IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

TRACY ANN SMITH, Admin., etc., * Case No. : 327823
Plaintiff
* November 4, 1999

vs. *

UNIVERSITY HOSPITALS OF CLEVELAND, *
et al
*

Defendants

* * * * *

Deposition of THOMAS E HOBBINS, M.D., taken on behalf of the Plaintiff, before Lorne Langer, a Notary Public in and for the State of Maryland, County of Baltimore, at 6701 N. Charles St., Conference Room 4, Baltimore, Maryland 21204, at 2:44 p.m., November 4, 1999.

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APPEARANCES:

JEANNE M. TOSTI, Esquire
On behalf of Plaintiff

KRIS H. TREU, Esquire
On behalf of Defendant

Reported By:
Lorne Langer

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T H Θ M A S E. H Θ B B I N S, M.D., called as a witness, and after having duly affirmed, testified as follows:

EXAMINATION BY MS. TOSTI:

MS. TOSTI: Before we get started, let the record show that this deposition is being taken pursuant to Ohio rules of civil procedure. This is a discovery deposition under Ohio civil rules and under cross-examination, to elicit opinions held by Dr. Hobbins relative to this case.

As this deposition is being taken by agreement of the parties, can I have a stipulation from defense counsel that any notice, service, or the use of a Maryland court reporter is waived?

MR. TREU: Sure.

Q. Doctor, would you please state your full name.

A. Thomas Eben Hobbins.

Q. And your business address?

A. 6701 North Charles St, Baltimore, Maryland 21204, Suite 4100.

Q. Have you ever had your deposition taken before?

A. Yes.

Q. I want to go through a few of the ground rules. I'm sure counsel has had a chance to talk to you. This is a question and answer session. It's under oath. You have taken an affirmation. It's important that you understand the questions that I ask you. If you don't understand them, just tell me, and I will be happy to repeat them or rephrase them. Otherwise, I will assume that you understood my questions and you are able to answer them.

It's important that you give all of your answers verbally, because the court reporter can't take down head nods or hand motions. If at some point you would like to look at the file or review some records that you have available to you, feel free to do so. This isn't a memory test at all.

At some point, Mr. Treu may choose to enter an objection. You are still required to answer my questions unless he tells you not to. Do you understand those instructions?

A. Yes.

Q. Now, Doctor, did you bring your complete file in

this case with you?

A. Yes.

Q. I would like to take an opportunity to look through that now.

A. Certainly.

MR. TREU: Except for the sleep study.

A. Yes. A one-thousand page record I didn't carry.

Q. Let the record show that the documents that are in Dr. Hobbins' file is a single piece of paper with the title "Maryland Sleep Disorder Center," with some handwritten notes, a copy of Dr. Hobbins' report dated May 20th of 1999, the data collection sheets from the overnight polysonogram, with polysonogram final report, a group of records that appear to be from The University Sleep Center, expert reports from plaintiff's experts, Dr. Meister, Dr. Pelayo and Dr. Sutherland, the deposition of Dr. Brooks, the deposition of Dr. Michael Rowane, autopsy report of Patricia Smith, the deposition of Dr. Collins, the deposition of Dr. Martin, office records of Dr. Rowane, Collins and Hlavin, regarding Patricia Ann Smith, in a bound condition, and office records of -- I'm sorry.

Medical records of Patricia Smith from University Hospitals of Cleveland. I return those to you, Doctor.

A. Thank you.

Q. Doctor, has anything been removed from the file that I just reviewed?

A. No. Other than the thousand pages of sleep recording.

MR. TREU: And our correspondence.

Q. Were you provided with any fax summaries or time lines on this case?

A. No. Not to my knowledge. All I have is what is here. I don't remember anything else.

Q. Did you receive any deposition summaries?

A. No.

Q. Have you provided any bills to Mr. Treu or Mr. Treu's office?

A. No.

Q. Doctor, I would like you to tell me a little bit about your experience in medical-legal matters. When was the first time that you offered your service as an expert medical-legal consultant?

A. Probably 1984 or so.

Q. And how many medical-legal matters have you consulted on?

A. Hundreds.

Q. How many have you consulted on in the last year?

A. Just this one.

Q. So is this the only file that you currently have in your possession?

A. Yes.

Q. What proportion of the medical-legal matters on which you consulted have been for plaintiff, and what proportion have been for the defendant?

A. 95 percent have been plaintiff.

Q. The other five percent are defendant, I assume.

A. Yes.

Q. On cases in which you consulted by plaintiff, how many times have you found substandard care?

A. Say again, please.

Q. In the number of cases that you have consulted for plaintiffs, how many times have you found substandard care for a percentage of times?

A. I must say these were plaintiff actions on product liability, namely asbestos and other noxious, toxic elements.

Q. Let me refine my question a little bit. How many times have you consulted in a medical malpractice case against a hospital or a doctor?

A. Maybe ten times.

Q. Of the ones that you have been consulted on in regard to a medical malpractice case against a hospital or a doctor, what proportion have you done for plaintiff and what proportion have you done for defendant?

A. I think it's probably one-hundred percent for defendant.

Q. How many times have you had your deposition taken as an expert and in a medical malpractice case?

A. Maybe twice.

Q. Have you ever given trial testimony in a medical malpractice case?

A. No.

Q. Have you given trial testimony in the product liability cases that you were consulted on?

A. Yes.

Q. And have you also had your deposition taken in those cases?

A. Yes.

Q. How many times, approximately?

A. Too many to count.

Q. Have you ever been consulted in a case where the allegations had to do with mismanagement o substandard care of a patient that had obstructive sleep apnea, other than this case?

A. No.

Q. What is your charge for consultation on legal matters?

A. $300 an hour.

Q. Is it the same for depositions?

A. Yes.

Q. Now, Doctor, are you currently consulting on product liability cases? Do you have some cases that are currently pending?

A. No.

Q. Forgive me if I asked you this. In regard to the

medical malpractice cases that you have been consulted on as an expert, did you tell me that you did or didn't ever give trial testimony?

A. I never gave testimony in trial.

Q. Okay. Do you provide your name to any professional services or any medical-legal consulting firms, indicating that you are available to do medical-legal reviews for a fee?

A. No.

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

A. No.

Q. Have you ever worked with Mr. Treu or Miss Cuthbertson prior to this case?

A. Not to my knowledge.

Q. Do you know how it is that Mr. Treu's office came to contact you regarding this case?

A. No.

Q. When were you first contacted?

A. May 1999.

Q. Who was it that contacted you?
A. Miss Cuthbertson.
Q. Have you ever been named as a defendant in a medical negligence case?
A. Yes.
Q. When was that? First off, let me ask, how many times?
A. Once.
Q. Okay. When was that, approximately?
A. Approximately 1984.
Q. Where was that case filed?
A. In Maryland.
Q. What was the allegation of negligence in that case?
A. The allegation was that I ordered amino acids by IV improperly.
Q. How was that case resolved?
A. The case was settled by all the other defendants, and they closed the case.
Q. Was your deposition taken in that case?
A. Yes.

Q. Do you recall the name of the plaintiff in the case?

A. No, but I can look it up. It's a Polish name. It's not easy to remember.

Q. Would you do that and tell Mr. Treu so that he can convey that to me?

A. Sure.

MS. TOSTI: Now, Doctor, Mr. Treu provided me with a copy of your curriculum vitae, and I'm going to ask if the court reporter would mark this as Plaintiff's Exhibit 1.

(Hobbins Deposition Exhibit No. 1 was marked by the reporter.)

Q. If you would look at it and identify it for us for the record,

A. My curriculum vitae.

Q. Okay. Is that -- I would like you to look it over and tell me if it is current and up to date and if there are any additions and corrections that you would like to make to it.

A. I'd say it's current. No corrections.

Q. Have you authored or co-authored any medical journal articles on the subject of sleep apnea?

A. No.

Q. Have you had any publications? I don't see any on your curriculum vitae.

A. I have about 12. They are on the subject of medical education and lung disease.

Q. Do you have anything currently pending in publication on the subject of sleep apnea?

A. No.

Q. Any of the publications that you have, do you consider any of those to have relevancy to this case?

A. No.

Q. What is the area of medicine in which you currently practice?

A. Sleep disorders in medicine.

Q. Are you board certified in a medical specialty?

A. Yes.

Q. Could you please tell me what areas you are board certified in?

A. I'm certified by the American Board of Sleep

Medicine, the American Board of Internal Medicine and by the subspecialty of pulmonary diseases.

Q. Did each of those certifications require a test in order to obtain the certification?

A. Yes.

Q. Did you pass those on the first try?

A. I passed the medicine one and the pulmonary one on the first try and I passed the sleep one on the second try.

Q. When did you obtain your board certification in sleep medicine?

A. 1990.

Q. Who is your present employer?

A. I'm self-employed.

Q. Do you have any associates in your practice?

A. I'm the only physician. Wait a minute. I just -- I -- yes. I have a pediatrician who just joined me to practice in the sleep --

Q. How is it that you receive reimbursement for your services? **Do** you bill the patients directly?

A. I bill patients directly for the consultations and I bill the sleep laboratory for the interpretations of the

sleep records.

Q. Do you provide your services for any entity other than your own medical practice?

A. No.

Q. Now, Doctor, would you tell me what titles and positions you currently hold?

A. Well, I'm the medical director of the Maryland Sleep Disorder Center. That's the only one that pays. I have other jobs I do in nongovernmental organizations. Are you interested in those?

Q. On your vitae, it says, "Director, sleep disorders, laboratory, 1974 to 1985." Now, are you saying there is another appointment that you have?

A. In those years, I was the director of the sleep laboratory, University of Maryland Hospital. In 1985, I left the university to come out here to Towson to start my own laboratory.

Q. Under your current appointments on your curriculum vitae, I would like you to take a look at it.

A. Uh-huh.

Q. I don't see listed "medical director of Maryland

Sleep Disorder Center." Now, is that an additional appointment that just isn't on your curriculum vitae?

A. Correct.

Q. Okay. In regard to your position as medical director of the Maryland Sleep Disorder Center, do they pay you a salary for that position?

A. I am paid by the Maryland Sleep Disorder Center for services rendered.

Q. It's for services? It's not for your position as director of the Medical Sleep Disorder Center?

A. Correct.

Q. The title --

A. Let me correct that.

Q. It's the Maryland Sleep Disorder Center?

A. Yes.

Q. Okay. Go ahead, Doctor.

A. At the end of the year, if there is a profit, as a part owner of the entity, I get some money that is not directly related to services, but as my share of the profit.

Q. So you are part owner of the Maryland Sleep

Disorder Center?

A. Correct.

Q. What percentage of the Sleep Disorders Center do you own?

A. 55 percent.

Q. You have other partners in the center?

A. Yes.

Q. How many other partners?

A. One.

Q. Is the majority of your income generated through the services that you provide at that center?

A. Yes.

MR. TREU: Objection. It's really not relevant.

