accepting this case for review, did you have any contact with any of the medical providers named in Patricia Smith's medical records?

A Yes. I know Dr. Brooks at least professionally. I don't think we have discussed this case specifically ever.

Q When was the last time you saw Dr.

Brooks?

A In October, I think, because we were both at the American College of Chest Physicians meeting in Chicago.

Q Has your contact with him been through professional activities?

A Yes.

Q Such as meetings and that?

A Yes.

Q Have you seen him other than going to a professional meeting?

A No. There are actually several meetings that we end up in together. The last time was the last time I was at the meeting.

Q How is it that you ended up agreeing to act as an expert for Dr. Brooks? Did he contact you?

A No. In fact, I'm not sure how. I suspect it's because -- I give a talk every year, actually run a review course every year, a national review course in sleep medicine. One of the things I often speak of is how to run a sleep lab. I am interested in issues of sleep lab management.

Dr. Brooks is also a speaker there.

He speaks about pediatric sleep disorders. And I suspect that is why my name probably would have come up. I don't know that for sure.

Q Have you ever had any contact with any of the experts identified in this case?

A No.

Q You don't know Dr. Hobbins?

A I do know Dr. Hobbins.

Q He is one of the experts identified in this case.

A Okay.

Q You weren't aware of that?

A I was aware of that, actually. The name was mentioned before, but I haven't seen anything from him.

Q What is your relationship with Dr. Hobbins? How would you describe that?

A We are both on a committee. I don't know him very well personally. We are both on the health care policy committee of the American Academy of Sleep Medicine.

Q Have you ever discussed this case with him?

A No.

Q When as the last time you saw Dr. Hobbins?

A Probably in monthly conference calls he also is on line. Actually his term of office may be over. That may not be true.

In June at the American Sleep Disorders Association meeting, he and I were actually both on the podium in a meeting on business practices of sleep standards in Orlando.

Q Have you ever had any affiliation with University Hospitals of Cleveland?

A No.

Q Have you generated any personal notes in this case?

A Yes.

Q They are not in your file that I saw, Doctor.

A There is, I think, one page of notes. That's my handwriting.

Q May I see those?

A I'm not sure I can tell you what they mean anymore.

Q I am going to request a copy of this.

Are those the only notes that you have

generated on this case?

A This is not this case. I'm sorry. It's in the wrong file. It's the other case. It's the wrong dates. I'm sorry. It's just in the wrong file. Dated 1992.

Q Let me ask my question again. Have you ever generated any personal notes on this case?

A I don't think so. I dictated a summary when I was first involved which I think you have.

Q The summary that you are referring to, do you have a copy of?

A Yes.

Q Is that your report?

A That's my report.

Q Then I have seen that.

(Curriculum Vitae of Dr. Feinsilver was marked as Plaintiff Exhibit 1 for identification as of this date.)

Q Now, Doctor, I have a copy of your curriculum vitae here that I have marked as Plaintiff Exhibit 1. I am going to give that to you.

I would like you to just identify what that document is.

A It's my curriculum vitae as of January 21, 1999.

Q What I would next to ask you is if it is current and up to date and if there are any additions or corrections you would like to make to it.

A There are certainly several additions that I could make. Additional things that have been published. I'm not sure that it changes things much.

I have just been recertified in critical care medicine, for example. My appointment is unchanged. There could be some minor additions I could make.

Q In regard to your publications, do any of them deal with the subject matter of obstructive sleep apnea?

A Yes.

Q The new ones.

A Oh, anything new, I think so. I think since this was published I had two things published in the Clinics in Chest Medicine. Let's see if that

is on here. There is probably one book chapter that has been published since that might be relevant.

Q Could you tell me what the book is and what the title of that chapter is?

A It would be easier for me to print out a copy of my current CV, if you wish. I can do that at the end.

Q It would be listed on a current CV?

A Yes, if you want, I can print out a current. I'm not sure if there are any major differences.

Q I would rather than take the time now, Doctor, request that you provide Mr. Treu with a copy and he will provide me with an updated copy with your current publications on it, all right?

A It's easy to do.

Q On your curriculum vitae that is marked as Plaintiff Exhibit 1, you have several publications dealing with the subject matter of sleep apnea, correct?

A Yes.

Q Do any of these publications have particular relevance to the issues in this case as you understand them?

A Certainly.

Q If you could look through and tell me which of those articles you feel have particular relevance to this case. I believe you have numbers next to the various citations. Just indicate what numbers.

A On page six, for example, number twenty-seven is on recognizing and treating sleep apnea.

An editorial on page seven, item number forty, actually deals very much with diagnosing and treating sleep apnea.

Item forty-two on page seven, on page nine, chapter number eighteen, methods for monitoring sleep. There are some abstracts and things, but that's probably enough.

Q Doctor, you received your board certifications in sleep medicine in 1991, correct?

A Right.

Q Did you pass that board certification on your first try?

A Yes.

Q Who is your present employer?

A North Shore University Hospital.

Q Do you provide professional services for any other entity besides North Shore?

A No.

Q Do you maintain any medical offices outside of North Shore University Hospital?

A No, I do not.

Q Now, I would like you to describe for me your professional responsibilities and how you divide your professional time. What percentage of time is spent in clinical practice of medicine versus administrative versus academics?

A My primary responsibility is as the chief of the division of pulmonary medicine at this hospital.

Overall, I would say that I spend about half of my professional time practicing pulmonary and critical care medicine and about half practicing sleep medicine.

I direct the pulmonary critical care medicine fellowship here and I am the co-director of the sleep disorder center.

I'd say that at least two-thirds of my time is directly involved with clinical activities. The remaining one-third is administrative and

teaching.

Q Would it be fair to say that your current medical practice has been limited to pulmonary critical care and sleep medicine?

A Yes.

Q Do you see both children as well as adults in your practice?

A No. I'm sorry, no children.

Q So your practice is limited to adults?

A Adult.

Q Aside from your responsibilities as director of the sleep disorder center and your responsibilities with the critical care unit, do you maintain a private practice?

A I see private patients but only in the context of being a full-time employee of the hospital.

Q Are those patients generally, are they seen on consult to you?

A Yes. Since I do not do primary care.

Q Are all of your patients that you see either in the acute care area, hospitalized or through this disorder center?

A No, not necessarily. We have a private office in a sense, although it is actually part of the University Hospital system.

Q Kind of like a clinic type of a situation? People would come from the outside to see you?

A Yes.

Q How much of your time is spent in office based practice where you see patients that come from the outside as opposed to hospital based?

A Approximately three half days a week.

Q And then the rest of your time?

A Is spent administering the sleep lab, doing inpatient consultation, rounding in the critical care units and running the sleep laboratory.

Q How much time do you spend in this sleep laboratory?

A I would say --

Q When I say "sleep laboratory," I mean the sleep center, sleep laboratory, whatever that area is called.

A The sleep laboratory is the place where we do the testing and look at the results. I

would say six or eight hours a week. That is exclusive of seeing the patients, which is separate.

Q How much time do you spend as far as seeing patients related to the sleep center?

A That is probably the majority of my outpatient practice now. Probably two-thirds. So if on an average week I spend three half days seeing patients, outpatients, the equivalent of two of those three half days is probably just sleep patients.

Q Now, are you currently involved in any research dealing with obstructive sleep apnea in adult patients?

A Yes.

Q Any dealing with sudden death in adult patients with sleep apnea?

A No.

Q What research are you presently involved in?

A I am interested in the follow-up of patients with obstructive sleep apnea in issues of compliance with treatment and also in issues of the epidemiology and case finding for sleep apnea.

Q Have any of the results from your research been published?

A Yes, a few publications. There are a few things in abstract form right now. Some manuscripts should get out soon too.

Q What was the scientific question that you were studying?

A One of my interests was in the clinical prediction of patients with sleep apnea. In other words, can you based on history and physical examination in an outpatient predict who has sleep apnea?

Q What were your findings at least to date?

A The findings are that it is very difficult to do so. The best we could do in a study of about two thousand patients using a fairly complicated computer modeling of all the data that we could find was to accurately predict perhaps seventy percent of those patients.

Q Do you have a research protocol for that particular study?

A No. I was looking at clinical data.

Q In regard to your training, can you describe for me the training that you have had specifically related to sleep disorders?

A During my fellowship I had some exposure to sleep disorders. I was at Stanford for two years. More of what I learned about sleep disorders was actually in my first few years as an attending after training including some additional courses at Stanford.

Q Was that through your clinical experience?

A No. Well, yes. Both through clinical experience and through some additional training.

Q You had specific courses?

A Yes.

Q Where did you have those courses? At Stanford?

A At Stanford. I spent, I think it was, a ten-day course at Stanford when I was preparing for board certification.

As you may know, there are very few specific fellowship programs in sleep medicine and even fewer in 1989 or so when I was doing this.

Q Do you admit patients to the hospital under your medical management?

A Yes.

Q Now, Doctor, you are currently

director of the sleep disorder center here at North Shore University Hospital; is that correct?

A More properly as of November I am the co-director of the North Shore-Long Island Jewish sleep center because we have merged with Long Island Jewish Hospital.

Q As co-director then would you describe for me what your duties and responsibilities are?

A Okay. I evaluate patients before they are seen in the sleep disorder center. Some of them are people that I would see in an office setting. Some of them will be requests for sleep studies from outside physicians.

I am responsible for the management, day-to-day management of the sleep laboratory, its policies and procedures, and I will personally review the sleep studies from all the patients referred from the North Shore University Hospital side of that sleep laboratory as a combined venture.

It's hard to explain how it works sometimes. It means I'm reviewing about fifteen to twenty sleep studies a week.

Q Who owns and operates the sleep disorder center here?

A North Shore-Long Island Jewish Health System.

Q How many sleep studies are done in the sleep disorder center here per week?

A Our maximum capacity was 42. Six bed lab, open seven nights. We have a certain number of cancellations and no shows. We are averaging about thirty-five a week.

Q And then you would normally reviewed fifteen or twenty of those?

A I basically review half of them. Half are referred from North Shore and half from Long Island Jewish.

Q Is there another sleep specialist from the other side who comes and reviews the additional ones?

A Yes, there are actually two of them.

Q Are there two sleep specialists on staff here at North Shore?

A No, there are -- in the North Shore side of North Shore-Long Island Jewish -- we are increasingly combining everything, divisions, departments, everything.

At the moment at the North Shore side

there is myself and one other person who has just taken their sleep boards and waiting to hear the results.

On the Long Island Jewish side, there are three people I believe with boards in sleep medicine, one other who is also waiting to hear his results having just taken it. There may be another person actually who is board certified there too.

Q Is the sleep center an accredited training program in sleep medicine?

A It's an accredited laboratory.

Q Is it an accredited training program in sleep medicine?

A Centers are not training programs. We do not have an accredited fellowship in sleep medicine.

Q Do you have facilities for portable sleep studies here?

A Yes.

Q How long does it usually take to schedule a sleep study with your center after a request is received?

MR. TREU: As of now?

MS. TOSTI: As of now.

A As of now, the minimum time is probably two weeks because it takes about that long for an insurance company to give authorization. Our waiting period is generally not much longer than that. It's generally about three weeks. It could reach four weeks.

Q Now, prior to this time, did you have a different waiting period?

A Well, I came here from Winthrop-University Hospital where I ran a sleep lab. Because this lab is relatively new, I have been here a little over two years, our waiting period is significantly shorter than it was when I was at Winthrop until 1997.

Q What was it at Winthrop?

A Probably six to eight weeks. That is probably more typical of older established laboratories in the area.

Q How big a lab was Winthrop?

A Four beds.

Q Was Winthrop an accredited lab?

