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

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IN THE COURT OF COMMON PLEAS

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ALAN S. SIMS, Executor of the Estate of Hortense J. Sims, Deceased,

Plaintiff,

vs.

CLEVELAND CLINIC FOUNDATION and STEPHEN A. OCKNER, M.D.,

Defendants,

No, 94099

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Deposition of DR. HOWARD TUCKER, a witness called by the Defendants pursuant to the Ohio Rules of Civil Procedure, taken before me, George L. Blam, a Registered Professional Reporter and Notary Public for the State of Ohio, pursuant to notice of counsel, at the office of Dr. Howard Tucker, 26900 Cedar Road, Beachwood, Ohio, at 5:00 o'clock P.M., on Tuesday, the 16th day of June, 1987.

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APPEARANCES:

On behalf of the Plaintiff:

Ulmer, Berne, Laronge, Glickman & Curtis:

Maurice L. Heller, Esq.
Alan S. Sims, Esq.
Jeffrey W. Van Wagner, Esq.

On behalf of the Defendants:

Reminger & Reminger Co., L.P.A.:

Gary H. Goldwasser, Esq.

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DR. HOWARD TUCKER,

a witness called by the Defendants pursuant to the Ohio Rules of Civil Procedure, was by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. GOLDWASSER:

Q Dr. Tucker, with reference to the matter of the late Mrs. Sims, I understand you have been retained to testify on behalf of the plaintiff. Is that your understanding?

A Yes.

Q Doctor, what material have you been provided as relates to this case?

A I have here reviewed the report of Dr. John Gardner, Cleveland Clinic office notes of two years, from 1981, records from the Mt. Sinai Center, deposition of Dr. Ockner, St. Luke's records parts of it.

Q Have you actually examined any C.A.T. scans?

A Have I looked at the actual records? No,

Q The actual scans themselves you have not?

A No.

Q Have you looked at; any films at all in this case?

a N

Q Have you written any reports to any of the attorneys in this case?

A Just a single note on January 31, 1986.

Q Doctor, what is your fee for giving testimony here this afternoon?

MR. HELLER: Objection.

MR. GOLDWASSER: I don't have to pay him a fee?

MR. HELLER: I just objected. I didn't tell him not to answer,

MR. GOLDWASSER: What is the basis of the objection?

MR. HELLER: Because the rule provides you are entitled to know his opinions and the basis for them. I don't know if the fee he is getting or not getting has anything to do with his opinion,

MR. GOLDWASSER: I never had anyone object to it before, I was curious,

MR. HELLER: There is always the first time.

MR. GOLDWASSER: I know.

Q What is your fee for giving your testimony here this afternoon?

A Did my secretary say $1000?

Q Last week you charged $1000. This week I wasn't told anything.

A It would be the same,

Q $1000?

A Yes.

MR. HELLER: I object to the line of questions about fee.

Q Based upon your review of the case involving Hortense Sims, will you please tell me what you perceive to be the malpractice in this case?

A Yes. I think that Mrs. Sims had an event which no one could call anything but a transient ischemic attack which was sufficiently impressive to her that the following day she made an emergency appointment to see her physician to whom she gave that history, which is unmistakably a transient ischemic attack, and in the face of a blood pressure which was truly dangerously high at about 190 over 120, he reduces her medicin and permits her to go home,

It's my opinion that she should have been admitted to the hospital immediately. I doub that I would have allowed her to o home to get garments. I would have had her family bring them

in and admitted as a genuine medical emergency.

Q What is the history that Mrs. Sims presented with on the date in question, February 1984?

A Isn't that February 1st, 19843

Q February 1st, 1984, what was the history she presented with?

A I am reading from the written notes: "Yesterday had episode of amnesia while sitting at table per following event. Answered Tanglewood to question of high school graduation. Said something about granddaughter. Mouth was drawn to one side and the head tilted, funny look on the face, lasted probably less than a minute and felt well after that, Prior to that had been having a heaviness sensation of head and felt light-headedness yesterday, past two" something, "dull headache." I think that says "past two hours." I am not sure about the time, "Du11 headache," Can you read the next line?

Q No, E can't.

A The second word is "episode." Is anyone! able to figure that line out?