Q. Now, Doctor, outside of the Maryland Sleep Disorder Center, do you have any other practice? I know that you have a background in pulmonology, Do you see patients in the office aside from the Maryland Sleep Disorder Center? Do you maintain another office?

A. No. I have three separate sleep laboratories that are run by the Maryland Sleep Disorder Center. I do not practice lung disease or internal medicine any longer. I

do not have other offices where I go to. The services other than those in the sleep laboratories.

Q. The Maryland Sleep Disorder Center, are all of them under the same title, or do they have different names?

A. They are under the same title.

Q. Are they all located in this area in Baltimore?

A. They are in Baltimore County or Harford County, Maryland.

Q. Doctor, you also have listed on your curriculum vitae the University of Maryland clinical associate professor. Are you still a clinical associate professor at the University of Maryland?

A. Yes.

Q. What duties and responsibilities do you have there?

A. I teach university medical students who come here to work with me. I teach house officers and fellows as well who come to study with me.

Q. Do you have any duties at the university in regard to lecture in classroom, or is it clinical supervision of these individuals?

A. It's clinical supervision.

Q. You also have listed that you are an attending physician at Greater Baltimore Medical Center, Baltimore, Maryland. Could you tell me what your duties and responsibilities are as an attending physician?

A. I am able to admit patients, but I don't.

Q. You have, "Consultant in pulmonary diseases, Fallston General Hospital."

A. Yes.

Q. Could you tell me what you do in regard to that appointment?

A. Pay annual dues.

Q. Do you actually do medical consulting at Fallston?

A. No.

Q. In regard to your duties and responsibilities with the Maryland Sleep Disorder Center, could you describe for me what it is that you do?

A. I see patients in consultation who have complaints about their sleep or awake troubles, and I interpret tests performed on some of those patients, treating others who aren't tested, as needed. In addition, I train employees

of the laboratory and provide supervision and management services.

Q. How much -- it sounds like a hundred percent of your time is spent either in the clinical area or in your teaching capacity, Is that fair? Do you have any other responsibilities beyond what you described for me, your clinical and the educational endeavors that you have with the house officers and medical students?

A. All the other jobs I have are volunteer jobs.

Q. As far as your professional time, is there anything else that you are involved with other than what you already described for me?

A. Well, there are other professional duties I do as a volunteer.

Q. Do you have any administration positions that you hold that require time out of your daily or weekly time?

A. Yes.

Q. What administrative positions do you hold?

A. I'm president of the national group of physicians known as Physicians with Social Responsibility.

Q. What type of group is that?

A. A group of about sixteen thousand physicians who are concerned with reducing the risk from nuclear weapons, working for a sustainable healthful environment and decreasing interpersonal violence.

Q. Doctor, I would like you to describe what your typical schedule is in a day or, if it's different from Monday to Tuesday, describe for me what you usually end up doing over the course of a week.

A. I usually see about eight new patients -- scratch that. I usually see six new patients a day and see two patients in follow-up, patients I have seen before, in a typical day. Some days, like the first day of the month, I don't see any patients. I just pay bills. There are several half days, maybe two half days per week, where I don't have any patients scheduled. I just interpret the sleep tests and answer the phones.

Q. The patients that you see at the Maryland Sleep Disorder Center, are all these patients experiencing or are thought to be having a problem with sleep disorders?

A. Yes.

Q. You don't see any pulmonary patients that are

strictly pulmonary without a sleep problem involved, do you?

A. I see only patients with sleep concerns.

Q. That have been referred because of a concern with sleep disorders?

A. Correct.

Q. The patients that you see, are they all adult patients?

A. No.

Q. Can you give me a breakdown as to the proportion that are adult as opposed to children, or infants?

A. I'd say 95 percent are aged 20 or greater. Five percent are 19 or less.

Q. Are you currently involved in any research projects related to sleep disorders?

A. No.

Q. Have you ever been involved in any research dealing with sleep apnea in adult patients?

A. No.

Q. Now, Doctor, in regard to your training, could you describe for me the training that you had specifically in

regard to sleep disorders?

A. I attended meetings of the American Sleep Disorders Association every year and went to other lectures on sleep. I studied on my own. I failed the test by one point. So then I went to Stanford School of Sleep Medicine and passed the test the next year with flying colors.

Q. Doctor, your **CV** does indicate that -- I believe that you attended some type of postgraduate course at Stanford. Could you tell me a little bit about that course?

A. The course was about two weeks in duration. It was a course with three or four lectures a day, and with many adjudicated sleep recordings, so that when a learner wasn't busy in a lecture, that learner could be busy interpreting or data-reducing sleep records that are adjudicated. The standard of truth.

Q. Who was the instructor for the course, or the preceptor?

A. There were so many different lecturers, I can't identify any one who was in charge. Sharon Keenan -- K-E-E-N-A-N -- was the staff -- chief of staff of the

course.

Q. The course was taught by a variety of different people?

A. Yes.

Q. Now, Doctor, in your responsibilities -- I'm just going to refer to the sleep center. Do you do actual sleep evaluations with the patients, where you take a history and do the physical exam and collect data on the patient, in addition to evaluating the polysonograms or other sleep tests that they might have done?

A. Yes.

Q. In other words, you take the patient and do the complete analysis on the patient?

A. Yes.

Q. How many sleep studies are done in the Maryland Sleep Center? There is one center at this hospital, is that correct?

A. Correct.

Q. How many are done at the center that is at this hospital in a week's time? How many polysonograms?

A. 14.

Q. And you indicated that you had two other centers, is that correct?

A. Yes.

Q. In regard to the size of those three centers, how many, I guess, sleep bedrooms does each one of those centers have?

A. Each of the other two laboratories has two bedrooms.

Q. How many are at this facility here at Baltimore Medical Center?

A. Two.

Q. Are the sleep centers staffed by additional physicians besides yourself?

A. (No verbal response.)

Q. Well, let me rephrase that if that's difficult. Is there anyone else who is evaluating overnight polysonograms, other than yourself, at the three centers?

A. There is nobody else who is geographically assigned to any of the centers. There is a pediatrician who has just joined me to start doing the pediatric work at all three centers, while I do the adult patient work at all

three centers.

Q. That individual will be reading polysonograms for the pediatric clients?

A. Yes.

Q. At this point, or up until the point where this pediatrician was hired, were you doing all the evaluations of the sleep studies?

A. Yes.

Q. Doctor, are your three sleep centers accredited training programs in sleep medicine?

A. No.

Q. Do you have facilities for doing portable sleep studies at any of these three centers?

A. No.

Q. Is the Maryland Sleep Center an accredited sleep center?

A. Yes.

Q. When I say that, are all three under one accreditation?

A. No. Just the headquarters is under one accreditation. It is fully accredited.

Q. I'm not sure how this works, but the other two centers that you have, do they fall under the main centers of accreditation, or are they unaccredited?

A. They -- with respect to the accreditation, they are not accredited. They have not been evaluated for accreditation. There is no application to accredit them.

Q. How long does it usually take to schedule a sleep study after a request is made?

A. It takes -- there is about a six-week delay from the time of the patient -- is ordered to have a sleep study to when the study can be done at GBMC. The time delay for our Essex laboratory is about two weeks. The time delay at our Fallston laboratory is about four weeks.

Q. Do you ever move a patient from one center to the other in order to move them up on the list to get a sleep study done?

A. Yes.

Q. In regard to a patient, is it possible to expedite a sleep study if circumstances warrant it here at the Baltimore Hospital center?

A. Yes.

Q. Okay. How would you do that?

A. It's not easy. Basically, it depends on my telling the staff that someone has to have a test done as soon as possible, and should anyone cancel, give up an appointment that they have, we will fill it with this person who needs to have a test.

Q. What type of circumstances would warrant moving up -- moving a person up the pipeline to have their sleep study done, to expedite it?

A. Evidence of the patient -- a risk to him or herself or to others, by sleeping behind the wheel, or a patient may have evidence of heart disease as a result of sleep apnea.

Q. Why in the case with a patient with heart disease would it be important to have the sleep study done in a timely manner?

A. Because there is evidence that resolving sleep apnea resolves the heart,

Q. Do all the patients referred to your center by a nonsleep specialist receive a sleep evaluation in conjunction with their sleep study?

A. No.

Q. *So* you receive some referrals just for a sleep study, would that be correct?

A. Yes.

Q. Okay. If you receive a referral just for a sleep study, what information do you require that you have before you start the sleep studies? What is important for you to know about that patient?

A. I have to know if the patient snores and is sleeping during the daytime, sleeping behind the wheel. I have to know if that -- I have to know the patient's height and weight and age. I have to know the results of a physical examination, particularly an examination with the nose and throat and heart and lungs.

Q. What do you want to know about the nose and the throat?

A. I want to know if there is any anatomic structure which would decrease airway resistance.

Q. You mentioned twice now if the patient was sleeping behind the wheel, that that might be something that would cause you to expedite a sleep study. Could you

tell the patient, "Don't drive"?

A. I do.

Q. Why would that be something that would cause you to expedite the study?

A. Common sense. It's the best thing to do.

Q. Now, Doctor, if your center determines that a patient has severe obstructive sleep apnea, does your center make written follow-up recommendations for the patient?

A. Yes.

Q. Once the study is done, the overnight portion of the study at your center, how long does it take before a final report is disseminated to a referring physician?

MR. TREU: Objection. Go ahead.

A. The report of tests done in the Fallston laboratory is issued on the seventh through the ninth day after the test. The test results for those procedures done at the GBMC or Essex laboratory are reported within two or three days.

Q. Is that the final report that comes out?

A. Yes.

Q. Okay. The form of your report, can you tell me what is included in that report when you send it out?

A. The day of the study, the name of the patient, the height, weight, mass body index, the reason for the study, the method for the study, the findings of how long it took to fall asleep, how long it took to get the first REM period, how many times the patient woke up during the study, what the total wake time after sleep onset was during the study, what the total sleep time was during the study and what the sleep efficiency index is. That is, the percent of time that recording was going on that the patient slept.

The report goes on to state how many apneas and hypopneas a patient had. And it goes on to describe how many of those apneas occurred in REM sleep, how many occurred in nonREM sleep, how many hypopneas occurred in REM sleep and in nonREM sleep.

And it describes the longest apnea observed and the longest high hypopnea observed. It describes the lowest oxygen observed resulting from the apnea or hypopnea, and it describes the amount of oxygen in the

blood during normal breathing when there was no apnea or hypopnea.

The report goes on to describe any limb movement arousal. Finally, there is a statement about cardiac rhythm and the average heart rate. That completes the first page of the report, which is the report of the overnight study.

Q. Is there a second page on the report?

A. The interpretation where I make a comment about the adequacy of the sleep record for the purpose of the test, and comment about the proportion of REM versus nonREM sleep.

And I offer an opinion combining the facts taken from the intake history, together with the frequency of apneas and hypopneas, and express an opinion whether this represents apnea or not. If it's apnea, I comment on how low the oxygen was and how abnormal the heart rhythm was.