A Yes.

Q Is North Shore an accredited lab?

A North Shore-Long Island Jewish, yes.

Q Now, Doctor, is it possible to expedite a sleep study if circumstances warrant it?

A Yes.

Q How would you do that?

A Possibly by cancelling someone who already has an appointment or by filling in if someone doesn't show up or cancels.

Q So you have like a standby list; in case someone cancels, you can fit somebody in?

A Yes, we try. That is very efficient from a business standpoint, making a lab full. It is actually practically difficult and not often absolutely necessary either.

Q If there was a need to expedite, there would be a way to move somebody up the pipeline to get them a study sooner, correct?

A Yes, I suspect I do that a half a dozen times in a year. If that many.

Q What type of circumstances would warrant expediting a sleep study?

A It's often somebody who is being discharged from the hospital. There generally has to be a compelling medical reason that makes that particular case -- we are generally talking about

sleep apnea as the disease. Probably another complication that makes that sleep apnea particularly important to diagnose or treat in a hurry.

Q Can you give me an example of what one of those medical conditions would be?

A Oh, a patient with, for example -- I am trying to think of the last time we did it. Someone with severe congestive heart failure where the cardiologist wants an answer in a hurry. Perhaps someone who is about to be or just been discharged from the hospital.

It's not a very common occurrence. I must admit, sometimes we are doing it as a favor because somebody is interested.

Q How about someone who has coronary artery disease, would that be a patient that you would want to expedite a study in?

A I don't know.

Sleep apnea doesn't have much to do with the treatment of coronary artery disease. I am trying to think of the circumstance where that would be relevant.

Q Do all patients referred into your center by a non-sleep specialist receive a sleep

evaluation in conjunction with their sleep study?

A No.

Q You receive such referrals then just for a sleep study?

A Yes.

Q If you receive a referral for a sleep study, what information do you require that you have before you start the study?

A We have a one-page document which asks questions about symptoms, medications the patient is on, height, weight, blood pressure, a few brief things about physical exam and sort of a check-off for any other medical issues that we need to know about.

We also request some copy of a history and physical examination from their referring physician. We usually do it by fax and I will review this before okaying somebody to have a sleep study.

Q Why is it important for you to have that information before the sleep study?

A Two reasons: One is to make sure that it is safe to do a sleep study and that we know everything that we need to know about the patient.

A second is to know what kind of a

sleep study we are going to do. We will do slightly different diagnostic procedures depending on what we are looking for.

Q If you receive a referral for a sleep study from a non-sleep specialist, how do they know what information to provide to you? Do you send them this form?

A Yes.

Q When you get the request, you then write a form back to the referring physician?

A Yes, we would usually fax them back a form that they could check off. Sometimes that is sufficient, but actually that is kind of the bare minimum. I usually want that plus a copy of some records.

Q Does somebody from the sleep center then contact the referring physician and ask for additional information?

A Yes.

Q If your center determines that a patient has severe obstructive sleep apnea, does your center make written follow-up recommendations regarding that diagnosis?

A No. What we will do typically if we

see somebody very severe, which might happen once a week, I will fax usually a brief note to the referring physician. If it's very severe, actually I will call up the referring physician if I see something that I don't like.

It is also fairly common for me to fax a brief note just saying that your patient was here last night, appears to have severe sleep apnea and a full report will follow.

Q Do you make any suggestions in regard to treatment when you make that phone call or you fax a brief note?

A On a phone call I might because I get a chance to talk to the physician referring and find out some things. Generally I will not make treatment recommendations for someone I have not seen.

Q Now, once an overnight portion of a sleep study is completed at your center, how long does it take before the final report is disseminated to the referring physician?

A Our goal, and we are somewhat short staffed with secretaries recently, but our goal is to get reports out no later than two weeks from the date of the study.

Q When you do your final report, do you include any information on precautions for that patient?

A No.

Q Do you provide any treatment recommendations along with your final report?

A No.

Q Other than the faxed note or the phone call that you referred to, does the sleep disorder center provide the referring physician with any other type of preliminary report before the final report is sent out?

A Sometimes we will. We can produce a preliminary report that will often generally be modified by me within a few days. We may fax that out.

Q What would be contained in the preliminary report?

A Essentially most numbers concerning how low the oxygen level went, how many times the patient may have stopped breathing, what the sleep looked like generally without an interpretation, which is something that I will produce later after looking at that.

Even then, it is a little preliminary and it is not infrequent for me to change even the numbers.

This generally goes to physicians that are pretty well versed in dealing with sleep -- other pulmonary physicians that treat sleep disorders fairly frequently. It is only they who are likely to understand the significance of the numbers and act on it.

Q Now, Doctor, do you supervise the administration of overnight polysomnograms in the sleep?

A I am not physically present during it.

Q Is any physician physically present generally?

A No.

Q But you do evaluate them as part of your practice, correct?

A Yes.

Q Generally speaking, it would be technicians that would be administering the actual overnight test, correct?

A Yes.

Q Now, when you are doing an evaluation of the raw data from an overnight sleep study, do you look at all the raw data or do you do a sampling of various portions of the sleep study when you evaluate it?

A It depends on the study. A very straightforward study, I might just sample. More interesting ones, I may look at every bit of data.

Q In most cases, what do you do?

A In most cases, I look at -- I sample the data.

Q Now, Doctor, I note on your curriculum vitae, that you are a member of the American Sleep Disorder Association, correct?

A Yes.

Q And and that organization has recently changed its name to the American Academy of Sleep Medicine; is that correct?

A Yes.

Q How large an organization is that?

A I don't know. It's a national organization. I would seem to think it has about on the order of two thousand members.

Q How long have you been involved with

that group?

A Probably fifteen years.

Q Doctor, you mentioned that the sleep center here is accredited by the American Sleep Disorder Association, correct?

A The combined North Shore-Long Island Jewish Center is.

Q What does accreditation by the American Sleep Disorder Association mean?

A Accreditation is a very high set of standards that requires a great number of things to be done in concordance with what the accreditation committee thinks is right. Everything from the way tests are done to the recordkeeping before and after, policy and procedures.

Q Now, you have listed on your curriculum vitae that you were a site visitor for the American Sleep Disorders Association from, I believe, 1997 through the present; is that correct?

A I have been on that committee for a few years. I only started doing site visits in the past year.

Q What is a site visitor?

A Site visitors are volunteers, all of

them are boarded in sleep medicine who agree to, a few to several times a year, visit sleep laboratories and make sure they are in substantial compliance with the accreditation guidelines.

We will go to a lab -- I took one last week -- one evening and watch the setting up of the patients and all the procedures and what the lab looks like, and then see the outcome of the study the next morning, meet with administration and go through all the policies and procedures.

There are two or three people, two or three site visitors at a given site visit.

Q So would it be fair to say that you are familiar with the accreditation standards of the, I will call them, the ASDA?

A Yes.

Q What areas do you evaluate when you are doing the site visits?

MR. TREU: Objection. Asked and answered.

A Well, everything from the paperwork to the physical plant to the qualifications of the technicians and the medical staff.

Q How many site visits have you actually

made?

A I have just done two.

Q Have you ever been connected with any site visits to University Hospitals' sleep centers?

A No.

Q Doctor, isn't it true that a sleep disorder center requesting accreditation by the American Sleep Disorders Association is required to undergo a site visit verifying that they are adhering to the American Sleep Disorders Association standards?

A Yes.

Q And your role as a site visitor is to verify that sleep disorder center that you visit is continuing to meet the standards of the accreditation set by the American Sleep Disorder Association, correct?

MR. TREU: Objection. Asked and answered.

Q You may answer, Doctor.

MR. TREU: He said substantial compliance.

A Yes.

Q Now, in order obtain accreditation, a

center must not only meet the accreditation standards at the time of your site visit but they also have to agree to continue to adhere to those standards, correct?

A I would assume so, yes.

Q When a sleep disorder center is accredited by the American Sleep Disorders Association is the center then permitted to publicize the fact that they are accredited?

A Yes.

Q You would agree that accreditation by the American Sleep Disorders Association is a way of letting the public know that a sleep disorder center has agreed to provide care in conformance with the standards set by the American Sleep Disorders Association, correct?

MR. TREU: Objection.

A I'm not sure what you mean. Well, the public certainly wouldn't be aware of what the standards are. I guess so.

Q You don't believe that that provides the public with some knowledge as to the quality of the care that they are going to receive at a particular sleep center when the sleep center

publicizes that they have been accredited by the American Sleep Disorders Association?

A That's a fair statement. Okay.

Q Have you participated in the formulation of the American Sleep Disorders Association standards?

A No. I have been to meetings where it has been discussed, but that was my first year on this committee, so I can't say that I really participated in the formulation of any of the standards.

Q You are not involved in any committee work working on standards?

A No, not yet.

Q Can we agree that these standards are what the organization deems to be reasonable and prudent procedures that should be followed by a sleep center?

A I'm not sure that every member, that all of the organization would agree. There remain some things that are, I think, fairly controversial about this.

Q But as far as the organization in general is concerned, this is what they deem to be

reasonable and prudent?

A Yes.

Q As far as procedures that should be followed by a sleep center, correct?

A Yes.

Q Have you participated in any accreditation process for the sleep center here or the one at Winthrop?

A Yes.

Q Both places?

A We haven't been site visited here since I have been here.

Q But at Winthrop?

A Yes.

Q You were involved with the accreditation --

A Accreditation and reaccreditation. Reaccreditation takes place every five years.

Q When is the last time that you were involved in the accreditation at Winthrop before you left?

A Between three and four years ago.

Q So 1996, 1997?

A I think it's earlier than that. I'd

say 1995 or 1996.

Q Do you consider the American Sleep Disorders Association to be an organization that provides authoritative information on the subject of sleep disorders and sleep disorders treatment to practitioners the field?

MR. TREU: Objection.

A I think it's very difficult to find any organization that can provide authoritative information to the field about some areas of sleep medicine.

Q So is that a no, Doctor?

A I guess so. I mean, I guess I'll say no to that.

Q Would you agree that the American Sleep Disorders Association's accreditation criteria or standards for sleep centers reflects the accepted standard of care for sleep centers?

A No.

Q Why do you disagree with that?

A Because the vast majority of sleep laboratories in the country are not accredited. So it would not be the standard of care with what is actually going on out there.

Feinsilver

Q Doctor, the standards that the American Sleep Disorders Association promulgates, do you believe that those reflect the standard of care?

I realize that some sleep centers have not gone through the process to become accredited. I am asking you whether you believe that the standards that are promulgated by the American Association of Sleep Disorders reflect the standard of care?

MR. TREU: Objection. Asked and answered.

A My understanding of standard of care means what is actually the current standard practice of sleep medicine, and since the accredited laboratories represent probably a fairly small fraction of sleep medicine being practiced, my understanding of the term is that I would have to say the standard of practice is not reflected by accreditation.

Q Let me define standard of care for you. It is what a reasonable and prudent sleep center would do in like or similar circumstances.

MR. TREU: Objection.

A I never thought of it that way.

MR. TREU: It's a legal

Feinsilver

standard that she is stating, Doctor.

A I would have to say that an accreditation is not standard of care since there are many -- actually fairly well-known practitioners of sleep medicine are not accredited and doing a very good job.

Q Is there anything specific about the standards that you feel, the standards of the Association that you feel do not reflect the standard of care? Anything in particular?

MR. TREU: Objection to the broad question.

A I'm not sure. There are certainly issues in -- even as a member of the site visiting committee, that I disagree with.

Q Can you tell me one or two of those, please?

A One specifically is that I think that sleep laboratories should not give advice about treatment recommendations without seeing a patient. I don't think that should be part of the sleep study.

