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

IN THE COURT OF COMMON PLEAS

FRANCES SMITH,
ADMINISTRATRIX, etc.,

Plaintiff,

vs.

Case No: 100877

ST. LUKE'S HOSPITAL, et al.,

Defendants.

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Deposition of ALAN MARK OLIVER, M.D., taken by the Plaintiff as if upon cross-examination before Aneta I. Fine, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., Fourteenth Floor, 100 Erieview Plaza, Cleveland, Ohio, on Thursday, the 21st day of May, 1987, commencing at 10:00 a.m., pursuant to notice.

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APPEARANCES:

Charles Kampinski Co., L.P.A., by:
Charles Kampinski, Esq. and
Christopher M. Mellino, Esq.

On behalf of the Plaintiff.

Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., by:
Stephen J. Charms, Esq.,

On behalf of Alan Mark Oliver, M.D.

Arter & Kadden, by:
Michael C. Zellers, Esq. and
Jim Grove, Esq.,

On behalf of the Defendants, St. Luke's Hospital, Fedeshen and Edmonson.

Reminger & Reminger, by:
Marc W. Groedel, Esq.,

On behalf of the Defendants, Timothy Stephens, M.D. and Curtis Smith, M.D.

ALSO PRESENT:

Christine J. Orlinski for Steven W. Albert, Esq., Kitchen, Messner & Deery on behalf of Nurse Sims.

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STIPULATIONS

It is stipulated by and between counsel. for the respective parties that this deposition may be taken in stenatypy by Aneta I, Fine; that her stenatype notes may be subsequently transcribed in the absence of the witness; and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taking this deposition are waived,

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ALAN MARK OLIVER, M.D.,

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

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your full name, please?

A. Alan Mark Oliver.

Q. Spell Alan.

A, A-l-a-n.

Q. Would you state your address, please?

A. 25000 South Woodland, Beachwood.

Q. Is that an apartment?

A. It's a home.

Q. Okay. Where's that?

A. Beachwood.

Q. Doctor, I'm going to ask you a number of questions this morning. Some of the other attorneys may ask you some questions also, If you don't understand any questions, pleas? tell me, I'll be happy to rephrase them,

A. All right,

Q. When I ask you a question I'll ask that

you respond verbally to the question, She can't take down a nod of your head, Okay?

A. I understand,

Q. How long have you lived at the South Woodland address, Doctor?

A, Three years,

Q. Where did you Live before that?

A, Van Aken in a rented condominium.

Q. Okay. How long there?

A. Two years,

Q. And before that?

A, Lexington, Kentucky.

Q. Attending medical school?

A, No. Residency training.

Q. How long were you there?

A. Two years,

Q. And before that?

A. Back in Cleveland I was an intern at Richmond Heights.

Q. Okay,

A. That was a hospital.

Q. How long were you in Cleveland?

A. One years.

Q. Okay. Before that?

A, Kansas City, Missouri.

Q. That was medical school?

A, Yes,

Q. Four years?

A. Four years, yes.

Q. Before that?

A. Kansas City. I'm from there.

Q. Okay. You went to undergraduate school then?

A. Yes. University of Missouri at Kansas City.

0. And you were born and raised in Kansas?

A, Missouri, Kansas City, Missouri.

Q. I'm sorry.

A, There's a Kansas City, Kansas across the state line.

Q. I understand. How old are you, Doctor?

A, 35.

Q. Date of birth?

A. February 28, 1952.

Q. Okay. If you would fill in some years for me. When did you graduate from high school, sir?

A. 1970.

Q. Okay. That was in Kansas City?

A. Yes.

Q. All right, And where did you yo to undergraduate school, University of Missouri?

A. At Kansas City, yes.

Q. 1970 till when?

a. '73. I finished in three years.

Q. Going summers?

A. Yes.

Q. Okay. Three years chronologically but I take it you took the right number of hours?

A, Yes, that's correct.

Q. Where did you go to medical school?

A. Kansas City College of osteopathic Medicine.

Q. When did you attend that?

A, 1975 through '79.

Q. What kind of degree have you received from medical school?

A. D.O., Doctor of Ostepathy.

Q. And how is that different from M.D.? I mean is there a different philosophy?

A. The philosophy is different.

Q. What is the philosophy of osteopathy?

A. The philosophy includes manipulative therapy, evaluation of the patient as a whole rather than individual systems or organs or

individual. disease states. We feel that diseases can affect the whole body, not just one particular system or organ.

Q. Does that preclude you from treating any particular organ if it is, in fact, diseased?

A. Not at all. Not at all. Our training is the same as M.D. except we are additionally trained in manipulative therapy.

Q. And once again, manipulative meaning the entire body or --

A, Manipulative regarding the musculoskeletal system.

Q. Well, how would you treat a heart attack, Doctor?

A. How would I treat a heart attack?

Q. Sure,

A. Once I have diagnosed it?

Q. Yes.

A. Admit the patient to the coronary care unit, Put the patient on monitoring, check his cardiac enzymes, check his EKC, chest x-ray.

Q. Okay.

A. And I personally would call in a cardiologist as a consultant.

Q. Okay. I take it that's because that's

not your specialty?

A, That's correct. That's correct.

Q. Where did you do your residency or your internship?

A. At Richmond Heights General Hospital, Richmond Heights, Ohio,

Q. That would have been 1979, '80?

A, Yes.

Q. Okay. And then your residency where?

A. University of Kentucky Medical Center

Q. What years was that?

A, '80 to '82.

Q. Okay, Did you specialize at all during your residency?

A. Emergency medicine.

Q. Are you Board-certified?

A. Yes, I am.

Q. In emergency medicine?

A. Yes, I am.

Q. When were *you* Board-certified?

A. April '85.

Q. Both oral and written?

A. *Yes.*

Q. Was that the first time you were eligible to take the Boards?

A. No. I was eligible as soon as I finished my residency.

Q. Okay. Did you take them before April of '85?

A. No, I did not.

Q. So you passed your first --

A, Oh, yes, the first time I took them.