"One plus right eye. Yesterday felt tender spot left temporal area."

Then I think it says "No Inderal for 24

hours. Blood pressure was 190 over 120 in left arm."

Q Just the history at the moment. That's the history as you read it,

Any other source that you have utilized to obtain a history as Mrs. Sims presented to Dr. Ockner on February 1?

A Will you repeat that?

Q Is there any other source that you utilized to obtain a history other than the Cleveland Clinic notes you are reading from?

A That's what I had.

Q That note you are unable to read apparently is, "Single episode of rotational vertigo one plus weeks ago."

A Okay. That's a very important part of the history.

Q That is what I am here to ask you about, Doctor, what is it in the history, if anything, which gives you reason to conclude that Mrs. Sims presented with a T.I.A.?

A There are very few ways to explain such an episode we just described in which there is a focal deficit, a twisting of the face, there is ar alteration of consciousness in a known

hypertensive lady of older age bracket.

We went through all the symptoms which were short-lived, and I think the sentence that you gave me which I would never have been able to read is most critical because it relates so heavily to what we know later happened,

If I had that history at that point, if I were there and somebody said they had an episode of vertigo and now add these, I would say this vertigo plus these focal deficits tells me what I am dealing with,

Q Would the history of vertigo be that significant if you had known far many years she had conveyed a history of transient vertigo?

A She had transient light-headedness, a rare episode which they talked about vertigo, but you now take it with all the other things and it takes on a whole new meaning, where before it was vertebral insufficieney that isn't as critical as you are putting it into a very, very concise meaningful frame.

Q Putting aside even any examination, do I understand it's your opinion that merely from the history and the history alone you would conclude that this is an elderly woman, age 78,

I believe, who presented with a diagnosis of transient ischemic attack?

A I don't know how else to interpret that episode.

Q Is there any other diagnosis which would be consistent with that history that you can think of?

A I could say it's a transient ischemic attack and may be due to a cardiac irregularity for which I would want to get further documentation of a rhythm disorder or a heart rhythm.

I can think of an embolus causing it but we are still within the framework of blood circulating through brain and particularly in view of the vertigo, that to me is localizable to brain stem.

Q Do I understand your testimony to be that with that history this patient required hospitalization for further work-up? Is that what you are saying?

A That's what I am saying,

Q Dr. Ockner, as you know, if you read his deposition, has indicated that his working diagnosis, although he considered others, but his provisional working diagnosis was Inderal toxicity.

A I know that.

Q Do you find that the history is inconsistent with such?

A To me the history is inconsistent with Inderal toxicity.

Q What contained in that history does not jibe with a patient who presents with Inderal toxicity?

A First oE all, I have never known Inderal toxicity to be this transient an episode, It's inconceivable to me.

Usually when you are toxic from any medication you become toxic and you remain toxic.

She had no other symptoms of Inderal toxicity. She did have control of her blood pressure on that dose. To me it was a poor diagnosis, one which I can't think in any medical setting which would be an unjustifiable diagnosis.

Q I want to make sure I understand why you conclude it's a poor diagnosis, I know you have been alluding to it, I am not sure I understand it.

When a patient presents with a drug reaction, in this case Inderal, what would the typical pattern be if there was such, just hypothetically?

A A drug reaction?

Q Yes, to Inderal since that is the drug we are

talking about.

A First of all, Inderal has many but when you get into the brain manifestations you usually find drowsiness, a lassitude, lack of energy, and it's usually an almost progressive ongoing picture,

You have your drug on board and you are having a progression of toxicity. I have never seen any toxicity corning and going such as this,

Q What if the patient voluntarily stops use of the drug once these symptoms appear and then they pass in a matter of 24 hours?

A I think your Inderal half life is longer than the length of time this was stopped here. Besides, she took it the morning before when the great episode happened

As I recall it, it was the night after the incident that she didn't take it but she had it on board when the episode happened,

Q That is right, That's where I am having trouble. It's not your fault, She takes the medication in the morning?

A Correct.

Q And if hypothetically she is having a drug reaction one would expect a patient to have a

drug reaction within a few hours after the drug is beginning to metabolize. Isn't that reasonable?

