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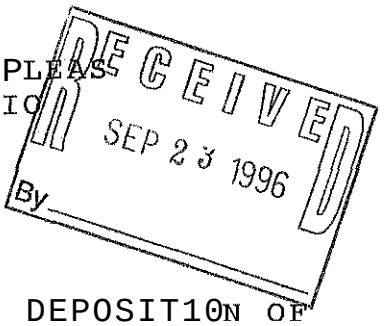

IN THE COURT OF COMMON PLEAS
MAHONING COUNTY, OHIO
CASE NO. 95-CV-335

MARY E. ADAMCHICK, ET AL.

Plaintiffs

vs.

ST. ELIZABETH HOSPITAL MEDICAL CENTER, ET AL.

Defendants

DEPOSITION OF

RASHID A. ABDU, M.D.

Deposition taken before me, Micheline Simoni, Notary Public within and for the State of Ohio, on the 18th day of September, 1996, at 3:25 PM, pursuant to agreement, taken at St. Elizabeth Hospital Medical Center, 1044 Belmont Avenue, Youngstown, Ohio, to be used in accordance with the Ohio Rules of Civil Procedure or the agreement of the parties in the aforesaid cause of action pending in the Court of Common Pleas within and for the County of Mahoning and State of Ohio.

APPEARANCES

On Behalf of the Plaintiff:
Pamela Pantages, Attorney at Law
LANCIONE & SIMON

On Behalf of the Defendants:
Marshall D. Buck, Attorney at Law
COMSTOCK, SPRINGER & WILSON

I N D E X

INDEX OF OBJECTIONS

DEPONENT -- RASHID A. ABDU, M.D.

(NO OBJECTIONS MADE BY COUNSEL)

P R O C E E D I N G S

RASHID A. ABDU, M.D.

having been duly sworn according to law, on his oath, testified as follows:

CROSS EXAMINATION BY MS. PANTAGES:

Q. Doctor, could you state your full name for the record, please?

A. Rashid A. Abdu.

Q. You might want to spell that for our court reporter.

A. R A S H I D, A., A B D U.

MS. PANTAGES: Dr. Abdu, my name is Pam Pantages. You and I just met for the first time a moment ago. I represent the Adamchick family in this case that's been filed against you and against St. El zabeth's Hospital.

Q. Have you ever had your deposition taken before?

A. Yes.

Q. On how many different occasions have you had your deposition taken?

A. Two or three times.

Q. What were the circumstances of those two or three depositions?
A. One was a lawsuit against me; one was somebody else and I was an expert witness.
Q. There were just two times, or was there a third time in addition to today?
A. That's it. That's all I can remember.
Q. How long ago was the deposition where you were an expert witness?
A. Five, six years.
Q. Was the case one where you were a treating doctor or were you independent of the case altogether?
A. I was participating in that, but I was not the one who was sued.
Q. And, in the situation when you were a Defendant and had your deposition taken, how long ago was that deposition?
A. Probably about six years. I can't remember the date.
Q. That's all right. How did that lawsuit end up?

A. In my favor.
Q. Did it go to trial or was it dismissed?
A. It went to trial.
Q. And, you had a Jury verdict in your favor?
A. Yes.
Q. What was the circumstance of the lawsuit?
What was the case about -- just briefly?
A. I removed a lump from a woman's breast and later on she developed swelling of her hand, and she thought that was related to my surgery, and she went to various places for consultations and no one sa d that it was related.

Then they decided to take the case to arbitration, and three of the arbitrators voted in my favor. Then they decided to take it to appeals, and the three Judges voted in my favor, but one of the lawyers then convinced a Judge almost a month later to change his mind, which he did, and we went to trial.

Q. Was that here in Mahoning County?

A. Yes.

Q. Other than that case, and this case involving the Adamchick family, have you been sued in any other medical malpractice cases?

A. No, Ma'am.

Q. Have you ever had any money paid on your behalf by way of settlement, either inside or outside of a lawsuit?

A. No, Ma'am.

MS. PANTAGES: Dr. Abdu, I'm going to be asking you some questions today about your background and about your relationship with Mary Adamchick. The most important thing is that you and I understand each other; so, if I ask you a question and you don't understand my question, I would rather that you tell me that than try and speculate as to what you think the question means. All right?

THE WITNESS: Thank you.

MS. PANTAGES: If you answer one of my questions I'm going to presume you understood it the way 1 phrased it. Fair enough?

THE WITNESS: Fair enough.

Q. Doctor, what is your business address?

A. Right now I am full-time in teaching here at St. Elizabeth's Hospital, running the surgical education program.

Q. Do you have a practice?

A. Not right now.

Q. How long has it been since you maintained private practice?

A. Since I closed my practice?

Q. Well, however long it's been since you have had a private practice, whether by closing or some other means.

A. I had my private practice until the first -- until actually the end of February.

Q. February of 1996?

A. 1994.

Q. And, how was it that you closed your private practice?

A. My wife became very ill with cancer, and I wanted to spend time with her and take care of her.

Q. Was there a particular date that you closed your practice?
A. The first of March.
Q. Was there a period of time between the time you decided to close your practice and actually closing the practice?
A. What do you mean?
Q. When did you make the dec sion to close your practice?
A. Probably a week or two before that -- something like that -- when I saw my wife was getting very ill.
Q. When was the date of the last surgery that you performed?
A. I can't remember.
Q. If we know that you performed surgery on Mrs. Adamchick on February 8, 1994, can you give me any estimation of how many other surgeries you performed after Mrs. Adamchick's surgery?
A. I can't really remember. I can't tell you. It was a very traumatic time for me. I

can't remember.

Q. I understand, and I'm sorry I have to ask you these questions.

A. That's all right.

Q. Is it poss ble that Mrs. Adamch ck was the last surgery that you performed?

A. It's entirely possible.

Q. Do you recall if you performed any surgeries at all between February 8 of 1994 and the present time?

A. I assisted some young surgeons who had difficult cases here at least twice in the last year.

Q. Within 1996?

A. Yes.

Q. Was Mrs. Adamchick the last surgery that you recall performing in 1994?

A. Probably.

Q. And, since 1994, if I understand your testimony correctly, you have assisted on a couple of surgeries?

A. Yes.

Q. When we say couple, are we talking two?
A. Maybe three.
Q. What kinds of surgery would those have been?
A. One was a total gastrectomy, and two were parathyroid surgery.
Q. And, that would have been this year -- 19967
A. This year, maybe last year -- I can't remember the dates, but that's what they were.
Q. Dr. bdu, do you have a CV with you?
A. I have it in my office.
MS. PANTAGES: Can you give me a copy, Marshall, when we have a chance?
(OFF THE RECORD)
Q. Just briefly, Doctor, could you summarize for me your education and training, starting with undergraduate school?
A. I went to medical school -- is that what you mean?
Q. Yes.
A. I went to George Washington University School of Medicine in Washington, D.C., and then I came to Youngstown, to this hospital,

and I had one year of internship and four years of surgical residency.

Q. Prior to medical school where did you go to school?

A. I went to Lafayette College in Easton, Pennsylvania.

Q. Doctor, where were you born?

A. I was born in Ymen, Y M E N.

Q. And where is that?

A. That's in southwest part of the Arabian Peninsula.

Q. When did you come to the United States?

A. 1948.

Q. So, the bulk of your education occurred in the United States?

A. Yes.

Q. Are you a U. S. citizen?

A. Yes.

Q. When did you become a citizen?

A. 1970.

Q. You told me at the beginning of your deposition that you are involved in the

hospital's education program; correct?

