

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

- - -
TRACY ANN SMITH, : CIVIL ACTION
et al. :
VS :
UNIVERSITY HOSPITALS :
OF CLEVELAND, et al. : NO. 327828
- - -

Oral deposition via telephone
of Dr. Steven G. Meister, Witness, on behalf of
the Defendants, pursuant to the Ohio Rules of
Civil Procedure, taken in the offices of Dr.
Steven Meister, Medical College of
Pennsylvania, 3300 Henry Avenue, Philadelphia,
Pennsylvania, November 17, 1999, commencing at
or about three-thirty o'clock p.m., Eastern
Standard Time, before Karen M. Unghire, Court
Reporter - Notary Public.

- - -
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18 - - -

19 DR. STEVEN G. MEISTER, having
20 been duly sworn, was examined and
21 testified as follows:

22 - - -

23 BY MR. TREU:

24 Q. Doctor, this is Kris Treu. We met, I
don't know how long ago, when I was in
Philadelphia when we unsuccessfully attempted
to complete your deposition.

A. Yes.

1 Q. Just one thing about this phone
2 deposition. I think what you'll find with
3 these speaker phones is oftentimes if we speak
4 over each other, one of us is not going to hear
5 the other.

6 A. I understand.

7 Q. So I'll do my best to not speak over you
8 if you'll wait until I finish with my question
9 before you begin your answer and I'll wait
10 until you're done with your answer before I
11 begin my next question. Is that all right?

12 A. That is correct, and please tell me if I
13 violate that.

14 Q. Sure. I'll do my best. It's sometimes
15 hard with these speaker phones.

16 MS. TOSTI: And I would also
17 ask, Doctor, that you hesitate just for a
18 second before you give your answer in
19 case I want to enter an objection, so we
20 aren't stepping on each other either.

21 THE WITNESS: Okay.

22 MR. TREU: Just for the
23 record, this is the discovery deposition
24 of Dr. Meister taken pursuant to Rule

1 26B.4B of the Ohio Rules of Civil
2 Procedure.

3 BY MR. TREU:

4 Q. Doctor, would you just please state for
5 us your full name?

6 A. Steven, with a V, Gerard, G-E-R-A-R-D,
7 Meister, M-E-I-S-T-E-R.

8 Q. Doctor, have you given deposition
9 testimony before?

10 A. Yes, I have.

11 Q. As an expert witness?

12 A. Yes.

13 Q. On approximately how many occasions?

14 A. I don't know how many. I've been doing
15 it from time to time since 1977.

16 I would say in recent years
17 the number of depositions I give has gone up to
18 probably three or four a year, perhaps even
19 more than that. I'm not sure, maybe less.

20 Q. And those are as an expert witness you're
21 speaking of?

22 A. Yes.

23 Q. Have you also given deposition testimony
24 as a care provider?

1 A. You mean have I been sued? Yes, I have,
2 a few times.

3 I would say total suits may
4 amount to half a dozen. Depositions, three or
5 four, one court appearance, only one.

6 Q. Have you ever been asked to testify as a
7 witness just in terms of your care of a
8 patient, not in a situation where you've been
9 sued?

10 A. I think so, but I don't remember.

11 Q. Are you an invasive cardiologist, Doctor?

12 A. I was at one time from -- really from the
13 end of my training. When I began as a -- when
14 I began as a faculty cardiologist and an
15 attending cardiologist in 1970, I was director
16 of the cardiac catheterization laboratory at
17 Presbyterian-University of Pennsylvania
18 Hospital in Philadelphia.

19 And 1973, I came here to
20 M.C.P. as director of the cardiac
21 catheterization laboratory. I held that
22 position until 1979 or '80, and at that time, I
23 became chief of cardiology here.

24 I continued as an invasive

1 cardiologist and as an interventional
2 cardiologist until the late 1980s or early
3 1990s when I stopped the interventional work
4 and then in about 1994 or '95, I decided not to
5 do any more diagnostic catheterization either.

6 Q. So you have done any number of
7 catheterization procedures in your career?

8 A. I have.

9 Q. And as part and parcel of doing those
10 catheterization procedures, do you prepare
11 reports of your findings?

12 A. Yes.

13 Q. What is the average it would take for you
14 to usually produce a report from one of your
15 catheterization procedures?

16 A. In our laboratory today, the reports are
17 expected to be out within forty-eight hours.

18 I can't tell you it has never
19 taken longer than that but --

20 Q. If you did a catheterization procedure
21 and you didn't produce your report for a month,
22 whose fault would that be?

23 A. It would be mine if I did it
24 occasionally. If it was done on a regular

1 routine basis, it would be the fault of the
2 institution that permitted me to work in their
3 laboratory and let this happen.

4 Q. How many times would you be permitted to
5 do it before it's the institution's problem?

6 A. Technically, I think it becomes the
7 institution's problem after I've done it once,
8 but they may not find out about this for
9 awhile.

10 Certainly, if they find out
11 that I'm doing this, immediately upon finding
12 out, they have a duty to make that change.
13 That's my understanding of it.

14 Q. What is it that requires you to produce
15 your reports within that period of time?

16 Is it a standard practice, is
17 it a policy and procedure?

18 A. I can only speak for what we've done here
19 at our institution.

20 I don't know what really is
21 the situation nationwide, but in our
22 institution, it was just considered good
23 practice and I believe it was also feared that
24 if there were a pattern of this sort, that a

1 couple possibilities would occur.

2 One would be that the Joint
3 Commission on Hospital Accreditation would give
4 us bad marks for that and require us to correct
5 it, if we didn't correct it ourselves.

6 And, secondly, we thought it
7 was bad practice and, thirdly, we would be
8 leaving ourselves liable to suit if something
9 happened to a patient while our report was
10 tardy.

11 Q. You would agree with me the simple fact
12 is you don't need the institution to tell you
13 that you should get your reports out in a
14 reasonable period of time?

15 A. I shouldn't have to, but if I violate
16 that, then the institution should surely tell
17 me.

18 Q. I believe we were provided with a
19 Curriculum Vitae of yours.

20 MR. TREU: Jeanne, correct me
21 if I'm wrong. I got an updated one when
22 we were in Philadelphia, correct?

23 MS. TOSTI: Correct.

24 BY MR. TREU:

1 Q. Is that the most recent copy of your
2 C.V.?

3 A. It should be.

4 Q. And that would be --

5 A. I'll tell you the way to tell. The most
6 recent revision that I made was when I stepped
7 down as the chief of cardiology at M.C.P. and
8 that was in June of 1998, I believe.

9 MS. TOSTI: Kris, if I can
10 just interject here. The copy that I
11 gave you when we were in Philadelphia,
12 Dr. Meister's secretary had just run off.

13 So I believe it was the most
14 recent one that they had available.

15 MR. TREU: Okay.

16 BY MR. TREU:

17 Q. You're a cardiologist, correct, Doctor?

18 A. That is correct.

19 Q. Do you have any subspecialties within
20 your area of practice?

21 A. Well, first off, I'm an internist first.
22 Cardiology is a subspecialty of that.

23 And for a long period of
24 time, I was an invasive and interventional

1 cardiologist which would be a subspecialty of
2 cardiology.

3 Now, it wasn't formally
4 recognized as that until quite recently. In
5 fact, my colleagues right now are taking the
6 very first board certification examinations in
7 cardiology. Long answer for a short question,
8 sorry.

9 Q. You are board certified?

10 A. In medicine and cardiology.

11 Q. Passed on your first attempt?

12 A. Yes.

13 Q. What hospitals do you have privileges at?

14 A. Right now?

15 Q. Yes.

16 A. The Hospital of the Medical College of
17 Pennsylvania, Fitzgerald Mercy Hospital, John
18 F. Kennedy Hospital of Philadelphia, and I have
19 at least courtesy privileges at Frankford
20 Hospital in Philadelphia. I should say
21 hospitals. It's plural.

22 Q. Can you give me a sense of the size of
23 these hospitals where you have privileges in
24 terms of beds?

1 A. All right. To the extent that I know,
2 and, frankly, I don't really know.

3 This hospital at M.C.P. is
4 rated, I believe, for three hundred and
5 twenty-five beds. I think it only keeps about
6 two hundred and twenty-five, two hundred fifty
7 occupied at any one time.

8 Frankford, I haven't the
9 faintest idea. My guess would be, between the
10 two Frankfords, they probably have two hundred
11 and fifty beds.

12 Fitzgerald Mercy is probably
13 good for two or three hundred beds. J.F.K. is
14 probably a hundred beds. It's small.

15 Q. Can you describe your current practice
16 for me?

17 A. Yes. I spend, currently, about ninety
18 percent of my time, maybe ninety-five percent
19 of my time, caring for inpatients and
20 outpatients. I round two or three days a week
21 in the hospital on inpatients and then I see
22 inpatients at the hospital in our outpatient
23 area. Excuse me. I said that wrong.

24 I see outpatients in our

1 outpatient area of the hospital two days a week
2 or two afternoons a week, half days, and then I
3 spend a day in an office in Northeast
4 Philadelphia seeing outpatients there.

5 Q. Are you a part of a group?

6 A. Well, I'm an employee of the Medical
7 College of Pennsylvania. I should say M.C.P.
8 Hahnemann University, the combined university,
9 and I also am employed on a part-time basis by
10 a group called Greater Philadelphia Cardiology
11 Associates. It's sort of a split position at
12 this point.

13 Prior to this year, I was
14 always completely full time at Medical College
15 of Pennsylvania with the medical school.

16 Q. So are you an employee of the hospital,
17 Doctor?

18 A. Yes, I am, not the hospital, the
19 university, forgive me, but the hospital and
20 the university used to be the same entity.
21 They are no longer, as of a year ago.

22 So I'm an employee of M.C.P.
23 Hahnemann for sixty percent of my time.

24 The remainder is the

1 Philadelphia Cardiology Associates.

2 Q. And you practice at a number of different
3 hospitals, but primarily out of M.C.P.?

4 A. That's correct, almost exclusively at
5 M.C.P. at this point.

6 Q. Because you happen to practice at M.C.P.,
7 if by chance you were to fail to meet accepted
8 standards of care, would the hospital be
9 responsible for your failing to meet accepted
10 standards of care because you practice there?

11 A. It's my understanding that they would, to
12 the some extent, be responsible for that.

13 Q. And how is that?

14 A. Well, I'm not a lawyer, sir. I don't
15 know that for certain, but I do understand in
16 my capacity, in my former capacity of chief of
17 cardiology for a number of years here, the
18 understanding was that the hospital was
19 required to maintain oversight and to maintain
20 an environment in which people did practice
21 according to appropriate standards and to
22 maintain some degree of surveillance.

23 And, certainly, if they were
24 running an organized program that we're part of

1 the university, it would seem to me that the
2 university, or whoever owned the program, would
3 be responsible to be certain that its workings
4 were reasonable and appropriate.

5 Q. So if you go over to J.F.K. Hospital, for
6 example, and do a procedure and you fail to
7 meet the accepted standard of care, it's your
8 understanding that J.F.K. Hospital would
9 somehow be responsible for your actions?

10 MS. TOSTI: I'm going to
11 enter an objection here because you're
12 asking the Doctor for a legal conclusion
13 and I don't believe the Doctor has
14 represented that he's qualified to give
15 any type of a legal opinion.

16 BY MR. TREU:

17 Q. Can you answer that question, Doctor?

18 A. I'm not qualified to give a legal
19 opinion.

20 As I said, I don't know what
21 the reality is. However -- I mean, I don't
22 know what the legality is.

23 I know that as a practical
24 matter, if it's discovered by the hospital that

1 I'm not doing things in an appropriate and
2 reasonable way, they are required to prevent me
3 from doing this or apply some sort of
4 corrective measures to make sure that I do it
5 right or not at all.

6 Q. Are you saying that hospitals should
7 somehow direct how doctors provide care?

8 A. No. They do direct certain aspects of
9 it. There are certain standards for how things
10 are done.

11 For example, as I think might
12 be applicable, I think we both know might be
13 applicable to this case, there are certain
14 standards for reporting of critical data.

15 If I pick up an
16 electrocardiogram, in the course of reading
17 electrocardiograms at this hospital, find
18 something such as an ongoing myocardial
19 infraction or some other very abnormal finding,
20 I'm expected to be certain that this is known
21 about.

22 I may only have to look on
23 the request sheet and see that the patient is
24 in the coronary care unit and that's

1 sufficient, but there are certain kinds of
2 things that I'm required to report, critical
3 data I think it's called.

4 I remember setting something
5 like that up for our institution in
6 cardiology. We had to look over the kinds of
7 laboratory reports and procedures that we do in
8 which prompt notification would be necessary
9 and designate them as such and publicize the
10 fact that these things had to be reported on
11 promptly. That was a long time ago.

12 Q. My question is, how is the hospital to
13 know in each instance that, for example, that
14 report is not being done in an appropriate time
15 frame?

16 A. Well, in the first place, I'm not a
17 hospital administrator, but I do know that, at
18 least in our institution, and I suspect this
19 -- I believe this is a common practice, that
20 from time to time, they take appropriate
21 samples to find out if things are being done in
22 a timely fashion.

