State of Ohio,)
) SS:
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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William C. Tracek, Admr.,)
Plaintiff,)
vs.) Case No. 400269
Kaiser Permanente, et al.,) Judge Peggy Foley Jones
Defendants.)

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DEPOSITION OF BERNARD OWENS, III, M.D.

MONDAY, NOVEMBER 6, 2000

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The deposition of Bernard Owens, III, M.D., called by the Plaintiff for examination under the Ohio Rules *of* Civil Procedure, taken before me, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at the offices of Bonezzi, Switzer, Murphy & Polito, 1400 Leader Building, Cleveland, Ohio, commencing at 9:00 a.m., on the day and date above set forth.

APPEARANCES:

On Behalf of the Plaintiff:

John F. Norton, Esq.
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On Behalf of Defendant Cleveland Clinic Foundation:

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BERNARD OWENS, M.D.

called by the plaintiff for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS EXAMINATION

BY MR. NORTON:

Q. Tell me your full name, please?

A. Bernard J. Owens, 111.

Q. What is your occupation?

A. I am a surgeon.

Q. Where did you obtain your medical training?

A. I finished medical school in New York, in Brooklyn, New York, at the State University of New York, and did surgical training at University of North Carolina, as well as at Charlotte Memorial Hospital, now Carolinas Medical Center in Charlotte.

Q. What year did you graduate from medical school?

A. '72.

Q. And what year did you complete your last year of residency?

A. My last year of training, I completed in 1980.

Q. And where was that?

A. That was at the Naval Regional Medical Center in San Diego, California.

Q. And what professional affiliation did you have

after 1980, where did you go next, in other words?
A. I was chief of vascular surgery for the United States Navy at Portsmouth Naval Hospital.
Q. For how long?
A. Three years.
Q. That is in 1983, right?
A. Yes, sir.
Q. Then where did you go after that?
A. I practiced for about ten years in Greensboro, North Carolina, doing general and vascular surgery.
Q. To '93?
A. To '93, January -- December 31st. And then moved to Michigan for two years.
Q. Where were you in Michigan?
A. St. Joseph, Michigan.
Q. That is a city, St. Joseph?
A. Yes.
Q. What hospital?
A. I am not sure I can remember. I think it was Lakeland Regional. I am sorry, I don't recall.
Q. In what capacity were you associated with that hospital?
A. I was a vascular surgeon, I did vascular surgery for a group called Cedarwood Medical Center, they were my employers.

Q. That would be to 1995?
A. Yes, sir.
Q. Where did you go after that?
A. I moved to New York for a short period of time, I was with a group called Carmax, C-A-R-M-A-X.
Q. Is that in the City of New York?
A. No, sir, it is on Long Island, it is in a place called Patchogue, East Patchogue.
Q. How do you spell that?
A. P-A-T-C-H-0-G-U-E. It is an Indian name. It is on Long Island, on the South Shore.
Q. How long were you there?
A. I was only there a few months. After that I moved to a place called Poplar Bluff, Missouri.
Q. And what hospital or group were you affiliated with in Poplar Bluff?
A. I was back in solo private practice, I was affiliated with a hospital called Lucy Lee Hospital.
Q. Spell that, please.
A. L-U-C-Y, first name, second is Lee, L-E-E. And that is in Poplar Bluff.
Q. That would have been in 1995?
A. No, sir, 1996. From 1996 to 1998.
Q. And after 1988, where did you go?
A. 1998.

Q. 1998.
A. I moved to Cleveland and joined Kaiser.
Q. Was that your first relationship with Kaiser?
A. Yes, sir.
Q. What group did you join?
A. I joined OPMG, Ohio Permanente Medical Group.
Q. When in '98?
A. May the 14th.
Q. Is Ohio Permanente Medical Group a professional corporation, do you know?
A. I am sorry, I don't know.
Q. You don't know.
Are you a member of it, or an employee?
A. Well, I function in both capacities. I am an employee, I think that is my function.
Q. Okay.
You are not an officer or director?
A. No, sir.
Q. Do you know who the officers are?
A. The only officer I can think of is Ron Copeland, he is our president.
Q. Is he a doctor?
A. Yes, sir.
Q. C-O-P-E-L-A-N-D?
A. C-O-P-E-L-A-N-D, yes.

Q. Where is he located?
A. North Point, somewhere around here.
Q. He is the president.
He is the only officer you are aware of?
A. I am not involved in that part of the corporation, so I don't know. It is a very complicated situation, which I don't exactly understand. We have a thing called Health Plan, we have the OPMG. OPMG, the president is Ron Copeland. He is the medical director. The president or the chief executive officer of the Health Plan is Chris DuLaney, and then there are a whole bunch of people who kind of do the work, and I am sorry, I don't know any of them.
Q. Are you compensated by OPMG?
A. Yes, sir.
Q. And how are you compensated, on a W-2 or W-9?
A. W-2, it is a salary.
Q. Salary.
Do you have an employment contract?
A. Yes, sir.
Q. And what are your duties?
A. Provide surgical services to members of OPMG -- patients who are members of Kaiser. They are not members of OPMG, I believe.
Q. All right.

Do you directly bill the patients for your services?

A. No, sir.

Q. Is your compensation as an employee of OPMG in any way -- or directly related to the work that you do, in other words, on a per patient or per case basis?

A. No, sir. No, sir. I am on a fixed salary.

Q. Per year?

A. Yes.

Q. So it doesn't make any difference how many patients you see or treat, or how many patients other members of the group would see or treat --

A. That is correct.

Q. -- your compensation remains the same?

A. That is correct.

Q. Do you maintain any record of the patients you see or treat?

A. Other than --

Q. Other than the medical record, I am talking about.

A. No, sir.

Q. By the medical record, I mean the chart in the hospital, or the office chart you might keep.

A. We have -- the record is fairly complex, even as it is maintained. Of course anything we do in the Cleveland Clinic is maintained by the Cleveland Clinic.