This is something that we have discussed on a couple of different committees and I

don't think there is a broad consensus.

Q Anything else that you can think of off the top of head that you disagree with with regard to the standards?

MR. TREU: Objection.

A What else did we talk about? No.

Q Now, the accreditation that is provided by the organization is an accreditation provided to a sleep center and not to individual doctors at the sleep center, correct?

A Yes.

Q Yes?

A Yes.

Q That means that the sleep center's operations must conform to the accreditation standards, correct?

MR. TREU: Objection.

A Yes.

Q Now, does it also mean that the physicians staffing an accredited sleep center must conform to the standards to maintain their accreditation?

A I don't think the standards specifically describe what physicians do. I'm not

sure what you mean by that question, perhaps.

Q Well, Doctor, if you have the sleep center staffed by sleep specialists that are providing care, don't they have to provide it in conformance with the Sleep Disorder Association's standards in order to maintain the accreditation?

A Yes, but the standards don't really control the practice of medicine, so I'm not sure. They don't say much about how I take care of patients. It is more standards for diagnostic study.

Q Then it is the responsibility of the sleep center to make sure that they are adhering to the standards for accreditation, correct?

MR. TREU: Objection.

A For performing testing.

Q For performing tests and all of the other things included in the standards?

MR. TREU: You are putting words in his mouth.

MS. TOSTI: Let him finish his answer.

MR. TREU: You changed the question.

Feinsilver

MS. TOSTI: He can answer it whichever way he sees fit.

A You have to restate the question. I think I lost you.

Q Is it the sleep disorder center's responsibility to make sure that all of the procedures are in conformance with the accreditation standards?

MR. TREU: Objection. I don't know what you mean by "procedures."

A The sleep laboratory's accreditation extends to the diagnostic procedures being done in the laboratory.

Q Doctor, now you have indicated that you are a site visitor, correct?

A Yes.

Q You are familiar with the accreditation standards, correct?

A Yes.

Q And you have looked at those standards and are aware that many of the standards don't deal specifically with how to do a sleep study. They deal with documentation. They deal with reporting. Correct?

Feinsilver

A Yes, that's right.

Q Now my question again: Is it the sleep center's responsibility to make sure that the people practicing in the sleep center are in compliance with the standards set by the organization in order to maintain their accreditation?

MR. TREU: Objection.

A Yes.

Q Now at the time that Patricia Smith received her care at the sleep center at University Hospitals of Cleveland, it was an accredited sleep center, correct?

A That's my understanding.

Q Well, you saw that on the final sleep study report, correct?

A That's true. It does say that.

Q And a sleep center like University Hospitals of Cleveland that chooses to become accredited is required to meet the accreditation standards and to continue to adhere to them in order to keep their accreditation, correct?

MR. TREU: Objection. Asked and answered.

A Yes.

Q Would you agree that most patients with sleep disorders require follow-up?

A All patients require follow-up.

Q Do you know whether the accreditation standards state that most patients with sleep disorders require follow-up care?

A Yes, they do.

Q Can we agree that the standards of your organization require that a center must have an effective mode and rationale for scheduling the initial and follow-up visits to the sleep center and to consultants?

MR. TREU: Objection.

A There are many patients in my laboratory whom I may see only for the purposes of an initial testing and -- let me think about that.

There are many patients I may see only to perform a diagnostic study, the results of that which are returned to the referring physician, and I will not be making follow-up plans.

Q Do you know whether the accreditation standards require that a sleep center have an effective, rational system in place for scheduling the initial and follow-up visits to the sleep centers

and scheduling visits with consultants?

A I'm not aware of that particular wording, no.

Q Can we agree that it would be a violation of the standards of the American Sleep Disorders Association for an accredited center not to have an effective mode and rationale for scheduling the initial and follow-up visits?

MR. TREU: Objection. If you are going to ask questions about the standard of care, ask questions about the standard of care. We are not here to determine whether there were violations of the accreditation standards.

MS. TOSTI: Well, I will ask whatever questions I determine to be significant to this case.

MR. TREU: They speak for themselves.

Q Would you agree that accreditation standards require that a formal, efficient and effective vehicle must be used to convey the results of the evaluation and treatment to the patient and

the physicians who have referred the patient to the center?

MR. TREU: Objection.

A I'm not sure how it is worded in the accreditation standards. That is an area, as I mentioned before, I somewhat object to about which there is a great deal of controversy.

I can't defend all of the accreditation standards as being the appropriate practice.

Q Would you agree that at an accredited sleep center each patient's chart should have a copy of correspondence which states the diagnostic assessment of the patient and a recommended treatment plan if the disorder has a known treatment?

MR. TREU: Objection. Asked and answered.

A No, I don't agree and, in fact, my laboratory does not do that.

As I mentioned, that remains somewhat controversial.

Q Doctor, as an accredited sleep center, that is what the sleep center is supposed to do though, correct?

Feinsilver

MR. TREU: Objection.

A I run an accredited sleep center and we do not do that.

Q Then you are not in compliance with the accreditation standards; is that correct?

A That may be true.

Q You may disagree with the accreditation standards, but you would agree that is what the accreditation standards state?

A I not only disagree with them but being involved with the enforcement of them, I will tell you the people that are involved in the accreditation committee are still coming to terms with them, and I think that will be changed very shortly.

Q In your review of Patricia Smith's records, did you find any records documenting the diagnostic assessment and recommended treatment plan?

A No, I don't think treatment was ever mentioned from the sleep center to the referring physicians.

Q You would agree that communication should be sent regarding the results of the tests

within a reasonable time after completion of the evaluation, correct?

A Certainly.

Q Does the accreditation standards suggest that this is preferrably done within five working days?

A I think it is five working days for a preliminary report.

Q And the preliminary report should contain both the diagnostic assessment and recommended treatment plan, correct?

MR. TREU: Objection.

A I don't think that is spelled out.

Q Would you agree that each patient's chart, according to the accreditation standards, should contain a summary of the final contact if the patient is a consulted case and documentation that the patient has been adequately informed about the results of the diagnostic process?

MR. TREU: Objection.

A I don't believe that is true. Should I refer to this?

Q Pardon me?

A Should I refer to the accreditation

document?

Q I'm not going to have you read the whole document.

A You are asking me what I remember of it and I may not remember it all. Okay.

Q Is that a document that you referred to in your review of this particular case, Doctor?

A No. This is a document that I refer to. It's on my desk because I did a site visit last week.

Q And you don't know whether that specific set of criteria were the ones that were applicable to University Hospitals at the time of Patricia Smith's care, correct?

A It wouldn't have been. This is from April 1999.

Q So those would not be applicable?

A I assume it has changed over the last four years.

Q Did you find any documentation in the sleep center's records that Patricia Smith had been informed about the results of her diagnostic process?

A I'm not sure that I'm in -- that I

have all the sleep center's records. What I have is the reports it sent out. I suspect there is additional information.

Q What do you think you are missing, Doctor?

A I don't know. I mean, I don't have their telephone log of who they called or when they called, I suppose. I suspect --

MR. TREU: Are you asking is there some documentation of a direct contact between the lab and patient with the results?

MS. TOSTI: I am asking him if he thinks he is missing something, what he thinks he is missing.

MR. TREU: I am getting back to your prior question that I don't understand.

MS. TOSTI: I asked him if he found any documentation in the sleep center records that Patricia Smith had been informed about the results of his diagnostic process.

He indicated that he felt he

Feinsilver

did not have portions of the records.

MR. TREU: I am simply asking a different question. Are you asking whether they contacted her directly or some other doctor?

MS. TOSTI: I am asking the question I just repeated to you.

MR. TREU: I am asking you a question. Can you answer it?

MS. TOSTI: I will ask whatever questions I deem are important.

MR. TREU: If you want to ask vague questions, that's fine. They mean nothing.

BY MS. TOSTI:

Q Did you understand my question, Doctor?

A Yes. I don't have any evidence that the laboratory contacted the patient. I will not permit my technicians to contact patients directly. It was not something I was looking for.

Q That would be something that the physician would do? If the patient is to be contacted, it would be done through the physician?

Feinsilver

A The referring physician.

Q Doctor, would you agree that the chart of a patient at an accredited sleep center should include a reasoned analysis of the critical significance of the procedures performed and their implications for management of the patient?

MR. TREU: Objection.

A No.

Q Why not?

A I believe it's the same question you asked me before, the issue is whether a polysomnogram report should include treatment recommendations. It's my opinion that it should not.

In our laboratory there are only two possibilities: Either I have not seen a patient, which means I should not give a treatment recommendation, or I have seen the patient, in which case I don't have to send myself a treatment recommendation.

I realize in that statement I represent something other than what the sleep disorder center accreditation standards say.

I will also say that is probably not even a minority view among accreditation people at

Feinsilver

the last meeting and I suspect you will see that standard change probably for exactly this reason.

Q Would you agree that the failure to record appropriate actions and summaries in a patient's records demonstrates a lack of professional commitment on the part of the sleep disorder center?

A Could you say that again?

MS. TOSTI: Read my question back.

(The record was read.)

MR. TREU: I object to that. It is incredibly vague.

A I have a copy of the overnight polysomnogram report which has a reasonable amount of data and seems to come to a reasonable assessment. I don't know if there are any other records that I should know about.

Q Do you know whether the accreditation standards say that?

MR. TREU: Objection again. Can you give me a continuing objection to questions about accreditation standards, so I don't

Feinsilver

have to keep interrupting?

MS. TOSTI: Yes.

A I no longer remember.

Q Doctor, at an accredited lab, would you agree that each patient must have a clearly identifiable center staff physician who is responsible for the patient's care throughout the patient's active status at the sleep disorder center?

A I don't know.

Q Would you agree that the medical director at an accredited sleep center is responsible to ensure and document that each patient seen at the sleep disorder center has had an appropriate diagnostic evaluation, discussion of the diagnosis and treatment options, and follow-up of the patient's sleep disorder?

A No.

Q Why not?

A Again, I'm not sure. You are asking me, it seems again, the same thing: Do I agree with the standards for accreditation requiring the laboratory to initiate a treatment? I think I have explained why I don't agree with that.

If you are to ask me -- if you want to ask do the standards of accreditation say that --

Q Let me clarify my question.

MR. TREU: Let him answer.

MS. TOSTI: I think he misunderstood the question. I will withdraw the question and ask it again.

Q I asked whether you thought that the medical director at an accredited center is responsible for ensuring and documenting that each patient seen at the sleep disorder center had an appropriate diagnostic evaluation, discussion of the diagnosis and treatment options and follow-up of the patient's sleep disorder, not necessarily that the center did it, but that it's documented and the medical director ensures that somebody is doing it.

A The accreditation standards may say that. However, I would disagree with that. In practice, it's almost impossible to do that.

In fact, the example I would give as a pulmonary physician is, if I send a patient for a chest x-ray, the radiologist's responsibility is to get me an accurate and timely report. I would not

expect the radiologist who has not examined the patient's chest to recommend the treatment for pneumonia. His responsibility is to say that the x-ray is abnormal. Might have pneumonia.

If I haven't seen the patient in my laboratory as the medical director, I strongly feel that our responsibility should be similar to that. It's a more complicated test, but it is the same idea.

Q Would you agree that sleep disorders require careful and total evaluation?

A I think patients always require careful and total evaluation.

Q And would you agree that sleep disorders often require the utilization of knowledgeable consultants?

A Absolutely.

Q Do you agree that an accredited sleep disorder center should have evidence in its records that appropriate consultants have been utilized?

A Absolutely.

Q Would you agree that prompt communications between the center's professionals and the technical personne1 and the consultants is

crucial to integrated clinical effort?

