IN THE COURT OF COMMON PLEAS
FOR THE STATE OF OHIO, COUNTY OF LORAIN

LENORE LIND, et al,

Plaintiffs,

vs.

COMPREHENSIVE HEALTH CARE OF OHIO, INC., et al,

Defendants.

CIVIL DIVISION
Case No. 93CV110798

DEPOSITION TRANSCRIPT OF:
Ronald A. Stiller, M.D.

DEPOSITION DATE:
February 2, 1995

Doc. 429

PARTY TAKING DEPOSITION:
Plaintiffs

COUNSEL OF RECORD
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REPORTED BY:
Rebecca L. Schnur, RMR
Notary Public

ORIGINAL

DEPOSITION OF RONALD A. STILLER, M.D., a witness, called by the Plaintiffs for examination, in accordance with the Ohio Rules of Civil Procedure, taken by and before Rebecca L. Schnur, RMR, a Notary Public in and for the Commonwealth of Pennsylvania, at the Holiday Inn, 100 Lytton Avenue, Pittsburgh, Pennsylvania, on Thursday, February 2, 1995, commencing at 1:25 p.m.

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* I N D E X *

* INDEX OF EXHIBITS *

RONALD A. STILLER, M.D.,

having been duly sworn,

was examined and testified as follows:

- - - -

EXAMINATION

- - - -

BY MR. KAMPINSKI:

Q. Doctor, would you state your full name, please, sir.

A. Ronald A. Stiller.

Q. Have you been deposed before, sir?

A. Officially, I don't think so.

Q. Does that mean you have unofficially?

A. Well, I was at a discovery once. I had a patient who was an attorney who had kind of a rocky course, and he decided that he wanted to have a discovery. And I remember meeting with him with hospital counsel, but I don't think that was a formal deposition.

Q. Okay. Have you ever been retained as an expert before?

A. Somebody once asked me to review a case two or -- It was more than that. It was about three or four years ago. It never amounted to anything. I reviewed a case, and I submitted a written

narrative. The case never came to trial. And I have seen a couple of patients for asbestos exposure. And that's been about it.

Q. I take it then you've never testified in court before.

A. That's correct.

Q. Do you know how it is you were retained in this case?

A. I was asked by Dr. Arthur Greenberg at the University of Pittsburgh Medical Center if I would be willing to review a case, and I agreed.

Q. Who is Dr. Arthur Greenberg?

A. Dr. Greenberg is a physician who has provided expert consultants for attorneys in the past. To be honest with you, I don't remember the name of his company. I think Mr. Feltes and his office have dealt with Dr. Greenberg before.

Q. How do you know that?

A. Because Mr. Feltes' associate, Mr. Reichel, knew of Dr. Greenberg.

Q. If I understand correctly, Dr. Greenberg runs a service that assists in attorneys finding physicians who would be willing to look at cases and testify?

A. Right. That's my understanding.

Q. Had you registered with Dr. Greenberg, or how is it that he called you?

A. He knows me. He knows I'm a pulmonologist, and he was looking €or one.

Q. Do you know if he contacted other pulmonologists before you?

A. I don' t know.

Q. Is he here in Pittsburgh?

A. Yes. He's on the faculty at the university.

Q. I see. That's how he knew you?

A. Yeah.

Q. And this is a separate business that he has, that is, obtaining experts for attorneys?

A. I believe so. I've never asked him about it, but, I mean, it's not related to the university in any way as far as I know.

Q. Do you know the name of that company?

A. Not of€ the top of my head, no.

Q. All right. I assume you're paid for the time that you put in. Are you paid by him or Mr. Feltes, or how does that work?

A. I'm paid by him.

Q. All right. And how much do you get paid?

A. I think -- I think it's $200 an hour, but I'm not

sure.

Q. All right. So he made the first contact with you?

A. Uh-huh. Yes.

Q. And was your contact after that with Mr. Feltes or someone with his firm, or was it all through Dr. Greenberg?

A. I spoke to Art a couple of times, since this is kind of a new adventure for me, so I needed a little bit of guidance. But then I was contacted by Mr. Reichel, and except for one or two occasions I have dealt solely with Mr. Feltes and Mr. Reichel.

Q. All right. Did Dr. Greenberg have any input into the formulation of your opinion at all?

A. No, he did not.

Q. Do you know what kind of physician he is?

A. He's a nephrologist.

Q. Had he reviewed the case before calling you?

A. I'm not sure. He knew something about the case because he told me that the attorneys were looking for a pulmonologist who could evaluate an ICU course, so he knew that much, but I don't know if he reviewed any of the depositions or anything.

Q. Did you get any summaries from him or anything of that nature, indicating his understanding of the

case?

A. Huh-uh. No.

Q. What's the first -- Did you receive any correspondence from him at all?

A. Only a letter confirming that I was willing to review the case.

Q. When was that? Do you have that with you?

A. I don't know. I don't think so. I'm not sure.

Q. Did you bring your file here with you today?

A. Well, I have this, and I have a bag of things, which has a variety of depositions and whatnot. But do you want me to look for Dr. Greenberg's --

Q. Why don't you just pull it all out because I'm going to ask you to show it to me anyhow.

A. Can't you guys do this electronically? That's everything.

Q. Has anything been removed from your file prior to right now?

A. No. Actually, everything was added this morning.

Q. Where is the correspondence pertaining to this case?

A. I don't know. I'm not -- Well, I'll just go through the pile. I don't know whether it's even here.

There is a letter from -- Okay. There you go.

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(Documents marked for identification Deposition Exhibits Nos. l-A, l-B, l-C, l-D, 1-E.)

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Q. All right. Doctor, I'm going to hand you each of these in order just so we can identify them for the record. Okay. Exhibit l-A is not addressed to you but rather to Dr. Greenberg. Correct?

A. Correct.

Q. It's a March 9, 1994 letter from Attorney Reichel. Apparently, that was forwarded to you then by Dr. Greenberg in accordance with Exhibit 1-B here.

A. Uh-huh.

Q. Okay. And if you would, identify what 1-B is.

A. 1-B is a letter from Dr. Greenberg outlining the position of the attorneys with whom I would be associated and also kind of giving me some guidelines as to what I'm supposed to do.

Q. And that's dated what?

A. March 21, '94.

Q. All right. And with that letter he forwarded the materials, I assume, that are set forth in the letter to him that had been marked as l-A. Would that be correct?

A. That's my recollection, right, in addition to -- Oh, yeah. Right -- and the medical records. Right.

Q. In the letter that is 1-B he refers to a chronology that he's also forwarding. What is he referring to there?

A. I don't know whether this is it or not, but there is a section in the beginning of the chart here that is, I think, labeled chronology.

Q. Okay. Did you put this in the folder, or was it in the folder when you got it?

A. I put nothing in that folder other than that little piece in the front there.

Q. Do you know who prepared this?

A. No, I do not.

Q. Is the rest of what's contained in this black folder medical records?

A. Yes.

Q. So this portion labeled chronology would be the only part that is not part of the medical records?

A. Yes. I think so.

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(Documents marked for identification Deposition Exhibits Nos. 2-A, 2-B and 2-C.)

- - - -

Q. I'm going to hand you what's been marked as 2-A, B and C. If you can, identify just what that is, sir.
A. It is listed as a chronology, which was in the front section of the medical record that was sent to me through Dr. Greenberg's office.
Q. And that was referred to in Exhibit 1-A -- 1-B rather?
A. Correct.
Q. Now, if you would, just identify what 1-C is.
A. It's a form letter from Dr. Greenberg, which I guess is kind of an agreement concerning --
Q. The date on that is what, sir?
A. I don't think there is one.
Q. Undated?
A. Undated.
Q. Okay. And then 1-D?
A. This is a format of the case evaluation sent by Dr. Greenberg just kind of giving me headings in terms of how I should present the narrative.
Q. And then 1-E?
A. A letter from Dr. Greenberg dated April 9, indicating that some material that I was looking for that was not in the medical record was forwarded to me. There was one page that was missing.

Q. Do you know what page that was?
A. No. I can't remember exactly. I want to say 326. I'm not completely certain because it's been a while. I think there was some blood gas data on there though that was not available when I was doing the preliminary review.
Q. Is that something that you could pull out by looking at it? I mean, did you put it in here?
A. Yeah, it's in there. I really don't have a clue. I can't remember now.
Q. But you think it was a page of the record that you just didn't have?
A. That's correct.
Q. You referred a few minutes ago to additions to the record today or additions to, you know, what you had. Did you get additional material today?
A. Today? No, I got nothing additional today.
Q. All right. Did you get anything additional after these letters that we've gone through?
A. Subsequent to my initial review I got, I think, three more depositions concerning Mrs. Lind's care in radiology. I think one was a radiology nurse. And I don't remember everybody involved. So there were like three more depositions that were sent to

me by Mr. Reichel some months after my initial review of the case.

Q. Anything after that?

A. I had returned the bulk of the material to Dr. Greenberg after I was completed with it, for some reason or other anticipating, maybe based on my prior experience, that that was going to be the end of it. He held it. And when I was in communication with Mr. Feltes, he suggested I take a quick look-see at the medical record again, so I called Art and asked that everything be given back to me.

Q. I see. So he still had it all?

A. That is correct.

Q. So what we've got here today is everything that you looked at initially plus the few depositions that you referred to, and that's it?

A. I believe so.

Q. All right. You haven't gotten then any of the expert depositions?

A. That's right. I'm sorry. Yeah. Good point. I got Dr. Mazal's deposition.

Q. Yeah.

A. I got Dr. Martin's deposition, and I don't remember what else because those were the two that I read

most recently.

Q. I'll tell you what: Why don't you just hand me what you've got there and let me take a look at it. Just hand me the stack so I can tell what you do have and what you don't have. I would do it myself but --

A. I understand. I have been in a similar situation, but I had my surgery and I ski now.

Q. I'm happy for you.

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(Documents marked for identification Deposition Exhibits Nos. 3-A and 3-B.)

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Q. Would you identify this, please?

A. This was my initial --

MR. SCOTT: What is the exhibit number?

THE WITNESS: 3-A and B.

MR. SCOTT: Thank you.

A. This is my initial draft that I sent -- after reviewing the case, that I sent to Mr. Reichel in April of '94, where I discussed, according to the outline provided by Dr. Greenberg, my assessment of the case.

Q. Do you have a copy of your report somewhere? Is it in these materials here?

A. I got it here, I think.
Q. Do you have it there?
A. Yeah.

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(Document marked for identification Deposition Exhibit No. 4.)

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Q. Doctor, I've marked as Exhibit 4 a report of yours also. Correct?
A. Correct.
Q. That doesn't have your name on it or any letterhead. Neither one does, I don't think.
A. No, it doesn't.
Q. Is there a reason for that?
A. I didn't think it was appropriate.
Q. The forwarding letter that you referred to, that you sent this to Mr. Reichel, do you have that anywhere, or didn't you keep copies of it?
A. Of --
Q. Of the letter that you sent to him.
A. No. I sent him this, the initial --
Q. Referring to 3?
A. Yeah. I sent him 3. I mean, I probably sent a little cover letter with it. I don't have it. This

is what I gleaned from reading the case.

Q. 3-A and B are different than 4.

A. That is correct.

Q. What is the reason for that, sir?

A. After Mr. Reichel received 3-A and B he called me. I basically sent this to him, saying: Well, this is my first shot at doing something like this, 3-A and B.

Q. Right. Okay.

A. And how does it look? I mean, is this good? Because I really -- You know, I need a little guidance. He said it was fine, and he asked me to prepare what he described as kind of a summary for other counsel in this document, 4.

Q. Uh-huh. I mean, how was it decided what would be taken out of 3 and left into 4? Did he offer you some guidelines as to that?