A. Yes. I'm director of surgical education.

Q. Are you an employee of St. Elizabeth's Hospital?

A. Yes.

Q. How long have you been an employee of St. Elizabeth's?

A. I started half-time in 1976, and then when I closed my office I became full-time.

Q. Did you take any time off between March 1, 1994, and your full-time employment with St. Elizabeth's?

A. No, because, really, I was -- I can't remember taking any time off. My wife was ill.

Q. Is your job as director of surgical education affiliated with any medical school or institution?

A. The Northeastern Ohio University College of Medicine.

Q. Do you have an appointment with the NEOUCOM?

A. Yes.

Q. What is your appointment?

A. Professor of surgery.
Q. You're a full Professor?
A. Yes.
Q. How long have you been a full Professor with the NEOUCOM?
A. Since '89, I think.
Q. '89, did you say?
A. I think so.
Q. How long have you had any affiliation with the NEOUCOM?
A. What do you mean how long?
Q. Did you start out as a clinical instructor or --
A. I started as an Associate Professor of surgery.
Q. When did you start as Associate Professor of surgery?
A. 1976.
Q. Okay. At some point were you made Assistant Professor?
A. NO.
Q. So, you started with the NEOUCOM as Associate

Professor and were promoted to full Professor?

A. Yes.

Q. You are a general surgeon?

A. Yes.

Q. Are you board certified?

A. Yes.

Q. When did you become board certified?

A. 1966.

Q. And, what did you have to do to become board certified? I'm assuming that you are board certified in general surgery; is that correct?

A. Yes.

Q. Do you have any other areas of certification?

A. I was certified in abdominal surgery, also, by this organization -- by the Association of Abdominal Surgeons.

Q. That's not the same as being board certified?

A. They give you a board certification, but the main one is really the American Board of Surgery, yes.

Q. And you don't get a certification by the American Board of Surgery in abdominal surgery? That's a different group; right?

A. Different group.

Q. What did you have to do to be board certified in general surgery in 1966?

A. Meet the requirements.

Q. Which was what -- which were what?

A. Submit a list of my experience, and also take a written examination, and take an oral examination.

Q. Did you pass your written examination on the first try?

A. Yes.

Q. And did you pass your oral examination on the first try?

A. Yes.

Q. Have you had to do anything since 1966 to maintain your board certification? Is there a renewal process or recertification process?

A. I didn't have to do that.
Q. In 1994, February of 1994, did you have any area of specialty other than general surgery, or beyond general surgery?
MR. BUCK: Subspecialty?
A. Subspecialty in surgery? No. Areas of interest.
Q. What areas of interest did you have?
A. Endocrine surgery, thyroid, parathyroid, adrenals.
Q. When year did you graduate from the George Washington Medical School?
A. 1960.
Q. And did you complete your internship the following year?
A. Yes.
Q. And, thereafter, did you go immediately into your residency?
A. Yes.
Q. So, you completed your residency in 1965?
A. Yes.
Q. And, did you engage in private practice of

general surgery from 1965 to 1994?

A. Yes.

Q. Full-time?

A. Full-time, yes -- while at the same time running the educat on program.

Q. And, you started running the education program in 1976?

A. Yes, '76.

Q. Can you estimate for me how many thyroidectomy procedures you have performed over the course of your career?

A. A lot. Gosh, maybe hundreds.

Q. Are we talking 100, 200, 500, 900?

MR. BUCK: Can you tell us in an average year how many you might perform?

A. Well, in some years I would probably do 30, 20, 10 -- it depends -- but I did quite a few.

Q. So, between 1965 and 1994 you performed an average of ten to 30 thyroidectomies per year?

A. Something like that.

Q. When you trained as a general surgeon I'm assuming that your general surgery training included surgical technique; is that correct?
A. Yes.
Q. Did your general surgery training also include post-operative management of surgery patients?
A. Yes.
Q. And, when I say post-operative management of surgical patients, what does that mean to you,.as a general surgeon?
A. To make sure that -- I think you have to clarify that a little bit, because it varies with each patient.
Q. Let's talk about a tracheostomy patient.
A. A tracheostomy patient, you make sure they have no injury to the nerves, they are breathing well, they are not hoarse, that they would not have any problems the first 24 hours, and essentially that's what you do. That they are hydrated

until they are able to eat, and they go home.

Q. So, you manage these patients pretty much from the time of your surgery to the time of discharge; correct?

A. That's on the usual type of surgery, If a situation is more complicated, then you will elicit the help of those people who are experts in those areas.

Q. The help of consultants?

A. Yes.

Q. Would you agree with me that even though, as a surgeon, you elicit the help of consultants, as primary surgeon you still manage the case?

MR. BUCK: Are you talking about if he admits the patient, or --

MS. PANTAGES: He's fine, Marshall. You don't have to testify for him. I asked him if he doesn't understand my questions, to let me know. I don't want you to coach him. You're not the deponent.

MR. BUCK: I'm not coaching him. I didn't understand your question.

Q. Doctor, did you understand my question?

A. The question was, again?

Q. If, as primary surgeon, you have elicited the assistance of consultants, would you agree with me that you are still the primary physician on the case?

A. If I'm the only person admitting the patient, then that's true.

Q. What does that mean if you are the only person who admitted the patient?

A. If I admitted the patient to my care and this patient does not have a physician who is managing other problems, that's true. But, if there are other physicians managing other problems, then it becomes a team effort, like it is anyway.

Q. Well, we were talking about football a moment ago. A football team still has a captain?

A. Yes.

Q. And if you are the admitting physician you're the captain of the team; correct?
A. All right, yes.
Q. The same question with respect to what your post-operative management involves in the case of a patient like Mrs. Adamchick upon whom you have performed a thyroidectomy with a tracheostomy. What does your role in her post-operative management involve?
A. In her situation I was actually a consultant. Dr. Cleary was her admitting and primary physician.
Q. Have you had an opportunity to review these records? Indicating)
A. Yes, I have.
Q. Are you aware that these records of St. Elizabeth's Hospita lists you as the admitting physician?
A. I don't know how that is because -- really, I can't remember that I was the admitting physician. Dr. Cleary sent me this

patient.

Q. Why did Dr. Cleary send Mrs. Adamchick to you?

A. To do this surgery.

Q. Well, Dr. Cleary didn't order the surgery; correct?

A. He sent the patient to me to do the surgery.

Q. Well, Dr. Cleary is an internal medicine specialist, is he not?

A. Right.

Q. Internal medicine specialists do not make the decision to do surgeries on people -- they send people to surgeons to consult as to whether or not surgery is needed; correct?

A. Yes, but he also -- he thought it was needed, I thought it was needed, and other consultants thought it was needed.

Q. What other consultants thought the surgery was needed?

A. Dr. Batista, for example, who looked in her throat. He had difficulty seeing.

Q. All right. So, prior to Mrs. Adamchick's

admission on 2-8-94 you saw Mrs. Adamchick; correct?

A. Yes.

Q. What day did you see her?

A. I can't remember. I saw her in my office with her family.

Q. Do you have office records?

A. No. I transferred them to another surgeon.

Q. Who has Mrs. Adamchick's records?

A. Dr. Dallas.

Q. What his first name?

A. James.

Q. Is he here in the Youngstown area?

A. Yes.

Q. What street is he on?

A. On Parmalee -- 540 Parmalee.

Q. And, if Mrs. Adamchick was admitted on February 8, 1994, what day did you see her prior to that admission?

A. I can't remember the date.

Q. Wow many times did you see her before she was admitted to St. Elizabeth's Hospital on

February 8?

A. If I recall, one time -- with her family.

Q. All right. And tell me everything that you remember about that visit that took place in your office.

A. She came with her family. She was having problems breathing. She had a massive mass in her neck, veins distended, and she was a heavy lady. Her daughter, who was, I be ieve, a practical nurse was with her, her husband, and we talked about the surgery.

Q. What did you talk about?

A. What did we talk about?

Q. Right.

A. That her difficulty in swallowing and breathing was due to this large thyroid that had pushed the trachea markedly to the right side, and surgery was indicated. And I agreed with Dr. Cleary's recommendations, and I explained to them the procedure and the

complications.