23 I know that they look at the
24 time that it takes us to report an

1 echocardiogram on a routine basis, never mind a
2 critical echocardiogram, or a cath report or a
3 nuclear cardiology study, things of this sort,
4 echocardiograms, for example.

5 Things of this sort we're
6 expected to have a report in the chart quite
7 promptly.

8 Q. Where do those standards come down from?

9 A. I know that the major oversight
10 organization is the JCAHO, Joint Committee for
11 Accreditation of Hospitals, and I'm not sure
12 what the O stands for, but there is a committee
13 that does this and I believe it's a national
14 organization. At least we have it here in
15 Pennsylvania.

16 Q. Do you know if the JCAHO has any
17 requirements for signing of reports of sleep
18 studies?

19 A. I have no idea. I would think that, in
20 general, it would be expected that sleep
21 studies that have serious implications for the
22 patient, there ought to be some standards, but
23 I don't know what they are.

24 Q. How many patients have you referred for

1 sleep studies in your practice?

2 A. Oh, I would think a dozen, a dozen and a
3 half.

4 Q. That's in how many years of practice?

5 A. Well, I've been practicing as an
6 independent attending physician since 1970. So
7 that's twenty-nine years.

8 Sleep studies first became
9 available, I believe, and I'm just guessing at
10 this, probably in the early 1980s.

11 We hadn't begun to use them
12 with regularity until probably the mid late
13 '80s. I'm not really an expert on the history
14 of sleep studies and sleep study laboratories,
15 but I know that I use them more now than I ever
16 did, using them with some frequency.

17 Q. So a dozen patients since the early '80s
18 for you?

19 A. I'm guessing, sir. I don't really know
20 if that's the correct answer.

21 MS. TOSTI: Objection,
22 because he said a dozen, dozen and a
23 half.

24 MR. TREU: Okay, fine.

1 BY MR. TREU:

2 Q. Is that more accurate, Doctor?

3 A. I'm guessing, probably. I have sent this
4 year, I would guess, I've sent, oh, I don't
5 know, probably four to six this year.

6 Q. How about in 1995?

7 A. Probably a smaller number, but we did
8 send them for sleep study then.

9 Q. Can we agree that utilization of sleep
10 labs are recognition of the -- efficacy of
11 sleep lab studies has been something that has
12 grown over time?

13 A. I think that's true of any other
14 successful modality and I'm certainly not an
15 expert on, again, on the history of sleep
16 studies other than to tell you in a general way
17 that I know that there was a time when they
18 didn't exist during my professional lifetime
19 and they have become more and more utilized.

20 Q. I'm really asking from your perspective
21 as an internist slash cardiologist, in terms of
22 the acceptance of this type of study and its
23 utilization, you would agree with me that it
24 has become more known, recognized over the

1 years?

2 A. I would think. It has to be.

3 Q. In 1995, do you have any idea how long it
4 was taking you to get a patient of yours
5 scheduled for a sleep study?

6 A. I honestly don't know. I don't recall.

7 Q. Do you know how many labs were in your
8 area in 1995?

9 A. Oh, this is Philadelphia. It's a pretty
10 big city. I guess Cleveland is, too.

11 I know there were several.
12 1995, this was not experimental material. This
13 was a routine thing.

14 Q. Routine, but you would say that you
15 probably didn't refer any more than two or
16 three patients in 1995?

17 A. Well, I'm a cardiologist. I'm not a
18 primary physician.

19 And when the patient comes to
20 me, they have already been screened and there's
21 a pretty fair chance that if they needed a
22 sleep study, that the individual who sent the
23 patient to me has already sent them to a sleep
24 study and I have seen that a number of times.

1 And that kind of thing, I
2 would say probably I have seen several dozen.

3 Q. Again, since the early '80s?

4 A. Again, I'm not sure exactly when we began
5 to do them very frequently, but I would guess
6 since the mid '80s.

7 But I really have no -- I
8 just know it was a fairly common thing. I
9 can't tell you with what -- exactly what
10 frequency.

11 Q. Do you have any publications that have
12 any bearing on this case?

13 A. Any bearing on sleep study, none. I have
14 some that probably would have some bearing on
15 management of angina pectoris. Not probably,
16 do.

17 Q. Can you identify them or do you not have
18 your C.V.?

19 A. I don't have my Curriculum Vitae in front
20 of me.

21 Specifically, I've done some
22 publications that were related to the discovery
23 of the mechanism for unstable angina pectoris.

24 Now, that's not a direct

1 bearing, but angina pectoris is probably what
2 this lady had at certain times in her last year
3 or two.

4 Q. Can you do me a favor, when you send me
5 your bill for this session, can you also just
6 include in that a letter and identify for me
7 which of these publications in your C.V. you
8 believe would bear on the --

9 A. Yes. It depends on how direct a bearing
10 you want, but I'll look that over and underline
11 those.

12 But, again, the lady had
13 angina pectoris and --

14 MS. TOSTI: If you send it to
15 me, and then I'll forward it to Mr. Treu.

16 THE WITNESS: Surely.

17 MR. TREU: What's the
18 difference?

19 MS. TOSTI: Because that's my
20 request since he's my expert, that he
21 provide it to me so I get to see it and
22 then I will provide it to you.

23 MR. TREU: If there's any
24 deep dark secret, but that's fine.

1 THE WITNESS: I have a lot of
2 deep dark secrets on my Curriculum
3 Vitae.

4 MS. TOSTI: Well, at this
5 point, I'd like to see what he's sending
6 you so I will make my request, Doctor,
7 that you provide it to me and I will be
8 happy to provide it to Mr. Treu.

9 THE WITNESS: Surely.

10 BY MR. TREU:

11 Q. Doctor, what did you review in connection
12 with this case?

13 A. First off, I reviewed University Family
14 Practice office records from April '92 through
15 April '96, Dr. Collins' office records, Dr., I
16 don't know how you pronounce this, H-L-A-V-I-N,
17 I guess Hlavin, the neurosurgeon's office
18 records, the St. Luke Medical Center Emergency
19 Department records, the University Hospitals
20 Sleep Center records, the death certificate,
21 the autopsy report.

22 I received some pages from
23 the polysomnogram to look at directly, mainly
24 for the electrical parts of that.

1 I've got depositions of Dr.
2 Collins and several other people here. Let me
3 pull them out and I will give them to you.

4 I got Dr. Rowanne's
5 deposition, Dr. Martin's deposition, Dr.
6 Hlavin's deposition, Dr. Collins, Dr. Brooks,
7 and I also have some expert letters.

8 Q. From whom?

9 A. I'm looking. Dr. Richard Watts, Dr.
10 Hobbin, Dr. Cully, Dr. Feinsilver, Dr. Smith
11 and Dr. Dinner.

12 I have the depositions of
13 Tracy Smith, Geneva Smith, and Dr. Craig
14 Whiting, and I think that's all I've got here.

15 Q. Did you review all that data?

16 A. I did not really look at the depositions
17 of the patient's relatives, did not have a
18 chance, and some of this stuff I looked at
19 awhile ago. I'm not positive I've seen it
20 all. Some of it I've looked at more recently.

21 Q. What about the depositions, do you know
22 how many of those you read?

23 A. It's been awhile since I received them
24 and looked at them.

1 Q. You're not sure.

2 A. I'm not sure.

3 Q. How about the letters, you read all the
4 letters?

5 A. All of them.

6 Q. Were you provided with any additional
7 information?

8 A. Not off the top of my head.

9 Q. Were you given any deposition summaries?

10 A. I believe that I was, but I don't look at
11 them.

12 I prefer to read the
13 depositions myself.

14 Q. Were you provided with any letters
15 summarizing the facts of this case?

16 A. I don't know. If I have, it's been a
17 long time since I looked at it. Let me look
18 through.

19 That one doesn't, and this
20 one doesn't. That one doesn't. Still
21 checking. Hold on.

22 Here's one that looks like a
23 summary. I can't read it. It's from November
24 1997, but I probably could read it when I got

1 it.

2 Q. Was that a letter?

3 A. Yes. It's a letter from Jeanne Tosti.
4 That's routine, which is why I was looking
5 because I thought there would be one.

6 Almost any time I'm asked to
7 look at a case, I'm given a summary by the
8 lawyer, whether it's for the defense, which is
9 what I do mostly, or for plaintiff, as in this
10 case. There's usually a summary from the
11 lawyer and that's a useful -- a good way to get
12 started.

13 Q. So you reviewed that letter when you
14 initially got the case?

15 A. I probably did. That would be my
16 practice.

17 I haven't looked at it since
18 1997, I don't believe.

19 Q. Do you know when you first got involved
20 in this case?

21 A. I bet that that November '97 letter was
22 probably when I was asked to be involved. I'm
23 guessing, but I would think so.

24 Q. Then --

1 A. There might have been a phone call first,
2 but I don't recall because I'm contacted by
3 lawyers at different times in different ways,
4 sometimes by telephone, sometimes with a
5 letter.

6 Q. What were you asked to do when you
7 received this case?

8 A. Review some records and comment, prepare
9 a report.

10 I think, first of all, talk
11 to the lawyer, and consider preparing a report.

12 Q. Do you know how much time you spent
13 reviewing this case?

14 A. Not off the top of my head, but I think
15 to begin with it probably was somewhere between
16 six and twelve hours. That's what it usually
17 takes me, depending on how much material there
18 is.

19 This one was nicely arranged
20 with everything put in categories so that it
21 made it easier to go back and forth between the
22 records which might have made it a quicker case
23 to do.

24 Q. Do you know how plaintiff's counsel got

1 your name?

2 A. I do not. However, I would say this.
3 That every now and then I'm asked from
4 Cleveland to -- I think there are two or three,
5 maybe even four firms in Cleveland that will
6 send me cases to look at or have over the
7 years.

8 How it is that I'm known to
9 that many firms in Cleveland, I have no idea.
10 My guess is that I probably worked for one at
11 one time.

12 I would add that I began
13 doing this in 1977 as a favor to a colleague of
14 mine who looked at quite a lot of these and
15 found himself involved either with two
16 different parties in the case and asked if I
17 would take over one and I found it interesting
18 and told him that I would like to do more at
19 any time.

20 And at some point along the
21 line, I saw an ad in the New England Journal of
22 Medicine for someone looking for physicians who
23 would be willing to function as expert
24 witnesses and I answered that ad.

1 And every now and then I get
2 a case through them. I think on the order of
3 once a year, once every two years, something
4 like that. Some of the additional cases may be
5 metastases, may be offshoots, children of
6 previous cases that I've taken.

7 Q. Is that some expert witness service?

8 A. That was an expert witness service.

9 Q. Do you know the name of it?

10 A. It will come to me, but I can't think of
11 it.

12 Q. Is it an individual's name?

13 A. Sapanaro.

14 Q. Do you have any idea how many reviews
15 you've done for Sapanaro?

16 A. First of all, I don't know when I first
17 contacted them, but I would bet that I've
18 reviewed over the years maybe ten or fifteen
19 cases for them.

20 Q. Do you know the names of any of the
21 Cleveland firms you referenced earlier?

22 A. Not off the top of my head. There's a
23 Novak.

24 Q. Bill Novak?

1 A. That might be the guy. That's one of the
2 firms, yes.

3 Q. Were these primarily plaintiff's firms?

4 A. I think so.

5 Q. Anything for the Neurenberg firm?

6 A. That doesn't sound familiar.

7 Q. Weisman Goldberg?

8 A. That really doesn't sound familiar.

9 Q. Bangenberg?

10 A. Not that I know of.

11 Q. Have you ever done any prior cases for
12 the Becker and Mishkind firm?

13 A. I think so, but I'm not sure.

14 Q. Did you ever work with Ms. Tosti before?

15 A. I don't think so. You could ask her, but
16 I don't think so.

17 Q. She would never tell me.

18 A. Okay.

19 Q. Do you consider yourself an expert in
20 sleep medicine?

21 A. I do not.

22 Q. How about family practice?

23 A. To an extent, not an expert in family
24 practice, but I know in my own area in

1 cardiology what is reasonable to expect of a
2 family practitioner and what's not reasonable
3 to expect pretty well.

4 I'm kind of an expert on
5 that.

6 Q. Are you an expert in neurology?

7 A. No, sir.

8 Q. I have been provided with a report from
9 you dated January 26, 1998.

10 Is that the one and only
11 report you've prepared relative to this matter?

12 A. Yes.

13 Q. Is it accurate and complete?

14 A. What do you mean by that?

15 Q. Does it accurately reflect your opinions
16 in this case and does it cover all of the
17 opinions you have in this case?

18 A. It certainly -- everything that's in
19 there accurately reflects my opinions.

20 I can't say that I might not
21 at some point think of something that isn't in
22 there.

23 Q. Well, that's the purpose for today, I
24 guess. I need to leave you today being

1 comfortable that you have told me all the
2 opinions that you're going to offer in this
3 case.

4 A. Well, I think so.

5 Q. Tell me --

6 A. I've read that letter recently and
7 there's nothing there that I don't still agree
8 with having reviewed some more of the material
9 or re-reviewed it, I should say, and I don't
10 have any really new ideas that are not covered
11 in there. At least new ideas that are relevant
12 to the case itself.

