

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

LENORE LIND, et al,

CIVIL DIVISION

Case No. 93CV110798

Plaintiffs,

vs.

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

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

Defendants.

DEPOSITION DATE:
February 2, 1995

PARTY TAKING DEPOSITION:
Plaintiffs

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REPORTED BY:
Rebecca L. Schnur, RMR
Notary Public

ORIGINAL

1 DEPOSITION OF RONALD A. STILLER, M.D.,
2 a witness, called by the Plaintiffs for examination, in
3 accordance with the Ohio Rules of Civil Procedure, taken
4 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.

5 - - - -

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1 RONALD A. STILLER, M.D.,
2 having been duly sworn,
3 was examined and testified as follows:

4 - - - -

5 EXAMINATION

6 - - - -

7 BY MR. KAMPINSKI:

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

9 A. Ronald A. Stiller.

10 Q. Have you been deposed before, sir?

11 A. Officially, I don't think so.

12 Q. Does that mean you have unofficially?

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

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

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

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

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

6 A. That's correct.

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

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

12 Q. Who is Dr. Arthur Greenberg?

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

18 Q. How do you know that?

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

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

24 A. Right. That's my understanding.

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

3 A. He knows me. He knows I'm a pulmonologist, and he
4 was looking for one.

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

7 A. I don't know.

8 Q. Is he here in Pittsburgh?

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

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

11 A. Yeah.

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

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

17 Q. Do you know the name of that company?

18 A. Not off the top of my head, no.

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

22 A. I'm paid by him.

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

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

1 sure.

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

3 A. Uh-huh. Yes.

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

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

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

14 A. No, he did not.

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

16 A. He's a nephrologist.

17 Q. Had he reviewed the case before calling you?

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

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

1 case?

2 A. Huh-uh. No.

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

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

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

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

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

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

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

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

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

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

20 Q. Where is the correspondence pertaining to this case?

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

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

- - - -

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

- - - -

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 1-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 1-A. Would that be correct?

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

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

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

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

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

13 Q. Do you know who prepared this?

14 A. No, I do not.

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

17 A. Yes.

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

20 A. Yes. I think so.

21 - - - -

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

24 - - - -

1 Q. I'm going to hand you what's been marked as 2-A, B
2 and C. If you can, identify just what that is, sir.

3 A. It is listed as a chronology, which was in the front
4 section of the medical record that was sent to me
5 through Dr. Greenberg's office.

6 Q. And that was referred to in Exhibit 1-A -- 1-B
7 rather?

8 A. Correct.

9 Q. Now, if you would, just identify what 1-C is.

10 A. It's a form letter from Dr. Greenberg, which I guess
11 is kind of an agreement concerning --

12 Q. The date on that is what, sir?

13 A. I don't think there is one.

14 Q. Undated?

15 A. Undated.

16 **a.** Okay. And then 1-D?

17 A. This is a format of the case evaluation sent by
18 Dr. Greenberg just kind of giving me headings in
19 terms of how I should present the narrative.

20 Q. And then 1-E?

21 A. A letter from Dr. Greenberg dated April 9,
22 indicating that some material that I was looking for
23 that was not in the medical record was forwarded to
24 me. There was one page that was missing.

1 Q. Do you know what page that was?

2 A. No. I can't remember exactly. I want to say 326.
3 I'm not completely certain because it's been a
4 while. I think there was some blood gas data on
5 there though that was not available when I was doing
6 the preliminary review.

7 Q. Is that something that you could pull out by looking
8 at it? I mean, did you put it in here?

9 A. Yeah, it's in there. I really don't have a clue. I
10 can't remember now.

11 Q. But you think it was a page of the record that you
12 just didn't have?

13 A. That's correct.

14 Q. You referred a few minutes ago to additions to the
15 record today or additions to, you know, what you
16 had. Did you get additional material today?

17 A. Today? No, I got nothing additional today.

18 Q. All right. Did you get anything additional after
19 these letters that we've gone through?

20 A. Subsequent to my initial review I got, I think,
21 three more depositions concerning Mrs. Lind's care
22 in radiology. I think one was a radiology nurse.
23 And I don't remember everybody involved. So there
24 were like three more depositions that were sent to

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

3 Q. Anything after that?

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

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

13 A. That is correct.

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

17 A. I believe so.

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

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

22 Q. Yeah.

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

1 most recently.