The report goes on to a new section called "Clinical Implications," where I have several paragraphs about precautions and one paragraph about treatments that

are appropriate for this finding.

Q. Is there any more to your report?

A. Yes.

Q. Okay. Go ahead.

A. The final paragraph says -- it says, "We have not made an appointment to see this patient. Again, if you would like us to see the patient, to advise them of the results and tell them about the treatment options, please let us know." That's the end.

Q. Okay. You mentioned that there was a section there on precautions. What type of information do you put in the paragraph that deals with precautions?

A. The paragraph says that the patient with sleep apnea should not use medicines that affect breathing breathing, such as sleeping pills, narcotics, barbiturates, analgesics and alcohol.

The paragraph goes on to say the patient should avoid becoming overly tired, as that will make it harder to wake them up and it will make apneas worse.

The final precaution -- no. That's not the final. The next precaution is that a patient -- should the

patient need anesthesia for surgery, the patient should give a copy of the report to the anesthesiologist, because it's not safe for a patient to have sleep apnea and have that as a secret in the recovery room.

The other precautions are that they will get worse with the weight gain, or if the patient gets a stuffy nose. Then the apnea will get better with weight loss.

Q. Is that --

A. That's the end of the precautions.

Q. You indicated there was a section on treatment options also?

A. Yes.

Q. What do you usually put in the report in regard to treatment options?

A. For a patient with sleep apnea, I say continuous positive airway pressure, known as "CPAP", is appropriate. Another night in the laboratory to determine the proper CPAP pressure is needed. And surgery, known as "avulopalatopharyngoplasty." Shorthand, U, triple P. It's a treatment for some people.

Finally, protryptline, a drug that can be used

when most of the apneas are in REM sleep.

Q. Does that complete what would generally go into the section regarding treatment options?

A. Yes.

Q. You have indicated that generally, at your three centers, you have a final report out within nine days, a little bit shorter time for two of your centers, and between seven and nine days for one of your centers. Do you provide a preliminary report prior to the final report?

A. No.

Q. That's the first piece of information disseminated from your centers?

A. Yes.

Q. Now, in regards to the actual administration of the polysonograms at your centers, who is actually present when the particular overnight sleep studies are being done?

A. Sleep technicians are present.

Q. In regard to the evaluations that are done, do the technicians do any preliminary evaluations, going over the data, prior to the time that you look at the data?

A. Yes. There is a technician whose primary job is

to do data production and summarization.

Q. When you evaluate the raw data, are you sampling it or do you look at all of it? I understand that these can be very lengthy in the -- in the Patricia Smith case, I believe there is over a thousand pages. Do you usually sample the various portions of the sleep study when you are evaluating?

A. Yes.

Q. You don't usually sit down and look through every single page of the sleep study, is that correct?

A. Correct.

Q. That's typically what most physicians that are doing sleep evaluations do, correct?

A. Yes.

Q. Over the course of a week, how many sleep studies would you say you evaluate, just approximately, Doctor?

A. 25, maybe.

Q. Now, Dr. Hobbins, I notice on your curriculum vitae that you are a fellow of the American Sleep Association; is that correct?

A. Yes.

Q. Can you tell me how large an association that is?
A. I think there are two thousand sleep physicians who are members.
Q. How long have you been involved with that group?
A. I think I've been involved with the group since about 1986.
Q. In fact, Doctor, I believe, according to your CV, you are a current member of the governing board of that organization; is that correct?
A. Yes.
Q. I also understand that this organization has recently gone through a name change, 1 believe, to the American Academy of Sleep Medicine; is that correct?
A. Yes.
Q. The same group, it's just a little different name, correct?
A. Correct.
Q. Doctor, can we agree that University Hospitals of Cleveland was an accredited sleep disorder center in 1996 when Patricia Smith was a patient there?
A. Yes.

Q. It's my understanding that there is certain hospitals or centers in the country that operate sleep disorder centers that are not accredited. Is that also correct?

A. Yes.

Q. Can we agree that in order to become an accredited -- I will refer to it as the American Sleep Disorder Association, which is also the American Academy of Sleep Medicine. One of the requirements is that they comply to certain standards, correct?

A. Yes.

Q. In fact, the hospital like University Hospital of Cleveland, that chose to become accredited, has to meet standards in order to keep their accreditation, correct?

A. Yes.

Q. Can we agree that these standards are what the program directors deem to be reasonable and prudent procedures that should be followed by a sleep center if it's going to be accredited by your national organization? Correct?

A. Yes.

Q. Now, Doctor, can we agree that the standards of the organizations require that a center must have an effective mode and rationale for scheduling the initial and follow-up visits to their sleep center and to consultants?

A. It's been some time since I reviewed the accreditation requirements. So I can't comment, other than I would be surprised if it didn't have some standards for intake and testing.

Q. Would you agree that the mode of intake and testing should reflect sensitivity to the concerns of patients and referring physicians in regard to what a patient may undergo during the evaluation, sensitive to the concerns of the patients and the referring physicians?

MR. TREU: Objection.

A. I'm not sure what you mean by being sensitive to the patient.

Q. Okay. Would you agree it would be a violation of the standards of the merican Sleep Disorder Association not to have an effective mode and rationale for scheduling the initial and follow-up visits to the center and to consultants?

MR. TREU: Objection. "Effective mode and rationale."

A. I think the accreditation should probably cover that. I can't speak to that. I haven't reviewed that.

Q. Doctor, would you agree that as an accredited sleep center, such as University Hospitals of Cleveland Center, that it was responsible for formulating explicit written follow-up recommendations and plans for each patient?

MR. TREU: Objection.

A. Yes.

Q. Can you show me in the records of University Hospital Sleep Center in this case where they complied with that requirement, explicit written follow-up recommendations and plans?

A. I recall seeing the final report, but I can't bring it up in the stack right now. So if you can supply that to me, or we can take a break and you can find it for me, I will -- okay.

Q. Page 2 of the documents that I believe are the sleep center documents, the final report from the sleep

study.

A. Okay. This looks like a summary, and if this is the final report -- now I remember this is. There is no note here about what the options are for treatment.

Q. Okay. You would agree that an accredited sleep center such as the University Hospital Sleep Center, must make sure that a patient's records -- in this case, Patricia Smith's records. -- contain the following procedures, whether or not the treatment is executed by the center or elsewhere --

MR. TREU: I will object to the question. You are phrasing the question as to the sleep center. Obviously, this is a doctor's work product and not some sleep center's.

Q. Doctor, would you look at the final report and tell me -- it was signed at the bottom. It bears --

A. The signature of Lee Brooks.

Q. What's the title at the top of the page of that report?

A. University Sleep Center.

Q. Thank you, Doctor. When you reviewed these

records, was it your understanding that the University Sleep Center was a part of the University Hospitals of Cleveland?

MR. TREU: Objection. What do you mean by "a part"?

A. It never occurred to me to wonder or even inquire about that.

Q. Do you know whether University Sleep Center is owned and operated by University Hospitals of Cleveland?

A. No.

Q. Doctor, as an accredited sleep center, would you agree that University Sleep Center had an obligation as an accredited center to make sure there was no question as to how contact would be maintained with the patient or with the referring physician?

MR. TREU: I'm going to object to any questions that you are going to phrase in this deposition as to responsibilities of the University Sleep Center, University Hospital Sleep Center, since you are not differentiating between responsibilities of the individual physician, who did the study, and the report. And whatever the University

Sleep Center, University Hospitals of Cleveland Sleep Center, might be.

MS. TOSTI: Would you repeat my question for the witness, please.

(The question was read back,)

A. I think the obligation of the accredited center is to send the results of the test to the referring physician, and, in fact, I don't think the -- Dr. Brooks has an obligation to maintain contact with this patient, because I'm not sure this is Dr. Brooks' patient.

Q. You believe it's the sleep center's patient?

MR. TREU: Objection.

A, If Dr. Brooks did a pretest consultation, I would say it was probably Dr. Brooks' patient. But if Dr. Brooks never saw the patient, but only saw the sleep records, then I think it's Dr. Rowane's patient.

Q. Do you believe that the sleep center had any obligation to this patient.

MR. TREU: Objection.

A. The sleep center had an obligation to have a medical director to send the records, the report, out to

the referring doctor.

Q. Doctor, we discussed previously that one of the things that you routinely do is send out recommendations, and you agree that that is appropriate for the sleep center to do, to make recommendations regarding the sleep study, correct?

A. Yes.

MR. TREU: Objection again to "the sleep center."

Q. Doctor, would you agree that one of the purposes of the standards of the American Sleep Disorder Association is to make sure that appropriate communications take place so that the patient -- so that patient care is not compromised?

A. Yes.

Q. Would you also agree that the University Hospitals of Cleveland's responsibility, in operating the sleep center, is to very clearly show that the duties and responsibilities of the sleep specialists that are staffing the center are discharged in each case?

MR. TREU: Objection as to "operating."

A. Would you repeat the question?

MS. TOSTI: Would you read my question back, please.

(The question was read back.)

MR. TREU: I note my objection.

A. I don't think the University Hospitals has any obligation other than hiring a medical director that can do a top-flight job. I don't think the university has any responsibilities or right to tell that person how to do is work.

Q. What's the basis for that opinion, Doctor?

A. The universities don't know the first thing about sleep, or how to operate a sleep laboratory. They have to turn that responsibility over to someone they trust to do it right.

Q. Your feeling is that the University Hospitals of Cleveland is not ultimately responsible for the individuals that they pick to carry out those responsibilities and duties, is that correct?

MR. TREU: What particular duties and responsibilities?

MS. TOSTI: The ones that the doctor is referring

to in his answer.

A. I think the employer is responsible for hiring the right person.

Q. Okay. Who was the employer in this case?

MR. TREU: If you know.

A. I don't know.

Q. Do you know who was responsible for the University Sleep Center in regard to policies and procedures, hiring **of** personnel?

A. No.

Q. Do you know whether or not the personnel that worked in the sleep center were employees of University Hospitals of Cleveland?

A. I asked this question of counsel before this meeting today, and I remember hearing that they were probably employees of the hospital, but I don't think there was any certainty in that.

Q. You don't believe that the hospital has any duties in regard to the sleep center, even though they are the ones employing individuals working in the center?

A. No.

MR. TREU: Nonphysician employees.

MS. TOSTI: Any employees.

MR, TREU: You are totally distorting his answers.

MS. TOSTI: I'm trying to find out what his answer is. I would like him to please explain it so I can understand it.

A, My answer is that the University's responsibility for the sleep laboratory ends when they hire the medical director who is then responsible for the day-to-day operations, to make the place work right. The university may have other obligations, like cleaning and laundry. The personnel and management would be entirely up to the medical director.

Q. Doctor, would you agree that if the duties and the responsibilities of the staff of the sleep disorders clinic are not discharged in accordance with the standards of care, that that would be unacceptable to your organization, the American Sleep Disorders Association?