MR. TREU: Objection.

A Yes.

Q Now, Doctor, is one of the duties of the medical director as a board certified sleep specialist, is there a responsibility for quality control at the sleep center?

A Yes. Absolutely.

Q When you have your sleep center accredited, aren't you required to agree to continue to follow the accreditation standards?

MR. TREU: That is asked and answered.

A Yes.

(Letter dated May 5, 1999 to Mr. Togerson from Dr. Feinsilver was marked as Plaintiff Exhibit 2 for identification, as of this date.)

Q Now, Doctor, I have a copy of your expert report. I have marked that as Plaintiff Exhibit Number 2. If you would just take a look at it and would you identify that document for the record for us?

A Yes, I wrote this.

Q And that is a letter dated May 5, 1999 to Mr. Torgerson, correct?

A Right.

Q Now, did you provide any drafts of your report to Mr. Torgerson before you provided that letter?

A No.

Q And that is the only report that you have written on this particular case?

A Yes.

Q Do you still hold the opinions that you have expressed in your report?

A Yes.

Q Does your report of May 5, 1999 summarize all the opinions that you intend to offer at trial regarding this case?

A As far as I can see, yes.

Q Do you intend to do any additional work or review any additional materials in this case before trial?

A I'm not sure there is any additional materials to review.

Q At this point in time, you don't have an intention of doing any additional reviewing?

A No.

MR. TREU: If he does, I'll let you know.

Q For the balance of this deposition, when I am speaking about sleep apnea, I am referring to obstructive sleep apnea and I realize there are other types.

A Yes.

Q I also am speaking only as it applies to adults and I realize that there is also involvement with children.

A Okay.

Q Can you tell me what obstructive sleep apnea is?

A Obstructive sleep apnea is a condition where patients stop breathing during sleep by definition for at least a period of ten seconds. It's generally associated with snoring and daytime sleepiness.

Q What causes it?

A There are several factors probably involved. Much of it has to do with the anatomy of the upper airway which is everything from the neck up.

Humans have collapsible tubes for upper airways. The tendency when muscles relax, particularly when lying on one's back during sleep, is for this tube to partially collapse which causes snoring or totally collapse which causes cessation of air flow.

Many people snore. It is unclear whether snoring itself is a disease. Some will also have enough pauses in their breathing called apneas to be clinically significant.

Q So the anatomy of the upper airways.

A Have the most to do with that.

Q Anything else?

A Medications can also influence it.

In some people, undoubtedly, what we call the respiratory drive, the drive to breathe is stronger than some others.

Being overweight also makes things worse. It makes it harder to breathe against a collapsible tube.

There are probably familial factors involved.

Q Is obesity frequently associated with obstructive sleep apnea?

A Yes.

Q Can obstructive sleep apnea cause hypertension?

A Probably. It appears the two things are linked.

Q Do you find that frequently with severe obstructive sleep apnea there may be a component of hypertension associated with it?

A Yes. It's hard to sort those things out because the majority of people with obstructive sleep apnea are male, in their forties or fifties, and overweight and that is exactly who gets hypertension as well.

So deciding whether sleep apnea is an independent risk factor for hypertension has been difficult to do statistically.

Q Aside from what you just previously mentioned as far as obesity and structures, anatomical structures, are there any other signs and symptoms that may be associated with obstructive sleep apnea? I think you also mentioned daytime sleepiness?

A Snoring and daytime sleepiness are most important. Some patients may also have

hypertension. Many people have hypertension. Some patients will complain of morning headaches. That is not a very sensitive nor specific finding either.

You get some clues by looking at the upper airway and seeing if the anatomy looks particularly crowded, but that is relatively difficult to do too.

Q Are there any complications associated With severe obstructive sleep apnea?

A There is beginning to be evidence that people with severe obstructive sleep apnea live longer if they are treated. Mortality from all causes. The data is not very good yet.

There is at the moment, as you may know, a national, what is called a sleep heart health study going on to try to get data about that.

It is somewhat difficult to prove but it would appear that the mortality is -- the only way I can make the statement really is mortality of patients with sleep apnea who are treated appears to be less than people who are untreated.

Q Is there any association of cardiac arrhythmias with severe obstructive sleep apnea?

A Yes. It is not unusual to see some

arrhythmias during a sleep study. It's not unusual to see some during normal sleep either.

There are more arrhythmias in people with severe obstructive sleep apnea. Original reports suggest that was very common. Actually more recently there have been a couple of papers written suggesting that it is actually very uncommon to see arrhythmias during bad sleep apnea in a sleep laboratory.

Q Do you recall the title or authors of that those particular papers?

A I could get that for you. Something I reviewed about a year ago.

Q Any association between sudden death and obstructive sleep apnea?

A I don't know.

Q You have not seen any studies on that particular subject?

A Sudden death and sleep apnea. I don't think anybody has proven that in adults. Even in children it is not clear, the relationship between sudden infant death and apnea in children is somewhat debatable as well. In adults I think that is very hard to know whether that is real.

Q What about accidents due to falling asleep?

A Accidents are probably more common and more important, I believe in many of the studies when you look at mortality of patients with sleep apnea, I think at least about half of the excess mortality is related to accidents.

Q What parameters or criteria do you use to differentiate between mild, moderate and severe?

A That's a very good question. There is no accepted standard for that. I look at three things in judging how bad someone's sleep apnea is. I can't give you quantitative numbers for that.

I look at how disturbed the sleep architecture is, which means, how disturbed, the way patients go from one stage of sleep to another, and how many times they wake up and disturb their sleep. That is number one.

Number two, I will look at how many times they lower their oxygen level and how low the oxygen level might go during sleep.

Number three, simply the number of respiratory events that happen per hour during sleep.

Q What are you looking at specifically in regard to disturbance of the sleep architecture?

A It's hard to put that in numbers. Sleep architecture has a particular pattern. It involves things like sleep efficiency which is what percentage of the time in bed you are asleep, also whether the patient has deep stage three and stage four sleep, basically better sleep, has more of that, whether rapid eye movement sleep happens in a particular period or every ninety minutes or so and the number of arousals which are brief awakenings from sleep, a few seconds, or awakenings which by definition last at least half a minute during sleep.

Q You also mentioned lower oxygen saturations and also numbers of respiratory events. If you are looking at the difference between mild, moderate and severe, what numbers are we looking at for those particular things?

A It's hard to come up with numbers.

Q Or a range?

A The numbers of respiratory events, that includes both people who have apnea, stop breathing totally and have hypopneas, partial obstructions, which is a much more difficult thing to

even quantify.

One of the very important debates in the sleep field right now is to try to come up with just a standard criteria for diagnosing hypopneas, these hypoventilations.

When someone stops breathing, we can all agree on what that is. When someone slows down their breathing, it is a little harder to get different centers to agree, and it is not a quantitative signal we are looking at. That is very tough.

In general, you can look at the apnea index, which is the number of times you stop breathing totally per hour of night's sleep, and a number greater than probably ten or fifteen becomes abnormal. Someone with terrible apnea might have a number like fifty or sixty.

More commonly, we will look at an apnea/hypopnea index or respiratory disturbance index which includes both stopping and slowing down. There the variability from laboratory to laboratory is greater. It is harder to agree on the definitions.

In our laboratory someone with a respiratory disturbance index of twenty would

probably be mild; forty or better becomes moderate; and sixty or seventy might be the cutoff for severe.

Again, I will factor in how long the events are, how low the oxygen level will go and how disturbed the sleep will be.

There are patients with an index of thirty that I might very, very much treat in a hurry and patients with an index of thirty I might not want to do much anything with.

Q If a patient has an index of 30 and you want to treat them, why might you want to treat them? What other factors would you look at to tell you this is a patient who should be treated?

A How sleepy they are, which is one of the greater sources of morbidity and mortality is simply being too sleepy. Again, that is a very tough symptom to be very good at.

How disturbed their sleep is also and how low the oxygen level might be. Everyone's oxygen level goes down a little bit during sleep. We think the consequences of having a very low oxygen level at night are significant, although it is actually very difficult to prove.

Q What do you consider to be a low

oxygen level?

A Below -- 80 or below as a saturation, oxygen saturation percentage.

Q How do you diagnose obstructive sleep apnea?

A It's a clinical diagnosis. Again, looking at sleep study, looking at those three things, what the sleep looks like, how low the oxygen level is and how many events there are.

However, factored into that also is how sleepy the patient might be, what the upper airway anatomy looks like. Particularly in describing treatment options it would be important to know what the patient looks like, what the upper airway looks like, whether the patient is significantly overweight.

It is actually very difficult to be certain about the level of severity of sleep apnea and exactly where this problem becomes a disease is unclear. There is undoubtedly a spectrum from people who simply snore, but have pretty good sleep and don't stop breathing at night and don't lower their oxygen levels, to people who snore badly and have a couple of times here and there where they stop

breathing, to people who snore badly and stop breathing all the time and really get into trouble.

Particularly because it is such a common disease, in some of the studies, the sleep heart health study for example, the prevalence of the disease is very arguable based on where you set the limits. If you say anybody with an apnea index greater than ten, for example, has the disease, the prevalence becomes very, very high.

Q Doctor, when an overnight polysomnogram is done, the data that is collected during the test we have spoken about some of them. One of them is the oxygen saturations. Another one electrocardiogram monitoring. There is respiratory patterns.

Is there any other data that is included in the polysomnogram that is collected?

A A typical polysomnogram will include a minimum of two, more commonly four or even five, EEG leads. That is electrical activity in the brain. A measurement of eye movements with an electric -- an EEG lead also in the corner of the eyes so you can tell when the eyes are moving, mostly to document rapid eye movement sleep, a few different

measurements of breathing which is done both by a band typically around the chest and belly, chest and belly movement; a flow sensor near the nose and mouth looking at air going in and out; an oximeter which is a probe usually placed on a finger to measure oxygen level, typically also -- well, electrocardiogram is always, I think, and typically also electrodes or EMG, electromyogram, tracings of leg movements which is another thing that can disturb sleep frequently.

Q The electrocardiogram is utilized to monitor for arrhythmias that may occur during sleep; is that correct?

A Yes.

Q And the oxygen saturations are used to monitor for levels that may fall at some point if a patient has apneas or hypopneas?

A Yes.

Q Do you see an increased number of arrhythmias when there are longer apneas?

A I think so. Yes. Actually it is more remarkable looking at sleep studies as a critical care doctor how low oxygen levels can go and how long these pauses can be without seeing arrhythmias in many patients.

Q Do you see increased numbers of arrhythmias when there is an increased number of apneas?

A I assume so. I'm not sure anybody has proven that. But I think that would stand to reason. Yes.

Q Would it be fair to say that when the oxygen saturations fall there is an increased risk for cardiac arrhythmias then?

A Yes. That's the assumption.

Q Now, generally speaking, are patients in the sleep lab when they are undergoing a sleep study in the lab for about an eight-hour period? Is that generally the length of the test?

A Perhaps a little bit longer. Our patients come in about 8:30 or 9 o'clock at night and go home the next day about 7.

We attempt to get an eight-hour sleep recording or eight hours of lights out time during which hopefully the patient will sleep.

Q Once the test is completed, the test is then interpreted. Is it first interpreted by a technician?

A Yes.

A Actually we say it is scored by the technician, meaning that they count up all the events and decide what things look like and what stage of sleep it is.

Q How long does it take the technician to evaluate a polysomnogram?

A It varies. Some are much easier than others. We generally allot between two and three hours of a technician's time to review a study. Some will take much more than that and some will be very simple.

Q Then following that review, then the sleep specialist physician would do his review?

A Yes.

Q How long does it take a sleep specialist to then do a review of the data?

