IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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

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

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BY MR. TREU:

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.

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

A. I understand.

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

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

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

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

THE WITNESS: Okay.

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

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

BY MR. TREU:

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

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

Q. Doctor, have you given deposition testimony before?

A. Yes, I have.

Q. As an expert witness?

A. Yes.

Q. On approximately how many occasions?

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

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

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

A. Yes.

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

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

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

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

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

Q. Are you an invasive cardiologist, Doctor?

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

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

I continued as an invasive

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

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

A. I have.

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

A. Yes.

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

A. In our laboratory today, the reports are expected to be out within forty-eight hours. I can't tell you it has never taken longer than that but --

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

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

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

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

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

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

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

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

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

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

couple possibilities would occur.

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

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

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

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

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

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

MS. TOSTI: Correct.

BY MR. TREU:

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

A. It should be.

Q. And that would be --

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

MS. TOSTI: Kris, if I can just interject here. The copy that I gave you when we were in Philadelphia, Dr. Meister's secretary had just run off. So I believe it was the most recent one that they had available.

MR. TREU: Okay.

BY MR. TREU:

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

A. That is correct.

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

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

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

cardiologist which would be a subspecialty of cardiology.

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

Q. You are board certified?

A. In medicine and cardiology.

Q. Passed on your first attempt?

A. Yes.

Q. What hospitals do you have privileges at?

A. Right now?

Q. Yes.

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

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

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

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

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

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

Q. Can you describe your current practice for me?

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

I see outpatients in our

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

Q. Are you a part of a group?

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

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

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

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

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

The remainder is the

Philadelphia Cardiology Associates.

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

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

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

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

Q. And how is that?

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

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

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

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

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

BY MR. TREU:

Q. Can you answer that question, Doctor?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Where do those standards come down from?

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

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

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

Q. How many patients have you referred for

sleep studies in your practice?

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

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

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

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

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

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

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

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

MR. TREU: Okay, fine.

BY MR. TREU:

Q. Is that more accurate, Doctor?

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

Q. How about in 1995?

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

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

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

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

years?

A. I would think. It has to be.

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

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

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

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

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

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

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

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

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

Q. Again, since the early '80s?

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

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

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

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

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

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

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

Now, that's not a direct

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

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

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

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

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

THE WITNESS: Surely.

MR. TREU: What's the difference?

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

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

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

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

THE WITNESS: Surely.

BY MR. TREU:

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

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

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

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

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

Q. From whom?

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

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

Q. Did you review all that data?

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

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

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

Q. You're not sure.
A. I'm not sure.
Q. How about the letters, you read all the letters?
A. All of them.
Q. Were you provided with any additional information?
A. Not off the top of my head.
Q. Were you given any deposition summaries?
A. I believe that I was, but I don't look at them.

I prefer to read the depositions myself.

Q. Were you provided with any letters summarizing the facts of this case?
A. I don't know. If I have, it's been a long time since I looked at it. Let me look through.

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

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

it.

Q. Was that a letter?

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

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

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

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

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

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

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

Q. Then --

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

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

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

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

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

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

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

Q. Do you know how plaintiff's counsel got

your name?

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

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

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

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

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

Q. Is that some expert witness service?

A. That was an expert witness service.

Q. Do you know the name of it?

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

Q. Is it an individual's name?

A. Sapanaro.

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

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

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

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

Q. Bill Novak?

A. That might be the guy. That's one of the firms, yes.
Q. Were these primarily plaintiff's firms?
A. I think so.
Q. Anything for the Neurenberg firm?
A. That doesn't sound familiar.
Q. Weisman Goldberg?
A. That really doesn't sound familiar.
Q. Bangenberg?
A. Not that I know of.
Q. Have you ever done any prior cases for the Becker and Mishkind firm?
A. I think so, but I'm not sure.
Q. Did you ever work with Ms. Tosti before?
A. I don't think so. You could ask her, but I don't think so.
Q. She would never tell me.
A. Okay.
Q. Do you consider yourself an expert in sleep medicine?
A. I do not.
Q. How about family practice?
A. To an extent, not an expert in family practice, but I know in my own area in

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

I'm kind of an expert on that.