Q. After your residency what did you do at the University of Kentucky?

A. I left and went to the Cleveland Clinic Foundation,

Q. Why?

A. For a one year fellowship in critical care.

Q. What year was that?

A. '82, '83.

Q. And what did you do then?

A. I accepted at the present position of director of the surgical intensive care unit at St. Luke's Hospital.

Q. I'm sorry. Director?

A. Of the surgical intensive care unit,

Q. When was that, sir?

A. July '83.

Q. And that's still your present position?

A, That's correct,

Q. Is that position as an employee of the hospital?

A. It's an administrative position, I'm in private practice,

Q. I see.

A, But it's --

Q. What do you do as director of surgical intensive care?

a, The administrative functions or the clinical functions?

Q. Well, let's deal with each of them.

A, The administrative fuctions, I manage the unit, help develop the policies and procedures, protocols. I'm involved in nursing as well as resident education,

Q. All right, Let's go slow through that.

A. Okay,

Q. In terms of the practices, the procedures --

A. Yes.

Q. -- arc you the one that establishes them?

A, Yes.

Q. All right.

A, With consultation with my nursing staff.

Q. Okay,

A. And other attendings, time to time,

Q. Have you changed the protocol since you have been there?

A. Some of them, yes, As an example or --

Q. Oh, sure,

A. A pulmonary catheter also known as a Swan, S-w-a-n, Ganz, G-a-n-z, catheter. Prior to my arrival residents were not gowning, gloving, putting the hats and mask on to make it as sterile a technique as they should have,

Q. Okay.

A. Plus we developed a cart to hold all the equipment to make it extremely convenient,

Q. What other things have you changed?

A. Nursing education for one, We're giving more inservices. We have developed a videotape type program where we videotape lectures and developing an archival system.

Q. Did you do any changing with respect to the duties of nurses within the surgical intensive care unit?

A. In consultation with the directors of the nursing department, the nursing administration. For example, we now have a clinical instructor which we did not have to help our preceptors teach

new recruits in a more organized fashion, and we have also just developed a clinical nurse specialist position to oversee all of the clinical. instructors for a11 of the critical care units of the hospital, not just surgical ICU.

Q. How about a recovery room? Have you dealt with any protocols in terms of changing?

A, No. That's not my --

Q. Let me finish my question,

MR. CHARMS: Let Mr. Kampinski finish his question, then you can answer.

A, I'm sorry, Excuse me.

Q. Have you changed any of the protocols with respect to any of the nurses having duties within the recovery room?

A. No.

Q. Have you dealt in your tenure since July of '83 at St. Luke's in any facet of the recovery room?

A. No.

Q. Okay, You also have clinical responsibilities?

A, Yes.

Q. What are those?

AS As far as patient care?

MR. ZELLERS: Objection. And my only objection is so he clarifies what he does as director of the surgical intensive care unit and as a private physician. He can answer any way he wants to answer, I'm just objecting.

MR. KAMPINSKI: You are not trying to help him at all?

MR, ZELLERS: Not at all.

MR. KAMPINSKI: Okay, good.

Q. Now that that's clear, why don't you tell me what your clinical duties are,

A. Direct patient care. I'm the responsible physician for all surgical patients admitted to the surgical intensive care unit as a consultant,

Q. All right, The patients I take it have no choice in who they are going to get as a doctor when they come into the SICU? I mean you are there to assist them?

MR. ZELLERS: Objection.

Q. On behalf of the hospital, correct?

MR. ZELLERS: Doctor, I objected, You go ahead and answer the question unless Mr. Charms instructs you not to answer the question.

A. Would you restate it, please?

Q. I'll try to. I think you answered that the patients that come to SICU do not have a choice in who it is they have as a physician, correct?

A. I see what you're saying. That's not entirely true. If the attending surgeon did not want to consult me he would not have to.

Q. I see,

A, But as a rule I am consulted.

Q. Has that ever happened?

A, That I have not been -- yes, that has happened,

Q. Ever happened by Dr. Smith?

A, Not that I can recall,

Q. But once again, the patient corning to SIGU, he doesn't have the choice I take it that you are aware?

MR. ZELLERS: Objection.

MR. CHARMS: If you're aware.

A. He doesn't have a choice. That's a difficult question to answer.

Q. And I'll rephrase it. Maybe it's not a fair one. It's asking you to get inside the patient's head, I'll withdraw it.

A. And they may not be aware. They may be on a respirator.

Q. Which means they may not have a choice?

A. That's right, they may not have a choice.

Q. Do you have regular hours in the SICU unit in terms of your clinical work?

A. Not really.

Q. How is it determined when you are there and --

A. To rephrase in a routine fashion, I make rounds at 8:30 in the morning with the residents. We usually look at x-rays first. We have an x-ray view box area in the intensive care unit. After we finish viewing x-rays, we make detailed bedside rounds and then the residents and myself go on about getting some of the daily functions done. In the afternoon I usually --

Q. Wait a minute. ~ a i fl~etions in terms of?

A. Patients that need to be --

Q. Patient care?

A. Patient care. Patients that need to be transferred, orders that need to be written, changes that need to be made in therapy or diagnostic modalities.

Q. Okay, You arc talking now in terms of what you're doing I take it in a teaching setting?

A. Teaching and clinical,

Q. Both?

A. It's both. It's simultaneous. You really can't separate it.

Q. What does your contract with the hospital call for in terms of your duties?

A. I don't have a contract per se, a written contract, Is that what you're asking?

Q. Yes,

a, We don't have a written contract,

Q. You don't have a written contract with the hospital?

A, I have a letter of understanding when I first started.

Q. Did that delineate your duties?

A, Yes.

Q. Or what you would be doing?

A. Yes, it did.

Q. Were part of those duties to provide clinical care to patients in the SIGU?

A. Yes.

Q. All right, And these are not private patients of yours, I take it these are staff

patients or patients of some other staff physician?

A. Private physician, that's correct. I do not have my own private patients. I do not have an office practice,

Q. All right, And is your office within the hospital?

A. Yes. It's around the corner Erom the intensive care unit.

Q. What is the address of the hospital?

A. 11311 Shaker Boulevard.

Q. And that's your office address?

A. Yes, that's correct.

Q. And they provide secretarial service for you?

a. That's correct.