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

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

8 Q. I'm happy for you.

9 - - - -

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

12 - - - -

13 Q. Would you identify this, please?

14 A. This was my initial --

15 MR. SCOTT: What is the exhibit number?

16 THE WITNESS: 3-A and B.

17 MR. SCOTT: Thank you.

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

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

1 A. I got it here, I think.

2 Q. Do you have it there?

3 A. Yeah.

4 - - - -

5 (Document marked for identification

6 Deposition Exhibit No. 4.)

7 - - - -

8 Q. Doctor, I've marked as Exhibit 4 a report of yours
9 also. Correct?

10 A. Correct.

11 Q. That doesn't have your name on it or any letterhead.
12 Neither one does, I don't think.

13 A. No, it doesn't.

14 Q. Is there a reason for that?

15 A. I didn't think it was appropriate.

16 Q. The forwarding letter that you referred to, that you
17 sent this to Mr. Reichel, do you have that anywhere,
18 or didn't you keep copies of it?

19 A. Of --

20 Q. Of the letter that you sent to him.

21 A. No. I sent him this, the initial --

22 Q. Referring to 3?

23 A. Yeah. I sent him 3. I mean, I probably sent a
24 little cover letter with it. I don't have it. This

1 is what I gleaned from reading the case.

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

3 A. That is correct.

4 a. What is the reason for that, sir?

5 A. After Mr. Reichel received 3-A and B he called me.

6 I basically sent this to him, saying:

7 Well, this is my first shot at doing something like

8 this, 3-A and B.

9 Q. Right. Okay.

10 A. And how does it look? I mean, is this good?

11 Because I really -- You know, I need a little

12 guidance. He said it was fine, and he asked me to

13 prepare what he described as kind of a summary for

14 other counsel in this document, 4.

15 a. Uh-huh. I mean, how was it decided what would be

16 taken out of 3 and left into 4? Did he offer you

17 some guidelines as to that?

18 A. Not really. What he said to me was that his firm

19 was primarily interested in -- from me, anyway --

20 was interested in the care provided by the nurses

21 and the sort of immediate peri-arrest period.

22 And it was with that in mind that I

23 elected -- I mean, without guidance, I just elected

24 to remove certain bits of data that were obtainable

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

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

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

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

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

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

18 A. Right.

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

1 meperidine.

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

5 A. Right.

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

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

10 Q. Is there a reason that you took that out of Exhibit
11 4? I mean -- All right. Let me ask it differently.
12 Let me withdraw that.

13 Were you told to --

14 A. No.

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

16 A. Okay.

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

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

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

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

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

18 A. Correct.

19 Q. Why was that taken out?

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

24 It just -- I was sort of on this playing

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

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

7 A. Fair enough.

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

12 MR. FELTES: Objection.

13 A. That was not my thought at the time.

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

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

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

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

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

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

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

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

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

16 A. Correct.

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

22 MR. SCOTT: Objection.

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

1 Q. Okay. Well, I mean, did I state it incorrectly?

2 A. No. I have a problem with the concept of standard
3 of care.

4 Q. Okay.

5 A. I don't -- I just am not -- There is no written
6 document to that effect. There is no, quote,
7 unquote, standard of care. We don't get little
8 manuals when we graduate from medical school. So
9 when one uses the term standard of care, I'm
10 somewhat reluctant to just headlong agree.

11 Q. Okay. Let me state it in a different way that
12 perhaps you're comfortable with. The doctors
13 treating Lenore Lind should, in fact, in your
14 opinion, have done additional tests prior to sending
15 her down for the CT?

16 A. If I were one of the physicians caring for
17 Mrs. Lind, I certainly would have performed
18 additional tests.

19 Q. It's your opinion that the physicians that were
20 caring for her should have --

21 MR. SCOTT: Objection.

22 Q. -- based on her condition?

23 MR. QUANDT: Join.

24 A. Again, you know, it's very difficult to be able to

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

7 Q. Such as what?

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

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

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

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

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

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

1 record.

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

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

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

6 A. Nope.

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

9 A. Essentially, yes.

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

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

17 Q. Did you review those at all?

18 A. No.

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

21 A. Yeah.

22 Q. Are you board certified in internal medicine?

23 A. Yeah.

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

1 the clinical practice of medicine? -

2 A. Uh-huh. Yes.

3 **a.** Do you have any opinions with respect to the
4 emergency room care that she was provided with?

5 MS. MOORE: Objection.

6 A. I do not.

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

11 **A.** Thank you.

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

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

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

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

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

1 drugs --

2 A. Sure.

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

5 A. Yes.

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

8 A. Yes.

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

12 A. Pretty much.

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

16 A. No.

17 Q. -- or are these the only ones?

18 A. That's it.

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

22 MR. QUANDT: Objection.

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

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

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

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

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

8 A. Yes, I have.

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

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

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

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

22 Q. Right.

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

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

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

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

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

18 Q. So it would not have cleared?

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

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

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

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

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

5 A. That is correct.

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

9 MR. QUANDT: Objection.

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

15 MR. QUANDT: Move to strike the answer.

16 Q. Go ahead.

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

19 Q. I see.

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

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

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

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

7 A. Yeah.

8 Q. That's really the issue?

9 A. Right.

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

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

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

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

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

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

14 Q. I take it the increasing respirations throughout the
15 morning and -- or evening and morning of the 6th and
16 7th was as a result of her worsening metabolic
17 acidosis. Would that be a fair statement?