A It stayed on board, She never had any trouble with it before and she is now having one isolated incident, Isolated incidents are never a drug toxicity.

Q Is that what you are keying on, that it's an isolated incident?

A There is not a progressive toxicity. She is on that drug for a while now. This is not a new thing. Usually you see a drug reaction come early and they maintain as the drug concentration progresses,

This is not a downhill course of progressive findings of toxicity. She was as good afterwards. We said she was alert afterwards.

If it's on board how would she recover that spontaneously?

Q What you are saying is the fact that within a few hours or less after these signs appear, that the patient is rebounded or recovered transiently that that is inconsistent with a drug reaction? Is that what you are saying?

A Of this type, that's what I am saying.

Q Would you agree just for the purposes of discussion that many if not most of the history she presented with is described as a potential side effect from the drug Inderal?

A Would you repeat that?

Q Would you agree that the history she presented with is consistent with that which is found as a side effect of Inderal?

A In this episode?

Q I am not talking about this particular episode. Just hypothetically if we academically outlined everything you have read to me in the history, would not most of what you have read been consistent with that which is found as a reaction to the drug Inderal?

A I don't think so.

Q What is there which it is not consistent with?

A There is no lassitude, there is no lethargy, there is no slowing of her heart rate, there is no proper control of her blood pressure.

I don't know where you are coming from. There is nothing consistent with an Inderal toxicity.

Q Doctor, by virtue of being a law school graduate as we have discussed years past, did you take the

bar exam the last time I had questioned you?

A I had not.

Q Are you a licensed lawyer now?

A No.

Q Based upon your law school education, define for me malpractice, please.

MR. HELLER: Objection.

A I am not here as a lawyer.

Q I know but you are a graduate of a law school, are you not?

A Yes.

Q I want to know based upon your law school education how you define malpractice.

A I never studied that in law school but to me malpractice is a deviation from a standard of care that is unacceptable.

Q What is your definition of proximate cause as it relates to a negligent act?

MR. HELLER: Objection.

A That the breach of the negligent act was the direct cause of the later event.

Q Dr. Tucker, you have told me that you feel that acceptable care required Dr. Ockner to admit Mrs. Sims to the hospital?

A Yes.

Q If such had been done what would you have expected the diagnostic work-up to include?

A I think the very first thing I would have done would have been to treat her emergently because I would have put her to bed and I would have expected to reduce her pressure. I would have kept her at bed rest.

If her pressure didn't come down immediately or overnight, then by morning, at least, I would have gone into another group of drugs but I would have called someone at that point.

I am not going to get into treatments of blood pressure per se. I would have her admitted to my service and called in an expert to reduce blood pressure.

Q What diagnostic studies, if any, would you have avoided?

A I would have probably started with Doppler duplex to see what her carotid circulation was doing; I would have more than likely put her on telemetry to see her rhythm for the next 24 hours day and night to see if there were any skipped beats or anything else like that.

When stabilized I would have gotten an intravenous digital subtraction arteriogram or

angiogram to see the caliber of the vessels and to see if she was throwing any small clots from the ulcerated plaque.

Q Angiogram of the carotid?

A And vertebrobasilar.

Q Is that customarily done to obtain angiograms of vextebrobasilars?

A It would help me make a diagnosis although you are not going to do surgery on your vertebrobasilars.

Q Anything else?

A Then with that all done, then I would have maintained her on anticoagulation and particularly in view of a history which I did have of vertigo as one of my symptoms, I would have probably anticoagulated her with Heparin and later Coumadin.

Q What did Dr. Ockner's examination consist of on February 1, 1984?

A He had blood pressures on her, someone took her pulse, which was perfectly normal and did not show any signs of being slowed by the Inderal, found her to be alert and oriented, He found a normal examination beyond that including carotid arteries and listening for bruits.

Q Do you find Dr. Ockner's examination of the patient in his office to be a deviation from acceptable standards of practice?

A No.

Q What is the significance of his negative findings on examination?

A The significance of it as I would put it together is that it did not show any evidence of Inderal toxicity.

If he found something 24 hours later he could no longer call it a transient ischemic attack and after an ischemic attack this is what I would expect to find.