A. Not really. What he said to me was that his firm was primarily interested in -- from me, anyway -- was interested in the care provided by the nurses and the sort of immediate peri-arrest period. And it was with that in mind that I elected -- I mean, without guidance, I just elected to remove certain bits of data that were obtainable

through the medical record, and I felt, you know, with the idea of trying to be concise and to summarize that were redundant, simply by repeating, so that was how I did it.

Q. Some of the material -- And I'll refer to them specifically -- contained in 3, not contained in 4 are your opinions as opposed to things contained in medical records. Is that true?

A. That's correct. I don't know if I eliminated anything -- Well, tell me what you're thinking.

Q. Sure. Let's see. You make this comment on 3-A, which is the first page. You can read along with me to make sure I'm reading it right. Do you have another copy of this?

A. I don't. That's it for me.

Q. Okay. All right. Quote: I do feel that the -- and now is a quote of yours in that sentence --

A. Right.

Q. -- no sedatives, end quote -- still quoting -- order of May 6, '92 was inappropriately ambiguous, i.e., it did not delineate the specific drugs of concern to the ordering physician, particularly in view of the fact that the only sedating drugs which the patient was receiving were midazolam (Versed) and

meperidine.

Okay. That's not contained in 4. And this is, I guess, your opinion as to the adequacy of the order with respect to the sedatives. Correct?

A. Right.

Q. In other words, you don't feel that the order was written adequately to alert the nurses. I mean, is that what you're saying?

A. Yeah. I thought it was an ambiguous order.

Q. Is there a reason that you took that out of Exhibit 4? I mean -- All right. Let me ask it differently. Let me withdraw that.

Were you told to --

A. No.

Q. -- take out -- Let me finish the question.

A. Okay.

Q. Were you told to take out criticisms of any of the other physicians? I mean, you're being critical of the doctor who wrote the order there.

A. Yeah. No is the answer to the question. The specific charge, after speaking with Mr. Reichel, was primarily directed toward the care provided by the nurses. And I think that as I was thinking through what I had written in the initial draft, I

was, personally -- my opinions aside ---I was somewhat reluctant to be accused of casting stones at a colleague if that wasn't my charge.

Q. Okay. All right. You also withdrew, however, the part of that where you cast aspersions on the nurses' conduct, where you said: I must also fault the nursing staff, not for actions which may have contributed to the patient's arrest but rather for failing to recognize and/or respond to the order in question. It is reasonable to assume that a qualified ICU nurse is aware of sedating effects of meperidine and, therefore, should have considered contacting the responsible physician for clarification of this order.

I mean, that's not contained in Exhibit 4, and that does relate to the nurses, to what your charge was.

A. Correct.

Q. Why was that taken out?

A. I was not directed to take it out. It seemed like the right thing to do at the time. I mean, I wasn't -- Nobody was telling me to delete certain areas of the initial draft.

It just -- I was sort of on this playing

field and I'm wearing the red shirt; the other guys are wearing the white shirts, and it just seemed that's what I was kind of dealing with. I was trying to be as honest as I could without --

Q. Lenore Lind isn't wearing either a white shirt or a red shirt.

A. Fair enough.

Q. If I understand what you're saying to me -- I mean, you took an advocate's position as opposed to an expert -- independent expert's position in the decision to remove that particular sentence.

MR. FELTES: Objection.

A. That was not my thought at the time.

Q. That's the effect of what you did though.

A. Perhaps, in retrospect. Perhaps. That was not my intent.

Q. In the middle of the next sentence -- I'm now on 3-B where I was with the last quote. You go through what occurred in between the time she came back from the HIDA scan and then the decision to transport her to radiology for the abdominal CT, and you state -- and I'll quote:

In my opinion, this decision in the absence of any additional therapeutic intervention

represented an error in judgment on the part of the treating physicians. As the clinical record shows (page 612), at the time of transport, the patient was markedly tachycardiac and tachypneic and had remained so on the morning of May 7, 1992. The respiratory rate throughout the morning of the arrest ranged from 46 to 56 breaths per minute which represents a significant increase in the patient's work of breathing and should have suggested to the examining physicians the possibility of impending respiratory failure. Furthermore, an arterial blood gas at 10:46 a.m. revealed that the patient was significantly acidotic, and no follow-up blood gas immediately prior to the CT was obtained to confirm that the patient was stable enough for transport. While I agree that the CT was a reasonable diagnostic test, I do not feel that sufficient attention was paid to stabilizing the patient prior to transport. I believe that the persistent metabolic acidosis and tachypnea led to worsening respiratory muscle fatigue, which culminated in the respiratory arrest. This hypothesis is supported by the arterial blood gas obtained at 14:46 on the day of the arrest (Lab Reports, page 330) which shows

severe, combined metabolic and respiratory acidosis, for which the patient was unable to compensate.

That's not in your report contained in Exhibit 4; is it, Doctor?

A. I don't recall. No, but it's summarized in Exhibit 4.

Q. Yeah. In fairness to you, you sort of hint at it. In your last paragraph you indicate that she was tachycardiac and tachypneic and that ABG at 10:46 showed significant acidosis and no follow-up blood gas. What you don't say, however, was your criticism of the physicians for failing to do that. And, once again, I take it the reason you didn't put that in 4 was what you stated earlier, that is, you didn't believe that that was your charge.

A. Correct.

Q. It was, however, your opinion -- and I take it it still is your opinion -- that they failed to adhere to the standard of care required of them in taking these additional tests prior to sending her down for CT.

MR. SCOTT: Objection.

A. My opinion, as stated in the initial draft, is certainly unchanged.

Q. Okay. Well, I mean, did I state it incorrectly?
A. No. I have a problem with the concept of standard of care.
Q. Okay.
A. I don't -- I just am not -- There is no written document to that effect. There is no, quote, unquote, standard of care. We don't get little manuals when we graduate from medical school. So when one uses the term standard of care, I'm somewhat reluctant to just headlong agree.
Q. Okay. Let me state it in a different way that perhaps you're comfortable with. The doctors treating Lenore Lind should, in fact, in your opinion, have done additional tests prior to sending her down for the CT?
A. If I were one of the physicians caring for Mrs. Lind, I certainly would have performed additional tests.
Q. It's your opinion that the physicians that were caring for her should have --
MR. SCOTT: Objection.
Q. -- based on her condition?
MR. QUANDT: Join.
A. Again, you know, it's very difficult to be able to

conclude or imagine what other physicians saw, having never stood at the bedside. Again, suffice it to say, I believe that if I were one of the physicians caring for Mrs. Lind, I would have done additional interventions and evaluations prior to transport.

Q. Such as what?

A. At the very least I probably would have obtained another blood gas.

Q. What do you think that would have shown based upon what you've seen in the chart?

A. I believe it probably would have shown worsening respiratory acidosis.

Q. Given that, what should have been done with Mrs. Lind?

A. What I would have done with Mrs. Lind, if that were the case and she were, in fact, physiologically, as I imagine her to have been based on my review of the record, I expect that I would have either elected not to send her to the CT scan, feeling that she was too unstable, or I probably would have intubated her.

Q. All right. You have a section on Exhibit 3-B called additional comments. Let me read those into the

record.

As I have suggested above, at least some of the difficulties experienced by the patient prior to her respiratory arrest may be related to premature discontinuation of mechanical ventilatory support. According to Nursing Care Records (page 980), the patient was extubated at 1:00 p.m. on May 6, 1992. A blood gas obtained at 9:50 a.m. revealed significant acidosis with a pH of 7.25 (page 981) which would lead me to question the decision to discontinue mechanical ventilation. Following extubation, the patient remained tachypneic (28 to 40 breaths per minute) and acidotic (pH 7.32) and required several doses of sodium bicarbonate. On the day of the arrest, the patient's tachypnea was more pronounced (40 to 56 breaths per minute), and she remained acidotic. In the face of this continuing respiratory stress, I believe that the patient eventually fatigued and arrested. In my professional opinion the condition of the patient on the morning of May 6, 1992 should have alerted the physician that extubation was premature, and further, that the events documented on the morning and early afternoon of May 7, 1992

should have suggested impending respiratory failure and the need to re-intubate the patient prior to additional diagnostic studies.

That's not contained in Exhibit 4; is it, sir?

A. Nope.

Q. And does that remain your opinion as we sit here today?

A. Essentially, yes.

Q. Were you provided with the emergency room records at all?

A. I don't think so. Not -- Well, wait. Maybe I was. I don't know that I looked at it though because I was dealing primarily with the peri-arrest period. There is a section in the medical record that I was provided with that is labeled ER record.

Q. Did you review those at all?

A. No.

Q. Doctor, are you a board-certified pulmonary medicine physician?

A. Yeah.

Q. Are you board certified in internal medicine?

A. Yeah.

Q. Do you spend more than 50 percent of your time in

the clinical practice of medicine?

A. Uh-huh. Yes.

Q. Do you have any opinions with respect to the emergency room care that she was provided with?

MS. MOORE: Objection.

A. I do not.

Q. All right. Doctor, if at any time throughout the rest of my questioning you need to refer to any of the records or depositions, I mean, feel free to do so. Okay?

A. Thank you.

Q. Do you consider a PDR an authoritative source for various medications?

A. Oh, not -- Well, it's kind of hard to say. PDR information is provided by the drug companies; so, therefore, one can't view them as being totally objective.

Q. Are you suggesting they're going to hype their drug in there, or they are going to be overprotective in terms --

A. In the current day and age of complete disclosure I think some would question. It's a reasonable reference. It certainly is helpful.

Q. Okay. It can tell you some of the side effects o

drugs --

A. Sure.

Q. -- some of the contraindications, things of that nature?

A. Yes.

Q. I take it in that regard it's better to be over-inclusive than under-inclusive.

A. Yes.

Q. For you, as a physician looking up a drug, I mean, you want to know all the possible potential side effects and harmful effects?

A. Pretty much.

Q. From looking at both -- By the way, were there any other reports other than what's contained in **3-A** and B and 4 --

A. No.

Q. -- or are these the only ones?

A. That's it.

Q. Were you apprised at any time that **3-A** and B would not be forwarded to the other attorneys, including myself, in this case --

MR. QUANDT: Objection.

Q. -- or did you know one way or the other?

A. I didn't know one way or the other.

Q. All right. So you really left that up-to Mr. Reichel and the attorneys as to what they felt appropriate to send me and what they didn't?

A. I have enough trouble doing medicine, let alone law. Yes.

Q. Okay. Have you had an opportunity to review Dr. Mazal's deposition before today?

A. Yes, I have.

Q. I take it -- Well, I won't take it. Do you still disagree with his analysis of the effects of the administration of Demoral as is set forth in your reports?

A. Dr. Mazal went on somewhat, as I recall, at length, giving generalities as well as particulars with respect to the administration of Demoral, so his -- I think his generalities were reasonably appropriate.

Q. Okay. What about the specifics as they pertain to this case?

A. I looked at this once. And, as you know, it was six hours, 200-plus pages --

Q. Right.

A. -- so I don't remember each and every detail. One particular point that does stand out in my mind was

Dr. Mazal's contention that the Demoral, because of Mrs. Lind's body habitus, hypotension, et cetera, would accumulate and then suddenly, kaboom, it would sort of have its impact on the patient some hours later, and one would account -- which could account for its contribution to the respiratory arrest. I don't know that I fully agree with that.

Q. Okay. He was asked by Mr. Reichel about whether or not it would have been metabolized or expelled from her body by the time of the arrest and he said no. There weren't any follow-up questions by Mr. Reichel in that regard.

Do you have any opinion as to that in light of her condition at that time?

A. The half-life of Demoral is four to five hours. To totally clear a drug from the system takes approximately five half-lives.