Q. And you are paid how, Doctor?

A. I'm paid a stipend from the hospital for my administrative and educational role, but the bulk of my income is fee for service, private billing of the patients.

Q. And that's handled by whom?

A. The billing?

Q. Yes.

A. I have an outside billing service that does it.

Q. Qkay. And do you have a separate corporation that you bill through?

A. Yes, I do.

Q. What is the name of the corporation?

A. Critical Care Associates, Inc.

Q. And who is the shareholder of that corporation?

A. Myself and my wife.

Q. Who makes the decision as to whether a patient goes to the surgical intensive care unit?

A. It could be any number of people, For example, I might get a call, either I might get a call, the resident in the unit might get a call or our nurse in charge might get a call from the operating room. That call could be from the charge nurse in the operating room, a circulating nurse in the operating room, a surgeon from the operating room, the resident who assisted on the surgery in the operating room or someone from anesthesia saying we'd like to bring this patient over for observation or for whatever reason.

Q. Okay, Do you know of a different decision-making process between sending a patient to surgical intensive care unit versus recovery?

A. I do not.

MR. CHARMS: Objection.

Q. All right, You are not aware of any protocols within the hospital dealing with that decision-making process?

A. I am not aware. I am not aware,

Q. Is there a hierarchy, and that may not be the proper word, but let me use it in the context of the question, of care provided to a patient in SICU versus recovery room?

A, Restate that, please.

Q. *Yes.* Are there different services provided to a patient in SICU than in the recovery room?

A, Different services?

Q. Monitoring, for example?

A. Monitoring?

MR. ZELLERS: Objection. If you know.

Q. And let me even add, I'm talking about November of 1984 now.

A. Okay. Not that I'm aware of that there are differences,

Q. Were there EKG machines in the SICU?

A. Are there?

Q. In November of '84?

A. Yes, there are.

Q. How about in the recovery room?

A, I wouldn't know.

Q. How far is the recovery room from the SICU?

A. It's right next door.

Q. But you don't know if there were or weren't?

A, At that date I don't remember.

Q. What kind of machines did you have for monitoring heart activity in November of 1984 in SICU?

A. In the surgical SICU?

Q. Yes.

A, We had bedside monitors at each bedside.

Q. Do they provide continuous readout?

A. That's correct.

Q. And does that become a continuous part or part of the patient's record?

A, No.

Q. Why not?

A. It's not computerized for that purpose,

Q. Well, how about physically taking it out of the machine and --

A. Oh, yes, we do that.

Q. So it does become part of the patient's chart?

A. In that regard, yes, but there are some systems that are computerized enough that everything is recorded permanently, I thought that was what you were getting at.

Q. But you don't know if that capability existed in the recovery room in November of 1984?

A. I know that it exists now and I would assume it existed then.

Q. Okay.

A. I know that they have monitors.

Q. Do you know what kind?

A. Currently?

Q. No. November of '84.

A. I believe it was Honeywell. E for M.

Q. What kind did you have in SICU?

A. I believe we still had an older -- we just changed it a couple years ago, Abbott is what we had. We have a different product now.

Q. They both provide continuous readout then?

A. That's correct.

Q. When a decision is made that a patient is to be admitted to the surgical intensive care

unit following surgery, how is it determined who will care for him or who will undertake primary care for him or her in the surgical intensive care unit?

A. As I stated earlier, I am the responsible physician although surgeons do have the capability of not consulting.

Q. All right. Let's assume that that's not the case and let's assume that you then have responsibility for care of that patient.

A. I am responsible for the care of that patient in the surgical intensive care unit,

Q. What if you are not physically there?

A. The residents are there 24 hours a day, surgical residents.

Q. All right, How about if you're there?

An Both --

Q. Do you take primary care then and give orders to the residents in terms of what you want them to do?

A. Both. Both of those things happen. Either he will take care or I'll take care or I'll. instruct him.

Q. How many beds were there in the surgical intensive care unit in November of 1984?

A. Eight.

Q. On November 14, 1984 do you know how many were occupied?

A, I do not,

Q. Do you have records khat would reflect how many were occupied?

A. Yes. We would have a log book,

Q. Okay. And that is maintained where?

A. In the surgical intensive care unit.

Q. Okay, And that would reflect what, how many patients were in the SICU on any particular day?

A. That's correct.

Q. All right. You haven't checked that though for purposes of determining how many were there November 14, 1984?

A. I have not.

Q. Do you recall that date in terms of anything that occurred?

A. No, I do not.

Q. Have you reviewed the records pertaining to Mr. Smith?

A. I have briefly reviewed the chart, yes,

Q. Wow many times?

a. Once,

Q. When?

A. Shortly before talking to Mr. Charms.

Q. Today?

A. Well, today but -- no. When I talked to him a few weeks ago, a couple weeks ago.

Q. Has he apprised you that his firm is also representing Dr. Smith?

A. No.

MR. GRQEDEL: You mean Dr. Lee?

Q. I'm sorry. Dr. Lee?

A. Yes.

Q. And that they have filed a crossclaim against the hospital?

A. They meaning who?

Q. Dr. Lee?

A, Yes.

Q. When did you first see Mr. Smith?

A, November 14, 1984.

Q. What time?

A. That, I do not remember.

Q- You can look at the chart if it will assist you at all, Doctor.

MR. CHARMS: Can you help, Chuck? Do you have --

MR. KAMPINSKI: Yes, But my pages

are not numbered the same so I really can't tell to be honest with you.

A. It looks like it was two in the afternoon.

Q. You got to tell me what you are looking at, Doctor,

A. I'm looking at the surgical intensive care flow sheet for November 14.

MR. CHARMS: Our page number 79.

MR. KAMPINSKI: Yes, but: that's not going to help me I don't think.

Q. I will tell you what, why don't you, if you don't mind, let me look over your shoulder here.

A. This is November 14.

a. Okay. And your page 79?

A. Right.

Q. All right.

A. Two or maybe 1:30. The photocopy is not exact. Between 1:30 and 2 in the afternoon.

Q. How can you tell that by looking at this, and where does it tell you that that's when he came in?

A. Because numbers would have been -- when nurses admit patients to the surgical intensive

care unit they mark the time by noting the initial vital signs,

Q. And it's got what?

A. A temperature, it's good blood pressure, heart rate, I.V. fluids, some other I.V. fluids here, some initial assessment values, looks like blood gas, some laboratory data.

