The State of Ohio,
County of Cuyahoga. :

IN THE COURT OF COMMON PLEAS

Ella Ruth Weatherspoon, :
Extrx., etc., :
Plaintiffs,
vs. : No. 297651
Cleveland Clinic Foundation,
et al.
Defendants.

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Video deposition of EZRA STEIGER, M.D., a witness herein, taken by the defendants as if upon direct examination before Diane D. Barto, a Certified Professional Court Reporter and Notary Public within and for the State of Ohio, at the Cleveland Clinic Foundation, Building A, 8th Floor, Cleveland, Ohio, on Saturday, the 30th day of November, 1996, at 2:00 p.m., pursuant to notice and agreement of counsel.

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APPEARANCES:

Ms. Donna Taylor-Kolis
Ms. Ann Garson

On behalf of the Plaintiffs;

Jacobson, Maynard, Tuschman & Kalur, by
Mr. Dale L. Kwarciany,

On behalf of the Defendants.

EZRA STEIGER, M.D.

of lawful age, a witness herein, called for direct examination by the defendants, being by me first duly sworn as herinafter certified, deposed and said as follows:

DIRECT EXAMINATION

BY MR. KWARCIANY:

MR. KWARCIANY: Ladies and gentleman of the jury, this is attorney Dale Kwarciany. It is Saturday, November 30th. We are here at the Cleveland Clinic this afternoon in order to video tape the deposition of one of the witnesses who will be testifying on behalf of the defense in this lawsuit.

DIRECT EXAMINATION

BY MR. KWARCIANY:

Q. Doctor, would you introduce yourself to the jury, please?

A. I'm Ezra Steiger.

Q. And what is your medical specialty, Doctor?

A. General surgery.

Q. Do you have any sub-specialty or area of special expertise or interest within your

field of specialty?
A. Yes, surgical nutrition.
Q. What is surgical nutrition?
A. The nutritional care or rehabilitation of people who are post-operative patients or pre-operative patients with specialized forms of nutritions for it. That is either intravenous feeding or tube feeding.
Q. By whom are you currently employed?
A. Cleveland Clinic Foundation.
Q. How long have you been employed by the Cleveland Clinic Foundation?
A. 21 years.
Q. Can you briefly describe for us your medical education and training beginning with undergraduate school and take us up to the present date, please?
A. Sure. I went to undergraduate school at Ohio State University in Columbus, Ohio. I went to medical school at the Ohio State University College of Medicine in Columbus, Ohio. I did my surgical internship and residency at the hospital of the University of Pennsylvania. Did my two years in the air force in Biloxi, Mississippi as a

general surgeon, then came to the Cleveland Clinic Foundation in August of 1975.

Q. Now Doctor, did you have the opportunity to treat a patient by the name of Leotis Weatherspoon here at the Cleveland Clinic Foundation?

A. Yes, I did.

Q. For what sorts of problems did you treat Mr. Weatherspoon over the years?

A. For malnutrition.

Q. Can you basically summarize for us the treatment that you provided to Leotis Weatherspoon here at the Cleveland Clinic over the years?

A. Yes. We initially had him on some tube feeding and at one time had him on some intravenous feeding in the hospital as well as home setting and saw him at -- several years after that for an opinion about possible intravenous feeding before plan does surgery.

Q. Approximately how many years did you treat this man?

A. Approximately -- I'm just looking at my records -- since 1984.

Q. Were there other doctors who are also involved with this man's nutrition problems?
A. Yes. Dr. Signor.
Q. Dr. Steiger, what do you recall of this man's overall physical appearance?
A. Mr. Weatherspoon appeared wasted, malnourished, had evidence of significant weight loss throughout my exposure to him -- or experience with it.
Q. Was this man cachectic?
A. He was cachectic.
Q. What does that mean?
A. That means someone who's had a lot of weight loss.
Q. What was your prognosis for this man?
A. Actually every time I saw him it was amazing that he was still going of the years that I had seen him at the Clinic. He just looked very malnourished, like somebody you would expect to see coming out of a concentration camp.

MR. KWARCIANY: Thank you, Dr. Steiger. I have nothing further.

CROSS-EXAMINATION

BY MS. TAYLOR-KOLIS:

Q. Dr. Steiger, good afternoon. Of course you know I am Donna Kolis. Although, I wasn't actually planing on doing this, let me ask you:

If I have now fairly read all of the Cleveland Clinic records, in January of 1987 that particular -- let's call it 60 day hospitalization which you and I are going go through today -- you had the photography department take photographs of Mr. Weatherspoon. Those would be contained in the original charts, wouldn't they?

A. The photographs themselves?

Q. Yes.

A. I'm not sure if they keep photographs in the original charts.

Q. Well, let me indicate to you -- and if we need to go off the record we will -- that contained within those records are some manila envelopes that have been sealed and I suspect that they are the 1987 photographs of Mr. Weatherspoon.

Would that refresh your memory of

where those photographs might be?

A. No, not necessarily. I could say that we often would take photographs of patients before starting them on intravenous feeding. I'm not sure if those were those photographs that you were talking about.

Q. Those would be the ones I'm referring to.

Let me ask you a candid question: Are you indicating for the jury that between the time when you were caring for him in -- and we're focus on early 1987 and the end that he never gained weight and never looked better than he did early in 1987?

A. No. I think there were times where he gained some weight and looked better and there are other times when he lost the weight and looked worse.

Q. Well, let's focus on this, let's see how well you looked at these records. Do you recall that in early 1987 when he was under your care Mr. Weatherspoon weighed approximately 114 pounds?

A. Again, these -- I wouldn't be able to be accurate --

Q. That's okay.
A. -- as far as absolute weights and dates but I would be happy to look at the charts to corroborate them.
Q. Well, I think we're going to be going through those records shortly so that would be all right. So why don't I start with some general questions and we'll come back to that later.

As a surgeon, a general surgeon who specializes in nutritional therapy and in total parenteral nutrition you would be familiar with the organs of digestion and essentially what they do, correct?

A" Correct.
Q. All right. Let's see if you agree with me on these issues.

Serum albumin, Dr. Steiger, is the most abundant of the liver synthesized proteins. Do you agree with that?

MR. KWARCIANY: Let me just show an objection to this line of questioning as going beyond the scope of direct examination, but go ahead.

MS. TAYLOR-KOLIS: Your

objection is duly noted and I believe it goes directly to the questions that you posed to this doctor.

Q. Doctor, your answer to the question?

A. Again restate the question. I'm sorry.

Q. Oh, sure. Serum albumin I think you and I can agree is the most abundant of the liver synthesized proteins. Would you agree with that?

A. I would agree with that.

Q. Okay. Albumin is not stored, Doctor, but it is secreted continuously into the blood plasma, correct?

A. Yes. But albumin is not only in the blood but it's in the subcutaneous tissues or other areas than the blood.

Q. Oh, I agree with that. I'm sorry.

What I was indicating is blood that's synthesized through the liver isn't stored there it is distributed continuously --

A. It's distributed, correct.

Q. Correct? Albumin, Doctor, would be responsible for osmotic mediation between blood water and tissues, correct?

A. Correct.
Q. It's its primary function, in fact?
A. It's certainly an important function.
Q. All right. If you have a protein losing enteropathy due to malabsorption in the intestines, there just essentially isn't enough proteins for synthesis through the liver, correct?
A. Correct. In that there is more being lost or destroyed than is being produced.
Q. Okay. Pancreatic enzymes, Doctor, break down carbohydrates, fats and proteins into usable units of nutrition, correct?

MR. KWARCIANY: Again, show a continuing line of objection to these questions.

MS. TAYLOR-KOLIS: Well, let me state now since the Court will need to rule on it, you have set forth this witness to indicate a poor prognosis for this patient.

Dr. Steiger, has cared for Mr. Weatherspoon over a substantial period of time. I need to test his knowledge, as it were, as to the conditions that Mr.

Weatherspoon suffered from and be able to go through what treatment he rendered for him and how effective it was.

And with that we're going to continue with these questions.

Q. Now the last question I had asked you, Doctor, was about pancreatic enzymes. Of course, as you would agree with me that prior to becoming your patient Leotis Weatherspoon had had a Whipple, correct?

A. Correct.

Q. All right. Of essence of having this Whipple he lost some of those digestive enzymes that could cause malabsorption, correct?

