DOC. 158

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

IN THE COURT OF COMMON PLEAS

GRACIE W. DUREN, Administratrix of the Estate of John H. Duren, Deceased,

Plaintiff,

vs.

SUBURBAN COMMUNITY HOSPITAL, et al.,

Defendants.

Case No. 55142

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Deposition of KEVIN GERACI, M.D., taken by the Plaintiff as if upon cross-examination before Sandra L. Price, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the office of Kampinski, White & Cohn, 1530 Standard Building, Cleveland, Ohio, on Wednesday, the 22nd day of February, 1984, commencing at 3:00 p.m., pursuant to notice.

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APPEARANCES:

Kampinski, White & Cohn, by:
Charles Kampinski, Esq., and
Robert L. White, Esq.,

On behalf of the Plaintiff.

Weston, Hurd, Fallon, Paisley & Howley, by:
Patrick J. Murphy, Esq., and
Maureen Murhy, Esq.,
and
Arter & Hadden, by:
Michael C. Zellers, Esq.,

On behalf of Defendant Suburban Community Hospital.

Nurenberg, Plevin, Jacobson, Heller & McCarthy Co., LPA, by:
Cyril J. McIlhargie, Esq.,

On behalf of Defendants Dr. Lissauer and Gastroenterology Associates of Cleveland, Inc.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Sandra L. Price; and that her stenotype notes may be subsequently transcribed in the absence of the witness.

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KEVIN GERACI, M.D.

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

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. State your full name for the record, please.

A. Kevin Geraci.

Q. And your business address?

A. 1161 South Green Road, South Euclid, Ohio.

Q. And your residence address?

A. 2700 Claythorne Road, Shaker Heights, Ohio.

Q. If you don't understand any of my questions, Doctor, tell me. I will be happy to rephrase it, okay?

A. Yes.

Q. You have to respond verbally. She can't take down a nod of the head.

A. All right.

Q. Have you brought a CV with you, Doctor?

A. No.

Q. Do you have one?

A. Yes.

Q. Could you provide that to Mr. Murphy within the next day or so, so that he can get it to us?

A. Certainly.

Q. Since I don't have it, what I would like you to do is run me through your educational background, if you would, commencing with college; when and where you went and how long you went, what degrees you received.

A. I began at Holy Cross College in Worcester, Massachusetts. Went there for four years and then went to --

Q. What period of time was that?

A. Graduated there in 1963.

Q. Would that have been four continuous years?

A. Yes.

Q. '59 to '63?

A. Yes.

Q. All right.

A. Then from '63 to '67 I was at Ohio State University Medical School. The following year, '67 to '68, I interned there. Then I had a period of

time in the U.S. Navy from -- it would have been from '68 to '71. Following that, I had residency at University Hospitals of Cleveland. That was two years. And then following that, I had --

Q. '71 to '73?

A. Right. '73 and '74 was a fellowship in gastroenterology at University Hospitals of Cleveland. Following that, I was made the head of the division of gastroenterology at St. Luke's Hospital and was assistant professor at Case Western Reserve University Medical School.

Q. What years was that at St. Luke's, by the way?

A. That was from 197 -- Well, when I got out, what was that? '73 or '74 to 1981, I believe.

Q. Okay.

A. And then since the end of 1981, I was in private practice with Cleveland Physicians, Incorporated.

Q. What is Cleveland Physicians, Incorporated?

A. It's a 13-man internal medicine group.

Q. I notice on the letterhead that your name is not on there. Is there any reason for that?

A. That's an old letterhead. We are still

trying to use up the old stationary over there. My name is on the letterhead of anything that should come out of there. That was just an oversight by my secretary.

Q. When you say it's a group, it's a corporation, is it not?

A. Yes.

Q. Are you a shareholder?

A. Yes.

Q. And an employee?

A. Yes.

Q. And I take it another shareholder and employee is Dr. Franklin Plotkin?

A. Franklin Plotkin, right.

Q. Are you aware of the fact that he was also retained as an expert in this case prior to your providing a report?

A. No.

Q. You've since been made aware of that, I take it?

A. I read a report of his.

Q. When?

A. Week and a half ago, maybe; two weeks.

Q. After you wrote your report --

A. Yes.

Q. -- or before?

A. After.

Q. Did you ever treat John Duren?

A. No.

Q. He was seen at St. Luke's, wasn't he?

A. I believe somewhere along the line, his past history was at St. Luke's for pancreatitis, yes.

Q. Did he recieve good treatment there?

A. I think he did. At least he --

Q. Survived?

A. Yes. With pancreatitis, it's not a matter of good treatment if you survive or die.

Q. I see. So you can go to a hotel just as well?

A. No, you can't.

Q. I see.

A. You can die despite good treatment.

Q. Certainly, you would expect one to give good treatment at a quality health care facility, wouldn't you?

A. Yes.

Q. Do you have privileges at various hospitals?

A. Yes.

Q. Which hospitals?

A. St. Luke's and University.

Q. Why did you leave St. Luke's as the head of gastroenterology?

A. Because I had a good offer from University and Suburban. I thought it was a time in my life when I was ready to broaden my expanses; getting tired of shoving tubes up people and down people, and it was just not fun anymore to be doing that localized of a practice.

Q. Do you or does your corporation have any relationship with Gastroenterology Associates, Inc.?

A. No.

Q. Do you refer patients to that group?

A. No.

Q. Do they refer patients to your group?

A. No.

Q. Okay. Would you do the same things that they do?

A. I would do the same things they do, yes.

Q. The one-paragraph report that you prepared, when were you first retained to do anything with relation to providing an opinio in this case?

A. I would have to look at Pat's lette .

MR. MURPHY: I think in May of '83.

Q. (BY MR. KAMPINSKI) Well, why don't you look at the letter. Is that your entire file back there, by the way?

A. No. It isn't.

Q. Where is your file, Doctor?

A. I didn't bring the copy of the Suburban file but this is everything else they sent.

Q. Other than the Suburban medical record, this is your entire file?

A. That's it, right.

Q. Could I see it?

MR. MURPHY: Except for the correspondence, on the same basis you wouldn't let us see Shapiro's correspondence.

A. That's not part of my file.

Q. (BY MR. KAMPINSKI) That's *not* part of your file?

A. This is my own reference.

Q. Well, it's part of your file. Did you refer to this or use it at all about --

A. No, I didn't.

Q. Why is it here?

A. I just thought I'd bring it along to

refresh my memory.

Q. Is there anything in it about pancreatitis or diabetes that has anything to do with Mr. Duren or his care?

A. Yes.

Q. Why don't you leave it there?

MR. MURPHY: He can see that. Dr. Geraci's file that he just provided doesn't contain a May, 1983 letter that I sent to Dr. Geraci, that is the time frame for my records.

Q. (BY MR. KAMPINSKI) Just so we have it all clear, what you have provided to me, this is all Dr. Beckerman's records, I take it?

A. Yes.

Q. And then this is the office file of Gastroenterology Associates?

A. Right.

Q. And this is a report of Dr. Shapiro to Mr. White?

A. Yes.

Q. And there is a report of Dr. Plotkin to Mr. Nurenberg --

A. Right.

Q. -- dated November 30, 1983. Another copy of Dr. Shapiro's report, correct?

A. Right.

Q. And three articles, one of them New England Journal of Medicine, October 19, 1972, regarding Blood Pressure in the Development of Congestive Heart Failure. December 23, 1971, same publication, Natural History of Congestive Heart Failure. The Framingham Study and the Role of Diabetes in Congestive Heart Failure, Framingham Study in American Cardiology Journal?

A. That's the American Journal of Cardiology.

Q. 1974, July?

A. Yes.

Q. And you mentioned before that you did not bring with you the Suburban Community Hospital records?

A. That's right.

Q. Are there any other records that you reviewed prior to preparing your report?

A. No.

Q. Did you have Dr. Shapiro's report prior to preparing your report?

A. Yes.

Q. So the only thing that's contained in here, and correct me if I'm wrong, that you did not have prior to preparing your report was Dr.

Plotkin's report?

A. I think that's correct. And I'm not a hundred percent sure of that, whether I had it or not.

Q. Okay.

A. I think I just don't know with certainty. I know I'd seen Shapiro's. I don't know whether I'd looked at Frank Plotkin's before.

Q. Yes. Would it have caused you any concern or difficulty or problems in providing any opinion in this case had you knon that Dr. Plotkin was also doing so?

A. No. No. In fact, I did --

MR. MURPHY: So the record is clear, if you can refer to this one letter of January 23, '84, it makes reference to enclosing Dr. Plotkin's report.

MR. KAMPINSKI: That's what you sent to him.

MR. MURPHY: Yes.

Q. (BY MR. KAMPINSKI) Dr. Geraci's was February 17. So you had Dr. Plotkin's report before you prepared yours?

A. I had it in my office but I don't know whether -- but I think to answer your question, I

had no concern whether Dr. Plotkin was involved or not in the case.

Q. Is he a pretty competent doctor?

A. Dr. Plotkin is a competent doctor, yes.

Q. With respect to the three articles that are included in your records, do any of those either add or detract from any opinions which you have provided in your report?

A. They substantiate it. They don't add or subtract. They just substantiate by opinion.

Q. What portion of your opinion do any of these articles substantiate, Doctor?

A. They substantiate -- No. In fact, they go a little further than substantiate. My figure for the mortality of somebody with congestive heart failure, hypertension, was 50 percent. As in the case of Mr. Duren who had signs of congestive heart failure.

Q. When was that?

A. That was in his admission to the hospital down in Virginia, or West Virginia.

Q. What does that have to do with 1982, Doctor?

A. It has a lot to do with it. In the hospitalization previously -- And that was how long

before? Five years? Seven years? -- he had had first his diagnosis of congestive failure, I think looking at the figures and looking at in my opinion, his life was already on borrowed time. I mean we are talking about a 50 to 60 -- well, for a man with congestive heart failure, 60 percent mortality at the five-year level.

Q. Are you saying that once somebody has the symptomatology of congestive heart failure, that he is not in all probability going to live more than five years after that symptomatology, whether or not it's cleared up or not?

A. If he is a man, he has a 40 percent chance of living beyond five years.

Q. Once he has congestive heart failure at all, is that right?

A. That's correct.

Q. Did he evidence any symptoms of congestive heart failure at St. Luke's?

A. I would have to review the record on that.

Q. Did you before you came here today?

A. I did not look at the St. Luke's record, no.

Q. Wouldn't that have been important to determine?

A. I looked at it, but not right before I came. But I would have to refresh my memory.

Q. Well, it's not here. Maybe I'm wrong. Why don't you look through whatever records you have got there --

A. Yes, because it's mentioned in one of these things here that he was in St. Luke's, and that's where I knew he was at St. Luke's.

Q. My question was, did he have any symptomatology of congestive heart failure --

A. I would have to review the records.

Q. Why don't you?

MR. McILHARGIE: I have a copy.

MR. KAMPINSKI: Well, first let's see what it is that we have got if he reviewed it.

MR. McILHARGIE: I was attempting to assist you. That's all.

MR. KAMPINSKI: Yes. I understand.

A. I don't see St. Luke's here. I had Hillcrest, and I see -- That's what I see.

Q. (BY MR. KAMPINSKI) Well, let's start very slow so I understand. Did you or did you not review the St. Luke's records pertaining to Mr.

Duren's hospitalization there prior to writing your report?

A. If it's not here, I didn't review it, but there is mention of St. Luke's.

Q. All right. Would it have been important for to you determine whether or not there was any symptomatology of congestive heart failure at the time that he was hospitalized at St. Luke's for pancreatitis?

A. Not for -- not to determine whether or not his prognosis varied. The point is during his hospitalization down with Dr. Robinson, he did have signs of congestive heart failure and that was as oE the date, 1977.

Q. The fact that it never was evidenced at any time after that isn't important to you?

A. With observation it was. He had signs of a large heart on other admissions.

Q. Well, is that the same as congestive heart failure?

A. It's one of the criteria.

Q. Well, the large heart is evidenced where, Doctor?

A. Large heart is evidenced by his admission to Suburban, is evidenced by his admission in 1977.

Q. Did that receive any attention by Gastroenterology Associates in his treatment at Hillcrest and/or subsequent follow-ups?