Q. So it would not have cleared?

A. It would have not totally cleared. That's correct.

Q. How does it clear? How does Demoral clear somebody? I mean, what process is used? Is it cleared through the kidneys, liver? I mean, what happens?

A. It's my understanding that the liver processes it, but there are some active metabolites that are

excreted by the kidney, but, to be honest with you, I'm not 100 percent sure.

Q. Wasn't she having some liver and kidney abnormalities?

A. That is correct.

Q. Would that have had any impact on the time in which the Demoral would have either acted upon her or been excreted?

MR. QUANDT: Objection.

A. It could, yeah, but the question that you have to consider is what is the therapeutic dose of Demoral. I can't give you the answer for that. I don't know the number of milligrams per milliliter of serum. And how much --

MR. QUANDT: Move to strike the answer.

Q. Go ahead.

A. -- and what the effective concentration of Demoral was at any one time in Mrs. Lind.

Q. I see.

A. Obviously, as has been stated numerous times in the record, she was -- is an obese woman. Demoral is a lipid soluble. How much would be stored -- The volume of distribution is large. How much would be released from the lipid stores at any one time I

don't have a clue; I couldn't begin to imagine.

So, yeah, while the clearance might be impaired, the question -- and no one knows -- the question is what was the effective serum concentration at any one time.

Q. So it's the delivery as opposed to the clearance?

A. Yeah.

Q. That's really the issue?

A. Right.

Q. I see. And there is no way that you can tell that from looking at the record, or is there?

A. Well, by looking at the record one can, I think, get some inferences as to the effect of the Demoral. Now, I think it was after the second dose at 2:00 a.m. She was in a great deal of pain. It was 2:00 a.m. on the morning of the 7th of May. She was in a great deal of pain. She was administered an additional 75 milligrams IM of Demoral without, by the way, any adjunct agent, such as Vistaril, which is commonly given. I mean, she just got it as a single agent, so there was no sort of synergistic effect.

According to the nurses' notes, shortly following the administration of Demoral she

experienced some degree of pain relief. However, at no point did they comment that her mental status was in any way impaired, nor did they comment that she was particularly lethargic. And, indeed, shortly thereafter the nurses' notes go on to indicate that she was moaning and groaning for pain again, so that the effect of Demoral was very short-lived.

Q. That's assuming it took any effect at that time.

A. Assuming it took effect at all, that's correct. The only reason I would conclude that perhaps there was an effect was based on the nurses' notes that indicated she was feeling less uncomfortable following the second dose.

Q. I take it the increasing respirations throughout the morning and -- or evening and morning of the 6th and 7th was as a result of her worsening metabolic acidosis. Would that be a fair statement?

MR. QUANDT: Objection.

A. That's a possibility.

Q. Do you have an opinion -- any other opinions as to why it was worsening?

MR. SCOTT: Objection.

MR. WEITENDORF: Objection.

A. I'm supposed to keep talking. Right?

Q. Yeah.
A. In the setting of respiratory failure the body's compensation mechanism is to initially decrease tidal volume. And as one decreases tidal volume with increasing respiratory fatigue, muscle fatigue, one increases the rate.

So the underlying etiology for the lady's problem was at least the metabolic acidosis and whatever else was going on. One could postulate that her increasing rate on the morning of the 7th was a reflection of that fact, that this lady was starting to deteriorate further.

MR. GALLAGHER: Objection.

A. This is speculation now.

MR. SCOTT: Objection.

MR. GALLAGHER: Continuing objection.

Q. Doctor, look, your opinions are your opinions, and you're basing them on the record. Correct?
A. Well, I'm basing -- You asked me for another possible mechanism to explain why this lady's respiratory rate could increase. I'm giving you another possible opinion --
Q. That's fine. Go ahead.

MR. GALLAGHER: Objection.

A. -- and that being that her tidal volume-was going down, and to compensate in whatever way she could, ventilatory rate was going up.

MR. QUANDT: Objection. Move to strike it.

Q. So that we can't then readily determine whether or not the Demoral was having an effect based upon her respirations. I mean, it may or may not have because her respirations, apparently, were increasing aside from anything the Demoral might have been doing. Does that question make sense?

A. Yeah. You know, the mechanism of respiratory depression with a narcotic, an opiate, is to decrease ventilatory drive.

Q. Okay.

A. There is no evidence this lady had a decrease in her ventilatory drive. She was breathing for all she was worth.

Q. But we've already talked about why she was doing that. Right? I mean, you've given me a couple of possibilities as to why she was doing that.

A. Yeah.

Q. All right. And it might have been, in fact, greater respirations had it not been for the Demoral.

MR. FELTES: I object.

Q. I mean, it may have, in fact, been having an effect, yet we don't necessarily see it in the numbers.

MR. FELTES: Objection.

MR. QUANDT: Objection.

A. We are clearly speculating here. I'll give you a for-instance.

Q. Okay.

A. All right. The lady gets Demoral, and what she might do is have depression of her chemosensory cells. In other words, let me -- I'll say it simply.

Q. Okay.

A. She gets respiratory depression from the opiate, and what happens is her respiratory rate goes down.

Q. All right.

A. It's not that her muscles get weaker from the opiate so she tries to breathe faster. It's just with the opiate on board affecting the central nervous system her rate is going to drop.

Q. I follow you. And I think that's one of the things you said in your report, that her rate didn't drop, which leads you to believe that it didn't have an effect.

A. Correct.

Q. I guess my question is a little different though, and that is: If we're hypothesizing, could it not, in fact, have had an effect and yet not been shown in the numbers? In other words, had she not been given Demoral, as opposed to a respiratory rate of, let's say, 46 or 48 at any given time, it might be 56 or 58.

MR. FELTES: Objection.

MR. QUANDT: Objection.

Q. Do you follow what I'm saying?

A. I follow what you're saying. You are, therefore, postulating that one would envision a decline in the respiratory rate in the absence of any kind of signs suggesting an impact of Demoral, i.e., she's more lethargic.

Q. No. No. No. No.

A. You're not going to have a single effect of the agent. That's the point. It's not going to have an effect on the central nervous system without affecting other parameters.

Q. I see. I gotcha. All right. So that if, in fact, it had a sedative effect, which we know it can have -- I mean, it can have. We agree with

that.

A. Sure.

Q. -- that would argue or would militate more for Dr. Mazal's conclusion that, in fact, it hadn't loaded until a later period of time; otherwise, we would have seen this reduction in respiratory rate?

MR. FELTES: Objection.

MR. QUANDT: Objection to the form.

A. Why would one imagine that somewhere between eight to 13 hours after either the initial or second dose suddenly it appears?

Q. So what you're saying is we can't tell one way or the other then?

MR. FELTES: Objection.

A. I think it's a stretch. I don't think the drug -- Based on the time course of the events, I do not think that the drug was responsible for the lady's decompensation, but I also know never to say never.

Q. Okay. Clearly, it shouldn't have been given, according at least to the doctor's orders.

MR. FELTES: Objection.

Q. You admit that much?

A. It's hard for me to say that. I don't know the policies at Elyria Hospital with respect to

sedatives versus analgesics.

Q. I mean, you did say that.

A. I did say what?

Q. That it shouldn't have been given.

A. My statement in the initial draft was that it was a vague order and should have been clarified.

Q. No. No. You also said you must fault the nursing staff for failing to recognize and respond to the order in question. I mean, you said that also. I mean, we went through that.

A. Yeah. If it's there, that's what I said.

Q. Yeah.

A. Yeah.

Q. So they shouldn't have given the drug. I mean, I'll read it again here: I must also fault the nursing staff, not for actions which may have contributed to the patient's arrest but rather for failing to recognize and/or respond to the order in question. It is reasonable to assume that a qualified ICU nurse is aware of the sedating effects of meperidine, and, therefore, should have considered contacting the responsible physician for clarification of this order.

I mean, you fault them both: one, for him

not making it as clear as he should have, and her for giving it in the absence of knowing, you know, that it had a sedating effect and/or clarifying it with the doctor.

MR. FELTES: Objection.

Q. Correct?

A. Yeah. That's how I wrote it.

Q. All right. And I want to make sure that we're not really at loggerheads over semantics. I tried to listen carefully to your answer a minute ago about your belief of the Demoral not -- and I don't want to paraphrase this wrong. If I do, correct me -- not contributing -- or not causing the arrest. Is that what you said?

A. I guess Becky can read back what I said, but I think the time course of the events would suggest that Demoral was not responsible for the lady's respiratory arrest.

Q. Okay. Did it contribute to cause her respiratory decline in your opinion?

Or let me ask it differently. Could it have? I mean, you've already told us to some extent we are guessing about the effects, so let me ask it that way.

MR. FELTES: Objection.

MR. GALLAGHER: Objection.

MR. SCOTT: Objection.

MR. QUANDT: Join that objection.

A. It's fair to say that Demoral has a dose-dependent effect on ventilatory drive. The question one needs to ascertain here is whether the dose given to Mrs. Lind was sufficient enough to impact on her ventilatory drive.

Q. Have you done that?

A. Well, I mean, 75 milligrams is a fairly conventional dose, particularly in a lady of her size, so from that standpoint I think it was an okay dose, but I don't know what the serum concentrations were. I don't know what was where. I don't know what was cleared. I don't know what was effective at any given time. So at high enough doses Demoral can impair ventilatory drive. I do not know if that was the case in Mrs. Lind's care.

Q. All right. When you say 75, you're talking about 75 every four hours or 150 here over a four-hour period of time?

A. Demoral is written as a -- generally, as a Q four- to six-hour medication.

Q. When did you send Mr. Reichel Exhibits 3-A and B? I thought you said April.

A. I think so.

Q. April of '94?

A. Yeah.

Q. And when did you send him 4?

A. I don't really remember.

Q. Was it in the Summer, Fall, shortly after you sent him 3-A and B?

A. I think it was a while, but 1 just don't remember. It was -- I mean, I do something. I hear nothing for a while, and then I get a phone call. I really don't remember when I sent it.

Q. Did you analyze the conduct of the nurses and/or physicians from the time that she began experiencing additional respiratory difficulties during the CAT scan until the time the code was called?

A. I did pay attention to that portion of the medical record.

Q. Did not?

A. Did.

Q. Did. Okay. When was that, on your initial review or since then?

A. Both.

Q. All right. Because you really don't talk about that in your reports. Is there a reason for that?

A. No particular reason.

Q. Okay. I assume that you saw the discussion with Dr. Mazal in his deposition and also --

- - - -

(Whereupon, there was a discussion off the record.)

- - - -

Q. Did you get Dr. DeMarco's deposition, by the way?

A. I didn't read it. I don't know if I got it.

Q. Okay.

A. Who was he?

MR. KAMPINSKI: Who was he?

MR. MELLINO: He's a pulmonologist.

Q. He's a pulmonologist.

A. I did not read that one.

Q. He was retained by Mr. Scott.

A. I did not read that one. Sorry.

Q. All right. Do you agree that Mrs. Lind should have received some attention other than what she did receive prior to the time that she coded on May the 7th?

MR. FELTES: Objection.

MR. SCOTT: For clarification, Mr. Kampinski, are you speaking from the time of the CAT scan to the time of coding?

MR. KAMPINSKI: Yeah. Yes, I am. I didn't know I was unclear, but, yeah, I am.

A. It's not clear to me that she wasn't being attended to, so I'm not sure exactly what you have in mind.

Q. Well, should a physician, for example, have seen her sooner than she was seen, because the first time a doctor saw her was when the code was called?

MR. FELTES: Objection.

MR. QUANDT: Was there an answer to that question?

MR. KAMPINSKI: No. He's thinking about it.

A. Yeah, I'm still thinking.

I mean, you know, this is a community hospital. It's not a university hospital. Where I work there are people -- house staff physicians in the ICU at all times, so, clearly, people can't be in two places at once.