A That varies enormously too. A simple one I might spend 15 minutes with. There are some I would want to myself look at every single piece of it and I might spend upwards of an hour with one.

Q What would cause you to want to look at the whole test?

A Generally things that do not have to do with sleep apnea, actually. The more challenging

things we diagnose in a sleep laboratory are parasomnias, sleep walking, unusual things that happen during sleep or narcolepsy, being really uncertain what the kind of sleep is.

The majority of patients in any sleep laboratory are there for the diagnosis or treatment of sleep apnea. Actually most of those are somewhat easier to deal with. It's the non-apnea patients that tend to be more interesting and take more time.

Q Do you have a procedure in your lab whereby an technician can institute C-PAP titration if the patient is observed to meet certain criteria for obstructive sleep apnea during the first portion of the night?

A Not as a routine. There are some patients that I will order specifically what we call a split night, spend the first few hours watching the patient and the techs have the okay if the problem is very severe to institute treatment that night. In our laboratory they don't have the blanket okay to treat anyone who looks severe.

Q In your lab if they see a patient that to them looks like severe obstructive sleep apnea, they could not convert over to a C-PAP titration with

a patient?

A Not unless we already planned that or unless they called me up. That happens occasionally. If they saw something very severe, they might call me up.

Q But there is no set protocol that they can just institute automatically?

A No, I wouldn't let them do that.

Q What would you be looking for if you were going to order that for a patient, to say, I want you to do first half diagnostic and the second half a C-PAP titration? What type of patient would you recommend that for?

A Largely I would do that if I had a patient in the office who has very severe symptoms of sleepiness, particularly if he is in a sensitive occupation, for example, driving for a living and if the patient seems to be fairly intelligent and likely to be compliant.

Actually to come into a sleep laboratory on one night, sleep in an unusual situation with wires on you and to be introduced to a new form of treatment at the same time I think is very difficult for most patients.

Q Now, in Patricia Smith's case she had an occupation of a school bus driver. Would she be a patient that would be a candidate for a split study as you have described it?

A If I had seen her first, maybe. Unfortunately, it is very difficult to do that.

In fact, it occurs to me on my curriculum vitae somewhere, we published an abstract looking for compliance with patients on a split night protocol and it is substantially worse.

The problem is that the best treatment we have for sleep apnea at this point is somewhat imperfect and it is the institution of nasal C-PAP.

Compliance with nasal C-PAP is generally not very good and the initial acceptance of nasal C-PAP is very much dependent on what you do on those first few visits.

Since I am looking at a very long-term treatment, I personally have patients who have been on C-PAP now for 15 years, I am less interested in doing it in one night versus two nights than in trying to get somebody comfortable with it.

We did a quality assurance project and

one of the abstracts found our compliance with split night was about half of what it was if we spent two nights and accordingly, I would try very hard to get patients in for two nights to try to do it in what I consider the best way.

This also, you hit upon raging controversy in sleep medicine. People feel very differently about it.

Q Do you schedule people for the diagnostic and the titration?

A No. At the same time, no.

Q I don't mean on the same night. I mean you bring the patient in and do your evaluation and then say on Monday we will do the diagnostic portion and then come back and we will do the titration portion?

A I understand. No, I don't.

There are several reasons for that. Insurance would not pay for it, first of all. You could not get the second study approved without the information from the first study.

Secondly, as I mentioned awhile ago, my ability to predict who has sleep apnea seeing them in the office is actually not very good. I will get

it wrong a lot of times.

Thirdly, it's not an emergency.

Q Doctor, in regard to the treatment options for obstructive sleep apnea, is C-PAP the primary treatment option for patients?

A Yes, it's the best we have.

Q There are other options. I think surgery is also a possibility in certain patients?

A Yes.

Q There is also some other additional measures that can be used such as oral appliances that may be of some assistance, correct?

A Yes.

Q And special sleeping pillows, also?

A There are many things that have been tried. The gold standard remains nasal C-PAP or perhaps tracheotomy, which very few people do anymore but reliably works. It's an imperfect solution certainly.

Q What about protryptline?

A It was used years ago. I'm not sure that many people are using it at all. It has a pretty small beneficial effect on sleep apnea. Largely any medication to treat sleep apnea has not

been very useful. Most people don't consider them.

Q So you would disagree with Dr. Hobbins who is an expert also for University Hospitals who suggested that Patricia Smith should be treated with protryptline initially?

A If he said that, as far as I could tell, I would disagree with him.

Q Doctor, Would you agree that when C-PAP is utilized it is a highly effective therapy for obstructive sleep apnea?

A Yes.

Q What percentage of adult patients trying C-PAP for apnea are able to continue to use it, would you say?

A In our laboratory about eighty-five percent I believe of patients will initially comply with C-PAP. There are about fifteen percent of people I can never get to try it.

In long-term follow-up, we had a sample of people we followed for five years, I believe we were at about sixty-five percent. Something under seventy percent of patients who comply with treatment long term, or patients who said they comply with treatment long term.

Feinsilver

Q You found most patients do comply with the C-PAP long term?

A Yes, a majority.

MR. TREU: How many years?

THE WITNESS: Five years.

Q If a referring physician is concerned that a patient is having seizures during sleep due to oxygen saturation, do you have an opinion as to whether sleep evaluation is indicated?

MR. TREU: Objection.

A That's a very rare occurrence. It is very unusual for us to see seizures in the laboratory at all. Actually seizures require some fairly specific looking at the EEG to look for which we may not be able to find in a sleep laboratory very easily. We can do it, but it requires some special technical tricks.

Speaking as a lung doctor also in addition to a sleep doctor, it's really very rare to see anybody get seizures on the basis of hypoxemia during night. I'm not sure I have ever seen it honestly. Certainly many patients with sleep apnea get prehypoxic. It is certainly not a common cause of seizures, if at all.

Q Do you know whether or not oxygen desaturations, low oxygen saturations increase the risk or decrease the thresholds for seizures?

A I'm sure it does. So does sleep deprivation. There will be in our laboratory tonight, I will say, at least three people of the six who will be there tonight are likely to have oxygen desaturation that will be substantial, and I'm not sure that I have ever seen a seizure in our sleep laboratory.

Q Doctor, if the patient has had several seizures at night and the referring physician feels that it may be due to oxygen desaturation, do you have an opinion as to how soon a sleep study should be undertaken for that patient?

MR. TREU: Objection.

A I guess I've never heard of seizures being caused solely by nocturnal oxygen desaturation.

Q So you don't have an opinion as to whether that patient that I just described --

A You are asking me if this was an emergency. I'm not sure that it ever happens. Maybe I'm misunderstanding something you are saying.

Feinsilver

Q If you receive a referral from a physician similar to what we have in Patricia Smith's case in which the doctor indicates on the referral that there is a concern that desaturations during sleep may be causing seizures, is that a patient that' should have a sleep study done on a fairly prompt basis?

MR. TREU: Objection.

A It's not what I consider to be an indication for a sleep study. In fact, my reaction would be, this is a person who doesn't know much about sleep or oxygen.

Q Would you pick up the phone and call him up and say, "Hey, Doc, I don't think you know what you are talking about"?

A Perhaps, yes. I don't know. I don't know what the referral specifically -- I guess it is in here. I don't think the referral was specific for nocturnal seizures.

Q Would you like to take a look and see what it says.

A It's in here somewhere.

Q I think it says that desaturations may be the etiology.

Feinsilver

A Diagnosis number one, seizure disorder; number two, rule out nocturnal hypoxia.

Actually if this was a patient referred for a seizure disorder and they are worried about nocturnal hypoxia, I think that is a very unusual indication for a sleep study and certainly it would be actually a much less concern to me.

Q Why is that, Doctor?

A Because it's not a common problem. It's not something I'm aware of being a reason for concern.

Most of what I am concerned with within a sleep laboratory is seeing patients who have -- what we do in a sleep laboratory largely is look for some of the more severe forms of sleep apnea and seizures and nocturnal hypoxia is not a common problem. I don't think -- I don't know who filled this out or who was requesting the study.

Q You don't know who filled this out?

A I don't know.

Q Have you read Dr. Rowane's deposition?

A Is that the person who filled it out?

Q Yes, and he described that he filled

this out in his deposition.

A You may be right. So that is his signature here? It says work-up requested by Dr. Steven Collins, I think.

Q Do you see where it says, concerned patient may desaturate is etiology for seizures disorder. Do you see that?

A Yes.

Q If that is what the referring physician says and Dr. Collins, as you know in this case, is a neurologist?

A Yes.

Q Dr. Rowane is a family practice physician. Would this type of a referral, would this be the type of patient that should have a prompt sleep study done?

A No. This is not a common problem that I'm worried about.

Q That would be the decision, if you were looking at that, that you would say this just falls into the normal stream of requisitions for a sleep study?

A Yes, I think the reason for the sleep study is not to look for nocturnal seizures but to

look for sleep apnea. That is the common disease.

There is nothing particular about this referral that would put it on top of the pile, if that's what you are asking.

Q That's what I am asking.

A Okay.

Q Doctor, in a patient with obstructive sleep apnea the heart can beat irregularly and may even pause for several seconds during sleep, correct?

A It's a rare occurrence, but it can happen.

Q Once the diagnosis of severe obstructive sleep apnea has been confirmed by polysomnogram, are there any clinical reasons for delaying therapeutic evaluation with C-PAP or bilevel therapy?

A Any reasons to delay it? It's hard to ever argue there would be a reason for delay. There are times when C-PAP would not be the first choice of therapy.

Q In what instances?

A If someone had a significant cranial facial abnormality, extremely crowded upper airway

where the surgical approach might be more reasonable or someone who, which is not that unusual, would not be considered to be a compliant enough or likely to comply with treatment with nasal C-PAP.

Q In Patricia Smith's case once she received her overnight polysomnogram, is there any reason that you are aware of to delay C-PAP titration for her?

A I don't have that information. I don't know. Again, it's been awhile since I looked at all of it, but I don't believe I saw any ear, nose and throat evaluation. I don't know what her upper airway looks like. I don't know what her primary physician would have thought for her to be compliant with this.

Q Isn't one of the things that the accreditation criteria requires is either you do the evaluation yourself or you make sure that you have sufficient information on the patient?

A Yes.

Q Including what you just described?

A I don't know what information the sleep lab had at the time they ordered the sleep study.

Feinsilver

Q They should have had that information, either they do the evaluation themselves or they get it from whoever is referring the patient?

A You are asking me specifically whether accreditation would require that, yes.

Q Wouldn't a reasonable, prudent sleep specialist want that information before they go forward with a sleep study for a patient?

MR. TREU: Objection.

A Yes, that's okay. That's fair. That is information that I would like to have before a patient comes into my laboratory. It's not clear to me what information they did have, whether they had any referral information, any parts of charts or just that piece of paper.

Q You did review the medical records as well as the sleep center records, right? You saw what information was contained in the sleep center records, correct?

A I believe so. I don't know. I don't know exactly -- what I have from the sleep center appears to be the final report, a preliminary report, some technician notes. I do not know if there was additional information in the sleep center. I

suspect there might have been.

Q I believe you do have some additional information because I saw it when I reviewed your file.

A It's possible. It would be typical to have some questionnaire information and more information of her referring physician. I don't remember anymore what is in there. I can look, if you wish.

MR. TREU: You want him to look?

MS. TOSTI: If he thinks he needs to look at it, I think he should look at it.

MR. TREU: Let's take a break. We have been going two hours. I need to make a call.

(Whereupon, a recess was taken from 3:57 pm to to 4:05 pm.)

