THE STATE of OHIO,

COUNTY OF LORAIN. : SS:

No. 443

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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.

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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.

FLOWERS & VERSAGI
COURT REPORTERS
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THE 113 SAINT CLAIR BUILDING - SUITE 505
CLEVELAND, OHIO 44114-1273
(216) 771-8018
1-800-837-DEPO

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

Christopher M. Mellino, Esq.
Charles Kampinski Co., L.P.A.
1530 Standard Building
Cleveland, Ohio 44113.
(216) 781-4110
and
Gerald R. Horning, Esq.
1419 W. 9th Street
Cleveland, Ohio 44113.
(216) 241-2258.

ON BEHALF OF THE DEFENDANT COMPREHENSIVE HEALTH CARE of OHIO, INC./ELYRIA MEMORIAL HOSPITAL:

Joseph Feltes, Esq.
Buckingham, Doolittle & Burroughs
624 Market Avenue N
Canton, Ohio 44702
(216) 456-2491.

APPEARANCES: (continued)

ON BEHALF OF THE DEFENDANTS DAVID BRANCH, M.D., and ACUTE CARE SPECIALISTS, INC.:

(NOT PRESENT)

Lynn L. Moore, Esq.
Gallagher, Sharp, Fulton & Norman
Seventh Floor Bulkley Building
Cleveland, Ohio 44114.
(216) 241-5310

ON BEHALF OF THE DEFENDANT HARINATHROA DACHA, M.D.:

John P. Gallagher, Esq.
Fauver, Tattersall & Gallagher
400 Premier Bank Building
Elyria, Ohio 44035
(216) 322-3784.

ON BEHALF OF THE DEFENDANT ROMEO MICLAT, M.D.:

Robert G. Quandt, Esq.
Quandt, Giffels & Buck
800 Leader Building
Cleveland, Ohio 44114.
(216) 241-2025

APPEARANCES: (continued)

ON BEHALF OF THE DEFENDANT PARESH PATEL, M.D.:

Kurt Weitendorf, Esq.
Roderick, Meyers & Linton
1500 **One Cascade Plaza**
Akron, Ohio 44308
(216) 434-3000

ON BEHALF OF THE DEFENDANT DINUBHAI C. PATEL, M.D.:

John R. Scott, Esq.
Reminger & Reminger
The 113 **Saint Clair Building**
Cleveland, Ohio 44114
(216) 687-1311

I N D E X

WITNESS: **DONALD G. VIDT, M.D.**

(FOR COMPLETE INDEX, SEE APPENDIX)

DONALD G. VIDT, M.D.

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

CROSS-EXAMINATION

BY MR. MELLINO:

Q. State your full name, please, Doctor.

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

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

Q. Where do you live, Doctor?

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

Q. Have you been deposed before?

A. I have.

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

A. Do you mean deposed or appearing in court?
Q. I didn't mean that. I mean retained as an expert witness.
A. I can think of three occasions in the past several years where I was asked to review a case.
Q. Is that including this one or in addition to?
A. That was in addition to this one.
Q. On how many of those occasions were you deposed?
A. One time.
Q. One other deposition?
A. Um-hum.
Q. How many times have you appeared in court to testify as an expert witness?
A. One time, that was approximately 20 to 25 years ago.
Q. Was that the same case you were deposed in?
A. No.
Q. The other times you've been retained as an expert, was that was on behalf of a defendant in a lawsuit?
A. It was on behalf of a defendant.
Q. Did any of those involve Dr. Miclat?
A. No.
Q. Elyria Memorial Hospital?

A. No.
Q. Any physicians involved in this case?
A. No.
Q. What were the issues involved in those three other cases?
A. One was I guess about three years ago, it was a nephrologist in the Akron area who had cared for a patient with acute rapidly progressive renal failure. That patient suffered an intracranial hemorrhage, expired during that hospitalization.
Q. Were you deposed in that case?
A. Yes, I believe that that is the case that I was deposed in.
Q. Do you know the name of that case?
A. I am sorry, I don't recall the name.
Q. Do you recall the name of the person who took your deposition?
A. I do not.
Q. Who retained you in that case?
A. I am sorry, I can't even tell you that at this time. It's several years ago, I don't know that I've kept any file on that.
Q. It was three years ago?
A. Um-hum.
Q. You have no recollection of who retained you

or what firm retained you?