Q. If an internal medicine specialist recommends a patient to you for a surgical consult and you conclude that surgery is not warranted, would you perform surgery on that patient?

A. Absolutely not.

Q. The ultimate decision to do surgery is yours as the general surgeon correct?

A. Yes.

Q. An internal medicine specialist is not qualif ed to make that decision, is he?

A. No. He can recommend.

Q. When you saw Mrs. Adamchick prior to -- at your office prior to February 8, 1994, her trachea was moved out of position; correct?

A. Yes.

Q. And, as a result of that, her airway was compromised; correct?

A. Yes.

Q. Did you tell Mrs. Adamchick before you

admitted her to the hospital that you wanted to do a tracheostomy?

A. Yes.

Q. Why did you think that a tracheostomy was warranted?

A. This patient had this large thyroid for a long time. In fact, she had radiation at one time for an overactive thyroid.

What happens, if a trachea is being compressed for many, many years, sometimes it becomes thin, and then after surgery it can collapse. That's one reason. The other reason is the anesthesia people had a very diff cult time intubating her. In fact, it took two anesthesiologists and an ear, nose and throat, one hour to intubate her awake. Because of that, I thought also there would be trauma to the upper airway and if she had swelling after surgery, then she will have problems breathing.

Q. All right. So, at the time you performed

surgery, if I understand your testimony, Mrs. Adamchick was at risk for compromised airway because, number one, her trachea may have been thinned as a result of this thyroid tumor; correct?

A. It makes it weak because of the compression, yes.

Q. So, after the surgery was over she was at risk for having a weakened trachea

A. That's possible. It was a concern of mine, correct.

Q. And also, anesthesia had a difficu t time intubating her, *so* her airway was subjected to trauma as a resu t of that; correct?

A. I would think so.

Q. And, as a result of the intraoperative trauma she was at risk for airway swelling?

A. That was pre-operative trauma.

Q. Pre-operative trauma?

A. Yes.

Q. Caused her airway swelling?

A. I would think so.
Q. Typically, how long does it take for that swelling to go away?
A. I don't know. It depends on the magnitude of the swelling.
Q. Could it take as many as three days to go away?
A. It may take three days, may take longer, maybe less.
Q. May take three, five, seven days?
A. I can't tell you. I don't know.
Q. An from an hour of intubation it stands to reason that there was substantial pre-operative trauma to the airway?
MR. BUCK: Are you talking about this patient now?
Q. For Mrs. Adamchick.
A. To the upper airway.
Q. When you say "upper airway" what are you referring to?
A. The beginning, in the area of the vocal cords.
Q. Why did anesthesia have such a difficult time

intubating her?
A. Because the trachea was deviated so far to the back.
Q. As a result of the tumor?
A. Yes.
Q. After the tumor was removed would the trachea continue to be deformed?
A. What do you mean by "deformed"?
Q. Well, if there's a substantial deviation to the right.
A. No.
Q. Would there be any deviation once the tracheostomy was performed?
A. It would be minimal, if any.
Q. But it still could be deformed because of the amount of time that it had been pushed over to the side?
A. Yes.
Q. So, it wasn't going to be normal even after the surgery, correct -- most likely? Most likely it was not going to be normal?

A. Right.
Q. What are the complications that can occur in a tracheostomy patient post-operatively?
A. Bleeding, the tracheostomy tube falling off after surgery, getting plugged by mucous. Post-operatively that's about it.
Q. How about aspiration of food?
A. It shouldn't really, because if they eat why would they aspirate? I don't understand. Aspiration of food in what way? Because there is a cuff inside. There's a balloon that occludes the trachea. The esophagus is behind the trachea, and when the patient eats the food goes into the esophagus.
Q. Does the tracheostomy or the tracheostomy cuff put any pressure on the esophagus?
A. It shouldn't, really. It should not, because it has to be huge to do that.
Q. So, in a normal situation when you inflate a tracheostomy cuff it doesn't affect the esophagus at all?

A. No.
Q. Does a tracheostomy patient have any feeding problems that a non-tracheostomy patient wouldn't have?
A. No.
Q. You have no concerns about feeding at all in a tracheostomy patient as compared to a non-tracheostomy patient?
A. You are talking about when? Feeding when? The first day? The second day? After the tracheostomy, a month?
Q. Let's talk about the first post-operative date.
A. You don't want to feed them because they are not ready to eat, for one thing.
Q. Why is that?
A. Usually, they may have ileus and also you want to make sure they are alert and are able to cough, so that in the event of, say, some clear liquid slips -- like we all choke on liquid once in a while -- that they can cough it. Otherwise, you will

have no concerns.

Q. When you talk about slipping with liquid, that's aspiration; correct?

A. Yes. You drink a glass of water and you say it went the wrong way.

Q. We aspirate the liquid?

A. Yes.

Q. Is a tracheostomy patient at greater risk to any degree for aspiration of liquid than a non-tracheostomy patient?

A. Shouldn't be.

Q. You don't see any difference between those two patients?

A. Should not be.

Q. What feeding concerns do you have with a thyroidectomy patient on the second post-operative day?

A. The only thing is can they tolerate it.

Q. You can start a regular diet on the second post-operative day?

A. Well, we do when we do the routine test, yes. They get whatever they want to eat. You

said thyroidectomy?

Q. With a tracheostomy.

A. You would not start then on solid food the following day, because you want to make sure they are able to swallow.

Q. Why not? And why would a tracheostomy patient have any difficulty swallowing?

A. Reflux, for one thing. They have a sore throat. These people have had greater surgery usually than ordinary.

Q. How about on the third post-operative day? Do you have any feeding concerns on the third post-operative day?

A. Again, it would depend on the patient. If they are able to swallow liquids then 1'11 have no concern, and I will advance them slowly until they get into solid food.

Q. How do you advance a patient's diet? What does the standard of care require in a tracheostomy patient?

A. The patient is alert, oriented, coughing,

bowels functioning.

Q. Anything else?

A. That's it.

Q. When you advance a patient's diet, a tracheostomy patient, post thyroidectomy, how specifically do you do that? Start with the day of surgery and take me forward.

A. You don't give them anything the day of surgery. Following that, you may give them water, and if they tolerate that you may start them on clear liquids, and if they tolerate that, then you advance them to full liquids, which would include soups and pureed food. If they tolerate that, then you feed them as tolerated. And a very special diet, of course, and you put them on a special. d et -- diabetics or whatever.

Q. Is there anything between full. liquids and a regular diet? Is there any intermediate dietary level?

A. You can give them so-called soft diet, but sometimes patients like the regular diet better than soft.

Q. In Mrs. Adamchick's case was it your plan to go from clear liquids, to full liquids, to soft diet, to regular diet, or to go from clear liquids, to full liquids, to regular diet?

A. To go from clear liquids, to full liquids, and then advance to solids, and the diet then would be determined by Dr. Cleary because the lady was diabetic.

Q. Who made the decision to advance the diet?

A. I can't remember.

Q. Is that something that you would be concerned about in managing a patient like Mrs. Adamchick in the immed ate post-operative phase?

A. I believe when I saw her and she was tolerating, and I said we may advance diet. That was the morning when she was arrested. So, I did not -- she did not

have any advance.

Q. Excuse me?

A. The day when I saw her on the 12th, in the morning, and I was considering of advancing her diet, but she then arrested before I did anything to advance her diet.

Q. Okay. Who ordered clear liquids for her?

A. I believe it was a resident.

Q. What kind of resident?

A. Surgical resident.

Q. And that surgical resident would have been operating under your authority?

A. Yes. He was a chief resident under my responsibility.

Q. Did you have any problems with Mrs. Adamchick receiving clear liquids?

A. No.

Q. From a general surgeon's standpoint can you define clear liquids for me?

A. Water, clear juices, apple juice.

Q. What was that resident's name, if you

remember?