Anything we do in our office is kept both in a paper trail where appropriate and where possible, and in a computerized memory device. But I don't keep anything other than that. I write my note, it is copied and put in the Kaiser chart, the OPMG chart.

Q. So you are not creating the record designed to show what services you perform for a given patient for billing purposes?

A. Absolutely not. No, never.

Q. When you see patients in the office, though, you say there is some record made that --

A. We have a chart.

Q. Just the normal doctors office chart --

A. Yes, sir.

Q. -- on the patient?

A. I believe so.

Q. Do you see any patients yourself privately, other than Kaiser patients?

A. No.

Q. Where is your office located?

A. I work out of two places, I work at 10 Severance Circle, and the Kaiser office on Snow Road, which is 12304 Snow Road in Parma.

Q. Now, the location in Severance Center --

A. Yes, sir.

Q. -- is that the location of the surgical group or surgical department of Kaiser, if you will?
A. The surgery group, the group that I am most closely affiliated with, we cover two -- or actually a third place, we cover Willoughby. But we have three, plus myself, at Parma, and Ron Copeland previously mentioned does work out there, and then we have three, plus myself, at Severance.
Q. Are there any other locations in the Cleveland area where surgeons employed by Kaiser work out of?
A. Yes, sir. Larry Scott works out of the Willoughby facility.
Q. Other than Willoughby, Snow Road and Severance, are there any other locations?
A. No, sir, not that I am aware of.
Q. And where do you have hospital privileges?
A. At the Cleveland Clinic.
Q. Now, do your duties as an employee of OPMG obligate you to consult with other OPMG physicians on the care and treatment of patients?
A. I believe the answer is yes. I have an ethical obligation to consult with other physicians whenever medically indicated, and that is, I believe, what my contract with Kaiser expects me to do. But I really haven't read it in a long time, so I assume -- you know,

I pretty much have continued my practice according to the ethical standards that I have always had, which would ignore -- I mean, I do what I think is best for the patient, always.

Q. Well, actually, what I am trying to learn, and perhaps you can help me, is whether patient care, the care of a patient who is a Kaiser member, and who is being seen by doctors employed by the OPMG group, whether that is sort of a collaborative effort, or is there individual physician responsibility for a given patient?

A. There is always a sense of individual physician responsibility, but I don't think that excludes collaboration. We collaborate whenever we need to.

Q. Is there one doctor that would be following a patient that would have the overall authority to make decisions concerning that patient?

A. The patients make the decisions, sir.

Q. All right.

A. Twenty years ago, maybe we made the decisions, but today, we --

Q. Let me rephrase it.

Is there any given doctor that has overall responsibility, final authority to recommend what treatment is given?

MR. HUPP: For just any patient in general,

you are saying?

Q. (Continuing) Well, I suppose what I am asking is, does a Kaiser member have a personal physician?

A. I believe so, yes. I believe every Kaiser patient has a personal physician.

Q. And is that the physician that has the overall authority with reference to that patient among the doctors in your group? Bearing in mind, of course, that as you have told me, patients make the final decisions.

A. I guess -- can I answer with a metaphor?

MR. HUPP: *Go* ahead.

A. (Continuing) The only way I can answer that is, everybody has got a personal physician, and it is possible, for example, that your family practice person's skill level might be exceeded. And so that patient may be ending up in the hospital at the Cleveland Clinic on an internist's service, and they may seek consultation from a number of people.

So under those circumstances, they would never discuss with the family practice person, although the family is free to -- family or the patient would be free to have that person come in and make a suggestion.

But it is not as if you have to have -- you are associated with Dr. Healy, and you can't operate -- you can't offer surgery until Dr. Healy approves, or you

can't offer a medical treatment until some physician somewhere else approves. You are being cared for by the physician, and that person is your main doctor for a time.

Q. Okay. I understand what you are saying.

Let's take your example --

A. Yes, sir.

Q. -- where the patient's personal physician's skill level has been exceeded, and the patient is admitted to a hospital on the service of, as you say, an internist.

A. Yes.

Q. But that the patient's in-hospital care might require the services of other specialists --

A. Sure.

Q. -- such as a surgeon.

A. Sure.

Q. Is the internist the physician who has the ultimate authority to make decisions on behalf of the patient?

A. I would say at that point, until such time as the patient passes out of his care, yes.

Q. Okay.

A. He would be the captain of the ship, to bring back an old, dead metaphor. I am sorry.

But he would direct, and assist, and say, sir, you

know, I would really like you to see this doctor, because he might have more expertise.

MR. HUPP: Move to strike "captain of the ship."

THE WITNESS: I am sorry.

MR. HUPP: You are not supposed to know the law.

THE WITNESS: Excuse me.

BY MR. NORTON:

Q. So that within this collaborative endeavor in the care and treatment of a Kaiser member by physicians employed by OPMG, and within the scenario that we have just been discussing, a hospitalized patient, might a surgeon recommend a procedure to the internist on whose service the patient was admitted, and the internist decline?

A. Yes, sir.

Q. And the responsibility of the surgeon offering the procedure ends at that point?

A. I think so, sir.

Q. The surgeon doesn't have any obligation to speak directly with the patient?

A. I don't know. I would probably -- in my case, I would probably look very carefully at that, depending on the patient's ability to participate. I am not sure who

the decision-making person is. If appropriate, I might recommend, but not usually.

Usually, there are good reasons for declining a recommendation, and it would depend upon the strength of my feeling in that regard. But I don't think there is any rule about how that has to be.

Q. All right, I would like to talk for a few minutes about Alice Tracek --

A. Yes.

Q. -- who was a Kaiser member.

Was she your patient?