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

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

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

Q. Do you know the name of the patient?

A. No, not at this time.

Q. Run me through the other two,

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

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

THE WITNESS: Certainly.

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

Q. Do you know the name of that case?

A. No.

Q. Do you know the name of the nephrologist?

A. Yes, the nephrologist was a Dr. Roberto B-a-c-a-n-i.

Q. The third case?

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

It was a situation whereby a patient with renal artery stenosis had an interventive surgical procedure performed, the physician that performed the initial surgical procedure did in fact perform a technique, a procedure that was inappropriate for that patient with his disease. The patient survived but had recurrent and persistent hypertension.

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

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

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

A. I did.

Q. Stating that the first surgeon acted inappropriately?

A. I did.

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

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

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

Q. You knew both of those physicians prior to

your becoming involved in their lawsuit?
A. I did.
Q. Did either one of them refer patients to you prior to you becoming involved in a lawsuit?
A. Yes.
Q. You said the third physician, what was his name, the third lawsuit?
A. I don't recall. If you would like I will have my secretary see if I have files on those for your records. I can't recall.

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

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

Q. You know Dr. Miclat, don't you?
A. Again, professionally. As a nephrologist, we are associated through area wide nephrology committees, et cetera. I know him as a referring physician, he has referred patients to me on occasion.
Q. Has he undergone any training at the Cleveland Clinic?
A. No.

Q. Does the Cleveland Clinic have any affiliations with Elyria Memorial Hospital?
A. I believe we may have an affiliation in the cardiac area at the present time.
Q. Not in your area?
A. Not in our area.
Q. Is that something that is being discussed or worked on?
MR. QUANDT: Objection. Go ahead.
A. If it is, it's at a higher level in the organization.
Q. Who contacted you to become involved in this case?
A. Mr. Quandt.
Q. Have you ever had any contact with Mr. Quandt prior to this case?
A. Not to my knowledge.
Q. How much are you charging to review or to act as an expert in this case?
A. My charges are $300 an hour for materials that I review at home, evenings and weekends, and $500 an hour during my usual working day.
Q. How about for testifying?
A. I haven't had to deal with that question

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

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

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

Q. I see.

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

A. I do not.

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

A. I did not.

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

A. Literature review, not really, no.

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

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

Q. Mr. Miclat?

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

Dr. Miclat's part in this patient's illness.
Q. Did he ask you to limit your opinion to Dr. Miclat, to the exclusion of other physicians? Did you understand that to be the request?
A. He did ask me to focus on Dr. Miclat's involvement in this case.
Q. You authored a report dated December 5, 1994, you have that in front of you?
A. Is that a letter to Mr. Quandt?
Q. Yes.
A. I have a copy of that here.
Q. This is your report containing your opinions in this case?
A. That was my opinion rendered to Mr. Quandt.
Q. Does that contain a summary of all of the opinions that you hold in this case as a result of your review of the materials?
A. Give me a moment to review.
Q. Sure, take your time.
A. I think it summarizes my impression of the patient, her illness and Dr. Miclat's involvement.
Q. As you were going through the materials did you form any opinions regarding the involvement of other physicians?
MR. QUANDT: Objection.

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

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

Q. Can I see your copy?

A. Yes.

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

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

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

A. That is correct.

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

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

A. Yes, I did say that.

Q. Did you do that?

A. I did not.

Q. Why not?

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

Q. Did you search out the papers?

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

Q. Where are the materials?

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

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

MR. MELLINO: December 5, 1994.

Q. Can you provide those materials?

A. Certainly can provide any materials that I have.

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

record -- received any of the fruits of any search

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

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

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

Q. Where are the depositions then?

MR. QIJANDT: Summaries I think is more accurate.

A. Summaries may be a more accurate description.

Q. Maybe my question wasn't clear.

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

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

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

A. That is Dr. Miclat again. This is Dr. Ferguson.
Q. You are identifying the depositions you reviewed, correct, so the record is clear what you are doing?
A. Not prior to my letter to Mr. Quandt.
Q. Right.
A. These additional depositions were reviewed more recently.
Q. What deposition was that?
A. Mazal, Flynn, Stiller, and Ferguson.
Q. *So,* Dr. Flynn, Dr. Stiller, Dr. Ferguson, Dr. Mazal and Mr. Miclat are the only depositions you reviewed in this case, correct?
A. I believe so, but -- I believe everything else in this box is part of the hospital chart duplication, that is correct.
Q. You reviewed summaries of the depositions of the physicians and nurses that were involved in her care, correct?
A. Correct.
Q. Those summaries were prepared by who?
A. I can't answer that.
Q. You have not looked at the actual deposition testimony of these people?