A. Danny Sankovick.

Q. In what year of his residency was he?

A. He was chief resident.

Q. Which would have been?

A. Fifth.

Q. Fifth year. Who wrote the order to change the clear liquid diet to a full liquid diet?

A. I don't know. Do you have it th re? I see an order here on the 11th by Dr. Sankovick. It says to encourage fluid intake. Dr. Cleary, I see here on the 11th, at 8:15, "Change diet to full liquid diet and transfer to regular floor, Dr. Cleary."

Q. That's not what that says, Doctor. It says, "Number one, change diet to full liquid diet." That's the complete order as far as the diet is concerned; correct?

A. Can you tell me the date?

Q. Sure. On 2-11-94 at 8:15, the record says, "Number one, change d et to full liquid diet."

A. That's Dr. Cleary.
Q. Where does it say that?
A. "Okay with Dr. Cleary."
Q. You're getting ahead of me, Doctor. It says, "Number one." Are you with me on the same page?
A. Okay. I see it, yes.
Q. "Number one, change diet to full liquid diet." That's the complete order a far a the diet instruction is concerned, correct?
A. Okay, I see what you mean. All right.
Q. Whose order is that?
A. That's my order.
Q. All right. At any point in time did you observe Mrs. Adamchick eating a full liquid diet?
A. Not prior to this.
Q. My question is, at any point in time did you observe Mrs. Adamch ck eating a full liquid diet?
A. No.
Q. What orders did you write concerning

post-operative care of Mrs. Adamchick's tracheostomy?

A. Those are routine orders that when the patient goes to the floor the nurses have a routine protocol to take care of tracheostomy patients.

Q. Is that anywhere in the hospital record?

A. Not here, no, but it's in the nurses' manual, and they are now on all floors.

Q. I have a page in my record that's marked 2-13-94.

A. Is that an order?

Q. It's Department of Respiratory Services, Physician Order Sheet, "Aerosolyzed Bronchodilator Therapy." It's a standing order sheet. Can you find that for me in that chart?

A. What date is that?

Q. 2-13-94.

MS. PANTAGES: I want him to find the original on the chart, please

A. Okay. I see 2-13.

Q. Well, Mr. Buck is showing you his photocopy. Can you find the original of this photocopy that he's showing you?

A. All right.

Q. I'm going to come around and look and see what you have got.

A. Okay.

Q. The order says, "See reverse." What's on the reverse?

MS. PANTAGES: I don't have a copy of this. I would like a copy of this. I mean, to the extent that many of these are two-sided pages. None of mine are two-sided, so I need a copy of the --

MR. BUCK: None of the physicians orders are two-sided. I don't have two sides, either.

MS. PANTAGES: Well, we need to get a copy, because I don't have a complete record.

Q. Now, you said that there's a hospital protocol as far as post-operative tracheostomy care?

A. For nurses, yes.
Q. Are you familiar with that protocol?
A. Yes.
Q. What is the protocol for nurses as far as trach care is concerned?
A. To keep it clean, to suction if needed -- and it depends on the status of the patient. If the patient is doing it herself or himself, then it would be minimal.
Q. When you say to keep a trach clean, what is the protocol require in keeping a trach clean?
A. Well, I cannot give you word for word. If there is mucous a lot outside, to clean it if the patient cannot do it himself or herself; to suction it if the patient is unable to suction it, or there's a great deal of mucous coming out, frothing. Essentially that's -- to make sure it's in place.
Q. How about as far as replacing the tracheostomy parts -- the cannula -- anything like

that? Is there a protocol?
A. If you have metal cannulas, yes.
Q. Are there circumstances where it would not be metal?
A. Yes, there are circumstances when it would not be metal.
Q. Was Mrs. Adamchick's cannula metal or non-metal?
A. Non-metal.
Q. Plastic?
A. Yes.
Q. How often does the plastic cannula have to be changed?
A. There is no cannula.
Q. Is there any part of her tracheostomy apparatus which would require changing?
A. If there is a tube in it, but those usually come without tubes.
Q. How often are nurses required to clean out the tracheostomy apparatus?
A. I cannot really give you times. I can't remember all the details in the

protocols, but I would suppose as needed, and it depends on the status of the patient. Some patients may require care every 30 minutes, some might not require care for maybe several hours for a shift.

Q. How about on the first post-operative day? How many times would you expect a tracheostomy apparatus to be cleaned out; once a shift, three times a shift?

A. Hourly -- it depends on excretion, whether or not the patient is able to cough.

Q. If a patient is producing secretions, if it's documented in the nurse's note that a patient is producing copious amounts of secretions or copious amounts of mucous, would you agree that that patient needs to be suctioned?

A. Yes.

Q. How about moderate amounts of secretions or moderate amounts of mucous; would you agree that needs to be suctioned?

A. Suctioned by the nurse or the patient.

Q. How about mild amounts of mucous or secretions; does that patient need to be suctioned?
A. Yes, he does.
Q. At what point in time does a patient no longer need suctioning?
A. When the patient is able to do his or her own suctioning.
Q. Did you ever see Mrs. Adamchick sucti n herself?
A. No.
Q. Did any nurse ever tell you that he or she saw Mrs. Adamchick suctioning herself?
A. I don't recall.
Q. You don't remember any nurse ever telling you that?
A. No.
Q. Did you ever instruct Mrs. Adamchick as to how to suction herself?
A. The nurses instruct them.
Q. Did you ever instruct Mrs. Adamchick to suction herself?

A. I can't recall that, no.
Q. Were you present when any nurse instructed Mrs. Adamchick how to suction herself?
A. No.
Q. Did any nurse ever tell you that she told Mrs. Adamchick how to suction herself?
A. No.
Q. Does it show in any of these records that any nurse instructed Mrs. Adamchick how to suction herself?
A. No.
Q. Does respiratory therapy also manage a patient's tracheostomy apparatus?
A. They do it, yes.
Q. Is it routine, as far as your experience as a surgeon at St. Elizabeth's Hospital, that respiratory therapy follows tracheostomy patients while they are hospitalized at St. E's?
A. It depends on the pulmonary physician.
Q. Why does it depend on the pulmonary physician?
A. It's up to him whether he wants them to follow

them or not.

Q. If from whatever source respiratory therapy has gotten involved with a tracheostomy patient, would you expect them to continue seeing that patient until ordered to stop?

A. Yes.

Q. And that's irrespective of if a patient gets transferred from one floor to another -- respiratory therapy has a duty to follow those patients?

A. Yes.

Q. And failure to follow those patients is a breach in hospital protocol; isn't it?

A. If they were instructed to do it in the first place, it would certainly be.

Q. How often should a patient who is producing copious amounts of secretions be suctioned?

A. Could be hourly.

Q. How often should a patient who is producing moderate amounts of secretions be

suctioned?

A. Two, three, four hours. What is moderate, first of all?

Q. If it's described in the medical records as a moderate amount of secretions, what does that mean to you?

A. It's nothing -- it's not a great deal.

Q. But it's more than mild; correct?

A. Yes.

Q. And mild secretions means secretions are still present?

A. Yes.

Q. Does the color of secretions make any difference to you; say, if secretions are yellow or tan as opposed to white?

A. If it persists.

Q. What's the significance of yellow or tan secretions versus white secretions?

A. Of course, that depends on the person who describes it, too. White may be clear mucous. Yellow could be yellow, and it could be infection in the lungs. So, if

it's a one time, two times, it doesn't mean anything. If it's persistent, then you worry about it.

Q. If a patient is documented as having rhonchi, and the patient is a tracheostomy patient, does that heighten your concern for any reason?