I mean, should a physician have seen the patient? I don't know if I have an answer to that.

Q. Well, I mean, a doctor was there within, I believe,

a minute or two of the code being called, and he intubated her within a minute or two.

A. Correct.

Q. So we know there was fairly fast response --

A. Uh-huh.

Q. -- if, in fact, somebody wanted a doctor, so I'm not sure I understand your answer.

A. It was my understanding that upon the return of the patient to the ICU the attending physician responsible, Dr. Dacha --

Q. Yeah.

A. -- was paged.

Q. I see. Well, should a physician have seen her prior to that time?

MR. FELTES: Objection.

A. Can't tell. I mean, I don't know.

Q. Why is that? I mean, you know what her blood pressure was and her respiration was when she came back. You know they had to terminate the procedure at the CAT scan because she was having increasing respiratory difficulty. You've already told us she shouldn't have even gone down for the CAT scan.

MR. SCOTT: Objection.

A. I think --

MR. FELTES: I'll object to the form of the question because I'm not sure if that was a question.

Q. Yeah, it was. Should a physician have seen her prior to even Dacha being called?

A. Again, you know, it's a little hard as you read the record to know what transpired over what period of time. Clearly, the nurses dealt with Mrs. Lind on her return to the ICU. They attempted to assess her by drawing a blood gas, getting vital signs --

Q. Okay.

A. -- getting some data. I mean, if you're going to call a physician, you've got to give him some data, I suppose. I don't know.

So, you know, obviously, by the nature of your question you're saying to me -- you're implying that the nurses didn't do something as quickly as they should have, and I just don't know that that's the case. I can't tell.

Q. Okay. Let me ask you this: What is your understanding of the timeframe from when she began having additional respiratory distress in the CAT scan sufficient for the nurse to stop the procedure and take her back to the ICU until the time that the

blood gases were drawn? What's your understanding of that timeframe?

A. I had a tough call with that one. I thought the documentation was a bit unclear with respect to times going on. Let me glance here.

Q. Sure.

A. If I understand the notes correctly, the patient returned to the ICU from CT scan at 2:45, arrested at 2:55. We're talking about a total of ten minutes.

Q. What are you referring to when you say that?

A. Page 1135 of the patient progress notes, I guess it is. Those are notes by E. B., Elizabeth Boisvenue, I think her name was.

Q. Are there graphic charts that indicate when she returned?

A. This is written. Somewhere there is graphic charts.

Q. Page 988. I don't know if yours are in order or not. Is that not a page you were given?

A. I probably was. It's just in a different section.

Q. Okay. Middle box there is a blood pressure of 66 over 46 and the box of 2:30.

A. 2:30?

Q. Yeah.

A. Yeah.
Q. And the pulse ox, if you look over farther to the right, it's got 69.
A. Right. I see that.
Q. Yeah. If that was at 2:30, then does that --
A. Yeah, but I guess the question is, you know, just because it says 2:30, was it 2:30? And I don't know.
Q. Yeah.
A. I mean, it's a hard call. According to the notes on 987 it was 2:45 that she was back. It's going to take a finite period of time to do a blood pressure, to look at a pulse ox.
Q. You'll excuse me, but you read the nurse's deposition who wrote this note; right, Boisvenue?
A. Yeah.
Q. And you read where she testified that she didn't fill these in until later that evening in terms of times and what happened when.
A. I remember you discussed that with her, yes.
Q. Right. I mean, was that one of the problems you had in determining what happened when as far as the times?
A. Well, I think it -- You know, it's fair to say that

in the heat of battle you can't sit down and write notes.

Q. Right.

A. So to the best of your recollection you put it in the box that most closely approximates when the thing actually happened. Whether it happened at 2:30 or 2:44, I don't know.

Q. It makes some difference to Mrs. Lind though; wouldn't it?

A. Yeah, it does, but -- When it was written in the box doesn't make any difference to Mrs. Lind.

Q. When it happens --

A. Yeah. How she was cared for does.

Q. I agree. If it happened at 2:30 -- Yeah, when it happened at -- If it happened at 2:30, then how would you characterize the nursing care from 2:30 until 2:45?

MR. FELTES: Objection.

A. I don't know if I can comment on that.

Q. Why not?

A. I'd have to see it. I'd have to be there.

Q. I'm asking you to assume it. I mean, if there was a 15- to 20-minute delay in this lady getting any care, Doctor, would that be below the nursing

standards as you know them to be?

MR. FELTES: Objection.

A. That's a -- What do you call it? -- a hypothetical?

Q. Yeah.

A. Yeah. A hypothetical?

Q. Yeah. I told you I'm asking you to assume that.

A. Right. Then if a patient were lying on a bed, hypotensive, and nobody was paying any attention to her for 20 minutes, sure, that's not good quality care. I don't know that that's what was happening.

Q. Was she receiving oxygen during this period of time?

A. It's my understanding that she was ordered to be receiving 50 percent via Ventimask in transport.

Q. Should she have been getting something in addition to that once she started exhibiting respiratory distress in the CAT scan?

MR. FELTES: Objection.

A. Well, if her oximetry revealed that she was hypoxic in the CT scanner, then she probably required more oxygen.

Q. How would that be delivered?

A. Either by face mask or by intubation, endotracheal intubation.

Q. How about fluids? Should she have gotten any kind

of fluids, pressors or anything of that nature?

A. Acutely, if somebody is hypotensive, it's probably reasonable to give them a volume infusion.

Q. Did she get it?

A. I do not recall. She had been receiving fluids throughout much of the previous couple of days. I believe she was negative on the 6th, but I can't remember for sure.

Q. Negative meaning the output --

A. More outs than in.

Q. Yeah. That's not good either for someone who has metabolic acidosis.

MR. FELTES: Objection.

A. Can't tell. Can't tell.

Q. Can't tell if it's good?

A. Can't tell if it's good or bad.

Q. Was she volume depleted?

A. Don't know.

Q. Why is that, because the tests weren't done?

A. Correct.

Q. What would that have --

A. The lady was fluid positive for two or three days, fluid negative for one day, had no idea how much volume she was third-spacing.

- - - -

(Whereupon, there was a discussion off the record.)

- - - -

A. That means leaking. One of the things that I will tell residents when I round with them in the ICU that the hardest thing to do is to figure out volume status on a patient.

Q. What do you need to do, use a Swan-Ganz to determine that?

A. Yeah, a Swan-Ganz catheter can be helpful. It's not the end all and the be all, but certainly that would be -- in some settings that would be helpful.

- - - -

(Whereupon, there was a discussion off the record.)

- - - -

MR. KAMPINSKI: One of the things that -- I'm sorry. What did you call Dr. Martin, what kind of pulmonologist?

MR. SCOTT: DeMarco.

MR. KAMPINSKI: What did you call him?

MR. SCOTT: I think I said remarkable.

MR. KAMPINSKI: Remarkable or preeminent

or something of that nature.

MR. HORNING: Renown.

Q. Renown. Renown, yeah.

He testified that she should have gotten additional fluids when her blood pressure was 66 over 46, whatever time that was -- I mean, it's in the 2:30 entry -- and that she didn't get any until CPR, and that was a failure to act in accordance with reasonable nursing standards.

Do you agree with that?

MR. FELTES: Objection.

A. I don't know the standards at Elyria, whether or not a nurse should feel free to just hang a liter of saline and infuse it. I don't know.

Q. Let's assume that she can do that in an emergency situation. I mean, would you agree then with that statement?

MR. FELTES: Objection.

A. If a patient is hypotensive and you want to get their blood pressure back, the first thing to do is hang some fluids.

Q. Okay. And that wasn't done until CPR, I mean, unless you can show me something to the contrary.

A. I can't tell you one way or the other.

Q. If it wasn't done until CPR started, was that a failure to adhere to appropriate nursing standards?

MR. FELTES: Objection.

A. You know, I don't know. I mean, it's -- I don't know what nursing standards are here, you know. You're asking me to comment --

Q. Let's assume they're the same here as they are anywhere else in this country.

A. Well, you know, I don't do nursing policy. The patient needed some volume. I'll give you that.

Q. Right. Okay.

A. Okay.

Q. And if the nurses --

A. Who's supposed to be responsible for it, I can't tell you.

Q. All right.

A. Whether it's the doc, whether it's the nurse, I don't know. The patient needed some volume.

Q. Okay. Fine. Who in your opinion was responsible for the failure to do the things that you say should have been done before she went down for CT?

And I'll take them one at a time. I assume Dr. Dacha would be one of the people responsible for getting the information tha you

believe should have been obtained.

MR. SCOTT: Objection. I don't know that he has specified the particular information that he says was --

MR. KAMPINSKI: I have read into the record. If you want to object, fine.

Go ahead, Doctor.

A. Reviewing the record, it was somewhat difficult for me to exactly determine what the lines of authority were in this particular case, so I'm a bit reluctant to name any individual physician as being primarily responsible for the evaluation at any given time.

Q. Weren't they all responsible? Weren't they all part of the team taking care of this lady?

MR. QUANDT: Objection.

MR. SCOTT: Objection.

MR. WEITENDORF: Join in that.

Q. When I say all I mean Drs. Miclat, D. C. Patel and P. Patel.

MR. QUANDT: Objection.

A. There were physicians who were consultants, and there were physicians who were attendings, and there were physicians who were, I guess, the intensivists or at least responsible for the care in the ICU.

Q. Okay.
A. But, again, it wasn't clear to me who was in charge.
Q. Who should have been in charge?
MR. FELTES: Objection.
MR. QUANDT: Join that objection.
A. I'm not sure what the policy is at Elyria.
Q. In your opinion, based upon your careful review of this record, regardless of the policy at Elyria or Podunk or University of Pittsburgh -- Let me just finish -- a patient is entitled to have a physician looking out for her. I mean, that's one of the reasons she's in the hospital. She needs care.
A. Right.
Q. In your opinion, who had the responsibility for either coordinating this care and/or delivering it? If it's all of them, fine. If it's one of them, that's fine, too.
A. At some institutions the attending physician of record would be responsible. At other institutions the physician in charge of the ICU would be responsible. And I don't know what the policy is at Elyria.
Q. So whatever their policy is in terms of responsibility, that's the way you see

responsibility falling in terms of who should take care of this patient?

A. If the attending physician is primarily responsible for doing what's supposed to be done for his patient, then, you know, he's the guy that's signing on the bottom line on the face sheet when the patient gets discharged; he's the one that needs to be responsible.

If the policy is that when the patient is transferred to the ICU the admitting physician is no longer the primary physician in charge of the case, then, fine, then the ICU physician is in charge.

Q. All right. Let me switch gears on you. Let me ask it differently.

A. Okay.

Q. All four of those doctors that I mentioned, that is, D. C. Patel, P. Patel, Miclat and Dacha, were all there, according to the record, prior to her being sent down to CAT scan after she came back from HIDA scan. We've got a note reflecting that. They have all testified to that effect.

Shouldn't all of them have recognized her problems at that time?

MR. QUANDT: Objection.

MR. WEITENDORF: Objection.

Q. I mean, the chart was there at that time just as it was for you to look at. So, I mean, all of them were aware of her condition; weren't they?

MR. WEITENDORF: Objection.

MR. QUANDT: Objection.

MR. SCOTT: Objection.

MR. FELTES: Objection.

A. I would assume, if they were standing at the bedside.

MR. QUANDT: Objection to the assumption.

Q. Shouldn't they all have recognized the problems she was having, just as you did, Doctor?

MR. SCOTT: Objection.

MR. QUANDT: Objection.

A. You know, you're asking me to stand in these guys' shoes.

Q. No, I'm not. I'm asking you what a reasonable, careful, prudent physician should have recognized, standing there at Mrs. Lind's bedside, based upon the record just like you had it. I assume you consider yourself a reasonable, careful, prudent physician.