MR. TREU: Objection.

A. If a laboratory does not meet the standards for accreditation, they would not be reaccredited.

Q. Do you believe that the accreditation standards for the American Sleep Disorder Association reflect the standards of care in sleep medicine?

MR. TREU: Objection.

A. Yes.

Q. Doctor, in your own center, have you participated in .the accreditation process?

A. Yes.

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

A. Yes.

Q. Now, are sleep labs accredited by the American Sleep Disorder Association required to have in place policy and procedures for the administration of overnight polysonograms?

A. Yes.

Q. Are those written policies and procedures that you are required to have?

A. Yes.

Q. Was that also true in 1995?
A. Yes.
Q. In 1996, at the time when Patricia Smith had her polysonogram done?
A. Yes.
Q. Do you do split studies at your lab, Doctor?
A. Yes.
Q. When you do split studies, are you required to have policies and procedures in reference to doing a split study, to help the technicians know what they are supposed to do in that particular situation?
A. I don't know if that's a requirement, but that's what we have.
MR. TREU: You keep asking questions about what he does. You haven't asked many questions about what the standard of care requires in this deposition.
Q. Doctor, you don't hold yourself out as an expert in the field of family practice, do you?
A. No.
Q. Or cardiology or neurology?
A. No.

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

A. No.

Q. You have mentioned that you have privileges here at Greater Baltimore Medical Center. Do you have privileges at any other hospital?

A. Fallston General Hospital.

Q. Are those admitting privileges at both places?

A. Yes.

Q. And you have indicated that generally you don't do admissions for patients, is that correct?

A. Correct.

Q. Have your hospital privileges ever been suspended or revoked?

A. No.

Q. Have you ever lectured or taught on the subject of complications associated with adult obstructive sleep apnea?

A. Yes.

Q. Was this in a formal classroom lecture or in an informal clinical type of a situation?

A. Both.

Q. Do you have any notes or outlines, tapes or videos, from those presentations?

A. I might have some notes.

Q. Would you be able to produce those to counsel?

A. Sure. I can look.

MS. TOSTI: I would request a copy of his notes from his presentations.

MR. TREU: I'm not agreeing to produce anything like that at this point. We will see.

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

A. No.

Q. Is there any that you utilize in regard to the teaching that you do with students or house officers, residents?

A. Yes.

Q. Can you tell me the name of that text?

A. Principles and Practice of Sleep Medicine.

Q. Can you tell me what you reviewed prior to generating your report in this case?

A. The thousand-page sleep records and some of these records hear on this desk. That's it,

Q. Okay. Can you tell me which of the records that are in front of you you reviewed prior to your report?

A. All of them, I think.

Q. Okay. I believe that your report only references the deposition of Dr. Rowane and Dr. Brooks. I believe you have in your pile the additional deposition of Dr. Whiting. Did you have his deposition at the time that you wrote your report?

A. I think it's best to go by the report. I think the answer to your question is right there, that second paragraph. I don't know what date I received that.

Q. In regard to the medical records that you received, did you review all of the medical records?

A. Most.

Q. Is there any portion that you did not review?

A. It would be unidentified.

Q. You did not have the depositions of Tracy Smith or Geneva Smith in this case, correct? You have never seen those?

A. Tracy Smith?

Q. Yes. The sister of Patricia Smith. Or Geneva Smith, the mother of Patricia Smith.

A. No. I haven't seen those.

Q. Have you had an opportunity to see the depositions of Dr. Pelayo or Dr. Sutherland in this case?

A. I've seen only those papers that you reviewed before the deposition began.

Q. Doctor, in regard to the sleep study raw data, did you, when you looked at that, just sample it as you would normally do with a sleep study, or did you look at it from beginning to end, all thousand pages?

A. This record, I looked at all pages.

Q. At any time, did you request that defense counsel send you any additional material when you were evaluating this case?

A. I don't think so.

Q. In regard to the depositions that you have in the materials in front of you, have you read those depositions?

A. Yes.

Q. In formulating your opinions, did you refer to any

medical literature or journal articles **or** textbook articles?

A. No.

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

A. No.

Q. Did you consult with any physicians at any time during this case in regard to this case?

A. No.

Q. Prior **to** accepting this case for review, did you have any contact with any of the medical providers that are identified in the medical records?

A. No.

Q. Have you had any contact with any of the experts that have been identified in this case?

A. **No.**

Q. You haven't met Dr. Pelayo or Dr. Feinsileer at any type of a professional meeting, that you recall?

A. If it's Dr. Steven Feinsileer, **I** met him.

Q. **Do** you have any recollection of those meetings, other than a casual meet?

A. We were in the same organization. We were there on business. His name didn't come up in connection with this case.

Q. You haven't discussed this case with him at all?

A. Correct.

Q. Have you ever had any professional affiliations with University Hospitals of Cleveland?

A. No.

Q. Doctor, you had one page of notes, I believe, at the top of the materials that you had in front of you.

A. Yes.

Q. Can you tell me when you generated those notes?

A. I generated these notes when I was going through the medical records.

Q. Okay. Are those the only notes that you generated in this case?

A. Yes.

Q. Can you just read through the notes? There doesn't appear to be very many on the page. Can you read what you have written on that page?

A. "Patricia Ann Smith, school bus driver.

42-year-old black female. Epilepsy diagnosis. 11-3-95. cardiovascular disease, ASCVD. Cardiovascular disease. Left anterior descending, severe. Obesity. Two hundred and forty-three pounds, sixty-one inches. Body mass index, 46. Sleep study, 2-6-96. Preliminary report, 2-7-96. Referred for sleep -- referral for sleep was 11-3-95." At the bottom, the time I spent on May 5th, May 6th and May 7th on the case.

Q. How much time was that?

A. About three hours. Two and a half hours.

Q. Did you read what's on the bottom on the other side of the page?

A. This one?

Q. Yes.

A. "Send malpractice information to Mr. Treu." The Polish name. "Send Dr. -- notes on lectures."

Q. I saw in your materials that you had the expert reports of plaintiff's experts in this case. You reviewed those reports, is that correct?

A. I reviewed the reports that are here.

Q. Have you received the reports of Dr. Feinsileer in

this case?

A. Not to my knowledge.

Q. Any of the other defendants' experts that were in the case before this?

A. Only what I have here.

MS. TOSTI: Doctor, I have a copy of your report, and I will ask if you would please mark this as exhibit 2.

(Hobbins Deposition Exhibit No. 2 was marked by the reporter.)

Q. You have a copy there. If you could just identify this for me. Is this a copy of your report that has been marked as Plaintiff's Exhibit 2?

A. Yes.

Q. Probably the one in your file is a little bit clearer, since mine is faxed and Xeroxed. Did you provide counsel with any drafts before rendering your May 20th, 1999 report?

A, I don't think so.

Q. Is this the only report that you provided to defense counsel?

A. Yes.

Q. Did Mr. Treu ask you to make any changes in this report?

A. No.

Q. What was the assignment that you were given relative to this case?

A, I think I was asked to comment on the timing of the -- the time interval from when the referral was made to when the patient was tested, the time from the test to the report. I think there was additional query about whether sleep apnea was related to epilepsy.

Q. In regard to the report that we just looked at as Plaintiff's Exhibit 2, does your May 20th report summarize all of the opinions that you currently have concerning this case?

A. Yes.

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

A. No. Unless you challenge me with something I don't know the answer to. I might go to the library.

Q. You haven't been asked to do that, though?

A. No.

Q. For the balance of this deposition, when I speak about sleep apnea, I'm referring to obstructive sleep apnea, and when I'm talking about patients, I'm talking about adult patients. I understand that there are other types of sleep apnea and --

A. Yes.

Q. And infants and children may also have sleep disorders. Can you tell me what "obstructive sleep apnea" is?

A. It's a disease of repeated airway blockage during sleep with consequences of health costs and daytime decrements and daytime functioning.

Q. What causes it?

A. It's a combination of predisposing anatomic features and weight gain.

Q. Are there certain risk factors for obstructive sleep apnea in an adult?

A. Yes.

Q. What would those be?

A. A family history of snoring, obesity, tonsiler

hypertrophy, retrognathia.

Q. What is that, Doctor?

A. A jaw that is positioned backward. Posterior. Also a low uvula, or low soft pallet, low uvula, deviated septum, large tongue. Those are some of the predisposing causes.

Q. In your practice, Doctor, do you find that obesity is frequently associated with patients that have problems with obstructive sleep apnea?

A. Yes.

Q. In regard to hypertension, is hypertension a risk factor, or is that thought to be a result of -- well, let me ask. Is it a risk factor for obstructive sleep apnea?

A. No.

Q. Can obstructive sleep apnea -- is it thought to cause hypertension?

A. Yes.

Q. What signs or symptoms, when you are doing an evaluation of a patient, do you look for, or what might be associated with obstructive sleep apnea in evaluating a patient?

A. Snoring. Witnessed apnea by a partner. Waking from sleep tired. Excessive somnolence during the daytime.

Q. Is depression associated with sleep apnea?

A. No.

Q. What about heartburn?

A. I don't know.

Q. Large neck circumference?

A. Yes.

Q. Elevated hematocrit?

A. Yes. A consequence **of** that.

Q. Arrhythmia?

A. It can be a consequence of that.

Q. Are there any complications associated with severe obstructive sleep apnea?

A. Yes.

Q. Can you tell me what those are?

A. Fall-asleep accidents. Those are motor vehicle accidents when the driver falls asleep. And patients with apnea have more heart attacks than strokes. They can also have polycythemia and impotence.

Q. Doctor, we have seen that in the final report on

Patricia Smith's polysonogram, they have indicated she had severe obstructive sleep apnea. You indicated in your report that she had a moderate level of sleep apnea. What parameters or criteria do you use to differentiate between what would be termed mild, moderate or severe obstructive sleep apnea? I'm speaking as to what you use, as a specialist in that field.

A. I don't have a standard rule for what's moderate. When I say "moderate," that means not severe. When I said "moderate" in this case, I was disagreeing with Dr. Brooks on the issue of severity.

Q. You don't have any particular criteria that you look at to label something as moderate obstructive sleep apnea?

A. Correct.

Q. Do you have any criteria for labeling something as severe obstructive sleep apnea? Is there something you look at to say "this is now severe"?

A. Yes.

Q. Can you tell me what that is?

A. Evidence of falling asleep behind the wheel,

evidence of cardiac arrhythmias that are linked to apneas in the overnight records, and a high apnea-hypopnea frequency.

Q. When you say "high," what level are you talking about?

A. 50 and above.

Q. Any other criteria you look at to judge something as severe obstructive sleep apnea?

A. No.

Q. You don't take into consideration, in differentiating between moderate and severe, the respiratory disturbance. I guess you do that, because it would be included in the hypopneas you were talking about. What about oxygen desaturation?

A. No.

Q. What about the sleep architecture? Do you consider the sleep architecture in trying to determine whether the obstructive sleep apnea is moderate or severe?