DR. STEVEN H. FEINSILVER, called as a witness, having been previously sworn, resumed, testified further as follows:

BY MS. TOSTI:

Q Doctor, once you have done the initial

diagnostic portion of a sleep study, how long does it usually take before you are able to schedule the patient for the C-PAP titration?

A Again, the delay in our laboratory is about three weeks. It can sometimes be longer and if something looks very abnormal, I can make it shorter.

Q Now, in Patricia Smith's case, aside from the diagnostic results of her sleep study, did she have any other clinical indicators that you found in the record that were consistent with or would be something that you would identify with obstructive sleep apnea?

A In retrospect, yes, I think, but reading her clinic chart or what I am calling her clinic chart, the notes from outpatient office visits, there are some suggestions that she has been complaining of, what I think it was described as, fatigue and certainly it is possible in retrospect that those were symptoms related to sleep apnea.

The other key symptom that I would have been interested in -- fatigue is not the same thing as sleepiness, and I would be curious about some specific symptoms of sleepiness, like falling

asleep at inappropriate times.

Also, I do not believe, going back, anybody had asked her about snoring.

These are both very common and fairly nonspecific complaints and as I alluded to before, this is a tough diagnosis to make on clinical grounds.

Q You don't recall reading anything in Dr. Hlavin's records or Dr. Collins' records in regard to falling asleep at inappropriate times or that she was having snoring?

A I think the only time that I found that mentioned was Dr. Hlavin who obtained the history described daytime somnolence and snoring. I think she was the first person in the records that I reviewed that specifically mentioned sleep apnea. That was not until I think it was about December of 1995. I didn't write down the exact date.

Q Do you know whether the equipment used at the time that Patricia Smith had her polysomnogram was capable of accurately measuring oxygen desaturations below sixty percent?

A I don't know. Much equipment is not accurate below sixty percent. But it is also

somewhat clinically irrelevant. Anyone getting close to those numbers has a severe abnormality. An exact modification is not too important.

Q So sixty percent oxygen saturation is a level that should raise concern for a patient, correct, if that is appearing during a sleep study?

A If it is true and not artifact, yes, that is low.

Q In Patricia Smith's case do you think it is true or artifact?

A I don't know. I was not able to find, on looking at her raw data, anything as low as sixty percent. However, that could take me a few hours to look for.

It strikes me as a little unusual looking at her summary here that since less than ten percent, or I think it was -- let me get the number exactly -- eight percent of the time she was below ninety percent, which is one of the sign posts that we look for, that is not that unusual. To see her hit as low as sixty percent strikes me as unusual. The rest of her study I would not have called that severe. I don't know.

Q What is your understanding as to how

Patricia Smith's sleep study came to be scheduled? How did the sleep center become aware that a sleep study was being requested?

A I do not know. Actually, getting back to the question that you asked before we took a break, what I was trying to get at before is, I'm not sure how much of this information was available at the sleep center at the time of her sleep study.

I have a bunch of things. There is a letter from Dr. Collins dated November 3rd and it's attached to this response for production of documents. I'm not sure if this was something in possession of the sleep lab at the time she was there. Maybe you know. I can't tell.

Q You would agree that before they should even be doing a study on Patricia Smith, they should have either done their own evaluation of her or had sufficient information from her referring physicians?

A Yes.

Q Including some of the things that you previously discussed such as a history and physical and those types of things, correct?

A I'm guessing this is what they had but

again I don't know what they had. It's not obvious. Maybe you can figure it out.

This is the patient information from the sleep laboratory. This is what I discussed for some of the other forms that I expect to see that is attached to that.

Q Neither Mr. Treu nor Mr. Torgerson identified to you what were the records from the sleep center, Doctor?

A Correct.

Q So you are rendering your opinions without knowing exactly what the sleep center's documents and chart contain? I want to understand what you are saying here. You are not sure what is contained in those records?

MR. TREU: Object.

A Response to question number six. I can figure this out. Okay. I believe that this, under response to question number six is, a complete file including, but not limited to, the office part on the patient from, this says, University Hospitals of Cleveland.

I am assuming that this is what the sleep center had in their possession when the patient

came to the sleep laboratory.

Q Well, Doctor, at the time that you wrote your report, were you assuming that that was also true?

MR. TREU: Do you remember?

A No. I don't remember.

Q Doctor, I would like you to take a look at that referral form that is contained in those records.

A Yes.

Q It is filled out, as we discussed previously, by Dr. Rowane. It is dated November 3rd.

A Okay.

Q And you are aware that her sleep test was not scheduled until February 6. Were you able to determine why there was a three-month interval between the date that the request is dated and the date that the test was actually done?

A No. I might speculate. From Dr. Hlavin's letter, one of her office charts, she seemed to be one of the first people to specifically suggest the diagnosis of sleep apnea. She makes a comment that she recommended that the patient follow-up with the original suggestions. I'm suspecting that the

patient didn't do anything about coming in at that point.

Q That is sheer speculation on your part; is it not, Doctor?

A I said that. I said speculation based on seeing several thousand sleep patients over the last fifteen years, yes.

Q You also know that particular requisition is dated November 3rd, correct?

A Yes.

Q You read in Dr. Rowane's deposition that he took the requisition and sent it through the appropriate channels?

A I'm sure he did.

Q Was Patricia Smith's referral to the sleep center appropriate from your review of the records?

A It was appropriate for her to have a sleep study I think, yes.

Q Now, Dr. Rosenberg's name appears on the referral form. Do you know who Dr. Rosenberg is?

A I believe he is administratively or was administratively one of the directors of the

sleep laboratory.

Q He was a co-medical director?

A I believe that is true.

Q Now, would you agree that when this referral form came into the sleep center, personnel should have alerted Dr. Rosenberg to the fact that this referral came in?

A I don't know what their policies are. I don't know how involved he was in scheduling or who would take responsibility for that.

What I would expect is that this referral with some additional information would be reviewed by someone in the sleep laboratory who would probably, if it's like my laboratory, okay the patient to have a sleep study and then someone should contact the patient and get them in.

Q And do some people then also contact you and ask you to work the patient up and do additional testing on the patient?

A Yes. I will do that either way. Patients can come in here for a study or I can see them in the office as well.

Q This particular request form, if you look at it, it authorizes three visits and it says

the work-up requested, Dr. Steven Collins. Do you see that?

A Yes.

Q What is your understanding as to what was done about that part of the test that called for work-up and authorized three visits?

A The work-up was requested by Dr. Steven Collins, I assumed. Isn't that what that means?

Q The work-up, Dr. Steven Collins?

A It was Dr. Collins referring the patient.

Q Dr. Collins and Dr. Rowane is what --

A Okay. I'm sorry, I'm not sure what that means "work-up requested Dr. Steven Collins." I assumed that it perhaps meant that the work-up was requested by Dr. Steven Collins since Dr. Collins had already seen the patient.

Q Work-up, wouldn't that include an evaluation for sleep disorders beyond just a sleep study?

A I think that can be done either way.

Q Wouldn't it raise a question in your mind if you see an authorization for three visits and

also the words "work-up requested Dr. Collins"?

A I don't know.

Q That this patient is being sent to the sleep center for evaluation as well as a sleep study?

A I don't know what their routine is. I don't know what they were thinking when they wrote it. I don't know.

Q You have no opinion as to whether this should have been referred to Dr. Rosenberg or whoever was covering for him at the time for evaluation of the patient in addition to the sleep study?

A I'm not sure what their policy was. It can be done either way. I guess since the patient had already been seen by a neurologist to have another office visit by a neurologist prior to having a sleep study seems unusual to me.

Q You have seen Dr. Collins' deposition? I don't recall whether you said you did or not.

A I think that is one that I didn't have.

Q Dr. Collins has testified that he is not a sleep specialist and has no expertise in that

particular area.

A Okay. I don't know. I don't know what he was thinking. Perhaps you know what he was thinking. Did he think he was referring somebody for consultation rather than study?

Q If you see the words "work-up" what would you think and "three visits authorized"?

A Three visits authorized is a standard thing to put in almost every referral form. Often it might means you have the option of doing it either way, I would think.

Many times I will see it -- particularly if I have patients referred by another pulmonary specialist, I will see people after the sleep study but not before the sleep study. Actually the majority of people referred by another fellow specialist, I won't see at all.

I don't know what he was thinking. Anything is possible. This is Dr. Collins that was filling out this form? No, Dr. Rowane.

Q Dr. Rowane filled out the form.

A But it is dated the same day as Dr. Collins who saw the patient. Okay. I'm sorry if it seems confusing.

Feinsilver

The date of the visit is November 3rd. The date of the referral form is also November 3rd. It's Dr. Collins who saw the patient on November 3rd but Dr. Rowane who filled out the referral form, okay.

Q I think you already told me this, but it is your opinion that Patricia Smith's sleep study based on that particular request isn't necessarily a high priority; is that correct?

A Yes. Particularly based on the information. She had the right study done for somewhat the wrong reasons.

Q Now, Doctor, if the sleep center received this referral within a few days of the date that Dr. Rowane filled it out -- I want you to assume that for purposes of this question.

A Okay.

Q Assuming that to be true, do you have an opinion as to whether the sleep center met the standard of care by waiting until February 6, three months, to schedule this sleep study?

MR. TREU: That's an objection. That's your fact pattern.

A If they waited until February 6th,

Feinsilver

yes. I doubt that is true.

Q I am asking you to make an assumption that they received that particular request within a few days of the date that Dr. Rowane filled it out.

Assuming that basis, would you agree that the sleep center did not meet the standard of care in scheduling Patricia Smith's sleep study?

MR. TREU: Objection again. You are assuming that they didn't schedule it for that period of time.

MS. TOSTI: And I have asked the Doctor to assume that the requisition was received.

MR. TREU: No, no, wait. Let me talk. Don't interrupt me please. I'm not interrupting you. Let me place my objection on the record, please.

My objection is that you are assuming that the referral or the study was not scheduled until that date simply based on the decision-making determination of the people at the sleep lab and that certainly has not been established.

A I'm not sure what the events were. There are many indications. For example, the letter that Dr. Collins wrote on November 3rd, that the patient may not have been compliant with any treatment recommendations. In fact, a great deal of this letter refers to the fact that he had been treating her for seizures and she was not compliant with taking medication.

There are parts of the country where it might take, in fact, months to get into a sleep laboratory. I don't know if Cleveland is one of them.

Q Doctor, it is strictly speculation on your part --

A Absolutely.

Q -- in regard to whether Patricia Smith had anything to do with the delay in scheduling that particular sleep study, correct?

A Yes. It would also be speculation on my part to assume the sleep center --

Q Assuming that recommendation was received by the sleep lab and assuming there were no other obstructions that would have prevented it from scheduling it, such as an authorization from the

insurance company or whatever, if they received that particular request for the sleep study and there were no other things that would have prevented them from scheduling it, would you agree that it would be substandard care to wait three months to get this lady in for a sleep study?

MR. TREU: Objection. Including the patient? You are asking him to speculate.

MS. TOSTI: Yes, excluding that, excluding all other obstacles.

MR. TREU: Including the patient?

MS. TOSTI: Yes.

A There are parts of the country in which a three-month wait for a sleep study is --

Q I am asking you the standard of care.

A I am saying that there is no standard of care. In parts of the country, it would take six months to get into a sleep study.

In our area, it is about four weeks. Until we opened this laboratory at Winthrop, it was closer to two months.

I don't know what the standard of care

was in 1995 to get into a sleep laboratory in Cleveland.

Q Have you ever sent a patient to another sleep center when you couldn't get them into the sleep center within a reasonable period of time?

A Never had the experience. There has never been another sleep laboratory that could do it quicker than I could.

Q You don't know what the situation was in Cleveland at that time?