A. No.

Q. Rhonchi don't increase he risk f airway obstruction, in your opinion, in a tracheostomy patient?

A. No. I would worry if it's wheezing, but not rhonchi.

Q. How about crackles?

A. It's like rattling, crackles. Maybe the patient is congested.

Q. There's some mucous or secretions down deep?

A. That's right.

Q. And the patient is not coughing it up?

A. Right.

Q. That's what "crackles" means?

A. Yes.

Q. Doctor, over the course of your practice as a surgeon, how many patients have you had experience a respiratory arrest as a result of an airway obstruction?
A. None.
Q. That includes your tracheostomy patients?
A. Yes.
Q. Do you agree that a tracheostomy patient is at a higher risk of airway obstruction than a non-tracheostomy patient?
A. Yes.
Q. Why is that?
A. If they don't keep it clean, if they don't know how to manage it -- if they take a shower, if they go home with it, water will get into it.
Q. They are at risk for mucous plug?
A. That's right, risk for mucous plug.
Q. Between post-op day one and post-op day four in Mrs. Adamchick, what did you, as the primary surgeon, intend to monitor in her over that time period?

A. How she breathes, if she's alert, if she's coughing, breathing.

Q. Fever?

A. Fever.

Q. That would be a concern to you?

A. If it's excessive, yes, it certainly would.

Q. How about fluids?

A. What do you mean?

Q. Intake, output?

A. Yes.

Q. Is that something that you monitor post-operatively?

A. Yes.

Q. Do you rely upon the nurses to monitor the patient's input and output?

A. Yes.

Q. Is failure to monitor input and output within four days post-operatively a departure from standards of care as far as you're concerned?

A. How many days?

Q. Four days.

A. No. Depends on the patient.
Q. How about three days?
A. Depends on the status of the patient.
Q. Let's talk about Mrs. Adamchick. Would you expect on post-op day one her input and output to be recorded?
A. Yes.
Q. How about post-op day two?
A. Yes.
Q. How about post-op day three?
A. Yes.
Q. Would failure to do that on post-op day three be a departure from standards of care?
A. Yes.
Q. Doctor, when Mrs. Adamchick was in the hospital in February of 1994, what was your practice as far as days you had office practice, days you had surgery, and when you would do your rounds?
A. I did my rounds usually in the morning.
Q. Was there a particular time that you did rounds?

A. Anywhere between 8:00, 10:00. Any time in those hours. Sometimes in the afternoon. It would depend whether I had emergencies or surgeries or -- but I saw by patients.

Q. When you do rounds for your patients post-operatively, how long do you typically spend with them or would you spend with them when you were doing your rounds?

A. It depends on the problems they have. Maybe two minutes, maybe ten minutes, maybe an hour, maybe much longer.

Q. Okay. In our records we have got a note from you on the morning of Mrs. Adamchick's arrest.

A. Yes.

Q. I have February 12, 1994, at 9:40 a.m.

A. Uh huh.

Q. Are you with me on that page?

A. Yes -- 9:40 a.m.

Q. Was that the standard time you saw Mrs. Adamchick while she was in the

hospital?

A. No. It varies, as I said.

Q. Do you remember this morning, February 12, 1994, at 9:40 a.m.?

A. I put it down there -- yes.

Q. Independent of what's written here, do you remember?

A. Yes. I remember, yes.

Q. What was Mrs. Adamchick doing when you saw her?

A. She was sitting in a chair.

Q. What else was she doing besides sitting in a chair?

A. Nothing, really.

Q. Did she have a roommate?

A. No.

Q. Did she have any food in front of her?

A. I can't remember.

Q. Do you remember seeing her eat anything?

A. No.

Q. How long did you stay with her on that morning?

A. Oh, probably five minutes. Of course, I remember talking with her about we better get going, go home, and encouraging her, you know, looking at her. She looked good.

Q. You have a note, "Pulmonary will teach patient trach care. Discussed with Dr. Cropp"?

A. Yes.

Q. As of 9:40 a.m. on 2-12-94, was it your understanding that no one had yet instructed Mrs. Adamchick on trach care?

A. This is for home. You see, we were thinking of already sending this patient home, really.

Q. So, no one had taught her trach care yet?

MR. BUCK: That's not what he said. This is home trach care.

A. Home trach care.

Q. To your knowledge, had anyone taught Mrs. Adamchick trach care when you wrote this note on February 12 at 9:40?

MR. BUCK: Home?

A. There are two types of trach care. You have trach care in the hospital where the patient suctions himself or herself, and she had the suction next to her -- suction apparatus -- and there's a home care, which is entirely different.

Q. Okay. My question is, do you know if anyone -- do you have firsthand knowledge or personal knowledge of anyone teaching Mrs. Adamch ck trach care -- hospital trach care?

A. No.

Q. What else do you remember from this visit on February 12, 1994?

A. That she looked well, and that I wanted to advance her to regular diet and start thinking of sending her home.

Q. Okay. Did you have any knowledge at 9:40 a.m. on February 12, 1994, of whether or not Mrs. Adamchick had had full liquids yet?

A. I believe she did have.

Q. What I'm asking you is, do you know if she had

full liquids as of 9:40?

A. May I look at something?

Q. Well, Doctor, my question is a simple one.

A. I want to look at the nurses' notes. I can't remember. I don't know. I can't remember, really.

Q. The nurses' notes speak for themselves. What does a full liquid diet involve?

A. Broths, soups.

Q. Would a full liquid diet include soup with vegetables?

A. No. Cream soups. Ice cream.

Q. Would it include soup with noodles in it?

A. It could.

Q. Basically, your understanding of a full liquid diet is a cream soup that's very soft?

A. Yes.

Q. You would not want an ord nary bowl of chicken noodle soup or vegetable soup, or something like that?

MR. BUCK: He just told you noodles would be permissible.

A. Noodles would be all right.
Q. Anything else in the soup besides noodles?
A. NO.
Q. When you saw Mrs. Adamchick on February 12, 1994, what was the status of her secretions?
A. She had minimal -- hardly any secretions.
Q. Do you remember that as you sit here today?
A. Yes. As I was talking with her, looking at her.
Q. Did she cough while you were sitting there?
A. I can't remember.
Q. Did you ask her to cough?
A. I can't remember that, either.
Q. So, as you sit here today --
A. She was breathing fine.
Q. Do you remember if she was coughing into Kleenex?
A. No. I can't remember.
Q. So, as you sit here today you don't have any recollection one way or another about whether or not she had secretions or

didn't have secretions: correct?

A. That's right.

MR. BUCK: He told you a minute ago in response to your question that she had no secretions. He answered the question.

MS. PANTAGES: You can't testify for him.

MR. BUCK: I'm telling you what his previous answer was -- that she had none.

MS. PANTAGES: That's not his answer.

Q. Doctor, as you sit here today do you remember whether or not Mrs. Adamchick had any secretions?

A. I didn't see any.

Q. That wasn't my question. Do you remember whether or not you saw secretions or didn't see secretions?

A. I did not see secretions.

Q. Did you ask her to cough?

A. I can't remember asking her, no. I can't remember.

Q. You can't remember anything about it?
A. Asking her to cough.
Q. Do you remember whether she was producing anything in Kleenex?
A. I didn't see anything.
Q. My question was, do you remember if she was producing sputum into Kleenex?
MR. **BUCK**: That's the third time you asked that. He told you he did not see her produce anything in Kleenex. That's a clear answer.
Q. Do you remember?
MS. PANTAGES: Marshall, you're testifying for him.
MR. **BUCK**: I don't know how many times you want to ask him. ne said he didn't see her to produce anything in a Kleenex.
Q. Do you remember specifically that you did not see her produce sputum in Kleenex?
A. I did not see her produce sputum in Kleenex.
Q. You do not remember that she was producing sputum in Kleenex?
MR. **BUCK**: That's not what he's

saying.

Q. At any point in time did you see her produce sputum?

MR. BUCK: From the admission?