Q You would expect the carotids upon clinical examination to appear to be clear?

A By his clinical exam,

Q And you would expect a neurological examination as Dr. Ockner described in some detail in his deposition to be negative?

A Negative exam,

Q It was a reasonably thorough neurological examination, was it not?

A He wrote down salient features, correct,

Q Would you agree it was a complete neurological examination?

A I wasn't there. I say he wrote down things that I would be interested in reviewing,

Q Based upon his testimony in his deposition which you have read, would you agree that it was a complete neurological examination?

A All I can say, I wasn't there and everything he wrote down was appropriate and covered the important salients,

Q If someone presents with a transient ischemic event or attack, is it your testimony then that you would expect to find a negative neurological examination?

A Yes, because by definition it's a reversible event, It clears within 24 hours by definition,

Q Dr. Ockner also ordered the results of some laboratory studies on February 1. Is that not true?

A A C.B.C.

Q He got a C.B.C., a KP6 and a Westergren sedimentation rate,

Do *you* have any quarrel with the laboratory studies ordered by Dr. Ockner?

A I have no quarrel, They don't address the issue of a transient ischemic attack,

Q What issues do those tests address?

A Infection, perhaps anemia.

Q What does the KP6 address?

A I don't know what the KP6 is,

Q What is the Westergren sedimentation rate?

A Inflammatory disease of a vessel like the temple arteritis.

Q That will be an inflammatory disease of a blood vessel?

A Of a certain artery that doesn't cause strokes unless it is a stroke to the temple artery. This picture isn't that of temple arteritis.

I don't know why he got the sedimentation rate. Will you please tell me, if you know, what a KP6 is?

Q A KP6 is a chemistry profile of the kidney.

So you are saying that the sedimentation rate study for vascular arteries is insignificant when a patient presents with a possible diagnosis of T.I.A.?

A It has no bearing on this type of T.I.A. It only tells us about inflammatory disease of arteries in the context of blood vessels. It's a non-specific test for infection any place in the body.

Q So you don't quarrel with the test but your

opinion is that it's irrelevant as relates to what should have been a provisional diagnosis of T.I.A.? Is that what you are saying?

A That's what I am saying,

Q Doctor, what is the treatment for vertebral vertebrobasilar ischemia?

A That's too broad a question.

Q If you have a patient who is diagnosed with having basilar ischemia, how do you treat it?

A I told you in the first place you get their blood pressure down, In the second you anticoagulate them because you don't want them to go onto catastrophe,

Then you evaluate your total circulation to see if some major vessels that are accessible for s rgical correction are involved.

When Mrs. Sims presented to St. Luke's Hospital, what was the diagnosis after she had been evaluated?

A rain stem infarction.

Q Do you have any reason to di- gree with that diagnosis?

A o.

Q Doctor, what is the etiology of that brain stem infarction?

A What do you mean etiology?

Q What is the cause of it, what is the source?

A Someplace in the vertebral basilar system not enough blood was getting through so the brain stem suffered this major insult.

Q Would you agree that it was probably from the source of the vertebral basilar rather than the carotid?

A No question.

Q So we now are retrospectively dealing with what tragically turned out to be a basilar artery ischemia resulting in brain stem infarction, is that fair?

A Why do you say retrospectively? I think prospectively when you have vertigo plus everything we said, I think you can project a vertebrobasilar problem.

Q I say retrospectively because you yourself have a provisional diagnosis and want to put her in the hospital for further tests. That's why I say retrospectively.

I understood from your testimony your criticism of Dr. Ockner is that he did not admit the patient to the hospital for a work-up with the provisional diagnosis of T.I.A.

A Yes, that's the diagnosis.

Q A T.I.A. could be diagnosed as a consequence of the carotid too?

A That's right, if you want to treat it as a T.I.A.

Q Nevertheless, the patient has brain stem infarct secondary to basilar artery ischemia, am I correct?

A Correct.

Q What is the treatment for that condition?

A You mean when she entered St. Luke's?

Q Just generally speaking, what would the treatment for that condition be?

A Once you have infarcted a tissue there is no treatment other than support.

Q What is the treatment for basilar artery ischemia before there is the event of a brain stem infarction?

