

THE STATE of OHIO,  
COUNTY OF LORAIN.

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IN THE COURT OF COMMON PLEAS

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LENORE LIND, et al.,  
plaintiffs,

vs.

: Case No. 93CV11079

COMPREHENSIVE HEALTH CARE of  
OHIO, INC., et al.,  
defendants.

- - - - -

Deposition of DONALD G. VIDT, M.D.,  
a witness herein, called by the plaintiffs for the  
purpose of cross-examination pursuant to the Ohio  
Rules of Civil Procedure, taken before Constance  
Campbell, Notary Public within and for the State of  
Ohio, at the Cleveland Clinic, 9500 Euclid Avenue  
Cleveland Ohio, taken on FRIDAY, MARCH 24, 1995,  
commencing at 2:00 p.m. pursuant to notice.



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I N D E X

WITNESS: DONALD G. VIDT, M.D.

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DR. VIDT DEPOSITION EXHIBITS MARKED

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1                                   DONALD G. VIDT, M.D.

2       of lawful age, a witness herein, called by the  
3       plaintiffs for the purpose of cross-examination  
4       pursuant to the Ohio Rules of Civil Procedure,  
5       being first duly sworn, as hereinafter certified,  
6       was examined and testified as follows:

7                                   -----

8                                   CROSS-EXAMINATION

9       BY MR. MELLINO:

10      Q.       State your full name, please, Doctor.

11      A.       My name is Donald middle initial G., stands  
12      for Gardner, Vidt, V-i-d-t.

13                               MR. MELLINO:               Before we get  
14      started let's have the record reflect that Bob Orth  
15      and Lynn Moore have not appeared as yet. It's 17  
16      minutes after 2:00, the deposition was scheduled to  
17      start at two o'clock, we're going to go ahead in  
18      their absence.

19      Q.       Where do you live, Doctor?

20      A.       I live at 2899 Concord Road, Pepper Pike  
21      44124.

22      Q.       Have you been deposed before?

23      A.       I have.

24      Q.       How many times have you been an expert  
25      witness in a medical malpractice case?

1 A. Do you mean deposed or appearing in court?

2 Q. I didn't mean that. I mean retained as an  
3 expert witness.

4 A. I can think of three occasions in the past  
5 several years where I was asked to review a case.

6 Q. Is that including this one or in addition to?

7 A. That was in addition to this one.

8 Q. On how many of those occasions were you  
9 deposed?

10 A. One time.

11 Q. One other deposition?

12 A. Um-hum.

13 Q. How many times have you appeared in court to  
14 testify as an expert witness?

15 A. One time, that was approximately 20 to 25  
16 years ago.

17 Q. Was that the same case you were deposed in?

18 A. No.

19 Q. The other times you've been retained as an  
20 expert, was that was on behalf of a defendant in a  
21 lawsuit?

22 A. It was on behalf of a defendant.

23 Q. Did any of those involve Dr. Miclat?

24 A. No.

25 Q. Elyria Memorial Hospital?

1 A. No.

2 Q. Any physicians involved in this case?

3 A. No.

4 Q. What were the issues involved in those three  
5 other cases?

6 A. One was I guess about three years ago, it was  
7 a nephrologist in the Akron area who had cared for  
8 a patient with acute rapidly progressive renal  
9 failure. That patient suffered an intracranial  
10 hemorrhage, expired during that hospitalization.

11 Q. Were you deposed in that case?

12 A. Yes, I believe that that is the case that I  
13 was deposed in.

14 Q. Do you know the name of that case?

15 A. I am sorry, I don't recall the name.

16 Q. Do you recall the name of the person who took  
17 your deposition?

18 A. I do not.

19 Q. Who retained you in that case?

20 A. I am sorry, I can't even tell you that at  
21 this time. It's several years ago, I don't know  
22 that I've kept any file on that.

23 Q. It was three years ago?

24 A. Um-hum.

25 Q. You have no recollection of who retained you



1 or what firm retained you?

2 A. I am sorry, I don't recall.

3 Q. Do you know the name of the nephrologist that  
4 you testified on behalf of?

5 A. Yes, Dr. Donald Eipper, E-i-p-p-e-r.

6 Q. Do you know the name of the patient?

7 A. No, not at this time.

8 Q. Run me through the other two,

9 A. The second case was, as I recall, was a  
10 nephrologist who practices in the Youngstown area  
11 if I recall the case, it was a patient that had  
12 suffered a peri-renal bleed following a  
13 percutaneous renal biopsy, happened to be a patient  
14 that had problems with chronic thrombocytopenia,  
15 the litigation involved the appropriateness of  
16 doing a renal biopsy in that situation.

17 MR. QUANDT: I ask you to  
18 keep your voice up a little bite, you are a soft  
19 spoken gentleman.

20 THE WITNESS: Certainly.

21 A. As I recall the situation was one of the  
22 appropriateness of doing a percutaneous needle  
23 biopsy in that situation. In that case I reviewed  
24 the case, gave an opinion, was not deposed.

25 Q. Do you know the name of that case?

1 A. No.

2 Q. Do you know the name of the nephrologist?

3 A. Yes, the nephrologist was a Dr. Roberto

4 B-a-c-a-n-i.

5 Q. The third case?

6 A. The third case was again, a situation where  
7 the physician involved I did not know. I was asked  
8 to review the case through a friend of a friend, to  
9 render an opinion.

10 It was a situation whereby a  
11 patient with renal artery stenosis had an  
12 interventional surgical procedure performed, the  
13 physician that performed the initial surgical  
14 procedure did in fact perform a technique, a  
15 procedure that was inappropriate for that patient  
16 with his disease. The patient survived but had  
17 recurrent and persistent hypertension.

18 As I recall, about a year later the  
19 patient was admitted to another hospital in  
20 Philadelphia, I believe the University of  
21 Pennsylvania, where he was evaluated and a second  
22 interventional surgical bypass on the same kidney was  
23 performed, after which the patient had just a  
24 series of unfortunate complications and prolonged  
25 illness and died in the hospital.

1                   The initial surgeon had in fact  
2                   done what I agreed was the inappropriate procedure  
3                   for that problem. The patient survived. The  
4                   patient had controlled blood pressure in fact.  
5                   Following his demise, in reviewing the case, it may  
6                   well have been the second surgical procedure was  
7                   inappropriate. I reviewed that, was not deposed in  
8                   that case.

9           Q.       Did you write an opinion letter in that case?

10          A.       I did.

11          Q.       Stating that the first surgeon acted  
12                   inappropriately?

13          A.       I did.

14          Q.       Did you know Dr. Bacani or Dr. Eipper?

15          A.       Yes, Dr. Eipper was a Fellow of mine, he  
16                   trained her at the Cleveland Clinic a good many  
17                   years ago. He's been practicing in the Akron area  
18                   for somewhere between 15 and 20 years.

19                   Dr. Bacani is a collegial  
20                   relationship because he's too a nephrologist, I've  
21                   known him for more than 20 years because of state  
22                   wide nephrology organizations, renal disease  
23                   network and as a referring physician. We're not  
24                   socially friends though.

25          Q.       You knew both of those physicians prior to

1 your becoming involved in their lawsuit?

2 A. I did.

3 Q. Did either one of them refer patients to you  
4 prior to you becoming involved in a lawsuit?

5 A. Yes.

6 Q. You said the third physician, what was his  
7 name, the third lawsuit?

8 A. I don't recall. If you would like I will  
9 have my secretary see if I have files on those for  
10 your records. I can't recall.

11 As I said, I did not know the  
12 surgeon involved in that case. I reviewed it  
13 because that individual was an acquaintance of a  
14 colleague of mine, I rendered an opinion.

15 MR. QUANDT: That answers  
16 the question, Doctor, thank you.

17 Q. You know Dr. Miclat, don't you?

18 A. Again, professionally. As a nephrologist, we  
19 are associated through area wide nephrology  
20 committees, et cetera. I know him as a referring  
21 physician, he has referred patients to me on  
22 occasion.

23 Q. Has he undergone any training at the  
24 Cleveland Clinic?

25 A. No.

1 Q. Does the Cleveland Clinic have any  
2 affiliations with Elyria Memorial Hospital?

3 A. I believe we may have an affiliation in the  
4 cardiac area at the present time.

5 Q. Not in your area?

6 A. Not in our area.

7 Q. Is that something that is being discussed or  
8 worked on?

9 MR. QUANDT: Objection. Go  
10 ahead.

11 A. If it is, it's at a higher level in the  
12 organization.

13 Q. Who contacted you to become involved in this  
14 case?

15 A. Mr. Quandt.

16 Q. Have you ever had any contact with Mr. Quandt  
17 prior to this case?

18 A. Not to my knowledge.

19 Q. How much are you charging to review or to act  
20 as an expert in this case?

21 A. My charges are \$300 an hour for materials  
22 that I review at home, evenings and weekends, and  
23 \$500 an hour during my usual working day.

24 Q. How about for testifying?

25 A. I haven't had to deal with that question

1 yet. If and when I am requested to I would  
2 probably set that charge based upon what I perceive  
3 would be my missed income from a day lost in the  
4 office.

5 Q. You are giving testimony right now, you  
6 haven't decided how much you are going to charge  
7 for this?

8 A. Probably the same range if I had to be out of  
9 the office, out of my practice, probably be \$500 an  
10 hour. I hadn't given thought to that question.

11 Q. I see.

12 Do you know if any other physician  
13 reviewed this case before you were contacted?

14 A. I do not.

15 Q. Did you consult with any of your colleagues  
16 regarding this case?

17 A. I did not.

18 Q. Did you review any medical literature before  
19 or while reviewing this case?

20 A. Literature review, not really, no.

21 Q. What was it that Mr. Quandt asked you to do?

22 A. As I recall, from his initial request, it was  
23 to review and comment on Dr. Bacani --

24 Q. Mr. Miclat?

25 A. I am sorry, Dr. Miclat, my apology,

1 Dr. Miclat's part in this patient's illness.

2 Q. Did he ask you to limit your opinion to  
3 Dr. Miclat, to the exclusion of other physicians?  
4 Did you understand that to be the request?