Q. Are you an expert in neurology?

A. No, sir.

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

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

A. Yes.

Q. Is it accurate and complete?

A. What do you mean by that?

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

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

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

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

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

A. Well, I think so.

Q. Tell me --

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

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

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

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

A. That's correct.

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

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

A. Not materially.

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

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

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

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

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

Q. Did you make any markings on the records

as you reviewed them?

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

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

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

Q. Okay.

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

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

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

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

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

A. I really didn't.

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

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

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

A. Yes.

Q. What are those?

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

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

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

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

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

Q. Do you work with residents in your practice?

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

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

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

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

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

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

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

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

A. I haven't read that.

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

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

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

MR. TREU: That's fine.

BY MR. TREU:

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

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

Q. Yes.

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

Q. Why not?

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

There were episodes of chest,

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

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

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

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

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

do.

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

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

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

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

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

Q. Sure.

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

sentence.

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

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

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

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

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

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

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

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

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

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

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

standard of care?

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

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

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

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

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

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

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

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

A. Yes.

Q. On all of those occasions?

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

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

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

A. Detail provided.

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

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

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

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

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

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

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

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

it.

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

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

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

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

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

this university clinic setting.

Q. Do you know that?

A. No, I don't know that.

Q. You're guessing?

MS. TOSTI: In regard to what?

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

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

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

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

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

MR. TREU: Jeanne, I don't

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

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

BY MR. TREU:

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

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

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

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

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

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

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

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

goes in the chart.

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

1996.

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

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

Q. How do you know that?

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

Q. Did Ms. Tosti tell you that?

A. No.

Q. Go ahead.

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

Q. Have you consulted with someone from a

sleep lab on this case?

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

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

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

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

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

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

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

A. I believe that's correct.

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

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

BY MR. TREU:

Q. Go ahead, Doctor.

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

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

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

went back and forth and were not answered.

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

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

A. Pardon me?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Surely.

Q. And my question first is this, the report

was sent to Dr. Rowanne, correct?
A. Which report now, the preliminary report or the final report?
Q. Both.
A. They were both sent to him.
Q. He received both of them, did he not?
A. That's correct. The other person who was supposed to receive the result didn't get it, I understand, but I don't know that for a fact.
Q. I'm not asking about him.
A. Okay.
Q. Dr. Rowanne was driving the bus?
A. Sure.
Q. Dr. Rowanne was this patient's attending physician, he's admitted that in his deposition, correct?
A. He was.
Q. He received both of these reports from the sleep study, correct?
A. He did.
Q. It was Dr. Rowanne's responsibility to follow up on those reports, true?
A. It certainly is.
Q. How is it then the responsibility or a

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

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

Q. Whose fault was that?

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

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

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

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

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

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

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

A. No, I don't.

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

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

A. It certainly is.

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

A. I have no way of knowing that.

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

other than Dr. Brooks?

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

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

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

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

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

BY MR. TREU:

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

A. Surely, that's correct.
Q. Would you agree with me, Doctor, from your review of the report and Dr. Rowanne's deposition testimony that he did have the final polysomnogram report available to him and he had an opportunity to initiate treatment for this sleep disorder prior to the time the patient died?
A. He had the report in his possession just a little over a month after the study was done and he had plenty of time after that to initiate therapy and it was not initiated.
Q. I want to get back I guess to my question as to the residents.

I'm not going to go back over what you've already testified to, but, again, any other areas where you believe the residents failed to meet accepted standards of care?
A. I don't think so.
Q. Do you have opinions in this case as to whether anyone else failed to meet accepted standards of care?
A. In reading one of the depositions recently, it was mentioned, and I believe it

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. In an analogous situation --

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

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

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

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

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

A. Yes.

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

A. Well, did the hospital --

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

A. I'm going to say that these individuals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Steps should have been taken --

Q. Do you have a page, sir?

A. Yes, I better answer that one.

Q. Okay. Fine.

A. Sorry.

- - -

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

- - -

BY MR. TREU:

Q. I think you were talking about the referral.

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

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

writing on it at all.

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

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

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

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

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

A. That is correct.

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

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

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

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

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

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

BY MR. TREU:

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

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

laboratory and the procedure was about the same in both.