13 Q. Since you prepared this report of January
14 26th, 1998, you've been provided with
15 additional information?

16 A. Yes, some of the depositions and the
17 expert reports were not available to me at that
18 time.

19 Q. So this opinion letter was based on the
20 records which you outlined in page one of this
21 report?

22 A. That's correct.

23 Q. And you're telling me today that you have
24 not changed any of your opinions based on what

1 you've read subsequent to the time you prepared
2 this?

3 A. Not materially.

4 Q. Did you prepare any drafts before you
5 produced this report?

6 A. No. The way I do it, and I've just begun
7 doing this in January, which is why it's a
8 little choppy, in January I got my first
9 computer and I absolutely love the word
10 processor because I could build the letter up
11 as I went along and that was the method that I
12 used at that time.

13 I've subsequently started
14 using a different method which is to prepare an
15 outline first. Again, the computer is ideal
16 for that sort of thing and then use that as a
17 guide for doing the letter and I find that to
18 be a little more efficient.

19 Q. Did you make any notes as you reviewed
20 these records?

21 A. Just of the time spent. I used to do
22 that with some frequency, but I don't see any
23 here.

24 Q. Did you make any markings on the records

1 as you reviewed them?

2 A. Probably not. From time to time, if I
3 see something I really don't like, I might
4 throw in an exclamation mark or an expletive or
5 something of that sort, but I don't think I did
6 any of that here.

7 Q. What are some of the leading texts and
8 journals in the area of cardiology?

9 A. Oh, there is Brownwald is a good textbook
10 and -- hang on a second.

11 Q. Okay.

12 A. I don't use textbooks very much. There's
13 one by Parmley that I'm sure is good. I
14 haven't spent a lot of time. There's one by
15 Eric Topal and these are edited by these people.
16 They, obviously, don't write everything in
17 them.

18 One of my favorites was one
19 that I read during my training, Friedberg,
20 which is no longer in print, but you see
21 textbooks, for me anyway, are things that I
22 used in the course of my training.

23 They're a great place to
24 start and I keep them around, relatively

1 up-to-date, if I want to look up something that
2 I really don't know anything at all about,
3 something comes up either in my practice or
4 occasionally in the business of functioning as
5 an expert witness.

6 Q. Did you review any literature relative to
7 this matter?

8 A. I really didn't.

9 Q. You haven't done any reading on sleep
10 studies or anything like that?

11 A. No. I was asked to testify as a
12 cardiologist.

13 Q. Are there journals that you refer to from
14 time to time?

15 A. Yes.

16 Q. What are those?

17 A. I read the New England Journal of
18 Medicine, the American Journal of Cardiology,
19 the Circulation, Circulation is the name of it,
20 American Heart Journal, the Annals of Internal
21 Medicine are the ones that I look at
22 primarily.

23 And I must tell you that I do
24 not read them cover to cover or even close. I

1 like to look through principally at the
2 summaries, the abstracts that are present at
3 the beginning of each chapter, and if I'm very
4 interested in the article, then I may open it
5 up and read it more carefully, particularly
6 with regard to the methods.

7 I also enjoy a tape that's
8 put out by the American College of Cardiology
9 on a monthly basis called Accel, A-C-C-E-L,
10 which consists of abstracts and speakers from
11 the major cardiology conferences around the
12 world, at least those in the English language,
13 which is a nice way of keeping up-to-date on
14 things that might be going on that I can, in
15 this manner, become aware of before they reach
16 the journal.

17 They are nice summaries that
18 you get on a monthly basis and I can play them
19 in my car on the way back and forth to my
20 offices and to the hospital.

21 Q. Do you work with residents in your
22 practice?

23 A. Yes, I do. I spend a lot of time working
24 with residents. Every day that I round, I

1 round with the residents and that typically
2 runs one and a half to three hours, plus which
3 I interact with them at other times of the
4 day.

5 One of the phone calls that I
6 got during this deposition a few minutes ago
7 was from one of my residents and they know I'm
8 not supposed to be disturbed.

9 Q. Can we agree that residents are doctors
10 in training?

11 A. Yes. In that connection, one of the
12 residents whose summary I -- whose deposition I
13 looked at was actually a fourth year medical
14 student acting as an intern. So just these
15 kinds of things exist.

16 Q. Have you read the deposition of Dr.
17 Southerland?

18 A. No. I don't think I've read that or if I
19 did so, I haven't done so recently.

20 Q. He's another expert identified by the
21 plaintiff in this case.

22 A. I haven't read that.

23 Q. If I were to advise you that Dr.
24 Southerland testified that he had no criticisms

1 of any of the residents in this case, would you
2 agree with that statement?

3 MS. TOSTI: I'm going to
4 object to that since the Doctor has not
5 had an opportunity to read any of Dr.
6 Southerland's deposition testimony and to
7 see the context which any statements that
8 you're representing he made was made in.

9 MR. TREU: That's fine.

10 BY MR. TREU:

11 Q. I just ask you to assume he said that.
12 Would you agree with that?

13 A. Would I agree that the residents didn't
14 do anything wrong?

15 Q. Yes.

16 A. No, I wouldn't agree with that.

17 Q. Why not?

18 A. Where I come from, where I trained and
19 where I teach, we teach our house staff to be,
20 especially our medical students, to be somewhat
21 more compulsive than the people who wrote a
22 number of the notes that were in the chart,
23 even seeing outpatients.

24 There were episodes of chest,

1 shoulder, hand discomfort, things that could
2 have been construed as cardiac origin in a
3 patient with a lot of risk factors for cardiac
4 disease where there were no follow-up questions
5 asked.

6 The woman came in saying she
7 had pain in her wrists coming and going, pain
8 in the throat coming and going.

9 The word angina pectoris
10 -- the word angina means throat pain. Pectoris
11 means throat and chest pain.

12 When you hear about that,
13 especially in somebody who carries risk factors
14 like hypertension, elevated cholesterol,
15 triglycerides, cigarette smoking, you're
16 supposed to at least ask under what
17 circumstances the pain occurs, is there
18 anything that brings it on, how long does it
19 last, what's the quality of the pain, things of
20 that sort.

21 And we really expect our
22 house staff to be more compulsive about it, at
23 least in recording it, than attendings, because
24 that's what they're supposed to be learning to

1 do.

2 And I didn't see very much
3 questioning that was really intensive, that was
4 goal directed.

5 Q. Are you going to render an opinion in
6 this case that the residents failed to meet the
7 accepted standards of care?

8 A. If you look at my letter I did comment on
9 this. I don't know exactly where. I would
10 have to look through it, but I did mention
11 there wasn't enough data reported in some of
12 these records for us to be able to know what
13 the significance of some of these symptoms were
14 and there should have been.

15 Q. I guess I have to go back because I need
16 to know whether you're going to offer an
17 opinion in this case that a resident or
18 residents failed to meet accepted standards of
19 care in this case and, if so, where and how?

20 A. Let me look through then. Can you wait a
21 second?

22 Q. Sure.

23 A. I don't know if Dr. D.L. Kaliff was a
24 resident or an attending. Let me read you this

1 sentence.

2 She was first seen at the
3 family practice clinic on April 28th, '92 by
4 Dr. D.L. Kaliff. She was thirty-nine years old
5 and complaining of what was said to be
6 heartburn and digestive problems. I qualify
7 this simply because Dr. Kaliff did not specify
8 in his note precisely what Mrs. Smith's
9 complaints actually were like. This may be
10 important since heartburn is typically located
11 in the midline of the front of the chest,
12 substernal area or precordium, which is also a
13 typical location for angina pectoris. And at
14 that time, she had a bunch of risk factors. I
15 don't need to read everything out.

16 Let me see if I can find
17 something else in there.

18 On 3-13-95, Mrs. Smith
19 complained of a one year history of pain in the
20 left shoulder and both arms, the greater on the
21 right of one year's duration.

22 No further details as to
23 circumstances of occurrence or duration of
24 these pains are noted.

1 And, in addition, she
2 complained -- well, that isn't really
3 relevant. This is when she had her changes in
4 the electrocardiogram.

5 Those are the kinds of things
6 I'm talking about.

7 Am I making a specific
8 allegation that the house staff were doing
9 substandard work, only to the extent that in
10 these particular instances, the patient
11 complained of symptoms about which further
12 details ought to have been put in the record
13 and I think in the process, the diagnosis of
14 coronary heart disease was missed, of angina
15 pectoris based on coronary heart disease.

16 Q. Unfortunately, I need to be more specific
17 in terms of knowing where your criticisms are
18 going to come down.

19 A. Well, I think I just told you, but I'll
20 try again.

21 Q. I have to ask you to because I'm still
22 not certain.

23 Are you testifying that Dr.
24 Kaliff, on April 20, 1992, failed to meet the

1 standard of care?

2 A. There are complaints that could be angina
3 pectoris, they could be of cardiac origin, that
4 were not, at least as far as the records are
5 concerned, did not contain sufficient
6 information. More information should have been
7 obtained and documented.

8 It's possible that Dr. Kaliff
9 obtained the information and didn't document
10 it, but I don't see it there.

11 And, again, as I mentioned,
12 on 3-13, there was a complaint of pain in the
13 left shoulder and both arms, which could
14 certainly be the pain of coronary heart
15 disease. No details are given.

16 On 2-21-95, she complained of
17 pain in both hands and an electrocardiogram was
18 done, but there are no changes -- there are no
19 comments on the conditions surrounding the pain
20 in both hands.

21 And on that visit, an
22 electrocardiogram was done and it was
23 distinctly abnormal and we don't have any
24 details of what the pain was like.

1 So I think that kind of thing
2 is substandard by whoever saw the patient and
3 recorded the notes on those days.

4 I think that both the
5 residents and the attending to whom they
6 reported were responsible for that failure to
7 meet standards.

8 Q. That's on 4-20-92, 2-21-95 and 3-13-95?

9 A. Yes.

10 Q. On all of those occasions?

11 A. Let's see, also on January 25th and
12 February 14th, '95, she complained of a sore
13 throat and pain in her wrist.

14 We have no further details
15 and we should have. Pain in the throat can be
16 angina.

17 Q. So what you're saying is on all of these
18 occasions; 4-20-92, 2-21-95, 3-13-95, 1-25-95,
19 2-14-95, there's not enough --

20 A. Detail provided.

21 Q. Detail in the chart as to follow up of
22 these complaints?

23 A. Just asking more specific questions. You
24 come to me and say you have pain in the chest.

1 I'm supposed to ask you where is it located, is
2 there anything that brings it on, what's the
3 quality of it, are there any associated
4 symptoms like shortness of breath or sweating,
5 things of that sort, how long does it last.

6 There's a whole bevy of
7 questions that should be asked and these aren't
8 just the province of the cardiologist.
9 Generalists are supposed to ask these questions
10 as well, or at least some of them.

11 No questions were asked. I
12 think this is not adequate history taking.

13 Q. Anywhere elsewhere you believe the
14 residents failed to meet accepted standards of
15 care?

16 A. That's one whole category. Now, there's
17 another area. It's not clear to me whose
18 responsibility it was to find out about the
19 results of tests that were ordered and the
20 results of consultations that were ordered.

21 The obvious one being the
22 lady had a sleep study, the result of which was
23 pretty frightening, and no one really checked
24 to see what the result was even when alerted to

1 it.

2 Now, I don't know how much of
3 that is the attending physician and how much of
4 that responsibility might desolve upon the
5 residents who apparently saw the patient in
6 each case.

7 The only piece of this is the
8 system. There are so many different people
9 seeing this patient, different house officers
10 practically every time, different attending
11 with distressing frequency. The lady fell
12 through the cracks basically is what happened.

13 She had -- she died from
14 something that was pretty preventable, almost
15 certainly preventable, and it could have been
16 stopped.

17 There was plenty of time to
18 do it, but there was nobody driving the bus.
19 There was no one at the controls. There was no
20 captain, nobody functioning really as captain
21 of the ship and this is a systemic problem.

22 One gets the impression that
23 nothing was done here was the least bit out of
24 line with the way things were normally done in

1 this university clinic setting.

2 Q. Do you know that?

3 A. No, I don't know that.

4 Q. You're guessing?

5 MS. TOSTI: In regard to
6 what?

7 MR. TREU: In regard to his
8 sense that this is how things went on in
9 this setting.

10 THE WITNESS: No, I don't
11 know that for certain.

12 MS. TOSTI: He's already
13 identified a number of things in the
14 medical records that were concerning to
15 him.

16 MR. TREU: That's not the
17 question, Jeanne. The question is, he
18 said one gets the sense that this is how
19 things went on. I want to know where he
20 gets that from.

21 MS. TOSTI: Doctor, if you
22 can identify specifically those things
23 that were concerning to you, go ahead.

24 MR. TREU: Jeanne, I don't

1 want him to answer your question. I want
2 him to answer my question.

3 THE WITNESS: Would you
4 repeat it. You guys lost me.

5 BY MR. TREU:

6 Q. Doctor, at the conclusion of the answer
7 you just gave you made reference to the fact
8 that one gets the sense that this is how things
9 went on at this primary care center. Did I
10 mishear that?

11 A. No. I said that because it seemed as
12 though on a number of different occasions,
13 things were done in a kind of we'll get these
14 things done on a routine basis when we get
15 around to it sort of thing.