A. Correct.

Q. All right. Now at a later time, after the Whipple, I assume that you knew when he became your patient, that he had had partial removal of his stomach, the Billroth series of surgeries, correct?

A. Correct.

Q. All right. Now that stomach, so the ladies and gentleman of the jury understand, it secretes pepsin which breaks down proteins,

correct?

A. Pepsin helps to break down proteins, correct.

Q. Sure. I'm not saying it's solely the function of the stomach but it's something that the stomach does, right?

A. Right.

Q. All right. The stomach itself also secretes and intrinsic factor that absorbs B12 in the intestinal tract; isn't that right?

A. Correct.

Q. Okay. The other thing the pancreas does, Doctor -- or at least it's my understanding is that it does secrete a bicarbonate that will help to neutralize hydrochloric acids coming out of the stomach; isn't that right?

A. Correct

Q. So when you have a Whipple, likewise, the bicarbonate function is also impaired, isn't it?

A. Could be, sure.

Q. Okay. And these are things that you would have known as you began your treatment of

Mr. Weatherspoon --

A. Correct.

Q. -- because he was minus two thirds of his pancreas essentially, correct?

A. Correct.

Q. And a good portion -- and I'm just going to say a good portion because I'm not a surgeon -- of his stomach because of his Billroth initially, correct?

A. Correct.

Q. Now during the time that you treated him beginning in 1984 through approximately, let's deal first with the fall of 1989, half a decade, a five year period. Mr. Weatherspoon in fact did have a malabsorbitve disorder, didn't he?

A. In my own mind I'm not too clear about that. I always consider malabsorption to occur when people have intractable diarrhea, steatorrhea and conditions like that. That wasn't a prominent part of his complaints or symptoms.

Q. Okay. You've given me an answer that I think is fairly direct, but let's sort of clarify it.

You're indicating that your review of the records and your recollection of Mr. Weatherspoon is that he didn't have diarrheal symptoms associated with his Billroth procedures and his Whipple; is that right?

A. Correct.

Q. Now you can have a malabsorbtive disorder which does not include diarrhea as a component of it, correct?

A. Not too many that I'm familiar with. Again, I'm not a gastroenterologist who would be most knowledgeable about that type of thing. But most of the malabsorption disorders that I come in contact with, in my area of surgical nutrition, are those people who have significant diarrhea.

Q. Okay. The medical definition of malabsorption, so the jury understands what we're talking about, isn't that a person is having diarrhea, it's their malabsorbing proteins, carbohydrates and fats, correct?

A. Correct.

Q. All right. To clarify, perhaps, your thinking, there are other people that

treated Mr. Weatherspoon in that period of 1984 through 1989 along side of you, correct?

A. Correct.

Q. Some of them were gastroenterologists, weren't they?

A. Correct.

Q. And they have made notes in the charts, correct?

A. Correct. I think that's right.

Q. If they call it a malabsorption disorder, do you defer them to their judgment since, as you've indicated, you are not a gastroenterologist?

A. That would be up to their definition. Again, my definition would not be a malabsorption disorder.

Q. Well, I'll tell you what, we need to go through these records so there is some clear thinking for the jury in terms of that component.

I know that you have the original records but what I've done is pulled the records chronologically and highlighted them so that you can easily read them.

The first note that I'm going to hand you, I believe, is from 1984, isn't it?

A. The first note you handed me, yes.

Q. 12/15/84.

A. It looks like 12/15 or 12/5/84.

Q. Okay. One or the other dates.

But the initial impression is malnutrition with a GI disorder. That's about as specific as that is; isn't that correct?

A. Correct. From the department of nutrition services.

Q. All right. If you want to hand me that one back, that would be all right.

Let me ask you this, Doctor: Even though you're not a gastroenterologist you work extremely close with that discipline of medicine in your capacity as director of nutritional surgical services, don't you?

A. Yes, I do.

Q. Okay. If I said to you that someone was known to have a GI dismotility, dismotility is what?

A. Where the intestine doesn't work

appropriately in carrying food through it.

Q. Okay. And if it doesn't work appropriately in carrying food through it there is probable an element of malabsorption, isn't there?

A. No, not necessarily.

Q. Okay. Dr. Carey -- Dr. Carey was a gastroenterologist here, correct?

A. Correct.

Q. I haven't seen his name recently, that's why I said "was", I don't know.

This is his May 20, 1985 note. Do you see that?

A. Yes, I do.

Q. And he documents IV leave intermittent nausea and vomiting. All right. That's a dismotility in the stomach essentially, isn't it?

A. Well, there are a lot of things that can cause intermittent nausea and vomiting but dismotility of the stomach can be one of those.

Q. All right. Dismotility is what he's documenting, isn't it, in that note?

A. I can read the whole note, should I do

that?

Q. If you can see where he indicates there's a dismotility I would like an acknowledgment to that. If it's not there, just let me know.

A. I do not see that in that highlighted note of May 20, 1985 by Dr. Carey, no.

Q. All right. Well, let's see if I can locate it. I thought it was in there. Oh, sorry.

Second page. I should have turned it over for you. Dr. Carey on your service at that time says what? On the highlighted portion. "Motility disorder of the small bowel", correct?

A. It says impression -- "IMP", which stands for impression, "motility" there's some initials there that I'm not familiar with. Could be disorder of the small bowel.

Q. Okay. All right. December of 1986 Dr. Carey, of course, is involved in your team. He indicates based on Mr. Weatherspoon's weights, it is needed to keep careful tabs on him regarding his enteral feedings and if not go to TPN if not successful.

Can you confirm that that's what his

note says a year later based on on-going care?

A. See Dr. Carey December 9, 1986 that part you have outlined, "need to keep careful tabs on" something "of enteral feedings and go to TPN if not successful", correct.

Q. Okay. Let me ask you at this point, now we're talking close to the end of 1985 when this note's written -- and it does pretty clearly show the weight is 114; is that right?

A. Correct. It shows 114.4 pounds.

Q. Okay. If he doesn't gain weight on enteral feedings the note is indicating it should go to TPN. Now I don't know if the jury would have at this point heard TPN. TPN, is this the intervenous feeding that your referring to earlier when you spoke to Mr. Kwarciany?

A. Yes, it is.

Q. That's total parenteral nutrition, correct?

A. Correct.

Q. Now so that the jury can see what your assessment of this is, TPN provides a pure source of nutrition to a person when the

person's digestive tract is not absorbing all the nutrition they need, isn't that correct?

A. Correct.

Q. All right. And at this point, although we're going to discuss it later, shortly after that note you did have him in the hospital and you put him on TPN in the hospital. Does refresh your recollection about early 1987?

A. That's certainly possible. Again, I don't remember exact dates.

Q. That's all right, we'll get to it.

Much later, August of 1988 there's a note by yourself, Dr. Steiger. At this point can you tell the jury -- the highlighted portion shows what is your impressions or carrying medical characterization of this person?

A. Let's see this was an introductory sentence written by the resident on my service who saw the patient as an outpatient August 2, 1988 and that first introductory sentence that person wrote, "58 year old black male status post-Whipple with GI motility

disorder."

Q. Okay. And that's written by your resident and I gather that the jury probably will know these kind of things by now, you supervised these residents, correct, as a method of teaching?

A. Correct.

Q. And if a resident writes something in an office note of yours that's in error you would correct it either by an additional note or correctly on this note?

A. Not necessarily, no. That may have been taken from other notes. A lot of times people will write their beginning note by quoting what's been written before as a way of introducing who the patient is that they're seeing.

Q. So that the jury is clear, are you saying that you wouldn't correct something that a resident wrote if it was in error?

A. Not that if I felt it was not a significant error, no.

Q. Okay. Doctor, what is a nutritional cripple in terms of a medical term?

A. What I would consider a nutritional cripple

is someone who's unable to function normally because of their nutritional status.

Q. Now at a later point in time, Dr. Signor became part of your team; is that right? Dr. Signor is the gastroenterologist?

A. Correct.

Q. Dr. Signor writes the note in May of 1993 -- I believe that's all Dr. Signor's handwriting, I think you'd recognize it?

A. It sure looks like it, yes.

Q. Okay. And I've highlighted for you his diagnoses at that visit and they are malabsorption and malnutrition, aren't they?