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

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

Q. Have they always included treatment recommendations?

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

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

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

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

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

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

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

A. I think that is principally it.

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

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

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

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

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

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

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

BY MR. TREU:

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

A. I believe that as the operators of the

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

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

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

Q. No, I'm really not.

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

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

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

equipment, but maintaining standards.
Q. The name of your hospital is?
A. Medical College of Pennsylvania Hospital.
Q. Do you have groups of doctors, let's say, orthopedic doctors, who use the name of the hospital or the name of the university in the name of their corporate practice?
A. We do have an orthopedic clinic that's operated by the hospital and our orthopedists are there.
Q. For example, here in Cleveland we have University Orthopedic Associates. Okay?
A. Yes.
Q. They are a group of orthopedic surgeons who operate at a number of different hospitals, one of which is University Hospitals of Cleveland, and they have offices in the hospital and outside of the hospital.
Are you saying that because they have the name University --
MS. TOSTI: Objection because the name of this institution is University Hospitals of Cleveland.
Are you suggesting that these

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

MR. TREU: Are you done, Jeanne?

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

That's what you're suggesting to him.

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

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

BY MR. TREU:

Q. University Orthopedic Associates.

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

Q. Right.

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

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

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

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

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

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

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

A. Pardon me?

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

hospital becomes somehow responsible and then they're not?

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

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

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

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

A. That's correct.

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

MS. TOSTI: Again, I'm going to enter an objection here in that there is an outstanding deposition of the director of the Family Practice Center. We have not had an opportunity to depose this individual

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

BY MR. TREU:

Q. Can you answer that question, Doctor?

A. Would you repeat the question?

Q. I'll ask you this question.

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

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

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

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

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

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

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

A. What I understand --

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

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

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

Q. Somehow related?

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

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

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

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

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

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

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

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

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

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

A. No, I didn't.

Q. Does that make a difference to you?

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

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

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

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

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

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

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

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

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

A. That's my understanding.

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

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

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

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

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

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

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

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

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

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

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

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

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

A. That's correct.

Q. And they found a healing ulcer and gastritis?

A. That's correct.

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

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

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

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

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

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

A. That is correct.

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

A. That is correct.

Q. So --

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

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

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

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

certainty.

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

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

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

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

A. Right.

Q. Attribute this to anything?

A. Pardon?

Q. Do you attribute that complaint to anything specifically?

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

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

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

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

A. Yes.

Q. And that was essentially normal, correct?

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

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

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

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

Q. In fact, it was Dr. Rowanne who saw the patient on that day, on the 13th, and indicated that exercise and stress testing should be considered?
A. Correct.
Q. And is it your opinion that, in fact, those studies should have been done?
A. Surely.
Q. Or a cardiology consult should have been done?
A. One or the other or both.
Q. And would you agree that was Dr. Rowanne's responsibility?
A. That's correct.
Q. I'm going to page, although they're not numbered, I can see --
A. I was really new with my computer at that time.
Q. Didn't have a secretary do this for you, did you?
A. No.
Q. Now, at the top of page four, you indicate that -- you're talking about the sleep study?

A. Yes.
Q. You say it's common knowledge that sleep events such as these are dangerous?
A. Correct.
Q. Do you see that?
A. Yes.
Q. I guess I have to ask you on what do you base that statement?

And you're talking about the oxygen saturation?
A. Yes. You're not supposed to get down to sixty percent when you're awake or when you're asleep or any other time.

If I catch a patient with an oxygen saturation of sixty percent in my coronary care unit, there's a pretty good chance they're going to get intubated right on the spot and be put on a respiratory.
Q. Does it depend how long they're at sixty percent?
A. Yes.
Q. Do you know how long this patient --
A. As a practical matter, I would think that that would make a difference, but I can assure

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

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

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

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

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

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

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

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

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

Q. Why does that make a difference?

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

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

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

orange.

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

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

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

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

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

Q. How much of that study did you get?

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

Q. No.

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

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

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

THE WITNESS: I'm sure she will.

- - -

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

- - -

BY MR. TREU:

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

A. That's correct.

Q. Is that true in her case?

A. I don't know.

Q. Did you look at the autopsy?

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

Q. Would you take a quick look?

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

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

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

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

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

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

Q. Glad to hear that.

A. Including lots of physicians.

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

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

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

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

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

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

A. Yes.

Q. What is it?

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

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

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

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

Q. Okay.

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

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

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

So when blood has been

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

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

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

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

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

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

A. That's correct.
Q. Premature ventricular beats can occur during apnea, to your knowledge?
A. I don't know that one way or another.
Q. Do you know if it should make a difference?
A. I think if you saw a lot of them during an apnea period, it would point even more strongly in that direction, but the opposite is not true if I didn't see more of them during the episode of apnea that occurred here.