16 At one point they apparently
17 were thinking -- somebody thought of coronary
18 disease and said we'll get an electrocardiogram
19 next time.

20 Well, if you think someone
21 should have an electrocardiogram for anything
22 but the most routine reasons, you get it then
23 and there. I mean, I can't believe they didn't
24 have the capacity to do this.

1 Then, the next time she comes
2 in, the electrocardiogram is obtained and it's
3 abnormal and another electrocardiogram is
4 obtained and the abnormality is no longer there
5 or it's practically entirely gone.

6 And someone says, you know,
7 maybe she's got a lot of risk factors. She
8 probably ought to have a stress test at some
9 point and then they never get around to doing
10 that.

11 A sleep study is ordered and
12 the result doesn't come back for several weeks
13 and nobody turns a hair. Nothing is done about
14 this. Nobody calls to see what the result may
15 have been, even though a letter was sent quite
16 promptly saying that this is a very abnormal
17 situation, very abnormal result, nobody tries
18 to get the final report.

19 And when it finally comes,
20 nothing is done about it. Someone, apparently
21 not Dr. Rowanne, who I gather was supposed to
22 be the physician in charge at that time, picks
23 it up apparently because Rowanne wasn't there
24 and looks at it and puts it back down and it

1 goes in the chart.

2 And there needs to be -- if
3 you're taking care of real people with real
4 medical problems, even though it is in a
5 training situation, there needs to be a system
6 for reacting to serious problems when they
7 appear, for being alert to them, and doing
8 things in a timely fashion.

9 And it happened enough in
10 this case that I think it justified my at least
11 getting the sense that things were not done on
12 a really heads-up fashion in this clinic
13 situation, at least in this part of it.

14 Now, perhaps there's evidence
15 somewhere else that entirely the opposite is
16 true, but I'm telling you what impression I get
17 from the way things happened in this case, the
18 way a number of different individuals behaved
19 in several different situations, all happened
20 to involve the same patient.

21 Q. Well, the fact is, Dr. Rowanne did follow
22 this patient consistently for an extensive
23 period of time, correct?

24 A. Yes.

1 Q. You're indicating somehow that -- I think
2 you said that this patient had different
3 attendings for a period of time?

4 A. I don't think Rowanne was involved with
5 her when she first came on. I think perhaps
6 Dr. Kaliff or somebody, who I now recall
7 probably was an attending, had her for awhile.
8 He wasn't always there when she came in.

9 Apparently, he wasn't always
10 the person that was consulted.

11 Let me put it this way. The
12 ball was dropped at several places along the
13 line, particularly in the end of things.

14 Two months, over two months
15 went by from the time that a critical piece of
16 evidence with serious implications I believe to
17 the lady's health and nobody did anything about
18 it.

19 Q. During which time you would agree with me
20 Dr. Rowanne, per his own testimony, received
21 that sleep study report in that period of time,
22 correct?

23 A. Well, what really happened was that the
24 sleep study was done, I think, February 6th of

1 1996.

2 And the very next day, the
3 doctor, I think it was Brooks, prepared a
4 report saying that the patient had severe sleep
5 apnea, that her blood oxygen saturations fell
6 as low as sixty percent.

7 And, in fact, it's my
8 understanding of the devices that are used
9 quite commonly in sleep laboratories will not
10 show -- don't read any lower than that because
11 the people who set them up didn't think they
12 would have to go any lower than that.

13 Q. How do you know that?

14 A. This is -- can't tell you really how I
15 learned that, but I've talked to people about
16 this kind of thing at various times.

17 Q. Did Ms. Tosti tell you that?

18 A. No.

19 Q. Go ahead.

20 A. Some time ago I spoke to someone who runs
21 a sleep lab and they mentioned that to me and
22 that's how I came across that piece of
23 information.

24 Q. Have you consulted with someone from a

1 sleep lab on this case?

2 A. Just in the corridors at times I've asked
3 people what that meant, if that was important,
4 because I thought it was, but that wasn't even
5 at the time that I wrote the report.

6 It stuck in my mind that at
7 some time I spoke to someone about it. I
8 happen to know, as a cardiologist, that being
9 desaturated to sixty percent is a very serious
10 matter and that's what I had in my mind when I
11 wrote my report.

12 And I think that that can
13 combine, as I mention in my report, with
14 coronary artery disease to result in
15 potentially fatal arrhythmias.

16 That's my best explanation of
17 what happened in this case, why this lady died.

18 Q. Well, I'm still addressing your statement
19 that this lady feel through the cracks and
20 there was no one driving the bus during the
21 time that the results of the sleep study became
22 available.

23 Would you agree with me from
24 your review of these records, and Dr. Rowanne's

1 deposition testimony, that he had the sleep
2 study results in his hands and was aware of
3 them at least as of March 12, 1996?

4 A. I believe that's correct.

5 MS. TOSTI: I'll enter an
6 objection here because you're
7 misrepresenting the testimony that's been
8 in this case.

9 Dr. Rowanne did not testify
10 that he had the sleep study results in
11 his hand March 12th of 1996.

12 BY MR. TREU:

13 Q. Go ahead, Doctor.

14 A. I was just going to comment that if the
15 sleep study was done on February 6th, 1996 and
16 the final results weren't in his hands until
17 March 12th or thereabouts, that in itself
18 strikes me as not exactly being heads-up
19 medicine.

20 I think that that's a
21 critical result that should be in his hands a
22 lot sooner.

23 It then didn't get acted upon
24 until her death because of phone calls that

1 went back and forth and were not answered.

2 And this, again, gave me the
3 -- this all added to my impression that I
4 confided to you a little bit before that things
5 were done in a sort of lackadaisical fashion in
6 this clinic.

7 Q. What about the clinic is lackadaisical as
8 far as that's concerned?

9 A. Pardon me?

10 Q. Dr. Rowanne got the report, he called Dr.
11 Collins, right?

12 A. Dr. Rowanne got the report and he didn't
13 call Dr. Collins until some time later.

14 Q. He called Dr. Collins on March 25, 1996,
15 correct?

16 A. Yes, but I think there are days between
17 March 12 and March 25th. I think there are
18 several days. It's more than a week.

19 That, in fact, was the day
20 that the patient actually came in and according
21 to the records asked about the results of the
22 sleep study.

23 And so, you know, that was a
24 stimulus to do it. I think that he should have

1 done some investigating the minute that he saw
2 the report and I think, in fact, that the
3 letter that probably came to him a great deal
4 earlier ought to have stimulated some concerted
5 action because that was kind of a scary letter
6 when you look at it.

7 I realize that the letter
8 said don't take any action on this. This lady
9 has severe sleep apnea.

10 And I think it also mentioned
11 the saturations were quite low, but this is a
12 preliminary report so don't take any clinical
13 action on this.

14 Seems to me that under those
15 circumstances, the follow up complete report
16 ought to be done on an accelerated basis, some
17 steps should be taken to see that the patient
18 is appropriately managed, and this was --
19 everything was left hanging here. Nobody was
20 driving the bus. I repeat.

21 Q. The letter went to Dr. Rowanne, didn't
22 it?

23 A. The letter went to Dr. Rowanne. The
24 letter said this is serious business we think

1 we have here, but don't act on it just yet
2 until we have a chance to get a better look at
3 the data, and a better look at the data came
4 over a month later, and then nothing was done
5 about it.

6 I mean, there was a pattern.
7 A number of different people in this chain of
8 events took a long time to -- did not act with
9 appropriate speed.

10 Perhaps that was not the way
11 things were normally done in that clinic.
12 Perhaps there was some special concatenation of
13 cracks to fall through that all -- that only
14 affected this patient.

15 To me, it seems improbable
16 just from my general experience. I cannot tell
17 you that every patient was handled in this very
18 desultory fashion, but I can sure tell you this
19 lady was.

20 Q. With all due respect, Doctor, this is
21 going to go a lot faster if you answer the
22 questions that I ask you. Okay?

23 A. Surely.

24 Q. And my question first is this, the report

1 was sent to Dr. Rowanne, correct?

2 A. Which report now, the preliminary report
3 or the final report?

4 Q. Both.

5 A. They were both sent to him.

6 Q. He received both of them, did he not?

7 A. That's correct. The other person who was
8 supposed to receive the result didn't get it, I
9 understand, but I don't know that for a fact.

10 Q. I'm not asking about him.

11 A. Okay.

12 Q. Dr. Rowanne was driving the bus?

13 A. Sure.

14 Q. Dr. Rowanne was this patient's attending
15 physician, he's admitted that in his
16 deposition, correct?

17 A. He was.

18 Q. He received both of these reports from
19 the sleep study, correct?

20 A. He did.

21 Q. It was Dr. Rowanne's responsibility to
22 follow up on those reports, true?

23 A. It certainly is.

24 Q. How is it then the responsibility or a

1 problem with the system if, in fact, Dr.
2 Rowanne was the attending physician, received
3 the reports, and he did not follow up? How is
4 it the system's fault?

5 A. Because he didn't receive the report in
6 the proper -- in a fast enough fashion.

7 Q. Whose fault was that?

8 A. Well, in that case, that's the fault of
9 the way the sleep clinic ran.

10 The report may or may not
11 have been sent to Dr. Collins. Dr. Collins,
12 when called about this case, and I'm not at all
13 sure that Dr. Collins, the neurologist, was
14 really the person to have been called, but when
15 he was called about it, he didn't respond. If
16 he was out of town, someone should have picked
17 that up and directed the call to someone else
18 who could perhaps have handled it.

19 Everywhere you turn, there
20 was delay. There was failure to take
21 responsibility or so it seems to me.

22 Q. How is it that you conclude that it's
23 somehow the sleep lab's fault that this report
24 didn't get out?

1 Isn't it Dr. Brooks'
2 responsibility to get his reports out?

3 A. If Dr. Brooks routinely got his reports
4 out with this kind of a delay, it seems to me,
5 especially if they were critical reports, with
6 potential serious clinical implications, then
7 he shouldn't have been working for this outfit.

8 Q. That's if. I want to know in this case,
9 do you know that he didn't get his reports out,
10 all his reports out in this time frame?

11 A. No, I don't.

12 Q. I'm not asking you about ifs. I want to
13 know about this case.

14 Isn't it Dr. Brooks'
15 responsibility to timely produce his reports?

16 A. It certainly is.

17 Q. Do you have any evidence or are you aware
18 of any evidence that it was anyone else's fault
19 that this report did not get generated in a
20 more prompt fashion?

21 A. I have no way of knowing that.

22 Q. Are you aware of anything to indicate
23 that there was somebody in the sleep lab who
24 didn't do their job in getting this report out

1 other than Dr. Brooks?

2 MS. TOSTI: I'm going to
3 enter an objection here because he has
4 not had an opportunity to read the
5 testimony of Dr. Landis.

6 Dr. Landis' depo was just
7 taken yesterday and that may address some
8 of this information and this individual
9 was not produced, although requested
10 months and months ago.

11 So with that objection,
12 Doctor, if you have an answer to his
13 question, go ahead and give it.

14 THE WITNESS: I don't know if
15 anyone else was involved in handling the
16 report.

17 If there was no standard for
18 reporting of critical data, then I would
19 think that whoever was in charge of the
20 sleep laboratory and whoever was running
21 it was derelict in their duty.

22 BY MR. TREU:

23 Q. Again, that's an if on your part,
24 correct, you don't that to be true?

1 A. Surely, that's correct.

2 Q. Would you agree with me, Doctor, from
3 your review of the report and Dr. Rowanne's
4 deposition testimony that he did have the final
5 polysomnogram report available to him and he
6 had an opportunity to initiate treatment for
7 this sleep disorder prior to the time the
8 patient died?

9 A. He had the report in his possession just
10 a little over a month after the study was done
11 and he had plenty of time after that to
12 initiate therapy and it was not initiated.

13 Q. I want to get back I guess to my question
14 as to the residents.

15 I'm not going to go back over
16 what you've already testified to, but, again,
17 any other areas where you believe the residents
18 failed to meet accepted standards of care?

19 A. I don't think so.

20 Q. Do you have opinions in this case as to
21 whether anyone else failed to meet accepted
22 standards of care?

23 A. In reading one of the depositions
24 recently, it was mentioned, and I believe it

1 was probably Dr. Collins' deposition. No, it
2 was Dr. Rowanne's deposition.

3 He apparently wasn't around
4 when the sleep study finally was delivered in
5 its final form or the final report came in and
6 I'm told that the report was looked at and
7 initialed by someone else who took no action.

8 And so I think that
9 individual ought to have taken action and I
10 don't think that that was appropriate action at
11 that point. No action was taken.

12 If you look at a critical
13 study, a critical result, then you should take
14 some action, even if it's just to go look at
15 the rest of the chart and see if there is
16 anything else you should know.

17 I think knowing that this
18 patient was having seizures at night while
19 sleeping and had this kind of a result required
20 prompt action.

21 I think an additional person
22 who perhaps, not perhaps, who I think should
23 have taken action would be the person who read
24 the sleep study.

1 Here was an individual, again
2 an individual, a patient, having seizures at
3 night and having very severe sleep apnea,
4 desaturating the blood to sixty percent.