A Reduce the pressure, you place your patient at rest, you thin their blood, you prevent clotting as best you can, seek out a source for emboli but nevertheless that's part of the diagnostic work-up. I told you what I would do.

Q Dr. Ockner in this case discharged the patient from his office on February 1 with the drug Clonodine. Is that a drug recognized for the

treatment of hypertension?

A It is.

Q In your opinion is that drug insufficient treatment for the hypertension that Mrs. Sims presented with?

A I don't initiate treatments on hypertension. Clonodine is an accepted drug.

Q You don't have an opinion as to the specific question I asked?

A You mean about whether there is proper dosage?

Q Yes.

A I do not.

Q Is it your opinion stated with reasonable medical certainty that if Mrs. Sims had been admitted to the hospital with antihypertensive medications, anticoagulation medications and bed rest she would not have suffered a brain stem infarction?

A The medical probability is that she would not have.

Q Can you tell me why you so conclude?

A For the reason that the corrective measures that we talked about have proved to be effective corrective measures and that's why we persist in doing it all these many years. That's why we are so intent on following blood pressures.

That's why it is called the silent killer.

Q If her blood pressure is reduced but a patient is not put on bed rest and is not given anticoagulation therapy, is that on occasion adequate treatment for basilar artery ischemia?

A That would depend upon the degree of blood pressure. This is a very impressive blood pressure, 190 over 120. I do not think this patient should go home.

Q The patient is admitted to the hospital hypothetically and given, for the purpose of my question just assume, which it may or may not be accurate, but just assume that she is given the same blood pressure medication she was given as an outpatient.

I know you are not qualified to comment upon the dosage, I am accepting that, but for the purpose of my question if hypothetically Dr. Ockner indicated she had been admitted to the hospital she would have been given the same medication, and assume she wasn't given anticoagulation drugs but just given the blood pressure medication, would that have been sufficient in most instances?

A It's possible that would bring down the blood

pressure at this point because when you relieve the spasm, you have to remember what blood pressure elevation, particularly diastolic of 120 means, It means that the small arteries are in constriction so blood is not going to go through the small arteries,

That may be but you bring down your blood pressures immediately when they are that dangerously high and you put them at rest, and remember the stresses in an isolated hospital room are much less than they are out in the world.

Driving home, I presume she drove home, you have to worry about the guy cutting in front of you. It's just a whole different environment. That is not the way to treat a blood pressure like that, letting her go home. There is no monitoring at; home,

Q Dr. Tucker, I want you to assume that the patient was instructed to take her Clonodine commencing forthwith from the time it was prescribed, which was February 1.

I want you to further assume that she did not start taking that until February 5 contrary to the doctor's instructions.

I want you to further assume that she was no longer on Inderal because the doctor assumed the patient would be on the drug Clonodine.

If that assumption is correct, that is, the patient in essence was off of antihypertensive medication for four days contrary to the doctor's instructions, what effect is that likely to have upon a person who presents with vertebrobasilar ischemia with a history of T.I.A.?

A I think going off hypertensive medicine increases the risk, which is another reason to admit the patient.

Every sophisticated doctor knows about about non-compliance. We hate to admit it but it's just another reason to hospitalize to make sure about compliance.

Q Do patients you treat in your judgment have an obligation to comply with your instructions as relates to the taking of medication?

A What I am saying is that the incidents of non-compliance are very high and when you are dealing with an emergent situation that is part of your responsibility to think about it.

MR. GOLDWASSER: Read my question back.

(The last question was read by the Reporter.)

A I would hope that they would take the medicines that I prescribed.

Q And you would expect them to, particularly if you are dealing with a patient who is one you can communicate with?

a I would expect them to,

Q She was admitted to St. Luke's on February 6th.

a You are telling me that she went from February 1st --

Q According *to* the history she didn't start her Clonodine until the day before her admission to the hospital,

Do you know Dr. Gardner?

A Surely.

Q Do you respect him as a competent neurologist?

A I do.

Q You have indicated you have read his report.

A Yes.

Q As you noted Dr. Gardner holds a different opinion than you as to Dr. Ockner's standard of care,

A Yes.