A. I have not.
Q. Is there anything you did review that is not here today?
A. No.
Q. Has anything been removed from your file?
A. No.
Q. Did you undergo any training in pulmonary medicine?
A. I did not.
Q. Are you Board certified?
A. I am Board certified in internal medicine.
Q. You're not Board certified in nephrology?
A. I'm not Board certified in nephrology.
Q. When did that certification come into being?
A. The specialty of that certification of nephrology came about in the late 1970's, 1980, early '80s.
Q. You did a Fellowship in metabolism and renal disease at Metro 1963, 1964?
A. Correct. They were all part of the University Hospitals system at that time.
Q. Is it because you had -- were you grandfathered or is there a reason you didn't take the Board exam for nephrology?
A. No, when I completed my training in

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

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

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

A. My interest in cardiovascular disease and hypertension.

Q. Is there some requirement to become a member?

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

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

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

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

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

A. Hypertension.

Q. What is the Kolf, K-o-1-f, Foundation?

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

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

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

assistance to be able to train patients for home dialysis.

Q. Is that still in existence?

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

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

A. Yes. Core Journal in Clinical Pharmacology is no longer in existence. Still on the editorial board of the Injury Consultant. I'm an editor of the Cleveland Clinic Journal of Medicine. Cardiovascular Perspective is no longer in existence. I believe I'm still on the board of Illustrated Medicine. It's an industry supported publication that is published periodically. Hypertension and Cardiovascular Risk Reduction is no longer active. High Pressure Life Styles is no longer active. I'm an editor of Heartline, which is a Cleveland Clinic publication.

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

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

A. That is a rather complex question.

Would you read back the question for me, please.

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

THE WITNESS: Hold it.

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

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

A. An area of interest. From the standpoint of

publications, no, I have not written on that.
Q. Do you have an opinion in this case as to what the cause of her cardiopulmonary arrest was?
MR. QUANDT: Objection. Go ahead, Doctor.
A. I have an opinion, yes.
Q. What is your opinion?
A. I believe that this patient may have suffered a hypotensive episode and possibly a bradycardic arrhythmia that was the precipitating factor in her arrest.
Q. Have you written any articles or had any videotapes or motion pictures, spoken on hypotensive episodes and bradycardic arrhythmias?
A. No.
Q. Did you review Dr. Stiller's deposition?
A. I did.
Q. Do you agree with his opinions in this case?
MR. SCOTT: Objection.
MR. FELTES: Objection.
MR. GALLAGHER: Objection.
Q. You can answer.
A. I did review Dr. Stiller's deposition. I obviously do not remember it verbatim. I think he may have expressed several opinions. I'll be

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

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

MR. QUANDT: Objection.

MR. GALLAGHER: Objection.

MR. FELTES: Objection.

MR. QUANDT: You can answer.

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

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

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

MR. SCOTT: Objection.

MR. FELTES: Objection.

MR. GALLAGHER: Objection.

MR. QUANDT: Objection.
A. Offhand I can't recall anything. Again having read and reviewed a number of depositions, over several weeks, it's difficult to separate them. If you would like to ask specific questions I'll try to respond.
Q. What facts do you base your opinion on she -- first of all do you believe she had a respiratory arrest?
MR. GALLAGHER: Objection.
MR. FELTES: Objection.
A. I believe that the precipitating event may have been a hypotensive, again possibly I believe a bradycardic event.
MR. QUANDT: Keep your voice up. Thank you.
Q. That may have been the precipitating cause. Could a respiratory arrest also have been?
MR. GALLAGHER: Objection.
MR. QUANDT: Objection.
MR. FELTES: Objection.
MR. QUANDT: Could have been.
A. I think looking at the the events surrounding this lady's problems on the 7th, and trying to

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

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

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

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

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

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

MR. QUANDT: Join the objection.