A. Well, I was a consultant.

Q. She was not admitted to the Clinic on your service, then?

A. I believe she was on the medical service, sir.

Q. You were involved in her care --

A. I was.

Q. -- in 1998?

A. Yes, sir.

Q. Where did you first see her?

A. As I recall, in bed at the Cleveland Clinic.

Q. Did you ever see her at Snow Road?

A. I believe I did. But I don't have that record with me.

Q. What record would that be?

A. There was an outpatient record in which I may have seen her.
Q. What record do you have with you?
A. I have the record from the Cleveland Clinic admission that I participated in her care.
Q. Doctor, at Tab 5 in this binder, I have got what I believe is the entire emergency room record of Alice Tracek at the Snow Road facility at Kaiser --
A. Yes, sir.
Q. -- for -- I take that back. I think it is what they call a CDU --
A. Yes, sir.
Q. -- admission, for July 27th. You can take a look at it.
A. (Witness complies).
Q. Do you see any -- is that record at all familiar to you?
A. I have read it.
Q. Before today?
A. Yes, sir.
Q. Did you make any notes in it, and having read it, is your recollection refreshed to the point where you can tell me whether or not you did see her in the Snow Road facility in July of '98?
A. I can't answer that. Dr. Raykov says I saw the

patient. I don't remember seeing her. I was aware of the patient. There is ample evidence that there was telephone contact with me, and I don't have the pages numbered, but at that time, there was a question of an appendicalith or a fecalith, and Dr. Raykov and I agreed that the safest thing for the patient would be to transfer her to the Cleveland Clinic and continue the treatment from there. But I do not remember seeing her.

Q. In looking over that section of the record, you don't see any of your initials anyplace?

A. No, sir, I don't.

Q. Okay.

Now, I do have the emergency room record for July 26th, it is at Tab 4.

Did you ever see that record, July 26th, '98 at Snow Road?

A. Yes, sir.

Q. Before today, I mean.

A. Yes, sir.

Q. Have you made any notes or initials on that record?

A. No, sir.

Q. Were you present at the Snow Road facility on July 26th or July 27th of '98?

A. I doubt I would be able to answer that, but I will

try.

No, sir, I don't know.

If you could tell me what day that was, I might -- I just don't know.

Q. Do you work certain days of the week there?

A. I do. Currently, I am going out to Snow Road Tuesdays and Wednesdays. But early on, as I recall, it might have been just one of those days, but I don't recall which.

Q. Okay.

In your consultation, you have indicated there was some telephone contact at least between you and Dr. Raykov, and perhaps others at the Snow Road facility?

A. Yes, sir.

Q. Did you have any information at that time as to what her presenting complaint to the emergency room was?

A. Again -- may I?

MR. HUPP: *Go* ahead.

A. (Continuing) My recollection is mostly from the notes that I was able to review in preparation for this.

The question of abdominal pain and appendicalith was raised, and this would lead to a possible appendicitis. And on that basis, I felt that it would be best that we bring the patient over to the hospital. There was also a -- beyond that, I don't recall.

Q Do you remember what history she gave, or did you ever know what history she gave when she presented to the emergency room on July 26th, '98?

A. Other than from the chart, no, sir.

Q And from the chart, what is your impression of the history?

A. May I have yours, since you have got it out there?

(Thereupon, the document was handed to the witness.)

A. (Continuing) It records complaints of abdominal pain, weakness and loss of appetite for two weeks, no history of fever, no extreme obesity. And they raised the issue of spastic colon.

Q Were you aware that she had informed someone in the emergency room that she hadn't eaten solid food in 14 days prior to presenting at the emergency room?

A. At that time, I can't answer that I became aware of that only after the patient was admitted to the hospital.

Q. That is admitted to the Clinic?

A. To the Clinic, yes

Q Well, how soon after she was admitted to the Clinic did you see her?

A. I saw her on the morning of the 27th.

Q Is t at when you learned for the first time that

she hadn't eaten solid food for 14 days?
A. I can't answer that. I don't know when I became aware of it.
Q. At what point --
A. I don't know.
Q. -- during this admission?
A. I knew that she had not eaten for a long time, but not until -- I can't tell you when I became aware of it.
Q. In connection with whatever care and treatment you provided to her while she was hospitalized at the Clinic in July of '98, did you ever learn of her past medical history?
A. There was some data about the past medical history. We knew that she had very, very restricted activity. We were under the impression that she had used laxatives. I think the remainder of the history was developed during the hospitalization.
Q. Were you aware that she was seen in the emergency room at Snow Road Kaiser facility in August of '97?
A. No, sir.
Q. Were you aware that she had a prior history of diverticulosis?
A. Yes, sir.
Q. When did you become aware of that?
A. That was noted in the first day that we saw her.

Q. And were you aware that she had some prior documented episodes of diverticulitis?
A. I would have to look at our note.
We recognized that she had diverticular disease, yes. It is in our note of the 27th.
Q. Now, when you consulted with -- was it Dr. Raykov at the CDU unit, in July of '97?
A. Yes, sir.
Q. Is he the one that asked you what care and treatment we should provide to this woman? We, meaning --
A. He asked my advice.
Q. Your advice.
What information do you remember he gave you?
A. I don't know, sir. I could only -- I would have to go back to the notes that are written. I mean, I don't remember, other than what is in the chart.
Q. But in any event, it was your recommendation that she be transferred to Cleveland Clinic?
A. Yes, sir.
Q. For surgery?
A. No, sir.
Q. For surgical evaluation?
A. I felt it was safest for this patient to be transferred to the Clinic so that we could evaluate her

and then offer her treatment, best possible treatment.

Q. And who was going to do the evaluation?

A. In this case, we moved her to the medical service, because we felt that this was still a medical problem, and that we would assist in it.

Q. So it was never your intention, initially, at least, to have her evaluated surgically?

A. I didn't say that. I always seek what is best for the patient. It seemed at that time that the patient would be best treated by putting her on the medical service and having us consult. Because based upon the presentation by Dr. Raykov, we had no indications for surgery at that time.