A. Both, yes, I think so.

MR. QUANDT: Objection to the form of the question.

Q. Okay. You know, I'm not trying to play games with you, sir.

A. I understand. If this information is available, then, you know -- and they have the luxury of saying: Yep, look at her blood pressure. It's down. Yep, her pulse ox is down. Then, sure, somebody needs to pay attention.

I don't know what they were looking at. I don't know what they saw. I don't know the condition of the patient at the time that they were standing at the bedside prior to -- you know, how she was responding in terms of her mental status, in terms of her complaints, how she looked, physically. I don't know that. I don't have that information, and I can't testify one way or the other as to what these guys were thinking at that time.

Q. Since you started to get good at hypotheticals a little bit ago --

A. I learned it from YOU.

Q. Good. I'm glad I was helpful -- let me give you another one. And it's really not a hypothetical. It's a little different. What I'm going to do is

I'm going to ask you to assume certain facts to be true. Okay. Ultimately, somebody else will have to determine whether they are true or whether they aren't true, but I'm going to ask you to assume that they're true. Then I'm going to ask you to answer a question based upon those assumed facts. Okay?

A. Okay.

Q. All right. I'm going to ask you to assume, Doctor, that Mrs. Lind was seen in the emergency room on four separate occasions starting on April 4th; second time on April 8th, third time on the 13th and the fourth time on the 17th of April; that originally an x-ray was done on the first visit which showed that she had pneumonia in, I believe, one lung; that no follow-up x-rays were done on any of the subsequent visitations.

Is that, so far, consistent with what you saw in the emergency room records?

A. I really didn't review them.

Q. Okay. That's why I'm giving you these, because you did say that. I'm trying to give you this information.

That on each of these occasions she was sent home and not admitted; that when she was

finally admitted on the 20th, not through the emergency room but by her family physician, that it showed bilateral pneumonia. And then you did, in fact, have the records subsequently, that is, the admission records up through May the 7th.

I'm going to ask you to assume that just by virtue of what I've told you that her condition worsened from the 4th until the 20th when she was admitted, all right, that it went from one lobe or one lung to bilateral, that her vital signs, in fact, got worse throughout that period of time.

Do you have an opinion, Doctor, as to whether the delay in treatment from, let's say, the 17th until the 20th, the last time she was seen in the emergency room until she's admitted, contributed to cause her ultimate respiratory distress and respiratory arrest?

MR. FELTES: Objection.

MS. MOORE: Objection.

MR. QUANDT: Join.

A. It's hard to say. I don't know the chest x-rays. I didn't see them. I do not believe reports of radiologists unless I see the x-ray, not to impune my radiologic colleagues, but pendulous breasts can

do some amazing things to a chest x-ray:

I guess the only comment I would make is, if you read the record, her pneumonia was getting better during her hospital stay.

Q. Okay. Her condition, however, was getting worse.

A. That's correct, but that may not be for the same reason.

Q. Why do you think her condition was getting worse?

A. I don't have a clue. I don't know what was wrong with this lady. It's a tough case. It clearly was.

Q. How do you treat pneumonia that doesn't respond to a specific or certain course of antibiotic treatment? What do you do?

A. It's my understanding that that question does not pertain to this case, since by the record her pneumonia was clearing.

Q. Well, I mean, obviously, you're entitled to your opinion.

A. Thank you.

Q. Since you've already told me you haven't seen the x-rays and you don't trust the radiologists' reports --

A. Right. I was reading the notes from the rounding physicians, I mean, you know, up to the 6th, I

think: condition improving, chest x-ray clearing, da-da-da-da. It was going on and on.

One of the problems here is that in a setting of the patient who's receiving imperic antibiotic therapy, in other words, they show up in the emergency room or their private physician's office; they get some antibiotics for a community-acquired pneumonia, most of the time patients will improve. Nobody knows what causes the pneumonia. And the doctor will take full credit for his insight and his cleverness.

Q. Okay.

A. However, from time to time a patient will go sour on antibiotics, and you are at the disadvantage of being able to recover no responsible organism because the antibiotics will prevent growth in culture.

So I don't know. You know, I just -- The fact that no material was identified that could account for the lady's pneumonia, you know, may be because it was an atypical pneumonia or may be because she was on imperic antibiotics and nothing would grow out.

Q. Do you think it was bacterial or viral, or don't you

have an opinion?

A. My suspicion -- I didn't see the x-ray. I don't know. You know, I can guess, but I don't know.

MR. QUANDT: We don't want you to guess.

Q. If a certain antibiotic doesn't work, okay, if a person is getting worse and she returns, do you put her on a broad-spectrum antibiotic, or what do you do?

A. What do I do?

Q. Yeah. Well, what should be done?

A. I can tell you what I do.

Q. Okay. What do you do?

A. I will either, depending on the patient's condition, either change the antibiotic; or, if the patient indicates, clinically, gives me some signs that she's not getting better, I would consider admitting her.

Q. All right. Even upon admission, would she then be subjected to a broad-spectrum antibiotic, or how would you do that?

A. Yeah, I would.

Q. What kind of antibiotic?

A. Parenteral intravenous antibiotics.

Q. What kind?

A. I mean, this is a very subjective kind of thing because everybody's got their own particular antibiotic du jour.

Q. Well, I'm asking it in the context of your not being able to grow anything out, so you don't really know, you know, what she's got.

A. What I do, personally, is I give broad-spectrum antibiotic coverage, probably using two agents.

Q. Which would be --

A. A synthetic penicillin -- semisynthetic penicillin and an aminoglycoside, or cephalosporin and aminoglycoside.

Q. Is the reason for that so that you would cover her for as many possible organisms as you could, not knowing which one was affecting her?

A. Correct.

Q. And would that be done in the emergency room as well? Could that be done in the emergency room?

MS. MOORE: Objection.

MR. QUANDT: Objection.

A. It kind of depends on your plan. One can broaden out orally, or one can give parenteral antibiotics. Conventionally, although this is subject to change in our current health care environment, but,

conventionally, if one is going to give parenteral antibiotics, it's not an emergency-room sort of situation.

Q. She should be admitted?

A. Yeah.

- - - -

(Whereupon, there was a brief recess in the proceedings.)

- - - -

Q. Doctor, maybe I didn't hear it right or I just didn't understand it. I think earlier you referred to her having respiratory acidosis. Is that different than metabolic acidosis? Is that the same thing? If it's different, what's the difference?

A. She always had a metabolic acidosis. At one point I believe she had a respiratory acidosis superimposed on the metabolic acidosis.

Q. What is a respiratory acidosis versus a metabolic acidosis?

A. Metabolic acidosis is simply an excess of acids that are not cleared either from the kidneys or because of ingestion of something. It's reflected in the loss of sodium bicarbonate in the serum.

Respiratory acidosis really refers to

carbon dioxide retention. When one refers to a respiratory acidosis, that's the equivalent of hypoventilation and an elevation in the **C02** in the blood gas.

Q. When did she have the respiratory acidosis superimposed on the metabolic acidosis? Refer me to a page, if you would.

A. Page **330** in the lab section, blood gases. May **7, 14:46,** pH **7.14; PC02 47;** P02 **49.**

What she had had previously, if you look at the 10:46 blood gas, she had a metabolic acidosis with a relatively small compensation in **C02.** Normal **C02** is about **40.** So she was able to blow off a little bit of **C02,** down to **32;** and by doing that, that's how she was able to maintain her pH a little bit higher, not adequate at **7.26** but a little bit higher.

Later on at the 2:46 blood gas you will note that the **PC02** has gone up approximately -- or 15 millimeters of mercury from **32** to **47,** coincident -- indicating that she's unable to blow off that amount of **C02.**

Q. So she is retaining it?

A. Yeah, she's retaining it. And coincident with that

increase in C02 you see that there is a drop in the pH at 7.14.

Q. So it's the C02 that is the respiratory acidosis that's superimposed on the metabolic?

A. Correct.

Q. That happened sometime between 10:46 and 2:46, or was it already in existence at 10:46?

A. She had -- If I were to review the blood gas from 10:46, I would say she had an insufficiently compensated metabolic acidosis. In other words, she got enough respiratory reserve to blow off some C02. She blew herself down to 32. That's not much. A healthy person ought to be able to blow themselves down into the low 20s or lower.

Q. So she already had it then at 10:46?

A. She had a metabolic acidosis, and she really wasn't able to breathe adequately in that setting. She should have blown off more C02.

Q. The saturation of 98 at that time, at 10:46, is that at all meaningful in the context of both the metabolic and respiratory acidosis?

A. Tell me what you're asking.

Q. I mean, is the saturation of 98 the be all and the end all in determining whether or not this lady

needs, number one, to be intubated or, number two, to be further tested?

MR. FELTES: Objection.

Q. Or does that just tell you that she's getting sufficient oxygen at her face?

A. The number -- Well, she's getting more than sufficient oxygen at her face. She's getting it into her blood also. But the number 98 percent saturation, if that were an isolated number with no additional data available, would not be sufficient when you are trying to assess somebody's ventilatory status.

Q. Well, is it sufficient in the context of the other numbers?

MR. FELTES: Objection.

A. No. I mean, it's a normal number; and, clearly, this lady did not have normal blood gases.

MR. RAMPINSKI: Thank you. That's all I have.

- - - -

(Whereupon, there was a brief pause in the proceedings.)

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MS. MOORE: I don't have any questions.

- - - -

EXAMINATION

- - - -

BY MR. GALLAGHER:

Q. Doctor, my name is John Gallagher, and I represent Dr. Dacha, and I have a few questions.

The second opinion letter that you sent to Mr. Reichel, the one sheet, the document --

A. It's 4, I believe.

Q. It seems to be separated into three parts. The first part is the case facts. Do you have a copy in front of you?

A. I do not.

MR. FELTES: Where is it?

- - - -

(Whereupon, there was a discussion off the record.)

- - - -

Q. The top part relates, essentially, to laying out the facts that you dealt with. Is that correct?

A. Yes.

Q. Then you have a heading that's medical opinion. And the first sentence after that is: As part of this review, two parts have been addressed in detail.

Am 1 correct in observing that the first part that you address in detail was the Demoral issue?

A. That's correct.

Q. And then the final paragraph says: The second area of interest concerns the condition of the patient during the interval immediately following her return from the **HIDA** scan until she was transported to radiology department for an abdominal CT scan.

Essentially, that paragraph deals with the period of time from the return from the **HIDA** scan until transport to the radiology department. Is that correct?

A. Yes, it is.

Q. Now, in the first letter that you submitted to Mr. Reichel you did not get into the matter of the extubation that occurred on the 6th. Isn't that correct?

A. The first --

Q. In the first draft that you prepared.

A. The first draft, Exhibits **3-A** and B --

Q. Right.

A. -- I did. If I'm understanding you correctly, I did address extubation.

Q. Right. But you didn't address it in the second one.
A. That is correct.
Q. What is the reason for that?
A. As I indicated earlier, after discussion with Mr. Reichel, it was felt more appropriate to confine my remarks more to the quality of care involving the nurses in the ICU.
Q. Is it your opinion that clinical observation by a physician is significant in terms of the decision the physician makes with regard to care and treatment of the patient?
A. You mean standing at the bedside and looking at the patient?
Q. Yes.
A. Sure.
Q. I wonder if we could take a look at the doctor's orders of the 6th and 7th, particularly turning to page 45.
A. Doctor's orders?
Q. Yes.
A. Page what?
Q. Progress notes. I'm sorry. Page 45.
A. Okay.
Q. In the center of the page appears the date May 6 on

the left. Do you see it there?
A. Yes.
Q. And if you would, just glance at that note in general and tell me whether or not you agree with me: This is a note that was entered at or about the time of the extubation.
A. Well, it is certainly on the same day. I don't know the time.
Q. If you want to look at the end of the note --
A. Recommend TPs. GYN consult as ordered. I mean, is that where you want me to look?
Q. Yes. Does that indicate to you that he's talking about extubation?
A. Yeah. He's certainly talking about weaning. TPs is a weaning modality.
Q. On May 6, right after the date it says: Looks better this morning.
A. Correct.
Q. Appears to be breathing comfortably. Is that a clinical observation that's significant to a treating physician?
A. Yes.
Q. And do you observe following the word lungs appear the words good air entry?