5 A. He did ask me to focus on Dr. Miclat's  
6 involvement in this case.

7 Q. You authored a report dated December 5, 1994,  
8 you have that in front of you?

9 A. Is that a letter to Mr. Quandt?

10 Q. Yes.

11 A. I have a copy of that here.

12 Q. This is your report containing your opinions  
13 in this case?

14 A. That was my opinion rendered to Mr. Quandt.

15 Q. Does that contain a summary of all of the  
16 opinions that you hold in this case as a result of  
17 your review of the materials?

18 A. Give me a moment to review.

19 Q. Sure, take your time.

20 A. I think it summarizes my impression of the  
21 patient, her illness and Dr. Miclat's involvement.

22 Q. As you were going through the materials did  
23 you form any opinions regarding the involvement of  
24 other physicians?

25 MR. QUANDT: Objection.

1 That was not asked or requested per my request. Go  
2 ahead, Doctor, you may answer.

3 A. In the light of trying to review this  
4 patient's total illness through her period of  
5 hospitalization, reviewing the progress notes of  
6 other physicians involved in the case, the  
7 interactions between those physicians, I felt that  
8 the overall care of this woman was appropriate.

9 Q. Can I see your copy?

10 A. Yes.

11 MR. WEITENDORF: My apologies to  
12 everybody, I hope you started without me.

13 -----

14 (Dr. Vidt Deposition Exhibit A  
15 marked for identification.)

16 -----

17 Q. Doctor, you had in front of you a packet of  
18 papers which I've marked as Dr. Vidt Deposition  
19 Exhibit A. That packet includes 1, 2, 3, 4, 5, 6,  
20 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 16 pages, the  
21 first page of that exhibit is a letter from you to  
22 Mr. Quandt, correct?

23 A. That is correct.

24 Q. In that letter you indicate that you were  
25 searching for additional published papers relative



1 to the transport of respiratory compromised  
2 patients, you would forward copies of those to  
3 Mr. Quandt, correct?

4 A. Yes, I did say that.

5 Q. Did you do that?

6 A. I did not.

7 Q. Why not?

8 A. The question just never came up again  
9 relative to those papers.

10 Q. Did you search out the papers?

11 A. I did a partial review of the literature in  
12 that regard. I did not review those materials in  
13 detail.

14 Q. Where are the materials?

15 A. I may have some of those reprints here, I may  
16 have some at home.

17 MR. FELTES: Is there a date  
18 on that letter?

19 MR. MELLINO: December 5,  
20 1994.

21 Q. Can you provide those materials?

22 A. Certainly can provide any materials that I  
23 have.

24 MR. QUANDT: Let the record  
25 indicate that I have not -- I'm going on the

1 record -- received any of the fruits of any search

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1 prior to rendering an opinion I may have received  
2 some of the other materials that are here on the  
3 table.

4 Q. What we have here on the table, and there is  
5 a box on the floor, is that everything you reviewed  
6 in this case?

7 A. This is everything that I received in the  
8 case. Some of the materials on the floor are a  
9 duplication of these. I received essentially two  
10 copies of the entire chart, which I have reviewed  
11 in part. I believe that I reviewed all or most of  
12 the depositions regarding the physicians and/or  
13 nurses in the case. Some of them were reviewed  
14 again last Fall.

15 Q. Where are the depositions then?

16 MR. QIJANDT: Summaries I  
17 think is more accurate.

18 A. Summaries may be a more accurate description.

19 Q. Maybe my question wasn't clear.

20 The only actual deposition you  
21 reviewed, as opposed to a summary, was Dr. Miclat's  
22 deposition?

23 A. Initially Dr. Miclat's deposition, unless  
24 there are depositions in there.

25 Q. I didn't see any depositions in there.

1 A. That is Dr. Miclat again. This is  
2 Dr. Ferguson.

3 Q. You are identifying the depositions you  
4 reviewed, correct, so the record is clear what you  
5 are doing?

6 A. Not prior to my letter to Mr. Quandt.

7 Q. Right.

8 A. These additional depositions were reviewed  
9 more recently.

10 Q. What deposition was that?

11 A. Mazal, Flynn, Stiller, and Ferguson.

12 Q. So, Dr. Flynn, Dr. Stiller, Dr. Ferguson,  
13 Dr. Mazal and Mr. Miclat are the only depositions  
14 you reviewed in this case, correct?

15 A. I believe so, but -- I believe everything  
16 else in this box is part of the hospital chart  
17 duplication, that is correct.

18 Q. You reviewed summaries of the depositions of  
19 the physicians and nurses that were involved in her  
20 care, correct?

21 A. Correct.

22 Q. Those summaries were prepared by who?

23 A. I can't answer that.

24 Q. You have not looked at the actual deposition  
25 testimony of these people?

1 A. I have not.

2 Q. Is there anything you did review that is not  
3 here today?

4 A. No.

5 Q. Has anything been removed from your file?

6 A. No.

7 Q. Did you undergo any training in pulmonary  
8 medicine?

9 A. I did not.

10 Q. Are you Board certified?

11 A. I am Board certified in internal medicine.

12 Q. You're not Board certified in nephrology?

13 A. I'm not Board certified in nephrology.

14 Q. When did that certification come into being?

15 A. The specialty of that certification of  
16 nephrology came about in the late 1970's, 1980,  
17 early '80s.

18 Q. You did a Fellowship in metabolism and renal  
19 disease at Metro 1963, 1964?

20 A. Correct. They were all part of the  
21 University Hospitals system at that time.

22 Q. Is it because you had -- were you  
23 grandfathered or is there a reason you didn't take  
24 the Board exam for nephrology?

25 A. No, when I completed my training in

1 nephrology between 1962 and 1964, there was no  
2 certification in nephrology. While I was trained  
3 in nephrology, I was also trained in hypertension.

4 I started practice at the Cleveland  
5 Clinic in 1964. Over the next 15 years, my  
6 practice, my research, my teaching has grown more  
7 and more into the hypertension area. There is no  
8 Board certification in hypertension. I no longer  
9 do dialysis, although I did for many years early  
10 on. Since I do less dialysis, I did not see the  
11 advantage of that certification to my practice.

12 Q. I see you are a member of the American  
13 College of Chest Physicians, what qualifies you to  
14 be a member of that organization?

15 A. My interest in cardiovascular disease and  
16 hypertension.

17 Q. Is there some requirement to become a member?

18 A. The American College of Chest Physicians is  
19 today a cardiovascular pulmonary society so that  
20 there are many, many cardiologists and  
21 hypertensionologists that belong to that  
22 organization as well as pulmonologists.

23 Q. What do you have to do to become a member?

24 A. You have to demonstrate an interest,  
25 practice, experience and expertise in some related

1 field. While one of those related fields is  
2 pulmonology, other related fields are cardiology,  
3 cardiovascular disease and hypertension.

4 Q. You became a member based on your expertise  
5 in hypertension?

6 A. Hypertension.

7 Q. What is the Kolf, K-o-l-f, Foundation?

8 A. Kolf Foundation was a nonprofit foundation  
9 established in the name of Dr. Wilhelm Kolf who is  
10 considered by many to be the father of  
11 hemodialysis. Dr. Kolf did the first artificial  
12 kidney treatment during Word War II on a patient in  
13 Holland.

14 Following the war Dr. Kolf came to  
15 the United States, joined the staff at the  
16 Cleveland Clinic where he practiced for some years,  
17 and in fact headed the department of artificial  
18 organs here at the Cleveland Clinic.

19 In later years moved on to the  
20 University of Utah. During his venue in Cleveland  
21 the Kolf Foundation was established with gifts from  
22 grateful patients to enable us to assist patients  
23 with end stage renal disease at a time when their  
24 catastrophic coverage under Medicare did not  
25 exist. In those days we provided financial

1 assistance to be able to train patients for home  
2 dialysis.

3 Q. Is that still in existence?

4 A. In all honesty it may exist in name, it does  
5 not exist in practice today.

6 Q. You listed on your CV several editorial  
7 boards, are you currently a member of the editorial  
8 boards you have listed? Do you need to see them?

9 A. Yes. Core Journal in Clinical Pharmacology  
10 is no longer in existence. Still on the editorial  
11 board of the Injury Consultant. I'm an editor of  
12 the Cleveland Clinic Journal of Medicine.

13 Cardiovascular Perspective is no longer in  
14 existence. I believe I'm still on the board of  
15 Illustrated Medicine. It's an industry supported  
16 publication that is published periodically.  
17 Hypertension and Cardiovascular Risk Reduction is  
18 no longer active. High Pressure Life Styles is no  
19 longer active. I'm an editor of Heartline, which  
20 is a Cleveland Clinic publication.

21 Q. Have you authored any articles or had any  
22 motion pictures or videotapes that are relevant to  
23 the issues in this case as they relate to the  
24 administration of Demerol, the question of  
25 extubating Mrs. Lind on May 6th, her being



1 clinically unstable May 7th, the decision to send  
2 her to the x-ray department or need to re-intubate  
3 her on May 7th?

4 A. That is a rather complex question.

5 Would you read back the question  
6 for me, please.

7 -----

8 (Question read as follows: Have you  
9 authored any articles or had any motion pictures or  
10 videotapes that are relevant to the issues in this  
11 case as they relate to the administration of  
12 Demerol, the question of extubating Mrs. Lind on  
13 May 6th - - )

14 -----

15 THE WITNESS: Hold it.

16 A. I've never done research with analgesic  
17 medication, Demerol. No, I have not published any  
18 papers dealing with Demerol nor any motion pictures  
19 nor something I speak on. I also have not had an  
20 area of interest or expertise from the standpoint  
21 of intubation/extubation.

22 Q. As to the issue whether she was clinically  
23 unstable on May 7th between the time of the HIDA  
24 scan and the time of the CT scan?

25 A. An area of interest. From the standpoint of

1 publications, no, I have not written on that.

2 Q. Do you have an opinion in this case as to  
3 what the cause of her cardiopulmonary arrest was?

4 MR. QUANDT: Objection. Go  
5 ahead, Doctor.

6 A. I have an opinion, yes.

7 Q. What is your opinion?

8 A. I believe that this patient may have suffered  
9 a hypotensive episode and possibly a bradycardic  
10 arrhythmia that was the precipitating factor in her  
11 arrest.

12 Q. Have you written any articles or had any  
13 videotapes or motion pictures, spoken on  
14 hypotensive episodes and bradycardic arrhythmias?