Q. And what was that presentation, Dr. Raykov's presentation?

A. Well, he described a patient with some abdominal pain that was relatively vague, that might have a colonic pseudo-obstruction, and might have an appendicalith and might not, and it was really incompletely evaluated. It is very hard to make calls over the phone. And again, I don't like to do that.

So my style is to see the patient rapidly, rather than wait for -- rather than try to make a resolution over the phone. And therefore I would always say, send the patient in, and let's sort this out.

Q. Send the patient in to CCF?
A. Yes, sir.
Q. So she was admitted, then, initially to Cleveland Clinic on the medical service?
A. Yes, sir.
Q. Then who would have been the responsible doctor?
A. The medical doctors.
Q. And what doctor would that be?
A. I don't know.
The note says, admit to medicine. Okay, the patient was admitted to the blue team.
Q. What is that?
A. It is one of the ways they divide folks, into blue versus red teams. I don't remember the -- blue, yellow.
MR. HUPP: He is going to ask what specialty you are talking about.
Q. Do these teams describe teams of OPMG doctors, or teams of Clinic doctors, or a combination?
A. I believe they are residents that are supervised by OPMG doctors.
Q. So Cleveland Clinic residents under the supervision of OPMG doctors?
A. Yes, sir.
Q. All right.
So from the record, you can't tell who her

personal physician was while she was admitted to the Clinic on the medical service?

A. I really can't. The senior medical resident admit note, Blue B, is not -- I don't have the signature for.

Q. Senior medical resident, that would be a Cleveland Clinic person, correct?

A. Yes, sir.

Q. Wouldn't she have to be admitted on the service of a Kaiser doctor?

A. This is a Kaiser service, I believe, the Blue B is a Kaiser medical service.

Dr. Wong, excuse me, Dr. Wong is, I believe, the medical attending.

Q. Now, after she was admitted to the Clinic on the medical service, it was your plan to consult with those doctors concerning her?

A. That is correct.

Q. And what kind of consultation were you anticipating, what did you intend to explore or examine, Doctor?

A. The first thing we did was our resident, Dr. Emad Zakhary, went and saw the patient --

Q. Who is that?

A. Emad, E-M-A-D, Zakhary, Z-A-K-H-A-R-Y, went and saw the patient and evaluated her, and at that time, he

identified a number of problems. That was the first time he saw her.

It says, GI for EGD --

Q. Excuse me, what are you reading from, Doctor?

A. Well, it is a note from 7-28-98.

MR. HUPP: Progress note.

A. (Continuing) It is a progress note.

Q. At the Cleveland Clinic?

A. Yes, sir.

Q. Okay, go ahead.

A. And he has written down his assessment, colonic pseudo-obstruction and upper GI bleeding, and at that time he recommended a GI consultation, that is gastroenterology, for EGD, esophagogastroduodenoscopy and colonoscopy and possible decompression, and he actually saw her before she was admitted and that she would be admitted to Kaiser medicine. So we would follow her along. And it was our belief at that time that her major issues were medical and not surgical.

She was also seen on 7-27 --

Q. I am trying to find that note. What is the date of it? The date you were reading.

A. 7-28 and 7-27.

Actually, I stand -- the first note is 7-27, again, Dr. Zakhary. I think that is 1330.

Q. I see, okay. Let me stop you right there and ask you some questions about that.
A. Okey-dokey.
Q. This Dr. Zakhary --
A. Zakhary, I think, we call him Zakhary.
Q. He is a resident?
A. Yes, sir.
Q. And in what service was he a resident?
A. He was on the Kaiser service.
Q. Medical?
A. General surgery.
Q. General surgery?
A. Yes, sir.
Q. All right.
So as a Cleveland Clinic resident on the Kaiser general surgery service, would you have been an OPMG doctor who would supervise him?
A. Yes, sir.
Q. So Dr. Zakhary examined her and made an assessment and a plan concerning her, as I understand it from the note on July 27th?
A. That is correct.
Q. And his assessment was that she had a colonic pseudo-obstruction?
A. That is correct.

Q. Earlier you talked about a fecalith. Are we talking about the same thing?
A. No, sir.
Q. What is a colonic pseudo-obstruction?
A. In colonic pseudo-obstruction, there is a failure of tr nsit through the colon, usually because of dystony or failure of the muscular propulsive mechanisms of the colon.
Q. That would not be a mechanical obstruction, then?
A. No, sir.
Q. More aptly described as a functional obstruction?
A. Very well done, yes. That would be good.
Q. What is the proper treatment for a colonic pseudo-obstruction?

MR. HUPP: Objection.

Go ahead.

A. I would say there is no proper treatment. You have a couple of choices. There are surgical choices. We would like to avoid them. There are medical choices. Those are probably better.

It would depend on the patient's needs and wants, and whether it could be controlled and also depend on the history and how it had been acquired.

Q. Now, in connection with his plan and assessment, Dr. Zakhary reports that radiology cannot -- what is

that, rule out cecal volvulus?
A. I believe so, yes.
MR. HUPP: Excuse me one second.
(Short recess had.)
BY MR. NORTON:
Q. Doctor, we have been talking about a note that Dr. Zakhary made on a clinical sheet, I think it is --
A. Yes, sir.
Q. -- for the date of July 27th --
A. Yes, sir.
Q. -- '98. What was the time of that note?
A. I am going to say 1330.
Q. Now, with reference to the radiology comment, to wit, radiology cannot rule out cecal volvulus, what is the relationship of that comment to the colonic pseudo-obstruction that appears immediately above it?
A. I don't know how to answer that, sir. I don't know that I can answer it.
Q. Would that suggest maybe he was considering it was the volvulus that was causing the colonic problem?
A. I don't know what Doctor -- there are a couple of -- there are a couple of questions I can never answer for anybody. And when you ask me, what did Doctor X mean when he said or wrote that --
Q. Okay.