Q. At any point in time.

A. In intensive care, coughing, intermediate, coughing.

Q. You remember her producing sputum?

A. Yes.

Q. What was the character -- what was the nature of her sputum when you saw it?

A. Like a sputum -- mucousy. Nothing spectacular about it or unusual.

Q. Do you recall if it had any color to it, whether it was tan, or yellow, or white?

A. No. I did not examine it that closely.

Q. Did you ask Mrs. Adamchick if she had been suctioning herself?

A. I can't remember.

Q. Did you talk with the nurses that morning as to whether or not they were suctioning Mrs. Adamchick?

A. I can't remember.
Q. Who is Dr. DiMarco?
A. Pulmonologist.
Q. Does he practice with Dr. Cropp?
A. They cover, I believe, for each other. I don't know whether they practice together. I don't know.
Q. And, you consulted Dr. DiMarco on February 8 for the purpose of managing Mrs. Adamchick's ventilator; correct?
A. Right.
Q. Did you consult him for any other reason on that date?
A. No.
Q. At any point in time did you consult pulmonology to manage Mrs. Adamchick's trach care?
A. No.
Q. Dr. Abdu, do you have any opinion as to what caused Mrs. Adamchick's arrest on February 12, 1994?
A. No, I do not.

Q. Did you see her after the arrest on February 12, 1994?
A. Yes, I did.
Q. Okay. Did you have ideas as to what were the potential causes of the arrest?
A. I did not know.
Q. Based upon your observation and knowledge of her case?
A. No, I did not.
Q. Did you develop a differential diagnosis as to what the cause of the arrest was?
A. It was speculated she was cardiac, some folks said mucous, but nobody could document suctioning any mucous plug. That's one of the things you have to worry about. Tachycardia, spasm -- I do not know. They were really speculating.
Q. Have you had an opportunity to review this record?
A. Yes, I have.
Q. What in the record would support the conclusion that this arrest was cardiac

in nature?

A. What would not?

Q. What would support the conclusion that the arrest was cardiac in nature?

A. If she had an infarct, or the arrhythmia that the heart stopped.

Q. My question to you was, what evidence do we have in Mrs. Adamchick's chart?

A. We do not.

Q. There's no evidence in the hospital record that would support that this was a cardiac arrest?

A. No. We have no evidence to support other causes.

Q. Is there any evidence that would support the conclusion that this was a respiratory arrest?

A. Yes, it was be a respiratory arrest.

Q. What would be the reasons for a respiratory arrest?

A. In her situation, I did not know.

Q. Did you develop at any point in time a

differential diagnosis as to what were the potential etiologies of the respiratory arrest?

A. Plug is one -- if that's the case -- and there was none removed. I can't really think of anything else.

Q. In light of what we know, a mucous plug is the most likely explanation of what happened to her. Is that a fair statement?

A. Fair statement.

Q. Dr. Abdu, do you have any criticisms of any of the care that any of the people provided to Mrs. Adamchick?

A. None whatsoever.

Q. Are you critical of Dr. Cleary's care at all?

A. No.

Q. Are you critical of Dr. Cropp's care at all?

A. No.

Q. Are you critical of any of the residents' care?

A. No.

Q. Are you critical of any of the nursing care

A. No.
Q. Is there anything in your own management that you would have done differently in retrospect?
A. No.
Q. Would you agree with me that if Mrs. Adamchick had been more closely monitored and more frequently suctioned that her respiratory arrest would not have occurred?
A. What do you mean by "frequently"?
Q. Well, would you agree with me that if she had been suctioned hourly on February 12, either by herself or by her care providers, that her respiratory arrest would not have occurred?
A. Possible. In retrospect, I don't know.
Q. In fact, it's likely if she had been suctioned her respiratory arrest would not have occurred?
MR. BUCK: He's answered the question. He said he doesn't know.
A. I don't know.

Q. Did your role in the course of Mrs. Adamchick's hospitalization ever change?
A. NO.
Q. Where are tracheostomy patients who are hospitalized at St. E's usually kept?
A. There is no specific area for them. Anyplace in the hospital.
Q. Where are the majority -- where have the majority of your tracheostomy patients stayed while they are patients at St. Elizabeth's?
A. Initially they will go into intensive care or intermediate; and then when they are stabilized they will go to any f oor where there's a bed available.
Q. When you write an order to transfer a patient from intermediate care to the regular floor and that patient is a tracheostomy patient, do you rely on the presumption that the nurses who are going to be taking care of that patient on the regular floor are qualified to take care

of a tracheostomy patient?
A. Yes.
Q. You would expect them to know the difference between a tracheostomy and tracheotomy?
A. Yes.
Q. You would expect them to know what kind of risk for airway obstruction a tracheostomy patient would have; correct?
A. Yes.
Q. You would expect them to know what's in a trach tray and how to use it; wouldn't you?
A. What's in the trach tray and how to use it?
Q. Yes.
A. What do you mean? What's the trach tray? What do you mean by "trach tray"? The nurses would not use --
Q. Can you refer in the orders to post-op orders?
A. Yes. I know those orders, yes. A trach tray is -- actually, you have tubes -- and the physician would do that. They are for when they call like team blue or express

team and the physician would respond; and that means the tube has come out, or a patient sometimes after thyroid surgery who does not have a tracheostomy, you will have that in the event they get into problems, then you will do a tracheostomy in bed. So, it has a knife, it has tubes in it. That's what that means. So, the nurse would not do that.

Q. The nurse would not use the trach tray?

A. No.

Q. When there's an order that says, "Trach tray set up in room at all times," what does that mean?

A. That means you have that tray that has all this equipment in it in that room. In the event the patient gets into problems, then you call the physician and they respond and then you do whatever is necessary, just like I explained to you.

Q. When you order that a trach tray is set up in a room, what does that mean?

A. Have it available.
Q. Somewhere open --
A. No, it's covered. It is sterile. It's in a tray.
Q. You expect the nurses on a general floor to monitor tracheostomy patients for secretions; correct?
A. Yes.
Q. They monitor the patient regularly for secretions; correct?
A. Yes.
Q. Hourly?
A. As needed.
Q. You would also expect nurses on a regular floor to provide tracheostomy care and cleaning to a tracheostomy patient; correct?
A. Yes.
Q. At minimum, you would expect nurses on the floor to investigate whether or not the tracheostomy patient is taking care of her own tracheostomy; correct?

A. Yes.
Q. Do you also expect the nurses on a regular floor to make sure that the tracheostomy is hydrated?
A. Hydrated?
Q. Moisturized, misted?
A. Yes.
Q. How do you expect on a general floor to maintain the mist in a tracheostomy of a patient?
A. Is it a conscious patient?
Q. Yes.
A. Just put it on the tracheostomy, connect it to moisturizing oxygen, and tell the patient not to remove it.
Q. What are the risks to a tracheostomy patient if the tracheostomy is not kept misted?
A. Mucous becomes dry in it, it becomes plugged.
Q. Do you agree that every time a diet is advanced that somebody should ascertain whether or not the patient is able to handle the advancement?

A. Yes.
Q. How should that be done?
A. To see whether the patient ate it or took whatever -- or tolerating it.
Q. Is that something that you do yourself?
A. The nurse does it.
Q. How long does a nurse need to watch a patient who has had her diet advanced for the first time in order to assure herself or himself that the patient is able to tolerate the dietary advancement?
A. Minutes.
Q. How many minutes?
A. Two, three, four, five. It depends on how slow the patient eats.
Q. You would expect the nurse to sit down and watch the patient and make sure that the patient is able to eat the food and swallow it?
A. Yes.
Q. And if there's more than one item on the tray the nurse should stay and make sure that

the patient can handle each different type of food; correct?

MR. BUCK: Are you talking about different classifications?

Q. I mean, if you axe advancing a patient's diet that's a risky situation for a patient, isn't it -- that first dietary advancement?

A. Not necessarily.

Q. How about in a tracheostomy patient on the third post-operative day? It can be risky?

A. No, it would not be risky.

Q. There's no risk to a patient of a dietary advancement who is a tracheostomy patient on the third post-op day?

A. If the patient is able to tolerate it, I see no risk. If the patient is alert, feeding herself, himself, I see no risk.