5 That individual should have
6 taken action to see that the patient was begun
7 promptly on treatment.

8 This might have involved a
9 phone call to Dr. Rowanne. In some
10 laboratories, I believe, I've seen this done at
11 our place, if somebody has bad sleep apnea,
12 they set them up with the equipment.

13 They get the -- I think
14 recognizing that many of the rest of us do not
15 understand the details of exactly how you treat
16 a patient with this condition, specifically
17 because certain respirators are required, and
18 this requires some technical expertise, these
19 people will set things up and get things going
20 on their own independently, particularly if the
21 need is urgent.

22 And no such thing was done
23 here. No action was taken on this other than a

1 severe sleep apnea, but don't do a thing about
2 it, and then there was a wait of over a month
3 before the final report came in, and no follow
4 up was done.

5 In fact, in looking at the
6 referral to the sleep study center, three
7 visits were authorized. The patient was never
8 called back.

9 Again, this speaks to me of a
10 systemic lackadaisicalness. It's not a word.
11 Systemic failure to act in a prompt
12 conscientious fashion just because everybody
13 that I run into seems to be behaving this way.

14 Q. Let me ask you something about -- are you
15 saying that the person then, the technician who
16 was there with the patient during the actual
17 sleep study, should have taken additional
18 steps?

19 A. No. Perhaps. This is hard to say.

20 I don't know how sleep
21 studies are run. I'm not an expert in the
22 area.

23 Q. That's why I'm asking you.

24 A. In an analogous situation --

1 Q. Doctor, excuse me, I have to interrupt
2 you.

3 What I have to know from you
4 is in this trial, who are you qualified to
5 testify about, number one?

6 And number two, who are you
7 going to come into court and say failed to meet
8 accepted standards of care?

9 A. Well, again, I refer you to my letter.
10 In some cases, I didn't specify who I thought
11 was responsible for whatever it was that wasn't
12 done.

13 Q. It's important in this case, I'm sure Ms.
14 Tosti has told you, that Dr. Collins, Dr.
15 Brooks and Dr. Rowanne settled and were
16 dismissed in this litigation.

17 A. Yes.

18 Q. So, the hospital is the only remaining
19 defendant at this point in time.

20 A. Well, did the hospital --

21 Q. I need you to be specific as to who it is
22 you're going to say failed to meet accepted
23 standards of care?

24 A. I'm going to say that these individuals

1 that we've talked about; Dr. Rowanne, Dr.
2 Collins for not following up on a study that he
3 had asked be done, Dr. Brooks, who interpreted
4 the report for not getting the report out
5 sooner, for not following up on a very
6 frightening result, were all responsible for
7 not taking appropriate action in time.

8 I think that the individual
9 who signed the report when it came in and took
10 no action on it was also not performing up to
11 acceptable standards and I think that the fact
12 -- I think also that the house staff not only
13 didn't ask the appropriate questions, the
14 attending didn't get in there to see if they
15 did ask the appropriate questions much earlier
16 on.

17 I think whoever read the
18 electrocardiograms might have made a point of
19 the fact that there was a change and these may
20 reflect ischemia. I'm not sure that there was
21 an official reading on these
22 electrocardiograms.

23 It just seems as though at
24 every possible juncture, the medical care did

1 not meet appropriate standards, not every
2 point, but a number of different places. The
3 ones that I mentioned to you so far.

4 Q. So I have the first resident which we
5 discussed earlier for not asking appropriate
6 questions and following up on the patient?

7 A. Yes, and Dr. Rowanne for not seeing that
8 they did.

9 Q. Then you have Dr. Collins for not
10 following up on the report which he had asked
11 for, the sleep study?

12 A. That's correct, and Dr. Brooks.

13 Q. And the individual that is -- is that the
14 initials BJ you're talking about on March 12,
15 '96, who received the report, apparently?

16 A. Yes, unless that was not a physician, in
17 which case it should have been the policy of
18 the clinic to see that a physician saw that
19 report.

20 Q. What I was getting at is you made
21 reference to when the sleep study was performed
22 actually rendering some treatment on the night
23 when the sleep study was performed?

24 A. I don't think it necessarily had to be

1 done at the time, but I believe the patient
2 should have been called back at that time.

3 Steps should have been
4 taken --

5 Q. Do you have a page, sir?

6 A. Yes, I better answer that one.

7 Q. Okay. Fine.

8 A. Sorry.

9 - - -

10 (At this point, a short
11 recess was taken, after which time the
12 deposition resumed.)

13 - - -

14 BY MR. TREU:

15 Q. I think you were talking about the
16 referral.

17 A. The referral stipulated that additional
18 visits were authorized. So there was certainly
19 an opportunity to follow up on this, this
20 particularly frightening report.

21 Another thing I point out,
22 the electrocardiograms that were taken in the
23 clinic, at least one of them, appears not to
24 have been read except by the computer, no

1 writing on it at all.

2 And, again, that's something
3 in a medical clinic, taking electrocardiograms,
4 it should be routine to have them looked over
5 by a cardiologist or someone known to be
6 capable of officially reading
7 electrocardiograms.

8 They are just in the chart
9 with a computer reading and the computer
10 readings are not reliable and this is
11 well-known.

12 Q. Whose responsibility was it to get the
13 patient back for treatment of that sleep apnea
14 which you just referenced?

15 A. Certainly the individual who read the
16 report and who presumably examined the patient
17 or interviewed the patient at the time of the
18 sleep study.

19 Q. We know Dr. Brooks is the one who sent
20 out the report, correct?

21 A. That is correct.

22 Q. Could it have been then Dr. Brooks'
23 responsibility?

24 A. Well, I'm assuming -- again, I'm not an

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1 expert on sleep studies, but I'm assuming that
2 it would be standard in a sleep study
3 laboratory for some physician to interview the
4 patient either before or directly after the
5 study.

6 I can't believe that the
7 patient -- this was done like doing
8 electrocardiograms. It's certainly not the way
9 it's done in the laboratories that I've been
10 familiar with.

11 So that there should be a
12 physician who serves as a physician for the
13 patient for the purpose of the sleep study.

14 MS. TOSTI: I'm going to
15 enter an objection here again because the
16 Doctor has not had an opportunity to read
17 the deposition of Dr. Landis which may
18 address some of those issues.

19 BY MR. TREU:

20 Q. Doctor, have you sent patients to
21 different sleep labs?

22 A. Mostly just to the one here at the
23 Medical College of Pennsylvania, but quite
24 recently, I sent one patient to another sleep

1 laboratory and the procedure was about the same
2 in both.

3 Q. And what have you gotten as far as a
4 report back from them?

5 A. I've gotten a letter or a phone call.

6 Q. Have they always included treatment
7 recommendations?

8 A. I don't have them all in front of me, but
9 my recollection is yes, there is, there has
10 been when treatment was appropriate.

11 I think that -- I know that
12 in some cases treatment has been initiated by
13 the sleep center physician.

14 Q. Again, I just want to make sure I
15 understand.

16 Are you saying then that it
17 would have been Dr. Brooks' responsibility to
18 bring this patient back after reading the study
19 and issuing the report?

20 A. After interviewing the patient and
21 reading the study and putting it in context,
22 because the context was pretty important,
23 namely the fact that the patient was having
24 seizures while asleep.

1 I think it would have been
2 his responsibility to have either initiated
3 treatment himself or seen that it was done.

4 Q. Anyone else who failed to meet the
5 standard of care?

6 A. I think that is principally it.

7 Q. Are you going to offer an opinion in this
8 case that University Hospitals of Cleveland
9 somehow failed to meet accepted standards of
10 care?

11 A. I think that the clinic that was run
12 under their auspices, as I mentioned earlier,
13 ran in a rather lackadaisical, we'll do it when
14 we can get around to it kind of fashion, and I
15 think that this lady was very ill-served by
16 that and I think would be alive had that not
17 happened.

18 To the extent that they
19 managed the clinic and, again, I'm not a
20 lawyer, but I would think that as a patient
21 signing up to be a patient of that clinic, I
22 would anticipate that the University or the
23 University Hospitals would have some
24 responsibility for seeing that things -- for

1 how things worked, how things were done, the
2 day-to-day running of the clinic and the way
3 that letters went out and were reported, the
4 time frame in which they ought to go out.

5 So to that extent, I think
6 it's an important thing. I would say that I
7 would be prepared to testify that the
8 University Hospitals was responsible, in part,
9 for what happened to this poor lady.

10 MS. TOSTI: I want to enter a
11 comment here in that we had requested the
12 deposition of the director of the Family
13 Practice Center.

14 He has not been produced at
15 this time and some of the questions in
16 regard to the management of the clinic
17 have, therefore, not been provided to Dr.
18 Meister.

19 BY MR. TREU:

20 Q. Doctor, what evidence do you have in
21 terms of the extent to which University
22 Hospitals had any control over how the clinic
23 was run?

24 A. I believe that as the operators of the

1 clinic, it's routine, at least in this state,
2 that they do have some responsibility for the
3 general procedures, the timeliness of
4 reporting.

5 Q. And, again, I have to ask you when you
6 say operators of the clinic, what do you mean?

7 A. I mean that the -- now you're asking me
8 for a legal opinion.

9 Q. No, I'm really not.

10 A. This is a university hospital clinic.
11 Therefore, the University Hospitals is -- to
12 me, it seems evident that the University
13 Hospitals run it.

14 Now, if you say to me that,
15 in fact, it belonged to three used car dealers
16 from around the corner and they're just using
17 that name and the hospital didn't object, then
18 I guess that would be different. They'd be the
19 ones responsible for running it, but it says
20 here, I believe, University Hospitals clinics.

21 University Hospitals has
22 something to do with the clinics. They are in
23 charge of making the rules, providing the
24 space, making the rules, providing the

1 equipment, but maintaining standards.

2 Q. The name of your hospital is?

3 A. Medical College of Pennsylvania Hospital.

4 Q. Do you have groups of doctors, let's say,
5 orthopedic doctors, who use the name of the
6 hospital or the name of the university in the
7 name of their corporate practice?

8 A. We do have an orthopedic clinic that's
9 operated by the hospital and our orthopedists
10 are there.

11 Q. For example, here in Cleveland we have
12 University Orthopedic Associates. Okay?

13 A. Yes.

14 Q. They are a group of orthopedic surgeons
15 who operate at a number of different hospitals,
16 one of which is University Hospitals of
17 Cleveland, and they have offices in the
18 hospital and outside of the hospital.

19 Are you saying that because
20 they have the name University --

21 MS. TOSTI: Objection because
22 the name of this institution is
23 University Hospitals of Cleveland.

24 Are you suggesting that these

1 orthopedic groups use the name University
2 Hospitals of Cleveland in their corporate
3 name?

4 MR. TREU: Are you done,
5 Jeanne?

6 MS. TOSTI: I'm asking you if
7 you are telling the Doctor that those
8 particular medical groups use the name
9 University Hospitals of Cleveland in
10 their corporate name?

11 That's what you're suggesting
12 to him.

13 MR. TREU: I'm not suggesting
14 anything to him. I'm telling him facts.

15 THE WITNESS: Well, let me
16 ask you, do they call themselves
17 University Hospitals of Cleveland
18 Orthopedic Group?

19 BY MR. TREU:

20 Q. University Orthopedic Associates.

21 A. So, it could be the university of
22 secretarial skills?

23 Q. Right.

24 A. So I don't think in that case, if they're

1 a private group with no connection to the
2 University, the University would have any
3 association with them at all.

4 Q. And if in this case, the name of the
5 clinic was University Primary Care Clinic --

6 A. I would suppose it would have something
7 to do with whether or not the University
8 Hospitals of -- the University owned the clinic
9 and the doctors are their employees and I have
10 no idea about those kinds of things.

11 I would suggest -- I'm not a
12 lawyer and I'm certainly not a lawyer in
13 Cleveland, and I don't know anything about the
14 ways in which things are set up in Cleveland.

15 If you were to say to me
16 that, in fact, the clinic had nothing to do
17 with the University Hospitals of Cleveland,
18 then I would be inclined to think that
19 University Hospitals of Cleveland bears no
20 responsibility.

21 Q. My question is where do you draw the
22 line?

23 A. Pardon me?

24 Q. Where do you draw the line as to when the

1 hospital becomes somehow responsible and then
2 they're not?

3 A. Again, you're asking me to give a legal
4 opinion and I can't give a legal opinion.

5 Q. I guess I'm asking you because you're
6 placing responsibility in this case for
7 operation of this clinic on the hospital and
8 I'm trying to understand why it is that you're
9 placing that responsibility on the hospital?

10 A. Well, I'm assuming because of the name
11 that --

12 Q. Well, it's based on the name that you're
13 making that assumption?

14 A. That's correct.

15 Q. Aside from that, are you aware of
16 anything that indicates to what extent, if any,
17 University Hospitals is responsible for the
18 running and management of this clinic?

19 MS. TOSTI: Again, I'm going
20 to enter an objection here in that there
21 is an outstanding deposition of the
22 director of the Family Practice Center.

23 We have not had an
24 opportunity to depose this individual

1 which you have identified and those
2 questions may be answered in his
3 deposition and the Doctor has not been
4 provided with that specific information
5 at this time.

6 BY MR. TREU:

7 Q. Can you answer that question, Doctor?

8 A. Would you repeat the question?

9 Q. I'll ask you this question.

10 Don't you think it's
11 important to know those facts before you offer
12 any opinion on whether the hospital is
13 responsible?