A. Yes, they are.

Q. Okay. So once again getting back to where we started, we had to take the long way there, there is a diagnosis by a gastroenterologist on your team of malabsorption in 1993, isn't there?

A. Yes, there's a diagnosis of malabsorption -- or at least the word malabsorption is made.

Q. All right. He continues that diagnosis

through his notes, doesn't he? Would you like to see another note?

A. Sure.

Q. Okay. His August 24, 1993 visit.

A. Yeah, he says secondary malabsorption at the third line from the top.

Q. Sure. And to clarify for the jury, when doctors write things like secondary malabsorption, in Mr. Weatherspoon's case the malabsorption that he's characterizing is once again caused by the lack of enzymes because digestive organs are missing from the body, correct?

A. I'm not -- you know there are a lot of things again that can cause malabsorption but I'm not sure that that characterizes what you say is causing it.

Q. Okay. can you think of something else that might have caused malabsorption in Mr. Weatherspoon?

A. If you don't have any food in the stomach then you're malabsorbing nutrients because there's no nutrients going through. There are a lot of different ways of diagnosing the malabsorption.

Q. Sure. But the August of 1993 he already had a completion gastrectomy so he had a very minimal portion of a stomach left, correct?

A. Correct.

Q. All right. Let's go to 1987. Okay. If I can find my way there. I will apologize because there is no admission/discharge chart in the original paperwork so I had to go based on notes.

You might want to look at this. This just may refresh your recollection. He was admitted at that time for suspected pneumonia; is that right?

A. This is dated January 7, 1987?

Q. Correct.

A. Do you want me to read the whole note?

Q. No. I'm just seeing if you can confirm through that note that that's what the admission was for?

A. The history said fever and pleuritic chest pain. Chest x-rays showed questionable right lower lobe infiltrate. The note isn't complete, but if the chest x-ray did show an infiltrate and he had fever and

chest pain that that could be, sure, consistent with pneumonia.

Q. Okay. Now this was your admission to the hospital, you were the attending. Do you have any reason to dispute me that you would have been the attending on this admission?

A. I really don't know. I don't see anything there that says admitted to Steiger's service.

Q. We'll find it for you, because it's in here.

A. Okay.

Q. What I wanted to show you is on 1/7/87 there's an ID consult, isn't there?

A. Yes. 1/7/87 ID consult.

Q. Okay. And the ID consult was to aide and assist in the diagnosis of pneumonia; do I gather that correctly?

A. Yeah. It said consulted to evaluate for possible right lower lobe pneumonia, correct.

Q. All right. Why would you call an ID service in to evaluate for the pneumonia?

A. Usually they help us diagnosis any

infection and help us to decide where the infection is coming from and what the infecting organism is and what the appropriate treatment for that infecting organism should be.

Q. Okay. Is that just something, as a general surgeon, that you prefer to do, is call in the ID service for that issue?

A. I generally do, yes.

Q. Okay. Now on the second page of that they're doing a history and they're indicating that he seems to be worsening because of malnutrition; do you agree with that?

A. Yeah, their note says "because this patient is malnourished and the process has literally galloped in two days I believe this patient should be considered for admission to MIC", or medical intensive care unit.

Q. Okay. At that point you hadn't started him on his TPN, as far as I know -- and we'll go through the chart.

Now there's a note by you, Dr. Steiger, your nutritional assessment of

this patient who's admitted on the 7th of 1987 and I've highlighted the labs that you wrote down. Those labs are involving the albumin, the transferrin and the PTs, aren't they?

A. Yes, those are the highlighted labs.

Q. Okay. Those labs were abnormal, correct?

A. Correct.

Q. All right. Now you are a person who takes advantage of -- I guess I'll use that phrase -- uses the nutritional assessment scoring profile, don't you?

A. Yes. The PNI or the prognostic nutritional index, correct.

Q. Right. But you call it the PNI. Can you indicate for the jury what Mr. Weatherspoon's PNI was in 1987 when you had him in the hospital?

A. 116 percent.

Q. Okay. 116 percent is what kind of number?

A. Severely malnourished.

Q. Okay. Thank you very much.

Now so that the jury understands this, because they'll probably hear a little about PNIs, you have a list of

factors that are evaluated to reach those PNI numbers, correct?

A. Correct.

Q. They're albumin, transferrin, pre-albumin TLC. What's TLC?

A. Total lymphocyte count.

Q. Okay. BUN, creatinine, glucose and then something called a skin test which isn't a laboratory test, correct?

A. Correct. But those don't go into evaluating the PNI. The PNI is based on albumin, transferrin, delayed hypersensitivity skin tests and tri-sub skin fold, those four measurements determine the PNI.

Q. All right. Then why do you then have creatinine and glucose?

A. Those are some other important parameters that we use to follow a patient.

Q. So it in fact is the albumin and transferrin along with two additional tests that are the most important it assessing those parameters, correct?

A. In deriving the PNI, correct

Q. Okay. And you weren't planning any surgery

on this patient you just did that 116 during this hospitalization to assess where this patient was from a nutritional standpoint, correct?

A. Yes. We often get PNIs or those nutritional assessments on patients who are malnourished to follow them over time.

Q. All right. Let me ask you something since we're doing these PNIs. He's got a 116 PNI in January of '87. As we go through the jury is going to see that you put him on TPN in the hospital, kept him on for 20 something days, and as one would expect you did a PNI at the end of that course of therapy.

Can you indicate for the jury what his PNI was on 2/26/87?

A. The PNI on 2/26/87 was 61 percent.

Q. All right. So in a period of time from the 16th of January until -- I'm sorry. I've lost track of what the date is -- about a month later in February, you took him from a 116 to a pretty respectable number, 63, right?

A. No. 61 is still severely malnourished --

it's better certainly than 116 but it still ends up being severely malnourished.

Q. Right. You had been able, in that time period, to improve the albumin and the transferrin numbers, correct?

A. You know, I'd have to look at what the albumin and transferrin were in that original one.

Q. Sure. I thought I had it listed serially.

A. Let's see, on 1/6/87 his albumin was 1.5 and on 2/26 the albumin was 3.0, so that certainly was improved.

The transferrin on 1/6/87 was 67 and on 2/26/87 it was 176, so that's certainly was improved, too, yes.

Q. So you brought those numbers up?

A. Made them better, sure.

Q. Okay. All right. Back to this hospitalization. Let me show you, this is a note -- and I have to honestly tell you I'm not certain whose signature it is, but it's a note in the chart. Maybe you'll recognize it. I think it's Dr. McHenry. Do you remember Dr. McHenry at the hospital?

A. Sure. I know who he is.
Q. All right. And I'm assuming it's dated 1/14/87 and basically so the jury can appreciate this, it said suspect patient's decreased TP, that's total protein in albumin with low plasma.

I can't make out this word. Is that osmotic oncotic pressure?

A. With low plasma oncotic pressure -- although it does look like a with-sign there, but I think it's oncotic pressure, right -- is allowing continuous pleural drainage to occur.
Q. Okay.
A. Yeah, that actually wasn't Dr. McHenry's -- that's Dr. McHenry's signature at the bottom of the note. I don't think that's his handwriting as I recall his handwriting being.
Q. Okay. He's signing off on this note probably for a resident, correct?
A. Could be, yes.
Q. All right. And just to point this out, it's there assessment which I think perhaps you would agree with based upon your

earlier answer, that when you've got low albumin and low total proteins it draws fluids into spaces where they don't necessarily belong, is that --

A. Yes.

Q. -- the sum and substance of the note?

All right. Now as I indicated the records reflect that you did put him on TPN during his hospitalization. If you want to look in the original you can, but I thought it was about 1/16/87, probably 12 days or so. You can look if you want to.

A. Could be. If the question is was he on it during that time, I'd be happy to look at the records.

You said 1/15/87?

Q. Yeah. I couldn't tell. As I said, I do apologize there is no admission/discharge summary in that chart so I had to react this out of notes.

A. I don't see where that's the case in the progress notes. We could look at the orders if we have that chart here.

Usually if TPN was started there would be an order for it to start. The

only note that I see that was in our service was Ed Copper and MVI to TF which I assume means tube feeding on 1/15/87.

So I would guess he would still be on tube feeding then. Although TPN may have been started that night, we'd have to look at the doctors orders for 1/15/87. And there is some doctor's orders that actually makes it appear that he was started on the TPN January 16, 1987 where it says "see TPN" -- "see TPN ancillary sheet" -- which is what started -- "when TPN started."