A I don't know. I don't know what it is today either.

Q If you found a patient to have severe obstructive sleep apnea, you stated that it may be as long as three weeks before you could get a patient in for a sleep study, is that correct, at your center?

A I could do it faster if I had an urgent clinical reason to do. The routine would be perhaps three weeks.

Q Would a two month wait be in conformance with the standard of care?

MR. TREU: Objection.

A From initial study to a follow-up study?

Q Yes.

A It depends on the availability. Unfortunately in some areas, it is that difficult. I don't know. I don't know what is available in the area.

Q If a patient has severe obstructive sleep apnea, it is okay to let him go for two months without bringing him back in for C-PAP titration?

A It certainly happens. Is it okay? It's hard to know. It depends on the availability.

Q In conformance with the standard of care?

A There is no standard of care for this. You are making the assumption that this patient has severe sleep apnea, which you may want to ask me about later.

Q Dr. Brooks felt she had severe obstructive sleep apnea and that was the assumption he was laboring under at the time he was treating her, correct?

A That's what it says.

Q Do you have an opinion as to whether Patricia Smith's severe obstructive sleep apnea required treatment?

A I would have treated her, I believe.

Q Was C-PAP the likely treatment option for Patricia Smith?

A Assuming her insurance would have paid for it and she would have been compliant.

Q Is that a yes?

A Assuming her insurance would have paid for it and she would have been compliant, that is the treatment of choice. There is actually an issue whether her insurance would have paid for this.

Q What is the issue?

A She had 59 sleep apneas in a night's recording. The Medicare guidelines, which are undoubtedly wrong, would require 20 episodes an hour or a hundred a night.

Q Is it your information she was on Medicare?

A No, but many insurances base their recommendations on Medicare guidelines.

Q Do you know what her insurance is?

A I don't know what her insurance is.

Q Dr. Brooks diagnosed her with severe obstructive sleep apnea, and you disagree with his diagnosis, correct?

A It's hard to know. I don't know exactly how he grades things. I looked at the raw data. It is moderate to severe sleep apnea. It's not among the worst I have seen.

Q Do you know where he is differentiating from your diagnosis as compared to his?

A Well, the majority of the episodes here are hypopneas or what he calls partial obstructions which I think he means hypopneas. The nomenclature has changed over the years. Generally it does not appear that she had severe oxygen desaturation.

I haven't looked at the raw data for awhile. But it is certainly moderate to severe.

Q You reviewed the preliminary report that Dr. Brooks sent out?

A Yes.

Q And in it he indicated that the study showed severe obstructive sleep apnea but that major clinical decisions should be deferred until the final official report was prepared. Do you recall seeing that?

A Yes, that's reasonable. Yes.

Q Do you agree with his advice?

A Yes, I think that is a fair thing to say.

Q What is the purpose of sending out such a report? What purpose does that serve when you tell someone this is severe obstructive sleep apnea but to defer major clinical decisions until the final report comes out?

A That's a good question. One can simply decide to wait until the final report came out. It at least tells the referring physician that the patient had shown up and had a sleep study and more information will be forthcoming.

Q Was it appropriate to say defer major clinical decisions until the final official report?

A It depends on how long it takes to get a final official report but yes, I think so.

Q In this case, it took almost five weeks. Is that appropriate?

MR. TREU: Objection.

A Actually I don't know how long it took. It's not what I would like.

Certainly, again as I said, my standard which I try to adhere but can't always,

based on the availability of secretaries more than anything else, is to get reports out within two weeks.

Q What does the standard of care require?

MR. TREU: Objection.

A The standard of care in the community for sleep is, I think, to get a report out in, I'd say, two or three weeks would be reasonable.

Q And it is your opinion that when the final report came out, it was appropriate to come out without recommendations for treatment; is that correct?

A Yes.

Q You don't believe Dr. Brooks or the sleep center had a duty to make any recommendations regarding treatment for Patricia Smith; is that correct?

A Yes.

Q Do you have any disagreement with the way that the respiratory index was calculated in this case?

A I don't think so. I believe I checked that when I first looked at this. It seems

reasonable.

Q Dr. Brooks' final report says that Patricia Smith had no dysrhythmias, correct?

A Yes.

Q When you looked at the raw data, did you find that she had arrhythmias?

A Look at my notes. Occasional premature ventricular contractions.

Q Now, at the time that you wrote your report, you hadn't looked at the raw data though, correct?

A I believe I had by then.

Q Doctor, down in the second paragraph on the first page --

A I could be wrong.

Q -- it says, "I do not have the raw data available to review"?

A I do have it. In fact, I believe in looking at that was even less impressive than the final report. The final report mentioned occasional premature ventricular contractions. Where did that come from?

Q That was my next question. In your report, where did that information come from?

A I think I did then have the final report then.

MR. TREU: I don't think we sent it to you.

A It wasn't your office.

Q The final report doesn't indicate a dysrhythmias, I don't believe.

A That's right. I wrote this nine months ago.

Q I want to know in your report where you got the information that there apparently were some since you don't have the raw data and it is not included in the final report.

A I don't know. It may be from what one of the depositions mentioned. This was in May. I probably did not have the raw data.

Q If she was having dysrhythmias, that should have been included on the report though, correct?

A If they are significant dysrhythmias.

Q What is significant and what is not significant?

A Occasional --

Q If there are ventricular premature

beats, should those be included on the report?

A It might. It is essentially of no significance.

Q Should it be included on the report?

A It might be but I think it is of no clinical significance.

Q No, Doctor. I am asking you whether it should be.

A I don't know.

Q In your sleep lab if the patient has isolated premature ventricular contractions during a sleep study, do you include it on the report?

A If I happen to notice it, I include on it on the report.

Q Shouldn't your technicians notice it if they are going through all of the data?

A Probably.

Q Doctor, would you agree that a patient with coronary disease, oxygen desaturations as low as sixty percent may increase the risk for lethal cardiac arrhythmias?

A I'm sure that is true.

Q Is respiratory disturbance index of 45.6 typically seen in moderate obstructive sleep

apnea?

A Yes. The other way to grade obstructive sleep apnea more traditionally is by the apnea index. Her apnea index is eight. Numbers up to ten are considered normal. It is a difficult field.

Q Doctor, what do you consider to be normal sleep architecture? What values are normally seen in each state?

A Roughly about fifty percent of your night should be spent in stage 2 which is sort of average sleep. Of the remainder time, a little less than a quarter should be spent in REM sleep, and the remainder is divided between stage 1 and delta sleep which is stage 3, 4 combined.

Q You had an opportunity to take a look at her raw data. Did you think that Patricia Smith should have been converted over to a split study based on her raw data that you reviewed?

A No.

Q Did she exhibit significant obstructive sleep apnea in the first half of the night based on the raw data?

A The requirement is generally the first

two hours of the night and I doubt she would have seen enough to qualify that in the first two hours.

As I mentioned before, my policy is not to convert anyone over to split night unless the patient is prepared for that in advance.

Q Once she was diagnosed on overnight polysomnogram with severe obstructive sleep apnea should she have received a complete sleep evaluation?

A I'm not sure what you mean. History and physical by another person?

Q Whatever a sleep specialist would normally do for a patient in evaluating a sleep disorder.

A Actually at this point things become very simple. You make the diagnosis and you treat it. I'm not sure that any additional information would be that important.

Q Not important?

A No, I don't think it is very important at this point.

Q It's okay to move to treatment then?

A Yes. The more interesting visit would be after treatment to try and get everything working

well.

Q Doctor, why if in fact there isn't any reason to do anything additional, why don't you make treatment recommendations after you complete a sleep study if there really isn't any reason to do an additional evaluation on the patient?

A I haven't seen the patient. I don't know. I guess I'm not following you.

The way I would like it to work is the referring physician gets the information, has some knowledge of this very common disease, and recommends the appropriate treatment the way it should work for all diseases.

Q Do you found that most family practice physicians have sufficient knowledge about sleep disorders to provide adequate treatment for the patients?

A No.

Q Generally speaking, --

A They should be able to, for sleep apnea, it being a disease that is as probably as common as asthma which is treated by primary care physicians -- you really hit on, this is a major problem of health care utilization delivery for a

very common disease.

Primary physicians know little about sleep despite the fact that sleep apnea is one of the more common conditions in the country.

Unfortunately, the standard of practice of sleep in the country is very poor. It's estimated that approximately three, maybe as much as six percent, of the adult population in the United States has sleep apnea and that is approximately in the same order of magnitude asthma.

As a pulmonary doctor, I can't treat everybody in Nassau County with asthma. Too many of them. They have to be treated by their primary care. This is why it takes months to be seen by a sleep, in many places several months to get into a lab, many places.

You are in a position -- Nassau County, where we are right now, has a total of ten accredited beds, sleep labs for two-and-a-half million people.

Q Doctor, we are only talking about Patricia Smith.

A You are asking about the standard of practice.

Q Being referred to Cleveland University Hospital.

MR. TREU: Excuse me. Let him finish his answer.

A When you say standard of practice and when we started this discussion a long time ago, I object in many ways to accreditation being the standard of practice because the health care resources just aren't there. These are very real issues.

The standard of practice in the community for sleep apnea is that an estimated 95 percent -- That is conservative. We used to say 97 percent. -- of patients with sleep apnea are not currently being treated for it. That is what makes all of this so difficult.

Q Doctor, in regard to the patients that are referred to you by family practice physicians do you find frequently that they are consulting you as a sleep specialist for guidance on how to then treat these patients?

A It goes both ways. In fact, after the first few times, after I was sent a patient or two, they often don't meet me anymore,

Feinsilver

Q How about when is the first time they sent a patient to you. Do they usually consult with you as *to* what is recommended for the patient?

A Not necessarily. I actually would prefer that they did. It makes my life simpler. To wait to see me may take awhile or two. Their insurance may not pay for that. May only pay for sleep study.

I may often get phone calls, as I got today, after the study is done and doctors call up and say, "What do I do with this information?" That's fine, a reasonable call to make.

Q I would like you to take a look at your report there. I have some specific questions.

A Okay.

Q Now, you indicate in this report that she was followed by the family practice group since 1991. Do you know where you got that date from?

A I believe that's from her records.

Q When I looked at her records, I see an initial intake of 1992 and I am wondering if you have something additional.

A Let's see how far back this goes. I have April of 1992 as the first note that I can

find.

MR. TREU: That is what I have for the first date.

Q So that may be an incorrect date then in your report?

A Maybe.

Q Your report also says that notes as far back as 1994 mentioned complaints of fatigue and she was thought to have some symptoms of depression but nothing specific is mentioned about sleep or snoring.

I would like you to take a look at a note that is written by Dr. Rowane on December 9, 1993 and on the left-hand side of his notes it says that, I think, depression inventory and he has noted under there positive poor sleep.

Do you see that?

A December 1993?

Q Yes.

A I have December 9, 1993. I believe. I don't see that here. Is there more than one note for 1993? Okay. I see where he says depression inventory. I don't think that is December 1993.

Q That is a continuation note. It's a

two-page note.

A The beginning of it is not dated.

Q Correct. It continues onto the second page?

A It could have been 1993.

Q You there is an indication that she has poor sleep that dates back to 1993?

MR. TREU: December.

A Depression inventory. Okay. I can barely read that. I think the first item says poor sleep. Okay. December 9, 1993.

Q That is a specific mention about a sleep problem, correct?

A It's actually mentioned as a symptom of depression.

Q Doctor, we are talking about poor sleep, correct?

A What I would mean something specific about sleep would include things, what time do you go to bed; what time do you get up; how long does it take her to fall asleep; snoring.

Q Poor sleep you don't consider to be a symptom of obstructive sleep apnea?