A. -- I can't touch that.
Q. I understand.
A. I don't know.
Q. The only reason I am asking the question is because he says he discussed the issue with you.
A. Right.
Q. And within the context of that discussion --
A. I can go --
MR. HUPP: Just let him finish the question.
THE WITNESS: Excuse me.
Q. -- did you gain any understanding of what he possibly meant?
A. We were concerned. Our list of concerns would include pseudo-obstruction and volvulus.
Q. What is volvulus?
A. In volvulus, a section of the bowel torses, turns, twists on its blood supply, its mesentery, and that could endanger the bowel.
Q. So when he refers to radiology, did you actually have the films or just looked at radiology reports?
A. No, we had the films.
I believe what he is referring to is the radiologists felt that they could not, with safety, inject dye and eliminate that as a possibility.

Q. Okay.
A. That is the fact. I am not sure exactly what he meant by this (indicating). But these were our concerns. We had Ms. Tracek, and we were trying to find out what was wrong with her, and we were trying to review the lists of possible threatening diagnoses, and isolate them, and pick out the best course for her.
Q. So following that discussion between yourself and Dr. Zakhary, the recommendation was a GI evaluation, a possible colonoscopy?
A. Yes, sir.
Q. And a CT to rule out free air?
A. Yes, sir.
Q. Now, CT was done, as I understand it?
A. I believe so.
Q. What was the result, no free air?
A. Our note says that she had no free air. The abdomen, again, on the 27th, when I saw her -- I had signed his note, and I also added to it -- the abdomen at that time was soft --
Q. You signed something?
A. Yes, sir.
MR. HUPP: The question was, what did the CT scan find. Just listen to the question and answer it.

A. (Continuing) No free air, yes.
Q. What note are you reading from?
A. A note on the 27th, which in my copy is in front of --
MR. HUPP: Well, that is just misfiled.
Q. Does it have a time?
A. No, sir.
Q. It is in front of what?
MR. HUPP: The pages are out of order in our bound copy. It has an AHODH at the top.
MR. NORTON: Let me see what you are looking at.
(Thereupon, the document was handed to Mr. Norton.)
MR. HUPP: There it is (indicating).
Q. (Continuing) I see it.
Okay, so this note, at the very top, that is your signature, your initials, then?
A. Yes, sir.
Q. On the date of -- well, the date is the 27th of July, it is before 11:00 o'clock, but we don't know when?
A. Yes, sir.
Q. All right.
Immediately following your note, there is a note

by general surgery, correct?
A. Yes, sir.
Q. 11:00 o'clock?
A. Uh-huh.
Q. What is that character after the words, general surgery? Is that a 7?
A. I believe so.
Q. What does it mean?
A. It refers to the Kaiser unit, which is sometimes called General Surgery 7.
Q. It is signed by a Joe Scharf?
A. Yes, sir.
Q. Is he an OPMG doctor?
A. No.
Q. Who is he?
A. He, at that time, was a resident with the Cleveland Clinic. He still is, in a different function.
Q. So again, this Dr. Scharf would have been under your supervision?
A. Yes.
Q. So his note reports that there was a CT without contrast?
A. Correct.
Q. And then what were the findings that he is reporting there, minus Z, it looks like, or is that a

negative?
A. I think that is a C with a slash over it, but I can't be sure.
Q. Okay.
A. He describes -- it could be an S.
Spleen, left and right kidney are normal, there is an adrenal nodule. There is marked dilatation of the transverse colon.
Q. These were his comments from the CT scan?
A. Yes.
Q. Now, did you see the CT scan yourself?
A. I don't recall. I believe I did, but I don't recall. I may have talked to -- the radiologist may have called me, but I don't really recall.
Q. Were you aware that this CT showed this marked dilatation of the transverse colon?
A. Yes, sir.
Q. What did you conclude was the cause of that?
A. At that time my leading diagnosis was that she had a colonic pseudo-obstruction.
Q. And the fact that the CT showed this marked dilatation didn't change that diagnosis?
A. No.
Q. Apparently there was another CT done at 11:25?
A. At that time, Dr. Scharf reports that there was a

CT with oral contrast, and again, no change, they found no additional findings.

Q. So having performed these tests, then, Dr. Zakhary makes another note, I guess, on July 28th at 8:20?

A. Uh-huh.

Q. Is that the morning or afternoon -- morning or evening?

A. It could be morning. I would go for morning.

Q. And again, he reports that the patient was seen and discussed with you?

A. Uh-huh.

MR. HUPP: You have to answer out loud.

A. (Continuing) Excuse me. Yes.

Q. Now, he reports that the KUB -- that is a film, right?

A. Yes, sir.

Q. -- of the cecum shows a 15 -- is that right, 15 centimeter?

A. Yes, sir.

Q. Is that larger than normal?

A. Very large.

Q. That is not the transverse colon we are talking about?

A. No. They felt, looking at the -- at that time, they felt that looking at the KUB, the cecum was

enlarged.

Q. Is that talking about diameter, 15 centimeters?

A. I believe so.

Q. Is that almost three times the normal diameter of the cecum?

A. The cecum can be small. It is usually bigger than five centimeters. I think three times is an exaggeration.

But the cecum is large, floppy, relatively. I have got -- certainly I have seen plenty of cecums in young people, up to 90 millimeters, or nine centimeters. And I would not say it is limited -- this is definitely enlarged.

Q. What would cause it to be enlarged?

A. Colonic pseudo-obstruction.

Q. At what level of the bowel?

A. Oh, I think the colonic pseudo-obstruction occurs throug out the bowel. There are other causes, but the most likely cause in a person of this age and habitus is going to be clonic pseudo-obstruction.