18 MR. QUANDT: Objection.

19 A. That's a possibility.

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

22 MR. SCOTT: Objection.

23 MR. WEITENDORF: Objection.

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

1 Q. Yeah.

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

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

13 MR. GALLAGHER: Objection.

14 A. This is speculation now.

15 MR. SCOTT: Objection.

16 MR. GALLAGHER: Continuing objection.

17 Q. Doctor, look, your opinions are your opinions, and
18 you're basing them on the record. Correct?

19 A. Well, I'm basing -- You asked me for another
20 possible mechanism to explain why this lady's
21 respiratory rate could increase. I'm giving you
22 another possible opinion --

23 Q. That's fine. Go ahead.

24 MR. GALLAGHER: Objection.

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

4 MR. QUANDT: Objection. Move to strike
5 it.

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

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

15 Q. Okay.

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

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

22 A. Yeah.

23 **a.** All right. And it might have been, in fact, greater
24 respirations had it not been for the Demoral.

1 MR. FELTES: I object.

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

4 MR. FELTES: Objection.

5 MR. QUANDT: Objection.

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

8 Q. Okay.

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

13 Q. Okay.

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

16 Q. All right.

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

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

1 **A.** Correct.

2 **Q.** I guess my question is a little different though,
3 and that is: If we're hypothesizing, could it not,
4 in fact, have had an effect and yet not been shown
5 in the numbers? In other words, had she not been
6 given Demoral, as opposed to a respiratory rate of,
7 let's say, 46 or 48 at any given time, it might be
8 56 or 58.

9 **MR. FELTES:** Objection.

10 **MR. QUANDT:** Objection.

11 **Q.** Do you follow what I'm saying?

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

17 **A.** **No. No. No. No.**

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

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

1 that.

2 A. Sure.

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

7 MR. FELTES: Objection.

8 MR. QUANDT: Objection to the form.

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

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

14 MR. FELTES: Objection.

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

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

21 MR. FELTES: Objection.

22 Q. You admit that much?

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

1 sedatives versus analgesics.

2 Q. I mean, you did say that.

3 A. I did say what?

4 Q. That it shouldn't have been given.

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

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

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

12 Q. Yeah.

13 A. Yeah.

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

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

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

5 MR. FELTES: Objection.

6 Q. Correct?

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

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

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

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

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

1 MR. FELTES: Objection.

2 MR. GALLAGHER: Objection.

3 MR. SCOTT: Objection.

4 MR. QUANDT: Join that objection.

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

10 Q. Have you done that?

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

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

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

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

3 A. I think so.

4 Q. April of '94?

5 A. Yeah.

6 Q. And when did you send him 4?

7 A. I don't really remember.

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

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

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

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

20 Q. Did not?

21 A. Did.

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

24 A. Both.

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

3 A. No particular reason.

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

6 - - - -

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

9 - - - -

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

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

12 Q. Okay.

13 A. Who was he?

14 MR. KAMPINSKI: Who was he?

15 MR. MELLINO: He's a pulmonologist.

16 Q. He's a pulmonologist.

17 A. I did not read that one.

18 Q. He was retained by Mr. Scott.

19 A. I did not read that one. Sorry.

20 Q. All right. Do you agree that Mrs. Lind should have
21 received some attention other than what she did
22 receive prior to the time that she coded on May the
23 7th?

24 MR. FELTES: Objection.

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

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

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

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

11 MR. FELTES: Objection.

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

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

16 A. Yeah, I'm still thinking.

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

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

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

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

3 A. Correct.

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

5 A. Uh-huh.

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

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

11 Q. Yeah.

12 A. -- was paged.

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

15 MR. FELTES: Objection.

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

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

23 MR. SCOTT: Objection.

24 A. I think --

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

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

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

11 Q. Okay.

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

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

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

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

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

6 Q. Sure.

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

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

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

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

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

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

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

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

23 A. **2:30?**

24 Q. Yeah.

- 1 A. Yeah.
- 2 Q. And the pulse ox, if you look over farther to the
3 right, it's got 69.
- 4 A. Right. I see that.
- 5 Q. Yeah. If that was at 2:30, then does that --
- 6 A. Yeah, but I guess the question is, you know, just
7 because it says 2:30, was it 2:30? And I don't
8 know.
- 9 Q. Yeah.
- 10 A. I mean, it's a hard call. According to the notes on
11 987 it was 2:45 that she was back. It's going to
12 take a finite period of time to do a blood pressure,
13 to look at a pulse ox.
- 14 Q. You'll excuse me, but you read the nurse's
15 deposition who wrote this note; right, Boisvenue?
- 16 A. Yeah.
- 17 Q. And you read where she testified that she didn't
18 fill these in until later that evening in terms of
19 times and what happened when.
- 20 A. I remember you discussed that with her, yes.
- 21 Q. Right. I mean, was that one of the problems you had
22 in determining what happened when as far as the
23 times?
- 24 A. Well, I think it -- You know, it's fair to say that