14 A. Well, I made an assumption here, the
15 assumption is that a suit was filed against a
16 hospital that, it was my understanding, owned
17 the clinics or operated the clinics.

18 And part of my understanding,
19 I think, comes from the fact that the suit was
20 brought.

21 Now if, in fact, there's no
22 connection of any kind, then I would be the
23 first to agree that it doesn't make very much
24 sense.

1 I'm assuming that the doctors
2 who work at the clinic are employees of either
3 the University Hospitals or the system and that
4 the equipment and offices of the clinics are
5 the property of University Hospitals.

6 If they are not, then that
7 may make a difference, but, you know, you're
8 asking me for a legal opinion and I can't give
9 that. I haven't been to law school.

10 Q. I'm really not. I'm asking for what you
11 understand to be the facts of this case --

12 A. What I understand --

13 Q. -- so I can understand your opinions in
14 this matter?

15 A. I'm sorry I spoke at the same time.

16 My understanding of the facts
17 are that University Hospitals of Cleveland are
18 somehow related to the clinics in which these
19 events took place.

20 Q. Somehow related?

21 A. In an operational fashion. That the
22 residents that were there were residents at the
23 University Hospitals of Cleveland, that the
24 physicians were, for the most part, the

1 employees of these people -- or were employees
2 most likely.

3 I suppose there may be some
4 fashion in which there were private
5 practitioners working there, but I'm under the
6 assumption that these clinics were operated by
7 the hospital.

8 Q. And if they were not run by the hospital,
9 would you agree with me that they are not
10 responsible for anything that may or may not
11 have happened to this patient?

12 A. Honest to God, I don't know the answer to
13 that one because I don't really know anything
14 about the law, but it would seem to me, and I
15 think I've heard that this is so, that if I let
16 you use my name for your operation, whatever it
17 happens to be, over a period of time and you
18 hold yourself out to be part of -- a part of me
19 and my operation, that even if you're not,
20 somebody goes to you and something bad happens,
21 that I share in some of the responsibility, but
22 I don't know if that's a factor or not.

23 And, again, I think it's kind
24 of silly to ask me things like that.

1 Q. Well, it's not really silly. I need to
2 know what it is you're basing your opinions on
3 and that's my job here today.

4 A. Sure. Okay. Well, I'm under the
5 impression that there is a significant
6 operational connection between the two
7 institutions, between the clinics and the
8 University Hospitals.

9 If they're not, then I'm
10 mistaken.

11 Q. Did you understand before today that Dr.
12 Rowanne was not an employee of the hospital?

13 A. No, I didn't.

14 Q. Does that make a difference to you?

15 A. Perhaps. It would depend on the nature
16 of his relationship to University Hospitals of
17 Cleveland.

18 Q. I guess I have to ask you to explain
19 that.

20 A. Well, I think that there can be a variety
21 of relationships.

22 For example, I've learned
23 this recently, that one can be a faculty member
24 and direct a program at an institution, a

1 medical school hospital, for example,
2 university hospital, and not actually be an
3 employee, but be entrusted with the direction
4 of the program.

5 It's my understanding that he
6 did direct this program and I made the
7 assumption that he was an employee. Perhaps he
8 is not.

9 But again, if I own -- if
10 this clinic is related to me as university and
11 I appoint Rowanne as director of that clinic,
12 then I still bear some responsibility. He's
13 not operating entirely as a free agent.

14 And the manner in which the
15 clinic is run, if the administrator works for
16 me, or even if he doesn't work for me, but I
17 appoint him as administrator and I have the
18 right to say who's the administrator and who
19 isn't, then I have responsibility.

20 Q. I will indicate to you Dr. Rowanne --

21 A. That's my understanding.

22 Q. -- Dr. Rowanne was never the
23 administrator of this facility when he was
24 taking care of this patient, okay?

1 A. Okay. Well, I don't know the nature of
2 his relationship and, obviously, the nature of
3 his relationship to University Hospitals makes
4 a difference in this case.

5 If there is no association,
6 than surely that makes a big difference.

7 Q. Do you have your report in front of you?

8 A. I'm looking. Unfortunately, I've
9 shuffled papers around, but I think this is
10 it. Sure. Go ahead.

11 Q. Top of page two. Do you believe that the
12 complaints made by the patient on April 20,
13 1992 were cardiac in nature?

14 A. They may have been. I don't know. There
15 was insufficient information provided by the
16 folks, by whoever wrote the notes in the
17 chart.

18 It's very possible it was,
19 but it may not have been. It's a good
20 question. It should have been answered.

21 Q. She came in primarily with heartburn and
22 digestive problems, correct?

23 A. Well, what was said to be heartburn and
24 digestive problems.

1 It is very common for the
2 pain of angina pectoris, of cardiac pain, to be
3 thought to be heartburn.

4 It's the job of the physician
5 to sort that out. The patient may think it's
6 heartburn. Physicians sometimes think it's
7 heartburn, but they're supposed to find out and
8 an easy way to do that is simply to take a more
9 complete history. We have been over this.

10 Q. She persisted with these problems, did
11 she not, and in July of 1992, had an endoscopy?

12 A. That's correct.

13 Q. And they found a healing ulcer and
14 gastritis?

15 A. That's correct.

16 Q. Based on that, do you think that explains
17 the complaints that she had in April of '92?

18 A. It may. It may also not. Highly
19 suggestive that it would.

20 Q. I mean, they found some objective
21 explanation for her complaints at that time?

22 A. That is correct. Does that mean for all
23 time, that every time she has any kind of pain
24 in her chest, that it's from those healing

1 duodenal ulcers and gastritis, no, it does not,
2 not in a patient heavily predisposed to
3 coronary artery disease.

4 Q. My question is, was it appropriate then
5 to treat her for the abdominal complaints, the
6 ulcer and the gastritis?

7 A. That is correct.

8 Q. And she did reasonably well after that
9 with a cessation of those complaints, correct?

10 A. That is correct.

11 Q. So --

12 A. Well, it's hard to say because --
13 although certainly those complaints, for the
14 most, yeah, were apparently cleared. That's
15 correct. Excuse me.

16 Q. So, fair to say, would you agree with me
17 that most likely those complaints in April of
18 '92 were gastric in nature and they were
19 addressed?

20 A. May have been gastric in nature. It was
21 reasonable to think that they were.

22 However, again, not an
23 adequate history is recorded in the chart. So
24 it's hard for me to say anything with any

1 certainty.

2 Q. So you're not going to say that probably
3 had, for example, a cardiac workup been done at
4 that time, that it would have disclosed
5 significant coronary artery disease?

6 A. I certainly can't say that. It might
7 have. It might have.

8 She could have had both
9 things going on at the time.

10 Q. In February of 1995, at the bottom of
11 page two, February 21, '95, complained of pain
12 in both hands?

13 A. Right.

14 Q. Attribute this to anything?

15 A. Pardon?

16 Q. Do you attribute that complaint to
17 anything specifically?

18 A. It could have been the pain of angina
19 pectoris. Somebody may have been wondering
20 about that because they ordered an
21 electrocardiogram for the first time.

22 That was the one that was
23 very abnormal and I certainly, in retrospect,
24 wonder whether that pain, as well as her sore

1 throat pain and the pain in her wrists that she
2 complained of a number of times, pain in the
3 shoulder, both arms that she complained of on
4 3-13-95, given what the electrocardiogram was
5 doing at that time, I'd be a little surprised
6 if some, if not all of that, were not cardiac
7 origin.

8 Q. There was a second EKG done in March of
9 '95?

10 A. Yes.

11 Q. And that was essentially normal, correct?

12 A. Let me look at it again. It was nearly
13 normal.

14 Q. You say at the top of page three of your
15 report that the two tracings taken together are
16 highly suggestive of ischemia?

17 A. Yes, particularly in a patient with this
18 predisposition to coronary disease and a
19 history of complaints that could have been
20 other things, but certainly could have been
21 cardiac pain, that at least something should
22 have been done.

23 I think Dr. Rowanne agreed,
24 but he didn't actually do anything.

1 Q. In fact, it was Dr. Rowanne who saw the
2 patient on that day, on the 13th, and indicated
3 that exercise and stress testing should be
4 considered?

5 A. Correct.

6 Q. And is it your opinion that, in fact,
7 those studies should have been done?

8 A. Surely.

9 Q. Or a cardiology consult should have been
10 done?

11 A. One or the other or both.

12 Q. And would you agree that was Dr.
13 Rowanne's responsibility?

14 A. That's correct.

15 Q. I'm going to page, although they're not
16 numbered, I can see --

17 A. I was really new with my computer at that
18 time.

19 Q. Didn't have a secretary do this for you,
20 did you?

21 A. No.

22 Q. Now, at the top of page four, you
23 indicate that -- you're talking about the sleep
24 study?

1 A. Yes.

2 Q. You say it's common knowledge that sleep
3 events such as these are dangerous?

4 A. Correct.

5 Q. Do you see that?

6 A. Yes.

7 Q. I guess I have to ask you on what do you
8 base that statement?

9 And you're talking about the
10 oxygen saturation?

11 A. Yes. You're not supposed to get down to
12 sixty percent when you're awake or when you're
13 asleep or any other time.

14 If I catch a patient with an
15 oxygen saturation of sixty percent in my
16 coronary care unit, there's a pretty good
17 chance they're going to get intubated right on
18 the spot and be put on a respiratory.

19 Q. Does it depend how long they're at sixty
20 percent?

21 A. Yes.

22 Q. Do you know how long this patient --

23 A. As a practical matter, I would think that
24 that would make a difference, but I can assure

1 you if I saw somebody, for whatever reason,
2 with an oxygen saturation of sixty percent, it
3 would surely enter my mind to have them
4 intubated.

5 If I went right away, maybe I
6 wouldn't, but I would surely get busy in
7 finding out what the heck was going on.

8 In this case, it was sleep
9 apnea, and it took place in the setting of a
10 sleep study. So it was pretty obvious that you
11 treat for that.

12 Q. Again, how are these dangerous? Why
13 would you consider intubating such a patient?

14 A. Well, it depends, of course, on the
15 setting.

16 If it's somebody with
17 congestion of the lungs, you would expect with
18 an oxygen saturation as low as sixty percent,
19 or as we know perhaps even lower, that you can
20 die from this alone, that you can have organ
21 damage, that you can have brain damage.

22 When the blood is just sixty
23 percent saturated, it doesn't contain a lot of
24 oxygen to deliver to the vital organs.

1 If, as in this particular
2 case, the patient had some coronary disease
3 underlying things, then part of the heart
4 muscle is not getting sufficient quantities of
5 oxygen. So this is how that's dangerous.

6 In a patient who has been
7 seizing, having seizures during their sleep,
8 common sense would make us even more prone to
9 think that action of some kind was needed.

10 Q. Why does that make a difference?

11 A. People don't usually seize in their
12 sleep. It's considered bad form. That doesn't
13 happen as a rule.

14 If you find that a patient is
15 getting down to a sixty percent hemoglobin
16 saturation with oxygen, it's likely to be
17 connected in some form or fashion, even though
18 I doubt -- I don't think that seizures are
19 common as part of sleep apnea.

20 The finding of these two
21 things is very difficult not to connect. It's
22 like walking through an orange grove and this
23 big round thing with dimples on it comes down
24 and pops you on the head. It's probably an

1 orange.

2 Q. She didn't have seizures during the sleep
3 study, did she?

4 A. No, she didn't, but she did have two
5 seizures within the past few months that
6 occurred during sleep.

7 Perhaps they weren't
8 connected, but I think the burden of proof was
9 on the docs taking care of her at that point to
10 establish if they weren't connected.

11 Q. Later in that paragraph you say that you
12 saw premature ventricular beats and one
13 couplet?

14 A. Yes, I did, just in the portion of the
15 study that I saw.

16 Q. How much of that study did you get?

17 A. I got one, two, three, four, five --
18 looks like I have about twenty pages of it
19 here. Do you want me to count it all?

20 Q. No.

21 A. Every page that I looked at looks like
22 it's got -- if you can see the
23 electrocardiogram at all, she was having
24 extrasystoles.

1 MR. TREU: What I'd like to
2 do is just have the Court Reporter mark
3 that as Exhibit-A.

4 And I don't care if you make
5 copies of it or what you do, but I just
6 want to mark those as Exhibit A. Can you
7 do that, please?

8 THE WITNESS: I'm sure she
9 will.

10 - - -
11 (Document received and marked
12 for identification as Defendant's
13 Deposition Exhibit-A, retained by Dr.
14 Steven Meister)

15 - - -

16 BY MR. TREU:

17 Q. Down the bottom of that page, in the
18 bottom paragraph, it states that the anterior
19 descending coronary artery is usually the
20 largest of the three coronary arteries.

21 A. That's correct.

22 Q. Is that true in her case?

23 A. I don't know.

24 Q. Did you look at the autopsy?

1 A. I haven't looked at it lately, but do you
2 want me to look at it?

3 Q. Would you take a quick look?

4 A. It's not usually mentioned, but I'm
5 coming to it.

6 The left anterior descending
7 coronary artery is approximately eighty-five
8 percent stenotic. The right coronary artery is
9 dominant.