Q. So Dr. Zakhary is reporting that the KUB shows this enlarged cecum --

A. Uh-huh.

Q. -- fifteen centimeters?

MR. HUPP: You have to say yes or no.

A. Yes, sir. Excuse me.

Q. He reports the abdomen, CT of the abdomen, shows no colonic obstruction.
A. Correct.
Q. Now, again, he discussed this information with you. Can we read that to mean, no mechanical obstruction, or no functional obstruction, or no pseudo-obstruction? What kind of colonic obstruction did the CT fail to show?
A. I believe he was referring to the absence of mechanical obstruction, because that is our major concern as surgeons, to prove that there is no mechanical obstruction.
Q. Okay.
A. That would change the needs of the patient, and therefore our recommended treatment.
Q. Is there any way to test for the presence of a pseudo-obstruction medically, apart from a colonoscopy or radiology?
A. Colonic pseudo-obstruction is a diagnosis of exclusion, that is, you prove that there is not a mechanical obstruction, and you go from there, and in the appropriate patient with the appropriate history and physical, it is a pseudo-obstruction.
Q. So when you talk about diagnosis of exclusion, you have to check out all the other possibilities first?
A. Yes, sir.

Could I -- you should.
Q. You should.
A. I am not sure you have to.
Q. It would be appropriate to?
A. In this particular case, time, after a while, begins to show you that it is a pseudo-obstruction, and it is supportive. But we did make recommendations to pursue this.
Q. Well, the plan was to further pursue the possibility of a colonic pseudo-obstruction, correct?
A. Correct.
Q. Possibility of upper GI bleeding?
A. Yes, sir.
The patient was anemic, and as I recall, they did find a source of bleeding, and she did require transfusion. So I think those were two issues that needed to be pursued, and that issue was pursued.
Q. And the recommendation was then to refer her to GI for EGD, that would be --
A. Esophagogastroduodenoscopy.
Q. And there is something that is cut off. That was 1. What was 2?
A. My copy suggests, Kaiser medicine evaluation for admission. So this evaluation may have been done in what is called the clinical decision unit. At that point --

Q. Well, this note --
A. Are we looking at the same note, 7-28?
Q. Yes, July 28th, 8:20.
A. Yes.
Q. This is when you and Dr. Zakhary are discussing this patient?
A. Yes, sir.
Q. And he is making his recommendations in consultation with you and under your supervision?
A. Correct.
Q. And his recommendation was GI for EGD and colonoscopy, and the second one was what?
A. Colonoscopy, and admission to Kaiser, to medicine. We are saying, this is a medical problem.
Q. Can I see the note?
A. Yes.
Q. Okay, so you want to have a GI done, and then admit to Kaiser medicine for further evaluation?
A. Yes, sir.
Q. What did you anticipate that Kaiser medicine would do to further evaluate colonic pseudo-obstruction?
A. The next step, we felt, was possible colonoscopy and input from our colleagues in gastroenterology.
Q. so --
A. May I --

MR. HUPP: Just answer the question, Doctor.

A. (Continuing) Excuse me. Go ahead.

Q. Well, I read the note as two recommendations, one, GI colonoscopy?

A. Uh-huh.

Q. Two, admit to Kaiser medicine for possible admission.

A. Uh-huh.

Q. Coming back to my question, what did you anticipate Kaiser medicine would do to either rule out or rule in colonic pseudo-obstruction?

A. I think at that point it was in the hands of the GI people.

Q. Okay.

So GI would be encompassed within the general description of Kaiser medicine?

A. We said specifically, GI consult. So the mechanics are that if it is a GI problem and nonsurgical, then in-hospital care is supported by the medical service.

Q. How does an upper GI operate to either rule in or rule out colonic pseudo-obstruction?

A. Oh, it has no function in that. The issue of her anemia also needed to be pursued. She had a number of

problems, other than this, including dehydration, generalized weakness. Our function at the first visit was to say, okay, does this patient have a surgical problem, does she need immediate attention in that regard.

Q. I just want -- the question was, the upper GI, then, is for the bleeding?

A. Yes, sir.

Q. Did you anticipate that there would be a colonoscopy, as well?

MR. HUPP: Objection.

Go ahead, the best you can answer.

A. Yes, sir.

Q. And can you tell me how a colonoscopy would operate to either rule in or rule out colonic pseudo-obstruction?

A. We had a CT that showed a patent colon. We would like to have supported this, to make sure that there is nothing missed on the CT.

CT is a wonderful device, and in 1998, was better than it was in 1980. But we would certainly like to see that indeed there was no obstruction.

Secondly, we would like to look for intrinsic lesions, is there anything else that could be causing this.

And thirdly, we already talked about this being a diagnosis of exclusion, but viewing the mucosa of the colon, you could see -- you can note the absence of appropriate movements, you could look at the vascular integrity of the colon, and so you would support that diagnosis with colonoscopy.

Q. So if I understand your answer, the function of the colonoscopy would be to support your earlier belief that there was no mechanical obstruction?

A. Correct.

Q. So as of the time that you anticipated that a colonoscopy would be performed, you had not definitively -- definitely, rather, ruled out the possibility of a mechanical obstruction?

A. To the best of our ability at the time, we had eliminated that, to the point where we felt that offering surgery was inappropriate, and we -- you always would like a little bit of support, but we were pretty comfortable with our diagnosis at that time.

However, we never turn anybody loose. We keep an eye on them throughout, because information may change, or the situation may change. And so we would like to be -- you can never get too much security, I guess is one way to put it.

Q. I understand that.

But as of the time that Dr. Zakhary wrote this note on the 28th at 8:20 after consultation with you, and suggested the admission to Kaiser medicine to rule out the colonoscopy, at that time --

A. Yes, sir.

Q. -- I mean, rule out the colonic pseudo-obstruction, at that time, did you believe that she had no mechanical obstruction?