A. I see that.
Q. And below that I think it's -- if you can help me with that --
A. Few rales at base.
Q. A few rales at base?
A. Yes.
Q. No wheezing?
A. Correct.
Q. Are those positive factors in terms of her respiratory condition at the time?
A. Yeah. Overall, that's a decent exam. That's basically a positive exam.
Q. And under impression near the bottom of the note he says: Better from pulmonary. Is that a positive factor in terms of her pulmonary condition? It seems to say so; doesn't it?
A. Yes. That's a positive impression.
Q. And then item number two, normal anion?
A. Anion.
Q. Anion. Can you explain what that is to me?
A. There are basically two kinds of metabolic acidosis, and it has to do with the chemistry of the minerals in the blood. And one type is an anion gap acidosis, which may reflect insufficient perfusion

of the tissues; and the other kind is a normal gap acidosis, which is frequently related to renal problems. And you'll note afterwards it says PROB -- probably RTA, renal tubular acidosis.

Q. Because Dr. Dacha makes reference to normal anion, and then what is the following language? That's either a positive or a neutral, right, in terms of what he's saying about her?

A. I'm not sure I could say it's positive. I guess I need some clarification what you're trying to get at.

Q. I'm just trying to understand what he's saying there.

A. He's admitting to the existence or indicating the existence of a continuing metabolic acidosis, and he's simply describing it as a nongap acidosis.

Q. In fact, she had the metabolic acidosis for some time. In fact, she had it that same morning. It was read at 6:35, and the metabolic acidosis was essentially the same as it was at 10:45 when there was a second ABG. Isn't that correct?

A. That's correct.

Q. Going back to the progress notes, page 47, Dr. Dacha makes an entry on May 6th at the top of the page

sometime on that day, saying doing good on TPs. Do you see those words there?

A. Yes, I do.

Q. With good airway?

A. Uh-huh.

Q. Are those positive factors in terms of her pulmonary condition?

A. Well, good on TPs indicates that he's pleased. Good air entry is decent. I mean, certainly, it's, at the very least, neutral, if not positive.

Q. May 6th, again, the next note: Continues to do good.

MR. KAMPINSKI: Which page are you on?

Q. I'm sorry. Page 47. Do you observe the declaration by Dr. Dacha there?

A. Yes, I do.

Q. And then another May 6th after that: Continues to do well. That's a positive consideration in terms of the clinical observation of a patient after extubation?

A. Continues to do good?

Q. Yes.

A. Yeah, that's a positive assessment.

Q. How about the May 6th note of Dr. McGowan? That's

the last one on the page where it says: Doing well, good breath sounds, lungs clear. Are those positive considerations in evaluating a patient's pulmonary condition?

A. Sure.

Q. I'd like to go over some of the vital entries for the 6th and the 7th. On the 7th -- That's page 988.

MR. KAMPINSKI: This is in the nurses' notes?

Q. Yes, page 988, nurses' notes.

What's the significance of, under breath sounds, that 8:00 -- apparently 8:00, 10:00, 12:00 and 2:00 breath sounds clear? Is that a positive consideration in terms of her pulmonary condition?

A. Yes.

Q. In fact, her pulse rate from 10:00 o'clock until 2:00 o'clock dropped from the 158 to lower pulse rates. Is that correct?

A. You mean from 158 to 136 to 128?

Q. Sure.

A. Yeah, it's lower. It's a lower number. I don't know if it's clinically significant, but it's a lower number.

Q. And her pulse ox is listed at 11:00 o'clock at 97.

Is that correct?

A. Correct.

Q. And at noon it's 98?

A. Yep.

Q. In terms of a pulse ox, just that consideration, that's within a normal range?

A. That's correct.

Q. Do you recall -- I'm reading Nurse Reshanko's deposition, who indicated that she brought Mrs. Lind back upstairs because her pulse ox had dropped to -- I think it was either mid or the low 90s. Do you recall that testimony of the nurse in radiology?

A. I don't recall that specific testimony. Which procedure?

Q. During the CAT scan.

A. Okay.

Q. Are pulse ox readings in the low or mid 90s -- are they significantly abnormal?

A. No.

Q. You've used some words in responding to questions put to you by Mr. Kampinski with regard to a number of matters here, indicating that a number of things presented a tough call or a hard call or it's hard to say. Do you recall those responses?

A. I do.
Q. Now, the opinions that you've rendered in this case, both with regard to the draft report and in final format the letter that you sent to Mr. Reichel, were both prepared by you knowing that, in fact, Mrs. Lind had arrested at approximately about 3:00 o'clock on the 7th. Is that correct?
A. That is correct.
Q. I'm looking at your CV, Dr. Stiller, and I notice that since 1990 you have been assistant professor of anesthesiologist and critical care medicine, secondary appointment.
A. That's correct, secondary appointment.
Q. Can you explain to me what that secondary appointment means.
A. My primary department is the department of medicine. As a matter of courtesy, because I'm an attending physician in the intensive care unit, I get a secondary appointment in the department of anesthesiology.
Q. Does the University of Pittsburgh --
A. It's more fluff than reality.
Q. Does the University of Pittsburgh have a pulmonary care division?

A. Do we have a division of pulmonary medicine?
Q. Yes.
A. Yes, we do.
Q. Is that separate from the department in which you work?
A. No. It's the same department. I'm in the department of pulmonary, allergy, and critical care medicine.
Q. What courses do you teach at the University of Pittsburgh?
A. There is in the second-year medical student curriculum a block on pulmonary medicine, and we have a number of workshops involved with different aspects of pulmonary medicine. I teach those blocks, those workshops. In addition, I teach residents, fellows and medical students during rounds in the intensive care unit and on the pulmonary consultation service.
Q. The block that you're referring to, how much time is involved in that, just roughly?
A. Two and a half, three weeks a year.
Q. With regard to Exhibit 3-B -- That's the draft report that you prepared -- about a fourth of the way down from the top of the page you're talking

about after the patient had returned from the HIDA scan. You state: The patient was appropriately treated with intravenous fluids, although she remained hypotensive, tachycardiac and tachypneic despite repeated infusions which were ordered at 12:35 and 1:00 p.m.

Is that still your opinion?

A. Yes, it is.

Q. And you go on to say that: Because of the concern that an acute intra-abdominal process was responsible for the patient's decompensation, she was transported to the radiology department at 1:00 p.m. for an abdominal CT.

Do you have any reason to believe that the physicians who were treating -- including Dr. Dacha -- treating Mrs. Lind did not hold the opinion that she had an acute abdominal process underway or may have had such a process underway?

A. They were certainly concerned about her.

Q. With regard to the meperidine, the Demoral, on the first page of that same report, Dr. Stiller, you state: At the outset -- This is about five lines down at the last paragraph: At the outset, I should note that I do not believe that the administration

of meperidine contributed to the subsequent arrest, which occurred approximately 13 hours after the second dose of the medication.

Is that still your opinion?

A. Yes, it is.

Q. As a part of reviewing material for rendering your opinion in this case did you review the written report of Dr. Martin?

A. Yeah. He was one of the experts; wasn't he?

Q. I'd like to ask you a question about the declaration made on page six of that report.

A. Okay.

MR. KAMPINSKI: Objection.

MR. FELTES: I don't know if he's got it.

A. Is it in the pile? You went through it. Here it is.

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(Whereupon, there was a discussion off the record.)

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A. I reviewed the deposition of Martin, I think.

Q. I can't ask you about something that you haven't seen and considered for your opinion.

A. I don't know if I saw that.

Q. Page six, Dr. Stiller.

MR. KAMPINSKI: Who is this, Martin?

MR. GALLAGHER: This is Martin, page six.

MR. MELLINO: Yeah.

Q. Did you review this opinion of Dr. Martin as part of the material you reviewed for rendering your opinion in this case?

MR. KAMPINSKI: What was that question? Does he agree?

Q. No. Did you review this letter along with other data for the purposes of rendering the opinion that you have rendered here today?

A. I did not.

Q. Thank you. You've looked at the ABG readings following the extubation. Is that correct?

A. Yes.

Q. Do you agree that the arterial blood gases were appropriate -- were indicated appropriate for hypoventilation for the degree of metabolic acidosis?

A. No, I do not.

Q. Why not?

A. She was still significantly acidotic. Her pH should have been higher.

Q. Are there any declarations set forth in any of the medical literature with regard to what the standard of care is in terms of sending a patient such as Mrs. Lind for radiology, tests, such as the CAT scan, the HIDA scan, in the condition that she was in?

A. I'm not aware of any such declarations.

Q. And the clinical observations are part of what goes into the decision-making of the physician with regard to sending a patient for such tests?

A. That's correct.

Q. You didn't have the benefit of the clinical observation that Dr. Dacha and perhaps the other physicians had. Is that correct?

A. That is correct.

Q. Do you have any quarrel with the manner in which the hospital records indicate that bicarbonate was provided Mrs. Lind on May 7th, 1992?

A. No quarrel.

Q. Is that an appropriate or one appropriate treatment with regard to the condition of metabolic acidosis?

A. Yes, it is.

Q. Again, referring to Item 3-A, which is your draft letter, about six lines down from the bottom of the

first paragraph you declare: Following-a period of initial stabilization, the patient returned to radiology later the same day for a CT scan of the abdomen.

A. I'm sorry. Where are you? Which page?

MR. KAMPINSKI: Where are you?

Q. This is 3-A, first page, under case facts. We're about six lines from the bottom of the first paragraph.

A. Got it.

Q. And I'm referring to the words: following a period of initial stabilization. What did you take that to mean?

A. Her blood pressure came back closer to normal, and her respiratory difficulties appeared to have subsided or -- I shouldn't say that -- her respiratory distress appeared to subside.

Q. Were there any risks attendant to re-intubating the patient between the HIDA scan and the CAT scan?

A. There are always risks associated with intubating the patient. The question is whether the risk of intubation outweighs the risk of not intubating the patient.

Q. Do the clinical observations of the physician who

has to make that decision weigh, to a reasonable degree, in making the decision whether or not to re-intubate?

A. Certainly.

MR. KAMPINSKI: Objection.

Q. Did you observe that Mrs. Lind was originally intubated on the 23rd of April, 1992, and the extubation occurred on the 6th of May?

A. Yes.

Q. Did you observe that? And considering the fact that that's a period of approximately -- involving two weeks of time, that it would be reasonable for a physician to consider extubating the patient at that time, if he felt clinically and based upon other information he has available to him that the patient can handle it?

A. I think to some extent that's physician dependent. There are no specific guidelines that are universally accepted. There are guidelines that exist but none that are universally accepted with respect to a, quote, unquote, safe period of endotracheal intubation. Clearly, if the patient is physiologically stable, the physician hopes to extubate the patient as soon as possible.

Q. Sometimes it's a close call; isn't it?
A. What's a close call?
Q. Deciding whether or not to extubate or re-intubate.
A. Sometimes it's a trial of life, yeah.
Q. Going back, putting yourself in the position of Dr. Dacha at the time of the extubation and the consideration of whether or not to re-intubate, were those circumstances involving close calls?
A. I think that's kind of a personal decision. It depends on the style and practice of the physician.
Q. You wouldn't say that just because a physician would have done what you would have done that he was guilty of malpractice, falling below the standard of care?