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

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

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

A. Yes.

Q. She was given fluids in ICU?

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

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

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

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

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

Q. My question was did she remain tachycardic

and tachypneic after the therapy, and hypotensive?
A. Her blood pressure did recover somewhat on that date. Let me go to the record.

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

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

Q. You don't believe she remained hypotensive between the HIDA scan and CT scan?
A. Her blood pressures are lower than normal blood pressures, she was a bit hypotensive. I believe she was not symptomatically in shock at

that time from her blood pressure.
Q. She was hypotensive?
A. She was a bit hypotensive.
Q. She was tachycardic?
A. She was tachycardic.
Q. And tachypneic?
A. And tachypneic.
Q. Do you agree that the decision to send Mrs. Lind for an abdominal CT in addition in the absence of any other therapy was an error of judgment on the part of her treating physician?
MR. FELTES: Objection.
MR. SCOTT: Objection.
MR. QUANDT: Objection.
MR. GALLAGHER: Objection.
A. I do not.
Q. Did you read that testimony in Dr. Stiller's deposition?
A. I did. I read it in some deposition.
MR. QUANDT: Doctor, just in case that it makes a difference, do me the favor of actually looking at Stiller's deposition, if you will, please, so you can be specific.
A. Do you have a page reference to help me in Dr. Stiller's deposition since it's a 100 plus page

deposition?

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

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

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

A. Page 21?

Q. Yes, line 23.

A. I believe that --

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

A. Yes.

Q. Can persistent metabolic acidosis and tachypnea --

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

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

A. Would you like me to respond?

Q. You already said you disagreed with him.

A. Okay, I still disagree.
Q. I assumed you would.
Can persistent metabolic acidosis and tachypnea lead to worsening respiratory muscle fatigue and lead to respiratory arrest?
MR. SCOTT: Objection to form.
MR. QUANDT: Objection.
MR. FELTES: Objection.
MR. GALLAGHER: Objection.
A. I would think that that degree of metabolic abnormality, acute illness in a patient, could contribute to respiratory problems.
Q. You don't think that is what happened in this case?
MR. QUANDT: Objection, asked and answered. Go ahead.
A. I don't think that's necessarily what happened on the morning of May 7th.
Q. What about the afternoon of May 7th?
A. Or the afternoon, early afternoon of May 7th. Many of this patient's problems were persistent from the standpoint of metabolic and clinical abnormalities.
As I stated earlier, I believe that

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

Q. Do you have any training in cardiology?

A. I'm not a cardiologist by training.

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

A. Specialty training, no.

Q. You've never practiced in cardiology?

A. I practice cardiology every day.

Q. Do you diagnose arrhythmias in your patients?

A. Yes.

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

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

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

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

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

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

A. Yes.

Q. Those are the strips you are talking about?

A. Yes.

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

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

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

MR. QUANDT: Take your time.

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

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

Q. When you say several days, be specific.

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

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

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

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

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

MR. SCOTT: What was the question?

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

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

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

MR. QUANDT: Objection.

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

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

A. From an amylase determination that was obtained.

Q. Does pancreatitis cause hypotension?

A. It can.

Q. Is that what was causing her hypotension?

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

Q. Does it cause bradycardic arrhythmias?

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

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

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

MR. FELTES: Objection.

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

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

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

clearly. Maybe I can answer that from the record.

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

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

Q. Show me where you are looking.

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

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

A. The fourth strip on the page.

Q. That shows she is tachycardic?

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

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

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

Q. Was she hypotensive at the time of the strip?
A. Let's try to answer that for you as best we can from the medical record.

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

Q. She was hypotensive at 12:20 when they took this, as near as you can tell from the record?
A. Yes, her blood pressure may have been lower at that time.
Q. I think you were looking at the strips, I lost the original question, you were determining when she had the arrhythmia?
A. I believe you asked me if she had any other arrhythmias prior to the time of her arrest and I was reviewing the fact she was tachycardic but regular rhythm on the morning of May 7th at 12:20.

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

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

Q. Was that an arrhythmia?

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

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

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

Q. It's **1452**.

A. It's not clear on my page.

Q. It's **1452**.

A. 1452?

Q. Yes.

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

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

Q. What caused this bradycardia?

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

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

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

MR. GALLAGHER: Objection.

MR. FELTES: Objection.

MR. QUANDT: I join the objection.

MR. SCOTT: Objection.

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

Q. Why not?

MR. FELTES: Objection.