A. I did.

Q. And the purpose of the colonoscopy that you anticipated, then, was just to further confirm that?

A. Yes, sir.

Q. Now, I think we have established that the colonoscopy itself was for the purpose of excluding mechanical obstruction, not for the purpose of proving or disproving pseudo-obstruction?

A. I don't think you can separate the two, sir. I think that --

Q. All right, let me ask it a different way.

MR. HUPP: Well, did you finish your answer?

THE WITNESS: Yes.

MR. HUPP: Okay.

Q. (Continuing) A colonoscopy will operate to find a mechanical lesion if one is present?

A. May, yes.
Q. May.
And that is why you thought it appropriate that she have one?
A. Yes, sir.
Q. But if in f ct there is no mechanical obstruction found on colonoscopy, what information, if any, will a colonoscopy provide as to either the presence or absence of pseudo-obstruction?
A. Again, you will see enlargement, which we expected, and you will see dystony, that is no movement in the colon, and it would be very flaccid, very enlarged, and then you will not see anything else causing a problem, such as a luminal lesion or mucosal lesion.
Q. Beyond the colonoscopy, what additional procedures or treatments, if any, did you anticipate that the medical service would provide on the issue of pseudo -- colonic pseudo-obstruction?
A. At that time, I thought no other was necessary.
Q. Now, was it your plan to continue to follow this patient after Kaiser made the decision -- Kaiser medicine made the decision to admit her, or whatever?
A. We would stand by, we would always be ready for any change, and she would stay -- I would be the attending that they would call. But there was very

little role for us at that time. We had very little to offer her.

We did see her again on the 29th, and I visited her on the 29th, as well.

Q. The 29th, that was after, then, Dr. Vogten -- I think it was Dr. Vogten -- did the upper GI?

A. Yes, sir.

Q. At that time, had he done the colonoscopy?

A. To my knowledge, no colonoscopy was done during this admission.

Q. On the 29th note, it has the word, Versed?

A. Visit.

Okay, visit.

private practice, for example, there are many people that I would continue to visit. Under those circumstances, I

would change a fee. I would just say, Hi. Mrs Jones, h as you doing, the medical guy is doing okay I have no role in her care at that time, until such time as we have a change in diagnosis

Q Did you ever see her, then, after the 29th?

A. I do not recall seeing her after the 29th

Q Is there any note in the chart of yours after the 29th?

A. May I look?

Q. Sure.

A. No, sir.

Q . once she admitted, you did learn that she hadn't eaten solid food for 14 days prior to her presentation to the emergency room?

A. Yes, sir.

Q. You were aware of the fact that she had abdominal complaints?

A. Yes, sir.

Q. You were aware of the films, the CT that showed dilated transverse colon?

A. Yes, sir.

Q. The flat films that showed the possibility of caecal volvulus?

A. That was excluded by the CT, yes

Q But a cecum of 15 centimeters in size?

A. Is large, yes.
Q. Were you also aware of her nutritional state?
A. That was in the hands of the medical people.
Q. As a surgeon, isn't it something you would want to know, what her nutritional state was?
A. If I was considering surgery, it would be very important. But from the first or second day forward, we had no indication to consider surgery.
Q. Did you ever look at her labs?
A. I did.
Q. When?
A. Probably when I first saw her.
Q. So that - yes, there were laboratory tests taken on the day of admission. So you would have been aware of those labs?
A. Yes, sir.
Q. Those labs show an albumin of 2.0?
A. Yes, sir.
Q. What is the significance of that to you?
MR. HUPP: Objection.
Go ahead.
A. Number one, it is abnormal; number two, it is low --
Q. It is near starvation, isn't it?
MR. HUPP: Well, wait a minute, let him answer your question, please.

MR. NORTON: Okay.

A. Number three, it provides her a higher risk for surgery, if it is contemplated, and certainly supports our decision to avoid surgery if at all possible.

Q. It is near starvation?

A. I don't know that I can answer that.

Q. When it is supported by the calcium level of 7.2, it suggests a --

A. She is malnourished.

Q. A severe state of malnourishment?

A. Yes, sir, she is malnourished.

Q. Okay.

So this woman is transferred to the Clinic on your recommendation --

A. Yes, sir.

Q. -- and you are a surgeon, for evaluation of abdominal complaints?

A. Yes, sir.

Q. You consider the possibility of pseudo-obstruction, you are aware that she hadn't eaten for 14 days, you are aware of a prior history of diverticulosis and diverticulitis, correct?

A. Yes, sir.

Q. Did you make any recommendation to anyone about improving her nutritional status?

A. I don't recall.
Q. Do you believe that it was important, given this history and these findings that we have just discussed, to find out why this woman couldn't eat solid food for 14 days?
MR. HUPP: Objection.
A. On a theoretical basis, it is certainly reasonable. It is also something that we expected the medical folks to do.
Q. How would they do that?
A. History and physical. I think the patient, as I recall, had a history of cessation of oral intake. Perhaps they could have started her on some -- had a dietician look at her and start her on some intake.
But may I --
MR. HUPP: Go ahead, if you are not finished.
Q. *Go* ahead.
A. Our issue was to establish the need for surgical intervention, and once we considered that that was not appropriate, then we asked the medical people to take over her care.
Q. Okay.
A. We had no place in that.
Q. But when you first saw her, you knew that she had

a history of no solid food for 14 days prior to her presentation to the emergency room, you have told me that.

A. Yes, sir.

Q. Well, did you ask her why she didn't eat solid food?

A. We were in the process of working up her theoretical appendicitis, which we excluded. We looked at her colon problems, which we excluded as surgical events, and once again, we turned her over to the medical folks for care.

Q. My question was, did you ask her why she wasn't eating for 14 days?

A. I don't recall.

Q. Did you ever look at the emergency room record and find that the reason she gave on presentation was that she wouldn't eat because it gave her stomach pains, cramping?