MR. KAMPINSKI: Objection. It's a nonsensical question. It has no legal significance. And he's testified directly to the contrary in terms of significance.

A. If a physician did not do what I would do, I would not consider that malpractice.
Q. Are you the person at the University of Pittsburgh Medical School who's in charge of the pulmonary department of the hospital?
A. No, sir.

Q. Who is?
A. The chief of pulmonary medicine is Dr. Robert Rogers.
Q. Is there anybody then in between you and Dr. Rogers in that same area?
A. Not -- I mean, I don't have a supervisor over me who's below Dr. Rogers in the area of ICU. I work also in another part of pulmonary medicine in addition to the ICU.
Q. You also work in general critical care medicine at the University of Pittsburgh Hospital?
A. I am not in the department of critical care medicine.
Q. You probably told me before, but I forget. Tell me again what department you are in.
A. The name of the division is the division of pulmonary, allergy, and critical care medicine.
Q. What is pulmonary allergy?
A. Pulmonary, comma, allergy, comma, and critical care medicine. That deals with one of the people in our division who's an asthma expert.
Q. In dealing with critical care patients, do you deal with critical care patients who do not have a primary pulmonary problem?

A. Yes.

Q. For example, what type of patients do you deal with who are in the hospital for conditions that are not primary pulmonary conditions?

A. I deal with patients who have gastrointestinal bleeds, patients who are septic, patients who have a seizure disorder. I do not deal with patients with primary surgical problems, although from time to time our patients do develop surgical problems.

Q. What percentage of the time that you put in clinically is time that involves dealing with patients whose primary problem is a pulmonary prob1em?

A. You mean all my patients?

Q. Certainly.

A. Primary pulmonary problems?

Q. Yes, sir.

A. 75, 80 percent of the time.

Q. Is obesity a factor in how a patient can handle pulmonary distress?

A. Sure.

Q. To what extent is it a factor?

A. Obesity in general impacts on health. Patients who are obese can have difficulties with their upper

airway. They can have obstruction of their upper airway, obstructive sleep apnea. They can have redundant tissue in the upper airway, making intubation difficult.

They can have hypoventilation on the basis of increased mass loading of their chest, because they've got 50 or 60 pounds laying on their chest that they have to breathe against. They can have hypoventilation because their stomachs are big, pressing their diaphragms up toward their head, therefore, decreasing the excursion of the diaphragm, making them less inclined to breathe deeply.

They are at increased risk of pulmonary thromboembolic disease because fat people just tend to get clots in their legs, and they can end up in the pulmonary vascular bed.

Q. Can it also pose a special problem for obese people when they are engaged in having a HIDA scan or a CAT scan prepared on them; they have to lie down --

A. Sure.

Q. -- and have a special problem?

A. Well, lying in a supine position can be a challenge for any obese patient.

Q. What do you claim should have been done to improve or repair the metabolic acidosis condition that Mrs. Lind had on May 7th before she was sent back for the CAT scan that was not done?

A. I think it's difficult for me to answer that specifically, since the etiology for the patient's metabolic acidosis was not obvious then, nor is it obvious to me now. I can't tell you specifically what should have been done to correct the metabolic acidosis.

Q. Is it possible that the metabolic acidosis would be related in some way to sepsis or the acute abdominal condition she had?

A. Certainly.

MR. GALLAGHER: May I see the correspondence that passed between Dr. Stiller and Mr. Reichel or Mr. Feltes as well as the correspondence involving the other physician that he worked with.

Q. You may have answered this, but I'm not sure. Do you have an opinion as to whether or not the arrest here was a respiratory arrest or a cardiac arrest? Do you have an opinion?

A. I can't really say which came first.

Q. I'm going to hand you what's been identified as Deposition Exhibit 1-A, which appears to be a letter to Dr. Greenberg from Attorney Reichel. Would you look at that, please.

You saw that letter before you commenced your efforts in this matter?

A. I don't know that I paid any particular attention to it. I probably glanced at it.

Q. Do you observe at the bottom of the page that it makes reference to the fact whether or not you've had any criticism of the doctors in the case? Do you observe that?

A. I'm sorry?

Q. At the bottom of the page there is reference made to whether or not you would have any criticisms of the doctors who were involved in this matter. I don't have the letter in front of me, something to that effect.

A. There was reference made: I would also be interested in any criticism of any of the doctors.

Q. Okay. Is there anything on that letter anywhere that asks you to render an opinion as to whether or not in your opinion any of the physicians fell below the standard of care with regard to the care and

treatment of Mrs. Lind?

MR. KAMPINSKI: I don't understand the question.

MR. GALLAGHER: I'm just asking whether or not that's contained in the letter.

MR. KAMPINSKI: Are you suggesting to him that that's different than what he just read?

MR. GALLAGHER: I'm asking how he takes the word criticism. I'm asking him whether or not --

MR. KAMPINSKI: You didn't ask him that. That's why I'm objecting.

Q. The specific question is: The letter does not contain any reference to asking you to render an opinion as to whether or not any of the physicians fell below the accepted standard of care in treating Mrs. Lind. That's not in there?

MR. KAMPINSKI: I object.

A. Those words, standard of care, are not in there.

Q. Likewise, the letter does not contain any request that you determine whether or not, if, in fact, there was a falling below the standard of care by any of the physicians, that the falling below the standard of care was the proximate cause of the

arrest?

MR. KAMPINSKI: I'll object to that.

Q. That's not in there either?

MR. KAMPINSKI: I object on the same basis. You're putting an imprimatur on what was said there. You know, that's not really fair to this doctor to throw legal words at him. It says what it says.

Q. Those words do not appear there?

A. They do not.

MR. GALLAGHER: I have no further questions.

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EXAMINATION

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BY MR. SCOTT:

Q. Doctor, my name is John Scott. I represent Dr. D. C. Patel, who is a gastroenterologist. Did you have Dr. D. C. Patel's deposition to read?

A. I don't think so, not by this outline. If I did, I didn't read it.

Q. My understanding as well is that you have not reviewed Dr. DeMarco's deposition. Am I correct in that?

A. That is correct.

Q. You did not review Dr. Ferguson's deposition. Am I correct in that as well?

A. That is correct.

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(Whereupon, there was a discussion off the record.)

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A. Didn't read it.

Q. Doctor, is it fair to say that you are not aware of the timeframe or timeframes in which Dr. D. C. Patel was present with the patient on May 7th? Is that correct?

A. To the best of my recollection, I believe Dr. Patel was at the bedside at some point between the time of the HIDA scan and the CT scan. However, I didn't pay a whole heck of a lot of attention to other appearances.

Q. Fair enough. You recollect that Dr. D. C. Patel was present at some point in time. Is it fair to say?

A. Yes.

Q. You do not recall the times that D. C. Patel was actually present and then absent from the side of the patient; do you?

A. Not really. I did read his consultation note, which -- but I can't give you the specific day that he wrote that or dictated that.

Q. Were you given any kind of summary as to the care by Dr. D. C. Patel?

A. No.

Q. Do you understand that Dr. D. C. Patel acted in the role of a consultant?

A. That was my understanding.

MR. SCOTT: May I look at the materials that you have been given.

That's all I have, Doctor. Thank you.

MR. QUANDT: No questions.

MR. FELTES: Are we done?

MR. KAMPINSKI: I'm sorry.

- - - -

RE-EXAMINATION

- - - -

BY MR. KAMPINSKI:

Q. Doctor, when Mr. Gallagher was asking you some questions and he went through the progress notes of May 6th, you kept looking at the arterial blood gases. I noticed that you were doing that.

A. I was doing that.

Q. I know.
A. Yes.
Q. The reason you were doing that was what, sir?
A. I was trying to find them from the 6th.
Q. Okay.
A. I didn't see them.
Q. What was the reason you were trying to find them while he was going through the progress note?
A. I wanted to see what the physiology of the patient was.
Q. Why is it you wanted to see that?
A. The question that obviously comes to mind is one has an opinion about a patient's condition, and one simply wants laboratory data to support or refute your impression.
Q. Okay. And you were looking for the ones on the 6th then I take it.
A. That's correct.
Q. That would be page 329, I think, if you want to take a look at that.
A. I'm sorry. What page?
Q. 329.
A. I go from 301 to 330.
Q. Here, you can take a look at this.

A. Okay.
Q. Is there anything you would want to add then in response to the questions that -- or your responses to the questions that he asked you now that you've had a chance to look at those?
MR. FELTES: Objection.
A. I would be concerned with the pH indicated on the blood gases of May 6th at 5:13 a.m. and at 9:52 a.m. and marginally concerned with the blood gas at 12:05 p.m.
Q. Okay. And I assume that's what you were referring to in your report, your initial report, 3-A and B, when you indicated that she should not be extubated.
A. Specifically, I don't remember, but I would certainly want to know these blood gases and would be concerned about extubating a patient with those blood gases.
Q. The opinions that you expressed in Exhibits 3-A and B, your initial report, were those to a reasonable degree of medical certainty?
MR. GALLAGHER: Objection.
MR. SCOTT: Objection.
MR. WEITENDORF: Join.
A. Those opinions were expressed based on my

experiences and my personal beliefs about patient management.

Q. Right. To a reasonable degree of medical certainty?

MR. GALLAGHER: Objection.

MR. SCOTT: Objection.

MR. WEITENDORF: Join.

MR. QUANDT: Join.

A. I don't know -- I mean --

Q. That means they are more probably true than not.

A. In my opinion.

Q. They are more probably true?

A. They are more probably true than not.

Q. I noticed in one of the letters that was sent to you that you did not receive the records following her arrest, I think, for some period of time, maybe May the 10th and thereafter.

You just mentioned a moment ago that you did review the consults, and I assume that includes the discharge summary as well.

A. Yeah, I looked at the discharge summary. Dr. Patel, I believe, saw the patient early on in the course of her care when there was some evidence of liver enzyme abnormalities. I think that was prior to the arrest.

Q. Okay. Her metabolic acidosis was, in fact, taken care of during the course of her hospitalization. I mean, that's something you were able to determine from reviewing the discharge summary, as opposed to going through all the records because I don't think you had them.

A. Yeah. Well, when she went home she had, I believe, normal serum concentration of bicarbonate.

Q. Was that done by virtue of just continuing the treatment that she had been on prior to the extubation? Do you know?

A. I don't know.

MR. FELTES: Objection.

MR. KAMPINSKI: I think that's all I have.

MR. SCOTT: That's all.

MR. KAMPINSKI: Doctor, you have a right to read your testimony. You also have a right to waive your signature. Mr. Feltes can advise you.

MR. FELTES: I can't advise you, but I would suggest that you read your testimony.

THE WITNESS: Okay.

- - - -

(Whereupon, the proceedings were concluded at 4:05 p.m.)

COMMONWEALTH OF PENNSYLVANIA) CERTIFICATE

COUNTY OF ALLEGHENY) SS:

I, Rebecca L. Schnur, RMR, a Notary Public in and for the Commonwealth of Pennsylvania, do hereby certify that the witness, RONALD A. STILLER, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the foregoing deposition was taken at the time and place stated herein; and that the said deposition was recorded stenographically by me and then reduced to printing under my direction, and constitutes a true record of the testimony given by said witness.

I further certify that the inspection, reading and signing of said deposition were not waived by counsel for the respective parties and by the witness.

I further certify that I am not a relative, employee or attorney of any of the parties, or a relative or employee of either counsel, and that I am in no way interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office this 7th day of February, 1995.