15 A. No.

16 Q. Did you review Dr. Stiller's deposition?

17 A. I did.

18 Q. Do you agree with his opinions in this case?

19 MR. SCOTT: Objection.

20 MR. FELTES: Objection.

21 MR. GALLAGHER: Objection.

22 Q. You can answer.

23 A. I did review Dr. Stiller's deposition. I  
24 obviously do not remember it verbatim. I think he  
25 may have expressed several opinions. I'll be

1       pleased to review it, comment, if you will be more  
2       specific.

3       Q.       Well, what I want to know is as you sit here  
4       today does anything stick out in your mind after  
5       reading his deposition you disagreed with?

6                       MR. QUANDT:               Objection.

7                       MR. GALLAGHER:           Objection.

8                       MR. FELTES:             Objection.

9                       MR. QUANDT:             You can  
10       answer.

11       A.       Dr. Stiller may have raised the concern  
12       regarding the fact that this patient suffered a  
13       respiratory arrest on the date of May 7th based on  
14       the data and the patient's status in this case.

15                       I believe one can view the same  
16       information and hypothesize this may not have been  
17       an acute respiratory arrest. May have been an  
18       acute hypotensive episode, possibly I believe  
19       precipitated by the bradycardic arrhythmia.

20       Q.       Are there any other areas that stick out  
21       right now as you sit here you disagree with  
22       Dr. Stiller?

23                       MR. SCOTT:             Objection.

24                       MR. FELTES:             Objection.

25                       MR. GALLAGHER:           Objection.

1 MR. QUANDT: Objection.

2 A. Offhand I can't recall anything. Again  
3 having read and reviewed a number of depositions,  
4 over several weeks, it's difficult to separate  
5 them. If you would like to ask specific questions  
6 I'll try to respond.

7 Q. What facts do you base your opinion on she --  
8 first of all do you believe she had a respiratory  
9 arrest?

10 MR. GALLAGHER: Objection.

11 MR. FELTES: Objection.

12 A. I believe that the precipitating event may  
13 have been a hypotensive, again possibly I believe a  
14 bradycardic event.

15 MR. QUANDT: Keep your voice  
16 up. Thank you.

17 Q. That may have been the precipitating cause.  
18 Could a respiratory arrest also have been?

19 MR. GALLAGHER: Objection.

20 MR. QUANDT: Objection.

21 MR. FELTES: Objection.

22 MR. QUANDT: Could have  
23 been.

24 A. I think looking at the the events surrounding  
25 this lady's problems on the 7th, and trying to

1     interpret some of the laboratory changes that led  
2     up to it and were occurring at the time, I think  
3     it's difficult to say with absolute certainty  
4     whether this was a respiratory or a hypotensive  
5     episode.

6                     I do believe there is information  
7     in the medical record to support a hypotensive  
8     episode being a trigger to the event that occurred  
9     in the ICU on May 7th.

10    Q.     Are you able to form an opinion based upon  
11    your review of the material whether it's more  
12    probable she sustained a respiratory arrest, as  
13    opposed to a hypotensive episode?

14    A.     My opinion it's more probable she had a  
15    hypotensive episode than a respiratory arrest.

16    Q.     Would you agree that when she returned from  
17    the HIDA scan she was hypotensive and hypoxic, had  
18    severe acidosis?

19                     MR. SCOTT:                     Objection to  
20    the multiple questions.  Objection to form.

21                     MR. QUANDT:                    Join the  
22    objection.

23    A.     The acidosis was ongoing, it was present  
24    prior to May 7th and present after May 7th.  She,  
25    as I recall from the events of the day, she went to

1 her HIDA scan with pulse oximetry readings in the  
2 high 90's. She dropped her pulse ox I believe from  
3 97 or 98 to 86 or in the mid 80's during the HIDA  
4 scan. At that time she also dropped her blood  
5 pressure, I believe was sent back to the ICU.

6 Q. So the answer would be yes, she was  
7 hypotensive, hypoxic, had severe acidosis upon  
8 return from the HIDA scan, correct?

9 A. Yes.

10 Q. She was given fluids in ICU?

11 A. I believe she received fluids, I believe --

12 MR. QUANDT: Doctor, excuse  
13 me, if you need to look at any of these records at  
14 all, I don't want you to guess at any of these,  
15 help yourself if you need it.

16 A. She did receive fluids after her return from  
17 radiology for the partially completed HIDA scan. I  
18 believe she was also placed in Trendelenburg, her  
19 pulse oximetry readings recovered, were again  
20 recorded in the high 90's.

21 Q. She remained hypotensive, tachycardic,  
22 tachypneic, despite that therapy?

23 A. She had been tachycardic and tachypneic prior  
24 to May 7th.

25 Q. My question was did she remain tachycardic

1 and tachypneic after the therapy, and hypotensive?

2 A. Her blood pressure did recover somewhat on  
3 that date. Let me go to the record.

4 During the HIDA scan her pulse ox  
5 was recorded at 86. She was hypotensive with a  
6 blood pressure recorded as low as 76 over 47. Her  
7 pulse rate had increased slightly from 148 to 158,  
8 respiratory rate had increased from the 46 to 56.  
9 She was also febrile at this time with a  
10 temperature of 39.7. Her breath sounds were  
11 reportedly clear.

12 On return to ICU she was  
13 Trendelenburg. In fact, her pulse ox at the time  
14 of return was again up to 97. Was recorded back in  
15 ICU at 97. She had not been intubated. Her pulse  
16 rate again dropped to 138, blood pressure rose to  
17 86 over 50. A bit later in the morning rose to 116  
18 over 58. She received I.V. fluids, was in fact  
19 receiving I.V. fluids at the time she went down for  
20 her HIDA scan.

21 Q. You don't believe she remained hypotensive  
22 between the HIDA scan and CT scan?

23 A. Her blood pressures are lower than normal  
24 blood pressures, she was a bit hypotensive. I  
25 believe she was not symptomatically in shock at

1       that time from her blood pressure.

2       Q.       She was hypotensive?

3       A.       She was a bit hypotensive.

4       Q.       She was tachycardic?

5       A.       She was tachycardic.

6       Q.       And tachypneic?

7       A.       And tachypneic.

8       Q.       Do you agree that the decision to send  
9       Mrs. Lind for an abdominal CT in addition in the  
10      absence of any other therapy was an error of  
11      judgment on the part of her treating physician?

12                   MR. FELTES:               Objection.

13                   MR. SCOTT:               Objection.

14                   MR. QUANDT:              Objection.

15                   MR. GALLAGHER:          Objection.

16      A.       I do not.

17      Q.       Did you read that testimony in Dr. Stiller's  
18      deposition?

19      A.       I did. I read it in some deposition.

20                   MR. QUANDT:              Doctor, just in  
21      case that it makes a difference, do me the favor of  
22      actually looking at Stiller's deposition, if you  
23      will, please, so you can be specific.

24      A.       Do you have a page reference to help me in  
25      Dr. Stiller's deposition since it's a 100 plus page



1 deposition?

2 Q. I don't know where it is in his deposition, I  
3 know it's in his report. Do you have his report?

4 A. Probably in here somewhere. I don't know  
5 whether this is what you are looking for, case  
6 facts, there is no signature on it.

7 Q. Here is page 21, Mr. Quandt wanted you to see  
8 it in the deposition, page 21 of his deposition  
9 says -- you can read it for yourself. Page 21,  
10 line 23.

11 A. Page 21?

12 Q. Yes, line 23.

13 A. I believe that --

14 Q. There is no question, Doctor. Mr. Quandt  
15 wanted you to look at it in the deposition, you've  
16 done that now, right?

17 A. Yes.

18 Q. Can persistent metabolic acidosis and  
19 tachypnea --

20 A. I haven't answered your last question, the  
21 question you opposed in this regard.

22 Q. There was no question. Mr. Quandt asked for  
23 you to look it up in here.

24 A. Would you like me to respond?

25 Q. You already said you disagreed with him.

1       A.       Okay, I still disagree.

2       Q.       I assumed you would.

3                       Can persistent metabolic acidosis  
4       and tachypnea lead to worsening respiratory muscle  
5       fatigue and lead to respiratory arrest?

6                       MR. SCOTT:                       Objection to  
7       form.

8                       MR. QUANDT:                       Objection.

9                       MR. FELTES:                       Objection.

10                      MR. GALLAGHER:                      Objection.

11       A.       I would think that that degree of metabolic  
12       abnormality, acute illness in a patient, could  
13       contribute to respiratory problems.

14       Q.       You don't think that is what happened in this  
15       case?

16                      MR. QUANDT:                      Objection,  
17       asked and answered. Go ahead.

18       A.       I don't think that's necessarily what  
19       happened on the morning of May 7th.

20       Q.       What about the afternoon of May 7th?

21       A.       Or the afternoon, early afternoon of  
22       May 7th. Many of this patient's problems were  
23       persistent from the standpoint of metabolic and  
24       clinical abnormalities.

25                      As I stated earlier, I believe that

1 the precipitating event in this patient's arrest  
2 may have been a hypotensive, possibly an acute  
3 arrhythmic event.

4 Q. Do you have any training in cardiology?

5 A. I'm not a cardiologist by training.

6 Q. I didn't ask you that. I asked if you had  
7 any training in cardiology?

8 A. Specialty training, no.

9 Q. You've never practiced in cardiology?

10 A. I practice cardiology every day.

11 Q. Do you diagnose arrhythmias in your patients?

12 A. Yes.

13 Q. When your patients have arrhythmias do you  
14 call in a cardiology consult, do you treat those  
15 yourself?

16 A. Some I may treat myself and others I may call  
17 for the assistance of a cardiologist.

18 Q. What facts in the record do you base your  
19 opinion on that an arrhythmia caused her arrest?

20 A. I would base this decision on review of the  
21 clinical events on the morning of May 7th,  
22 including her hypotensive episode at 10:00 a.m.,  
23 her subsequent episode in the early afternoon. The  
24 total clinical picture of the patient and based on  
25 a review of some electrocardiographic strips that

1       were reported in the record at or about the time of  
2       her episode in the ICU.