A. I recall she had pain when she ate, but also there was some question about whether she was avoiding food to lose weight, that was also mentioned. But that still doesn't make it a surgical issue.

Q. Well, if in fact Mrs. Tracek did have a mechanical obstruction, then that would impair her ability to eat, correct?

MR. HUPP: Objection, hypothetical.

Go ahead, you can answer.

A. Yes, sir.

Q. And even if you fed her intravenously, the mechanical obstruction would impair her ability, correct, to achieve a better nutritional state?

MR. HUPP: Objection.

A. I don't know. I think you can now -- at least theoretically you can feed people completely by TPN. It has got risks. I wouldn't want to do it unless the patient needed it and there was a clear indication.

Q. Apart from that, if the dietician were to have ordered some very nutritional regimen of food that she would have to take orally and she had a mechanical obstruction, it wouldn't work if she couldn't swallow the food -- or couldn't digest the food?

MR. HUPP: Objection, hypothetical.

A. I guess that is true.

Q. Were you aware of what the cause of death was in this case?

A. I became aware when I read the chart, which was urosepsis.

Q. And what was the urosepsis due to?

A. An infection of the urinary tract infection -- or an infection of the urinary tract.

Q. And why was she unable to deal with that infection?
A. I don't know.
Q. Did her state of malnutrition have anything to do with it?
A. It may have been part of the problem, but I don't know that.
Q. Were you consulted by medicine as to whether or not Alice Tracek should be discharged before her condition had been diagnosed?
A. I don't recall.
Q. Are you aware that she was discharged without --
A. Yes, sir.
Q. -- a diagnosis ever having been made?
MR. HUPP: Objection.
A. No, sir. She had a diagnosis. She did not have a colonoscopy.
Q. What was the diagnosis?
A. Well, mine was pseudo-obstruction.
Q. Okay.
A. And I don't recall what they -- I would have to take a look at the discharge summary.
I don't have a discharge -- I don't believe I have the discharge summary in this. May I look at yours?
Q. You are talking about a typewritten discharge

summary?

A. Yes, sir.

MR. HUPP: You mean for this admission?

MR. NORTON: Right.

MR. HUPP: I don't know if there is one.

MR. NORTON: What?

MR. HUPP: I don't know if there is one.

MR. KWARCIANY: I have got it.

MR. NORTON: How about this?

(Thereupon, the document was handed to the witness.)

A. (Continuing) They called it irritable bowel synarome, Dr. Wong was the attending. They also identified hiatal hernia, malnutrition, morbid obesity, immobility and diverticulosis.

Q. Did that discharge diagnosis include any reason for her malnourished state?

A. It indicates that the issues are not closed and that further evaluation will be completed both by her primary care and by the gastroenterologist, and there is a description of an intention to obtain colonoscopy as an outpatient.

Q. And you are aware that the colonoscopy hadn't been performed during the July admission to the Clinic?

A. I am.

Q. Did you have any discussion with Dr. Vogten about that procedure?

A. No, sir.

Q. Do you know who he is?

A. Yes, sir.

Q. Have you ever discussed this case with him?

A. No, sir.

Q. Do you know why he didn't do the colonoscopy while she was hospitalized?

A. No, I don't.

Q. Do you believe that it should have been done?

MR. HUPP: Objection.

A. I requested, I suggested, I indicated, we thought it was part of the evaluation.

MR. NORTON: Okay, thanks a lot, Doctor. I am done.

MR. HUPP: Questions, gentlemen?

MR. SCOTT: I don't have any.

MR. KWARCIANY: No questions.

MR. HUPP: We are going to order a copy so tne doctor can read it.

- - -

(DEPOSITION CONCLUDED)

- - -

_____

Bernard Owens, M.D.

CERTIFICATE

State of Ohio,)
) ss:
County of Cuyahoga.)

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named BERNARD OWENS, III, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 17th day of November, 2000.

Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.
My commission expires November 5, 2003.

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MEMBERS:
N.S.R.A.
O.S.R.A.

December 5, 2000

John F. Norton, Esq.
Cambridge Square Building - Suite 204
8251 Mayfield Road
Chesterland, Ohio 44026

Re: Alice F. Tracek, Deceased
vs.
Kaiser Permanente, et al.,
Case No. 400269

Dear Mr. Norton:

Enclosed please find the original errata sheet for the deposition of Bernard Owens, M.D. If I can be of any further assistance, please do not hesitate to contact my office.

Very truly yours,

Ivy J. Gantverg,
Registered Professional Reporter

Enclosure

cc: Marc Groedel, Esq.
Douglas Fifner, Esq.

Page	Line	
5	5	~~CARBOMAT~~ "CARBOMAX" should be "[illegible]"
19	12	strike "ND", 92
22	1	(the) "best treatment" should be "the best"
35	19	~~[illegible]~~ "clance" should be "colance

Thank you

[illegible signature]

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MEMBERS:
N.S.R.A.
O.S.R.A.

November 20, 2000

Steven J. Hupp, Esq.
Bonezzi, Switzer, Murphy & Polito
1400 Leader Building
Cleveland, Ohio 44114

Re: William C. Tracek, Admr.
vs.
Kaiser Permanente, et al.
Case No. 400269

Dear Mr. Hupp:

Enclosed please find the transcript of the deposition of Bernard Owens, III, M.D. which you have ordered.

Please have the witness read the deposition, make any corrections using the blue "Lawyer's Notes" sheet, and sign on page 53 of the transcript. When this has been accomplished, please return copies of said pages to me.

Please advise the witness that pursuant to the Ohio Rules of Civil Procedure, if the transcript is not signed within seven (7) days of receipt of this letter, unless otherwise stipulated by counsel, it may be filed without signature.

Very truly yours,

Ivy J. Gantverg,
Registered Professional Reporter

Enclosure

cc: John F. Norton, Esq.
Marc W. Groedel, Esq.
Douglas Fifner, Esq.