A. No.

Q. How is obstructive sleep apnea diagnosed?

A. By overnight recording and counting of the apnea

and hypopneas.

Q. Is that the gold standard for determining whether a patient has obstructive sleep apnea? Is the overnight polygram --

A. No. The standard is putting the result of the apnea-hypopnea frequency together with a history and physical findings that were gathered during pretest data collection. That's the gold standard.

Q. If you only do the polysonograrn, are you able to do the diagnosis if you are not doing the evaluation along with it?

A. You are able to come to a diagnosis, but without much confidence, because you don't have all the data.

Q. Would you expect, if you found that a patient had severe obstructive sleep apnea on an overnight polysonogram, that the diagnosis would change any, based on the history or physical on the patient?

A. The history and physical really tells you what kind of test to do, whether the patient needs to be assessed for narcolepsy as well. Because if -- in the scenario you paint, the patient doesn't come to the sleep

specialist just for a sleep test. The wrong test can be done.

Q. If the test shows the patient has severe obstructive sleep apnea --

A. It doesn't mean that's the only diagnosis. The patient could still be misserved.

Q. That would be a diagnosis that the patient has; it's just there may be additional diagnoses that the patient may have that go along with the sleep problem, correct?

A. Correct.

Q. When you are taking a history of a patient that is suspected to have obstructive sleep apnea, what type of information should you elicit from the patient?

MR. TREU: Objection. Go ahead.

A. I think I already answered this. I think I said we want to know do you snore, does someone who sleeps nearby witness apneas, do you fall asleep behind the wheel. That kind of thing.

Q. Does obstructive sleep apnea have any effect on oxygen saturation levels during sleep?

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A. Yes.

Q. What effect does it have?

A. Oxygen saturation falls during apneas.

Q. Doctor, I would like you to tell me, generally, what is an overnight polysonogram?

A. It's a study in which the brain waves, respiratory signals and oxygen signals, the cardiac rhythm and the muscle tone are monitored for six or seven or eight hours during the person's usual sleep phase.

Q. And why is the cardiac rhythm monitored with the polysonogram?

A. Because it's important to know if the apneas are linked with cardiac arrhythmias.

Q. Is that a finding sometimes?

A. Yes.

Q. You see increased number of arrhythmias when there are longer apneas?

A. Yes.

Q. I should ask that in two questions. **Do** you see an increase **of** cardiac arrhythmias when there are an increased number **of** apneas?

A. Yes.

Q. Do you also see an increased number of arrhythmias when there is an increase in time for the apnea?

A. Yes. Cardiac arrhythmias are related to the nadir -- N-A-D-I-R -- of the oxygen --

Q. As the oxygen saturations fall, there is an increased risk for cardiac arrhythmias, would that be fair?

A. Yes.

Q. Is there a particular number of hours that normally you -- you mentioned six, seven or eight hours. Is there a target time you would like the sleep study to extend over when you are evaluating a patient?

A. Yes.

Q. Okay. What range do you usually like to see these sleep studies --

A. Eight hours

Q. An eight-hour time period?

A. Yes.

Q. Now, once the sleep study is completed, how is the test interpreted?

A. The interpretation is based on the frequency of

the target events and the data from the pretest inquiry. If the patient does or doesn't have obesity, does or doesn't have hypertrophy, and does or doesn't have a high apnea, hypopnea, those are the pieces that go into the interpretation.

Q. If you haven't done the evaluation on the patient, do you have that information available to you from another source?

A, I require those referral sources to supply me with that data, if I'm not allowed to get them myself.

Q. Do you have a form or something that you ask them to fill out in regard to information about the patient?

A. I have my staff call and say, "We won't do the test until you send us the records."

Q. You get a copy of whatever office records there are?

A. Yes.

Q. Do you ever find you have to get additional information from the patient when they come in, if the office records aren't complete?

A. Sometimes I reject the records, saying they are

not adequate, and the patient is not going to have the test, or is going to have a consult with me first.

Q. Generally, a technician does the initial review on the raw data from the sleep study, is that correct?

A. Yes.

Q. Doctor, when you then go in to do the interpretation, tell me what you do with the information. What is it that you do to interpret the patient's sleep study? You indicated that you look over the information in regard to the evaluation of the patient. What do you do in regard to the actual data that's been collected during the polysonogram?

A. I review the data.

Q. How do you do that?

A. I open the chart and read all the numbers, and sometimes I look at the raw data.

Q. The technician has put together some type of sccumulation or --

A. Summary sheet.

Q. You look over the summary data?

A. Yes.

Q. You then sample some of the actual raw data on the polysonogram?

A. Sometimes. 1 usually go back to the pretest consultation and see what the suspected disorders was. I look to see the drugs the patient was on during the entire test.

Q. In some instances, it's not necessary to go through the raw data yourself?

A. Correct.

Q. How long does it take for the technician to review the raw data?

A. About an hour or two per record.

Q. Then the part that you do, how long does it take you? If you want to give me a range, that's fine also.

A. I'd say 15 to 45 minutes. About 15 to 60 minutes, probably.

Q. Now, can you tell me what a split study is? You indicated you do some split studies in your sleep centers. Can you tell me what that is?

A. One of the most common treatments for sleep apnea is CPAP. A split study is one where in the first hour or

two of sleep, the technician notes a high frequency of apneas and hypopneas, and may note whether or not the apnea-linked cardiac arrhythmias has low oxygen saturations.

When the criteria for split protocol is met, the technician is instructed to wake the patient up and offer CPAP use for the rest of the night. During that rest of the sleep test, when the patient is using CPAP, the technician remotely increases the CPAP pressure until the pressure is found which eliminates apneas and hypopneas and snoring.

Q. You mentioned that there is criteria that is met, and you mentioned, I believe, the oxygen saturation, cardiac arrhythmias and the hypopnea index. What criteria do you utilize in your lab for those various things? What's the level that the technician is looking at to make a determination as to whether a split study should be utilized?

MR. TREU: Objection.

A. I don't have that article in front of me. I think it's one apnea per minute, and any cardiac arrhythmia

linked to an apnea, or oxygen saturations falling below 85 percent.

Q. When you say "cardiac arrhythmias," are we talking ventricular arrhythmias?

A. Yes.

Q. Doctor, you mentioned briefly the treatment options in regard to what you would do in your reports. Are there any other treatment options, aside from the ones that we previously discussed, for obstructive sleep apnea?

A. Yes. Because, in mild apnea, there is an oral appliance that can be used, a mouthpiece made by a dentist. There is also a pillow called "Pillow Positive," a product which has been shown to -- a study to eliminate the snoring.

Q. Okay.

A. Mild apnea.

Q. In addition to the ones that you previously mentioned, and these are -- are there any other options for the treatment of sleep apnea?

A. Sometimes, when the apnea is positional, or a control of sleep position works.

Q. Doctor, what diagnostic criteria would indicate to you that obstructive sleep apnea should be treated?

A. If the patient is impaired by sleepiness during the daytime.

Q. Okay. If the patient is impaired by sleepiness during the daytime, what's the therapy that is most frequently utilized for the patient?

A. Weight loss through daily exercise, and CPAP, are the most common.

Q. Doctor, would you agree that CPAP is highly effective therapy for obstructive sleep apnea?

A. Yes.

Q. Would you agree at least 80 percent of the adult patients with sleep apnea are able to continue using it --

A. Yes.

Q. Doctor, if there is a concern that a patient is having seizures during sleep due to oxygen desaturations, do you have an opinion as to whether a sleep evaluation would be indicated?

A. If a patient with seizures during sleep doesn't have any other signs of apnea, such as snoring, obesity --

sleepiness during the daytime, I don't think the studies should be done.

Q. If they did have snoring and sleepiness during the day, would that be an instance where a sleep evaluation would be appropriate?

A. Yes.

Q. If the referring physician is concerned that seizures were occurring in sleep due to oxygen desaturations, do you have an opinion as to how soon a sleep study should be undertaken for that patient?

MR. TREU: Objection.

A. No.

Q. Doctor, in addition to the heart beating irregularly with obstructive sleep apnea, can patients also have periods of time where the heart pauses for several seconds during sleep?

A. Yes.

Q. Yes?

A. Yes.

Q. Once a diagnosis of severe obstructive sleep apnea has been confirmed on a polysonogram, are there any

clinical reasons for delaying therapeutic evaluation with CPAP or bilevel therapy?

MR. TREU: Objection.

A, You are asking are there any clinical reasons for delaying treatment? No.

Q. Doctor, once the diagnosis of sleep apnea has been confirmed on a sleep study, and we are talking the level that would require treatment, moderate or -- would you agree that a moderate level of obstructive sleep apnea would require treatment?

A. Yes.

Q. As well as a severe level, correct?

A. Yes.

Q. Once a determination has been made that the patient does have moderate or severe obstructive sleep apnea, what procedures do you follow regarding follow-up on that patient?

MR. TREU: Objection.

Q. A diagnosis has been made, the diagnosis is done, what do you --

MR. TREU: Objection. Can you answer that in a

vacuum?

A. My report in which the finding of apnea is presented states that the patient should have treatment.

Q. Does the patient require additional visits in order to have that done?

A. If the patient chooses CPAP, there is additional visits.

Q. How many visits normal y are needed in order to establish a patient on CPAP?

MR. TREU: Are you talking about a visit to the sleep specialist, or visits in general?

Q. Doctor, it's my understanding that when a patient starts on CPAP, they must go through a a titration in order to establish --

A. Yes.

Q. Is that generally done in the sleep center?

A. Yes.

Q. Once a diagnosis has been made of obstructive sleep apnea and it's been decided that the patient is going to have treatment, how many visits are necessary to establish that patient on the CPAP therapy, generally

speaking?

A. One or two.

Q. Okay. Is that an overnight --

A. One of those is an overnight.

Q. Then what would be -- if the patient had to come back again, what would be the second one?

A. I answered "one or two," because sometimes patients come back to see me and review the data from the first test, review the therapeutic options, then they choose CPAP. Then they have the titration.

Q. Sometimes there is a little more than the evaluation, but not necessarily -- where you actually talk with the patient and make a determination as to what the next step would be, then the patient comes in for the titration therapy?

A. Right.

Q. Once you have done the initial evaluation on the patient with an overnight polysonogram, how long does it take you to schedule the patient for CPAP titration? What's the time period between that?

MR. TREU: Objection.

A. It could take six weeks at the hospital center, and the delay to testing at the other site was the finder there. You get into the same queue. But I don't know.

MR. TREU: Six weeks from when?

A. Six weeks from the baseline determination of CPAP.

Q. Doctor, you had an opportunity to look through Patricia Smith's medical records. We have looked briefly at the final report. What clinical indicators did you find in the records that were consistent with the diagnosis of obstructive sleep apnea in Patricia Smith's case?

A. She was obese. I don't remember any of the other --

Q. Please feel free to review the sleep center records for any additional records.

A. She snores and is obese. I don't have any other data.

Q. Okay. Do you have any recollection of any of the records mentioning that she was falling asleep at inappropriate times?