Then it says -- one of the other things it says is, "DC TF" or tube feeding when TPN starts."

So that would make me think that TPN was going to be getting started on the night of the 16th, probably not the 15th.

Q. Okay. So I was right. Somewhere around the middle of January, 15th/16th, you at least left put him on TPN then?

A. It looks like he was placed on TPN the 16th, the night of the 16th probably.

Q. Okay. Now originally as you were

delivering that TPN it was probably or was in fact given through a TPN catheter, a central line.

A. There are a couple ways to check on that. One, is to see what type of TPN there is. There's some types of TPN you can get through a peripheral IV line and that is fat based on intravenous feeding and there's some you have to give through a central line.

If I can find the exact TPN orders here in the order sheet then I would be able to tell you for sure. Unless you have that underlined somewhere? No?

Q. As I said, I did the best I could. But let me just show you this, this might help you. This is from 1/22/87 when he's still receiving TPN, correct?

A. Correct. Yeah, it does make mention on the 22nd that the TPN catheter right subclavian, triple loom and dressing changed, no abnormalities noted.

Q. Okay. So that's how he was receiving the TPN.

As we progress along in his

hospitalization for pneumonia on the 27th I've highlighted -- you've probably had him on TPN then for about nine days, right, if you started on the 16th?

A. If he started on the 16th.

Q. Okay. And his albumin is up to 2.2, right?

A. Albumin increased at 2.2 is what the note says, right.

Q. Let me ask you a question, the jury is probably curious a little bit anyway. When we were talking about why you changed from enteral feedings to TPN, what did the note mean, the note that was written prior to this hospitalization if he wasn't gaining weight to switch him to TPN, what did that imply?

A. That implies that the nutrients given to him either were insufficient to allow him to gain weight or he wasn't able to metabolize them well enough to be able to gain weight.

Q. All right. And TPN has the advantage of the fact that it bypasses the intestinal tract and it basically -- the nutrition that's being received is pure nutrition

once again, correct?

A. It goes right into the blood stream, right.

Q. All right. Now, Doctor, suffice it to say, it is more difficult to be on TPN than enteral feedings, isn't it?

A. It's more dangerous, more difficult for the patient, family and a lot more expensive, yeah.

Q. Okay. Expense isn't a factor when someone's life depends on it, however?

A. No, it's not.

Q. Okay. Now the reason I brought that up is sequentially in the notes that I was able to go through that were done on your service, during that January of 1987 you had a psychiatry consultant done for Mr. Weatherspoon. Does that sound like something you would do in relationship to going on TPN?

A. Yes, we usually get a psychiatry consultant before putting people on TPN.

Q. As a matter of fact, if I've read the literature that you published which is prolific on TPN, that's part of good work-up for assessment for home TPN, isn't

it?

A. Yes, we believe so.

Q. You're looking to see if a person is emotionally going to deal with TPN, right?

A. Correct.

Q. Because you're looking to see what kind family structure they have, correct?

A. Right.

Q. All right. If you want to look at this, I just want the jury to be pretty sure about it. This psych consult, as I read it, says -- well, it says a couple things, all right.

First of all, you worked directly with the psychiatrist in giving him medical information, correct?

A. We worked together, yes. Usually we have a team conference once a week to talk about those issues.

Q. All right. This note -- and I'm going to show it to you, just so you can confirm that I'm reading it accurately -- says that he, being Mr. Weatherspoon, has a known slowed gastric motility and probable malabsorption. This is back in '87. He

was admitted to CCF and has been treated for dehydration, pneumonia and a pleural empyema. What's a pleural empyema?

A. A pleural empyema, which means a collection of pus in the pleural or chest cavity.

Q. Okay. That wasn't caused by the TPN?

A. Usually not, no.

Q. Okay. And this work-up essentially says that Mr. Weatherspoon is a candidate for TPN. There are no psychiatric contraindications to him going on TPN, correct?

A. I'd have to review that. Yeah, at the bottom it says, "no psychiatric contraindications."

Q. Cheated, I highlighted it for you.

A. Yes.

Q. Okay. All right. That little symbol does, so that I know, means psch, right?

A. Yes.

Q. All right. Now, it looks like there's several more notes, of course, regarding family, etc.

You still got him in the hospital on 2/3/87 and at this point he's still on TPN.

Can you tell the jury what his albumin is by 2/3/87?

A. "2.8 improving" is the words highlighted.

Q. All right. That's a pretty good number, right? That's written by you?

A. Countersigned by me, right

Q. Countersigned by you?

A. Right.

Q. All right. It would appear, based upon the notes, that you decided at the end of this approximately 30 something day hospitalization that you wanted to send him home on home TPN, right? Do you remember that?

A. I assume that's correct. I don't remember but I assume that it's correct.

Q. Okay. Well, let me just show you the preparations that are being made for a home TPN. Does that confirm it for you?

A. These are dated February 6th, it has to do with -- there is nothing specific that talks about going home on home TPN; is that what you mean?

Q. Does that refresh your memory that you were going to send him home on home TPN? If it

doesn't I can show you different document?
A. Yeah, maybe you better show me a different document.
Q. Okay. On 2/9/87 Mr. and Mrs. Weatherspoon are receiving home parenteral nutrition instructions, aren't they?
A. Yes.
Q. Same date, a little bit later, 2/9 we're talking about a Hickman catheter site. This isn't the same way he had been receiving TPN in the hospital, right? You're now placing a Hickman?
A. Hickman catheter is in, right.
Q. Okay. That Hickman is for what purpose?
A. For home-going on intravenous feeding on TPN at home.
Q. Okay. Now -- excuse me for coughing -- at this point it says patient -- that's you and you've countersigned, it says --
A. Right.
Q. -- "patient examined, Hickman exit site now has purulent material expressed." Do you see that?
A. Yes.
Q. Okay. Do you happen to recall what that

purulent material was?

A. No, I don't recall

Q. Okay. Two days later, it's staphorious, isn't it?

A. Moderate staphorious, right.

Q. Growing out of Hickman site, correct?

A. Right.

Q. All right. Couple days later, Doctor, you're back in assessing him, it's still the same hospitalization, February 12th, notes regarding staphorious, correct?

A. Correct. Outlined is -- or underlined is staph A in wound site.

Q. Okay. Now, let me ask you something. You can go through every note but the jury will be pleased to know, of course, you're giving him antibiotics in response to that staphorious, correct?

A. Okay.

Q. All right. You would assume that's what you would do, right?

A. Yes.

Q. Okay. A few days later he's still in the hospital 2/15/87 and I read another Steiger note and it says, we're going to continue

TPN and antibiotics and you put some silver nitrate around granulation site. That was the J2 granulation site, right?

A. I assume it was.

Q. Yeah.

A. It doesn't say but I assume it was.

Q. Okay. At this point, Doctor, you're getting ready to discharge him and you still got him on TPN. By 2/18 it was your impression that the catheter infection had cleared; is that right?

A. Yes. It says catheter infection cleared.

Q. Okay. All right. 2/20 is the discharge. There's the pharmacy order, correct?

A. Correct.

Q. For home TPN?

A. For home TPN, correct.

Q. Okay. Now I don't necessarily want it go through this, but to make it simple for the jury, he was discharged with a Hickman because you had him on home TPN.

A. Correct.

Q. You felt that was the best way to address his nutritional problems at that point?

A. Correct.

Q. The jury's already heard the numbers for improving in terms of the nutritional parameters, the jury's already heard that your PNI was much better, it was about 63 just before that release, correct?
A. Correct.
Q. All right. He came back four days later, correct?
A. Correct.
Q. Do you remember that?
A. Yes.
Q. I did find that admission and discharge summary.

Now the admission/discharge summary -- first, let me show you the bottom page. It's dictated by a resident, correct, Dr. DiSai (spelled phonetically)--
A. Correct.
Q. All right -- for you, of course.
A. Yes.
Q. That's something residents do, right?
A. Correct.
Q. Do you have an independent memory of how many infections he had during that hospitalization from 2/24/87 to 4/4/87?