MR. QUANDT: Objection. Go ahead, Doctor.

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

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

Q. Let me ask the question a little differently.

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

MR. GALLAGHER: Objection.

MR. QUANDT: Objection.

MR. SCOTT: Objection.

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

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

MR. QUANDT: Objection.

MR. FELTES: Objection.

A. Possibly.

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

MR. QUANDT: Objection. Go ahead.

A. Please repeat the question for me.
Q. If you sustain a respiratory arrest of the degree that Mrs. Lind had, wouldn't you probably have bradycardia?
MR. GALLAGHER: Objection.
MR. FELTES: Objection.
MR. QUANDT: Objection.
A. At some point in the course, yes.
Q. The fact there is bradycardia reflected on these strips that you pointed out is not inconsistent with her having sustained a respiratory arrest, correct?
MR. QUANDT: Objection, leading.
A. That's correct.
Q. Do you have an opinion whether or not she was prematurely extubated on May 6th?
MR. QUANDT: Objection.
MR. GALLAGHER: Objection.
MR. FELTES: Objection.
MR. SCOTT: Objection.
A. I do not.
Q. Do you have an opinion one way or the other?
MR. QUANDT: That can be answered yes or no, Doctor.

A. No.

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

MR. QUANDT: I realize that.

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

A. That is correct.

Q. Did those conditions worsen after she was extubated?

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

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

Q. Right.

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

Q. One o'clock.

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

Q. I got it.
A. She was extubated at approximately 1:00 p.m. in the afternoon you told me. If we look at her heart rates, her respiratory rate and particularly her pulse ox recordings for the rest of that day, from one o'clock through ten o'clock that evening, they really haven't changed. The pulse ox remains in the range of 97 to 98.
Q. Her pulse increases, doesn't it?
A. I think you have to go back, counselor, and look at her pulse rates in the early morning of May 6th. You see pulse rates of 131, 134 at that time as well. Her 135 heart rates are, as you've said, chronically at least for several days before, have been persistently high, as has her respiratory rate.

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

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

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

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

A. Her status changed.

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

MR. GALLAGHER: Objection.

MR. QUANDT: Objection. Go ahead.

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

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

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

A. Yes.

Q. What caused her to get worse?

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

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

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

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

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

Q. What does the pulse ox tell you?

A. She's getting adequate oxygenation.

Q. Even if she is acidotic?

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

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

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

see, couldn't recognize.

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

MR. FELTES: Objection.

MR. SCOTT: Objection.

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

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

What was the last question I asked him?

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

---

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

A. In retrospect.

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

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

being toxic on the morning of May 7th.
Q. The HIDA scan and CT scan were also negative that were done that day?
A. HIDA scan did not show any biliary obstruction or gallstones and CT scan showed no gross abnormalities in the abdomen --
Q. We have no evidence that there was an infectious process going on in the abdomen on Nay 7th?
A. The HIDA scan --
MR. SCOTT: Let him answer.
Q. The answer is yes or no.
MR. SCOTT: That is not right.
Q. Is there any evidence there was an infectious process going on in her abdomen May 7th, answer yes or no?
MR. QUANDT: Objection. Answer as you can.
MR. SCOTT: He has answered.
A. I can't answer that with yes or no, counselor.
MR. FELTES: Objection.
MR. SCOTT: Please don't

interrupt.
Q. Either there is evidence or there isn't?
MR. MELLINO: You are the only one interrupting, Mr. Scott.
MR. SCOTT: He talked about white count.
MR. MELLINO: Now you are coaching him.
A. I gave you that information, counselor. We have an acutely ill woman with evidence of infection, the fact that a HIDA scan is negative, a CAT scan shows no gross abnormalities, does not rule out an acute problem in the abdomen at that time.
Q. I'm asking you do you have evidence that there was an infectious process in her abdomen on May 7th?
MR. QUANDT: Objection. Go ahead.
A. We do not have cultural evidence of that, no.
Q. Do you have any evidence?
A. We have evidence that there might be something going on in her abdomen on the date of May 7th because of her clinical condition and

findings and complaints.

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

MR. SCOTT: Objection.

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

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

Q. I'm asking you do you?

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

Q. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I thought it was a possible cause.

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

MR. GALLAGHER: Objection.

MR. SCOTT: He answered that.