A. At that time it was under control. I mean it was --

Q. Did it receive any treatment, Doctor?

A. It received consideration.

Q. By whom?

A. By Gastroenterology Associates.

Q. When?

A. During the time that they were following him.

Q. Is that right? What consideration did they give him?

A. Well, they listened to his lungs, they listened to his heart.

Q. How were they?

A. Lung were clear.

Q. How about his heart?

A. Heart had no murmur, but that doesn't mean he wasn't a setup for congestive failure.

Q. Does it mean that he was though?

A. Congestive failure -- Let me make this clear to you, because I think it might not be. Congestive failure isn't a perpetual state of --

Q. It's not a perpetual condition?

A. Somebody, once they have it, either are compensated or uncompensated in it. If they are compensated in it, their lungs will be clear; heart sounds will be fine.

Q. So can somebody live 50 years with congestive heart failure?

A. According to the Framingham Study, once the diagnosis is made, regardless of modern medical management, the prognosis for a man is 50 percent, 60 percent mortality. That's surprising.

Q. The diagnosis, was that a diagnosis that was made to a certainty or was it an assumption?

A. It was a certainty.

Q. Was it?

A. Big heart, you've got failure. Moist lungs, you have failure. And I think with Dr. Robinson's notes, this man had on his second hospital day, congestive failure,

Q. What's an athletic heart?

A. An athletic heart is something that occurs in a man who is physically fit and not 286 pounds.

Q. I asked you what it is. Is that a large heart?

A. It's a slow heart.
Q. Is it a large heart?
A. Not necessarily.
Q. Is it normally a large heart?
A. Not necessarily.
Q. Is it usua7ly a large heart?
A. Not necessarily.
Q. In 51 percent of time, is it a large heart?
A. Might be 49 percent of the time.
Q. Did Mr. Duren have an athletic heart?
A. No.
Q. How much did Mr. Duren work prior to his death? What was his work history like?
A. I don't know what his work history is.
Q. Isn't that important to determine whether or not the man was physically fit?
A. No. In fact it might be a factor in his mortality. If the man had any heavy labor at 286 pounds, I think it's a risk.
Q. Well, there are lots of risks. In other words, walking across the street can be a risk, can't it?
A. Sure.
Q. What was the risk of Mr. Duren dying at

Hillcrest when he was admitted in 1981?

A. I think he had a risk.

Q. What was it? Was it 51 percent at that time? 90 percent?

A. I think it was -- His chances of getting out of the hospital were not real good even back in that time.

Q. Okay. And would you consider the appropriate medical management that he received at that time a reason for his getting out alive?

A. Oh, yes.

Q. Is there a greater risk for somebody who, assuming he has congestive heart failure diagnosed seven years prior to an admission, has obesity, has diabetes, has hypertension, is there an increased risk if he is not treated at all?

A. Yes.

Q. What is the appropriate treatment for congestive heart failure, Doctor?

A. Diuretics.

Q. When was John Duren given diuretics in his stay at Suburban Community Hospital?

A. I don't think he was given them.

Q. When was congestive --

A. But I don't think congestive heart

failure as a diagnosis was present except for the big heart. And I think diuretics would be appropriate if he had congestion in his lungs.

Q. Well, how was that addressed then? I mean this ultimate determination that you are making as to what he had, and what the ultimate end result of that is according to the study that you have referred to, how was that addressed by Dr. Lissauer during his last hospitalization, sir?

A. I think he had a chest x-ray. The chest x-ray did not show congestion.

Q. Well, what does that lead one to conclude then, sir?

A. It leads one to conclude that he didn't need a diuretic.

Q. Well, doesn't it also lead one to conclude that he was not suffering at that moment from congestive heart failure?

A. Not necessarily, no. I think he didn't need diuretics for his congestive heart failure, but as I mentioned before, once the diagnosis of congestive heart failure is made, I think the prognosis is there for poor long-term survival.

Q. Well, just getting back to my question that I asked a few moments ago, when you give a

prognosis, certainly the treatment enters into that prognosis, doesn't it?

A. Timely treatment, yes.

Q. Sure. And someone that doesn't receive treatment, it seems to me, is, given the figures you have just given me, probably about at a hundred percent risk of dying.

A. If he had pulmonary congestion from his congestive heart failure, which he did not.

Q. Did Mr. Duren?

A. No.

Q. What did Mr. Duren die of in your opinion?

A. I think he died of a complication of pancreatitis, and I think that complication involved many things which made him basically unstable to acute insult.

Q. You as a doctor had never seen Mr. Duren, and after reviewing a few records that you just referred to, are coming up with that conclusion. Do you see anywhere on the record where Dr. Lissauer was concerned with what you are saying were his problems when he was admitted to Suburban?

A. I think Dr. Lissauer from his Hillcrest notes had concern.

Q. All right. How did he address those

concerns to prevent precisely what you are saying in your opinion was going to happen from happening? How did he treat the potential congestive heart failure --

A. I think he --

Q. -- and resulting death, Doctor?

A. I think he was at a disadvantage to do that, and I think -- I think in retrospect certain other things might have been done.

Q. Well, he was aware of the patient's history before he admitted him, wasn't he?

A. Yes.

Q. Because he had seen him at Hillcrest before? You have to answer verbally.

A. Yes.

Q. And so what you are telling us today is something he was aware of before the insult, that is, the death, wasn't he?

A. That's right.

Q. So he didn't need retrospect, did he?

A. Oh, I need retrospect and you need retrospect.

Q. Yes, but he didn't.

A. Certainly, if the man would have survived, we wouldn't be sitting here today kind of surmising

what should have been done and what shouldn't have been done. So I'm saying in retrospect, now we can say certain things could have been done.

Q. What should have been done sitting here now looking back in retrospect by Dr. Lissauer to try to insure the survival of Mr. Duren?

A. I think the line of communication, more sensitive to how his condition was progressing.

Q. Well, give me some specifics.

A. Namely, a call from a nurse or a call from house officer.

Q. Well, is that totally the nurse or house officer's responsibility, or is it up to the doctor to insure that they will notify him in the event of changed circumstances or changed conditions?

A. I can't ever remember seeing a doctor write a note on a chart or order and chart "Notify me if changed condition, if condition changes."

Q. I don't think my question was limited to that. I mean isn't there supposed to be a certainty in terms of understanding between yourself as a doctor and the people to whom you leave your patients in their care as to what they are to do in the event of a change in circumstances?

A. Yes.

Q. All right. Because you are the doctor, you are the one responsible ultimately for that patient's well-being. Isn't that true, sir?

A. How far can you go with certainty?

Q. Well, let's talk --

A. Do you want to write it in the orders? I've never seen that written in the orders. I mean how far --

Q. Does it have to be done in the orders or can't there just be -- You are the one who mentioned the clear line of communications.

A. That's right.

Q. And I agree with you, sir. And isn't that the doctor's responsibility to insure that those communications will in fact be made?

A. By admitting somebody to a hospital floor, it's -- In every other situation outside of this one, I think it's automatically assumed that the nurse or the house officer will notify the doctor.

Q. You make that assumption as a doctor?

A. Yes, I do.

Q. With respect the initial orders written by Dr. Lissauer, should he have ordered a blood sugar?

A. Yes.

Q. And he didn't?

A. That's right.

Q. And that by the way is done with the same blood that is taken for purposes of the other tests, isn't that true?

A. He ordered a Chem 6, and usually the glucose is part of a Chem 6.

Q. Is there a monetary consideration for not doing that? And that is ordering additional tests, for example, the next day.

A. No.

Q. No. It's important, is it not, when a person is suffering from diabetes, whether or not pancreatitis exists, to treat the diabetes?

A. Yes.

Q. And it was in fact Dr. Lissauer's associate, I believe Dr. Frankel, who removed Mr. Duren from insulin the prior year, isn't that true?

A. Yes. Right.

Q. And wasn't one of the immediate things that was done at Hillcrest in the previous admission to provide him with insulin stat and do a blood sugar immediately?

A. Yes.

Q. And shouldn't that have been done here,

sir, in your opinion?

A. Yes.

Q. And had that been done, certainly the level of the blood sugar would have been immediately apparent?

A. That's correct.

Q And we do know that it showed up as a 5-plus in the urine at 9:00 that evening, which at lcast I have been told to this point, is difficult to then translate that into what the glucose level would have been?

A. It only means that it's above a certain threshold.

Q. It's off the chart?

A. Right.

Q. I mean that's the highest it can go?

A. Right.

Q. We know that at least with a 2-plus reading of the prior year, he had a glucose level of 368.

MR. McILHARGIE: Objection.

Q. (BY MR. KAMPINSKI) 326. I'm sorry. Is that correct?

A. Right.

Q. So could we reasonably assume that with a

5-plus reading, it would be even higher than that3

MR. McILHARGIE: Objection.

A. I don't think it's as clear cut as that, because I think we are looking at urine, which there is a delay.

Q. Right. It has to go through the kidneys?

A. Right.

Q. So you don't get as accurate a reading?

A. Right. Yes.

Q. But we do know it was very highly elevated?

A. Yes.

Q. At a minimum we know that --

MR. MURPHY: What are you talking about now?

Q. (BY MR. KAMPINSKI) The 5-plus.

A. Yes.

Q. All right.

A. I think that tells us it's high enough. I think the one thing we can say is it's high enough to give him insulin.

Q. And that's something that can't be done in the abstract, can it, Doctor? In other words, don't you have to know how the person then reacts to the insulin to determine whether or not the

insulin was effective and what future dosage should be given?

A. Yes.

Q. And that's something that has to be followed up after you give the insulin, isn't it?

A. Yes.

Q. Was that done here?

A. It was done with urine sugars but not a blood sugar.

Q. Was there any follow-up after the give -- assuming for the sake of argument that some insulin was given at 10:00.

A. Right.

Q. Was there any follow-up from that time until the time Mr. Duren died to determine the effectiveness of that insulin if it was given?

A. Well, no.

Q. Let's forget about the blood sugar test right now, all right. And let's assume fractionals could theoretically be appropriate. Shouldn't additional fractionals have been taken after that to determine what effect the insulin had?

A. At about four to six-hour levels, yes.

Q. So that would put us to, assuming it was given at ten, we would be talking two to four

o'clock in the morning?

A. Yes.

Q. And that wasn't done either?

A. Okay.

Q. And were there orders given for that to be done?

A. I don't think there were fractional orders written.

Q. Shouldn't --

MR. MURPHY: If you want to refer to the chart, it's here, for any of these questions, Doctor.

Q. (BY MR. KAMPINSKI) Yes, sure. Absolutely.

A. Yes, it should have been done.

Q. The order should have been given for that to be done, shouldn't it?

I'm sorry, Doctor. You really do have to answer verbally.

A. Yes.

Q. Isn't that in and of itself, when I refer to that, a high blood sugar level, or in this case a high urine fractional level, all right, a potential life threatening situation in and of itself?

A. Yes, it is.

Q. And since there was no autopsy, we don't know that that isn't what killed him, do we?

A. We don't know it is. We don't know it wasn't. I think if it was, he certainly didn't have all the signs that would go along with it.

Q. He had a lot of other things going on in his body in addition to that?

A. Yes.

Q. And that certainly didn't help, did it, Doctor?

A. No.

Q. By the way, have you been advised of any of the nurses' testimony in this case?

A. I haven't seen any of nurses' testimony yet.

Q. I assume you have talked to Mr. Murphy though about this case other than what's written down. Would I be correct in that, Doctor?

a, Yes.

Q. Has he advised you of the testimony of the nurses to the effect that it is hospital procedure that when medication is given, medication including insulin, that it must be, No. 1, slashed to insure that it is given, so that others will

know it's given, and also that it is to be put on the diabetic chart? Have you been advised of that, sir?

A. Yes.

Q. Have you looked at that record with respect to those aspects?

A. No, I haven't, as a matter of fact. But getting back to our other point, there were fractionals ordered.

Q. For what time?

A. qid.

Q. Which would mean what to you?

A. It would mean about every six hours.

Q. So that if I understand correctly, if they were taken at nine, they should have been done again approximately three a.m.?

A. Yes.

Q. They weren't done, were they?

A. Let me see. We have one at nine and they are not charted at three.

Q. While you are looking at that sheet, that sheet being the diabetic chart, is there an area on that chart that reflects the giving of insulin, sir?

A. Yes, there is.

Q. And is there any reflection of any

insulin being given at any time to Mr. Duren?