3       Q.       You are talking about the time of the arrest,  
4       when the code was called?

5       A.       Yes.

6       Q.       Those are the strips you are talking about?

7       A.       Yes.

8       Q.       Are there any strips prior to that that  
9       reflect an arrhythmia?

10                       MR. QUANDT:               Take your time,  
11       check your records.

12       A.       I could not answer that without looking back  
13       through --

14                       MR. QUANDT:               Take your  
15       time.

16       A.       -- through the record. I'll be happy to do  
17       that.

18                       Several days prior to the event her  
19       rhythm strips suggest a baseline tachycardia which  
20       was prevalent throughout her early  
21       hospitalization.

22       Q.       When you say several days, be specific.

23       A.       I've just flipped back as far as May 2nd.  
24       Coming from there **up** to May the 7th she remains  
25       quite tachycardic, until the 7th of May, with

1 rhythm strips that are noted to be May 7th and time  
2 noted to be 1453.

3 Q. Tell me again you think the cause of the  
4 arrest was a hypotensive episode brought on by a  
5 bradycardic arrhythmia, do I have that right?

6 A. I think the patient was hypotensive on the  
7 7th of May because she was toxic. Quite possibly,  
8 very reasonable concern being some acute ongoing  
9 intra-abdominal event.

10 Q. Was anything going on in her abdomen at that  
11 time?

12 MR. SCOTT: What was the  
13 question?

14 Q. Was anything going on in her abdomen at that  
15 time?

16 A. I think that was the primary concern of the  
17 physicians attending her.

18 Q. I'm asking you now in retrospect, based upon  
19 what you note from your review of the report, was  
20 anything going on in her abdomen on May 7th?

21 MR. QUANDT: Objection.

22 A. In retrospect there was no evidence of an  
23 abscess or cholecystitis. There was some evidence  
24 of possible pancreatitis.

25 Q. There was some evidence of that on May 7th?

1       A.       From an amylase determination that was  
2       obtained.

3       Q.       Does pancreatitis cause hypotension?

4       A.       It can.

5       Q.       Is that what was causing her hypotension?

6       A.       I don't think we know that for sure.

7       Q.       Does it cause bradycardic arrhythmias?

8       A.       In the context of an an acute illness in  
9       association with fever, acidosis, impaired renal  
10      function, impaired hepatic function, I think that  
11      pancreatitis could associate with a variety of  
12      acute cardiovascular events including hypotension,  
13      and possibly a cardiac arrhythmia.

14      Q.       When you say associate, to me that doesn't  
15      imply a cause and effect.

16                   MR. QUANDT:                   Objection.  
17      Move to strike the statement.

18                   MR. FELTES:                   Objection.

19      A.       I don't mean to imply cause and effect  
20      pacreatitis/arrhythmia. I do mean to imply that  
21      this patient was acutely ill.

22      Q.       Did the arrhythmia come before the  
23      hypotension or the hypotensive episode that you  
24      believe caused the arrest?

25      A.       I can't tell that. I can't tell that

1 clearly. Maybe I can answer that from the record.

2 MR. QUANDT: Take your time,  
3 look at whatever record you need.

4 A. On page 1452 of the medical record I'm  
5 looking at a strip dated -- timed 1220, this was  
6 after the hypotensive event in the radiology  
7 department for the HIDA scan but prior to her  
8 afternoon event after the CT scan. At 1220 she is  
9 tachycardic, the rhythm is regular.

10 Q. Show me where you are looking.

11 A. Page 1452, looking at -- this is a monitor  
12 strip.

13 Q. You are looking at the fourth strip on the  
14 page?

15 A. The fourth strip on the page.

16 Q. That shows she is tachycardic?

17 A. Tachycardia. The heart rate listed is 137  
18 but regular.

19 Q. What does that tell us about a hypotensive  
20 episode or arrhythmia?

21 A. That doesn't tell us anything about -- she  
22 does not have arrhythmia on that strip. That  
23 doesn't tell us she is not hypotensive because the  
24 normal response, a drop in blood pressure is a rise  
25 in heart rate.

1 Q. Was she hypotensive at the time of the strip?

2 A. Let's try to answer that for you as best we  
3 can from the medical record.

4 I don't believe there is any way  
5 one can get to the minute but if we look at blood  
6 pressures on May 7th, that period of time of this  
7 rhythm strip, her blood pressures were low at  
8 12:00, they were 80 over 46. At 1:00 p.m. they  
9 were 100 over 55. Also pressure as high at 116  
10 over 58. Let us keep in mind she had other reasons  
11 for tachycardia as well. While she was hypotensive  
12 she was also febrile.

13 Q. She was hypotensive at 12:20 when they took  
14 this, as near as you can tell from the record?

15 A. Yes, her blood pressure may have been lower  
16 at that time.

17 Q. I think you were looking at the strips, I  
18 lost the original question, you were determining  
19 when she had the arrhythmia?

20 A. I believe you asked me if she had any other  
21 arrhythmias prior to the time of her arrest and I  
22 was reviewing the fact she was tachycardic but  
23 regular rhythm on the morning of May 7th at 12:20.

24 As we go to the next page, there  
25 are several strips, one of which I can't identify



1 by time at the top of the page, that suggests that  
2 she has significantly slowed her heart rate and you  
3 will see the fourth strip on that page, **1453**, time  
4 **14** hours and **53** minutes, that there appears to be a  
5 marked slowing of her heart rate.

6 Q. Was that an arrhythmia?

7 A. That would certainly be suggestive of a  
8 marked bradycardia, which is an arrhythmia.

9 Q. You think this began at **1453** then?

10 A. I don't have the timing on the first strip on  
11 that page.

12 Q. It's **1452**.

13 A. It's not clear on my page.

14 Q. It's **1452**.

15 A. **1452?**

16 Q. Yes.

17 A. At least at **1452** and **1453** she would appear to  
18 be bradycardic and the next page the first strip I  
19 do not have a clear time on.

20 I am sorry, I do have **1455**, she  
21 again appears to be somewhat -- her heart rate is  
22 slowed down, is noted to be **73** beats per minute.

23 Q. What caused this bradycardia?

24 A. Hypotension, acidosis, acidotemia,  
25 electrolyte abnormalities. I think in the entire

1 context of her acute illness, I don't think that  
2 one can finger a cause and effect for an acute  
3 cardiac arrhythmic response in a patient such as  
4 this.

5 Q. Do you have an opinion as to if she was  
6 intubated prior to this time whether she would have  
7 sustained the bradycardia?

8 MR. GALLAGHER: Objection.

9 MR. FELTES: Objection.

10 MR. QUANDT: I join the  
11 objection.

12 MR. SCOTT: Objection.

13 A. I can't answer that on the basis of the  
14 data.

15 Q. Why not?

16 MR. FELTES: Objection.

17 MR. QUANDT: Objection. Go  
18 ahead, Doctor.

19 A. This woman was acutely ill. I think there  
20 was real concern that this woman was going to die.  
21 I believe that the context of the acuity of her  
22 illness and the multiple abnormal laboratory  
23 parameters in this woman on the morning and  
24 afternoon of May 7th, I think she could have  
25 arrested regardless of what had been done for her.

1 She might just as easily arrested -- she did arrest  
2 in ICU in fact, she could have arrested if she had  
3 been on a ventilator as well as whether she had  
4 been on a Venti mask as she was at the time.

5 Q. Let me ask the question a little  
6 differently.

7 If her arrest was caused by this  
8 hypotensive episode, arrhythmia as you postulated,  
9 could it have been prevented by putting her on  
10 mechanical ventilation?

11 MR. GALLAGHER: Objection.

12 MR. QUANDT: Objection.

13 MR. SCOTT: Objection.

14 A. I don't know the answer to that.

15 Q. Could a respiratory arrest have caused the  
16 bradycardia that we see on the strips that occurred  
17 at 1452?

18 MR. QUANDT: Objection.

19 MR. FELTES: Objection.

20 A. Possibly.

21 Q. If you have a respiratory arrest of the  
22 severity of Mrs. Lind wouldn't you probably have  
23 bradycardia?

24 MR. QUANDT: Objection. Go  
25 ahead.

1 A. Please repeat the question for me.

2 Q. If you sustain a respiratory arrest of the  
3 degree that Mrs. Lind had, wouldn't you probably  
4 have bradycardia?

5 MR. GALLAGHER: Objection.

6 MR. FELTES: Objection.

7 MR. QUANDT: Objection.

8 A. At some point in the course, yes.

9 Q. The fact there is bradycardia reflected on  
10 these strips that you pointed out is not  
11 inconsistent with her having sustained a  
12 respiratory arrest, correct?

13 MR. QUANDT: Objection,  
14 leading.

15 A. That's correct.

16 Q. Do you have an opinion whether or not she was  
17 prematurely extubated on May 6th?

18 MR. QUANDT: Objection.

19 MR. GALLAGHER: Objection.

20 MR. FELTES: Objection.

21 MR. SCOTT: Objection.

22 A. I do not.

23 Q. Do you have an opinion one way or the other?

24 MR. QUANDT: That can be  
25 answered yes or no, Doctor.

1 A. No.

2 MR. GALLAGHER: Objection. He  
3 said he doesn't have an opinion.

4 MR. QUANDT: I realize  
5 that.

6 Q. You mentioned a few times during this  
7 deposition a lot of the problems she has as far as  
8 tachycardia and tachypnea and acidosis were  
9 chronic, correct, she had them for several days  
10 before May 7th?

11 A. That is correct.

12 Q. Did those conditions worsen after she was  
13 extubated?

14 A. Let me again review the sequence of events,  
15 counselor.

16 As I recall she was extubated on  
17 the 6th of May.

18 Q. Right.

19 A. As I recall more specifically may have been  
20 in the early afternoon.

21 Q. One o'clock.

22 A. I am on page 983, although there are some  
23 pages a little out of place in here, 78, 79 may be  
24 page 980. It is the vital sign record for the  
25 24-hour period of May 6th.

1 Q. I got it.

2 A. She was extubated at approximately 1:00 p.m.  
3 in the afternoon you told me. If we look at her  
4 heart rates, her respiratory rate and particularly  
5 her pulse ox recordings for the rest of that day,  
6 from one o'clock through ten o'clock that evening,  
7 they really haven't changed. The pulse ox remains  
8 in the range of 97 to 98.

9 Q. Her pulse increases, doesn't it?

10 A. I think you have to go back, counselor, and  
11 look at her pulse rates in the early morning of  
12 May 6th. You see pulse rates of 131, 134 at that  
13 time as well. Her 135 heart rates are, as you've  
14 said, chronically at least for several days before,  
15 have been persistently high, as has her respiratory  
16 rate.