MR. MELLINO: He's now wavering.

MR. SCOTT: He's not wavering.

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

MR. SCOTT: Stop repeating question.

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

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

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

MR. GALLAGHER: Objection.

MR. FELTES: Objecting.

MR. QUANDT: Objection.

MR. SCOTT: Objection.

A. I believe it is the probable cause.

Q. When did you arrive at that conclusion it was the probable cause?
A. I think my initial review of the medical record suggested that was a likely cause, counselor.
Q. You arrived at the conclusion after initial review of the records?
A. I had not -- keep in mind, counselor, I had not been asked to comment on that event in my initial review of the records.
Q. Do you think that is pertinent at all to whether or not Dr. Miclat or any of the physicians adhered to the standard of care required of them?
MR. QUANDT: Objection.
MR. WEITENDORF: Objection.
MR. QUANDT: He wasn't asked to review the reports on what some other physician did. He was asked to review the records whether Dr. Miclat deviated from the standard of care.
Q. Can you answer the question, Doctor?
A. My initial review focused on Dr. Miclat's participation in the case. As I reviewed the record I was struck by the acuity, the apparent acuity of her illness, the change in her clinical course, including the hypotension on May 7th. I

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

Q. Could you answer the question, now?

A. I thought I just did, counselor.

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

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

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

Would you read the question back again.

(Question read.)

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

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

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

A. Maybe you're not.

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

MR. QUANDT: Objection.

MR. SCOTT: Objection.

MR. QUANDT: Form of that question.

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

Q. What about arrhythmia?

A. At that time, my initial review, 1 do not believe I looked at the rhythm strips in the chart, though I reviewed more recently and noticed the association of bradycardia.

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

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

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

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

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

MR. GALLAGHER: Objection.

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

A. That was just from the medical record.

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

A. No.

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

A. It's not what I was asked to comment on.
Q. That's what you put on the report?
MR. GALLAGHER: Objection. You read the statement, it says may,
Q. That is the cause you put down in the report?
MR. GALLAGHER: Objection.
MR. QUANDT: Objection.
A. No, that is not the cause I put down in the report. That was a review of information given in the medical record.
Q. You put down it was felt aspiration of the stomach contents may have contributed to respiratory arrest; is that correct?
A. That's what I said.
Q. Nothing about bradycardia, arrhythmia, or a hypotensive event,. correct, causing the respiratory arrest?
A. Not in that report.
Q. Was there another report?
A. No.
Q. Did you tell Mr. Quandt you felt that was the cause of the respiratory arrest?
MR. GALLAGHER: Objection.
MR. QUANDT: Join.
A, I mentioned that to him just before the

deposition as we were visiting, not before.
Q. That's the only time, first and only time you mentioned it to Mr. Quandt?
A. First and only time.
Q. This is an opinion you claim you held all along in this case, correct?
A. It's an opinion that I held from my time of initial review. It was only after review of the other medical records that it seemed appropriate to mention this.
Q. You had the other medical records before you wrote your report?
A. I mean everything on the table.
Q. The only thing you reviewed since your report is expert's depositions, correct?
A. Yes, and the full chart in order.
Q. You didn't have the full chart in order?
A. I had it in pieces.
Q. Did you have the full chart prior to authoring your report in this case?
A. Most of it. Did not review it in full detail at that time. Again, because I was focusing on Dr. Miclat's care of the patient.
Q. What parts of the chart did you review prior to rendering your report in this case?

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

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

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

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

A. 1 did.

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

MR. FELTES: Objection.

MR. QUANDT: Objection. Go ahead, Doctor.

A. Is the fact that she --

Q. Yeah.

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

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

records in this case, right?
A. I read the opinions of the pulmonologists who gave testimony in this case.
Q. They all agree she sustained a respiratory arrest, correct?
MR. GALLAGHER: Objection.
MR. FELTES: Objection.
MR. SCOTT: Objection.
MR. QUANDT: Objection.
A. They were of the opinion she did. I do not happen to agree with that opinion.
Q. You're not a pulmonologist either?
A. I'm not a pulmonologist.
Q. Would a blood gas show respiratory acidosis or metabolic acidosis?
A. Blood gases may show either or both.
Q. A patient can have both respiratory and metabolic acidosis, correct?
A. Yes.
Q. If her physicians would have expected or been concerned about her suffering an arrest, what precautions should they have taken on the afternoon of May 7th?
MR. SCOTT: Objection.
MR. QUANDT: Objection, form

of the question.