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

3 Q. Right.

4 A. So to the best of your recollection you put it in
5 the box that most closely approximates when the
6 thing actually happened. Whether it happened at
7 **2:30** or **2:44**, I don't know.

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

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

12 Q. When it happens --

13 A. Yeah. How she was cared for does.

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

18 MR. FELTES: Objection.

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

20 Q. Why not?

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

22 Q. I'm asking you to assume it. I mean, if there was a
23 15- to 20-minute delay in this lady getting any
24 care, Doctor, would that be below the nursing

1 standards as you know them to be? -

2 MR. FELTES: Objection.

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

4 Q. Yeah.

5 A. Yeah. A hypothetical?

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

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

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

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

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

17 MR. FELTES: Objection.

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

21 Q. How would that be delivered?

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

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

1 of fluids, pressors or anything of that nature?

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

4 Q. Did she get it?

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

9 Q. Negative meaning the output --

10 A. More outs than in.

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

13 MR. FELTES: Objection.

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

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

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

17 Q. Was she volume depleted?

18 A. Don't know.

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

20 A. Correct.

21 Q. What would that have --

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

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- - - -

(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

1 or something of that nature.

2 MR. HORNING: Renown.

3 Q. Renown. Renown, yeah.

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

10 Do you agree with that?

11 MR. FELTES: Objection.

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

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

18 MR. FELTES: Objection.

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

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

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

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

3 MR. FELTES: Objection.

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

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

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

11 Q. Right. Okay.

12 A. Okay.

13 Q. And if the nurses --

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

16 Q. All right.

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

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

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

1 believe should have been obtained.

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

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

7 Go ahead, Doctor.

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

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

15 MR. QUANDT: Objection.

16 MR. SCOTT: Objection.

17 MR. WEITENDORF: Join in that.

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

20 MR. QUANDT: Objection.

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

1 Q. Okay.

2 A. But, again, it wasn't clear to me who was in charge.

3 Q. Who should have been in charge?

4 MR. FELTES: Objection.

5 MR. QUANDT: Join that objection.

6 A. I'm not sure what the policy is at Elyria.

7 Q. In your opinion, based upon your careful review of
8 this record, regardless of the policy at Elyria or
9 Podunk or University of Pittsburgh -- Let me just
10 finish -- a patient is entitled to have a physician
11 looking out for her. I mean, that's one of the
12 reasons she's in the hospital. She needs care.

13 A. Right.

14 Q. In your opinion, who had the responsibility for
15 either coordinating this care and/or delivering it?
16 If it's all of them, fine. If it's one of them,
17 that's fine, too.

18 A. At some institutions the attending physician of
19 record would be responsible. At other institutions
20 the physician in charge of the ICU would be
21 responsible. And I don't know what the policy is at
22 Elyria.

23 Q. So whatever their policy is in terms of
24 responsibility, that's the way you see

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

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

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

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

15 A. Okay.

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

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

24 MR. QUANDT: Objection.

1 MR. WEITENDORF: Objection.

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

5 MR. WEITENDORF: Objection.

6 MR. QUANDT: Objection.

7 MR. SCOTT: Objection.

8 MR. FELTES: Objection.

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

11 MR. QUANDT: Objection to the assumption.

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

14 MR. SCOTT: Objection.

15 MR. QUANDT: Objection.

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

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

24 A. Both, yes, I think so.

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

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

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

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

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

21 A. I learned it from YOU.

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

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

7 A. Okay.

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

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

19 A. I really didn't review them.

20 **a.** Okay. That's why I'm giving you these, because you
21 did say that. I'm trying to give you this
22 information.

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

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

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

12 Do you have an opinion, Doctor, as to
13 whether the delay in treatment from, let's say, the
14 17th until the 20th, the last time she was seen in
15 the emergency room until she's admitted, contributed
16 to cause her ultimate respiratory distress and
17 respiratory arrest?

18 MR. FELTES: Objection.

19 MS. MOORE: Objection.

20 MR. QUANDT: Join.

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

1 do some amazing things to a chest x-ray:

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

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

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

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

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

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

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

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

19 A. Thank you.

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

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

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

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

12 Q. Okay.

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

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

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

1 have an opinion?