A Poor sleep is a symptom of a very high

percentage of all the medical illnesses in the world, yes.

Q Now, your report also says in, I think about line eleven, also in her records are two electrocardiograms done in February and March of 1995 which are nonspecifically abnormal.

Did you evaluate those EKGs yourself?

A They are right here, I believe. Yes, they are nonspecifically abnormal.

Q Is that your evaluation?

A Yes.

Q Taken together you don't believe they show any suggestion of ischemia; is that correct?

A That's correct.

Q Now, you have indicated that you have reviewed the raw data and so your comment in this report that you did not have the raw data is not correct currently?

A Yes, I got the raw data since this.

Q Doctor, when you reviewed the sleep center records, you saw that Dr. Collins is listed on that referral form. He is listed on the final report as being one of the referring doctors and there are a

couple of other documents in there he is listed on and information sheets I think she has him listed as primary care physician.

Should a copy of the preliminary report of that sleep study as well as the final report have been sent to Dr. Collins by the sleep center?

A I'm sorry, the referral came -- let me see if I can find the referral again. The referral came from --

MR. TREU: Dr. Rowane.

A It came from Dr. Rowane? But it was signed by -- this is Dr. Rowane's signature.

MR. TREU: Family Medical.

Q Doctor, the final report indicates at the top I believe -- if you take a look at the final report, do you see that?

A Yes.

Q Who is indicated at the top as the referring physician?

A Dr. Rowane and Dr. Collins.

Q Should that final report have been sent out to both Dr. Rowane and Dr. Collins as referring physicians?

A Yes, that would have been good.

Q And if the sleep center didn't send it to Dr. Collins, do you believe that is substandard care on the part of the sleep center not to send it to one of the reviewing --

A No.

Q No?

A I don't think you can have more than one referring physician.

Q You can't?

A I might, as a courtesy, send it to anybody involved in the care of the patient but when we bring someone in into the laboratory, we have a referring physician. It would be nice to send it to everyone involved in the patient's care.

Q Your report also says that the preliminary report was sent out at least my March 12. What is your understanding as to who received that report?

A No. The final report was sent out.

Q I'm sorry. The final report was sent out by March 12th.

A I don't know. The only reason I said that was that I see evidence in the March 12th office

visit that the report was received. It could have been received a long time before then. I don't think I could tell that.

Q You saw it in the March 12th office visit?

A I believe that's where I got that information. Let me see if I can find that again. I believe the information that I got was based on the receipt of it on -- an office visit. March 25th office visit with --

MR. TREU: Someone initialed it on the 12th if you look at the report that is in there.

A That's the copy of the report that is in this probably.

Q What is your understanding as to who received that report on March 12th?

A I don't know.

Q Now, on page two of your report you indicated that Patricia Smith was found dead on April 19, 1996. I think that that is probably a typographical error. That is not correct; is it, doctor?

A I don't know. I wasn't there. Let's

Feinsilver

see. I suppose there is --

MR. TREU: Do you have the autopsy?

A If I got it wrong, I apologize.

Q Her death was actually on August 8.

MR. TREU: That is a typo by you. It was April. You said August.

MS. TOSTI: I'm sorry. April 8, 1996.

Q That is incorrect in your report; is that correct?

A Evidently.

Q You indicated in your report, you said that the coroner's report that you received was missing a page. Did you subsequently receive the page that you were missing?

A Actually, I got it today.

Q What page were you missing?

A Let me get the coroner's report.

Q I am just interested in knowing what it was, Doctor. You don't have to find it for me.

A I'm not sure where it is anymore. There was a page one and three in there. Page two seemed to report the findings of the heart which I

thought were particularly interesting, which I would have liked to have had at the time. Now I can't find any of them. Something we had when we started this.

Q Do you recall, Doctor, without looking any further, do you recall which pages it was that you recently received?

A I believe it was marked page two. It was the page that had to do with the cardiac findings. I only saw that today.

Q At the time you wrote your report, you didn't have that; is that correct?

A Right. I had the final. On the last page there is a summary of the autopsy.

Q Now, it is your opinion that the cause of Patricia Smith's death was coronary artery disease; is that correct?

A I don't know. I think it's difficult without definite findings to know.

Q Doctor, in your report it says in this patient the cause of death was coronary artery disease and now are you saying you don't know what the cause is?

A That's what the coroner said.

Q Doctor, this is your report?

A I can't find the coroner.

Q I am talking about your report, Doctor.

A I understand that.

I believe I said that based on looking at the coroner's report. The coroner's a pathologist that determines the cause of death, not the critical care doctor. As a pulmonary care doctor, I try not to determine the cause of death. I can't find that report right now. I guess that sounds very reasonable.

Q I am trying to elicit what your opinions are in this case.

A I can't find the autopsy.

MR. TREU: Here is mine.

Q It is important for me to know if you have an opinion as to what this patient's cause of death is. In your report you stated in this patient the cause of death is coronary artery disease.

Is that your opinion that this patient's death was caused by coronary artery disease?

A Yes.

Q Do you know what the mechanism of her

death was? Do you believe it was a cardiac arrhythmia?

A That's something that can't be determined at autopsy. I assume she died of a cardiac arrhythmia. When people die and they have no other findings we assume their heart stopped as a cause of death.

Q It is also your opinion that longstanding hypertension in the presence of obstructive sleep apnea likely caused a worsening of her coronary artery disease, correct?

A Yes.

Q What is the basis for that opinion?

A The basis is that we know that longstanding hypertension is bad for one's heart and also that repetitive oxygen desaturations and repetitive sleep apnea over years increases the risk of cardiovascular disease. Much like hypertension.

Q She was receiving treatment for her hypertension from her family practice physician, correct?

A Yes.

Q She didn't receive any treatment for her obstructive sleep apnea, correct?

A Yes.

Q You would agree that untreated obstructive sleep apnea was a contributing cause to her death?

A I have to assume that, yes. It's hard to prove. I think I mentioned before the combination of sleep apnea and mortality remains somewhat controversial.

Q Doctor, do you think that the sleep center should have informed Patricia Smith of her diagnosis?

MR. TREU: Objection. Asked and answered.

A No. I think that is the responsibility -- the responsibility is to inform the referring physician, I think.

Q So there was no duty on the part of the sleep center to inform her of a diagnosis or treatment options or anything like that?

A No, the duty is to inform the referring physician.

Q Do you know -- in your review of the records, were you able to determine why she never received treatment for her sleep apnea?

A No.

Q Doctor, would you agree that obstructive sleep apnea is potentially life threatening?

A Yes, I think so.

Q Would you agree that untreated obstructive sleep apnea placed Patricia Smith at increased risk for sudden death during sleep as compared to a similar person without severe obstructive sleep apnea?

A I think that is probably true, but there is not much literature on that subject. There are people that would argue good against that even.

Q Now, in Patricia Smith's case she had undiagnosed coronary artery disease, correct?

A Yes.

Q Do you have an opinion as to whether low oxygen saturations during sleep increased her risk for cardiac arrhythmias?

A I assume that is true.

Q If the patient has coronary artery disease and obstructive sleep apnea, are they at increased risk for sudden death during sleep?

A I think so. I'm afraid there is not

much data on that so it may be hard, but I believe that is true.

Q Do you have an opinion as to whether untreated obstructive sleep apnea contributed in any way to Patricia Smith's death?

A It's hard to be certain. I think that it is quite possible. Unfortunately, there are many people with untreated sleep apnea. I think it's very hard to know.

Q If Patricia Smith had received treatment for her obstructive sleep apnea prior to her death, do you have an opinion as to whether she would have died on April 8, 1996 as she did?

A No, I don't think I could speculate on that not knowing the exact mechanism of death.

Q I am going to ask you the question and you can tell me if you have an answer. If she had received treatment for her coronary artery disease prior to her death, do you have an opinion as to whether she would have died on April 8, 1996 as she did?

A No, I don't have enough information to give you an opinion.

Q Therefore, you don't -- I just have to

follow up with this question. You don't have an opinion as to her reasonable life expectancy if she had been treated for coronary artery disease or her obstructive sleep apnea, correct?

A No, I can't tell you.

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

A No, I never blame a patient for a disease, I think.

Q Of all the care that you reviewed, Doctor, do you find fault with any of the care?

A There are always things that could have been done better and always things that could be done faster. I don't think that, unfortunately despite the bad outcome, this case had substantial deviations from the standard of practice.

Q It did or it didn't?

A No, I don't think it did.

Q There is nothing in the records that you reviewed that you would consider to be substandard care; is that correct?

A When you review this much information there are always things that can be improved but I don't think any of it represents substandard care.

Q Have you been asked to come to Cleveland to testify in person at the trial of this matter?

A I believe, so although I don't know specifics or a date.

Q Have we covered all the opinions that you intend to express at trial in this matter?

A Yes, probably.

Q Are there any that we haven't covered?

A We probably touched on all the issues, some of which have to do with the delivery of health care for sleep which is a tough problem.

MS. TOSTI: I don't have any further questions.

(Whereupon at 5:05 pm the deposition was concluded.)

C A P T I O N

The Deposition of DR. STEVEN H. FEINSILVER, taken in the matter, on the date, and at the time and place set out on the title page thereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

It was agreed by and between counsel and the parties that the Deponent will read and sign the transcript of said deposition.

C E R T I F I C A T E

STATE OF_____:

COUNTY/CITY OF_____:

Before me, this day, personally appeared DR. STEVEN FEINSILVER, who, being duly sworn, states that the foregoing transcript of his Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition.

_____

DR. STEVEN H. FEINSILVER

SUBSCRIBED and SWORN to before me this _____ day of _____, 2000, in the jurisdiction aforesaid.

_____ _____

My Commission Expires Notary Public

DEPOSITION ERRATA SHEET

RE:
FILE NO.
CASE CAPTION: TRACY ANN SMITH vs. UNIVERSITY HOSPITALS OF CLEVELAND

DEPONENT: DR. STEVEN H. FEINSILVER
DEPOSITION DATE: JANUARY 31, 1999

To the Reporter:
I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request for the following changes be entered upon the record for the reason indicated.
I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.

SIGNATURE_____DATE:_____

DR. STEVEN H. FEINSILVER

I N D E X

Witness:

DW. STEVEN H. FEINSILVER

E X H I B I T S

PLAINTIFF EXHIBITS MARKED FOR IDENTIFICATION		Page
1	Curriculum Vitae of Dr. Feinsilver	23
2	Letter dated May 5, 1999 to Mr. Togerson from Dr. Feinsilver	71

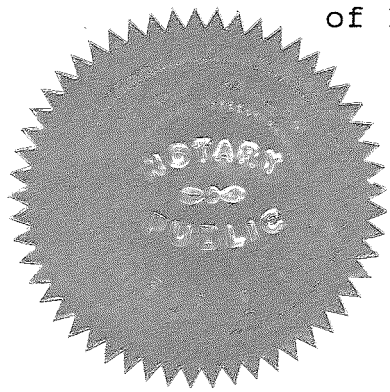
C E R T I F I C A T E

STATE OF NEW YORK)
) ss.
COUNTY OF NEW YORK)

I, JEAN WILM, a Registered Professional Reporter and Notary Public of the State of New York, do hereby certify that the foregoing Deposition of the Witness, DR. STEVEN H. FEINSILVER, taken at the time and place aforesaid, is a true and correct transcription of my shorthand notes.

I further certify that I am neither counsel for nor related to any party to said action, nor in any wise interested in the result or outcome thereof.

IN WITNESS WHEREOF, I have hereunto set my hand this 2nd day of February, 2000.



Jean Wilm

JEAN WILM, R.P.R., C.M.R.S.