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

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

MR. QUANDT: Objection.

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

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

MR. SCOTT: Objection.

MR. GALLAGHER: Objection.

MR. QUANDT: Objection.

A. I guess there are.

Q. What are they?

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

A. Besides constant attendance of a nurse,

oxygenation, she could have been re-intubated.
Q. Anything else?
A. She was already receiving I.V.'s, she was receiving oxygen, she had a nurse in attendance, on blood pressure and pulse ox monitoring. I believe that level of observation in the judgment of her physicians at that time was adequate.
Q. I know we've gone over this before, make sure I'm clear on this.
Did her hypotension cause the bradycardia that you feel led to her arrest?
MR. QUANDT: Objection, asked and answered. Go ahead.
MR. GALLAGHER: Objection.
A. That's not possible from the data to determine, counselor. We know she was hypotensive prior to the EKG readings that suggest the significant bradycardia. What other factors go into an acute arrhythmia in a critically ill patient are multiple.
Q. If they created her hypotension could they have prevented the arrhythmia?
MR. QUANDT: Objection.
MR. FELTES: Objection.
MR. QUANDT: Asked and

answered.
Q. In all probability?
A. I don't know that.
Q. Should they have corrected her hypotension?
MR. QUANDT: Objection.
MR. FELTES: Objection.
A. This lady was acutely ill enough that I'm not sure that we could have corrected her level of blood pressure at the time her physicians were concerned about her life.
Q. Was she given any therapy to correct her blood pressure from the reading at 2:30?
A. Let's go back and look at that. At 2:30 this is after the arrest, not the HIDA scan, the arrest.
Q. When did she arrest in your opinion?
A. Two something in the afternoon.
Q. I'm talking about page 988, 2:30 p.m. there is a note says her blood pressure is 66 over 46.
A. Um-hum.
Q. Is that hypotensive?
A. Yes.
Q. Should therapy be given to correct that hypotension?
A. I believe it was. I believe she received

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

Q. Should she have been given some pressor agents?

A. She may have been given pressor agents.

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

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

Q. Let me ask it a little differently.

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

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

Q. Did she need to get fluids?

A. She was getting fluids.

Q. Did she need to get fluids?

A. Did she need to get more fluids?

Q. Right.

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

Q. On May 6th were they adequate?

A. Yes, they were adequate.

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

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

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

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

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

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

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

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

MR. FELTES: Objection.

Q. Or did she?

A. She received --

Q. Did she receive any additional therapy?

A. I believe she did.

Q. What?

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

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

testimony?
A. No. What I have to do is try to find the location in the records that reflects her intravenous fluids. I'm trying to do that for you.
MR. GALLAGHER: Are you looking for nurses' notes?
THE WITNESS: I was looking for the notes that would reflect her intravenous fluid orders.
MR. GALLAGHER: May I suggest a page, Chris?
MR. MELLINO: Pardon?
MR. GALLAGHER: May I suggest a page he look at?
MR. MELLINO: Sure, go ahead.
MR. GALLAGHER: 1135. I'm not sure it's there, there may be something there.
Q. That is not the page though, what were you looking for?
A. What I'm looking for are the nursing notes that reflect the intravenous fluid orders for that day, counselor.
MR. GALLAGHER: Probably around page 992 somewhere.

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

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

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

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

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

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

Q.* Despite that --

A. Continued to receive intravenous fluids.

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

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

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

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

MR. QUANDT: Can you answer

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

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

MR. QUANDT: Objection.

MR. FELTES: Objection.

MR. QUANDT: Form of the question.

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

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

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

MR. QUANDT: You answered the question.

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

MR. FELTES: Objection.

MR. QUANDT: Objection.