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

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

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

9 A. What do I do?

10 Q. Yeah. Well, what should be done?

11 A. I can tell you what I do.

12 Q. Okay. What do you do?

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

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

21 A. Yeah, I would.

22 Q. What kind of antibiotic?

23 A. Parenteral intravenous antibiotics.

24 Q. What kind?

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

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

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

9 Q. Which would be --

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

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

16 A. Correct.

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

19 MS. MOORE: Objection.

20 MR. QUANDT: Objection.

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

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

4 Q. She should be admitted?

5 A. Yeah.

6 - - - -

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

9 - - - -

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

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

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

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

24 Respiratory acidosis really refers to

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

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

8 A. Page 330 in the lab section, blood gases. May 7,
9 14:46, pH 7.14; PC02 47; PO2 49.

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

18 Later on at the 2:46 blood gas you will
19 note that the **PC02** has gone up approximately -- or
20 15 millimeters of mercury from 32 to 47, coincident
21 -- indicating that she's unable to blow off that
22 amount of **C02**.

23 Q. So she is retaining it?

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

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

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

5 A. Correct.

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

8 A. She had .. If I were to review the blood gas from
9 10:46, I would say she had an insufficiently
10 compensated metabolic acidosis. In other words, she
11 got enough respiratory reserve to blow off some C02.
12 She blew herself down to 32. That's not much. A
13 healthy person ought to be able to blow themselves
14 down into the low 20s or lower.

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

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

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

22 A. Tell me what you're asking.

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

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

3 MR. FELTES: Objection.

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

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

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

15 MR. FELTES: Objection.

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

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

20 - - - -

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

23 - - - -

24 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.

a. 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.

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

4 A. That's correct.

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

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

14 A. Yes, it is.

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

19 A. The first --

20 Q. In the first draft that you prepared.

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

22 Q. Right.

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

1 Q. Right. But you didn't address it in the second one.

2 A. That is correct.

3 Q. What is the reason for that?

4 A. As I indicated earlier, after discussion with
5 Mr. Reichel, it was felt more appropriate to confine
6 my remarks more to the quality of care involving the
7 nurses in the ICU.

8 Q. Is it your opinion that clinical observation by a
9 physician is significant in terms of the decision
10 the physician makes with regard to care and
11 treatment of the patient?

12 A. You mean standing at the bedside and looking at the
13 patient?

14 Q. Yes.

15 A. Sure.

16 Q. I wonder if we could take a look at the doctor's
17 orders of the 6th and 7th, particularly turning to
18 page 45.

19 A. Doctor's orders?

20 Q. Yes.

21 A. Page what?

22 Q. Progress notes. I'm sorry. Page 45.

23 A. Okay.

24 Q. In the center of the page appears the date May 6 on

1 the left. Do you see it there?

2 A. Yes.

3 Q. And if you would, just glance at that note in
4 general and tell me whether or not you agree with
5 me: This is a note that was entered at or about the
6 time of the extubation.

7 A. Well, it is certainly on the same day. I don't know
8 the time.

9 Q. If you want to look at the end of the note --

10 A. Recommend TPs. GYN consult as ordered. I mean, is
11 that where you want me to look?

12 Q. Yes. Does that indicate to you that he's talking
13 about extubation?

14 A. Yeah. He's certainly talking about weaning. TPs is
15 a weaning modality.

16 Q. On May 6, right after the date it says: Looks
17 better this morning.

18 A. Correct.

19 Q. Appears to be breathing comfortably. Is that a
20 clinical observation that's significant to a
21 treating physician?

22 A. Yes.

23 Q. And do you observe following the word lungs appear
24 the words good air entry?

1 A. I see that.

2 Q. And below that I think it's -- if you can help
3 me with that --

4 A. Few rales at base.

5 Q. A few rales at base?

6 A. Yes.

7 Q. No wheezing?

8 A. Correct.

9 Q. Are those positive factors in terms of her
10 respiratory condition at the time?

11 A. Yeah. Overall, that's a decent exam. That's
12 basically a positive exam.

13 Q. And under impression near the bottom of the note he
14 says: Better from pulmonary. Is that a positive
15 factor in terms of her pulmonary condition? It
16 seems to say so; doesn't it?