A. Not on this chart, not on the diabetic sheet.

Q. All right.

A. I will have to check the nurses' notes and see if there is here.

Q. Okay. You had looked at the nurses' notes a minute --

A. 10:00.

Q. Excuse me. Let's go slow. You had looked through the nurses' notes a minute ago?

A. Yes.

Q. Did you see any indication of insulin being given to Mr. Duren in these nurses' notes?

A. No. It is charted on the medication administration record though.

Q. When you say charted, let's be very specific about what you are talking about. What is it that you are referring to, Doctor?

A. I'm referring to this entry, ten, 20 units.

Q. Is it slashed, Doctor?

A. Hard to tell.

Q. Well, let's --

A. It might be part of the R. It might be

part of the 00. But as far as a slash through it, no.

Q. And if the testimony, Doctor -- And by the way, before I even get to that, if you go back to the nurses' notes, and I'll ask you to assume that this was written down by Nurse Springborn who was the RN on duty on the evening shift. She has testified that that's her writing.

A. Okay.

Q. Okay. Now, if you will go to the nurses' notes. Would you indicate, please, for the record at ten p.m. who it was that was seeing Mr. Duren at that time?

A. Well, it's an LPN.

Q. Chrissman?

A. LPN Chrissman who wouldn't be allowed to give --

Q. That's right. And if you would just bear with me for a moment, she refers to some difficulty being exemplified by Mr. Duren at that time, does she not?

A. Yes.

Q. Would you indicate for the record what the difficulty is?

A. He had severe abdominal pain;

respirations were rapid and shallow; skin was hot and dry.

Q. And let's assume that she advised Miss Springborn of that, the RN, and she returned at 10:40, didn't she, Doctor?

A. Yes.

Q. And gave him pain medication?

A. She charted at 10:40 --

a. Right.

A. -- that pain medicine was given, yes. She may have -- Who knows whether she did. You would have to ask her.

Q. Why don't we look at the medication sheet and see what time is on the medication sheet when she gave pain medication?

A. It's at 10:40.

Q. And is it crossed out, Doctor?

A. There is a slash through it, yes.

Q. Yes.

A. And let's even assume something further, Doctor, and that is the vital signs -- right there.

A. All right.

Q. Do they reflect what time they're taken, sir?

A. Yes.

Q. Would you indicate for record what time the vital signs were taken?

A. Let me see here. Let's just go with the pulse at 10:00. Maybe about 10:30 at that time. And then it looks like about --

MR. MURPHY: I think that's two p.m.

A. Is that two p.m.?

MR. MURPHY: I'm not sure.

Q. (BY MR. KAMPINSKI) Here. Here's the time up here.

A. Right. Ten, two.

Q. Well, he wasn't admitted until 1:30 in the afternoon. So I think the first entry correlates to two p.m., Doctor, in the afternoon.

A. It's a little askew then. I don't think we could -- You have to push everything over.

Q. Well, I don't think we do. I think that's two p.m. Okay?

A. Let me see. We have a pen here.

Q. Don't write on that though, please.

A. It's before two. This two block is here. The two block comes down here.

Q. Right. And there are circles in the two block, aren't there, that reflect the temperature,

pulse and respiration?

A. All right. Yes.

Q. And when is the next time that temperature, pulse and respirations are circled?

A. It's in the ten box.

Q. Ten p.m., right?

A. Let me see.

Q. Well, I don't know what those red lines are, quite frankly. Neither does anybody at the hospital.

A. I'm looking at the dots now.

MR. MURPHY: Objection.

A. It looks like a dotted six for the pulse. It looks like at ten for the temperature.

Q. (BY MR. KAMPINSKI) How about the pulse?

A. The pulse looks like it's at --

Q. Well, what's the black line, Doctor? Is there a circle on the black line there?

A. The black line is at ten.

Q. Right, okay. And how about the respirations at the bottom?

A. Ten.

Q. So that if I read that correctly, both --

A. What do you think --

Q. I don't know. I have no idea. Let's

talk about what we do know. And that is the pulse, temperature and respiration taken at 10:00.

A. All right.

Q. Are they normal or abnormal?

A. Temperature is 38.8, mildly elevated. Pulse is 140.

Q. Pretty rapid, isn't it?

A. Yes. Respirations, 40.

Q. Pretty rapid, isn't it?

A. Yes.

Q. What is normal on respiration?

A. I like to see respirations about 20 or below.

Q. Is that arrhythmia, Doctor? Does that reflect arrhythmia?

A. No.

Q. Does not?

A. No.

Q. How do you define arrhythmia in terminology? Pulse rate?

A. Arrhythmia is heart rate.

Q. Can you correlate that to a pulse rate?

A. That's a tachycardia, I think, is the word you are looking for.

Q. Well, is tachycardia an arrhythmia?

A. Tachycardia is not an arrhythmia as we're talking about an arrhythmia. Tachycardia is usually a benign. Arrhythmia is signifying generalized condition of the patient. An arrhythmia usually is, I think you are trying to make me say, is a life threatening irregular --

Q. Of course, it is.

A. -- irregular rhythm, and this is not in that terminology a ventricular arrhythmia.

Q. I didn't say it was ventricular arrhythmia.

A. We are not skipping beats. It's a tachycardia.

Q. How do you define arrhythmia? Is it a heartbeat over a hundred? Or is that tachycardia?

A. That's tachycardia.

Q. And what is the irregular heartbeat?

A. Arrythmia.

Q. Is tachycardia a form of arrhythmia?

A. Yes and no.

Q. Well, in the generalized sense, we speak of --

A. In a generalized sense, it's not-- irregular heartbeat, as far as life threatening arrhythmias, it is not one.

Q. Sure, it was in Mr. Duren. He died.

MR. MURPHY: Objection.

A. But he didn't die from arrhythmia.

Q. (BY MR. KAMPINSKI) How do you know?

A. How do you know he did?

Q. Well, how do you know he didn't?

A. Because I think -- I don't know he didn't.

Q. Did you look at the nurses' notes throughout the entire evening?

A. Yes.

Q. Short of breath, wasn't he?

A. Yes.

Q. All night. Couldn't breathe?

A. Right.

Q. Taking his oxygen off?

A. But that doesn't mean he is having a ventricular arrhythmia or life threatening arrhythmia.

Q. But it sure could be, couldn't it?

MR. MURPHY: Objection.

A. He has so many other things going on that I think it would be wrong to say that this is the one cause of it.

Q. (BY MR. KAMPINSKI) Oh, but you think it would be right to say it was --

A. Pancreatitis.

Q. -- congestive heart failure, right?

A. No. I think pancreatitis would be quite appropriate because he came in with it.

Q. Well, can't pancreatitis unchecked, untreated lead to arrhythmias.

A. It can lead to tachycardia. It can also lead to arrhythmia, yes.

Q. Sure. So aren't we saying the same thing but getting there a different way, Doctor?

MR. MURPHY: Objection.

MR. McILHARGIE: Objection.

A. I don't -- I think he had a tachycardia, but I'm not about to say that he had a ventricular arrhythmia that caused his death. That's all I can say.

Q. There was no autopsy requested, was there?

A. No, there wasn't.

Q. 4nd shouldn't there have been?

A. Yes.

Q. And that failure to obtain an autopsy provides a predicate for you to come here today and say that it was something other than what it might be?

MR. MURPHY: Objection.

Q. (BY MR. KAMPINSKI) Because we don't know, do we? We just don't know.

A. No, we don't. We don't -- if you ask -- and I think your question is why did this man die. We can sit here and theorize why he died.

Q. Sure, sure. With respect to 10:00 vital signs that were taken, were there significant changes from the 2:00 vital signs taken?

A. Yes.

Q. And shouldn't somebody have been apprised of those changes?

A. Yes.

Q. The house doctor or Dr. Lissauer or somebody, anybody?

A. That's correct.

Q. And don't you as a doctor believe that had he received attention by 10:00 that night, that there would have been a significantly greater chance for this man to have survived?

MR. MURPHY: Objection.

A. I think that's difficult to say. I think for optimal medical management, somebody should have been apprised. To say that it would have made such a significant difference in his outcome, I don't think you can say, because you don't have an

autopsy to say what killed him.

Q. How can you say that it wouldn't have, Doctor? You don't know, do you?

A. I don't know.

Q. Of course not. And the fact --

A. But that wasn't the question. The question was would it have made a difference. I don't know.

Q. The fact that he didn't die shortly after 10:00 and continued to survive for a period of nine hours after that, in essence fighting for life, isn't that significant to you at all? I mean it's not somebody who is weak and immediately succumbs, is it, Doctor? Things kept going on in his body for a period of nine hours afterwards.

MR. MURPHY: Objection.

A. We are dealing with somebody who enters the hospital with pancreatitis, and pancreatitis in the acute stage is a dynamic event.

Q. Rapidly changes?

A. Rapidly changes.

Q. And has to be constantly observed, doesn't it?

A. Yes.

Q. And it wasn't here, was it? Or if it was

observed, it wasn't --

A. It might have been observed. It wasn't noted as properly as I think everybody involved in his care would have wanted it to be noted.

Q. And you are not saying that if in fact it had been treated, it couldn't have been treated successfully as it had been in the past. I don't think you are saying that, are you?

A. Again, I have to say I don't know what the outcome would be.

Q. But certainly the failures that we have already discussed prevented us from knowing that, isn't it? I mean wouldn't that be a fair statement? Nobody was even given an opportunity to provide appropriate medical care to try to save that man's life.

MR. MURPHY: Objection.

A. The outcome of this man with pancreatitis in the substrates that occurred, a man of poor general health, is not good. But for me to say that he would have lived or died had somebody been notified sooner, I can't say that either.

Q. What is your familiarity with mortality tables? Are you familiar with them, Doctor?

A. Mortality graphs, I am. Mortality tables

involving specific disease, I am, yes.

Q. Well, how about just mortality tables of the population in general?

A. In what contexts?

Q. Well, if you are born today, you would live, if you are a male, to age 73 or thereabouts.

A. I don't study those like an insurance company would.

Q. Okay. You don't to the extent they're provided with legal significance. You just don't know what significance that has or doesn't have?

A. Legal significance.

Q. That's correct.

A. Medical significance, yes.

Q. Well, would you agree or disagree -- And you may not know the answer, and if you don't, just tell me, okay? I don't want you to guess -- that the mortality tables that are used for legal purposes take into account the general population, including sick and not sick people? Do you know whether --

A. For legal reasons? I don't know.

Q. And would it be true that someone who survives to an age of 47, for example, would have a better chance of reaching age 73 than someone who

is just born having the life expectancy of 73 because he has already made it through 47 years?

MR. MURPHY: Under those same tables?

MR. KAMPINSKI: That's right.

A. Under legal tables, I don't know.

Q. (BY MR. KAMPINSKI) Okay. And to say one person will or won't die one year, two years, 20 years, 30 years from a given point in time, isn't the same as saying 50 percent or 20 percent or 90 percent of people with a certain disease may die in that period of time, is it, Doctor?

A. I don't understand your question.

Q. Okay. If you take a hundred people --

A. Yes.

Q. -- that had had congestive heart failure at some point in time, and if you are saying to me that a particular study has indicated that 50 percent of those will die in five years, I think you are saying to me that 50 percent of them won't. Is that right?

A. I'm saying 60 percent will and 40 percent won't.

Q. Okay. If you looked at those hundred, would you be able to pick those 60 that will die

out?

A. I think you could get a pretty good idea. For instance, like any other condition involved in a medical problem, if it's complex, if it's additive, if the man has congestive failure, also is hypertensive, also an obese --

Q. Well, if you wouldn't mind, Doctor, I would like when you refer to congestive failure, as opposed to saying "has," if you would refer to "had," so there is absolutely no confusion in the record.

A. It doesn't matter. If you look at the Framingham Study, essentially if somebody has hypertension to the point --

Q. Let's talk about congestive heart failure.

A. I am. If somebody has hypertension to the point that he has congestive heart failure, when you look at the Framingham Study, it made a difference. Now, that's in the general -- when they just look at people with congestive heart failure.

Q. Okay.

A. They had -- when you look at hypertension alone, I think there is some variability there, but when you look at just the presence of congestive

heart failure --

Q. If he didn't have congestive heart failure, then what would your entire discussion amount to?

A. Oh, I don't think I want to base it entirely -- this man was 300 pounds with triglycerides over a thousand at Hillcrest --

Q. What were his triglycerides when he was stopped being seen by Dr. Frankel?

MR. McILHARGIE: Objection.

A. Well, I don't think we can say. You know, triglycerides take about three or four days.

Q. We can say what they were when he stopped being seen by Dr. Frankel because you have got those records available, don't you?