Q. What were the blood gases?

A. Initially, pH, 7.38, PCO2, 39, P02, 71.

Q. Okay, Did you see him by the way when he first came in?

A. I don't recall.

Q. All right, Can you tell from this chart when you saw him or not?

A. Occasionally the nurses will write in the note, in their notes whether I was present or not and I'd have to look. Dr. Oliver was present.

Q. Okay, So you would have been in charge then?

A. *Yes*, that's correct.

Q. All right.

A. Here the strip shows 1 p.m. so that looks like the time of admission.

Q. All right, Is there anything unusual in this strip, Doctor?

A. Not this particular strip.

Q. All right. Any other strips?

A. Not that one. Nor that one. There's some ST segment depression and T wave inversion,

Q. What does that mean?

A. It could mean nothing.

Q. What could it mean?

A, It could mean strain Erom an enlarged ventricle, it could mean ischemia.

Q. What is ischemia, Doctor?

A. Poor flow to parts of the heart.

Q. Okay.

A. Then we're going to the next day.

a. Okay, Go ahead. Go through the entire strips if you have any more.

A. Strips?

Q. Sure.

A. No changes from the previous one we just saw. No change. All of these have been normal rhythm, normal sinus rhythm, no arrhythmias. Normal. Normal. It looks like that's the end of the --

Q. You referred, if you would find your note, Doctor, you referred to the extension of bigeminy.

A. In my personal note?

Q. Yes.

A. Yes. I found the note,

Q. Okay. Was that a finding that you made?

A. Yes.

Q. Okay. When did you make it?

A. I don't remember, I don't remember.

Q. All right. Is there anything in the records that would reflect how you made it or when you made it?

A, There should be a twelve lead EKG somewhere in the chart. It could be this one.

Q. Well, is it? Take a look.

A, It looks like it would be the one I would have looked at,

Q. Where do you see bigeminy?

MR. ZELLERS: What page are you referring to, Doctor?

MR. KAMPINSKI: 1.36.

A. It may not -- I don't see atrial bigeminy here. I see premature atrial constrictions.

Q. Why did you write bigeminy then?

MR. CHARMS: Wait a minute, Doctor. Then take the time and go through the

whole chart.

Q. Sure.

A. On looking more closely on the original strip I do see what I would call atrial bigeminy.

Q. What page?

A. It looks like 78.

Q. Show it to me, Doctor.

A. This interval from here to here is narrower than from here tu here. This is narrower than from here -- this one is -- I don't know whether that is artifact, but again, this one is narrower and then the next one is cut off. That is an alternating bigeminy.

Q. Okay. Going back to your note, Doctor, what did you find to be the problem with Mr. Smith?

A. What do you mean?

Q. Well, what was your diagnosis?

A. Re had hip surgery. A replacement of a femoral head, and he was admitted to the intensive care unit on a ventilator for ventilator management.

Q. Why?

A. That, I don't know.

Q. Didn't you find out?

A. Well, the main reason would be that they

didn't reverse the anesthesia, Why they didn't reverse the anesthesia, we don't know that, On open heart patients -- we don't do that an many patients. I leave that to the judgment of the anesthesiologist,

Q. So it was your opinion that he was there for the reversal of anesthesia?

A. *Yes.* To allow the anesthetic agents to metabolize naturally.

Q. How long did that take?

A. He was taken off the ventilator on the 25th.

Q. Did you conduct any tests?

a. What do you mean?

Q. While he was in SICU?

A, Laboratory tests?

Q. Sure.

A. Yes.

Q. What did you conduct?

A, Electrolyte studies, You want specific electrolytes?

Q. Why don't you refer to the page. Why don't you go to doctor's orders, Doctor and see what it is you ordered.

A. Okay, We have a panel called a CHEM-7

which includes --

Q. What page?

A. I'm sorry. 46.

Q. Go ahead,

A. CHEM-7 which includes electrolytes, blood urea, nitrogen,

Q. You are Looking now what, in the middle of that page, Doctor?

A. *Yes.*

Q. Before that up above you have got -- why don't you read the whole thing if you would.

A. Top of the page? Ventilator orders, VT is title volume at 1,000. IMV 10 is intermittent of 10. .50 of FI02 which is the fraction of inspired oxygen in percent, and plus five PEEP which stands for Positive and Expiratory Pressure, ABG's, arterial blood gases in one half hour, verbal order, Dr. Oliver, and it looks like it was signed by a respiratory therapist.

Q. And then countersigned by you?

A. Yes.

Q. And the next order is the same date. Can you determine the time of these orders, Doctor?

A. Probably by going back to the flow sheet.

Q. Okay.

A. Approximately it looks like 1:30 in the afternoon,

Q. Okay.

A. That's beyond page --

Q. Are we looking at the first order?

A. That would be on page 79D.

Q. Okay. Go ahead.

A. You want me to go to the next order now?

Q. Yes.

A. Increase PEEP to plus ten. ABG's, within one half hour. Verbal order, Dr. Oliver. Signed by the therapist, Ann Castellarin and countersigned by myself.

Q. And what time was that order, sir?

A. It's not time, It's dated.

Q. Can you determine what time? It's the same date?

A. I see what you're saying.

Q. Right,

A. Approximately between 1:30 and 2:00,

Q. That was the same time you gave me for the first order?

A. I said 1:30. And this would be between 1:30 and 2:00.

Q. Is there a repeat €or arterial blood

gases because you asked for that?

A. There was a change made in the ventilator,

Q. I see.

A. We went from plus five to plus ten.

Q. Okay.

A. That's the reason you check on the blood gas.

Q. Now, if you would continue with that order.

A. Next it says CHEM-7, CBC, PT, PTT, CA is calcium, MG, magnesium, cardiac isoenzymes, stat.

Q. Why stat? Stat means immediately, right'?

A. Yes.

Q. Why?

A. I don't know.

Q. Well, why don't you look through the chart and figure it out,

A. Okay. Most likely because of the irregular beat, heartbeat that the patient had that -- you are asking specifically why the isoenzymes or why the entire orders?