17 The other clinical impressions  
18 through the rest of that day breath sounds are  
19 clear, she has a few rhonchi. Her oxygenation  
20 continues to be quite adequate on what I believe  
21 was a Venti mask at 50 percent.

22 Q. So you don't believe after she's extubated,  
23 over the next 24 hours she got any worse from the  
24 standpoint of being hypotensive, tachycardic or  
25 tachypneic?

1 A. I don't believe she was any worse from that  
2 standpoint until the morning hours of May 7th.

3 Q. She did get worse then in the morning hours  
4 of May 7th?

5 A. Her status changed.

6 Q. Do you have an opinion as to whether or not  
7 that change in status is related at all to her  
8 extubation?

9 MR. GALLAGHER: Objection.

10 MR. QUANDT: Objection. Go  
11 ahead.

12 A. It was not my impression in reviewing the  
13 records that her change in status was the result of  
14 her extubation.

95 Q. What do you think caused her change in  
16 status?

17 When you say change in status, she  
18 got worse, right?

19 A. Yes.

20 Q. What caused her to get worse?

21 A. As we review her clinical course leading up  
22 to the morning of May 7th, this lady had been --  
23 back to where I was May 6th.

24 She had been on the afternoon of  
25 May 6th afebrile, she was again afebrile at

1 2:00 a.m. on the morning of May 7th. 6:00 a.m. her  
2 temperature increased to 38.9. By 10:00 a.m. her  
3 temperature increased to 39.7. Together with that  
4 change, her heart rate had increased somewhat and  
5 her blood pressure had dropped on the morning of  
6 May 7th.

7 This lady as we know had  
8 complaints, intermittent complaints of acute  
9 abdominal pain, she had become more distended, she  
10 was complaining of abdominal pain. On this morning  
11 there was, I believe, a very legitimate concern  
12 about some ongoing event in this woman's abdomen.

13 I believe that this lady was  
14 toxic. Toxic as demonstrated by the change in her  
15 clinical course the number abdominal complaints,  
16 worsening of temperature during this period in the  
17 early morning of May 7th, her pulse ox remained in  
18 the range of 97 to 98 percent, her breath sounds  
19 are reported as clear, they are reported as clear  
20 through the morning of May 7th. Her pulse ox, as  
21 we know, was okay until the one reported at 86  
22 during the HIDA scan.

23 Q. What does the pulse ox tell you?

24 A. She's getting adequate oxygenation.

25 Q. Even if she is acidotic?



1       A.       Even though she is acidotic. This was not a  
2       respiratory acidosis, that's a metabolic acidosis  
3       persistent since the time of her admission to the  
4       hospital, as had her tachycardia and increased  
5       respiratory rate, and her modest renal  
6       insufficiency,

7                       As you review the hospital course  
8       in this woman, look at the week leading up to the  
9       7th of May, this woman appeared to be improving  
10      from a pulmonary standpoint. There are reports of  
11      improvement in her chest x-ray prior to the 7th  
12      of May. Despite the improvement in her pulmonary  
13      status, the reason for her admission to the  
14      hospital with a bilateral pneumonia, her  
15      tachycardia, tachypnea, acidosis have not cleared.  
16      This very appropriately led her physicians to  
17      consider, and there are comments in the record to  
18      this, led her physicians to consider that there  
19      might be some other cause for her condition,  
20      including her leukopenia,

21                    Remember that she had a white count  
22      in excess of 20,000 that tended to wax and wane but  
23      in the couple of days before the 7th of May that  
24      white count again went up, which I think added to  
25      the concerns regarding an infection that we didn't

1       see, couldn't recognize.

2       Q.       Doctor, let me interrupt. I think you're  
3       pretty far afield.

4                       MR. FELTES:               Objection.

5                       MR. SCOTT:               Objection.

6                       MR. QUANDT:              Objection. You  
7       asked the question, he's being responsive.

8                       MR. MELLINO:            I don't think  
9       he is.

10                      What was the last question I asked  
11       him?

12                               -----

13                      (Question read as follows: Even  
14                      if she is acidotic?)

15                               -----

16       **a.**       We know now in retrospect she didn't have  
17       infection in her abdomen, correct?

18       A.       In retrospect.

19       Q.       Correct, that wasn't causing her to go down  
20       hill on the morning of May 7th, was it?

21       A.       We don't know what caused her to go down hill  
22       on the morning of May 7th. The fact that a  
23       laparotomy some days later did not indicate a gross  
24       abnormality on the morning of May -- at that time,  
25       does not rule out the possibility of this woman

1       being toxic on the morning of May 7th.

2       Q.       The HIDA scan and CT scan were also negative  
3       that were done that day?

4       A.       HIDA scan did not show any biliary  
5       obstruction or gallstones and CT scan showed no  
6       gross abnormalities in the abdomen --

7       Q.       We have no evidence that there was an  
8       infectious process going on in the abdomen on  
9       May 7th?

10      A.       The HIDA scan --

11                               MR. SCOTT:                       Let him answer.

12      Q.       The answer is yes or no.

13                               MR. SCOTT:                       That is not  
14      right.

15      Q.       Is there any evidence there was an infectious  
16      process going on in her abdomen May 7th, answer yes  
17      or no?

18                               MR. QUANDT:                      Objection.

19      Answer as you can.

20                               MR. SCOTT:                      He has  
21      answered.

22      A.       I can't answer that with yes or no,  
23      counselor.

24                               MR. FELTES:                      Objection.

25                               MR. SCOTT:                      Please don't

1 interrupt.

2 Q. Either there is evidence or there isn't?

3 MR. MELLINO: You are the  
4 only one interrupting, Mr. Scott.

5 MR. SCOTT: He talked about  
6 white count.

7 MR. MELLINO: Now you are  
8 coaching him.

9 A. I gave you that information, counselor. We  
10 have an acutely ill woman with evidence of  
11 infection, the fact that a HIDA scan is negative, a  
12 CAT scan shows no gross abnormalities, does not  
13 rule out an acute problem in the abdomen at that  
14 time.

15 Q. I'm asking you do you have evidence that  
16 there was an infectious process in her abdomen on  
17 May 7th?

18 MR. QUANDT: Objection. Go  
19 ahead.

20 A. We do not have cultural evidence of that,  
21 no.

22 Q. Do you have any evidence?

23 A. We have evidence that there might be  
24 something going on in her abdomen on the date of  
25 May 7th because of her clinical condition and

1 findings and complaints.

2 Q. You just testified that we don't know why she  
3 got worse in the early morning hours of May 7th,  
4 correct?

5 MR. SCOTT: Objection.

6 Q. You don't know why she got worse?

7 A. I think the physicians taking care of this  
8 woman --

9 Q. I'm asking you do you?

10 A. I don't know why she got worse.

11 Q. Thank you.

12 When did you develop this opinion  
13 that her arrest was caused by a hypotensive event  
14 and bradycardia?

15 A. In the course of reviewing the melange of  
16 records you see in front of you.

17 Q. Was it after you reviewed Dr. Stiller's  
18 deposition?

19 A. No, I think this was an ongoing concern from  
20 the first time that I reviewed the hospital  
21 records.

22 Q. So it was before you wrote your report then?

23 MR. QUANDT: Objection. If  
24 you can recall, Doctor, go ahead.

25 A. Yes, but I went back and re-reviewed

1 additional data to better support that opinion on  
2 re-review of the records.

3 Q. I take it you don't believe that the cause of  
4 her arrest was an aspiration?

5 A. Not having been there I have no opinion on  
6 that because there was apparently some difference  
7 in opinion in the medical record.

8 Q. You can't tell me when it was you came to the  
9 conclusion that the cause of her arrest was an  
10 arrhythmia?

11 A. No, I felt that that was a possibility on my  
12 initial review of the records, counselor. I again  
13 later went back, after reviewing other depositions,  
14 I later went back and re-reviewed the records  
15 again.

16 Q. So when did you determine that, it was after  
17 you reviewed the depositions?

18 A. No, I was concerned about this being a  
19 hypotensive episode on my initial review of the  
20 medical record, which was before I had seen any  
21 other deposition than Dr. Miclat's, had the chart  
22 at that time.

23 Q. So did you feel that was the probable cause  
24 of her arrest at that time?

25 A. I thought it was a possible cause.

1 Q. As you sit here today do you still think it  
2 is a possible cause or probable cause?

3 MR. GALLAGHER: Objection.

4 MR. SCOTT: He answered  
5 that.

6 MR. MELLINO: He's now  
7 wavering.

8 MR. SCOTT: He's not  
9 wavering.

10 MR. MELLINO: Why don't you  
11 object, not coach the doctor.

12 MR. SCOTT: Stop repeating  
13 question.

14 Q. This is a different question. Can you answer  
15 the question?

16 A. I think that a hypotensive episode is a --  
17 represents an appropriate cause of or precipitating  
18 event to her arrest.

19 Q. Do you think it's the probable cause or  
20 possible cause?

21 MR. GALLAGHER: Objection.

22 MR. FELTES: Objecting.

23 MR. QUANDT: Objection.

24 MR. SCOTT: Objection.

25 A. I believe it is the probable cause.

1 Q. When did you arrive at that conclusion it was  
2 the probable cause?

3 A. I think my initial review of the medical  
4 record suggested that was a likely cause,  
5 counselor.

6 Q. You arrived at the conclusion after initial  
7 review of the records?

8 A. I had not -- keep in mind, counselor, I had  
9 not been asked to comment on that event in my  
10 initial review of the records.

11 Q. Do you think that is pertinent at all to  
12 whether or not Dr. Miclat or any of the physicians  
13 adhered to the standard of care required of them?

14 MR. QUANDT: Objection.

15 MR. WEITENDORF: Objection.

16 MR. QUANDT: He wasn't asked  
17 to review the reports on what some other physician  
18 did. He was asked to review the records whether  
19 Dr. Miclat deviated from the standard of care.

20 Q. Can you answer the question, Doctor?

21 A. My initial review focused on Dr. Miclat's  
22 participation in the case. As I reviewed the  
23 record I was struck by the acuity, the apparent  
24 acuity of her illness, the change in her clinical  
25 course, including the hypotension on May 7th. I



1       felt that was a very appropriate, probably likely  
2       cause of her event.