17 A. Yes. That's a positive impression.

18 Q. And then item number two, normal anion?

19 A. Anion.

20 Q. Anion. Can you explain what that is to me?

21 A. There are basically two kinds of metabolic acidosis,
22 and it has to do with the chemistry of the minerals
23 in the blood. And one type is an anion gap
24 acidosis, which may reflect insufficient perfusion

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

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

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

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

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

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

22 A. That's correct.

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

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

3 A. Yes, I do.

4 Q. With good airway?

5 A. Uh-huh.

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

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

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

13 MR. KAMPINSKI: Which page are you on?

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

16 A. Yes, I do.

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

21 A. Continues to do good?

22 Q. Yes.

23 A. Yeah, that's a positive assessment.

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

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

5 A. Sure.

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

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

10 Q. Yes, page 988, nurses' notes.

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

15 A. Yes.

16 Q. In fact, her pulse rate from 10:00 o'clock until
17 **2:00** o'clock dropped from the 158 to lower pulse
18 rates. Is that correct?

19 A. You mean from 158 to 136 to **128**?

20 Q. Sure.

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

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

1 Is that correct?

2 A. Correct.

3 Q. And at noon it's 98?

4 A. Yep.

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

7 A. That's correct.

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

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

15 Q. During the CAT scan.

16 A. Okay.

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

19 A. No.

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

1 **A.** I do.

2 **Q.** Now, the opinions that you've rendered in this case,
3 both with regard to the draft report and in final
4 format the letter that you sent to Mr. Reichel, were
5 both prepared by you knowing that, in fact,
6 Mrs. Lind had arrested at approximately about 3:00
7 o'clock on the 7th. Is that correct?

8 **A.** That is correct.

9 **a.** I'm looking at your CV, Dr. Stiller, and I notice
10 that since 1990 you have been assistant professor of
11 anesthesiologist and critical care medicine,
12 secondary appointment.

13 **A.** That's correct, secondary appointment.

14 **Q.** Can you explain to me what that secondary
15 appointment means.

16 **A.** My primary department is the department of medicine.
17 As a matter of courtesy, because I'm an attending
18 physician in the intensive care unit, I get a
19 secondary appointment in the department of
20 anesthesiology.

21 **Q.** Does the University of Pittsburgh --

22 **A.** It's more fluff than reality.

23 **Q.** Does the University of Pittsburgh have a pulmonary
24 care division?

1 A. Do we have a division of pulmonary medicine?

2 Q. Yes.

3 A. Yes, we do.

4 Q. Is that separate from the department in which you
5 work?

6 A. No. It's the same department. I'm in the
7 department of pulmonary, allergy, and critical care
8 medicine.

9 Q. What courses do you teach at the University of
10 Pittsburgh?

11 A. There is in the second-year medical student
12 curriculum a block on pulmonary medicine, and we
13 have a number of workshops involved with different
14 aspects of pulmonary medicine. I teach those
15 blocks, those workshops. In addition, I teach
16 residents, fellows and medical students during
17 rounds in the intensive care unit and on the
18 pulmonary consultation service.

19 Q. The block that you're referring to, how much time is
20 involved in that, just roughly?

21 A. Two and a half, three weeks a year.

22 Q. With regard to Exhibit 3-B -- That's the draft
23 report that you prepared -- about a fourth of the
24 way down from the top of the page you're talking

1 about after the patient had returned from the HIDA
2 scan. You state: The patient was appropriately
3 treated with intravenous fluids, although she
4 remained hypotensive, tachycardiac and tachypneic
5 despite repeated infusions which were ordered at
6 12:35 and 1:00 p.m.

7 Is that still your opinion?

8 A. Yes, it is.

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

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

19 A. They were certainly concerned about her.

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

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

4 Is that still your opinion?

5 A. Yes, it is.

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

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

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

12 A. Okay.

13 MR. KAMPINSKI: Objection.

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

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

17 - - - -

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

20 - - - -

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

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

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

1 Q. Page six, Dr. Stiller.

2 MR. KAMPINSKI: Who is this, Martin?

3 MR. GALLAGHER: This is Martin, page six.

4 MR. MELLINO: Yeah.

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

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

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

13 A. I did not.

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

16 A. Yes.

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

21 A. No, I do not.

22 Q. Why not?

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

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

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

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

11 A. That's correct.

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

15 A. That is correct.

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

19 A. No quarrel.

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

22 A. Yes, it is.

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

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

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

6 MR. KAMPINSKI: Where are you?

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

10 A. Got it.

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

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

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

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

24 Q. Do the clinical observations of the physician who

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

4 A. Certainly.

5 MR. KAMPINSKI: Objection.

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

9 A. Yes.

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

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

1 Q. Sometimes it's a close call; isn't it? -

2 A. What's a close call?

3 Q. Deciding whether or not to extubate or re-intubate.

4 A. Sometimes it's a trial of life, yeah.

5 Q. Going back, putting yourself in the position of
6 Dr. Dacha at the time of the extubation and the
7 consideration of whether or not to re-intubate, were
8 those circumstances involving close calls?

9 A. I think that's kind of a personal decision. It
10 depends on the style and practice of the physician.

11 Q. You wouldn't say that just because a physician would
12 have done what you would have done that he was
13 guilty of malpractice, falling below the standard of
14 care?