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

It's clear that she was having a lot of extra beats.
Q. Next page of your report, the top paragraph, you say here that her death could have been prevented had she had appropriate treatment for her coronary artery obstruction.

Is it Dr. Rowanne's fault, in your opinion, that she did not have follow up for her coronary artery --
A. I think he took ultimate responsibility.

MS. TOSTI: Asked and answered.

BY MR. TREU:

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

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

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

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

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

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

of itself.

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

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

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

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

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

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

already. Bear with me, please?

A. Okay.

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

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

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

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

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

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

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

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

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

Q. Let's break it down.

A. Sure.

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

A. That is correct.

Q. Dr. Brooks' responsibility?

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

You have been through this

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

So objection to this line of questioning.

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

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

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

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

BY MR. TREU:

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

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

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

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

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

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

A. That's right, quite correct.

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

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

A. That what was the case, sir?

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

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

Q. Again, Doctor --

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

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

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

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

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

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

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

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

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

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

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

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

interruption.

BY MR. TREU:

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

MS. TOSTI: Objection, asked and answered.

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

BY MR. TREU:

Q. Why?

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

Q. How do they become aware of that?

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

Q. How often does it have to happen before

they have to do something about it?
A. They have to make periodic checks to see that reports reach the chart. It's easy enough to do and it's done.
It's done, I'm sure, in virtually every institution. It's certainly done in this one.
Q. Do you know whether it was done in this institution?
A. I don't. All I know is what happened, happened.
Q. Do you know whether the institution had any reason to believe that Dr. Brooks was not getting his reports out in a timely fashion?
A. It was their responsibility to know. I don't know if they did or didn't.
Q. If the institution established the standards and the doctor doesn't meet those standards, that's the doctor's responsibility, correct?
A. And the institution's responsibility. It's a shared responsibility.
Q. If they have an opportunity to address it?

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

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

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

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

Q. Everything?

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

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

MS. TOSTI: Objection.

THE WITNESS: Sure.

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

BY MR. TREU:

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

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

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

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

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

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

Q. What institution?

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

If that's wrong, then I stand corrected.

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

A. Yes.

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

A. Absolutely.

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

A. Absolutely.

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

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

plain old internist knows about it.

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

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

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

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

BY MR. TREU:

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

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

Q. Doctor, have we covered all the areas

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

A. Several times I think.

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

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

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

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

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

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

twenty percent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I've had some events that I

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

Q. What do you charge to review a case?

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

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

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

A. Yes.

Q. How about trial testimony?

A. Same.

Q. What is your date of birth, Doctor?

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

MS. TOSTI: Thank you, Doctor.

BY MR. TREU:

Q. What is your date of birth?

A. 9-13-37.

Q. Can we agree that the practice of medicine requires medical judgments on a day-to-day basis?
A. Absolutely.
Q. We agree that those judgments are not always black and white?
A. Absolutely, but there are some standards.
Q. Can we agree that a physician can make an incorrect judgment and still meet the accepted standard of care?
A. Absolutely.
Q. Have you ever made an error in judgment?
A. Yes.
Q. Have you breached the standard of care in those instances where you have made incorrect judgments?
A. It's hard to say because I know that, in general, I have done this.

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

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

occasions?

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

Q. Doesn't take much.

A. No.

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

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

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

I showed it to all of my

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

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

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

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

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

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

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

Those are the ones I can think of.

Q. Okay.

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

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

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

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

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

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

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

MS. TOSTI: From the surgery itself, Kris?

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

THE WITNESS: She would have

been.

MS. TOSTI: Increased risk of complications?

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

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

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

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

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

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

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

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

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

MS. TOSTI: I would object to anything additional.

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

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

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

THE WITNESS: Okay.

MS. TOSTI: In regard to signature on this, we will reserve signature for the Doctor.

MR. TREU: And I will order it and I will FAX you our information.

MS. TOSTI: We also will be ordering this deposition.

MR. TREU: Thank you.

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(DEPOSITION CONCLUDED)

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I, DR. STEVEN MEISTER, hereby certify that the foregoing is a true and correct transcript of my deposition.

_____
DR. STEVEN MEISTER

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WITNESS

I-N-D-E-X

EXHIBITS Documents received and marked for identification