3       Q.       Could you answer the question, now?

4       A.       I thought I just did, counselor.

5       Q.       The question was: Do you feel that the cause  
6       of her arrest is pertinent to whether or not the  
7       physicians in this case adhered to the standard of  
8       care required of them?

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

11       A.       I want to be s'ure I understand the intent of  
12       the question.

13                       Would you read the question back  
14       again.

15                       - - - - -  
16                       (Question read.)

17                       - - - - -  
18                       MR. QUANDT:               Objection to  
19       the form of the question.

20       A"       I did not have a problem with the  
21       appropriateness of the medical care rendered to  
22       this patient. I believe that with the acuity of  
23       this woman's illness, multiple medical problems she  
24       had, the care rendered to this woman by her  
25       attending physicians was appropriate.

1 Q. Maybe I'm not making myself clear. Let me  
2 ask it a different way.

3 A. Maybe you're not.

4 Q. When you considered the question of whether  
5 or not she received appropriate care, did you  
6 consider what caused her arrest?

7 MR. QUANDT: Objection.

8 MR. SCOTT: Objection.

9 MR. QUANDT: Form of that  
10 question.

11 A. When I initially reviewed the medical  
12 records, concentrating on Dr. Miclat's  
13 participation, reviewing the participation of other  
14 physicians, I felt that hypotension was a  
15 contributing factor to her arrest.

16 Q. What about arrhythmia?

17 A. At that time, my initial review, I do not  
18 believe I looked at the rhythm strips in the chart,  
19 though I reviewed more recently and noticed the  
20 association of bradycardia.

21 Q. Have you had any conversations with  
22 Mr. Quandt after the depositions were provided to  
23 you, prior to today?

24 A. No. Only to reschedule this deposition for  
25 which I apologize to all of you present.

1 Q. Why is it you didn't mention in your report  
2 you felt that the arrest was caused by hypotension  
3 and arrhythmia?

4 A. When I reviewed the record I asked Mr. Quandt  
5 how detailed a report he would like to have from  
6 me. He suggested that it did not have to be  
7 detailed. He asked me initially to concentrate on  
8 Dr. Miclat's participation in the care of this  
9 patient, which I did. Therefore, gave a relatively  
10 brief report.

11 Q. You did mention in there that it was felt an  
12 aspiration of stomach content may have contributed  
13 to the respiratory arrest on page 2, you felt it  
14 appropriate to comment on the cause of the  
15 respiratory arrest but you put down a cause you  
16 didn't believe was the cause, correct?

17 MR. GALLAGHER: Objection.

18 MR. QUANDT: Objection, that  
19 is not what he said.

20 A. That was just from the medical record.

21 Q. Right, you don't believe that was the cause  
22 of the respiratory arrest, do you?

23 A. No.

24 Q. That is what you put down in your report,  
25 correct?

1 A. It's not what I was asked to comment on.

2 Q. That's what you put on the report?

3 MR. GALLAGHER: Objection. You  
4 read the statement, it says may,

5 Q. That is the cause you put down in the report?

6 MR. GALLAGHER: Objection.

7 MR. QUANDT: Objection.

8 A. No, that is not the cause I put down in the  
9 report. That was a review of information given in  
10 the medical record.

11 Q. You put down it was felt aspiration of the  
12 stomach contents may have contributed to  
13 respiratory arrest; is that correct?

14 A. That's what I said.

15 Q. Nothing about bradycardia, arrhythmia, or a  
16 hypotensive event,. correct, causing the respiratory  
17 arrest?

18 A. Not in that report.

19 Q. Was there another report?

20 A. No.

21 Q. Did you tell Mr. Quandt you felt that was the  
22 cause of the respiratory arrest?

23 MR. GALLAGHER: Objection.

24 MR. QUANDT: Join.

25 A, I mentioned that to him just before the

1 deposition as we were visiting, not before.

2 Q. That's the only time, first and only time you  
3 mentioned it to Mr. Quandt?

4 A. First and only time.

5 Q. This is an opinion you claim you held all  
6 along in this case, correct?

7 A. **It's** an opinion that I held from my time of  
8 initial review. It was only after review of the  
9 other medical records that it seemed appropriate to  
10 mention this.

11 Q. You had the other medical records before you  
12 wrote your report?

13 A. I mean everything on the table.

14 Q. The only thing you reviewed since your report  
15 is expert's depositions, correct?

16 A. Yes, and the full chart in order.

17 Q. You didn't have the full chart in order?

18 A. I had it in pieces.

19 Q. Did you have the full chart prior to  
20 authoring your report in this case?

21 A. Most of it. Did not review it in full detail  
22 at that time. Again, because I was focusing on  
23 Dr. Miclat's care of the patient.

24 Q. What parts of the chart did you review prior  
25 to rendering your report in this case?

1 A. I reviewed primarily the progress notes and  
2 the orders on the patient through her hospital  
3 stay. I then focused on a couple of days in the  
4 hospital chart leading **up** to and following the 7th  
5 of May.

6 Q. Did you review Dr. Miclat's deposition prior  
7 to rendering your report?

8 A. That was the only deposition that I had at  
9 the time.

10 Q. Did you review the summaries that were  
11 provided to you prior to rendering the report?

12 A. I did.

13 Q. Is the question of whether or not she  
14 sustained a respiratory arrest, is that something  
15 that is within the expertise of a Board certified  
16 pulmonologist?

17 MR. FELTES: Objection.

18 MR. QUANDT: Objection. Go  
19 ahead, Doctor.

20 A. Is the fact that she --

21 Q. Yeah.

22 A. I would think that is within the expertise of  
23 a Board certified pulmonologist.

24 Q. You've read the depositions of the  
25 pulmonologists who were retained to review the

1 records in this case, right?

2 A. I read the opinions of the pulmonologists who  
3 gave testimony in this case.

4 Q. They all agree she sustained a respiratory  
5 arrest, correct?

6 MR. GALLAGHER: Objection.

7 MR. FELTES: Objection.

8 MR. SCOTT: Objection.

9 MR. QUANDT: Objection.

10 A. They were of the opinion she did. I do not  
11 happen to agree with that opinion.

12 Q. You're not a pulmonologist either?

13 A. I'm not a pulmonologist.

14 Q. Would a blood gas show respiratory acidosis  
15 or metabolic acidosis?

16 A. Blood gases may show either or both.

17 Q. A patient can have both respiratory and  
18 metabolic acidosis, correct?

19 A. Yes.

20 Q. If her physicians would have expected or been  
21 concerned about her suffering an arrest, what  
22 precautions should they have taken on the afternoon  
23 of May 7th?

24 MR. SCOTT: Objection.

25 MR. QUANDT: Objection, form

1 of the question.

2 A. I believe that some precautions were taken.  
3 This woman was receiving oxygen by Venti mask, she  
4 was on continuous pulse oximeter, blood pressure  
5 recordings and was accompanied by a nurse when she  
6 went down to radiology for her studies, when she  
7 again went down to radiology for the CT scan.

8 Q. Were there other precautions that could have  
9 been taken?

10 MR. QUANDT: Objection.

11 A. I believe that that would depend upon the  
12 judgment of the physicians caring for the patient,  
13 taking into consideration all of the facts of the  
14 acuity of her illness.

15 Q. I'm asking if there were other precautions  
16 that could have been taken?

17 MR. SCOTT: Objection.

18 MR. GALLAGHER: Objection.

19 MR. QUANDT: Objection.

20 A. I guess there are.

21 Q. What are they?

22 MR. QUANDT: Don't guess,  
23 Doctor, about anything. If you can think about it,  
24 formulate an answer, do so, don't guess.

25 A. Besides constant attendance of a nurse,



1       oxygenation, she could have been re-intubated.

2       Q.       Anything else?

3       A.       She was already receiving I.V.'s, she was  
4       receiving oxygen, she had a nurse in attendance, on  
5       blood pressure and pulse ox monitoring. I believe  
6       that level of observation in the judgment of her  
7       physicians at that time was adequate.

8       Q.       I know we've gone over this before, make sure  
9       I'm clear on this.

10                       Did her hypotension cause the  
11       bradycardia that you feel led to her arrest?

12                   MR. QUANDT:               Objection,  
13       asked and answered. Go ahead.

14                   MR. GALLAGHER:           Objection.

15       A.       That's not possible from the data to  
16       determine, counselor. We know she was hypotensive  
17       prior to the EKG readings that suggest the  
18       significant bradycardia. What other factors go  
19       into an acute arrhythmia in a critically ill  
20       patient are multiple.

21       Q.       If they created her hypotension could they  
22       have prevented the arrhythmia?

23                   MR. QUANDT:               Objection.

24                   MR. FELTES:               Objection.

25                   MR. QUANDT:               Asked and

1 answered.

2 Q. In all probability?

3 A. I don't know that.

4 Q. Should they have corrected her hypotension?

5 MR. QUANDT: Objection.

6 MR. FELTES: Objection.

7 A. This lady was acutely ill enough that I'm not  
8 sure that we could have corrected her level of  
9 blood pressure at the time her physicians were  
10 concerned about her life.

11 Q. Was she given any therapy to correct her  
12 blood pressure from the reading at 2:30?

13 A. Let's go back and look at that. At 2:30 this  
14 is after the arrest, not the HIDA scan, the  
15 arrest.

16 Q. When did she arrest in your opinion?

17 A. Two something in the afternoon.

18 Q. I'm talking about page 988, 2:30 p.m. there  
19 is a note says her blood pressure is 66 over 46.

20 A. Um-hum.

21 Q. Is that hypotensive?

22 A. Yes.

23 Q. Should therapy be given to correct that  
24 hypotension?

25 A. I believe it was. I believe she received

1 fluids or increase in fluids. She was already  
2 receiving intravenous fluids, she received increase  
3 in fluids. I believe she received some additional  
4 volume expanders.

5 Q. Should she have been given some pressor  
6 agents?

7 A. She may have been given pressor agents.

8 Q. That's appropriate therapy for somebody with  
9 that blood pressure reading?

10 A. That depends upon the clinical state of the  
11 patient.

12 Q. Let me ask it a little differently.

13 Would that have been appropriate  
14 therapy for Mrs. Lind to have received at that  
15 time, volume expanders and pressor agents?