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

19 A. If a physician did not do what I would do, I would
20 not consider that malpractice.

21 Q. Are you the person at the University of Pittsburgh
22 Medical School who's in charge of the pulmonary
23 department of the hospital?

24 A. No, sir.

1 Q. Who is?

2 A. The chief of pulmonary medicine is Dr. Robert
3 Rogers.

4 Q. Is there anybody then in between you and Dr. Rogers
5 in that same area?

6 A. Not -- I mean, I don't have a supervisor over me
7 who's below Dr. Rogers in the area of ICU. I work
8 also in another part of pulmonary medicine in
9 addition to the ICU.

10 Q. You also work in general critical care medicine at
11 the University of Pittsburgh Hospital?

12 A. I am not in the department of critical care
13 medicine.

14 Q. You probably told me before, but I forget. Tell me
15 again what department you are in.

16 A. The name of the division is the division of
17 pulmonary, allergy, and critical care medicine.

18 Q. What is pulmonary allergy?

19 A. Pulmonary, comma, allergy, comma, and critical care
20 medicine. That deals with one of the people in our
21 division who's an asthma expert.

22 Q. In dealing with critical care patients, do you deal
23 with critical care patients who do not have a
24 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?

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

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

14 A. You mean all my patients?

15 Q. Certainly.

16 A. Primary pulmonary problems?

17 Q. Yes, sir.

18 A. 75, 80 percent of the time.

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

21 A. Sure.

22 Q. To what extent is it a factor?

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

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

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

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

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

21 A. Sure.

22 Q. -- and have a special problem?

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

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

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

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

14 A. Certainly.

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

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

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

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

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

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

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

13 A. I'm sorry?

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

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

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

1 treatment of Mrs. Lind?

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

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

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

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

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

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

18 MR. KAMPINSKI: I object.

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

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

1 arrest?

2 MR. KAMPINSKI: I'll object to that.

3 Q. That's not in there either?

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

9 Q. Those words do not appear there?

10 A. They do not.

11 MR. GALLAGHER: I have no further
12 questions.

13 - - - -

14 EXAMINATION

15 - - - -

16 BY MR. SCOTT:

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

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

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

1 A. That is correct.

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

4 A. That is correct.

5 - - - -

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

8 - - - -

9 A. Didn't read it.

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

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

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

21 A. Yes.

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

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

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

6 A. No.

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

9 A. That was my understanding.

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

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

13 MR. QUANDT: No questions.

14 MR. FELTES: Are we done?

15 MR. KAMPINSKI: I'm sorry.

16 - - - -

17 RE-EXAMINATION

18 - - - -

19 BY MR. KAMPINSKI:

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

24 A. I was doing that.

1 Q. I know.

2 A. Yes.

3 Q. The reason you were doing that was what, sir?

4 A. I was trying to find them from the 6th.

5 Q. Okay.

6 A. I didn't see them.

7 Q. What was the reason you were trying to find them
8 while he was going through the progress note?

9 A. I wanted to see what the physiology of the patient
10 was.

11 Q. Why is it you wanted to see that?

12 A. The question that obviously comes to mind is one has
13 an opinion about a patient's condition, and one
14 simply wants laboratory data to support or refute
15 your impression.

16 Q. Okay. And you were looking for the ones on the 6th
17 then I take it.

18 A. That's correct.

19 Q. That would be page 329, I think, if you want to take
20 a look at that.

21 A. I'm sorry. What page?

22 Q. 329.

23 A. I go from 301 to 330.

24 Q. Here, you can take a look at this.

1 A. Okay.

2 Q. Is there anything you would want to add then in
3 response to the questions that -- or your responses
4 to the questions that he asked you now that you've
5 had a chance to look at those?

6 MR. FELTES: Objection.

7 A. I would be concerned with the pH indicated on the
8 blood gases of May 6th at 5:13 a.m. and at 9:52 a.m.
9 and marginally concerned with the blood gas at 12:05
10 p.m.

11 Q. Okay. And I assume that's what you were referring
12 to in your report, your initial report, 3-A and B,
13 when you indicated that she should not be extubated.

14 A. Specifically, I don't remember, but I would
15 certainly want to know these blood gases and would
16 be concerned about extubating a patient with those
17 blood gases.

18 Q. The opinions that you expressed in Exhibits 3-A and
19 B, your initial report, were those to a reasonable
20 degree of medical certainty?

21 MR. GALLAGHER: Objection.

22 MR. SCOTT: Objection.

23 MR. WEITENDORF: Join.

24 A. Those opinions were expressed based on my

1 experiences and my personal beliefs about patient
2 management.