A. No, I don't.
Q. Okay. The resident wrote that it was a Hickman catheter line sepsis that caused the hospitalization. Would you agree that's what the discharge summary says? You can look.
A. Yeah. A principle diagnosis, Hickman catheter line sepsis.
Q. Okay.
A. Right.
Q. And when you see principle, is that stirring something in your memory that he actually had a pneumonia going on in the lungs again?
A. No, it doesn't -- I don't recall a pneumonia at that time, no.
Q. Okay. I suppose then we're going to have to maybe go through the chart. Let me say this: Let's do it a different way, initially.

Shortly after that discharge -- and that hospitalization lasted until April 4th; is that correct?
A. Discharge date is listed as April 4th, '87, correct.

Q. We're going to move this around a little for the jury. He came back to see you on April 13, 1987. I want you first just to look at the note and I'm going to ask you a couple of questions about it.
A. Okay.
Q. Okay. First of all, at this point, so the jury understands it, he had been hospitalized initially in January, very low nutritional parameters, PNI 116, weight 114, correct? That's what we've just gone through.
A. Okay.
Q. All right. You had him on TPN in excess of 30 days and then you put together a nutritional plan for his J tube and by April 13, 1987 Mr. Weatherspoon weighs 139 pounds, doesn't he?
A. I'm sorry. I forget where it says that.
Q. Right at the top.
A. Yes, 139 pounds.
Q. All right. His nutritional parameters have improved, correct?
A. He's gained weight. I'm not sure, was there a mention about nutritional

parameters, then?

Q. Well, using your PNI assessment that he was up to 63 on that -- as a matter of fact, I can tell you that you have him at 61 on 2/26/87, all right?

A. Okay.

Q. And you didn't retest him at that point in time, correct?

A. At this point?

Q. Uh-huh.

A. It would be on the computerized assessment. So if it's not there --

Q. It's not there.

A. Then it probably wasn't retested completely.

Q. You don't run PNIs on people every time you see them when your managing them, correct?

A. Correct.

Q. And you would have run one if you thought he needed one but at that point he was gaining weight, correct?

A. Right. Usually weight gain in the out-patient setting is pretty good or an accurate indicator of how well a patient is doing.

Q Okay. Now -- hang on to those. Ann.

What I want to do is just briefly then go through -- see if this sounds right to you.

First, so the jury understands this, Mr. Weatherspoon had an awful lot of visits with you but those were planned visits to monitor his nutritional status; isn't that correct?

A I believe that's correct

Q Because according to the literature that you've published, when you got a person on nutrition support they need to be monitored on a regular basis?

A Correct When they're on -- especially TPN, that has to be done very religiously

Q Okay And at this point he's not on TPN anymore, he's taking enteral feedings because that's how you discharged him from the hospital, right?

A Right.

Q Okay. But I just want the jury to understand why he is coming to see you so often. It is to be weighed and evaluated, correct?

A. Yeah. This is a variable thing. I'm not sure in my own mind exactly why we had him come back.

Usually people on enteral feeding do not have to come back as frequently. It may have been a combination of he/family feeling more comfortable by being looked at more closely.

It may have been because we wanted to make sure the tube feedings were going well.

Q. Could it have been because you wanted to be comfortable with the fact that he was doing well given that his nutrition parameters were so poor in January of 1987?

A. That could have been part of it, too.

Q. Okay. All right. So he weighs 139 in April of '87. He comes back in May of 1987. Can you tell the jury what he weighs then?

A. The note says weight has increased ten pounds in the past month, feels well, tube works okay. His weight recorded at 149.6 pounds.

Q. Did you do some lab work on that visit?

A. I had a note saying check Zinc levels and monthly CBC. So I assume the Zinc and the CBC were checked.

Q. Okay. And why do you check Zinc and CBCs?

A. Zinc just as a trace element to make sure that he was getting enough of those trace elements. He also may have been -- there are a couple of things that happen with Zinc deficiency, although I don't have any note on it, sometimes people develop skin lesions, sometime hair falls out and that may have been happening in him at that time, though I didn't particularly note that.

Q. All right.' You continue to see him and then you see him again, pursuant to your instructions to him to come back, "return two months", July of 1987. How's he doing then?

A. It says, "weight decreased" it looks like "1.6 pounds in past two months. No trouble with diarrhea" -- I'm just reading the outlined things you have.

Q. That's okay.

A. "Gets sick spells with lots of abdominal

cramping and gas" and we had plans to increase tube feedings to eight cans a day, his weight recorded was 148 pounds.

Q. All right. He comes back in a couple of months, pursuant to your instructions, September of '87. What does he weigh then?

A. Weight increase 12 pounds. It looks like 160 pounds. "Patient feels sick and nauseated about every four to five days. Return to" -- again, I'm reading your underlined areas -- "return to Clinic, three to four months; Reglan ten milligrams b.i.d."

Q. All right. So he's actually doing pretty well. You've got him up to about 160 pounds in an eight month period of time; is that an accurate statement?

A. Yes, that's an accurate statement.

Q. Okay. And you're seeing him regularly and monitoring him.

Now he comes back in -- if you want to look at these for purposes of expediting the day a little -- you've got two scheduled visits early in 1988.

A. January 5, 1988, the weight recorded was

155 pounds. Your underlined segments say "weight has been stable according to patient, trouble with intermittent nausea and vomiting persists."

Q. Okay. Now just in terms of a generalized assessment, going way back to Mr. Kwarciany's talking to you about Mr. Weatherspoon's prognosis and your feeling about him to be lucky to be alive.

In that year period of time you took him from 114 pounds to a stable weight of a 155, correct?

A. Correct.

Q. If you had any concerns about any additional nutritional parameters I certainly would see a note about it, wouldn't I?

A. Probably.

Q. Okay. It seems like you saw him on a very regular basis, did complete blood work and mineral testing and kept him balanced -- that's how I like to say it, balanced. Is that your assessment of the situation?

A. It seems that he was pretty well balanced then, sure.

Q. All right. At that point what underlying health condition did Mr. Weatherspoon have that made him terminal?
A. At that point?
Q. Yeah.
A. I don't know that he had anything that made him terminal.
Q. Okay. Thank you very much, Dr. Steiger.

Now he did have some problem with nausea and vomiting on-going, didn't he?
A. Yes.
Q. Okay. And in fact, I believe that it was at your suggestion that he have an endoscopic evaluation in 1988. You want to take a look at that?
A. There's -- you don't have a report here.
Q. I'm sorry, I don't. But let me say this: I'll represent to you -- and I think the jury would be able to see it from looking at the chart -- that you decided that an endoscopy was a good thing for him. At that point Dr. Chung comes in the picture.

Dr. Chung does this endoscopic evaluation, correct? Do you see that in 1988?

A. Yes.
Q. So the jury knows, what kind of endoscopic evaluation was being done for the nausea and vomiting, if you can tell?
A. It looked like it was an upper GI endoscopy. He talks about a normal esophagus, no reflex, competent G junction, small gastric polyp. So it looks like it's an upper GI endoscopy.
Q. All right. And doesn't the note by Dr. Chung -- and I highlighted it for purposes of convenience -- indicate that there's no surgery necessary based upon that upper GI?
A. His impression was normal, post-Whipple upper GI endoscopy.
Q. Okay. Fair enough.
You continue to see him May of 1988. What's his weight?
A. May 10, 1988 weight is 155 pounds. The underlined sections say, "doing fair, weight stable at 155 pounds, taking 7 1/2 cans of Magnacal per day.
Q. Okay. And he comes back in August. How's he doing then, August of '88?
A. August of '88, weight is 70.7 kilograms. I

guess we would have to multiply it by 2.2 to get to the pounds.

58 year old black male status post-Whipple with GI motility disorder, weight stable at 155 pounds. Notes decreased nausea and vomiting, I think --

Q. Uh-huh.

A. -- has episodes every three to four days, no diarrhea, last lab is 8/10/88 it looks like.

Q. Okay. No notation of problems with the labs that you can tell?

A. There's no notation of problems with the labs, no. My last few words says "recheck labs."

Q. Okay. Moving along to November of 1988. Still stable. What's his weight?

A. Weight is 160.6 pounds, November lst, 1988. Underlined notes, "more difficulty with epigastric discomfort that comes and goes." And at the bottom, "Check SMA 18 plus Magnesium today."

Q. Okay. February, 1989 next scheduled visit, is he still stable with his weight and okay?

A. February, 1989 weight is 155 pounds, weight stable at 7 1/2 cans of Magnacal per day, is what the underlined notes say.