A. At some point in time that would be

appropriate.
Q. If she didn't receive additional fluids would that be below the standard of care?
MR. FELTES: Objection.
MR. QUANDT: Objection.
A. Not necessarily, counse or. Again, depending upon the clinical status of the patient.
Q. Assuming she didn't receive any additional fluids, her blood pressure dropped further down to 52 over 30 as reflected in the nurses' notes, would additional fluids be required at that time?
MR. FELTES: Objection.
MR. QUANDT: Objection.
A. Not necessarily since her blood pressures were back up over 100 an hour later.
Q. An hour later?
A. We're looking at hourly, we're looking at hourly recordings here on the vertical, if you follow them out.
Q. Talking 3:15?
A. At 3:15 she was 120 over 63.
Q. That was after the code?
A. After the code. The blood pressure at 2:00 p.m. reflects the time of the code.
Q. Did she receive therapy during the code that

would have raised her blood pressure?
A. I can't tell.
Q. Is that a normal part of a code?
MR. QUANDT: Objection.
A. A normal part of a code is resuscitating the patient. If that requires additional fluid, additional fluid should be administered.
Q. If her pulse ox is 69 at 2:30 when her blood pressure dropped to 66 over 46, with that additional information are you able to say whether or not she should have been given additional fluids and pressor agents?
A. I'm trying to bring myself to where you are at 2:00 p.m., are you looking at the pulse ox of 69?
Q. Right. If that happened at 2:30 along with blood pressure of 66 over 46, that required additional fluids be given or pressor agents, both, or a physician be notified or some form of intervention?
MR. FELTES: Objection to the multiplicity of the question.
A. I think some form of intervention would be appropriate here.
Q. What form of intervention?

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

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

MR. QUANDT: Objection, form of the question.

MR. FELTES: Objection.

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

A. I can't answer that.

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

A. Yes.

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

nursing staff of Elyria Memorial Hospital?

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

Q. Can you answer the question, Doctor?

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

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

MR. FELTES: Objection.

MR. QUANDT: Objection.

MR. SCOTT: Objection.

A. I can't answer that.

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

A, I don't have enough information.

Q. What other information do you need?

MR. QUANDT: Objection.

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

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

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

MR. QUANDT: Objection.

MR. FELTES: Objection.

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

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

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

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

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

MR. QUANDT: Objection.

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

busy trying to save this woman's life.

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

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

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

MR. MELLINO: Read back the question.

(Question read.)

MR. FELTES: Objection.

MR. QUANDT: Objection.

MR. SCOTT: Objection.

Q. I'll rephrase the question.

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

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

Q. Pardon?

A. I can't answer that.

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

A. No.

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

MR. QUANDT: Objection. That was not your charge. Bear in mind you are not required to guess about anything.

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

A. I did comment on them.

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

MR. QUANDT: Objection.

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

Q. You thought he did.

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

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

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

A. I will be happy to.

Q. Thank you.

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

A. It can certainly produce hypoxia, a rise in the blood C02.

Q. Can that lead to toxicity?

A. Can certainly lead to clinical symptoms.

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

MR. FELTES: Objection.

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

A. No comment.

Q. You don't have an opinion?

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

Q. Could you answer the question?

A. I did.

MR. FELTES: Objection.

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

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

MR. FELTES: Objection.

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

MR. QUANDT: Correct.

A. I did.

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

MR. FELTES: Objection.

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

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

MR. QUANDT: I'm serious.

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

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

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

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

A. Yes.

Q. What is your opinion?

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

Q. Do you believe that is what the nurse should

have done in this case?

MR. FELTES: Objection.

MR. QUANDT: Objection.

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

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

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

MR. FELTES: Objection.

MR. QUANDT: Objection. Go ahead.

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

Q. Was the order inappropriately vague?

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

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

A. Yes.

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

MR. QUANDT: Objection to

form.

MR. FELTES: Objection.

A. I have no comment on that, counselor.

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

MR. SCOTT: No questions.

MR. GALLAGHER: No questions.

MR. FELTES: No questions.

MR. WEITENDORF: No questions.

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

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

THE WITNESS: I would waive.

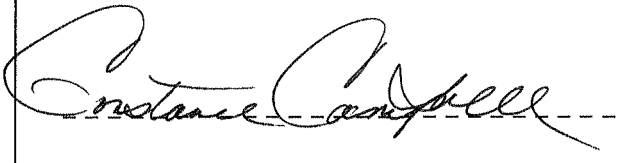
(Deposition concluded; signature waived.)

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

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

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

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



Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
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**

INCLUDES PURE NUMBERS

POSSESSIVE FORMS **ON**

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

NUMBER **OF** WORDS SURPASSING OCCURRENCE THRESHOLD: **6**

LIST **OF** THRESHOLD WORDS:

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