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

4 MR. GALLAGHER: Objection.

5 MR. SCOTT: Objection.

6 MR. WEITENDORF: Join.

7 MR. QUANDT: Join.

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

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

10 A. In my opinion.

11 Q. They are more probably true?

12 A. They are more probably true than not.

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

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

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

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

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

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

12 A. I don't know.

13 MR. FELTES: Objection.

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

15 MR. SCOTT: That's all.

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

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

21 THE WITNESS: Okay.

22 - - - -

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

COMMONWEALTH OF PENNSYLVANIA) CERTIFICATE

COUNTY OF ALLEGHENY) SS:

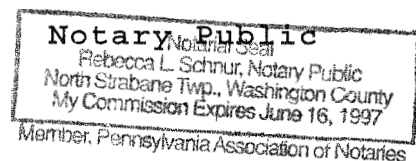
I, Rebecca L. Schnur, RMR, a Notary Public in and for the Commonwealth of Pennsylvania, do hereby certify that the witness, RONALD A. STILLER, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the foregoing deposition was taken at the time and 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



1 COMMONWEALTH OF PENNSYLVANIA) E R R A T A
 2 COUNTY OF ALLEGHENY) S H E E T

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

7 Pg. No. Line No. Change and reason for change:
 8
 9
 10
 11
 12
 13
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 15
 16
 17
 18
 19

20 In all other respects the transcript is true and correct.

21 _____
 22 RONALD A. STILLER, M.D.

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

 Notary Public RLS

1 AUL, KARLOVITS & FULESDAY, INC. -
2 312 Boulevard of the Allies
3 Pittsburgh, PA 15222
4 (412) 261-2323

5 February 7, 1995

6 TO: Ronald A. Stiller, M.D.
7 University of Pittsburgh
8 Medical Center
9 440 Scaife Hall
10 3550 Terrace Street
11 Pittsburgh, PA 15261

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


13 NOTICE OF NON-WAIVER OF SIGNATURE

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

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

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

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

24 
25 Rebecca L. Schnur, RMR
26 Court Reporter

27 cc: Joseph J. Feltes, Esq.
28 John J. Gallagher, Esq.
29 Charles Kampinski, Esq.
30 Robert G. Quandt, Esq.

'

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15:20; 43:4

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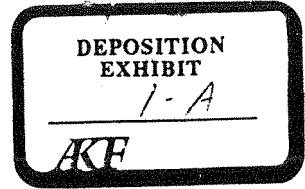
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BUCKINGHAM, DOOLITTLE & BURROUGHS

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

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:

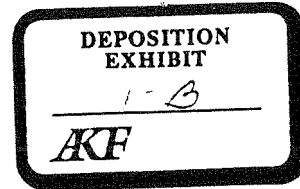
1. Excepts of the medical records from the date of admission to May 10, 1992. Since the event in question took place on May 7, 1992, I arbitrarily cut off the record at May 10. The patient remained in the hospital until July and additional records can be provided if your reviewer finds them necessary.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

A handwritten signature in cursive script, appearing to read "Arthur".

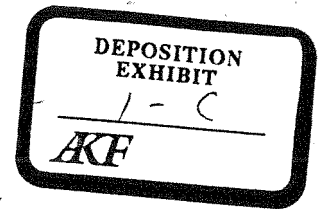
Arthur Greenberg, M.D.

AG:bb
Enclosures

COMPREHENSIVE
MEDICAL
CONSULTANTS, INC.

5811 Howe Street
Pittsburgh, PA 15232

(412) 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 (412) 647-3118 during the day or at (412) 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,

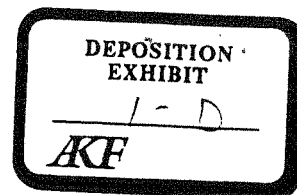
A handwritten signature in dark ink, appearing to read "Arthur Greenberg".

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.

A handwritten signature in dark ink, appearing to read "Ronald F. Shiller".

CASE EVALUATION



Case: Lind v. S. Comprehensive Health Care

Reviewer's Specialty: Pulmonary Medicine

Reason for Evaluation: Respiratory Arrest

Case Facts:

Medical Opinion:

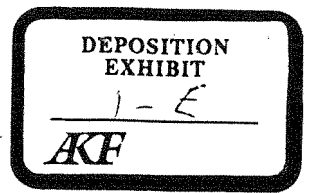
Medical Literature Documentation (as appropriate):

Additional Comments:

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,

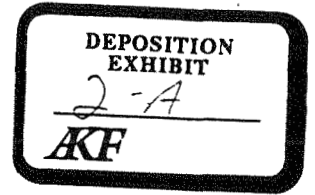
Sincerely,

A handwritten signature in cursive script, appearing to read "Arthur Greenberg".

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