Q. Okay. Comes back per your schedule May, 1989. How's he doing?

A. May 19, 1989 the weight noted is 151.8 pounds, decreased weight on seven cans of Magnacal, advised to increase to eight cans to see if weight increases, feels -- but feels more epigastric aching is what the underlined notes say.

No longer adding trace elements, will check blood, studies including trace elements.

Q. All right. So now we are about two years and several months post that initial major hospitalization of 1987 where there was pneumonia and you put him on TPN and he's doing stable, isn't he?

A. Seems pretty stable, yes.

Q. Okay. The next scheduled visit from the charts, as I perceive it, was August of 1989 with your service.

Now it shows the patient didn't show up that day, right?

A. Right. "Patient cancelled."
Q. But there's a weight there, isn't there?
A. 162 pounds.
Q. Okay. Do you assume that he called you?
A. I would guess so. I'm not sure how they got that weight.
Q. Okay. Because the next thing I see in the chart is September, 1989 another GI evaluation and endoscopic evaluation by Dr. Chung?
A. September 28, 1989, looks like a Dr. Chung's name on top, right.
Q. Okay. Now the reason I'm asking you about this, you've told me that you went through the outpatient records, Doctor, you told me that previously in reaching some of your conclusions and the admission and discharge summary. So I want to see what of this you may recall.

Here's Dr. Chung's assessment on the next page from that upper GI, right?
A. Correct.
Q. All right. And if I'm reading this correctly, but you can look at it, I think it says normal surgical artifact that's

what he found on the upper GI. Do you agree with me that that's what the note says?

A. I'm not sure. Can you --

Q. Okay. Sure.

A. -- show me where.

Q. Uh-huh. Questionable probable normal surgical artifact --

A. Correct.

Q. -- where there's a prolapse of some sort. Do you see that?

A. Yes.

Q. Okay. I'm going to hand this back. Because the next thing that I then see happen is October, 1989 there's a completion gastrectomy done by Dr. Chung, right? Do you remember that?

Here's the surgical consult. You might want to look at that first.

A. Okay.

Q. Okay. Now if I read this note correctly -- and I think the handwriting is pretty clear in terms of the surgical consultation -- what's being planned is to remove yet more of the stomach, correct?

You can look. I'm sorry. I shouldn't have taken it back so soon.

A. Do you want me to read it out as --

Q. I'm just asking you if that's the same impression. There's a surgical note in the chart, I just don't happen to have it with me.

A. It's hard for me to make out -- he proposes exploration with Roux-Y and revision of gastrojejunostomy but no guarantee offered as to eradication of symptoms, patient agrees.

Q. Okay. Isn't the eradication of symptoms that's being discussed the nausea and vomiting?

A. I would guess so. It's not clearly stated there, but I would guess so. Unless there's something else that came up. The nausea and vomiting and abdominal discomfort were there, things that seemed to recur.

Q. At that point in time his weight was about up to 162. The nausea and vomiting still persisted, okay? That's pretty clearly what the notes show, the notes that you

read, your own notes, right?
A. I'm not sure what his weight was at that time, that he saw Dr. Chung, you mean?
Q. Right.
A. Does it say?
Q. No, it doesn't.
A. Okay.
Q. The closest weight we have is about a month before that visit.
A. Okay. So we don't know.
Q. Right. But there's nothing in Dr. Chung's note that says serve weight loss in the last month or so.
A. Okay.
Q. Okay. So if you stay with me, the purpose of this correction revision surgery was to attempt to ameliorate nausea and vomiting, correct?
A. You would think so. The reason I'm hesitating is that -- and this is just a memory way back then. It seemed to me that, I'm just remembering a conversation with Dr. Zama -- you would have to check with him -- that people who seemed intent in getting him off the tube feeding. I'm

not sure if that's the case, but for some reason that sticks in my mind.

Q. Well, how would doing the revision jejunostomy get you off tube feedings?

A. I don't know. Unless -- again, I'd have to reread that Dr. Chung's note. Unless he felt that his intermittent nausea and vomiting is what prevented him from eating and if the revision could prevent the nausea and vomiting maybe he would be able to eat. I'm not positive, but you could conjecture that.

Q. Over the years -- and I don't expect you to remember every detail, but you know you're here as a witness talking about his prognosis. Do you recall that he was still able to eat, take things orally?

A. I think he had good days and bad days, as I recall. There were times when he would be able to eat and times when he wouldn't be able to eat --

Q. In -- I'm sorry.

A. -- as I recall. But I can't remember exactly how much or --

Q. Back in 1986 you -- I don't want to use the

word installed. You placed a tube in Mr. Weatherspoon; do you remember that?

A. A feeding tube.

Q. A feeding tube.

A. Correct.

Q. Because I assume that you believed that his nutritional needs couldn't be met through oral intake; is that right?

A. Right.

Q. Okay. Now after the surgery -- I would like for you to just briefly look at this note, because at a later time you take care of the patient again, but not now.

October, 1989. What's Mr. Weatherspoon's weight?

A. 145 pounds.

Q. Okay.

A. No more nausea. Again, the underlined sections that you have.

Q. Okay. If I represented to you, Doctor -- and I'm going let you look through these notes -- that after the surgery in 1989 we go through a different period of management. Dr. Chung is now managing Mr. Weatherspoon's nutritional status.

Does that refresh your recollection as to what might have happened?

A. Yeah, I believe Dr. Chung was managing him then, correct.

Q. Okay. All right. November, '89 what's the weight then?

A. Weight is 135 pounds. Your underlined section, however, he lost ten pounds.

Q. Meaning after surgery he lost ten pounds, right?

A. I guess it was six weeks post-op from the first sentence of that note.

Q. Okay. He comes back in December of '89, he's a 132 pounds, isn't he?

A. Correct.

Q. Okay. During the year 1990 I have reviewed the outpatient records and I do not see any referral to your service for nutritional evaluation. All I see is Dr. Chung seeing the patient.

I'm going to hand you that stack of notes to see if you agree with me that it's only Dr. Chung who is seeing him.

A. January '90, Dr. Chung; February '90, Dr. Chung; March '90, Dr. Chung; June '90, Dr.

Chung; another June '90, Dr. Chung; January 1991, Dr. Chung.

Q. All right. And his weights are about 132 all during that year. If you want to review that just to be certain.

A. 132, 132, 132, 132, correct.

Q. All right. Now I looked through the outpatient records for laboratories that might have been done between the surgery and March of 1992 and I only found two. If I can find them. I'm so sorry. I have so many -- there they are -- pieces of paper.

In 1990 this looks like June of 1990. Can you tell the jury what the albumin was.

A. Albumin 2.6.

Q. Okay.

A. June 12th '90.

Q. That's a little lower than where you had him, correct?

A. Correct.

Q. All right. And then we see the only and next albumin in that chart on 5/7/91, about a year later. Can you tell the jury what the albumin is?

A. 5/7/91 albumin 2.2.
Q. Okay. Now we're getting back into a low range on that albumin, aren't we?
A. Yes.
Q. Okay. After that visit in June I went through the charts and I found no other visits regarding nutritional status by Dr. Chung, okay, until the spring of 1992.

Do you recall that Mr. Weatherspoon was admitted in April of 1992 to the hospital?
A. I don't recall but I suppose I could have my memory refreshed.
Q. Okay. During that time he was put back on TPN for about 20 something days because he had low albumin. Does any of this sound familiar to you?
A. Not offhand but I'd be happy to look at those dates.
Q. Okay. If I can find my chart dates, I have to apologize to the jury for a moment.

All right. We're going skip that because I'm going to represent to you that you were not involved in the consultations of 1992 until July of 1992.

I want to show you -- if I can locate it quickly -- a note written by your service in July of 1992.

First, let me ask you this question: One of the complications that you can run into on tube feedings, and I'm talking enteral nutrition, is diarrhea, correct?

A. Correct.

Q. All right. From your previous review of the chart, Mr. Weatherspoon did not have diarrheal syndrome from his tube feedings, correct?

A. Correct. Diarrhea was not a prominent part of his symptoms.

Q. In 1992 there is a -- actually a TPN consultation ordered. What's a TPN consultation?

A. When they request the services of the TPN team to evaluate somebody to see whether or not intravenous feeding would be appropriate for them.