A. Right.

MR. McILHARGIE: I make reference to the fact that you are saying he was stopped being seen, and it would appear from your question that he was turned away by Frankel, which wasn't the case at all.

A. Okay. Let's see.

MR. KAMPINSKI: Well, if that's a conclusion somebody reaches some day, that's all right, too.

A. 1,900 here on the 27th of February.

MR. McILHARGIE: It would be nice to have some evidence in support of it.

A. I would say 1,900 is the last one I see charted here. No. I don't -- I certainly don't want to lead you to assume that I'm basing my entire prognosis for this man's longevity or brevity of life based only on the fact that he was hypertensive.

Q. (BY MR. KAMPINSKI) You've referred to one study. There are other studies, aren't there, that disagree with Framingham's?

A. Let me see this for a second. We are talking about a study of 5,192 patients.

Q. Yes.

A. A double blind follow-up study, which is probably the -- which is the Bible of heart disease in this country as far as studies are concerned. I think you can find a study to back up any statement anybody ever makes, but I don't think you can find 5,000 cases with --

Q. So you consider this the authoritative study on the issue?

A. Yes, I do. But I also think he has a lot of other things going on, or had a lot of other

things going on, besides his congestive failure; hypertension, metabolic processes.

Q. What's the difference between something that's acute and something that's -- Well, first of all, define acute for me.

A. Something that happens with a degree of intensity and with suddenness.

Q. Does that have any relationship to something happening on a continual basis?

A. Depends on the disease.

Q. Let's say congestive heart failure.

A. I think, oh, yes. Well, I think when we talk about acute fulminant congestive heart failure, you are talking about that something happens suddenly, boom?

Q. Yes.

A. And never happens again. I don't think we have a situation like that. I think if somebody is susceptible to that happening once, unless it's compensated for by several means, congestive failure will happen again.

Q. When did it happen again after 1977 in Mr. Duren?

A. I think he had the risk of it happening on --

Q. No. I asked when did it happen, Doctor?
A. He had a large heart on admission to Suburban. And a large heart is the first thing you look for for congestive failure.
Q. And it wasn't treated at all. And that was evidenced on the EKG.
MR. McILHARGIE: Objection.
Q. I am sorry. On chest x-rays.
MR. McILHARGIE: Objection.
Q. (BY MR. KAMPINSKI) It said prominent left ventricle, didn't it?
A. Yes.
Q. And does that equate to you a large heart?
A. Yes.
Q. It does?
A. Yes.
Q. How much larger was it than it should have been?
A. You have to look at the measurements to measure its size compared to the thoracic diameter of the chest. I would have to look at the interpretation. Left ventricle was prominent. They don't mention the size of the heart to the thorax.
Q. Well, does prominent mean large?

A. Yes.

Q. Or does it mean prominent?

A. Prominent means large.

Q. How much larger was it than it should have been, I guess, is my question.

A. I think you you need the specific measurement.

Q. Well then, how do you draw a conclusion that it was large enough to equate to congestive heart?

A. It was large enough to notice and read as being prominent.

Q. Is it cardromegalia?

A. Yes.

Q. It is? Please answer verbally.

A. Yes.

Q. Does it make any difference what the etiology of the congestive heart failure is?

A. For what?

Q. To bring it about. Or does it happen in a vacuum, or does it happen secondary to pancreatitis, for example?

A. You usually don't know. You don't see a secondary pancreatitis and congestive failure as one of the complications of pancreatitis.

Q. I'm sorry?

A. Congestive heart failure is not one of the complications of pancreatitis, no.

Q. So you would disagrees with the doctor who saw him at the time when he was diagnosed as having that, as it being secondary to acute pancreatitis?

A. Yes, I would.

Q. And if you don't agree with him there, why do you agree with him that he had congestive heart failure?

A. Because he has objective evidence that he did.

Q. I see.

A. But I disagree with his opinion of any -- That opinion regarding congestive heart failure, I disagree with.

Q. Do you disagree that he had no signs of cardiomegalia at that time, seeing as how you say they go hand in hand?

A I think it would depend on how he said it and I think he said it more in terms of clinical --

MR. MURPHY: Do you want to see the discharge summarya

A. Yes.

Q. (BY MR. KAMPINSKI) I'm referring to that last paragraph.

A. Yes, I would disagree with that because I think he is basing that on his physical examination, and it's very difficult to get an accurate assessment of cardiac size on physical examination. When he looks at his x-rays, he does have an enlarged heart.

Q. Did he have an enlarged heart at Hillcrest?

A. Hillcrest, I think his heart size was not noted as being large.

Q. Did he have a prominent left ventricle?

A. I don't think that was mentioned either.

Q. How about at St. Luke's?

A. I haven't seen the St. Luke's charts.

Q. Wouldn't that have been important for you to look at to know?

A. No.

Q. Doesn't matter?

A. No. As I said before, in the presence of congestive heart failure. It just means that at Hillcrest it was compensated. If it was not enlarged at St. Luke's, it was compensated.

Q. Let's assume, Doctor, that once having

congestive heart failure, you are always at risk, which I think is probably fair?

A. Yes.

Q. That's not to say you will or won't suffer from it again, but a certain number of people may and may die from it?

A. Right.

Q. Right?

A. Right.

Q. Especially if it's not treated?

A. Right.

Q. Shouldn't you order an EKG knowing that?

A. Yes.

Q. And shouldn't you insure that it's done?

A. Yes.

Q. Was that done here, Doctor?

A. It was ordered.

Q. It wasn't done, was it?

A. It wasn't done.

Q. And did the doctor inquire at 5:30 when he called what the results of the EKG were?

MR. McILHARGIE: Objection.

A. I don't know.

Q. (BY MR. KAMPINSKI) Have you been advised by Mr. Murphy that in fact he didn't? Did you

review Dr. Lissauer's deposition by the way?

A. No.

Q. Even given everything you're saying, you don't ignore somebody who is sick from this, do you? You treat them realizing these potential complications, don't you?

MR. MURPHY: Objection. You said sick from this.

Q. Pancreatitis, diabetes, potential congestive heart failure. You treat them for those things?

A. You monitor them for them, yes.

Q. And he didn't treat him for congestive heart failure, did he?

MR. McILHARGIE: Objection.

A. He didn't know at the time that he was in the failure. And I don't know that either.

Q. (BY MR. KAMPINSKI) Assuming he was, which was an assumption that apparently you are making?

A. I can't assume that because I don't have an autopsy.

Q. So that if he wasn't in congestive heart failure, your opinion, based upon his longevity at that point in time, doesn't make any sense, does it?

A. Yes. Oh, yes, it did.

Q. It might have five years from then or ten years from then?

A. Let's keep these issues straight. I'm making statements about the man's general condition. I think a man of this poor general condition given pancreatitis is at a much higher risk for having died from it. A man of this poor general condition is at a much higher risk of dying in the next five years of his life than the average individual.

Q. Okay.

A. That's what I am saying.

Q. Okay. All right. That's not to say he will die in the next five years, but he is at a higher risk to die?

A. Much higher risk.

Q. You mentioned strength earlier, but I take it that's not an overriding factor?

A. Mentioned what?

Q. Strength. The strength of a person.

A. No, it's not an overriding factor.

Q. I assume, and correct me if I'm wrong, but treatment certainly has to be plugged into the evaluation in terms of how long he is going to live?

A. Yes.

Q. And good medical management, I assume,

could prolong such a person's life for some period of time?

A. Good medical management, compliance, the fact that the man, who weighs 284 pounds, would trim down to his ideal body weight, which would be somewhere around 150 pounds, 160 pounds; possibly that would lower his cholesterol to the point that he might improve.

But we are talking about things that are very dramatic, things that he should have done with his first episode of pancreatitis, and things that I see no pattern for improvement on over the past seven years.

Q. Does the body configuration have an effect on how much weight you can carry? Does the size of an individual --

A. The height does.

Q. How about bones?

A. Bones, less. Bones, I think it used to be kind of fashionable to say somebody is big-boned and therefore you should weigh more weight, weigh more bone weight, but it's mainly a function of height.

Q. Going back, I think, to where we were earlier before I digressed, Doctor, we were looking

at the 10:00 vital signs, and I think we had concluded that there certainly was a failure to notify somebody of that change in condition?

A. Yes.

Q. Would you agree with that? And that equates, by the way, to the time at which the LPN was seeing Mr. Duren and put her nurses' notes in there?

A. Right.

Q. Do you have an opinion, Doctor, as to whether or not insulin was given to Mr. Duren that night?

A. My opinion is it was.

Q. And what do you base that opinion on?

A. Because it's charted. There may not be a slash, but it's charted. Somebody put down when it was given and the time.

Q. Well, you don't know that they put down when it was given as opposed to the time they intended to give it, do you, Doctor? What time were urine fractionals taken, sir?

A. 9:00.

Q. And isn't that a likely time when somebody would put down when they would give the insulin, if they would give it that night?

A. I think they would put down at 9:00 --

Q. At nine?

A. -- you get a fractional.

Q. At nine?

A. At nine. And then you give the insulin at nine. I think if it was charted at ten, it was to be given at ten.

Q. You say you think that's probably true?

A. I think that's true.

Q. Did you talk to Nurse Springborn about that?

A. No.

Q. Did you talk to any other hospital personnel about that?

A. No, I didn't.

Q. Does the fact that it's not slashed or not put on the diabetic chart have any effect on you, or are you just here to say it was probably given?

A. No. In knowing how things happen in the hospital, if it's somewhere on the chart, it was given. If it were not on the chart at all, if there were no 10:00 noted there and insulin 20 units given, it would have to be --

Q. Would you --

A. But I have to assume it was given.

Q. Would you look at the Maalox? Are there times on there when it's supposed to be given?

A. Yes, yes.

Q. They're not slashed, are they?

A. No.

Q. They weren't given, were they?

A. No. I think they more than likely were given at eight, ten, twelve.

Q. No. They weren't. The times that aren't slashed aren't given.

MR. MURPHY: Can you look at the order for Maalox?

Q. No. Let's just look at that, because the point I am making was he died before those were --

MR. MURPHY: Let's not play tricks here.

MR. KAMPINSKI: I'm not playing tricks. I'm not playing tricks one bit. Because he was dead. He died before they were given.

Q. (BY MR. KAMPINSKI) The times were written prior to the time that they were supposed to be given, weren't they, sir?

A. This is a different context, and let me not get confused here. With an order that was

scheduled, they would write for an order that is --

Q. Well, this couldn't be scheduled when the urine fractionals were taken.

A. Sure. But if they were going to do the same concept as you are saying, your thought process would be the same; then it would be charted all the way down the --

Q. I'm trying to deal with your thought process, which is, I think you told me, if it's written there, that means it's given?

A. For insulin, yes.

Q. Do you have privileges at Suburban?

A. No.

Q. Do you know Mrs. Springborn?

A. No, I don't.

Q. Do you know how busy she was that night?

A. No, I don't.

Q. Do you know whether this was her regular --

A. But I know --

Q. Do you know whether this was her regular work assignment that night?

A. No, I don't.

Q. Do you know what her predilections are with respect to when she writes it down?

A. I know a nurse writes insulin down when

she gives it.

Q. Supposed to.

A. And doesn't write it if she doesn't give it.

Q. She's supposed to slash it when she gives it.

A. She is supposed to write it and slash it.

Q. And slash it, sure.

A. But she is supposed -- A nurse will not write an insulin order if it's not given.

Q. Sure. Is that a rule?

A. It's not a rule, but it's the way of action. It's an accepted approach.

Q. Well, the accepted approach is a slash to put on the diabetic chart, Doctor. That's the only way that I have been told that you know that it's given by every nurse there, by the hospital administration, by Mrs. Springborn herself.

MR. MURPHY: Objection.

A. The only way I know in looking at a chart if a medicine has been given or not is if it's been charted. And that has been charted.

Q. (BY MR. KAMPINSKI) I see. Were vital signs taken at two a.m.?

A. Let's see here. Vital signs as being

charted on the graphic chart at six. Now, let's look at the nurses' notes.

A. I don't see nurses' notes here say that vital signs were charted at two.

Q. In fact, the graphics chart does not reflect that they were?

A. The nurses' notes don't either.

Q. Should they have been?

MR. MURPHY: Look at the order for vital signs.