A. I don't remember seeing that, but I noted -- my notes say she's a school bus driver. So that would be

pertinent.

Q. Did you happen to have records from Dr. Hlavin in the medical records that were provided to you?

A. I don't remember those. Maybe I have them here.

Q. I'm just asking if you have them. I'm not asking you to go through them.

A. I think I have them.

Q. Okay. Do polysonograms accurately measure oxygen saturations when they get down into the 60-percent range?

A. Well, I don't know. The old oxygen meters were not very good about that. They were good at only the range in which they were calibrated. I think the newer ones are better. I don't have the data on that.

Q. Okay. When you say "older" --

A. 1985.

Q. You are not referring to 1996, when Patricia Smith's polysonogram was done?

A. Correct.

Q. You don't have any information as to whether the accuracy of the equipment used in her polysonogram had any problems in measuring the low oxygen saturations, correct?

A. Correct.

Q. Does a 60-percent oxygen saturation raise the level **of** concern regarding the severity of the obstructive sleep apnea?

A. **No.**

Q. Now, what is your understanding as to how Patricia Smith's sleep study came to be scheduled?

A. Dr. Rowane sent the patient to Dr. Collins. Dr. Collins suggested the patient might need the sleep study done early. He agreed. He sent the patient to the laboratory.

Q. Did you, in looking through the records, see the requisition that was sent by Dr. Rowane regarding the sleep study?

A. I don't remember seeing it.

Q. You have the sleep records in front of you?

A. Yes.

Q. Would you look through there briefly and tell me if you can find the referral that was done by Dr. Rowane?

A. This is it. A referral from University Family Medicine Foundation to a specialist.

Q. That also indicates the request for the sleep study on there, is that correct?

A. Yes.

Q. Now, is it your understanding that that is the request sent by Dr. Rowane that then resulted in the sleep study that Patricia Smith had?

A. I think this is a request for a sleep study.

Q. Based on the information that is contained on that particular request, do you have an opinion as to whether the referral to the sleep center for the study was appropriate?

MR. TREU: Come again. I missed that.

(The question was read back.)

MR. TREU: The fact of the referral itself.

A. Well, I wouldn't have done the sleep study if this were the only data I had. This is not an adequate --

Q. Well, I believe in the sleep center records there is some additional information that was provided by Dr. Collins and Dr. Rowane in regard to their office records. I think you went through them at the beginning portion of the records.

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A. Yes.

Q. Whether they came at the time of the requisition coming in or shortly thereafter.

A. Yes.

Q. Would that be enough information to schedule the study?

A. This alone, no.

Q. Okay. In other words --

A. This referral alone, no.

Q. If you received just that requisition, what would be the appropriate thing to do?

A. If that's the only thing I have, I would go back to the referring doctor and say either I have to see the patient first or you have to get me the data.

Q. There is some additional records in the sleep center records, if you look through it. If you could tell me if the information that is contained in those records is sufficient to warrant or allow a sleep study to proceed. If you want to take a minute to look through that, please feel free, Doctor.

MR. TREU: It includes all of these records.

A. Just these. The answer is, the EEG record does not provide the database that would permit a sleep study. The consultation by Dr. Collins mentions snoring, but does not mention height or weight or sleepiness behind the wheel, or the job as a driver.

Here. She says she weighs over two hundred and twenty. This is a six-foot, four inch female. The weight alone is not sufficient. I probably would have called and said this is not right, I need to see the patient.

Q. You would like to have additional information in addition to what is contained in those records?

A. Correct. There is no comment here about the oral pharynx or nasal pharynx.

Q. Now, Doctor, that particular request that we were just looking at, also, if you look down, it authorizes three visits. Do you see that?

A. Yes.

Q. And just beneath that, I believe it says "workup requested. Dr. Steven Collins."

A. Just above, "Workup requested by -- workup

requested" -- something unintelligible. -- "Dr. Steven Collins.

Q. If you read Dr. Rowane's deposition, he read that particular statement in his deposition, and he said it reads "workup requested, Dr. Collins." Now, looking at that, do you believe that that's a request to the sleep center to do a sleep evaluation and a sleep study on this patient, where it says "workup requested, Dr. Collins"?

A. I think that's a request for evaluation for sleep study.

Q. What would the three visits then refer to?

A. I don't know. I imagine it's a pretest consultation and a sleep study, Maybe a second sleep study.

Q. Pretest consultation, the initial evaluation, taking a history?

A. Yes. I would guess that, but 1 don't know.

Q. Doctor, would you agree that when the sleep center receives a request such as this, where it says "workup and three visits," that there is a duty on the part of the sleep center to make sure that there is a follow-up on the

complete request?

MR. TREU: Objection again to "the sleep center,"

A. No.

Q. Why not? What's the basis of your opinion?

A. I never -- Dr. Brooks probably never saw this. It's part of the --

Q. Okay.

A. -- billing file.

Q. The question wasn't in regards to Dr. Brooks. The sleep center, when they received this request and scheduled the sleep study, do they have a duty to determine what the rest of that request says in regard to workup and three visits, and to following up to make sure that those things are taken care of or that it's referred to the appropriate request?

MR. TREU: Objection. Very broad.

A. My answer is "no."

Q. Tell me what the basis is.

A. The only person who has a duty here is Dr. Brooks, to do the right procedures.

Q. Do you believe that Dr. Brooks had an obligation

and a duty, based on that request, to do an evaluation of this patient?

MR. TREU: Objection,

A. I doubt that Dr. Brooks ever saw this piece of paper.

Q. Should that information have been transmitted to Dr. Brooks, by whoever received this referral?

A. I think the person who receives this would schedule the patient for intake evaluation, history and physical.

Q. What about the request for the workup and the three visits?

A. I think that that's not germane. The patient has been sent to the laboratory for evaluation. The doctor does a test if it's necessary, and maybe another test. The only time that anyone ever goes back to -- where it says "one, two or three," is to see whether or not they need to get more permission to keep on going.

Q. Doctor, I want to be clear on what you are saying. When Dr. Rowane sent this requisition, this referral, and wrote on there that there was a request for a workup and

three visits and a sleep study, is it your opinion that the only thing that the sleep center had a duty to do was to have that sleep study done?

MR. TREU: I object to the question because, as he just said, the form does not say she has to come for three visits. It's an authorization for three visits. You will note it also references the insurance carrier, which is relevant. The other pages of this document. The question is unfair and misleading.

A. Would you repeat the question?

MS. TOSTI: Would you repeat my question for me, please.

(The question was read back.)

MR. TREU: I note my objection.

A. I think the sleep center had a duty to do a sleep study, and I would have looked at this and said that I'm going to insist on a pretest physical examination.

Q. Now, the information on the referral form that Dr. Rowane has included says, number one, "Seizure disorder;" number two, "Rule out nocturnal hypoxia. Reason for referral, this patient has been recently diagnosed with

seizure disorder, request evaluation for sleep study, as concern patient may desaturate as etiology for seizure disorder. Workup requested, Dr. Collins."

Do you have an opinion as to whether Patricia Smith's sleep study should have been given a high priority, based on that information and the information contained in the additional records that are in the sleep center records that we previously looked at?

MR. TREU: Objection.

A. No. I don't think that is the basis for a high priority.

Q. What's the basis for your opinion?

A. I don't think -- looking for apnea as a precipitating or triggering event for seizure disorder, I don't think it should take priority for testing over people who are putting others at risk by being sleepy behind the wheel, for example, or other complications of sleep apnea.

Q. Okay. So people that are sleepy behind the wheel that refuse to give up driving would be **a** higher priority than what we see in these records in regards to Patricia Smith?

A. Yes.

Q. As an expert in sleep medicine, does the suggestion that nocturnal seizures may be caused by oxygen desaturations during sleep raise a high level of concern in your mind regarding this patient, Patricia Smith? Is that something to be concerned about?

MR. TREU: Objection.

A. This does not raise a high level of concern. To me, it's a reasonable rationale for doing a test.

Q. Doctor, the referral that you have in front of you, the date on the referral, I believe, is November 3rd of 1995, correct?

A. Yes.

Q. The sleep study was actually done, I believe, on February 6th of 1996, **Do** you believe that the sleep center met the standard of care by waiting that length of time, from November 3rd to February 6th, about four months, to schedule her sleep study?

MR. TREU: Did you say "four months"?

MS. TOSTI: About four months,

MR. TREU: Three months?

Q. I'm sorry. Three months?

A. That's a long time, but I think it's unfair to characterize that delay as being the responsibilities of the sleep laboratory.

Q. Why do you say that?

A. Many times the patient doesn't call the laboratory until a month or two have gone by. A lot of times these referrals come and the patient never calls up.

Q. Okay. Do you have any information that that happened in this case?

A. No. I'm just telling you my own personal experience. There are many reasons for delay. The laboratory can be one, but it's usually not the only one.

Q. Do you know if there were other accredited sleep labs in Cleveland at the time that Patricia Smith received her sleep study?

A. I don't know. I suspect there are, but I don't know.

Q. Assuming that the University Hospital Sleep Center was not able to schedule the sleep study for a three-month period, do you have an opinion as to whether she should

have been sent to another accredited sleep lab in the area?

MR. TREU: Objection.

A. As I said, I don't think this is a high priority for a sleep slot. I don't think they should bump someone else off the schedule, I don't think there is a rush on this study. No, I don't think there needs to be referral to another laboratory.

Q. Okay. Now, considering her referring doctors were concerned that she was having seizures in sleep due to desaturations, would it have been prudent to schedule her one night for diagnostic and one night for CPAP, rather than requiring her to wait again for CPAP titration?

MR. TREU: Objection.

A. It might be prudent, but it wouldn't be practical.

Q. It is not something normally done for a patient with this type of a history?

A. It would not normally be done.

Q. Doctor, you may have answered this. What, in your lab, is the normal time from the time you get a request to the time you actually schedule a study? Could it be as long as six weeks?

A. Yes.

Q. Now, Doctor, when a patient comes in for CPAP titration, could you tell me how that is done, what's done with the patient in order to get them onto the CPAP therapy?

A. The patient comes in at the assigned hour and meets the technician, who will be the overnight technician. The technician shows the patient five to seven separate masks or interphases, for the patient to choose one that is most comfortable. Then the patient is wired up with electrodes, the same way that was done on the baseline test.

The test proceeds with the CPAP, delivering a low pressure at the onset of the recording. Then after sleep starts, if there are apneas detected while using CPAP at the low pressure, then the pressure is remotely increased in stepwise fashion until the lowest frequency of abnormal breathing events is found.

Q. How big is the apparatus that the patient eventually will go home with if they are to be put on CPAP therapy? What does that apparatus look like?