10 Is there someplace that says
11 it's not the biggest artery?

12 Q. What does it mean when they say the right
13 coronary artery is dominant?

14 A. It doesn't mean it's bigger than the left
15 anterior descending.

16 What it does mean -- it's
17 very unfortunate terminology, and you're hardly
18 the first person to be confused by it.

19 Q. Glad to hear that.

20 A. Including lots of physicians.

21 It just refers to the blood
22 supply to the bottom surface of the heart
23 because in eighty-five percent of the cases,
24 that blood supply comes from the right coronary

1 artery. In a minority, about fifteen percent
2 of cases, it comes from an unusually large
3 branch of the left coronary artery. Both of
4 these situations are normal.

5 One is more common than the
6 other, and that's where the term dominance
7 comes from. It doesn't mean that the right
8 coronary is bigger than the left.

9 There are patients in whom it
10 can be quite small. That might be remarked
11 upon. It wasn't here.

12 I would also add that
13 whatever did happen to -- what did happen to
14 Mrs. Smith or Ms. Smith could have happened
15 with a smaller artery as well.

16 Q. Are you going to offer an opinion in this
17 case as to the cause of death?

18 A. Yes.

19 Q. What is it?

20 A. That the patient became hypoxic during an
21 episode of sleep apnea, that she had an
22 underlying narrowing, about eighty-five percent
23 as is described in the autopsy report, of the
24 left anterior descending coronary artery. That

1 caused ischemia or a state of insufficient
2 oxygen supply to a large portion of the heart
3 muscle. This, in turn, very likely caused a
4 fatal cardiac arrhythmia to occur, an abnormal
5 rhythm, and this can occur.

6 Q. Earlier in your report we talked about
7 your belief that --

8 A. Could I elaborate on that just for a
9 minute?

10 Q. Okay.

11 A. Because I will say this to the jury. The
12 heart takes more oxygen out of the blood than
13 any other organ.

14 When blood goes through any
15 organ, the oxygen saturation, the content of
16 blood in the oxygen drops, because that's
17 what's supposed to happen, that the blood gives
18 up its oxygen.

19 The heart muscle, I suppose
20 because it's constantly working so hard and has
21 such high demands for oxygen, will take more
22 blood out of the -- more oxygen out of the
23 blood than any other organ in the body.

24 So when blood has been

1 through the heart and appears in the vein that
2 collects the blood that's been through the
3 heart, its saturation is down around
4 twenty-five or thirty percent normally.

5 That's going in at
6 ninety-five to one hundred percent fully
7 saturated before it comes to the heart.

8 So if you drop your oxygen
9 saturation down to sixty percent, in an artery
10 that's already delivering insufficient
11 quantities of blood because of a narrowing,
12 you're just not going to get enough blood,
13 enough oxygen to that area to prevent bad
14 things such as arrhythmias from occurring.

15 So in this case, the heart
16 would be the most sensitive organ to this,
17 particularly if there was some coronary
18 disease, as there was in this case.

19 So I don't have much doubt
20 that this was the cause of death.

21 Q. On the bottom of that page of your
22 report, still on page four, you say that the
23 polysomnogram shows frequent premature
24 ventricular beats?

1 A. That's correct.

2 Q. Premature ventricular beats can occur
3 during apnea, to your knowledge?

4 A. I don't know that one way or another.

5 Q. Do you know if it should make a
6 difference?

7 A. I think if you saw a lot of them during
8 an apnea period, it would point even more
9 strongly in that direction, but the opposite is
10 not true if I didn't see more of them during
11 the episode of apnea that occurred here.

12 Remember, she didn't have
13 seizures or die during the time that this
14 recording was made.

15 It's clear that she was
16 having a lot of extra beats.

17 Q. Next page of your report, the top
18 paragraph, you say here that her death could
19 have been prevented had she had appropriate
20 treatment for her coronary artery obstruction.

21 Is it Dr. Rowanne's fault, in
22 your opinion, that she did not have follow up
23 for her coronary artery --

24 A. I think he took ultimate responsibility.

1 MS. TOSTI: Asked and
2 answered.

3 BY MR. TREU:

4 Q. Go head, Doctor. I couldn't hear you.

5 A. I said I think he took ultimate
6 responsibility, but I think that, in this case,
7 even the residents working under him had the
8 responsibility to look at the data that they
9 were producing and take the responsibility of
10 seeing that a stress test was done.

11 Q. Again, that would depend, of course, on
12 the way the clinic operated, true?

13 A. I think so, yeah, depends on who is in
14 charge of what, but it seems to me had they
15 been on the ball, that with these changes, they
16 should have been discussing it with the
17 attending and between them, together, there
18 should have been a joint decision to obtain a
19 stress test.

20 Q. And that was again as of that March 13th
21 visit?

22 A. Particularly as of that time. There was
23 ample justification for it on the previous
24 visit with a previous electrocardiogram in and

1 of itself.

2 I think that particular
3 electrocardiogram looks worse than the computer
4 reading.

5 Q. Doctor, are you going to offer an opinion
6 in this case as to Mrs. Smith's life expectancy
7 had she received the treatment that you believe
8 she should have received?

9 A. I can't say with any precision, but with
10 modern day treatment for coronary artery
11 disease, I think she would have lived at least
12 another fifteen to twenty-five years.

13 Treatment was very good at
14 that time. There were a number of
15 possibilities that -- modalities that could
16 have been used to treat her condition ranging
17 from medicine through coronary angioplasty and
18 stenting to coronary bypass surgery.

19 And her cholesterol could
20 certainly have been lowered and I think she
21 could have lived quite a lot longer had things
22 been managed properly.

23 Q. Doctor, I'm going through your report and
24 trying to check off things that we covered

1 already. Bear with me, please?

2 A. Okay.

3 Q. We probably have covered this. I'm on
4 the last page of your report, next to the last
5 paragraph.

6 You state that the Family
7 Practice Clinic itself apparently had no system
8 for capturing and reacting appropriately to
9 critical test results.

10 Again, my question to you is,
11 what was the Family Practice Clinic supposed to
12 do that it didn't do?

13 A. Well, maybe you need to tell me. There
14 were two months that elapsed between the time
15 that a test with a critical value, with a
16 critical result, was done and the time that the
17 patient died and still nothing was done about
18 this.

19 And this is because it took a
20 long time for the result to be reported. Then
21 after it was reported, it took a long time to
22 come to the attention of Dr. Rowanne. Someone
23 prior to that time apparently looked at it, but
24 didn't follow through on it.

1 Subsequent to that, Dr.
2 Rowanne tried to do something about it, but
3 there was apparently not even sufficient
4 promptness ethic in the clinic that when he
5 called someone, when he called Dr. Collins,
6 that Dr. Collins ever called him back.

7 Maybe all Dr. Collins was
8 going to tell him was go see a pulmonary person
9 or a sleep expert or have the sleep experts
10 that have seen her do something about it.

11 Two months -- over two months
12 elapsed, the lady fell through the cracks and
13 she's dead.

14 Things were not running right
15 in that clinic. That's all that I can say.

16 Q. Let's break it down.

17 A. Sure.

18 Q. The report was late getting out of Dr.
19 Brooks' hands?

20 A. That is correct.

21 Q. Dr. Brooks' responsibility?

22 MS. TOSTI: I'm going to
23 object to this line of questioning.

24 You have been through this

1 already, Kris. We've been at this for
2 over two hours now and the Doctor has
3 answered all of these same questions
4 previously in this deposition.

5 So objection to this line of
6 questioning.

7 MR. TREU: You're really in
8 no position to object to the length of
9 depositions, Jeanne.

10 MS. TOSTI: I'm objecting to
11 the repetition of the same questions that
12 the Doctor has already answered.

13 MR. TREU: Thank you. The
14 Doctor is raising another issue now and I
15 need to address it.

16 THE WITNESS: I don't think
17 this is another issue I think this is
18 basically what I said before.

19 BY MR. TREU:

20 Q. I'm trying to break it down and
21 understand how it is that you can put the blame
22 on the clinic somehow when it is individual
23 doctors who apparently are not communicating
24 here.

1 A. At every step along the line, the ball
2 was dropped. Everything took longer than it
3 should.

4 Whoever runs that clinic
5 bears some responsibility, I think, for the
6 fact that things went at a snail's pace at that
7 clinic, that there was no system whereby --
8 through which a dangerous value got reported to
9 the people who needed to know it and an
10 understanding that action had to be taken.

11 This whole situation was
12 -- failed this patient in this particular case
13 and it's hard not to suspect strongly that this
14 was the ethic under which this place ran or
15 operated.

16 Q. You're speaking in extreme generalities
17 here, Doctor, and I want to break it down
18 because I want to see how it is that you're
19 fairly blaming the clinic for what these
20 doctors did or didn't do.

21 Now, you agreed previously in
22 this deposition that it was Dr. Brooks'
23 responsibility to get his report out in a
24 timely fashion, correct?

1 A. That's right, quite correct.

2 And I also said at another
3 point in the deposition that if a doctor
4 doesn't get his -- if a doctor who is part of
5 an organization claiming to care for patients,
6 doesn't get reports out in a timely fashion or
7 at least critical reports out in a timely
8 fashion, that the institution bears or shares
9 the responsibility for that and that is an
10 established standard and an established way of
11 dealing with things.

12 Q. You've also said that you don't have any
13 evidence that that was the case here.

14 A. That what was the case, sir?

15 Q. Other than this one, or that the
16 institution had any knowledge about that? Is
17 that true?

18 A. I think the institution -- if this was
19 common practice, the institution had a duty to
20 know.

21 Q. Again, Doctor --

22 A. The only reason I think it's common
23 practice is that similar things happened at
24 every step of the way.

1 MS. TOSTI: I'm going to
2 enter an objection here. Again, the
3 deposition of Dr. Landis was taken
4 yesterday.

5 MR. TREU: You said that,
6 Jeanne. You know, we've heard this five
7 times. I'm well aware of that.

8 MS. TOSTI: Kris, let me
9 enter my objection. That the deposition
10 of Dr. Landis was taken yesterday which
11 may have some information in regard to
12 the management of the sleep center clinic
13 that Dr. Meister has not been provided
14 with that deposition as yet.

15 And also in regard to the
16 operations of the Family Practice Center,
17 there is an outstanding deposition of the
18 director of the Family Practice Center
19 which has not been taken at this point.

20 And, therefore, the Doctor
21 has answered your questions repeatedly on
22 those issues and I object to your
23 continually asking the same questions
24 over and over in this deposition.

1 If we would take those
2 depositions and provide them to the
3 Doctor, that's a different story, but at
4 this point, the Doctor does not have that
5 information because those people have not
6 been provided in deposition.

7 MR. TREU: Thank you. That's
8 exactly my point, because every time he
9 answers a question, he says if.

10 And all I'm trying to point
11 out is that the Doctor doesn't have any
12 evidence that the institution had any
13 knowledge or any responsibility --

14 MS. TOSTI: That is a
15 mischaracterization of what the Doctor
16 has testified to because he has said over
17 and over that he feels the institution
18 has responsibility for the standards that
19 are set and the way that those clinics
20 are operated.

21 Now, how many times are you
22 going to ask him that same question?

23 MR. TREU: I'll ask it as
24 many times as I want without your

1 interruption.

2 BY MR. TREU:

3 A. Doctor, again, I don't want to go back
4 and look at the transcript, but every time you
5 answer this question you say if, and my
6 question is, do you have any evidence that the
7 institution had any knowledge that Dr. Brooks
8 was taking this long to get his reports out?

9 MS. TOSTI: Objection, asked
10 and answered.

11 THE WITNESS: I don't know if
12 they had any knowledge. They should
13 have.

14 BY MR. TREU:

15 Q. Why?

16 A. Because when you run an institution of
17 this sort, it is your duty to have standards
18 and those standards -- no institution really
19 should permit dilatory reporting to this
20 extreme to go on.

21 Q. How do they become aware of that?

22 A. They have to have surveillance, they have
23 to make it their business to be aware of that.

24 Q. How often does it have to happen before

1 they have to do something about it?

2 A. They have to make periodic checks to see
3 that reports reach the chart. It's easy enough
4 to do and it's done.

5 It's done, I'm sure, in
6 virtually every institution. It's certainly
7 done in this one.

8 Q. Do you know whether it was done in this
9 institution?

10 A. I don't. All I know is what happened,
11 happened.

12 Q. Do you know whether the institution had
13 any reason to believe that Dr. Brooks was not
14 getting his reports out in a timely fashion?

15 A. It was their responsibility to know. I
16 don't know if they did or didn't.

17 Q. If the institution established the
18 standards and the doctor doesn't meet those
19 standards, that's the doctor's responsibility,
20 correct?

21 A. And the institution's responsibility.
22 It's a shared responsibility.

23 Q. If they have an opportunity to address
24 it?

1 A. If you come to my institution and I do
2 whatever the outrageous thing happens to be to
3 you, it's the hospital's duty to know about
4 that.

5 Perhaps we can forgive it if
6 it happened only one time, but just from the
7 pace at which everything took place in this
8 patient, it's hard to escape the impression
9 that slow and deliberate was the standard of
10 this clinic.