Q. All right. There was a rather lengthy assessment by your service with your signature at the end. But I would like for you to read that last line on that

assessment.

A. Assess calorie intake with 100 CC per hour of Jevity, may in fact be adequate intake -- although this isn't clear to me, it may be because of the copy -- ascites -- it seems to say ascites, no diarrhea, will discuss further with nutritionist.

Q. All right. Let me ask you, Doctor -- because I've read this several times -- it says, "may in fact be adequate intake assuming no diarrhea."

A. That looks great, yeah.

Q. All right. Now that assessment says to me that the on-going use of enteral feedings is appropriate as long as there is no diarrhea?

A. It would seem to indicate that, yes.

Q. Okay. Diarrhea is a contraindication to continuing to attempt to give a person enteral nutrition, isn't it?

A. Yes. Depending on the severity and other things. But in general it's a sign to back off on the tube feeding.

Q. All right. Doctor, although there was not a formal consult -- or at least from my

recollection as we sit here -- in April of 1992 with your service, you did do a PNI, didn't you?

A. Correct. A PNI was done by the dietitians on the nutrition support team

Q. And he was back up to what number?

A. 109 percent on April 20th, '92

Q. All right. In March of 1994 Mr. Weatherspoon was admitted to the hospital again for nutritional issues.

You did a PNI then, didn't you?

A. Correct. There's a PNI March 23, 1994.

Q. Okay. And that PNI was 116 percent, wasn't it?

A. Correct

Q. Isn't that the same PNI that he had in January of 1987?

A. As I recall it was, yes.

Q. Okay. Not very good nutritional parameters at that point, are they?

A. No, very bad.

Q. Okay. Very bad. You were called in, as I recall it when you indicated this to Mr. Kwarciany, to do a consult in case there was going to be a surgery, right?

A. Correct. I believe that's right.
Q. Your note in the chart says -- it's very brief -- but it says severe malnutrition would benefit from pre-op TPN of surgery planned.
A. I believe that's correct.
Q. Okay. Those numbers on a PNI also indicate a need for an update or an upgrade in nutritional support, don't they?
A. Yes. They would seem to indicate that, yes.
Q. All righty, then.
But you weren't asked to do a consult, were you, on the nutritional parameters other than to advise on the surgery?
A. Correct.
Q. Okay.
A. I believe that's correct.
Q. I believe it is, too.
As of March of 1994 when you were called in on this surgical assessment, what terminal conditions did Mr. Weatherspoon have?
A. I'm not sure that I evaluated him for any

terminal conditions except that his nutrition was severe -- malnutrition was severe.

Q. Sure. Sure, it was. And he would be terminal for the malnutrition if it wasn't improved; would you agree with that?

A. There would be a very high risk of death after major surgery without improving his nutrition, correct.

Q. Would he be at high risk of death, since you've just offered that opinion, for his malnutrition if his albumin's didn't improve?

A. I guess my familiarity with the nutritional assessment parameters including albumin relate to post-operative morbidity and mortality, as opposed to people who have low albumins who aren't going to be undergoing surgery. But there are some people who can have very low albumins and still do pretty well.

Q. But you have to watch it, don't you?

A. You have to be aware of it, sure.

Q. Because as we've talked and you agreed very early on in my questions, the albumin is

the -- I'm going to use the word mediator, something the jury can understand. It's the mediator between the blood, the fluids and the tissues. It keeps things in their place, so-to-speak?

A. Correct.

Q. Do you agree with that?

A. Yes.

Q. All right. Doctor, you've just told me that you're more familiar in the setting of surgery. However, isn't most of your writing about home TPN?

A. Usually in surgical patients.

Q. Well, when you say usually in surgical patients -- unless I've misread this literature and I'm certainly glad to offer it to you -- you assess people whose digestive tracts become non-functional for purposes of providing nutrition?

A. Correct.

Q. All right. So you're not just evaluating people post-surgically for short-term home therapy, you've written extensively about long-term home TPN, haven't you?

A. Correct. Yes.

Q. All right. As I recall it, you published an article in 1995 but it was based upon studies of patients that you did between 1989 and 1992 and the textbook called Gastroenterology.

Do you remember that current use in clinical outcomes of home parenteral and enteral nutritional therapies in the United States?

MR. KWARCIANY: Let me show an objection for two reasons.

Number one, the date in question 1995 post-states anything that we're talking about in this case as the patient died in March -- or May of 1994. But secondly, and most importantly, it's my understanding that if you're going to question the doctor about those writings, it's for impeachment purposes only and so far you haven't set him up.

MS. TAYLOR-KOLIS: All right. That's not my understanding of the law. I'm not trying to impeach him of something somebody else has written. I'm trying to allow the jury to understand how well Dr.

Steiger understood TPN, how much he had worked in the field and what his conclusions are about people's chances for success living on home TPN.

Noting your objection, of course, the Honorable Judge Gorman will rule on this matter.

Q. In any event, you had done some studies, which eventually got published, regarding home parenteral and enteral therapies in the United States, correct?

A. Correct.

Q. All right. In your article on page 363, Doctor, you noted that the quality of the clinical outcome in TPN is good in all age groups.

MR. KWARCIANY: Objection.

A. In all honesty, I would really have to have the article in front of me.

Q. Sure. I have your article. How about that?

A. Very good.

Q. You can take my stickies off, if you want.

A. Page?

Q. Page 363. I probably have it highlighted.

A. Yeah, what it refers to, I guess -- you have to read the sentence before it: To examine the effects of age on HPN the outcome was evaluated in pediatric, middle-age and geriatric groups including patients who had Crohn's disease, ischemic bowel disease or a motility disturbance.

These three diagnoses were chosen because they occur in all three age groups. Although younger patients generally had a better outcome, the quality of the clinical outcome was good in all age groups. Again, it refers to those three diagnostic groups.

Q. All right. And essentially the sum and substance of that article is that no one should be disqualified from consideration for a home TPN simply because of their age?

A. Again, I haven't reviewed the whole article but that seems like a reasonable conclusion.

Q. All right. You might want to keep your article because I wanted to talked to you about this.

This article was a compendium of 9,288 patients treated from '89 to '92, as

I read the introductory material looking at the patient base you used.

On page 362, in terms of complications I think I'm going to quote this verbatim. It says: "The home sepsis rate is lower than in the hospital and death in all patients was only caused five percent of the time by the HPN itself." Is that what that says?

A. There's one sentence that says "this home sepsis rate was much lower than that experienced by in-hospital patients treated with parenteral nutrition." And above that there's a sentence "of those patients who died while receiving treatment, the therapy was documented as the cause of death only five percent of the time."

Q. Okay. So it shows that home TPN itself is fairly safe?

A. Can be, yes.

Q. Can be. And it can be made very safe by frequent monitoring by the physician who is in charge of the case, correct?

A. Correct.

Q. All right. As a matter of fact, Doctor, I

believe that one of your writings from -- I'm doing this a little bit out of order -- indicates that catheter sepsis is less likely now because of the use of streptokinase. Do you remember writing about that?

MR. KWARCIANY: Objection.

A. No. I don't remember about that. Streptokinase makes it less likely that you'll have an occluded catheter --

Q. Okay.

A. -- but not necessarily less likely that you'll get an infected catheter.

Q. All right. In 1982, a long time ago, you wrote an article entitled "Morbidity and Mortality related to home parenteral nutrition in patients with gut failure."

I think that what you wrote in that article on page 104 -- and if you would like to look at the article, so that I don't misquote you. It's 104 to 103 -- that first all, when people are on home TPN, their food and electrolyte balances are good. There's -- it's very uncommon to have a problem with that once you have a

person on home TPN?

MR. KWARCIANY: Again, show a continuing line of objection to this area of inquiry.

A. I'm sorry. The question was?

Q. I'm sorry. Basically -- if you want to look at page 103, I believe this is where it is. As early as 1982 you were writing that fluid and electrolyte imbalances were uncommon in people on home TPN; is that right?

A. Correct.

Q. Okay. And is that because it's an easier way to keep up their protein level -- a better way, I guess?

A. No. It's just that you monitor their electrolytes and their blood and you're able to add more or less to the TPN based on monitoring --

Q. Okay.

A. -- and usually there aren't significant problems with the electrolytes.

Q. All right. Can I borrow that back?

I only have a couple more questions. If the jury will bare with me, so that I

can find this. I have a lot of material obviously.