Rebecca L. Schnur

Notary Public

Notarial Seal
Rebecca L. Schnur, Notary Public
North Strabane Twp., Washington County
My Commission Expires June 16, 1997
Member, Pennsylvania Association of Notaries

COMMONWEALTH OF PENNSYLVANIA)
COUNTY OF ALLEGHENY)

E R R A T A
S H E E T

I, RONALD A. STILLER, M.D., have read the foregoing pages of my deposition given on February **2, 1995**, and wish to make the following, if any, amendments, additions, deletions or corrections:

Pg. No.	Line No.	Change and reason for change:

In all other respects the transcript is true and correct.

_____
RONALD A. STILLER, M.D.

Subscribed and sworn to before me this
_____ day of _____, 1995.

_____
Notary Public

RLS

AUL, KARLOVITS & FULESDAY, INC.
312 Boulevard of the Allies
Pittsburgh, PA 15222
(412) 261-2323

February 7, 1995

TO: Ronald A. Stiller, M.D.
University of Pittsburgh
Medical Center
440 Scaife Hall
3550 Terrace Street
Pittsburgh, PA 15261

RE: DEPOSITION OF RONALD A. STILLER, M.D.

NOTICE OF NON-WAIVER OF SIGNATURE

Please read your deposition transcript. All corrections are to be noted on the preceding Errata Sheet.

Upon completion of the above, you must affix your signature on the Errata Sheet, and it is to then be notarized.

Please forward the signed original of the Errata Sheet to me and I will see that copies are sent to counsel.

Please return the completed Errata Sheet within thirty (30) days of receipt hereof.

Rebecca L. Schnur, RMR
Court Reporter

cc: Joseph J. Feltes, Esq.
John J. Gallagher, Esq.
Charles Kampinski, Esq.
Robert G. Quandt, Esq.

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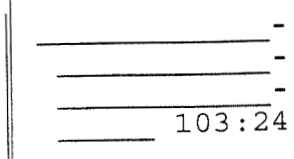
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BUCKINGHAM, DOOLITTLE & BURROUGHS

A LEGAL PROFESSIONAL ASSOCIATION

624 Market Avenue. N PO Box 21610 Canton. OH 44701-1610
Telephone 216/456-2491 Telecopier 216/456-1736

Richard G. Reichel

DEPOSITION EXHIBIT 1-A AKF

March 9, 1994

Arthur Greenberg, M.D.
Comprehensive Medical Consultants, Inc.
5811 Howe Street
Pittsburg, PA 15132

Re: Lenore Lind V Comprehensive Health Care of Ohio, Inc., et al
Our File No. 4572-8

Dear Dr. Greenberg:

Our office is defending Elyria Memorial Hospital and Medical Center in the above lawsuit. Enclosed are the following records:

1. Excepts of the medical records from the date of admission to May 10, 1992. Since the event in question took place on May 7, 1992, I arbitrarily cut off the record at May 10. The patient remained in the hospital until July and additional records can be provided if your reviewer finds them necessary.

2. Copy of Complaint filed in Lorain County Common Pleas Court.

3. Deposition of Dr. Dacha.

4. Deposition of Dr. Martinez.

5. Deposition of Nurse Phillips.

6. Deposition of Nurse Burgess.

7. Deposition of Nurse Boisvenue.

8. Deposition of LPN Underwood.

We would like the records reviewed by a physician in pulmonary medicine. Our primary concern is the nursing staff of our insured hospital. I am interested in knowing if the reviewer has any criticism of the nursing staff and if there is criticism, did it cause or contribute to the events of May 7, 1992. I would also be

COMPREHENSIVE
MEDICAL
CONSULTANTS, INC.

5811 Howe Street
Pittsburgh, PA 15232

(412) 362-2096

March 21, 1994

Ronald A. Stiller, M.D.
Division of Pulmonary Medicine
Department of Medicine
University of Pittsburgh
Scaife Hall, 4th floor
Pittsburgh, PA 15261

Re: Lind vs. Comprehensive Health Care of Ohio

Dear Ron:

Here are the records for the case we discussed. As our client indicates, he is defending the Elyria Memorial Hospital, so his main concern is the quality of care provided to Ms. Lenore Lind by nurses and other hospital employees. His cover letter and the "Chronology" will focus your attention on the time period in question.

In addition to the case records, I also enclose a copy of our Case Evaluation Form and informal Expert's Agreement which will provide some guidance on the type of review desired. I also wish to emphasize that although our organization only accepts cases from defense attorneys or insurers, we have no preconceived notion about whether a case is defensible. Should your opinion be negative, we would have no problem presenting it to our client. We only ask that any negative opinion be clearly stated so that our client will understand what problems he might have in mounting a defense.

The material enclosed makes reference to limiting the review time to 2 hours. This applies to an average length case, but would not be appropriate given the volume of material here. Take as much time to review the records as you need. With your report, please include a note indicating how many hours you did spend so that we can arrange payment. Also please include your Social Security number, as we will need it for tax reporting purposes.

If you have any questions along the way, please feel free to call me at the office (648-9084) or at home (362-5080). I look forward to reading your report.

Sincerely,

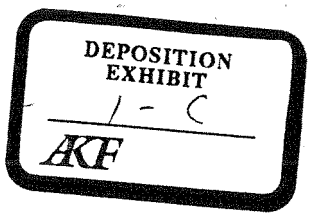
Arthur Greenberg, M.D.

AG:bb
Enclosures

COMPREHENSIVE
MEDICAL
CONSULTANTS, INC.

5811 **Howe** Street
Pittsburgh, PA 15232

(41*2) 362-2096*



Case: Lind v Comprehensive Health Care

The medical records that you have been asked to review accompany this form. Your report should highlight the relevant facts and events in the patient's course and then indicate whether the physician or hospital met or did not meet the standard expected. In general, the standard to be applied is that of the community from which the case originates. Whenever applicable, your opinion should be supported by citations from the medical literature; this is not necessary for basic patient care issues.

Your report will be forwarded to the attorney or insurer of the physician or hospital involved. To be of maximal benefit, a precise, complete, and objective evaluation of the records is needed. Neither we nor our clients have any difficulty accepting a negative opinion, but in that instance, please be sure to outline the problems in detail. Your initial review will be transmitted ***to*** the client in unsigned form.

You are under no obligation to render an opinion about this case. If for any reason you do not wish to do so, kindly return the records to our office promptly, so that we may secure another expert without undue delay to the client. If you would not be able to provide your opinion in the form of a deposition, kindly so indicate below.

Please keep these additional points in mind:

~~1. Limit the time for initial case review to approximately 2 hours.~~
2. Use the enclosed Case Evaluation form or follow its sequence. As your report will be re-typed in our office, handwritten reports are perfectly acceptable. If you prefer, you may dictate your report and send us the tape cassette (standard, mini, or micro size). After completion of transcription, the tape will be returned to you along with a typed copy of the report.
3. Try to complete your review and return the evaluation form or tape within 10 - 14 days. (such)
4. If you have questions, I can be reached most easily at **(4** 12) 647-3118 during the day or at **(4** 12) 362-5080 in the evening.
5. You will receive payment for your services upon receipt of the report at our office.
6. Billing for your initial review and for all subsequent work done for the client will be done by our office. Questions from a client about billing information should be referred directly to us.

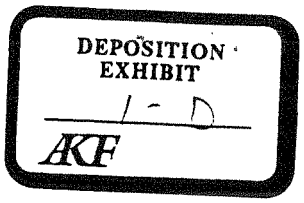
For Comprehensive Medical Consultants,

Arthur Greenberg, M.D.

I agree to the above conditions for case review and will/~~will not~~ be available to give a deposition as an expert medical consultant.

Ronald A Stiller MD

CASE EVALUATION



Case: Lind v. S. Comprehensive Health Ca

Reviewer's Specialty: Pulmonary Medicine

Reason for Evaluation: Respiratory Arrest

Case Facts:

Medical Opinion:

Medical Literature Documentation *(as appropriate)*:

Additional Comments:

use reverse or attach additional sheets as needed

COMPREHENSIVE
MEDICAL
CONSULTANTS, INC.

5811 Howe Street
Pittsburgh, PA 15232

(412) 362-2096

April 9, 1994

Ronald A. Stiller, M.D.
Division of Pulmonary Medicine
Department of Medicine
University of Pittsburgh
Scaife Hall, 4th floor
Pittsburgh, PA 15261

Re: *Lind vs. Comprehensive Health Care of Ohio*

Dear Ron:

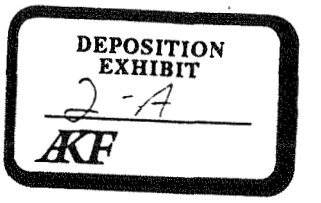
Here is the missing material you requested. Please let me know if you need anything else.

Best regards,

Sincerely,

Arthur Greenberg, M.D.

AG:bb
Enclosures



NJC
4572-8
11/12/33

LENORE LIND: CHRONOLOGY

4/20/92	7:02 pm	Admitted; Chief complaint: chest pain, cough, elevated temp, difficulty breathing
	8:00 pm	Examined by Dr. McGowan; impression - bilateral pneumonia, acute pulmonary failure, exogenous obesity
	9:25 pm	Medicine and resp. therapy prescribed; IV started, lab work ordered
4/22/92		Patient not responding well to treatment; Dr. H. Dacha called in for consult - exam revealed abdomen soft & non-tender - Note: "Suspect atypical pneumonia - Legionella pneumophilia pneumonia"
4/23/92		Noted patient transferred renal unit
4/23/92		Patient transferred to ICU
4/24/92		Nurses notes: "urine output low, color amber"
4/25/92		Nurses notes: "urine cloudy, light brown in color with brown sediment"
4/25/92		Consult Dr. R. Miclat due to elevated BUN & creatinine levels. Impression - "acute renal failure secondary to septicemia from pneumonia; bilateral pneumonia"
4/26/92		Condition unchanged
4/27/92		Consult Dr. D.C. Patel for gastrointestinal evaluation; impression - "Hepatocellular disease (hepatitis like picture multifactorial, probably related to septicemia, hypotension, chronic hepatocellular necrosis, hypoxemia & drug induced); acute respiratory failure bilateral pneumonia exogenous obesity acute renal failure (Need to rule out acute viral hepatitis)"
4/28/92		CAT scan ordered including pelvis
5/1/92		Condition unchanged; patient very tired and weak

5/3/92	15:20 - Patient complains of upper (R) quad abdominal pain
5/5/92	HIDA scan and CAT scan to be done
5/5/92	Consult Dr. P.A. Patel for abdominal pain & tenderness; Impression - "acute surgical abdomen with probably some degree of peritonitis. Cannot rule out gallbladder disease, diverticulitis or appendicitis; Note: Evaluate again in few hours, possible exploration"
5/7/92	Patient transferred to floor, then experienced abdominal pain and sent back to ICU
5/7/92	12:35 - Patient sent to radiology for HIDA and CAT scans
5/7/92	Patient developed respiratory distress with blood pressure dropping; testing not complete; sent back to ICU and stabilized
5/7/92	Patient resent to radiology; respiratory distress recurred; patient sent back to ICU
5/7/92	While being stabilized, patient lost consciousness/sudden respiratory arrest
5/7/92	Patient stopped breathing at 2:55 p.m.; was intubated and well oxygenated by 3:07 p.m.
5/10/92	Dr. D.C. Patel performed flexible sigmoidoscopy; findings normal
5/14/92	Dr. M. Mikhail performed tracheostomy
5/14/92	Dr. R. Miclat performed insertion of a double lumen hemodialysis catheter left internal jugular vein. Diagnosis - acute renal failure
5/19/92	Dr. P. Patel exploratory lap. Diagnosis - non-specific peritonitis; no infection
5/22/92	Nurses notes: "open eyes, awake most of day. Some improvement noted". Dr. McGowan " (patient) still comatose"
5/30/92	Appears to be waking up
5/31/92	Patient afebrile; moved eyes for sister

DEPOSITION EXHIBIT
2-B
AKF