A. (No verbal response.)
Q. I would assume there is the mask. Is there tubing that comes off the mask?
A. Yes. The mask, the tubing and the device.
Q. How big is the device?
A. It probably has the same volume as a soccer ball, but it's more square. More cubic.
Q. When they are in having the CPAP t tration, are the same readings taken with the overnight polysonogram?
A. The same hours --
Q. The electric cardiosonogram, et cetera, that you mentioned previously?
A. Exactly.
Q. Do you have an opinion as to whether Patricia Smith's obstructive sleep apnea required treatment?
A. Yes.
Q. What's your opinion?
A. She required treatment.
Q. Was CPAP the likely treatment option for Patricia Smith's obstructive sleep apnea?
A. CPAP would be one of the options.

Q. What other options?

A. Because most of her apneas were in REM sleep, protryptline should have been tried. Certainly daily activity for her weight loss should have been started.

Q. You are aware that Dr. Brooks diagnosed Patricia Smith with severe obstructive sleep apnea?

A. Yes.

Q. You are aware of the preliminary report by Dr. Brooks indicating that the study showed severe obstructive sleep apnea, but a decision should be deferred until the final report was prepared?

A. Yes.

Q. What did you interpret that preliminary report to mean? What purpose would there be to sending out such a report?

A. The purpose is to notify the referring doctor that the diagnosis of sleep apnea was made on a preliminary basis. I would have taken this to mean that you begin treatment. Certainly, you begin daily exercise, and you might want to begin by using protryptline.

Q. Was it appropriate for Dr. Brooks to give the

advice that major -- in this case, it was at least five weeks, or about five weeks. -- that major clinical decisions should be deferred?

A. I wouldn't choose to say that. I'm not sure what he means by "major clinical decisions." Maybe what he means is not planning any -- I think the statement kind of -- it doesn't say much to me.

Q. Should Dr. Brooks have included recommendations in his letter to Dr. Rowane?

MR. TREU: Objection.

A. I think the sleep report should have listed some therapeutic options.

Q. Now, there is testimony from Dr. Rowane that this report probably showed up in the family practice center in March, about five weeks after the test was done. If in fact that's when this report was generated, it would be appropriate to wait five weeks before making any type of recommendations?

A. No. It's not appropriate to wait five weeks.

Q. When should recommendations be made?

A. Well, I don't see them being made at any place

here. I have a problem with that. I don't think the recommendations for treatment should be on this preliminary report. They should have been on this overnight report.

Let me also say there are people that I respect in the sleep community who would disagree. Because this is not Dr. Brooks' patient, because Dr. Brooks didn't evaluate this patient, they would say that the information provided with the test should look just about like an EKG report or chest X-ray report.

Those doctors don't see the patient either, just the facts and no other information about treatment options. Their opinion is that Dr. Brooks has no obligation to provide treatment options.

Q. But that's not your opinion?

A. I tried that once. I said maybe they are right. Maybe all these people who don't stop to see me before the test -- I don't know who they are. Maybe I shouldn't be sending out any recommendations. I got a call from a doctor. He said, "You used to be sending out recommendations."

Q. So, Doctor, why do you send out recommendations?

A. Because I don't want to get calls from doctors saying "what do I do with this,"

Q. Doctor, do you know whether or not, under the accreditation criteria, they are required, the sleep center is required, to make recommendations?

MR. TREU: Objection. Reference to the sleep center. He said, "Dr. Brooks."

MS. TOSTI: My question is in regard to the sleep center doctor.

MR. TREU: I understand what they are. It is totally inappropriate.

MS. TOSTI: Your objection is noted.

A. I must say that I think Dr. Brooks has an obligation to give out treatment recommendations.

Q. Dr. Brooks was seeing patients through the sleep center, correct?

A. Right.

Q. Now, you disagree with Dr. Brooks' diagnosis, indicating that she had severe obstructive sleep apnea, correct?

A. Correct.

Q. Can you tell me where you differ from Dr. Brooks, what it is that you are looking at in determining that she had moderate obstructive sleep apnea, as compared to what Dr. Brooks is saying?

MR. TREU: It's 5:15. I need to make a call to my office before people leave.

MS. TOSTI: If you would like to take a break now, that's fine.

(A recess was taken.)

Q. Doctor, we had just discussed the fact that you differed from Dr. Brooks in what you thought was Patricia Smith's diagnosis. You said that you felt she had a moderate degree of obstructive sleep apnea, and Dr. Brooks said severe obstructive. I would like to know what criteria you were using or how you differentiate from what Dr. Brooks said.

A. I counted only apneas and hypopneas when I did the sleep data reduction. Dr. Brooks counted not only apneas and hypopneas, but other events, called "partial obstructions." I do not think there is any justification in the literature for counting partial obstructions.

Q. For the apneas and the hypopneas, is that a complete obstruction?

A. Apneas are a complete obstruction.

Q. What about the hypopneas, is that a complete obstruction?

A. No.

Q. What is that?

A. That's a time when the patient is st 11 breathing, but the resistance is high and they are struggling to breathe, it's so great, that that wakes the person up.

Q. How does that differ from a partial obstruction?

A. I'm not sure.

Q. Do you know what Dr. Brooks was counting on for partial obstruction?

A. I know it did not meet my criteria for hypopnea. The patient has to wake up as a result of high hypopnea.

Q. Do you know what Dr. Brooks was considering a partial obstruction?

A. No. I know there are a lot of events marked which did not meet my criteria.

Q. Doctor, in the field of sleep, are there

differences among sleep experts as to what differentiates mild, moderate and severe obstructive sleep apnea?

A. Yes.

Q. Would it be fair to say there is different schools of thought on that?

A. Yes.

Q. Do do you count anything called a "partial obstruction" when you do sleep studies?

A. Never.

Q. That's not a term that you utilize in your evaluations of the studies?

A. Correct.

Q. Do you you disagree with -- you disagree with the way that the respiratory index was calculated for Patricia Smith, is that correct?

A. Correct.

Q. I believe Dr. Brooks included partial obstructions in his calculations of the respiratory index.

A. Correct.

Q. Now, Dr. Brooks' final report says that Patricia Smith had no dysrhythmias noted.

A. Yes.

Q. Did you find, when you evaluated her sleep study -- you said you reviewed the raw data. Did you find any dysrhythmias?

A. No.

Q. You didn't find any ventricular or atrial --

A. I don't remember finding one.

Q. If there were, they should be noted on the final report?

A. Yes.

Q. If there is like two or three, would those be noted on the reports, even if they were isolated like that?

A. Yes.

Q. Now, Doctor, setting aside the fact that you disagree with the way the respiratory disturbance index was calculated, is an index of 45.6 typically seen in moderate disruptive sleep apnea?

MR. TREU: Objection.

A, Yes.

Q. What do you consider to be normal sleep architecture? What would be seen in each state?

A. REM would be 20 to 25 percent of sleep. The Stages 3 and 4 would be about 20 percent. Stage 1 would be less than five percent. The balance is Stage 2.

Q. Now, do you have an opinion as to whether Patricia Smith's sleep study should have been converted to a split study after the first half of the night?

MR. TREU: Objection. Are you asking whether standard of care --

MS. TOSTI: An opinion as to whether the split study --

MR. TREU: I'm assuming you don't want him to give you opinions that are not legally sufficient as to the accepted standard of care.

A. It's hard to know in this particular case whether a sleep -- why a split protocol would be indicated. I think it probably wasn't. I remember this record. I don't remember seeing enough apneas and hypopneas to justify CPAP intervention.

Q. Okay. You don't have a specific recollection of how many she was having in the first half of the night -- do you? -- at this point in time?

A. Correct.

Q. Okay. In regard to what you utilize in your lab, what is the criteria that you utilize in the first half of the night in regard to --

A. It's about one per minute. One apnea per minute.

Q. One per minute. Do you have an opinion as to whether Patricia Smith should have had a complete sleep evaluation?

MR. TREU: Objection.

A. As I said before, I think I would have not authorized this sleep study until I had seen the patient in a pretest consultation.

Q. Do you think the standard of care requires that this particular patient had been seen for a complete evaluation prior to the sleep studies?

A, My standard does.

Q. I'm asking as to whether the standard of care would require that.

A. I can't comment on that. I don't think the accreditation standards say anything about that.

Q. So you don't have an opinion then in regards to

that?

A. I have a definite opinion about what I think is right, but I can't comment about what the standard of care is.

Q. Do you have an opinion as to whether or not she should have received CPAP titration therapy?

A. Yes.

Q. What's your opinion?

A. My opinion is that she should have first been counseled on daily exercise for weight loss and have been tried on protryptline, because the majority of the avenues are in REM sleep. Only when that didn't work would I be persuaded to go to CPAP.

Q. I want to clarify what you are saying, Based on her sleep study and the information that we have in the records, there was no necessity to start her on CPAP before trying these other methods of weight loss and the medications that you mentioned?

A. Yes. The first thing to do was -- some 80 percent of her apneas are in REM sleep. The first thing to try would be protryptline.

Q. How long a period would you have her on the medication to determine whether or not the medication was going to be effective?

A. About a week.

Q. About a week?

A. Yes.

Q. Okay. Should that have been started right away, after the sleep study was completed, that trial period?

A. If -- it all depends on the communication between the sleep doctor and the primary care doctor. 80 percent or more. I think it was 87 percent. In REM, it's recognized by the sleep person and communicated to the primary care doctor, then that primary care doctor would get the right idea about using protryptline.

Q. Do you find fault with Dr. Brooks in not providing that information to the referring doctor, Dr. Rowane or Dr. Collins?

A. Yes. I think the final report is faulty because it doesn't point out -- you can derive the fact that a hundred and forty-two apneas in REM sleep -- that's out of a total of some two hundred. It's a high -- you can do

that, but that's work. I think they are referring -- the referring doctor isn't expected to know how to do that. I think the reports should say that 87 percent, or whatever it was, occurred in REM sleep. This means protryptline should have been tried.

Q. Recommendation should have been provided to the referring physician --

A. Yes. That's Dr. Brooks' responsibility.

Q. Doctor, you have a copy of your report, correct?

A. Yes.

Q. I would like to quickly go through a few things in there.

A. Okay.

Q. Now, you indicated in your report that the polysonogram was scheduled and performed in a reasonable period of time and in compliance with the standard of care, correct?

A. Yes.

Q. The fact that the referral that we looked at that was provided by Dr. Rowane, the date of November 3rd, then the actual sleep study that was done, I believe, on

February 6th, the time span between that referral and the sleep study, you felt it was in compliance with the standard of care, correct?

A. I think it's a long time, and I don't find any violation of the standard of care.

Q. What's a reasonable time, from the time that the referral is received, to schedule a sleep study?

MR. TREU: I will object. It's an overly broad question.

A. I think most sleep practitioners wish they had ten or 20 laboratories that could take care of all these things in a week or two, but few of us have the -- such a setup. So what's best? Two weeks.

Q. Doctor, you said that it was reasonable and in compliance with the standard of care. So I am asking you what the range is. Three months is a reasonable time, according to your report.