Q. When you say that the patient has to be able to tolerate it, somebody needs to sit there and figure out whether or not the

patient is able to tolerate it?
A. Yes.
Q. And that takes a little bit of time and patience on the nurse's part; doesn't it?
A. Yes
Q. In your care and treatment of Mrs. Adamchick, did you ever observe anything in her that would lead you to believe that she was a non-compliant patient?
A. No.
Q. Do you have any criticism of Mrs. Adamchick's transfer to 5-West extension?
A. No.
Q. Did you ever ascertain whether any of the nurses on 5-West extension were qualified to care for a tracheostomy patient?
A. No.
Q. Do you know, as we sit here today, whether or not the nurses who took care of Mrs. Adamchick on 5-West extension were, in fact, qualified to take care of a tracheostomy patient?

A. To my understanding?
Q. Beg your pardon?
A. The question was do I know?
Q. As you sit here today, do you have any understanding as to whether or not the nurses who took care of Mrs. Adamchick on 5-West extension were qualified to care for a tracheostomy patient?
A. this a negative question? Do I have an understanding?
MR. BUCK: Ask her to repeat the question.
Q. Sure. As you sit here today, do you know whether or not the nurses who took care of Mrs. Adamchick on 5-West extension were qualified to care for a tracheostomy patient?
A. I assume they were.
Q. Do you know if they were?
A. No, I do not.
Q. If you learned that the nurses on 5-West extension who were taking care of

Mrs. Adamchick lacked experience in caring for tracheostomy patients, would you ask her to be moved to a place where the nurses were experienced in caring for tracheostomy patients?

A. If I knew that they were not experienced, yes.

MS. PANTAGES: That's all 1 have.

MR. BUCK: We'll read the transcript.

(WHEREUPON THE DEPOSITION OF RASHID A. ABDU, MD, WAS CONCLUDED AT 4:50 PM)

REPORTER'S CERTIFICATE

I, Micheline Simoni, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named Rashid A. Abdu, MD, was by me first duly sworn to testify the truth, and that this deposition was written in the presence of the witness and by me transcribed, and that the deposition was taken at the time and place in the agreement specified.

I certify that I am not of counsel or relative to either party or otherwise interested in this action.

I further certify that the above and foregoing is a true and complete transcript of all the testimony and proceedings had in this deposition, as shown by stenotype notes written in the presence of the witness at the time of this deposition.

IN WITNESS WHEREOF, I have set my hand and Seal of Office at Warren, Ohio, this 19th day of September, 1996.

Micheline Simoni

Micheline Simoni
My Commission Expires 11-8-98

CORRECTION SHEET

PAGE NO.	LINE NO.	CORRECTION

SIGNATURE PAGE

I, Rashid A. Abdu, MD, have read or have had the opportunity to read the foregoing deposition and find it true and correct to the best of my knowledge, information and belief, unless otherwise specified and listed on page 79, and I hereby subscribe my signature thereto, this _____ day of _____, 1996.

_____

RASHID A. ABDU, M.D.

Before me, a Notary Public, in and for the State of Ohio, personally appeared Rashid A. Abdu, MD, who deposes and says that he has read or has had the opportunity to read the foregoing deposition, and that he finds it true and correct to the best of his knowledge, information and belief, unless otherwise specified and excepted to on page 79 of the deposition.

Sworn to and subscribed before me this _____ day of _____, 1996.

_____

NOTARY PUBLIC

#476

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A.B. Degree - 1956	Lafayette College Easton, PA
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Rotating Internship 7/1/60 - 6/30/61	St. Elizabeth Hospital Medical Center Youngstown, OH
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1961	National Board of Medical Examiners
1961	Ohio License #028019-1
November, 1966	American Board of Surgery
1977	American Board of Abdominal Surgery
November, 1986	Advanced Trauma Life Support

PROFESSIONAL EXPERIENCE - POSITIONS HELD:

St. Elizabeth Health Center

1965 - 1966	Associate Staff - Department of Surgery General surgery Service
1966 -	Active Staff - Department of surgery General surgery service
1970 - 1973	Secretary Treasurer - Medical Staff
1971 - 1974	Chief - General Surgery Section Department of Surgery
1973 - 1976	Vice President - Medical Staff
1976 -	Program Director, General Surgery
1976 -	Chairman, Surgical Education Council
1983 - **1992**	Board of Trustees
1984	Steering Committee, Assoc of Program Directors in Surgery
1987 - 1988	Chief, General Surgery Section Department of Surgery
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1978 - 1989	Associate Professor of Surgery Northeastern Ohio Universities College of Medicine Rootstown, **on**
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PUBLICATIONS - REFEREED JOURNALS:

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Abdu RA. Repair of Paracolostomy Hernias with Marlex Mesh, Dis of the Colon & Rectum, **1982;25:529-31.**

Abdu RA. Ambulatory Herniorrhaphy Under Local Anesthesia in a Community Hospital, American Journal of Surgery, **1983;145:353-56.**

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Abdu RA, Zakhour BJ and Dallis DJ. Mesenteric Venous Thrombosis - **1911** to **1984,** Surgery, April, **1987;101:4:383-88.**

Abdu RA, Garritano D and Culver O. Acute Gastric Necrosis in Anorexia Nervosa and Bulimia, Two Case Reports, Archives of Surgery, July, **1987;122:830-32.**

Abdu RA. Urgent Management of a Giant Scrotal Hernia, The American Surgeon, **Oct, 1990;56:624-27.**

Spirtos G, Abdu RA and Schaub CR. Osteosarcoma of the Spermatic Cord, Journal of Urology, April, **1991;145:832-33.**

Farhat GA, Abdu RA and Vanek VW. Delayed Splenic Rupture: Real or Imaginary? The American Surgeon, June, **1992;58:6;340-45.**

Sharp WV, Guyton DP, Crans CA, Abdu RA, et al. Initial Experience with Laparoscoic Surgery: Establishing a New Surgical Procedure, Journal of Laparoendoscopic Surgery, **1992;2:4;151-55.**

PUBLICATIONS - REFEREED JOURNALS (Continued):

Abdu RA, Carter K, Pomidor WJ. Gastric Syphilis Mimicking Linitis Plastica, Archives of Surgery, **1993;128;103-04.**

Abdu, RA. Survey Analysis of the American Board of Surgery In-Training Examination, Archives of Surgery, **1996;131:412-16.**

Vanek, VW, Abdu, RA. A General Surgery Resident Time Study in a Community Hospital, Current Surgery, **1996;53:100-05.**

MANUSCRIPTS IN PREPARATION:

Abdu RA, Breast Cancer Among White and Black Women

PUBLICATIONS - MISCELLANEOUS:

Abdu RA and McConnell RB. Trans Urethral Prostatectomy and Low Sodium Syndrome, Quarterly Bulletin, SEHMC, **1963;3:6.**

Sawyer JD and Abdu RA. Ruptured Gall Bladder with Massive Intra Peritoneal Hemorrhage, Quarterly Bulletin, SEHMC, **1963;3:6.**

Abdu RA and Herald JK. That Levin, Quarterly Bulletin, SEHMC, **1964;49.**

Lee HY and Abdu RA. Heterotopic Pancreas, Medical Bulletin #1, SEHMC, **1978;9:14.**

Wood L, Krishnan EU, Abdu RA, and Garg SK. Superior Mesenteric Artery Occlusion Following Therapy of Hodgkin's Disease, CONVERGENCE, **1981;1:2.**

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Abdu RA. (abstract) Ambulatory Herniorrhaphy Under Local Anesthesia in a Community Hospital, Modern Medicine of Canada, March, **1984.**

PUBLICATIONS - MISCELLANEOUS (Continued):