Q. Why the entire order of stat.

A. Probably because of the cardiac arrhythmia.

Q. Arrhythmia meaning irregularity?

A, Right, the bigeminy, the irregular heartbeat.

Q. And what would these tests have shown you, Doctor, or what would you be looking for?

A, Perhaps myocardial injury.

Q. And?

A. Or ischemia,

Q. Which of these tests would have assisted you in determining whether that was present?

A, The isoenzymes may be elevated, The white count on the CBC may be elevated.

Q. What is CBC?

a, Excuse me?

Q. What is CPK?

A. CBC or CPK is creatine phosphokinase.

Q. What is that?

A, It's an enzyme that is elevated with ischemia or injury to the myocardium.

Q. What would be an abnormal reading? What is normal range?

A. Usually five percent. Above five percent of the total CPK value concerning the MU fractions, the different fractions of this enzyme or other people consider that the total unit value of the MB fraction needs to be greater than 120 or

130.

Q. All right. Was there a determination made as to the MB fraction of the CPK?

A. I'd have to look at the Lab data.

Q. Okay,

A. The MB fraction is two percent of 339.

Q. Wow is that?

A. What do you mean?

Q. Well, is that normal?

a, I wouldn't consider that abnormal. I wouldn't -- yes, I wouldn't consider that abnormal.

Q. And you didn't at the time?

A. No.

Q. Did you do any follow-up tests on that?

A. I don't see any other reports of CPK.

Q. Why not?

A. I would just be speculating that we didn't order additional enzyme --

Q. I think your speculation is correct, but my question is why not?

a. We felt he didn't have any myocardial injury.

Q. You were wrong, weren't you, Doctor?

MR. CHARMS: Objection.

Q. Have you reviewed this chart in its

entirety?

A. No.

Q. Tell me again why you believe that two percent MB fraction is normal,

MR. CHARMS: Objection, It's been asked and answered,

Q. It's a fraction of what? What is the number that it's a fraction of?

A. Of the total CPK.

Q. Which is what? What was the number there?

A. 339.

Q. And you consider that normal?

A. No, that's slightly elevated,

Q. So it's not normal?

A. That's correct. The total CPK is not normal,

Q. The 339 you are saying is not normal?

A. That's correct,

Q. And what-, does that indicate to you if anything?

A. It could be from the surgery, from the hip surgery itself.

Q. Could it also be from myocardial damage?

A. The total CPK?

Q. Yes.

A. Not in this case.

Q. Why not?

A. Because the MB fraction is only two percent.

Q. And that's all right?

A. Yes.

Q. What, you are saying above five percent would be abnormal?

A. Four to five percent, yes. Or 120 to 130 MB fraction units.

Q. I am not sure I understand.

A. Well, if it's two percent of -- let's say it's two percent of 400,

Q. Okay.

A. That's --

Q. That would be 80?

A. That's 80. In my mind it's got to be 120 to 130.

Q. So two percent of 400 would be?

A. Eighty. So it's less than that.

MR. CHARMS: 8.

Q. No. It's 20 percent. Two percent of 400 would be 8.

A. Eight. Excuse me.

Q. Did you consider the prospect of any abnormal heart rhythm that you found in terms of the treatment of this patient?

A. No.

Q. Why not?

A. Because I reviewed -- there apparently was a pre-operative EKG that I mentioned in my note although I don't see it in the chart at this particular time. It says the --

Q. You don't see what in the chart?

A. The pre-operative EKG. And according to my note, it was unchanged Erom the pre-operative EKG.

Q. Well, how was it in the pre-operative EKG? Was it normal in that --

A. No. No, it was not,

Q. I see, So it was the same and that was fine with you?

A. Yes.

Q. You said that if there is a belief on your part of cardiac abnormality you call in a cardiac consult?

MR. CHARMS: Objection. That's not what he said at all.

Q. Is that what you said, sir?

A. That's not what I said,

Q. What did you say?

A. You asked me if I were in private practice. No. You asked me how would I treat a heart attack and I told you how I would treat a heart attack. Part of that would be to call in a cardiologist.

Q. What was the interpretation of the ECG?

A. ECG?

Q. EKG.

A. EKG?

MR. CHARMS: Which one, Chuck?

MR. KAMPINSKI: The one that was done right after he got to the surgical intensive care unit.

MR. CHARMS: You mean an offical interpretation or what Dr. Oliver sees?

MR. KAMPIMSKI: The official interpretation.

A. Do you want me to read it entirely?

Q. Sure.

MR. ZELLERS: What page, Doctor?

THE WITNESS: 136.

ne Compared to record for 10-23-84, there are now atrial ectopic beats and the P wave

morphology is variable.

Interpretation: Abnormal record due to atrial ectopic beats, a wandering atrial pacemaker, left anterior hemiblock, incomplete right bundle branch block, probable left atrial hypertrophy, left ventricular hypertrophy, and ST-T wave changes indicative of left ventricular strain or/and anterolateral wall myocardial ischemia. Signed by J. Krall, M.D.

Q. Well, do you disagree with that interpretation?

MR. CHARMS: I'll object to it only insofar as it's related to --

Q. I'll ask another question.

MR. CHARMS: Only insofar as it's related to a prior record which the Doctor doesn't have in front of him and they are talking about changes they see in those two, but beyond that you can go ahead and answer, Doctor.

A. It is difficult for me to see some of the ST segments, ST-T segments. However, I would agree other than not being able to visualize those with the rest of them.

Q. Well, then he found changes indicative of left ventricular strain or anterolateral

wall myocardial ischemia?

A. That's what it says.

Q. Did you call in a cardiac consult based on that finding?

MR. CHARMS: Objection, You can answer it,

A. I did not call in a --

Q. Why not?

A. Again, all I can do is go back to the note, again not seeing the prior EKG.

Q. I mean you saw this interpretation, didn't you, Doctor?

A. Yes.

Q. My question is why didn't you do anything based on it?

A. I probably did not feel it was clinically significant,

Q. Why do you do an EKG?

A, What do you mean?