A. Vital signs qid. You know, that order, it's difficult to say because qid means different things to different people, and I think as opposed to a q six hours or a q four hours --

Q. Well, given the vital signs at 10:00, should they have been taken at two?

A. Little too soon.

Q. Too soon to take them?

A. Yes.

Q. Should the midnight shift have been apprised of abnormal vital signs taken at ten?

A. Yes.

Q. Should the three to midnight shift have been advised of the fact that Mr. Duren was a diabetic?

MR. MURPHY: Objection.

A. Three to midnight, you mean?

Q. That's right. Evening.

A. Yes.

Q. (BY MR. KAMPINSKI) Would you agree with me that the -- I'm sorry. I take that back. Would you agree with Dr. Plotkin that the management by the hospital of Mr. Duren was appalling?

MR. MURPHY: Objection.

A. I think I would be a little -- use that in a little less strong language.

Q. Why? It was appalling, wasn't it, Doctor?

MR. MURPHY: Objection.

A. I don't think it was appalling. I think it was --

Q. Negligence?

A. I think it could have been better.

Q. Negligence?

MR. MURPHY: Objection.

Q. (BY MR. KAMPINSKI) Better word?

A. I would think -- I think negligence would be a term you could use.

Q. And just so we understand what you have said with respect Dr. Lissauer and the things he should have done and shouldn't have done, that

would be an appropriate term to use for him, too, wouldn't it?

MR. McILHARGIE: Objection.

A. No.

Q. (BY MR. KAMPINSKI) Well, are you saying that failure to order the blood gas was not negligence?

MR. McILHARGIE: Objection.

A. He order a blood gas.

Q. To order it immediately, stat, as it was at Hillcrest?

A. You mean blood sugar.

Q. I'm sorry. Blood sugar. I'm sorry.

A. I think retrospectively he could have done that, but to say it was negligence in not doing it, I would have to disagree.

Q. Well, given what he knew at the time, wasn't it negligence at the time? He knew that Mr. Duren was a diabetic and had a determined level of sugar in his blood, didn't he?

MR. MURPHY: Objection.

A. I would have liked --

Q. Wasn't it important to know?

A. Well, I would have liked to have seen --

Q. Shouldn't he have ordered a blood sugar?

Wasn't it negligent for him to --

MR. McILHARGIE: Objection.

Q. (BY MR. KAMPINSKI) In all fairness and all honesty, Doctor, wasn't it?

A. I'm sure if you asked Dr. Frankel, he would have preferred --

Q. I'm asking you, sir. You are the one who has come in here as an expert.

A. I would have liked to have seen a blood sugar.

Q. My question is isn't that negligent of him to have failed to do that?

MR. McILHARGIE: Objection. He already answered the question.

MR. MURPHY: Objection.

A. I think it was probably negligent, yes.

Q. (BY MR. KAMPINSKI) And his failure to by 5:30 insist that even a urine fractional was done, wouldn't that be negligence? Isn't it rather important for him to know what this man's level of sugar is --

MR. MURPHY. Objection.

MR. McILHARGIE: Objection.

A. He should know what the level of sugar is.

Q. What about the blood gas? When he

received that result at 5:30, he ordered oxygen, didn't he, based upon the H2 left?

A. The PO2 level.

Q. I'm sorry. The PO2. Wasn't it important for him to have complete follow-up studies of blood gases done to see if the oxygen that he ordered was adequate?

A. The blood gases done at that time with the PO2 of 60, it's not respiratory insufficiency, so I think that places us in a less urgent situation than if it were below 50. Definitely you would want a follow-up.

Q. But that's something that could change fairly rapidly, too, isn't it?

A. I think it can change with his general condition.

Q. Doctor, you just briefly glanced at the nurses' notes a few moments ago. What would I like you to do is take a minute to read the nurses' notes for the morning of February 18th commencing with the midnight shift. And just take --

A. O2 in progress, same one, February 18th, 12 midnight?

Q. Yes. Starting right from there reading the entire -- just to yourself for a moment.

A. Okay.

A. All right.

Q. First of all, from reading that note, would you assume that it was all written by the RN, that is Garrity?

MR. MURPHY: Objection.

A. It was signed by Garrity. It was done with her -- you know, she has authority for it. She has responsibility for it. I'm not sure that in the manner of nurses' notes, I don't know how they do it at Suburban, whether the LPN charted and the RN signs as a countersign or -

Q. Well, have you been told anything different by Mr. Murphy as to what was done with respect to this nurses' note?

A. No.

Q. Well, in looking at it, would you assume that she wrote it all? I mean she is the only person who signed.

A. I just don't know.

MR. MURPHY: Objection.

A. I don't know. I see her signature at the bottom.

Q. Okay.

A. We can assume that if she is the team

leader, she might take full responsibility and sign it.

Q. Would you assume that each entry was placed there at the time that purportedly the event portrayed therein occurred?

MR. MURPHY: Objection.

A. I don't know. Again, I think it depends. Nurses frequently chart their notes at the end of the shift at that time and keep their notes on separate sheets, and I don't know how her policy is or habit is.

Q. Would you read the four a.m. and five a.m. entry and tell me if that makes any sense at all to you as to those events having occurred at those respective times?

MR. MURPHY: Objection. HOB with the arrow means head of bed.

A. I think it would seem to be part of a progression of events.

Q. (BY MR. KAMPINSKI) Well, start with the entry regarding the removal of the I.V. when he went to the bathroom.

A. Okay. That's down at 5:00.

Q. Well, I think it's at four, isn't it?

A. Lying at foot of bed, still restless at

four. 5:00 he pulled out his I.V.

Q. All right. You are right. Okay. Though 02 still in progress. The last line on the four a.m. entry says still having difficulties breathing though. Correct?

A. Yes.

Q. And the next line has a 5, and adjacent to that is 02 still in progress?

A. Yes.

Q. It would appear that that was all part of one sentence?

A. Could be.

Q. Well, are you saying that somebody wrote at 5:00, 02 still in progress and that though --

A. At 5:00 she could be writing, "In bed elevated. Patient appears" --

Q. Appears worse. I.V. was pulled out by patient, right?

A. Right.

Q. House officer called to restart it?

A. Yes.

Q. Does it appear that the writing changes at that point?

MR. MURPHY: Objection.

Q. (BY MR. KAMPINSKI) After the word "it."

A. I don't know. I can't tell.

Q. But it goes on then to say that I.V. pulled out by patient's restlessness, whereas previously it had been pulled out when he was going to the bathroom.

MR. MURPHY: Objeetion.

A. All right.

Q. Do you know when --

A. It does say that.

Q. Do you know when the I.V. was pulled out?

A. I guess the best we can do is between five and five-twenty on that particular time period.

Q. Well, if I told you, Doctor, that the testimony of the nurses -- and I'll lay it all out for you. Originally Miss Garrity testified that this was all her writing, all right.

Subsequently, I scheduled the deposition of the LPN, that being Miss McDuffie, at which point Mrs. Garrity attempted to amend her deposition testimony to say no, that was not all my writing, but part of it was Mrs. McDuffie.

Mrs. McDuffie then came in and testified that it is her writing up until the word "it." That she did not in fact put the 5 into the left-hand column where you see it. Okay. You

follow me so far?

A. I can't see the "it."

Q. The word "it," which is the tenth line. House officer called to restart it.

A. Okay.

Q. That she wrote up to there.

A. All right.

Q. The rest of it apparently is Mrs. Garrity's writing.

A. Okay.

Q. The 5:00 entry, that is the numeral 5 and the 00, was not put in that column by Mrs. McDuffie; in other words, that her entire entry up to the word "it" is 4:00.

A. All right.

Q. Okay. That's the testimony as I understand as having come from the nurses up to this point in time, okay? Are we together so far?

MR. MURPHY: Objection.

A. Yes.

Q. Do you have an opinion then based -- Assume that to be the testimony as to what time the I.V. was pulled out.

MR. MURPHY: Objection.

A. Do I have an opinion of what time it was

pulled out?

Q. Sure. I mean would you conclude from that that it was pulled out at 4:00?

MR. MURPHY: Same objection.

A. Let me see. Where are we, in the bathroom again? That I think was at four.

Q. Everything up to word "it," according to the testimony as I understand it, occurred at 4:00.

A. Okay. All right. I.V. pulled out by patient. Up to the word, "it." All right. Fine.

Q. Wasn't this the only treatment that Mr. Duren was receiving at that time, his I.V.?

A. Oxygen, too.

Q. Well, he had pulled the oxygen off, hadn't he?

MR. MURPHY: Objection.

A. He was also without NPO, I believe.

Q. Right.

A. He was also ordered pain medication, so there were several others. But I V. were one of them.

Q. Pretty important, wasn't it --

MR. MURPHY: Objection.

Q. -- to have the I.V. in this man?

A. It's important to have an I.V. in, yes.

Q. Well, isn't one of the purposes of the I.V. in a person with pancreatitis to try to maintain an electrolyte balance?

A. Yes.

Q. And can't that cause significant complications in such an individual if he goes without that treatment?

A. Certainly, it can cause complications.

Q. All right. You are looking now at the various lab results, Doctor. A number of them were abnormal, weren't they?

A. Yes.

Q. Which ones were abnormal in your opinion, sir?

MR. McILHARGIE: I'm going to object to the assumption underlying this, but go ahead.

A. Okay. The one that I think that is abnormal, but you can't accept as abnormal is the sodium.

Q. (BY MR. KAMPINSKI) Should it have been redone?

A. Well, it would still be abnormal because assuming that the cholesterol and the lipids are high, it's going to be spuriously low. So I think

to act on a low sodium in this setting would have not been appropriate.

Q. Well, should it have been redone?

A. At some point, maybe the next day, yes, but I think the sodium of 125 --

Q. Well, why did he order it stat then if you don't care what the results would be?

MR. MURPHY: Objection.

A. Well, you do when you are ordering the electrolytes stat. I don't see a stat order for the sodium. I think he wants to see what the electrolytes are.

Q. How about calcium; was that ordered stat?

A. Calcium should have been ordered stat.

MR. MURPHY: Why don't you go to the order sheet, unless you remember. It's the green sheet.

A. I've got it. Now, your question was the calcium should have been ordered stat?

Q. (BY MR. KAMPINSKI) I'm asking was it ordered stat?

A. Yes.

Q. Was it done stat?

A. Let's see. It was ordered at -- let's see. Protime to follow. Amylase to follow.

Calcium to follow.

Q. What time was it done?

A. It was done on the 17th. It's listed at -- let's see. It's done at 13:45, February 23.

Q. Would you say that aloud for the record please?

A. February 23.

Q. It was ordered on February 17?

A. Yes.

Q. Is that stat?

A. It's not being run stat, no.

Q. That's six days. What does stat mean, Doctor?

A. Stat means as soon as you can.

Q. It means immediately, doesn't it?

A. It means as soon as you can.

Q. Well, for you as a doctor to order a test stat, what does that tell the people at the hospital, "I want this result right away"?

A. Right.

Q. It's important for me to know, right?

A. Right.

Q. For me to treat this man, for me to treat a patient, I need to know these levels; isn't that true, sir? Otherwise, you wouldn't order it stat?

A. That's what stat would mean, but I think -- in the setting of the lab, I think a lab does it as soon as they can. That's what it means to a lab.

Q. Well, to you as a doctor --

A. It means do it as soon as you can.

Q. You are not going to order something that's going to result in your waiting six days. Why order it stat? If you don't have the capability for getting it stat, why order it stat?

A. It's hardly in the concept of stat.

Q. Right.

A. I have to agree with you there.

Q. Isn't it up to the doctor to insure that he gets stat tests results stat?

MR. McILHARGIE: Objection. I would assume that the lab was capable of returning it under the circumstances stat.

Q. (BY MR. KAMPINSKI) Shouldn't he ask for the results?

A. He should. If they're not back, he should ask for the results.

Q. Right. And in fact, if they're not back and he wants it, shouldn't he insist on getting them?

MR. McILHARGIE: Objection.

Q. Isn't that the primary purpose of a doctor, to treat his patient?

A. Well, let's not cloud the issue here. There is frequently in real life a problem between ordering a test stat and getting it back as stat as you would like it back. If I got every test that I ordered stat back when I wanted it back, I think the lab would be out of business because it would have to drop everything.

Q. How important is calcium determination? I assume it has some importance; otherwise, it wouldn't have been ordered stat. Would you tell me what importance it has?