16 A. She received volume expanders, pressor agents  
17 could have been considered appropriate, not  
18 necessarily mandatory, dependent upon the state of  
19 the patient at the time. I can't judge that from  
20 this kind of review of the medical record.

21 Q. Did she need to get fluids?

22 A. She was getting fluids.

23 Q. Did she need to get fluids?

24 A. Did she need to get more fluids?

25 Q. Right.

1       A.       She had an adequate urine output on the  
2 morning of May 7th. Until the time her blood  
3 pressure dropped, it was not until her pressures  
4 were low or in the morning of the 7th her urine  
5 volumes decreased. As the day goes on, her  
6 pressures are back up, her urine output again picks  
7 up. This woman had adequate intakes and outputs  
8 through her hospital course up until the day of  
9 May 7th.

10       Q.       On May 6th were they adequate?

11       A.       Yes, they were adequate.

12       Q.       Weren't her outputs greater than her inputs?

13                       MR. QUANDT:               I think he said  
14 up to May 7th.

15       A.       That doesn't bother me a bit. That  
16 demonstrates, shows excellent urine output, which  
17 would certainly be against any evidence of volume  
18 depletion or hypovolemia or dehydration certainly.

19       Q.       If she is putting out more fluid than she is  
20 taking in, that is good?

21       A.       That's okay given the total picture of the  
22 patient.

23                       Number one, you can't utilize  
24 recorded intakes and outputs as an isolated  
25 observation to assess the adequacy of hydration of

1 a patient. We need to look at the clinical status,  
2 clinical evidence of fluid retention or tissue  
3 evidence of dehydration. What happened to this  
4 lady's weight over the period of time and  
5 concern -- you can't look only at intakes and  
6 outputs. In an acutely ill patient like this whose  
7 fluid requirements -- medication requirements,  
8 total personal nutrition all provide volume to this  
9 woman. You look at I's and O's as recorded, you  
10 are delighted to see adequate intakes and adequate  
11 outputs.

12 Q. So it's your testimony she received adequate  
13 therapy at 2:30 for her hypotension?

14 MR. FELTES: Objection.

15 Q. Or did she?

16 A. She received --

17 Q. Did she receive any additional therapy?

18 A. I believe she did.

19 Q. What?

20 A. In fact she received it prior to that event.  
21 She received Hespan and Albumin, which were ordered  
22 at 12:35 on that date.

23 Q. Her blood pressure dropped to 66 over 46,  
24 there is no further therapy required because she  
25 received treatment at 12:30; is that your

1 testimony?

2 A. No. What I have to do is try to find the  
3 location in the records that reflects her  
4 intravenous fluids. I'm trying to do that for  
5 you.

6 MR. GALLAGHER: Are you looking  
7 for nurses' notes?

8 THE WITNESS: I was looking  
9 for the notes that would reflect her intravenous  
10 fluid orders.

11 MR. GALLAGHER: May I suggest a  
12 page, Chris?

13 MR. MELLINO: Pardon?

14 MR. GALLAGHER: May I suggest a  
15 page he look at?

16 MR. MELLINO: Sure, go ahead.

17 MR. GALLAGHER: 1135. I'm not  
18 sure it's there, there may be something there.

19 Q. That is not the page though, what were you  
20 looking for?

21 A. What I'm looking for are the nursing notes  
22 that reflect the intravenous fluid orders for that  
23 day, counselor.

24 MR. GALLAGHER: Probably around  
25 page 992 somewhere.

1                   MR. SCOTT:                   Under the order  
2                   section, is that what you are interested in, the  
3                   particular orders?

4           A.       That's where I was when we got off because I  
5           was trying -- okay. Trying to find the -- excuse  
6           me, counselor, they are just so hard to read  
7           because of the copies, enough to give you an  
8           accurate comment.

9                   Let's start with 5-7 of the ICU  
10           records.

11          Q.       Are you looking for an order for I.V.  
12           fluids?

13          A.       Usually in most of our records we have  
14           comments relative to the rates that I.V.'s are  
15           being infused and that. I think we're getting to  
16           on page 990, I think you can see that she's  
17           receiving intravenous fluids on this day, dextrose,  
18           five percent dextrose and quarter strength saline.  
19           The rates as I would interpret them, the rates here  
20           usually would suggest that -- 150, that to me would  
21           interpret 150 cc's per hour, which is a very  
22           generous rate of intravenous infusion. You will  
23           see that her urinary outputs on that same morning  
24           are ranging from 46 to 10 cc's per hour, that's  
25           adequate urine output.

1                   In the subsequent morning hours in  
2     the middle of the page you will see her hourly  
3     urine outputs tend to drop a little bit. My  
4     impression is that this is consistent with lower  
5     blood pressure being experienced that morning in a  
6     patient I think was toxic. Then her urine output  
7     picked up again later in the day. The fact is she  
8     was receiving intravenous fluids throughout this  
9     day, she received some additional volume expanders  
10    prior to going back for her CT scan.

11   *a\**       Despite that --

12   A.       Continued to receive intravenous fluids.

13   Q.       Right. Despite that her blood pressure  
14   dropped while she was undergoing the CT scan,  
15   right?

16   A.       Despite that she dropped her pressure during  
17   her CT scan.

18   Q.       Now my question was: As she dropped in the  
19   CT scan, should she have received additional  
20   therapy, i.e. additional fluids, pressors?

21   A.       Depending upon her clinical status, some  
22   additional fluid my be considered appropriate.  
23   Large volumes of intravenous fluid might be  
24   detrimental to this woman.

25                   MR. QUANDT:                   Can you answer



1       that question as posed by counselor on the basis of  
2       what you have in the record?

3       Q.       Doctor, do you have an opinion based on  
4       reasonable medical probability as to whether or not  
5       when Mrs. Lind's blood pressure dropped at 2:30 to  
6       66 over 46 she should have received additional  
7       therapy?

8                       MR. QUANDT:               Objection.

9                       MR. FELTES:               Objection.

10                      MR. QUANDT:               Form of the  
11       question.

12       Q.       I have no opinion because I can't identify  
13       from the existing records whether or how much  
14       additional fluid she got at that time. I know she  
15       was already receiving intravenous fluids.

16       Q.       Can you tell if she received any additional  
17       fluids?

18       A.       I can't tell, counselor, from --

19                      MR. QUANDT:               You answered  
20       the question.

21       Q.       If she received additional fluids isn't that  
22       something that should be reflected in the records?

23                      MR. FELTES:               Objection.

24                      MR. QUANDT:               Objection.

25       A.       At some point in time that would be

1 appropriate.

2 Q. If she didn't receive additional fluids would  
3 that be below the standard of care?

4 MR. FELTES: Objection.

5 MR. QUANDT: Objection.

6 A. Not necessarily, counse or. Again, depending  
7 upon the clinical status of the patient.

8 Q. Assuming she didn't receive any additional  
9 fluids, her blood pressure dropped further down to  
10 52 over 30 as reflected in the nurses' notes, would  
11 additional fluids be required at that time?

12 MR. FELTES: Objection.

13 MR. QUANDT: Objection.

14 A. Not necessarily since her blood pressures  
15 were back up over 100 an hour later.

16 Q. An hour later?

17 A. We're looking at hourly, we're looking at  
18 hourly recordings here on the vertical, if you  
19 follow them out.

20 Q. Talking 3:15?

21 A. At 3:15 she was 120 over 63.

22 Q. That was after the code?

23 A. After the code. The blood pressure at  
24 2:00 p.m. reflects the time of the code.

25 Q. Did she receive therapy during the code that

1 would have raised her blood pressure?

2 A. I can't tell.

3 Q. Is that a normal part of a code?

4 MR. QUANDT: Objection.

5 A. A normal part of a code is resuscitating the  
6 patient. If that requires additional fluid,  
7 additional fluid should be administered.

8 Q. If her pulse ox is 69 at 2:30 when her blood  
9 pressure dropped to 66 over 46, with that  
10 additional information are you able to say whether  
11 or not she should have been given additional fluids  
12 and pressor agents?

13 A. I'm trying to bring myself to where you are  
14 at 2:00 p.m., are you looking at the pulse ox  
15 of 69?

16 Q. Right. If that happened at 2:30 along with  
17 blood pressure of 66 over 46, that required  
18 additional fluids be given or pressor agents, both,  
19 or a physician be notified or some form of  
20 intervention?

21 MR. FELTES: Objection to  
22 the multiplicity of the question.

23 A. I think some form of intervention would be  
24 appropriate here.

25 Q. What form of intervention?

1       A.       Whether that required additional oxygenation,  
2       turned out she was intubated as part of this code,  
3       she was already receiving I.V. fluids, I can't tell  
4       whether the intravenous fluid rates were increased  
5       at this time. Any or all of the above were  
6       appropriate at this time.

7       Q.       Would the failure to do any of those things  
8       be failure to adhere to the standard of care?

9                   MR. QUANDT:               Objection, form  
10       of the question.

11                   MR. FELTES:               Objection.

12                   MR. QUANDT:               Doctor, you've  
13       been asked to review this record primarily on the  
14       part of Dr. Miclat. That question is broad and all  
15       expansive with respect to all defendants. I don't  
16       think that is fair for you to even try to answer  
17       that. That was not your charge.

18       A.       I can't answer that.

19       Q.       Well, Doctor, to be fair you did put in your  
20       report you felt that it is in fact a credit to the  
21       medical and nursing staff of Elyria Memorial  
22       Hospital this patient survived to leave the  
23       hospital for continued rehabilitation?

24       A.       Yes.

25       Q.       Isn't that a comment on the medical and

1 nursing staff of Elyria Memorial Hospital?

2 MR. QUANDT: It compliments  
3 them, sure as the devil doesn't go to the point you  
4 are asking as to whether or not it met the standard  
5 of care of any of them.

6 Q. Can you answer the question, Doctor?

7 A. Well, relative to my compliment of the  
8 nursing and physician staff?

9 Q. No, relative to whether or not the failure to  
10 give any therapy when Mrs. Lind needed it at 2:30  
11 when her blood pressure is 66 over 46, pulse ox  
12 was 69, was a failure to adhere to the standard of  
13 care of the nursing staff and medical staff of  
14 Elyria Memorial Hospital?