Q In his report Dr, Gardner states, "Amnesia, confusion, and the funny look on her face could

have been attributed to alterations in her blood pressure, especially as influenced by Inderal.

Do you agree or disagree with that statement?

A I would have to disagree with that statement, In fact, I had a check mark on it when I reviewed it.

Q Why is it you disagree with that statement?

A Because we have already said that when blood pressure alterations do that it's because it's a T.I.A. It's not the blood pressure alone and I do not believe that Inderal ever caused this or ever will. If it has, it's the first time.

It's unfortunate medical dictum has to come out of a courtroom or a medical deposition instead of medical. I never heard of Inderal doing this or I don't know if Gardner has.

Q You don't know if he hasn't or are you saying i does?

a I don't know that he has.

Q Dr. Gardner says also in his report that, "There is no consistent medical agreement on the proper management of the vertebrobasilar insufficiency." Do you agree or disagree with that?

A I have to go back a minute. When he says alterations in blood pressure, if he meant a drop

in blood pressure that again gets us back into T.I.A. from whatever cause but it doesn't deny a T.I.A. He doesn't say alteration upper or Lower, What is the next thing?

Q Towards the bottom of the first page the doctor indicates there is no consistent medical agreement on the proper management of the vertebrobasilar insufficiency. Do you agree or disagree with that?

A He kind of leaves that very wide when he says no consistent medical agreement on the proper management.

I don't know how far afield he is taking it. If he is talking specifically about the anticoagulations, I would agree with him. If he is talking about bringing down the blood pressure, putting the patient at rest, then I would have to seriously and strongly dissent. There is a standard of medical care.

Q You have read Dr. Ockner's testimony, have you not?

A I have,

Q You know then that he has testified that although his working diagnosis was Inderal toxicity, he did consider T.I.A. as a potential problem.

He also testified that if it proved that such was the case, that it was reasonable for him to have sent the patient home on the hypertensive medication that he had prescribed for her,

Is it your testimony that such is sub-standard medical practice in this particular case?

A I get back to where we started, She had an extremely high blood pressure and she now has had within 24 hours an advance that has to represent a circulatory embarrassment and she should not have gone home. She should have been admitted to the hospital

Q In part Dr. Ockner testified that even if it was a T.I.A., since it was not in the carotid arteries, the only thing that could be done by way of management was to lower the blood pressure. Apparently you disagree with that, as I understand your testimony?

A Start that over again,

Q Dr. Ockner has testified that even if it was a T.I.A. as the patient presented in his office on February 1, the only thing that could have been done by way of management was to lower the blood pressure which he was attempting to do with

Clonodine.

As I understand your testimony you disagree with Dr. Ockner when he says that that is the proper way?

A We want to reduce the blood pressure but he is talking in terms of over weeks and I am talking about overnight.

I am talking about reducing the pressure today and not tomorrow and not a week from tomorrow, and I say put her to bed or at least do everything in your power to reduce the pressure, That doesn't mean driving up Carnegie during rush hour traffic.

Q Is that what the patient did?

A No, I don't know that, E am using that to explain to you that the outside world is rougher than the hospital. People coming here, rushing to get here, the pressure is sky-high and by the time they leave it's down,

Q Do I understand then from what you have testified to that you don't quarrel with Dr. Gardner's suggestion that there is not a uniform opinion on the use of anticoagulation therapy as relates to the treatment of this condition?

A There most certainly is not a uniform opinion

but I know that the majority agree to anticoagulation. There is a vocal minority that says there is no role for anticoagulation.

Q So ne understand what we are talking about as relates to this particular lawsuit, if hypothetically Dr. Ockner had done everything you suggested he should have done but had not used anticoagulation therapy but had done everything else, would his care of the patient be acceptable?

A That would depend on how the case unfolded, how the situation unfolded. You can't make a blanket statement on that.

Q Obviously if the patient gets better the question I am asking you is moot because if she got better --

A Better from what?

Q Better from the standpoint of -- that's a good question. Can you cure the condition with which Mrs. Sims present, vertebrobasilar insufficiency?

A We talked about that. First I want to know the status of all the vessels leading to the brain. This is something important to be done before you make a judgment on whether you anticoagulate or not. This was not done.