A. In pancreatitis serum calcium may drop and become life threatening.

Q. And you would expect it to drop, wouldn't you?

A. In severe pancreatitis -- it drops with the severity of the attack.

Q. What if it's elevated?

A. If it's elevated, it points more towards an underlying cause to it, such as a parathyroid adenoma.

Q. Sure.

A. Or oxygen calcium ingestion.

Q. What is parathyroid adenoma?

A. That's over activity of the parathyroid gland which leads to increased bone absorption, increased dietary absorption of the calcium.

Q. Parathyroidism, right?

A. Yes.

Q. Life threatening?

A. Not necessarily, no.

Q. Treatable?

A. Yes.

Q. Surgically treatable, too?

A. Yes.

MR. MURPHY: I'm sorry. What's treatable?

A. Parathyroidism.

Q. (BY MR. KAMPINSKI) That's pretty strong evidence that that's what Mr. Duren had, isn't it?

A. No, no.

Q. No?

A. No.

Q. Was there any evidence of his having that at Hillcrest in 1981?

A. He had a parathormone level drawn and I didn't see the graph, which I would like to see, o parathormone in relation to calcium at that time.

It's a scattered graph that is helpful in diagnosing the condition.

Q. Just to make sure I heard your response before, you are saying that that's not a life threatening condition?

A. I think you told me it was, and I think there is a possibility under certain circumstances it may be life threatening. But to make a blanket statement that it's life threatening, no.

Q. It could be under the circumstances, I take it, is what you are saying?

A. Under given circumstances, it may be, yes.

Q. Would this have alerted Dr. Lissauer to that possibility had he received the calcium test stat?

A. Oh, sure it would have -- I'm sure that's why he ordered it stat, to see whether it was sinking to a low level where it would be dangerously low or not.

Q. He didn't know that at 5:30 on February 17, did he?

A. No.

Q. So you don't know why he testified that he did, do you?

A. I don't know that he did or didn't. I

know that it was -- it's on the chart here as --

Q. Yes.

A. On the other hand, I think we also know that Mr. Duren wasn't around on February 23 to draw the blood at that point.

Q. Do you know of any reason why it would take a minimum of an hour and 53 minutes or two hours and 53 minutes for a house officer to respond when he is called?

MR. MURPHY: Objection.

A. I know of no reason except that he might -- the man might be busy.

Q. Absent that, I mean there is no reason that it should take him that long to respond, is there?

A. That's right.

Q. That's what he's there for, to respond in the event that somebody needs him, right?

A. That's correct.

Q. In having reviewed the nurses' notes for the morning of February 18, 1982, I would like you to take a look at the vital signs that were allegedly taken by someone who we don't know at six a.m. If you would look at the graph.

A. February 18, six a.m. On the graph?

Q. Yes.

A. All right.

Q. All right. Do those vital signs have any relationship to the condition as being exemplified by Mr. Duren in the nurses' notes?

MR. MURPHY: Objection.

A. No.

Q. They don't, do they?

A. No.

Q. (BY MR. KAMPINSKI) They're phony, aren't they?

MR. MURPHY: Objection.

A. I can't say they're phony.

Q. But they certainly don't relate to what he's going through at six a.m. in the morning, do they, Doctor?

MR. MURPHY: Objection.

A. I think that I would like to see a respiration a little faster because they are describing it as being quick in respiration or at least short of breath.

Q. (BY MR. KAMPINSKI) And he dies an hour later, doesn't he?

A. Yes.

Q. You don't know when those alleged vital

signs were put on that chart, do you?

MR. MURPHY: Objection.

A. Well, they're usually put on at the end of a shift, I think.

Q. Is it appropriate to call the wife after her husband has died and tell her over the phone that her husband has died?

MR. McILHARGIE: Objection.

A. I think it's done. I think it depends on the situation. I think it is done.

Q. I asked if it was appropriate, Doctor.

MR. McILHARGIE: Objection.

MR. MURPHY: Objection.

A. I think it depends on the circumstances. People have different philosophies about it. Some people call the patient down to the hospital and explain it to them then.

Other people feel that it's too unnerving for the person to have to hop in a car right after and drive down. So it's a matter of judgment more than anything else. And to say one is inappropriate and one is not, I don't want to get in that picture.

Q. Doctor, I have a couple questions on your report to Mr. Murphy. I don't understand this

inclusion here, zero percent to five percent. What does that mean?

A. That was in my opinion how long Mr. Duren -- what his odds were of living five years.

Q. Well, no. I just don't understand where the zero percent dash five percent fits into that sentence. He's got a zero to five percent of living five years; is that what you are saying?

A. Yes.

Q. You had never seen him, had you?

A. No.

Q. You didn't know him from the man in the moon, did you?

A. No. But I think if I saw him walk in the office, a man of his description, I would tell the man of this description, "You have a chance of zero to five percent of living five years from now" --

Q. You would tell him that?

A. -- "if you don't change your ways quite drastically."

Q. Oh, I see. So if he did change his ways quite drastically and received medical management, then that could be true?

A. Hard to say. Hard to say because this man in 1977 had that opportunity and didn't do it.

Q. I beg your pardon, sir?

A. Because of his attack of pancreatitis with all the things that we know we're going on with him in '77, I would say at that point his life had already begun to be shortened, and I probably would have told him then, "You better change your ways, or your life is going to be shortened."

Q. Any of the doctors ever do that to your knowledge to him?

A. That's something you don't put on a chart.

Q. So you don't know if they told him or not?

A. I don't know.

Q. Did Dr. Frankel ever tell him that?

A. I haven't talk to Dr. Frankel so I don't know.

Q. Are you social acquaintances with Dr. Frankel?

A. No, I'm not.

Q. Mr. Murphy?

A. No.

Q. Dr. Lissauer?

A. No.

Q. Did his condition improve after his discharge from Hillcrest in 1981?

A. I have been to a party with Mr. Murphy.

That's about it. I go to a block party with him periodically.

Q. Oh, you live in the same block?

A. Used to, yes.

Q. Did his condition improve after his discharge from Hillcrest in 1981?

A. I don't think so. I don't think as far as his underlying general health.

Q. Was he taken off insulin by Dr. Frankel3

A. Yes, he was.

Q. Did his weight decrease?

A. To some degree. I don't think he ever broke the 230 barrier.

Q. Did his triglycerides go down?

A. They did drop somewhat. 1,900 is the last I see at Hillcrest. Now, we have notes from Dr. Lissauer that show --

Q. Well, we have them from Dr. Frankel, I believe.

MR. MURPHY: You can point them out.

A. Sure. Try to.

Q. (BY MR. KAMPINSKI) What does it mean, by the way, in a chest x-ray where it says no definite evidence of acute disease otherwise. It starts out

left ventricular enlargement. What does that mean?

A. No evidence of --

Q. Acute disease otherwise.

A. It means there is no pneumonia, no chronic, passive congestion, or acute congestion in the lungs, no cancer.

Q. (BY MR. KAMPINSKI) Does alcohol intake have any effect on a person of Mr. Duren's character?

A. I don't understand the question. Does it have an effect on a man of his character?

Q. Well, no. An effect on his longevity.

A. Yes.

Q. What effect?

A. Yes and no. I think certainly it would to the extent that if a man who has previous pancreatitis start drinking, it's not good.

Q. I mean is there a difference between pancreatitis -- well, I should say, I guess, diabetes for a person who drinks and a person who doesn't drink? Is it more serious for a person who drinks, for example?

A. The pancreatitis, the attacks are usually milder with alcohol.

Q. Are they?

A. Yes. With diabetes, you certainly wouldn't want a diabetic to drink.

Q. I think those are Dr. Frankel's notes subsequent to the Hillcrest hospitalization?

A. Tryglycerides 350, okay. In '81.

Q. Does that help you?

A. Sounds like he was doing a little better.

Q. Sure.

A. But I think on the other than hand, he -- Let me see. Right. That was June in '81, and this admission was --

Q. February, '82.

A. February, '82. So somewhere between the two, I think he came to quite of bit of weight and lost control of his diabetes and regained his triglycerides.

Q. That certainly shows an ability, does it not, Doctor, to maintain the disease process in Mr. Duren?

A. It shows that for a transient period of time in the man's course of natural history of his disease, he dropped his weight and improved his situation.

Q. Sure.

A, But it also shows that he wasn't able to

sustain it.

Q. Okay. So that if we try to crystal ball, which is I guess the position we are in because there is no autopsy --

MR. MURPHY: Objection.

MR. McILHARGIE: I will object as well.

Q. -- had he in fact received appropriate medical care and survived his agonal period at Suburban, we have to make one or two assumptions; I guess, one, he would have changed his ways at that point and gone back to what we see here in June of 1982; or the other, that he wouldn't have?

A. Right.

Q. Right?

A. Yes.

Q. And there is no way that you or I could sit here and do that, is there, realistically?

A. Oh, yes, there is. My opinion is that he might have tried, but as his track record is before, he tried and then went right back to it, and that's usually the way it goes in somebody who is 250, 260 pounds. They can knock a little bit off, but they are right back.

Q. So that if his track record would have

changed, your opinion would be different then, I take it?

A. My opinion is his track record would not have changed. They followed this man from 1977 to 1982 and he hadn't changed yet.

Q. My question was if his track record would have changed, would your opinion be different?

A. If this man would have been reborn, he would do different.

Q. And just so I understand your report, when you say the presence of an enlarged heart and congestive heart failure, just so I'm very clear, you're not saying it existed on February 17th or 18th, but the fact that it had existed previously --

A. Had existed previously.

Q. -- had some significance to you?

A. Yes.

Q. Okay. What is hypercholesterolemia?

A. Well, hyperlipemia. Triglycerides and cholesterol are elevated.

Q. Same. When you say fulminant, what does that word mean to you, Doctor?

A. Very severe.

MR. KAMPINSKI: I would like to make copies of these articles if I could. I

believe the rest of the material we already have. And I think that's all the questions I have for you.

MR. McILHARGIE: I will have questions of the doctor. If you can make copies for me as well.

(Short break taken)

CROSS-EXAMINATION

BY MR. McILHARGIE:

Q. Dr. Geraci, my name is Cyril McIlhargie. I'm Dr. Lissauer's attorney. And I'll be asking you a few questions.

A. Okay.

Q. In the event I should ask a question that's not clear to you, simply prompt me by asking me to repeat or rephrase it. Will you do that for me?

A. Right.

Q. Thank you. Doctor, prior to Mr. Duren's admission to Suburban Hospital in February of 1982, you already indicated that he had gone for about one year without insulin. Is that correct?

A. Yes.

Q. And during that period of time, his diabetic condition was to have been controlled by diet?

A. Yes.

Q. And during that period of time, he was apparently seen off and on by Dr. Frankel and also Dr. Beckerman, am I right?

A. Yes.

Q. Have you reviewed the notations by Drs. Frankel and Beckerman from between the time that he was released from Hillcrest Hospital and his admission to Suburban in 1982?

A. I did at one point, but I think I have them here, and I will be happy to review them again.

Q. Take your time and take a look at them.

A. Okay.

Q. Those records essentially reflect that despite the fact he had been placed on a strict diet, he had failed to adhere to that diet and had in fact, gained about 40 pounds?

MR. WHITE: Objection.

A. He was back to 294 pounds, I think. Yes.

Q. So would you agree with that statement?

A. Yes.

Q. Doctor, the symptoms of chronic diabetes longstanding that is not controlled either by diet or insulin coverage, as I understand it, would include polyuria, frequency of urination, he would

be frequently thirsty, that he would exhibit fatigue. Is there any indication that he exhibited any of those symptoms during that period of time?

A. No.

Q. Is it fair to say that there is nothing in either Dr. Frankel's notations or Dr. Beckerman's notations which would indicate that his diabetes had actually reasserted itself during that period of time?

A. Not in Dr. Frankel's. Let me look at Dr. Beckerman's. Okay. Not in Dr. Beckerman's.

Q. Nothing. So in neither doctors' office notations is there any indication that this man exhibited symptoms consistent with a reassertion of uncontrolled diabetes?

A. That's correct.

Q. At the time Mr. Duren was admitted to Suburban Hospital, the initial orders for determination of the presence of an elevated level of blood glucose was done by urine fractional and insulin curve, is that correct?

A. Yes.

Q. In addition, Dr. Lissauer also wrote orders for an SMA 12 to be completed the following morning on February 18th?

A. Yes.

Q. And that would have required that a blood glucose level be obtained at that time, is that correct?

A. That's correct. Now, I don't know how they work it at Suburban, but let me just see. I remember when I originally went over these notes, I had presumed that the way he wrote them, that a blood sugar was being ordered then with the electrolytes, usually included in the electrolytes.