15 MR. FELTES: Objection.

16 MR. QUANDT: Objection.

17 MR. SCOTT: Objection.

18 A. I can't answer that.

19 Q. Do you have an opinion one way or the other?

20 A, I don't have enough information.

21 Q. What other information do you need?

22 MR. QUANDT: Objection.

23 A. I would like to know what changes, if any,  
24 were made in her intravenous fluids. Whether she  
25 was placed in Trendelenburg, any pressor agents

1       were given. I would like to know what the course  
2       of her pulse oximetry was over not the next hour  
3       but the next few minutes following the code. These  
4       are the things that had I been bedside I could have  
5       observed, but reviewing a record in retrospect I  
6       don't have that information base.

7       Q.       Those are things if they were done should be  
8       in the record, correct?

9                       MR. QUANDT:               Objection.

10                      MR. FELTES:               Objection.

11                      MR. QUANDT:               Ask yourself do  
12       you know, Doctor. I don't want you to guess. You  
13       are not required to guess about anything.

14       A.       At the time a code is called on a patient --

15       Q.       This is before the code is called, Doctor,  
16       this is at 2:30.

17       A.       Before the code we have the information on  
18       intravenous fluids in the record we know she  
19       received.

20       Q.       You said it would have been appropriate for  
21       her to get additional fluids?

22                      MR. QUANDT:               Objection.

23       A.       She got additional volume expanders before.  
24       What I don't have is the information immediately  
25       after the code when the professional staff were

1 busy trying to save this woman's life.

2 MR. QUANDT: Also let the  
3 record indicate this goes beyond your charge. The  
4 question is all inclusive with respect to the  
5 entire nursing staff as well as the medical staff.

6 Q. Doctor, you can't comment one way or the  
7 other whether or not they adhered to the standard  
8 of care based on the information that is in the  
9 record at 2:30, between 2:30 and the time the code  
10 was called, correct?

11 MR. QUANDT: Objection.  
12 That says "they," the pronoun is used. I don't  
13 know how anyone is going to interpret that.  
14 Certainly not that you were enlisted and called to  
15 frame an answer as relates to Dr. Miclat.  
16 Objection to that question.

17 MR. MELLINO: Read back the  
18 question.

19 -----  
20 (Question read.)

21 -----  
22 MR. FELTES: Objection.

23 MR. QUANDT: Objection.

24 MR. SCOTT: Objection.

25 Q. I'll rephrase the question.

1                   Doctor, you can't comment one way  
2                   or the other as to whether or not the medical and  
3                   nursing staff of Elyria Memorial Hospital adhered  
4                   to the standard of care required of them based on  
5                   this record from 2:30, the time Mrs. Lind's blood  
6                   pressure and pulse ox dropped, until the time the  
7                   code was called, can you?

8                   MR. QUANDT:                   You don't have  
9                   to answer that question.

10           Q.        Pardon?

11           A.        I can't answer that.

12           Q.        You don't have an opinion on that?

13           A.        No.

14           Q.        Do you have an opinion as to whether or not  
15                   the emergency room physician, Dr. Branch, adhered  
16                   to the standard of care required of him?

17                   MR. QUANDT:                   Objection.

18           That was not your charge. Bear in mind you are not  
19           required to guess about anything.

20           Q.        You did review the emergency room records,  
21                   you commented on them?

22           A.        I did comment on them.

23           Q.        Do you have an opinion as to whether or not  
24                   Dr. Branch adhered to the standard of care required  
25                   of him?



1 MR. QUANDT: Objection.

2 A. Based on the information provided in the  
3 medical record I thought that he did.

4 Q. You thought he did.

5 Did you say that you had records on  
6 this case you testified in, that you were deposed  
7 in, would you be able to find out the name of the  
8 case or person who deposed you?

9 A. I will ask my secretary to check my files.

10 Q. Could you provide that information along with  
11 the articles that you gathered on transporting  
12 patients in respiratory -- whatever it was referred  
13 to in your letter, can you provide those to  
14 Mr. Quandt?

15 A. I will be happy to.

16 Q. Thank you.

17 Can a patient's inability to remove  
18 carbon dioxide make her toxic?

19 A. It can certainly produce hypoxia, a rise in  
20 the blood CO2.

21 Q. Can that lead to toxicity?

22 A. Can certainly lead to clinical symptoms.

23 Q. Do you think it was appropriate for the  
24 nursing staff to give Demerol when the physician  
25 had ordered no sedatives?

1 MR. FELTES: Objection.

2 MR. QUANDT: Objection. You  
3 were not charged with that type of inquiry.

4 A. No comment.

5 Q. You don't have an opinion?

6 A. I do not think that the administration of  
7 Demerol was a factor in her subsequent hypotensive  
8 arrest on 5-7.

9 Q. Could you answer the question?

10 A. I did.

11 MR. FELTES: Objection.

12 Q. I asked you if it was appropriate for the  
13 nurses to give the Demerol in contravention of the  
14 doctor's order. I didn't ask you if it contributed  
15 to anything.

16 MR. QUANDT: Objection to  
17 the form of the question. Not something this  
18 witness was required to look at and formulate an  
19 opinion upon.

20 MR. FELTES: Objection.

21 Q. You formulated an opinion as to whether or  
22 not it caused anything, apparently, correct? You  
23 just volunteered that for us, right?

24 MR. QUANDT: Correct.

25 A. I did.

1 Q. Did you formulate an opinion whether or not  
2 it was negligent for the nurses to give Demerol in  
3 the face of an order for no sedatives?

4 MR. FELTES: Objection.

5 MR. QUANDT: Your answer can  
6 be yes or no. The mere fact you volunteered one  
7 thing does not mean you volunteered everything  
8 across the board.

9 MR. MELLINO: Bob, would you  
10 knock it off.

11 MR. QUANDT: I'm serious.

12 MR. MELLINO: If he has an  
13 opinion I'm entitled to know what that is.

14 MR. QUANDT: I told him to  
15 say yes or no.

16 MR. MELLINO: Let's wait for  
17 him to say yes or no, it's his turn to talk.

18 MR. QUANDT: I have no  
19 problem with that Chris, no problem at all.

20 A. Yes.

21 Q. What is your opinion?

22 A. That I believe it would have been appropriate  
23 for the nurse to check with Dr. Dacha before  
24 administering the Demerol.

25 Q. Do you believe that is what the nurse should

1 have done in this case?

2 MR. FELTES: Objection.

3 MR. QUANDT: Objection.

4 A. I believe it would have been appropriate to  
5 check with that order in the chart before  
6 administering a narcotic sedative agent.

7 Q. I want to make sure we're saying the same  
8 thing.

9 Was it inappropriate not to check  
10 with Dr. Dacha before administering the Demerol?

11 MR. FELTES: Objection.

12 MR. QUANDT: Objection. Go  
13 ahead.

14 A. Good nursing practice would have suggested  
15 the need to check with Dr. Dacha.

16 Q. Was the order inappropriately vague?

17 MR. QUANDT: Objection, go  
18 ahead. Do you have that order before you? Have  
19 you reviewed it?

20 Q. Are you familiar with that order for no  
21 sedatives?

22 A. Yes.

23 Q. Was that order inappropriately vague on  
24 Dr. Dacha's part?

25 MR. QUANDT: Objection to

1 form.

2 MR. FELTES: Objection.

3 A. I have no comment on that, counselor.

4 MR. MELLINO: I don't have  
5 any other questions for you, Doctor.

6 MR. SCOTT: No questions.

7 MR. GALLAGHER: No questions.

8 MR. FELTES: No questions.

9 MR. WEITENDORF: No questions.

10 MR. QUANDT: Listen to me  
11 now. I'm going to order that this be written by  
12 the court reporter. You have two options under the  
13 law of the State of Ohio. You can indicate to the  
14 court reporter that your choice is that you don't  
15 care to read the deposition. On the other hand,  
16 you certainly have the opportunity to request that  
17 it be written so you have the understanding and the  
18 opportunity to read it. That's your choice you  
19 must make, one way or the other.

20 I have every reason to believe we  
21 have a fine reporter, she has taken it all down.  
22 That need not be a deterrent to you requesting to  
23 read it, so you can read it to satisfy yourself.

24 THE WITNESS: I would waive.

25 (Deposition concluded; signature waived.)

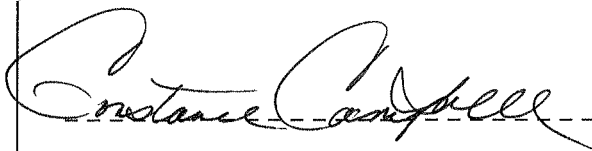
1 The State of Ohio,  
2 County of Cuyahoga.

CERTIFICATE:

3 I, Constance Campbell, Notary Public within  
4 and for the State of Ohio, do hereby certify that  
5 the within named witness, DONALD G. VIDT, M.D. was  
6 by me first duly sworn to testify the truth in the  
7 cause aforesaid; that the testimony then given was  
8 reduced by me to stenotypy in the presence of said  
9 witness, subsequently transcribed onto a computer  
10 under my direction, and that the foregoing is a  
11 true and correct transcript of the testimony so  
12 given as aforesaid.

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

18 IN WITNESS WHEREOF, I have hereunto set my  
19 hand and affixed my seal of office at Cleveland,  
20 Ohio, this 28th day of March, 1995.

21   
22 -----

23 Constance Campbell, Stenographic Reporter,  
24 Notary Public/State of Ohio.  
25 Commission expiration: January 14, 1998.

**Look-See Concordance Report**

--  
 UNIQUE WORDS: **1,256**  
 TOTAL OCCURRENCES: **4,676**  
 NOISE WORDS: **385**  
 TOTAL WORDS IN FILE: **13,353**

--  
 SINGLE FILE CONCORDANCE

--  
 CASE SENSITIVE

---  
 PHRASEWORD LIST(S):

--  
 NOISE WORD LIST(S): **NOISE.NOI**

---  
 COVER PAGES = 6

---  
 INCLUDES ONLY TEXT OF:

**QUESTIONS**  
**ANSWERS**  
**COLLOQUY**  
**PARENTHETICALS**  
**EXHIBITS**

--  
 DATES **ON**

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 POSSESSIVE FORMS **ON**

---  
 MAXIMUM TRACKED OCCURRENCE  
 THRESHOLD: 50

---  
 NUMBER OF WORDS SURPASSING  
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 LIST OF THRESHOLD WORDS:

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