Doctor, back in 1994 did you know what the approximate per day cost was for home TPN?

A. In 1994?

Q. Uh-huh.

A. I'm not sure that I know what it was back in 1994 but my assumption has always been between -- around $150,000 to $200,000 a year.

Q. Yeah. You had written an article -- and if I can locate it in this morass of papers -- that indicated that home TPN was about $280 a day. Does that sound right to you?

A. It could be. I'd have to multiply that by 365 days to see what that final figure was.

Q. I can probably do the math at a later time, but I just wanted to see if you knew that number.

Let me ask you another question. The jury is probably going to see the outpatient records. After the 1992 hospitalizations, you and your team got back involved in Mr. Weatherspoon's care,

you started seeing him again.

As a matter of fact, in October of 1993 you did a PNI then, didn't you?

A. No, it should be noted that these PNIs or these computerized nutritional assessments are done by the dietitian members of the team for any patient in the hospital that they're asked to do it for.

So it doesn't necessarily mean that we've seen the patient formally. In fact, anybody in the hospital who's on TPN usually gets a routine nutritional assessment even though we, the physician part of the team, aren't involved.

Q. Okay. I'm not sure why you told me that. Let me just go back.

In October of 1993 there is a note that you were actually once again seeing Mr. Weatherspoon in the office setting to aide and assist with his nutritional parameters. Does that sound correct to you?

A. It may be. If you had the -- do we have time to look that up here?

Q. We can stay on the record or off the

record. I have the notes somewhere in this stack.

A. It should be in here. October '93, did you say?

Q. Yes, sir.

A. Here's a note here, October 19th, '93.

Q. That's exactly the one.

In the body of that note, I believe you even commented upon the PNI being 49 percent. Can you find that?

A. No. I don't see anything here about PNI in the body of that note, no.

Q. I'll tell you what, that's because it's in the November note.

I have it highlighted for you so you don't have to dig through the records anymore. I'm so sorry.

A. Yes. Nutritional assessment of 10/19/93, PNI 49 percent. I guess it was ordered on that date.

Q. Right. So he's got a PNI of 49 percent in October of '93, his albumin is about 2.4; is that what the sheets say?

A. Yes.

Q. Transferrin is what?

A. 293.
Q. Which is in a normal range, isn't it?
A. Yes, but that has to be translated, too, in terms of his hemoglobin or his blood count. Because a low count can give you an abnormally high transferrin, which may not be good.

That's one instance where high transferrin isn't good because it just reflects the low hemoglobin or blood count.

Q. Okay. Are you indicating that 49 percent wasn't a good nutritional index number?
A. 49 percent is better than the previous 88 or 109 percent.
Q. Okay. So he's doing much better.

Is it clear to you -- and I don't know if it is or isn't -- that somewhere between October 1993 and March 23, 1994 something dramatic happened to change Mr. Weatherspoon's nutritional index numbers?
A. Between those two days there's a dramatic decrease in the albumin and in the transferrin and an increase in the PNI.
Q. Okay. And you weren't asked to evaluate at any time what caused that change, were you?

A. I don't recall, to tell you the truth.
Q. Okay. As of today's date have you ever read the hospital records for Mr. Weatherspoon's final hospitalization at the Cleveland Clinic?
A. I still haven't. I know that came out before and I still haven't read that final record.
Q. All right. Doctor, I only have one other question. If I can promptly find your CV. We had talked previously about Dr. David Grischkan's CV compared to yours.

MR. KWARCIANY: Show an objection to this line of questioning. This is clearly beyond the scope of direct examination.

MS. TAYLOR-KOLIS: Well, you know what, I'll withdrawal it and we'll let the jury examine them for themselves. I don't have any further questions.

REDIRECT EXAMINATION

BY MR. KWARCIANY:
Q. Doctor, very brief re-direct. You told Plaintiff's counsel earlier that home TPN

can be more dangerous than enteral feedings. What did you mean by that?

A. There's a greater chance of infection, there's not the -- there has to be much greater sterility involved in preparation of the solutions, in administrating of the solutions and in taking care of the access device -- the intravenous feeding access device compared to feedings going through the GI tract.

Q. Now we've heard you tell us a little bit about the costs associated with home TPN being *$280* a day or somewhere between $150,000 and $200,000 a year.

Can you contrast that with enteral feedings? What's the cost associated there, do you know?

A. I would guess it would be less than $20,000 a year or around *$20,000* a year.

Q. At any time after you resumed management of this patient from a nutritional standpoint, from the summer of 1992 through March of 1994 did you ever make any recommendation to Mr. Weatherspoon or to his family that he should go on home TPN?

A. Not that I recall.
Q. When you last saw the patient in March of 1994 did you make any recommendation to Dr. Chung at that time that the patient should be placed on TPN there in the hospital?
A. There was that one time -- if they were going to be doing surgery I made the recommendation that he should be, if that's in that time limit.
Q. Do you have any recollection as to whether or not the family wanted the patient to undergo home TPN?
A. I don't have a precise recollection. Again, it's something that should be corroborated with Dr. Zama, the family. It seemed to me that they did not want him to be on home TPN but I don't have any direct recollection of that. It's just an impression that I have. But I can't say that's 100 percent.

MR. KWARCIANY: Thank you, Dr. Steiger. I have no further questions.

RECROSS-EXAMINATION

BY MS. TAYLOR-KOLIS:

Q. I have a couple of things.

First of all, so that the jury is perfectly clear on this, enteral feeding and parenteral nutrition don't equal one another, they are not the same thing for the same reasons, correct?

A. There's different ways of providing nutrients to people.

Q. All right. And it isn't you get to randomly pick? In other words, Doctor stay with me, when a person is digestively dysfunctional, as was Mr. Weatherspoon, you always try enteral first, don't you?

A. Correct.

Q. And you do it, A, because of the cost, correct?

A. Correct.

Q. B, so that a person can have some part of their body still functioning, correct?

A. Correct.

Q. All right. C, emotionally it's a little easier to be on an enteral feeding than it is to be on a total parenteral source, correct?

A. Yes, it is.

Q. But when a person reaches a stage where it is manifestly clear that their body will not do what it is supposed to on enteral feedings they then go to total parenteral nutrition, don't they?

A. Yes. If they're not able, for whatever reason, to use the enteral nutrition then TPN is the next step.

Q. And when we say -- when we get to the phase where their body can't use it, what we mean is that they are not efficiently, effectively receiving the nutrition that they need to live through the enteral source; isn't that what we mean?

A. It depends what you mean by that. Obviously, you have to examine to see why they're not getting it. Are they really getting all the nutrients that were ordered for them? You'd have to look at that. You'd have to look at if there's any psychological gain to be gained by dumping nutrients down the drain, we've had that happen in some patients, not self administering the enteral nutrition for other reasons that they wanted a vascular

access device in.

You have to look at the whole person and evaluate everything.

Q. Sure, you do. But when you've tried for years to maintain a person on enteral feedings and their critical numbers -- or transferrin and albumin aren't being maintained, that would be a very high indication to put them on TPN, wouldn't it?

A. There would be a high indication to think about why it's not being maintained and try to figure it out and improve it and if you can't to consider TPN, sure.

Q. In terms of some vague recollection you have about the family not wanting him on TPN. TPN is nobody's first choice, is it, Doctor?

A. No.

MS. TAYLOR-KOLIS: All right. I don't have any further questions.

MR. KWARCIANY: Nothing further.

Doctor, because of the time constraints involved here, the parties have agreed that we can go ahead and waive your

signature and waive the viewing of the video tape and the filing.

MS. TAYLOR-KOLIS: Well, I would only say this just to be my usual comedic self, you never waive a trial depo. I mean you can't correct anything if you're on the stand but absolutely as to a waiver, and everything else. We're on a short time and everybody just do the best you can do. Thank you.

MR. KWARCIANY: Thank you, Doctor.

VIDEO TECHNICIAN: We're off the record.

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

I, Diane D. Barto, a Certified Professional Court Reporter and Notary Public within and for the State of Ohio, do hereby certify that the within named witness, EZRA STEIGER, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotype in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 2nd day of December, 1996.

Diane D Barto

Diane D. Barto, Holland & Associates Inc.
2000 E. 9th St., #608, Cleveland, Ohio, 44115
My commission expires 11-27-97.