11 Q. And that's just your impression from this
12 one case?

13 A. From everything that took place in this
14 one case.

15 Q. Everything?

16 A. Most things. Certainly all the things
17 -- I should say from everything that I've
18 pointed to that took -- that was handled in a
19 lackadaisical, we'll think about this kind of
20 fashion.

21 Q. Did anybody meet the standard of care in
22 this case?

23 MS. TOSTI: Objection.

24 THE WITNESS: Sure.

1 Different people did at different times,
2 but they slipped up at critical points.

3 BY MR. TREU:

4 Q. Who? Who met the standard of care in the
5 care of this patient?

6 A. I think both the neurosurgeon and the
7 neurologist in certain ways, important ways,
8 met the standard of care in this case.

9 Both of them suspected sleep
10 apnea in this patient, something which
11 apparently didn't occur to any of the primary
12 people taking care of her, although it is a
13 well-recognized disorder, and was in 1995, and
14 made recommendations that something should be
15 done about it. I think that's appropriate
16 action. I have no objection to that.

17 I think it was good thinking
18 on their part and in both cases they made their
19 suspicions clear to the primary physician, Dr.
20 Rowanne.

21 In fact, Dr. Collins, having
22 thought of it, called Dr. Rowanne and put it
23 into his recommendation, but then he never
24 followed up on it.

1 And the institution, it
2 appears, did not send him a copy of the report,
3 even though his name was included on the
4 request.

5 Q. What institution?

6 A. The sleep center. Well, I'm operating on
7 the assumption that the sleep center was all a
8 part of the University Hospitals clinic.

9 If that's wrong, then I stand
10 corrected.

11 Q. The report that was sent by Dr. Brooks,
12 the final polysomnogram report, was sent to Dr.
13 Rowanne, correct?

14 A. Yes.

15 Q. Dr. Rowanne's responsibility to read his
16 mail?

17 A. Absolutely.

18 Q. And Dr. Rowanne's responsibility to
19 follow up on that report?

20 A. Absolutely.

21 Q. You stated in your report and in this
22 deposition that you are not an expert in sleep
23 medicine?

24 A. I have. I know what the common, average,

1 plain old internist knows about it.

2 Q. Are you going to offer any opinions in
3 this case regarding the length of time it
4 should take to meet the standard of care to
5 address the results of a polysomnogram of this
6 nature?

7 MS. TOSTI: Can you clarify
8 what you mean by address?

9 MR. TREU: To initiate
10 treatment or evaluate the patient
11 further.

12 THE WITNESS: I think I'd
13 offer the opinion that it was much too
14 long in this case.

15 BY MR. TREU:

16 Q. My question is, are you familiar with
17 what the standard of care requires?

18 A. I don't know what the standard of care
19 requires, except that I do know, in general
20 terms, that when you have a critical result
21 that is potentially fatal in any subspecialty,
22 you report this very promptly, as soon as you
23 can do it.

24 Q. Doctor, have we covered all the areas

1 where you believe there was failure to meet the
2 accepted standard of care?

3 A. Several times I think.

4 Q. Give me some more specifics, if you
5 would, regarding your experience as an expert
6 witness?

7 Can you estimate how many
8 cases you have reviewed as an expert witness?

9 A. Well, let's think. Again, I have been
10 asked this before.

11 At different times, I've been
12 busier than others. As I said, I started doing
13 this in 1977 and I did it infrequently then.
14 Over the years, I've done it oftener.

15 I would estimate that I now
16 spend about ten to fifteen percent of my
17 working time doing this sort of thing and that
18 that's more than I remember in the past,
19 considerably more, as a result of the fact that
20 I've cut back somewhat on my work obligations,
21 as I mentioned earlier.

22 And on the whole, I think it
23 probably brings in something like ten to
24 fifteen percent of my income, maybe as much as

1 twenty percent.

2 Q. I'm just trying to get a handle.

3 Do you know how many cases
4 you might be working on or might be pending at
5 any particular point?

6 A. Right now, I think I have cases that I'm
7 working on, that are active, five or six,
8 conceivably seven, no more than that, because I
9 get these things and I will have them for
10 awhile before I get around to looking at them
11 and then I'll look at them and eventually I may
12 put out a report or I may not and that extends
13 the time that I'm looking at the thing, and
14 then it gets deposited in my attic where it
15 sits until -- where it ages, it ripens.

16 And if I'm asked to give a
17 deposition or go to court, then I know when it
18 finishes and if not, I don't know and
19 eventually I come across it up there and either
20 call the lawyer to find out if it's finished or
21 if it's a real long time, just throw it out.

22 So I may have more that you
23 could call active in a sense, but I don't
24 really know if they're active or not.

1 I do this on a regular
2 basis. I do expert witnessing on a regular
3 basis. About sixty, seventy percent of what I
4 do is for defense, and the remainder is for
5 plaintiffs.

6 Q. Doctor, you can't tell me like how many
7 in a year you will get in?

8 A. I'm going to guess at a dozen. At times
9 it's been more and at time it's been less.

10 Q. Are there any other expert witness
11 services you're associated with other than the
12 Sapanaro one?

13 A. I was once told that I was, but I don't
14 know how that happened. I don't know how they
15 got my name.

16 To the best of my knowledge,
17 Sapanaro is the only one that I ever signed on
18 to and volunteered for.

19 When you've been doing this
20 kind of thing for as long as I've been doing,
21 people get your name.

22 Q. I touched on this earlier. As far as
23 deposition testimony, I believe you told me
24 that you give three to four depositions a year?

1 A. Again, I'm guessing. I think that's
2 about right.

3 I think there's been years
4 that I may have done half a dozen and years go
5 by when I haven't done any.

6 Q. Is the breakdown the same, defendants and
7 plaintiffs?

8 A. I think that that's approximately
9 correct, and again, from year to year that may
10 vary, but it's always been the majority is
11 defense.

12 Q. What about trial testimony, what's your
13 experience been?

14 A. Once or twice a year, maybe three or four
15 times tops, and I doubt if ever I've done that,
16 and some years none.

17 Q. Have you always testified live or have
18 you done videotape depositions?

19 A. I've never done, I don't think, a
20 videotape deposition for court -- for a court
21 appearance.

22 I've done -- I'm not sure if
23 that's true or not to tell you the truth.

24 I've had some events that I

1 thought were videotape depositions, just
2 depositions as such. I don't know if any of
3 them were ever used in court or not.

4 Q. What do you charge to review a case?

5 A. I've recently raised my fees to three
6 hundred and twenty-five an hour.

7 They were formerly three
8 hundred and they've gone up over the years
9 starting at about two hundred, I guess.

10 Q. Is that the same that you charge for
11 deposition testimony?

12 A. Yes.

13 Q. How about trial testimony?

14 A. Same.

15 Q. What is your date of birth, Doctor?

16 A. I should add for Ms. Tosti that if I
17 started a case at three hundred dollars an
18 hour, that's what I charge when I finish it,
19 even though I changed my rates.

20 MS. TOSTI: Thank you,
21 Doctor.

22 BY MR. TREU:

23 Q. What is your date of birth?

24 A. 9-13-37.

1 Q. Can we agree that the practice of
2 medicine requires medical judgments on a
3 day-to-day basis?

4 A. Absolutely.

5 Q. We agree that those judgments are not
6 always black and white?

7 A. Absolutely, but there are some
8 standards.

9 Q. Can we agree that a physician can make an
10 incorrect judgment and still meet the accepted
11 standard of care?

12 A. Absolutely.

13 Q. Have you ever made an error in judgment?

14 A. Yes.

15 Q. Have you breached the standard of care in
16 those instances where you have made incorrect
17 judgments?

18 A. It's hard to say because I know that, in
19 general, I have done this.

20 Has what I have done ever
21 been a breach of the standard of care, I think
22 so. Hopefully, not very often.

23 Q. You indicated to me that you have been
24 sued for malpractice on approximately six

1 occasions?

2 A. Again, that's an estimate. I have
3 one in being right now. Someone is suing me
4 because they got a rash after I did a stress
5 test on them.

6 Q. Doesn't take much.

7 A. No.

8 Q. Can you briefly tell me the subject
9 matter of those cases, if you can recall?

10 A. Okay. Let me think now. There was one
11 that we did a heart catheterization on a
12 patient and I thought that a narrowing was
13 severe enough to be critical and it was a
14 judgment call and he had a history of having
15 -- I was told by the referring physician
16 responded very poorly and gotten very ill
17 during an exercise test that was done before
18 the patient was sent to me.

19 When we were considering
20 whether or not to send the patient to surgery,
21 someone -- the lesion, the narrowing, was
22 borderline in severity, right on the border,
23 and there was disagreement.

24 I showed it to all of my

1 colleagues to see what they thought, whether it
2 was severe enough to operate on because it was
3 the most important artery in the body, the left
4 main, of all of the coronary arteries.

5 And someone suggested, I
6 think more than once, that a stress test would
7 be indicated and I made the judgment that it
8 shouldn't be done because of his history of
9 previous difficulty.

10 Patient went to surgery. The
11 surgery didn't turn out well and then one of
12 his grafts closed, and we recatheterized him
13 and were able to see the narrowing in question
14 from a different angle, a different approach to
15 the graft by injecting the graft rather than
16 the artery itself and then it was apparent that
17 it was really only about fifty percent
18 narrowing instead of the seventy percent that I
19 thought it was and I was sued on that basis. I
20 told the patient about it because I thought it
21 was appropriate and I was sued for that. This
22 was 1981 or so.

23 More recently I've been sued
24 by a patient who was cath'ed on an emergency

1 basis by another individual and developed an
2 infection in the catheterization site, which is
3 extremely uncommon, but it did happen, and he
4 thought that as his general cardiologist taking
5 care of him in the hospital, I should have
6 picked it up. I thought not because it didn't
7 appear until a week or two after he left the
8 hospital, and that case went to trial and I
9 won.

10 What else have I been sued
11 for? I mentioned the one that is cooking for a
12 rash.

13 There's another one that I
14 think has gone away in which a patient
15 following a catheterization developed a large
16 bruise at the catheterization site which is
17 fairly common. She complained that it
18 interfered with her ability to use the leg and
19 I think that's gone away. I don't know exactly
20 what the conclusion was of that one.

21 Those are the ones I can
22 think of.

23 Q. Okay.

24 A. Oh, I can't remember the details, but

1 there was one that I was named in initially and
2 let out of simply because I was the head of the
3 department where the event took place, didn't
4 involve standards.

5 Q. Doctor, those EKGs done in February and
6 March of 1995, we agree that there were no
7 arrhythmias on those?

8 A. Let me look again. I'm pretty sure there
9 were not.

10 No, there were none, but I
11 would point out that these electrocardiograms
12 taken in this format cover a precise duration
13 of twelve seconds.

14 So that doesn't mean she
15 wasn't having some during the day. We know
16 that she was having some during the night.

17 Q. Do you agree with me that this patient
18 was at increased risk for complications if she
19 had undergone bypass surgery?

20 MS. TOSTI: From the surgery
21 itself, Kris?

22 MR. TREU: Increased risk of
23 complications from the surgery.

24 THE WITNESS: She would have

1 been.

2 MS. TOSTI: Increased risk
3 of complications?

4 THE WITNESS: Increased risk
5 of complications, but not hugely at
6 risk.

7 Perhaps instead of a risk of
8 two percent, it would have been three or
9 four percent.

10 And it's also clear that she
11 might not have needed coronary bypass
12 surgery. She might have gotten away with
13 an angioplasty and a stent, which was a
14 modality that was available in 1995.

15 And, in fact, there's a
16 pretty good chance that that might have
17 been done rather than bypass surgery.

18 MS. TREU: Doctor, that's all
19 the questions I have at this point.

20 As Ms. Tosti has pointed out
21 a number of times in this deposition,
22 there apparently is data that you may see
23 in the future and if, in fact, that
24 occurs, I would reserve the right to

1 question you if your opinions are
2 modified, changed or otherwise supported
3 by review of additional documents.

4 MS. TOSTI: I would object to
5 the supported portion of that question,
6 but if he does arrive at any new opinions
7 in regard to any additional information
8 that we may provide, we'll let you know.

9 MR. TREU: If he has other
10 data that he thinks supports his opinions
11 and he is going to testify to that at
12 trial, I want to know what it is and how
13 it supports his opinion and I'm going to
14 reserve my right to ask him about that.

15 MS. TOSTI: I would object to
16 anything additional.

17 He's already provided you with
18 the opinions and the support that he
19 currently has.

20 If he has anything new to
21 add, we will let you know about it.

22 MR. TREU: If he has anything
23 new to add, I will accept that. Okay?

24 THE WITNESS: Okay.

1 MS. TOSTI: In regard to
2 signature on this, we will reserve
3 signature for the Doctor.

4 MR. TREU: And I will order
5 it and I will FAX you our information.

6 MS. TOSTI: We also will be
7 ordering this deposition.

8 MR. TREU: Thank you.

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12 (DEPOSITION CONCLUDED)

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4 I, DR. STEVEN MEISTER, hereby
5 certify that the foregoing is a true
6 and correct transcript of my deposition.
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14 _____
DR. STEVEN MEISTER

15
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18 _____
WITNESS
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I - N - D - E - X

DR. STEVEN MEISTER

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