Q Let's talk about that for a moment. Let's talk

in the abstract about basilar artery insufficiency

Once that diagnosis is made and the patient presents with the age of 78 with a history of T.I.A., what is the protocol followed in an attempt to ascertain whether or not there would be any treatment, any treatment consisting of surgical treatment? What has to be done to make that decision?

A The critical issue will be whether your carotids, not the basilars, are surgically correctable, because what the carotids supply to the base of the brain reflects where the circulation from the posterior circulation -- in other words, there are steals where an impoverished area will take blood from another area and if your carotids are narrow you run the likelihood that you are stealing blood from your posterior circulation fos other areas; therefore, if you improve the anterior circulation you help the posterior circulation even though you can't operate on the posterior circulation, the posterior circulation being the vertebrobasilars,

Q So they are not operated on?

A They are not operated on, There has been some recent work on it,

Q So vertebrobasilar artery insufficiency can be alleviated with either clearing the carotids if they are occluded to any significant degree or just maintaining the patient's blood pressure at proper levels?

A Or anticoagulation and if there is one area, even those in the minority when they grudgedly concede that maybe there is a role for anticoagulation, they say it's in the vertebrobasilar insufficiency more so than in the carotid circulation problems,

Q So if we assume for the purpose of my next question that Mrs. Sims presented with vertebrobasilar insufficiency, which was to be treated medically rather than surgically, what is the life expectancy for ~~such a 78-year~~ old lady barring the fact that there is any other organ system failure? Is her life expectancy reduced by virtue of that disease with which she presents?

a P don't think I can answer that with any certainty because people go on for years and years and years and five out a full life span after vertebrobasilar insults.

Q Do you know what a statistical life expectancy

would be for a 78-year old white female?

A No

Q I don't either but for the purpose of my question let's assume the life tables suggest that it's five years, I don't know what it is, Let's assume that for the purpose of this question,

Is it your testimony then that with reasonable medical certainty a patient treated medically for such condition will five that statistical five years?

A Probably.

Q As you review the records, did Mrs. Sims present with any other disease process other than that which was affecting the central nervous system?

A I will have to sit here and look for it.

Q If you are telling me you have to go through the chart, it's not necessary. If you can't remember offhand, that's fine, You are telling me that the records will speak for themselves as to that question?

A What was the question specifically?

Q Did she present with any other disease entity?

A She had fecal incontinence, she had psoriasis, they say arthritis and hives.

Q You are reading that from what?

A The Cleveland Clinic discharge summary.

Q Dr. Tucker, to summarize your testimony if I may, please, and the reason I am doing this is I want to make sure I am walking out of here with the correct impression as to your opinion.

It is your considered opinion based upon your review of that material you have outlined for me that when Mrs. Sims presented to the doctor's office on February 1, 1984, Dr. Ockner's office, the history of those events which occurred the day previous were consistent with a T.I.A. Is that correct so far?

A So far it is.

Q That based upon that history regardless of the fact that his examination findings were negative, this patient required, save for her blood pressure which was markedly elevated, this patient required admission to the hospital for bed rest and the hypertensive medications and anticoagulation therapy?

A Possibly anticoagulation therapy.

Q But certainly antihypertensive therapy and rest?

A Correct.

Q By virtue of Dr. Ockner discharging the patient home from his office on merely an antihypertensive

prescription was inadequate based upon the history as presented. Is that your opinion?

A Inadequate is correct,

Q It is further your opinion that with reasonable medical certainty if Dr, Ockner had admitted the patient to the hospital on at least rest and antihypertensive therapy, that her condition would have stabilized and that she would have been discharged from the hospital in due time and she would have lived a statistical Life expectancy, Is that what you are telling me?

A Yes.

MR, GOLDWASSER: Thank you, We started this deposition about 5:00, wasn't it? It is now 14 minutes to 6:00 and I will send you $1000 as you have requested for this 40-plus minutes.

(Deposition concluded.)

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

I, George L. Blam, a Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, DR. HOWARD TUCKER, was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a typewriter; and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 30 day of June, 1987.

George L. Blam

George L. Blam, RPR, Notary Public
In and for the State of Ohio

My commission expires October 24, 1988.