Q. Why do you have an EKG done if the findings are not clinically significant?

A. It's not clinically -- I didn't **feel** it was clinically significant.

Q. In other words, it was your judgment that this was not --

A. It was a judgment,

Be -- appropriate for purposes of your going further in terms of diagnosing any potential heart attack?

A. That's correct.

Q. Who is J. Krall?

A. He is a cardiologist, non-invasive cardiologist.

Q. What is his relationship to the hospital? Do you know?

A. I do not.

Q. Why is it that his name is on this interpretation?

A. Because he interpreted it.

Q. What does he do vis-a-vis the hospital in terms of radiology?

A. Radiologist.

Q. Or I'm sorry, cardiology?

A. He has his own private practice.

Q. Does he contract with the hospital to interpret --

A. I don't know.

Q. -- EKG's?

A. I don't know. I don't know.

Q. How did the patient progress during the

day of the 14th?

A. Do you mind if I refer to notes?

Q. I don't mind at all.

MR. CHARMS: Please do, Doctor.

A. First day you are talking, November 14th?

Q. That's correct.

A. I am looking at our flow sheet again. And page 791. Blood pressure seemed to remain stable throughout the day, heart rate remained acceptable and stable throughout the day. IV's were infusing at ordered rates, Blood gases were checked throughout the day and they remained within normal limits,

Nursing assessment notes note that the patient was awake, had active bowel sounds. Laboratory studies later on in the day were normal. He was responding to verbal stimuli, opening his eyes. Fallowing commands without problems, Really no problems.

a. How did he do that night?

A. Okay. Beginning at what time?

Q. At the time you just left of€.

A. Okay. A portable chest x-ray was done at 11 p.m. At 12 a.m. the patient easily aroused

with verbal stimuli, Able to move extremities. Breath sounds were clear, Lab results were notified to the resident. His percent of oxygen was decreased,

Q. I take it you weren't there that evening?

A, That is correct.

Q. Okay, Go ahead.

A. At two a.m. patient complained of some hip pain and he was given pain medication for that. His endotracheal tube was cleared of secretions at 4 a.m. Six a.m. cleared of secretions again and breath sounds remain clear, Hip dressing was dry and intact.

Q. Is there any coffee-ground emesis that evening?

A. I don't see any mention of that, Again, I'm up to six a.m.

a. Okay.

A. That is the next day, 6 a.m., the 15th. Do you want me to continue?

Q. Yes, please.

A. At 8 a.m. awake and alert, moving all extremities, Dr. Smith in to visit at 8:45 a.m. I was there at, my first name is written in the chart at 9:15 a.m. Blood gases were drawn. We

was -- the endotracheal tube was removed at 10 --

Q. That was what time?

A. At 10 a.m.

Q. Okay

A. By respiratory therapy. Blood gases were sent. I was made aware of the results at 11 a.m.

Q. How were they?

A. They were normal. pH, 7.41, PCO2, 33. No. Excuse me. pH, 7.44, PCO2, 301 PO2, 61.

Q. Were you having blood work done also?

A. That's correct.

Q. How was the hemoglobin?

A. The hemoglobin was 11.4, hematocrit, 34.6.

Q. How was it when he first came in?

A. First day?

Q. Yes.

A. 13.4. That was the hemoglobin. I can't see the hematocrit. It's not on the photocopy, Do you want me to continue?

Q. Yes, please,

A. Sitting up in bed at noon, resting comfortably around 1 p.m. Feeling comfortable at 4 p.m.

Q. Bow about 2 p.m.?

A. I am trying to -- something to cough, I can't read it, and dry.

Q. What day are you on? I'm sorry.

a. I'm on page 80F. And that's the 15th.

Q. Okay. Go ahead,

A. Resting comfortably. I'm at 5:30 p.m. Medicated for pain. Family in to visit at 6 p.m. Patient repositioned at 10 p.m. with deep breathing and coughing exercises. At midnight the patient easily aroused to verbal. stimuli. Given pain medication at 12:30 a.m. Two a.m. neuro checks were done, Four a.m. awake, complaining of some gas pains. 4:30 p.m. -- I'm sorry, a.m., CBC, some of the lab work drawn, Five a.m. the bed linen was changed. Some swelling was noted in the left knee, On to the next day, the 16th.

Continue?

Q. Yes, please.

A. Eight a.m. awake, alert, oriented. 8:30 a.m. resting comfortably. Up on bed pan 8:45. Nine a.m. report called to floor, transport to floor via bed. In satisfactory condition,

Q. How about the 16th?

A. That is the 16th.

Q. Okay, What time was he sent out of the ICU?

A. 9 a.m.

Q. What was his hemoglobin on the 16th?

A. I believe it's 11.4, It's difficult to read. It looks like it's 11.4.

Q. Was the monitor, the EKG on the entire time that he was in the SICU?

A. *Yes*. The bedside monitor which monitors his rhythm, EKG.

Q. But you didn't have a continuous strip on it?

A. No.

Q. Why not?

A. Not hard copy.

Q. Why not?

A. We don't do that.

Q. What do you do, push a button on when you want to read out?

A, That's correct, or it will alarm, If it's an abnormal rhythm, it will pick it up, the computer will pick it up and start printing out the rhythm.

Q. I thought you said that you didn't have it on the computer before?

A. Not computerized data management, full data management where everything is recorded hard copy. It can be retrieved hard copy, We do not have that, It's computerized enough that when it picks up the arrhythmia it will record out.

Q. Good. Do you recall any consults with Dr. Smith or Stephens when Mr. Smith was in the SICU?

A. What do you mean?

Q. Any discussion with him as to the condition of your patient?

A. I don't recall, although I believe as I mentioned earlier I was mentioned present at the same time Dr. Smith was there. I would just assume I would have conversed with him about the patient.

Q. But you have no recollection?

A. I do not,

Q. And that would be also true of the orthopedic residents who also reflected as being present?

A. That's correct.

Q. Bow many residents did you have working in the SICU in November of 1984?

A. Two.

Q. Who were they?

A. I think it's Dr. O'Brien and Dr. Divida.

Q. Are they still there?

A. They are not.

Q. They are not?

A, No. And they are not surgical residents. Occasionally we have visiting residents from outside hospitals from other specialties, Divida is a surgery resident but he was from an outside hospital,

Q. Where?

A. Huron Road. Dr. O'Brien was an anesthesia resident from Brentwood Hospital.

Q. Are they still there? Do you know?

A, Dr. O'Brien is an attending anesthetic at Brentwood. I don't know if Dr. Divida is still at Huron Road, He may have finished his training. I don't know.