A. It's a long time. Yes.

Q. It's a reasonable time, according to your report, is that correct?

A. Uh-huh. I have people who wait that long, because

they get the -- they just don't act on it. They get the referral and they don't do anything about it until after Christmas.

Q. Okay. Now, you indicate in your report also that once the final report was prepared, it was appropriately forwarded to the physician that ordered the test, and the patient's primary care physician, Dr. Rowane, correct?

A. Yes.

Q. Okay. You didn't do any evaluation of Dr. Brooks' preliminary reports? You didn't comment on that in your report. Is there a reason why?

A. No. I thought it was good that it was faxed out or given out the next day, after.

Q. Now, you have indicated that you felt that the report that Dr. Brooks sent out, the final report, was inadequate and it didn't make recommendations in regard to treatment, correct? It should be part of the report?

A. My reports have that. I think that's the best.

Q. Do you think that's the standard of care for a reasonably prudent sleep specialist, to make recommendations in his reports?

MR. TREU: Objection. It was asked, and he answered that.

A. There are people who treat those who they don't see, who are not their patients, the same way cardiologists and radiologists do. They interpret the data and don't do anything else.

Q. Doctor, I'm asking you, with regard to the standards of care, what a reasonably prudent sleep specialist would do in similar circumstances.

MR. TREU: Objection. Asked and answered.

A. I go back to what I think is right. I think telling the doctor what the choices are for therapy is important.

Q. Okay. You indicated in your records that this was sent to the patient's primary care physician, Dr. Rowane?

A. Yes.

Q. How did you determine that he was the primary care physician in this instance?

A. I think that that was clear from the way that the records went. The patient was sent to Collins by Rowane, and Rowane sent the requisition. It looked like the

primary --

Q. Okay. Did you find in any place in the sleep records where Dr. Collins was listed as the primary care physician?

A. I don't remember that. It says referred by Rowane and Collins. Rowane is from family practice. This seems -- he was clearly the referring doctor.

Q. Do you have a copy in those records of the University Sleep Center, called "University Sleep Center Patient Information," and also a reservation form? Can you tell me who is listed on those forms as the primary physician?

A. Dr. Rowane. Oh, referring physician, Michael Rowane. Primary physician, Rowane is crossed off and Steven Collins is written in.

Q. Okay. What about on the reservation form?

A. This must be the reservation form. Is this a form from the sleep laboratory?

MR. TREU: The same thing.

A. Okay. Referring physician, Rowane. Primary care physician, Collins.

Q. Doctor, would you agree that the sleep center should have forwarded copies of the report to both Dr. Collins and Dr. Rowane?

MR. TREU: Objection.

A. Well, we all send it out to both doctors. I don't know if I have to say that when you don't, you are doing the wrong thing. I have do say that sending it out to the referring doctor is enough. But I like to send it out to everybody that is listed.

Q. Would you agree that when Dr. Rowane received that final report with both Dr. Collins' and Dr. Rowane's name at the top, that he would have a right to expect that Dr. Collins got a copy of it?

A. Yes.

Q. Doctor, is it your experience that most family practice physicians have the expertise to independently make care and treatment decisions for patients that are diagnosed with severe obstructive sleep apnea, or moderate levels of obstructive sleep apnea?

A. Probably most -- probably most know how to proceed. Most family physicians probably know what the

choices are for treating apnea.

Q. In your review of this case, did you find that the University Sleep Center did anything to find out whether Patricia Smith would have appropriate follow-up after her sleep study?

MR. TREU: Objection again to the "University Sleep Center."

A. What was the question?

(The question was read back.)

A. I don't find anything in the record that shows that the sleep center did anything about follow-up.

Q. Doctor, do you have any knowledge in regard to the policies and procedures of the family practice center at University Hospitals of Cleveland?

A. No.

Q. Are you going to be offering any opinions in regard to the way that the family practice center provides patient care?

A. Only that Dr. Rowane, I would expect, would know how to read this and what to do about it, where the rest of the medical students and interns and residents wouldn't be

responsible --

Q. Okay. What's the basis for your opinion that he would know what to **do** about it?

A. Because he probably referred other patients and been educated over time about sleep.

Q. Did you read Dr. Rowane's deposition?

A. Yes.

Q. Do you recall what he said about his knowledge in regard to sleep apnea?

A. No.

Q. Doctor, have we covered all of your opinions that you intend to offer at trial in this case?

A. I think so.

Q. Have you been asked to come to Cleveland to testify in the trial of this matter?

A. I don't think so.

MS. TOSTI: I don't have any further questions.

MR. TREU: When it's typed up, you can review it to make sure it was taken down accurately. Would you like to do that?

THE WITNESS: Yes.

MR. TREU: Okay.

(Examination concluded at 5:46 p.m.)

* * * * *

STATE OF MARYLAND)
) ss
COUNTY OF BALTIMORE)

I, Lorne Langer, a Notary Public in and for the County and State aforesaid, duly commissioned and qualified, do hereby certify that the above named, THOMAS E. HOBBINS, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth, and that his deposition as set forth above, which was reduced to writing under my direction and control, is a true record of the testimony given and/or as corrected by said witness.

I certify that I am not of counsel, attorney, or relative of any party, or otherwise interested in the event of this suit.

In witness whereof I have hereunto set my hand and affixed my notarial seal this 11th day of November 1999.

Lorne Langer
Notary Public

My commission expires July 1, 2000.

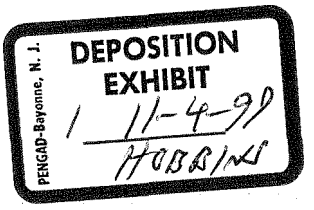
I N D E X

WITNESS	EXAMINATION BY	PAGE
Thomas E. Hobbins, M.D.	Ms. Tosti	2

EXHIBITS

NUMBER	PAGE	DESCRIPTION
1	11	Curriculum Vitae
2	56	Report 5-20-99

Thomas E **Hobbins, M.D., F.A.C.P.**



Birth: December 7, 1939; New York City

Home Address: 915 Poplar Hill Road, Baltimore, Maryland 21210-1221
(410) 433-3371 (voice) & 410-433-1270 (FAX)

Business address: Maryland Sleep Disorders Center
Greater Baltimore Medical Center, Suite 4100
6701 North Charles Street, Baltimore, Maryland 21204-6808
410-494-9773 (voice) & 410-823-6635 (FAX)
E-mail: psrmdteh@igc.org
Doctor's Tax ID: 52-1548460

Degrees:

A.B.	University of Pennsylvania	1961
M.D.	Hahnemann Medical College	1965

Medical Licensure:
State of Maryland, Certificate No. D14511

Postgraduate Education:

Hospital of the University of Pennsylvania, Rotating Internship	1965- 1966
National Institutes of Health, Division of Biologics Standards Laboratory of Viral Immunology, Staff Associate	1966-1969
University of Washington, Seattle, Medical Residency	1969-1971
Hospital of the University of Pennsylvania, Pulmonary Fellow	1971-1972

Postgraduate Courses:

Human Dimensions in Medical Education, 5-Day Program	1973
ACR sponsored "Teaching of Pneumoconiosis"	1974
Human Dimensions in Medical Education, 10-Day Program	1975
Course in Bronchoscopy, University of Iowa	1976
ACR sponsored "Radiology of Pneumoconioses"	1985
Clinical Polysomnography and Sleep Disorders Medicine, Stanford University	1989

Appointments:

University of Maryland, Assistant Professor of Medicine	1972-1933
Director, Medical Intensive Care Unit, University of Maryland	1973-1976
Director, Sleep Disorders Laboratory, University of Maryland	1974-1985
Medical Director, Respiratory Therapy, University of Maryland	1975-1985
Acting Chief, Division of Pulmonary Diseases, Department of Medicine, University of Maryland	1983-1984
University of Maryland, Associate Professor of Medicine	1983-1985
Secretary, Steering Committee, Prospective Investigation Human Rights Committee, Veterans Administration. Cooperative Studies Program Coordinating Center	1987.1996

Current Appointments:

University of Maryland, Clinical Associate Professor	1985-
Attending Physician: Greater Baltimore Medical Center, Baltimore, Md.	1985-
Consultant in Pulmonary Diseases: Fallston General Hospital	1997-

Honors:

Clinical Pharmacology Award, Hahnemann Medical College.	1965
Honorable Mention: The Nellie Westerman Prize for Research in Ethics (American Federation for Clinical Research)	1973

Distinguished Service Award for Advocacy, ALAM	1995
Distinguished Service Award for 1996, BCMA	1996
Community *Service* Award, Medical and Chirurgical Faculty of Maryland	1997
Marquis Who's Who	199s

Certification:

National Board of Medical Examiners, Diplomate	1966
American Board cf Internal Medicine, Diplomate	1972
American Board of Internal Medicine, Diplomate, Sub-specialty of Pulmonary Diseases	1974
National Institute for Occupational Safety and Health, "B" Reader	1985-1989
National Institute *for* Occupational Safety and Health, "A" Reader	1989-
American Board of Sleep Medicine. Diplomate	1990

Medical Societies:

American College of Physicians, Fellow	1974-
American Thoracic Society (ATS)	1971-
Member, American Lung Association/ATS Component Committee on Research Review	1976-1979
ATS Council *of* Chapter Representatives	1983-1989
Secretary & Member, Executive Committee	1987-1988
Chairman, Education Committee	1984-1986
Eastern Section, American Thoracic Society, Councilor from Maryland	1978-1982
Maryland Thoracic Society, President	1981-1983
American Federation of Clinical Research	1973-1985
American Medical Association	1984-
Medical and Chirurgical Faculty (Med Chi) ofrhe State of Maryland	1984-
Occupational Health Committee	1986-1993
Public Health Committee	1994-1997
Member, Steering Committee, Public Health Council	1986-
Chairman, Environmental and Occupational Health Committee	1997-1998
Task Force on Privacy and Confidentiality, Co-Chair	1997-1998
Baltimore City Medical Society	1984-1985
Baltimore County Medical Association	1985-
Delegate, Med Chi House of Delegates	1995-
Legistative Committee	1993-
Program Committee	1994-1996
Board of Governors	1995-
Chair, Ad Mcc Committee on Violence Prevention	1996-
Chair, Focus Group on Coordination with Component Societies	1996-1998
Baltimore County Physicians Political Action Committee	1995-
Treasurer	1996-1998
Clinical Sleep Society	1986-
American Sleep Disorders Association, Fellow	1990-
Co-Chair, Governmental Programs, Health Policy Committee	1994-
CPT Coding Subcommittee. Chair	1995-
Chair, Health Policy Committee	1996-1998
Government Relations Committee	1994-
ASDA representative at AMA RUC committee	1996-1999
Member, Board of Directors	1999-2002
Physicians for Social Responsibility (National)	
Board of Directors	1991-
Treasurer	1995-
President	1999
Baltimore Physicians for Social Responsibility. Steering Cmte.	1987-
Chair, Program Committee	1987-1989
Vice President	1988-1989
President	1989-1991