Abdu RA. Ambulatory Herniorrhaphy Under Local Anesthesia in a Community Hospital , CONVERGENCE, July, **1984:4;1.**

Vanek VW, Whitt C and Abdu RA. Carcinoma of the Right Colon, Left Colon and Rectum, CONVERGENCE, Feb, **1984:5;1.**

Abdu RA. Perspectives - Program Director's Advice: How to be the Leader of the Pack in a Surgical Residency, Current Surgery, Jan/Feb, **1987;44:1.**

Vanek VW, Whitt C, Abdu RA, Kennedy WR, PhD. Diagnosis and Preoperative Management of Colorectal Carcinoma, Contemporary Surgery, Jan, **1988;32:39-45.**

Cerame MA and **Abdu RA. Osteomyelitis of the Clavicle** Complicating Percutaneous Subclavian Venipuncture, Infections in Surgery, Aug, **1990;5-9.**

Abdu RA. Pilonidal Disease: Current Trends and Appraisal of a New Technique, Contemporary Surgery, June, **1992;40:6;11-13.**

Sharp WV, Guyton DP, Crans CA, Abdu RA, et al. Initial Experience with Laparoscopic Surgery: Establishing a New Surgical Procedure, Jr of Laparoendoscopic Surgery, Nov, **1992:2;151-55.**

Buss, TF, Abdu, R, Walker, Jr. Alcohol, Drugs, and Urban Violence in a Small City Trauma Center. Jr of Substance Abuse Treatment, **1995:12;2:75-83.**

FILMS:

1977	Repair of Groin Hernias Under Local Anesthesia
1978	Surgery for Pheochromocytoma
1986	Repair of Giant Hernia Without the Use of Pneumoperitoneum
1989	Parathyroidectomy

DEVICES:

1964	Gastro Duodenal Tube

PRESENTATIONS AND CONFERENCE PARTICIPATION:

February, **1981** Trauma
Medical Society, Sanaa, Yemen

February, **1981** Trauma
Medical Society, Taiz, Yemen

July **19, 1984** Focus On Health in the U.S.A.
Radio Presentation, Youngstown, OH

October, **1987** Repair of Giant Hernia Without the Use of Pneumoperitoneum
American college of Surgeons Meeting
San Francisco, CA

February, **1993** The Myths and Realities of an 80-Hour Week
Association of Program Directors in surgery
Dallas/Forth worth, TX

June, **1995** Violence: A Hospital's Perspective
Ohio Department of Youth Services
Columbus, OH

AWARDSIHONORS:

1960 Mosby Company Scholarship Award

1984 Boss of the Year
Gold Torch Chapter/American Business Women's Association
Youngstown, OH

COMMITTEE RESPONSIBILITIES:

St. Elizabeth Health Center

1966 - 1968	Member, Tumor Committee
1966 - 1970	Member, Intern Procurement Committee
1968 - 1979	Member, Medical Records Committee
1968 - 1982	Member, Special Emergency Room Committee
1969 - 1970	Member, Patient Care Committee
1970	Co-Chairman, Entertainment & Ex-Intern Committee
1970	Member, Joint Conference committee
1970 - 1975	Member, Medical Staff Education and Research Committee
1970 - 1976	Member. Executive Committee
1971 - 1974	Member, Entertainment Committee
1972 - 1973	Member, Library Committee
1972 - 1973	Member, Tissue Committee
1973	Member, Hospital Affairs Committee (Joint Conf Committee)
1975 - 1977	Member, Capital Expense Committee
1976 -	Member, Department of Medical Education Committee
1976 - 1980	Member, Tumor Committee
1976 - 1981	Member, Surgical Intensive Care Committee
1976 - 1982	Chairman, Benevolent Committee
1977 - 1979	Member at Large, Executive Committee
1977 - 1981	Member, Blood Transfusion Committee
1977 - 1982	Member, Autopsy Committee
1978 - 1980	Member, Editorial Board, Quarterly Bulletin
1978 - 1982	Member, Autopsy Committee
1979 - 1981	Member, Ambulatory Services Committee
1979 - 1981	Member, Tissue Audit Committee
1981 - 1983	Member, Surgical Audit Committee
1981 -	Member, Editorial Board, Convergence
1982 - 1984	Member, Medical Staff Research Committee
1982 - 1985	Member, Long Range Planning Committee
1983 - 1992	Member, Board of Trustees
1983 - 1985	Member, Ad Hoc Education Committee, Board of Trustees
1983 - 1995	Member, Personnel Committee, Board of Trustees
1984	Member, Capital Expense Committee
1984	Member, Utilization Review Committee
1984 -	Member, Dept of Surgery Research & Education Fund Committee
1984 - 1985	Member, Ad Hoc Committee, Medical Staff Finance
1984 - 1985	Member, Investigational Review Committee

COMMITTEE RESPONSIBILITIES (Continued):

1985 - 1988	Member, Development Committee of the Board of Trustees
1985 -	Member, Professional Education Committee for Cancer Symposium
1985 - 1995	Member, Think Tank
1986 - 1987	Member, Utilization Review Committee
1987	Member, Search committee, Medical Director
1988 -	Member, Trauma Systems Committee
1988 -	Co-Chairman, Medical Research Committee
1989 - 1996	Member, Committee on Continuing Medical Education
1990 -	Member, Surgical Directors, Quality Assurance committee
1990 - 1994	Member, Transitional Year Clinical Advisory Committee
1992 -	Member, Ohio Surgical Panel, Inc.
1994	Chairman, Breast Care Center Task Force
1994 -	Member, Cancer Activities Committee
1994 -	Chairperson, Breast Care Center Tumor Board
1994 -	Member, Breast Care Center Advisory Board
1995 -	Oncology Task Force
1995 -	Health Education Strategy Committee
1995 -	Community Health Education Diocesan Schools Committee
1996 -	Member, Nutrition Symposium Planning Committee
1996 -	Member, Ad Hoc Committe for TPN Credentialing

Northeastern Ohio universities Collage of Medicine

1976 -	Council of Chiefs - Surgery
1980 - 1981	Chairman, Advancement Committee of Year 4
1980 - 1984	Member, Academic Review and Promotions Committee
1989	Member, Search Committee, Internal Medicine Chief
1990	Member, Transitional year Clinical Advisory Committee
1994 - 1995	Acting Chairperson, Department of Surgery.
1994 - 1995	Member, M3/M4 Curriculum Committee
1994 - 1995	Member, Academic Council
1994 -	Member, Strategic Planning Advisory & Resource Committee
1996	Hospital Representative, American Medical Association, Section of Medical Schools
1996 -	Member, Overall Curriculum Committee

Other Organizations

1970 - 1975	Member, Council, Mahoning County Medical Society Youngstown, OH
1975	President, Mahoning County Medical Society Youngstown, OH
1976 - 1978	Member, Board of Trustees Mahoning Shenango Area Health Education Network Youngstown, OH
1976 - 1982	Member, Medical Education Committee Mahoning Shenango Area Health Education Network Youngstown, OH
1977 - 1978	Member Board of Trustees, International Institute Youngstown, OH
1979	Alternate Delegate, Officers and Council Mahoning County Medical Society, Youngstown, OH
1979 - 1981	Member, Insurance Committee Mahoning County Medical Society, Youngstown, OH
1979 - 1983	Member, Steering committee American Association of Program Directors in Surgery

other Organizations Continued:

1982 - 1986	Member, Medical School Committee of Mahoning County Medical Society, Youngstown, OH
1985	Co-Chairman, Insurance Committee Mahoning County Medical Society, Youngstown, OH
1986	Medical Advisory Board WYTV Television Station, Youngstown, OH
1993	Trustee, Mahoning County Medical Society Foundation Youngstown, OH
1995	Task Force to Promote and Facilitate Cooperative Graduate Educational Research Programming with SEHMC Youngstown State University Youngstown, OH