Q. By the way, was it you that ordered the cardiac enzymes or was it the orthopedic resident?

A. I did,

Q. Okay, Is it normal for the anesthesiologist to continue to follow-up the patient in the surgical intensive care unit especially when he hasn't been taken off the

anesthesia?

A. Yes.

Q. All right. Did that occur in this case?

A. I don't remember.

Q. Well, is there anything in the record that reflects that it did?

A. Progress notes. I do not see a note which -- yes, I do. Excuse me. I see a note by anesthesia on the 16th on page 119.

Q. What time on the 16th?

A. 1435 hours.

Q. Which would have been after he had left the SICU?

A. That's correct.

Q. So there was none?

A. That's correct.

Q. Do you know why?

A. I do not.

Q. I just want to make sure that I understand your testimony. You have indicated the CPK of 349 would then be two percent is not elevated? That's your testimony?

A. No, not -- that is not my testimony.

Q. The CPK you are saying is elevated but the MB fraction is --

A. Not elevated.

Q. All right, And that that finding does not indicate myocardial damage?

A. That's correct.

Q. That's your testimony?

A. *Yes*, that's correct.

Q. And that's why you didn't do an additional CPK?

A, That's correct,

Q. Did you see Mr. Smith at all after he was discharged from SICU?

A. I did not.

Q. Assuming that you had seen some clinical evidence of myocardial damage on Mr. Smith, what would you have done?

A. I would have notified Dr. Smith or the orthopedic resident and asked them do they want a cardiologist to see the patient,

Q. Why wouldn't you have done it yourself? I mean you are in charge of the patient in the SICU.

A. But I'm a consultant, I am not the patient's private physician,

Q. I see. So you have to yet their approval?

A. That is correct, I communicate with referring doctors,

Q. So they rely on you then to some degree to apprise them?

A. That's correct.

Q. Of the existence of any myocardial damage?

A. That's correct, or any problems.

Q. But Dr. Smith was also in the SICU, right?

A. According to records, yes.

Q. Okay. The findings that were made in the tests, where would they have gone? Would they have found their way to the chart?

A. They would have been available three different places. One, on the flow sheet, the surgical intensive care flow sheet that I looked at the nursing notes from.

Q. Where would that have been?

A. At the bedside.

Q. Qkay. Go ahead.

A. Second place would be on the lab computer. We have a computer in our unit where the laboratory sends up information and you can retrieve it.

Q. Okay.

A. The third place is that we have a hard copy, again, it's a computerized system but it's separate from the CRT screen. You can retrieve it, That's also in the surgical intensive care unit. We have a printer as well as the terminal.

Q. Okay. And I take it that's what we see in terms of the lab values here?

A, That's a computerized printout, yes.

Q. Would that have been in the chart with the patient when he left SICU?

A. Parts of it may have been.

Q. What do you mean? What parts?

A. Lab data was done on the 16th, the day he was -- the day he was transferred, that would not have been in the chart.

Q. How about the 14th?

A. I believe.

Q. 15th?

A. Maybe. I don't know how fast the lab is in getting their paperwork up to the --

Q. I am correct, am I not, Doctor, that no cardiologist assessed Mr. Smith's cardiac status in the SICU, is that correct?

A. That's correct, May I ask a question?

Are there any consulting forms, any consultant's records which are separate forms that I haven't seen?

Q. While he was in SICU you mean?

A. Yes.

Q. In other words, you arc. in charge of it. You would know, wouldn't you?

MR. CHARMS: He just told you he wouldn't know about other consultants.

Q. While he was in SICU. Well, go ahead and look.

MR. CHARMS: Look at your records,

A. There's one consultant's note and that's on the 13th before the patient came into the intensive care unit,

Q. So the answer was there's no cardiology consult while he was in SICU?

A. Right.

MR. KAMPINSKI: That's all I have. Some of the other attorneys may have questions of you, Doctor.

CROSS-EXAMINATION

BY MR. ZELLERS:

Q. Doctor, my name is Mike Zellers and 1 represent the hospital, and I have been a little

bit confused by your testimony in terms of your relationship with Mr. Smith in this case, You have said on several occasions that you did not consider Mr. smith to be your private patient?

A. That's correct.

Q. Is that your testimony?

A. That's correct, I'm a consultant.

Q. What do you mean by that?

A. Can I give you an analogy --

Q. Sure

a. -- to compare it? For example, a patient of a surgeon develops an infection somewhere and he decides he wants to have a consultant, an infectious disease consultant to see the patient; I am consulted for critical care management, surgeon consults me.

Q. Did you consider Mr. Smith to be your private patient in this case?

A. Private patient from the standpoint of having an office practice and following him on a routine basis, no, I don't have an office practice with, quote, "private patients."

Q. You and I talked a couple days ago, right?

A. That is correct

physician responsible for Mr. Smith?

A, Right.

Q. I guess throughout the course of his hospitalization?

A, Throughout the course of his intensive care stay,

Q. Would you consider an anesthesiologist to be in the same position with Mr. Smith as you were?

Ao While they are under anesthesia?

Q. Yes.

A. 1 suppose, yes. 1 mean if they are billing the patient in terms of private -- if that's you~definition of a private patient.

Q. And I'm just trying to flesh out your deposition so as we all go back and we look at this we understand what you meant when you used those wards.

A. When I mean private patient I mean a patient that I bill, That's all I mean. I don't mean it's a private patient that has been with me for months or years and then I see him in an office and I see his family and all that.

Q. Using that definition then, Mr. Smith was your private patient?

A. He is in that definition, yes.

Q. Now, you told Mr. Kampinski that in the SICU you had an EKG machine that produced a continuous readout?

A, No. Our bedside monitors have a CRT screen that gives us a continuous visual readout.