Q. So as of the following morning, Dr. Lissauer would have obtained, assuming that Mr. -- assuming that he had survived?

A. Yes.

Q. But my question is by his orders, he would have obtained the following morning an SMA 12 which would have given him a fasting blood sugar on Mr. Duren, is that correct?

A. Yes.

Q. At the time that Mr. Duren was admitted to Suburban Hospital, the history and physical examination were obtained. Well, let's go to the progress note that is written by Dr. Lissauer at the time of this man's admission.

A. All right.

Q. Is there any indication in the physical that was prepared by Dr. Lissauer which would indicate that this man had symptoms consistent with uncontrolled diabetes?

A. No.

Q. Have you in your review of that chart found anything which would indicate at the time Mr. Duren was initially admitted on the afternoon of 2-17-82, that he had symptoms consistent with uncontrolled diabetes?

A. No.

Q. In fact, Doctor, the early lab studies that were obtained and reported to Dr. Lissauer at approximately 5:30 by nursing personnel indicated that there was no presence of ketones in Mr. Duren's bloodstream?

MR. KAMPINSKI: Objection.

MR. WHITE: Object.

MR. KAMPINSKI: He didn't have it until 9:00 that night.

Q. (BY MR. McILHARGIE) Okay. Fine. Would you refer to the lab study that I am looking at?

MR. KAMPINSKI: The lab study wasn't until the next day.

A. The lab study or the -- lab study or lab

sheets? His blood gas was good, so --

Q. What does that indicate?

A. That means he doesn't have any diabetic acidosis, and that would be the natural outcome of having a high blood sugar, is diabetic ketoacidosis, so he doesn't have that. His blood gas is good.

Q. As of that time. The order, according to the lab, drawn at what time?

A. It's drawn 2-17, and done at what -- 15:39. So that would be what, about 3:40 in the afternoon.

Q. Doctor, elevated blood sugar, if it is at a sufficiently high level and it's not appropriately treated, can lead to death, as I understand it, either secondary to the development of diabetic ketoacidosis or non-ketonic osmolar coma, is that correct?

A. That's correct.

Q. And so principally what appropriate insulin coverage is designed to do is to prevent the occurrence of either one of those?

A. Yes.

Q. And in this instance, according to the laboratory studies that were drawn on the afternoon of his admission to Suburban Community Hospital on

2-17-82, Mr. Duren did not have any laboratory indications of acidosis?

A. He did not have acidosis and he wasn't -- he was not hyperosmolar.

Q. In addition, Doctor, what are the signs and symptoms which are consistent with the presence of ketoacidosis?

A. Sweet breath, lethargy, sliding deeper into coma. That's the main --

Q. Lethargy, decreased activity and gradually go into coma, okay. And from the onset of those symptoms, how long would it ordinarily take for that to transpire?

A. Usually four to six hours is the usual course, I would think, of somebody starting to get hypoglycemia and then developing it. It could be much longer, but I think we are talking about the near side of what happens, probably four to six hours.

Q. You have reviewed the nursing notations and the progress notes with reference to Mr. Duren's hospitalization at Suburban?

A. Yes.

Q. Is it fair to say that there is no indication that this man exhibited symptoms of

lethargy, decreased activity or coma prior to his death on 2-18?

A. His symptoms were restlessness.

Q. Okay. In fact, it was hyperactivity?

A. Right.

Q. And restlessness. Which is the opposite of lethargy and decreased activity, isn't it?

A. Yes.

Q. And again there was no indication anywhere on the chart that this man ever wene into a coma?

A. No.

Q. Whether secondary to ketoacidosis or secondary to osmolar non-ketonic coma?

A. That's correct.

Q. Then can you say, do you have an opinion then, sir, in probability whether or not this man's death was in fact the result of either ketoacidosis or non-ketonic osmolar coma?

A. I don't think it was either. I think something else had occurred or something in relation to his pancreatitis occurred rather than just a complication of his diabetes.

Q. So basically, for the sake of clarity, if I understand your opinion, it's that elevated blood

sugar was not the proximate cause of John Duren'S death?

MR. KAMPINSKI: Objection.

A. That's right.

Q. (BY MR. McILHARGIE) And you base that opinion on a reasonable degree of medical certainty?

A. I do. And I base that on mainly the pH of blood obtained at that time ruling out a diabetic ketoacidosis.

MR. KAMPINSKI: At which time?

A. On admission, right.

Q. As well as the clinical findings on the nurses' notations?

A. Right.

Q. With reference to the way --

A. That's correct.

Q. -- the circumstances leading to his death?

A. Yes. Yes. The general course of this is not that of a diabetic complication. Granted, it would be much cleaner to have some other data, but the general course of his fairly sudden development of an acute process rules against the first item of differential diagnosis being any ketoacidosis.

I would think in in terms something like pulmonary system, volume related, something cardiac,

and all of these could be occurring in a dynamic setting of pancreatitis.

Q. Would it be fair to say that even if we assume that the 20 units of insulin were not in fact administered by the nurses to John Duren as required by Dr. Lissauer's orders, that even if we assume that that took place, in other words, that they failed to administer it, that that was not the proximate cause of this man's death?

A. Yes.

Q. And likewise, assuming any omission on the part of Dr. Lissauer to appropriately order blood glucose levels, that omission would not have been the proximate cause of this man's death?

A. That's correct.

Q. And the basis for that opinion is, as you have already indicated, with reference to why you feel this man's death was not caused secondary to either ketoacidosis or osmolar coma?

A. That's right.

Q. Doctor, do you have an opinion based upon a reasonable degree of medical certainty in your field of specialization, and as a physician, as to John Duren's life expectancy as of January, 1982 prior to his admission to Suburban Hospital?

MR. KAMPINSKI: Objection.

Q. (BY MR. McILHARGIE) First of all, do you have an opinion?

MR. KAMPINSKI: Objection.

Q. Sir, just say yes or no.

A. Yes, I do.

Q. And what is that opinion?

MR. KAMPINSKI: Objection.

A. My opinion is it wasn't very good.

Q. Would you state that with greater specificity?

MR. KAMPINSKI: Objection.

A. Looking at Mr. Duren's general physical condition, it was one of poor health to begin with starting with his obesity to a very severe degree.

Q. Could you indicate in years, sir, what his life expectancy was in your opinion as of January 1982?

MR. KAMPINSKI: Objection.

A. I would be surprised in my opinion to see him live five years. I would give -- if you wanted figures, I would say zero to five percent as a percentage of probability that he would be around five years from that time.

MR. KAMPINSKI: Objection. Move

to strike.

Q. And the basis for that opinion, sir?

MR. KAMPINSKI: Objection.

A. The basis is poor general health prior to his hospitalization.

Q. Which included?

MR. KAMPINSKI: Objection.

MR. WHITE: Objection.

A. Which included obesity, hypertension, abnormal blood lipids, diabetes, high blood pressure, presence in the past of congestive heart failure. I think also we could add he has shown in the past he cannot sustain compliance to a medical regimen that is prescribed by his physician.

MR. WHITE: Objection. Move to strike.

Q. (BY MR. McILHARGIE) Doctor, that was demonstrated time and again from 1977 until his hospitalization in 1982, wasn't it?

A. It was documented well by the medical records of his physician.

MR. KAMPINSKI: Objection.

Q. (BY MR. McILHARGIE) He had been placed on a regimen of diet in 1977 when he was in Virginia, wasn't he?

A. Yes.

Q. And despite that, he continued to gain weight and his diabetic condition reasserted itself, didn't it?

A. Yes.

Q. And following his hospitalization in St. Luke's, he was again placed on a very strict low carbohydrate diet, wasn't he?

A. I presume he was. I haven't -- Though I haven't reviewed those records, I presume.

MR. KAMPINSKI: Well then, I object and ask that it be stricken. Don't presume anything, Doctor.

Q. (BY MR. McILHARGIE) That's fine. Doctor, we will show you.

MR. McILHARGIE: Off the record.

(A discussion was had off the record)

Q. (BY MR. McILHARGIE) Doctor, I ask you to refer to the dietary note of 9-29-78 from the St. Luke's Hospital chart of his admission from September 23, 1978 through September 30, 1978.

A. He was prescribed a diet for weight reduction and for diabetic control and also to hopefully stabilize his tendency towards

pancreatitis.

Q. Doctor, is there further an indication that he was classified dietitian at that time?

A. Yes.

Q. And discussions with his wife suggesting that she had been after him to try and lose weight time and time again and that he had been unsuccessful time and again?

A. That's correct. On follow up on his return to his private physician, he again was unable to sustain a reasonable weight loss.

Q. That's following his release from the hospital at St. Luke's in September of 1978?

A. That's correct.

Q. And according to the office records of Dr. Beckerman?

A. Yes.

Q. And again, following his release from Hillcrest Hospital, he was again put on a very strict diet.

A. That's correct.

Q. That was again a similar diet to what he had been placed on at St. Luke's, a low carbohydrate diet?

A. That's right.

Q. And in your opinion did he adhere to that diet?

A. No, he didn't. Not in any sustained manner.

MR. McILHARGIE: I don't have any questions at this point.

FURTHER CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Doctor, has the treatment for congestive heart failure changed since 1971?

A. No.

Q. Same treatment?

A. Yes.

Q. Have there been more --

MR. McILHARGIE: I'm going to object to this line of questioning.

Q. (BY MR. KAMPINSKI) Have there been more recent studies with respect to the mortality rate of someone having a single incident of acute congestive heart failure?

A. Not that I know of. Not that I know of.

Q. Is the underlying basis for congestive heart failure very often hypertension?

A. Yes.

Q. And was Mr. Duren being treated for

hypertension?

A. In a way, yes.

Q. Well, wasn't he receiving medication for it?

A. No. But I think he was receiving other things, including diet.

Q. It's your testimony that he was not receiving medication for hypertension, is that right, sir?

MR. McILHARGIE: Objection. At what point in time?

A. He was receiving care for hypertension.

Q. My question is was he receiving care for hypertension in the year 1982, sir?

MR. McILHARGIE: Objection.

A. In the year 1982, no.

Q. If I understand you correctly, you believe that there were a number of factors, including pulmonary congestion possibly, and some heart failure that was exhibiting itself in the early morning, late evening of February 17th and February 18th?

A. The symptoms that Mr. Duren had were non-specific. He was having respiratory problems, and the number of things that could lead to that

are quite numerous.

Q. Isn't one of them, by the way, elevated blood sugar?

A. No. Dyspnea, yes, but not labored respirations like he was having. To try to piece together what happened is, as you said, impossible because we don't have a post. A list of sudden events which could happen just like that include, in the setting of pancreatitis --

Q. Please allow me to stop you, Doctor. Because that's the second time you mentioned sudden. And correct me if I'm wrong, but from 10:00 until 7:00 is nine hours, is that correct?

A. That's -- in relative terms, that's sudden.

Q. Okay.

A. When we look at the nurses' notes, he suddenly became short of breath. It wasn't like he came into the hospital after days of being dyspneic.

Q. That was by 10:00?

A. That's right. Now, you wanted to know what caused it and I can't tell you that it was congestive failure as opposed to a problem with his pancreatitis as opposed to a pulmonary embolism as opposed to any number of things.

Q. Whatever it was, it wasn't addressed. Would that be fair?

MR. McILHARGIE: Objection.

A. That would be fair to say, that it was not addressed.

Q. (BY MR. KAMPINSKI) All right. And therefore, there is no way that you can sit here and say that had it been addressed, he would still have not survived that particular incident on that evening, is there, sir?

A. He might have. He might not have.

Q. But you can't say one way or another, can you?

A. I can say that, knowing his general condition, that he was at a poor risk to see it through.

Q. Well, that's really a different question, I think, than what I asked you. I'm talking --

A. If you were asking whether he would make it through the night, I would say that he may have made it through the night if he had received appropriate --

Q. Medical care?

A. -- monitoring. But to say that he would have made it out of the hospital, I can't say.

Q. Can't say that he wouldn't have?

A. I can't say either way. I don't see how anybody could.

Q. Sure.

A. But except I think th odds were stacked against him.

Q. That's your opinion?

A. That's my medical opinion.

Q. As opposed to Dr. Shapiro's?

A. That's my medical opinion. I'm not -- Dr. Shapiro is not a gastroenterologist.

Q. He is an endocrinologist and internal medicine.

A. Oh.

Q. Does that make him something different than yourself in terms of being able to offer an opinion as to whether this man would have survived?