Q. So when you referred to a continuous readout you were talking about a visual readout?

A. That is correct, at the bedside.

Q. Were you talking about a hard copy printout?

A. No, I an not talking about a hard copy printout,

Q. Now, there are some segments of hard copy printouts in the chart?

A. That's correct.

Q. How do you ga about obtaining those strips that go in the chart?

A, We have a recorder at the central station where you could touch a button either at the bedside or at the central station.

Q. So to get these strips you have to press a button?

A. That's correct or there has to be an abnormal rhythm that the computer picks up, The

bedside monitor is a computer and it will start recording, trigger the recording.

Q. So you don't have a strip that goes from the beginning of when Mr. --

A. No.

Q. -- Smith came in until he left the ICU?

A. No, we do not.

Q. And you had indicated to Mr. Kampinski that you thought the same type of equipment was available in the recowery room back in November of 1984?

A. Yes.

Q. What do you base your knowledge on?

A. I have been at St. Luke's since '83, July of '83 and as best I can recollect they have always had monitors in the recovery room.

Q. Do you know what other equipment they had in the recovery room in November of 1984?

A. They would have oxygen supply equipment, suction equipment. There's a code cart that sits between the recovery room and the intensive care unit. That's all I can think of for the moment.

Q. You are not responsible for the equipment in the recovery room, are you?

A. No.

Q. And the terms of the various brands of machines and what they could do or could not do, are you aware today of what could be done in the recovery room in November of '84?

A. As Ear as monitoring?

Q. Yes.

A. As best I can recollect. they have the Honeywell E for M that I mentioned earlier and those do have capability for printout as well as they do monitor on the CRT screen.

Q. Would the type of printout you get be the same type as in the SICU?

A. Yes.

Q. And to get a hard copy you'd have to press a button to get it?

A. Yes. It may also print out if it alarms. I am not sure. If there is an arrhythmia.

Q. Was the SICU open for business on November 17th around 5:00 or 5:30 in the afternoon?

A. 17th? *Yes*. Best I can recollect.

Q. Were you in the hospital at that time if you know?

A. At five in the afternoon, I don't remember.

Q. Would there have been SICU staff people?

A. Yes,

Q. People there?

A. Yes.

Q. So in terms of staffing, the patient could have gone to the SICU?

A. Yes.

Q. You are not involved in the decision, are you, as to whether or not a patient goes to the SICU or the recovery room?

A, NO.

MR. ZELLERS: I have nothing further.

CROSS-EXAMINATION

~~BY MR. GROEDEL:~~

Q. Doctor, my name is Marc Groedel. I have a few questions for you. I represent Drs. Stephens and Smith. The recovery room and the SICU, where are they in relation to one another at St. Luke's Hospital?

A. They are physically contiguous. They are next to each other.

Q. I take it then it wouldn't be a difficult task to get a patient from the recovery room over into the SICU?

A. Not at all. It's a matter of a few feet,

Q. Are they divided by any wall or curtain?

A. Yes, It's not a -- it's a utility room that separates the two.

Q. I take it that when a patient is in the recovery room following surgery and is having problems it would be no great difficulty to get that patient over from the recovery room to the SICU if it was found to be necessary to do so?

A. Assuming we weren't full.

Q. And that has happened in the past on prior occasions?

A' That we have been full?

Q. No, that patients have been transferred over from the recovery room to the SICU?

A. Many times,

Q. For any variety of reasons?

A. Yes, many times.

MR. GROEDEL: Thank you, Doctor.

MR. CHARMS: Chuck, anything?

MR. KAMPINSKI: Yes, Just a couple.

FURTHER CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Did they have a twelve lead E#G in the recovery room?

A' In November of '84?

Q. Yes.

A, I wouldn't remember.

Q. Were you aware of the fact that Mr. Smith had hypertension when he was admitted to the SICU?

A, I'd have to review --

Q. Go ahead.

A. -- the notes, I would have to say yes because I do review other peoples' notes and here is the consult from Dr. Jackson. His first statement is known for hypertension,

Q. Were you aware that he required vasopressor therapy?

A. Vasopressor therapy?

Q. Yes.

A, In specific what drug?

Q. I am not sure,

A. I am not aware of that.

Q. While he was in the hospital?

A. I am not aware of that.

Q. Dopamine infusion?

A. Yes.

Q. Were you aware of that?

A. Yes. That was in the surgical intensive care unit.

Q. What is that for?

A. The dose that we used was for kidney profusion, to improve the flow of blood to the kidney,

Q. And the reason for doing that is what?

A, Because his urine output had dropped,

Q. While he was --

A, In the surgical intensive care unit,

Q. Why did it drop?

A. That. could be for any number of reasons. He was on PEEP at the time.

Q. I'm sorry?

A. PEEP, Positive and Expiratory Pressure can reduce renal blood flow and thereby reduce urine output, That could be one reason.

Q. What is another reason?

A. Could have been behind in fluid or could have been both. Or he could have SIADH which is Inappropriate Secretion of Antidiuretic Hormone which would be stimulated by any number of things, anesthesia, major surgery, such as what he had,

Q. Was he hypoxemic while he was in SICU?

A. No, he was not. The lowest PO2 that I noticed reviewing was 70,

Q. What would you consider hypoxemia?

A. Less than 60 PO2 which is less than 90 percent saturated.

Q. He was 70 you said?

A. 70, He was 93 percent saturated.

Q. Did you review any other records in this case other than the chart?

A. I did not,

MR. KAMPINSKI: That's all I have.

MR. ZELLERS: Nothing further.

MR. CHARMS: The Doctor won't waive signature. As soon as it's ordered you can send it out to him.

- - -

I have read the foregoing transcript from page 1 to page 66 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

_____
ALAN MARK OLIVER, M.D.

Subscribed and sworn to before me this day of , 1987.

_____
Notary Public

My Commission Expires:

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

I, Aneta I. Pine, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that ALAN MARK OLIVER, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotypy and was subsequently transcribed into typewriting by means of computer-aided transcription under my direction; that said deposition was taken at the time and place aforesaid pursuant to notice; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 2nd day of June, 1987.

Aneta I. Fine, RPR, Notary Public
within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 441.23

My Commission Expires: February 27, 1991.