A. As far as pancreatitis, yes. I don't think he sees too many cases of that in the course of his --

Q. How many cases of diabetes do you see?

A. I see very many.

Q. You are qualified to talk about that then?

A. Yes. Sure, I am.

Q. But he is not qualified to talk about it.

Is that what you are saying?

A. I don't know how many cases he sees.

Q. Are you saying he is not qualified to talk about pancreatitis, sir? Do you know one way or the other?

A. I am saying that I am very happy to hear his opinion, but as far as my value in it, I wish you wouldn't quote him, because I am not going to take him as any authority on pancreatitis. I don't know of any endocrinologist in the world that's a --

Q. Do you know Dr. Shapiro?

A. I have never read anything by him on pancreatitis.

Q. How many articles have you written?

A. I have written two -- I have written one article.

Q. What is it?

A. It's pancreatitis.

Q. What's the name the article, where is it, and when was it written?

A. It was written in 19 -- Let me get the date here. The date would probably be 1979 or 1980. It's in Medicine 19 -- Medicine 1980, I guess is the name of the --

Q. Publication?

MR. MURPHY: Let him finish the answer.

A. The monograph.

Q. Monograph?

A. Right.

Q. Who publishes that?

A. Case Western Reserve University.

Q. And the name of publication is Medicine 1980?

A. Yes. I think it's in 1980. '79 or '80.

Q. Do you have a copy?

A. Not on me. I have one.

Q. Can you provide that to Mr. Murphy along with your CV?

A. Certainly.

Q. Any other articles?

MR. MURPHY: On pancreatitis?

Q. (BY MR. KAMPINSKI) Yes. Sure.

A. I have given speeches around the country. I was out in Montana speaking on it and in New York City speaking on it.

Q. How many articles have you written on other things, Doctor?

A. That will be in my CV. I have written two or three other articles on gastroenterology

related topics.

Q. Doctor, if I understood what you indicated earlier in response to Mr. McIlhargie's questions, you said something about -- and this is what my previous question was direct to -- about heart failure and pulmonary distress that morning. I think that's what you said. That that's what you believe ultimately led to his demise?

A. I think something led to his pulmonary distress. I don't think I said heart failure. But I would have to check. I'm sure, although I have been --

Q. Well, wouldn't you anticipate that congestive heart failure would have occurred given all these circumstances that evening?

A. Can't say. Can't say without a post.

Q. The EKG that was ordered, you are sitting here in hindsight looking back at --

A. Aren't we all?

Q. -- Mr. Duren's records going back to 1977. That information was available, I take it, to Dr. Lissauer because he had in fact treated him, as had his group, in 1982?

MR. McILHARGIE: Objection to the assumption.

Q. (BY MR. KAMPINSKI) Correct? Correct, sir?

MR. McILHARGIE: Object to the assumption.

A. Right.

Q. (BY MR. KAMPINSKI) Shouldn't he have inquired further into the potential of cardiac involvement on the part of Mr. Duren that evening?

MR. McILHARGIE: Objection. You have already been over this. And it wasn't an area of inquiry on cross.

A. On Dr. Lissauer's initial assessment when he examined the patient, there were no signs of precipitating congestive failure. His lungs were clear.

Q. Yes.

A. His heart was fine.

Q. What about the prominent --

A. So he did address the EKG.

Q. What about the left prominence in the ventricle?

A. Doesn't necessarily require treatment if there is no pulmonary congestion at the time.

Q. I see.

A. And in fact, the diuretic in the presence

of pancreatitis can be a precipitating agent.

Q. Well, don't you have to balance depending upon what condition is most life threatening at the particular time to the patient?

A. Dr. Lissauer listened to the lungs. The lungs were clear. I don't think there was a necessity for a diuretic when he examined him.

Q. Was the oxygen that he prescribed sufficient to take care of the respiratory distress that Mr. Duren was having that evening?

MR. McILHARGIE: Objection. At what point in time?

A. Yes.

Q. It was?

A. Yes.

Q. How do you know that?

A. Two liters a minute, I think anything -- taking the situation again, the very critical underlying health of Mr. Duren, he was at a risk for going any higher with oxygen because of his massive obesity. And because of that, we could have thrown him, or the doctor could have thrown him, into a respiratory arrest just from pure oxygen. There is a mechanism involved there. Somebody who is obese --

Q. Yes.

A. -- and is given oxygen, the only thing that drives this man to breathe at that time is his hypoxia. By giving a good dose of oxygen, say eight liters, ten liters, that wipes out the hypoxia drive. He slows down his breathing, accumulates carbon dioxide, and goes into acidosis or an arrest.

So I think he's -- I think that oxygen had to be given to this man, but I think it also has to be considered a drug and possibly a toxic drug in an obese individual. You are damned if you do and damned if you don't.

Q. Well then, don't you really have to follow it up to see how he takes it?

A. You do and you don't. I think in a low flow you are safe.

Q. Safe which way? From ever being questioned about what you did?

MR. McILHARGIE: Objection.

MR. MURPHY: Objection.

A. Safe because we don't have blood gases that were given. He was not in respiratory insufficiency, so it was safe to give oxygen in a low dose. And the low dose was reasonable enough

because of his being obese and the high dose would have polished him off.

Q. You have now referred to his extreme poor health and poor health, at least by my count, ten times throughout the this deposition. Why wasn't he in Intensive Care?

MR. McILHARGIE: Objection.

A. I think that's a question of judgment. When Dr. Lissauer saw him, I think looking at Dr. Lissauer's chart, there was nothing to site immediate admission to Intensive Care based on his cardiovascular status.

Q. Should he have been in Intensive Care later on that evening?

A. Yes.

Q. What time?

A. Between nine and ten o'clock.

Q. Is it likely he would have survived if he could have been?

A. Survived the night? I can't say. Survived the hospitalization? Possibly not.

Q. And I take it your opinion, once you had seen the 1977 Bedford Community Hospital record in Virginia, was that at that time he had a five-year survival rate, give or take zero to five percent,

right?

A. At that time of the first attack of pancreatitis, he'd probably had a better chance. He was a little younger. But I think in the basis of his other findings, I would say he was a poor risk then, too.

Q. So he surprised you just by living as long as he did, didn't he?

A. He surprised me to some degree.

Q. And if I understand your responses to Mr. McIlhargie's questions correctly, it's your opinion that he killed himself?

A. I didn't say that. I said -- I don't want to be harsh on the man for dying.

Q. But you do want to be kind on the doctor for not ordering the appropriate tests?

MR. McILHARGIE: Objection.

MR. MURPHY: Objection. You don't have to answer that question.

A. I think I better make it clear to you that in my medical opinion, the man did not die because somebody did not order a blood test or somebody did not institute management, basically, a blood test. He died because he had a bad disease.

Q. He died because he was neglected that

night, didn't he?

A. More than likely he would have died despite medical management.

Q. Well, he didn't receive any medical management, so we don't know.

MR. MURPHY: Objection.

A. Yes, we do. I think based on the substrate of Mr. Duren, we can say that he wasn't in the best of shape.

Q. Well, speak for yourself when you say we. You are saying --

A. I am saying --

Q. -- it's your opinion?

A. It's my medical opinion.

Q. Okay.

A. This man was in terrible physical condition.

Q. And you don't think he should have been in Intensive Care despite that, right?

A. Oh, I think he should have at one point, but I don't know whether that would have altered his survival, getting out of the hospital. I doubt that it would have.

Q. The only reason we don't know that, the only reason we are here is because of the failure

to adequately manage it. In other words, you sit here and say in your opinion he wouldn't have made it anyhow, but there were facts that we can deal with as opposed to opinion, isn't there?

MR. MURPHY: Objection.

Q. Those facts, Doctor, are that he didn't receive appropriate medical management that night.

MR. MURPHY: Objection.

A. The other, he had a high blood sugar, he had a high blood glucose, and the fact that he was obese --

Q. They didn't treat that --

A. He has to treat himself at one point.

Q. -- in the hospital --

A. It is a principle of a man who is a poor compliant personality. At some point you have to quit pulling him by nose and say, "Look, buddy, you are going to have to start taking care of yourself. Knock off that two hundred pounds."

Q. Let's deal with what happened at the hospital.

A. In the hospital the man's disease caught up with him.

Q. Regardless of any management?

A. Regardless of blood sugar.

Q. Regardless of the failure to report the vital signs?

A. An acute event happened in the hospital --

Q. Yes or no. Regardless --

A. -- that probably killed him.

Q. Regardless of failure to report the vital signs, right?

A. How do we know there is a failure to report the vitals signs?

Q. I'm telling you there is. Let's assume there is. Let's assume Nurse Springborn testified that she was never made aware of the vital signs and had she been aware, she would have notified a doctor.

A. I don't understand your question. Is that a question? What's your question?

Q. It's your opinion that he would have died even had she notified a doctor that he had abnormal vital signs at 10:00, right?

A. Yes.

Q. It's your opinion that he would have died even if he didn't get his insulin, right?

A. Yes.

Q. And it's your opinion that he would have died that night or in that hospital --

A. Not that night.

Q. -- in that hospital stay, even if the doctor had ordered blood sugar and seen his sugar extremely elevated and that condition was tended to?

MR. McILHARGIE: Objection.

MR. MURPHY: Objection.

Q. (BY MR. KAMPINSKI) Is that correct?

A. Yes.

Q. And it's your opinion that he would have died even if he didn't receive the insulin at 10:00 that night, is that correct?

A. You said that. Yes.

Q. Okay. And it's your opinion that he would have died at that hospital stay even if he had been put in Intensive Care, is that correct?

A. I'd say given this man's general poor health, it was a reasonable probability that he would have not made it out of that hospital.

Q. And it's your opinion that he would have died even if the house officer would have arrived within four minutes as opposed to an hour and 53 minutes after he was called, is that correct?

A. I think your watch --

Q. Yes or no, sir?

A. Yes.

Q. And it's your opinion that he would have died even if vital signs would have been taken at two a.m., is that correct, sir?

A. Yes.

Q. And it's your opinion that he would have died even if the first shift had told the second shift of the abnormal vital signs, is that correct, sir?

A. That's correct.

Q. And it's your opinion that he would have died even if he had been placed in the Intensive Care Unit between nine and ten o'clock?

A. Yes. That his disease was -- his general physical condition was poor enough --

Q. Sure.

A. -- and his pancreatitis --

Q. Sure.

A. -- documented when he came in the hospital, was enough of an insult that he may well have died during that hospitalization.

Q. So he should have just stayed home, right?

A. No.

MR. KAMPINSKI: That's all.

MR. McILHARGIE: I will object and move to strike the last comment.

MR. KAMPINSKI: I just have one further thing. I'm sorry.

Q. (BY MR. KAMPINSKI) You were retained by Mr. Murphy to testify in this case?

A. That's correct.

Q. Do you plan to be present at the arbitration hearing, sir?

A. No.

Q. How much are you being paid for your testimony in this case or your opinion?

MR. McILHARGIE: Objection. He is not being paid for his testimony. For his professional time.

A. For my time I really have to reach an opinion. Probably $150 an hour.

Q. You haven't even charged him yet, Mr. Murphy?

A. I sent him one bill.

Q. How much was it?

A. $150.

Q. One hour?

A. One hour.

Q. That's the amount of time you put into it case?

A. I haven't sent him the bill yet.

Q. When did you send that bill, sir?

A. I sent that bill when I -- Let me see. Before this, probably last week.

MR. KAMPINSKI: Could I see a copy of that, Mr. Murphy?

MR. MURPHY: I haven't seen it yet.

MR. KAMPINSKI: Are you going to provide Mr. Murphy a copy of that with your CV and articles?

A. It should be in the mail.

Q. I'd like to see a copy.

MR. McILHARGIE: I assume nobody else has any questions and this marks the end of the deposition.

I have read the foregoing transcript from page 1 to page 125 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

_____
KEVIN GERACI, M.D.

Subscribed and sworn to before me this day of , 1984.

_____
Notary Public

My Commission Expires:

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

I, Sandra L. Price, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that KEVIN GERACI, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotypy and was subsequently transcribed into typewriting by means of computer *3*ided transcription under my direction; that said deposition was taken at the time and place aforesaid pursuant to notice; that the reading and signing of the deposition by the witness were expressly waived; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 24th day of February, 1984.

Sandra L. Price

Sandra L. Price, RPR, Notary Public
Within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: January 7, 1989.