State of Ohio,)
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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DEWEY GLEN JONES, et al.,
Plaintiffs,
v.
MERIDIA HURON HOSPITAL, et al.,
Defendants.

Case No. 306012
Judge Lillian Greene

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THE DEPOSITION OF RAFAL A. BADRI, M.D., F.A.C.S.

THURSDAY, JANUARY 23, 1997

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The deposition of RAFAL A. BADRI, M.D., F.A.C.S., a Defendant herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Lauren I. Zigmont-Miller, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at the offices of Jacobson, Maynard, Tuschman & Kalur, 1001 Lakeside Avenue, Suite 1600, Cleveland, Ohio, commencing at 4:10 p.m., the day and date above set forth.

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Page 2

APPEARANCES:

On behalf of the Plaintiffs:
CHARLES H. ALLEN, ESQ.
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On behalf of the Defendant Rafal Badri, M.D:
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On behalf of the Defendant Beverly O'Neill, M.D:
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On behalf of the Defendant Winston Ho, M.D., and Lakeland Medical Group:
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On behalf of the Defendant Meridia Huron Hospital:
JAMES S. CASEY, ESQ.
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On behalf of the Defendant Peter Adamek, M.D:
SUSAN REINKER, ESQ.
Jacobson, Maynard, Tuschman & Kalur
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ALSO PRESENT: Keith E. McGregor - Videographics

Page 4

MR. JONES: Just for the record, the videotape that is here today, I'm objecting to its use. There was no notice sent when this was finally scheduled that this was going to be taken by video; therefore, the requirements of the civil rules haven't been met.

However, since the videographer is here and set up and since it's past 4:00 and we're unlikely to get a judge to make a final decision on this, I'm going to allow the video to stay, but I'm not waiving my objection.

MR. ALLEN: So noted.

We're going to take this by agreement of counsel, notice and agreement of counsel, with just the noted stipulation that you have here and waive all formalities?

MR. JONES: With the exception of the videotape.

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Page 3

INDEX

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PLAINTIFFS' EXHIBITS MARKED

OBJECTIONS BY

- - -

Page 5

RAFAL A. BADRI, M.D., F.A.C.S., a Defendant herein, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. ALLEN

Q. Good afternoon, Dr. Badri. I'm Charles Allen. I'm one of the plaintiffs' attorneys.

I'm going to ask you some questions today. If I speak too softly, if I speak in a tone or a method in which you cannot understand me, just ask me to repeat the question, I'll be happy to repeat it. If you need to take a break at any point in the deposition, if you need to refer to anything, you do so, whatever you want to, just let me know.

If you need to talk to counsel for any reason, need to go to the bathroom, be happy to do that, all right? If I ask you a question and you need to go to your records, please do so, okay?

A. Okay.

Q. If you feel like that's the way that you can answer it, I'd rather you do that, okay?

A. Fine.

Q. We'll just work through it and maybe we

Page 6

can get out of here in just a couple hours, okay?
A. Yes.
Q. Dr. Badri, I'd just like to go into your background a little bit. You were born and raised in Iraq; is that correct?
A. Correct.
Q. When did you leave that country?
A. 1978.
Q. Now, when did you enter -- when did you finish your undergrad training? You went to high school or an equivalence of high school and then you went to undergraduate school, correct?
A. I went to an American Jesuit high school back in Baghdad, it was a six-year program, and then I entered a six-year medical school program.
Q. How old were you when you finished -- I didn't mean to interrupt you. How old were you when you finished high school?
A. Eighteen. And I entered the medical school, it was a six-year program, and I graduated at the age of 24.
Q. And then at 24, what year was that?
A. 1976.
Q. Two years later you left Iraq?
A. Correct. I did one year of internship,

Page 7

rotating internship in internal medicine, pediatrics, OB-GYN and general surgery. The second year I did straight general surgery residency at the Medical City, which is the teaching hospital affiliated with the university.
Q. Now, were you married over there?
A. I got married in the year 1977.
Q. '77. So you left and you came to America in '78; is that correct?
A. No. I worked in the Persian Gulf in Abu Dhabi for three years. I did three years of surgery, further surgery training hoping to qualify and finish the requirements for the British boards. I changed my intentions towards the end of that based on my friend's recommendation that the surgical training in the United States is far superior to the British training.
Q. So what did you do then?
A. I came to the United States in the year 1981 and started a five-year general surgery residency training program.
Q. Did you have any family that was in America?
A. No.
Q. Tell me about your family background. How

Page 8

many brothers and sisters did you have?
A. I come from a family with, both parents are physicians. My father is a general surgeon, he's retired now, and my mother is an OB-GYN. I have one brother that is an engineer.
Q. And your family, your mother and father --
A. Are still alive, and they're still residing in Baghdad, Iraq.
Q. From '81 you came over here. what year did you take the F.L.E.X. exam?
A. was my to -- me, I'm mixing up. The F.L.E.X. exam is the one for equivalency?
Q. M-hm.
A. It was before my amval to the United States.
Q. Is that on your --
MR. JONES: Yes. Unless it's a memory test, it's all on his CV I just gave you.
MR. ALLEN okay.
BY MR. ALLEN:
Q. Did you pass that on your first time?
A. Yes.
Q. And then in that -- let me see where that

Page 9

is.
MR. JONES: Second page under certifications, third category.
BY MR. ALLEN
Q. That was in 1982; is that right?
A. The equivalency exam --
Q. If you just review that CV.
A. The equivalency exam, now that I'm looking at it, is the E.C.F.M.G. at that time. The name of those certifications have been changing over the years, but at that time it was the E.C.F.M.G. The F.L.E.X. is the medical licensure exam, the federal medical licensure exam, which I passed during my second year here, or actually it was during my first year of training.
I took the Georgia boards first that year and I passed it, and then I went on and got the Ohio license based on, first, the reciprocity with the State of Georgia, and Ohio would allow proper licensing only after two years of training.
Q. So when you first came over you came to Georgia; is that correct?
A. No. I came here to Cleveland and stayed in Cleveland.
Q. Tell me what you did after that. That was

Page 10

'81, correct?
A. I immediately enrolled in general surgery training. I did a year of internship and then four years of proper residency to qualify me for the boards.
Q. And you took the boards in?
A. 19 --
Q. 85, '86?
A. '86 was the written exam.
Q. Did you pass that on the first attempt?
A. Yes.
Q. Where did you take the boards; where did you physically sit for the boards?
A. Philadelphia.
Q. Now, tell me as far as where you've lived since 1981.
A. I've lived all this time here in Cleveland.
Q. What is the purpose for having licensing in Ohio, Michigan, New York, Georgia and Florida?
A. I was hoping during residency to get all my papers straightened out in case I would get a good opportunity to practice, and I did not know that I was going to settle here in Cleveland. My wife is a physician, she's a pathologist, and she was in training at the same time when I was. It worked out that she

Page 11

got a job offer at University Hospitals after she finished her training. It was difficult for us to find a job in one city at the same time, so we elected to settle down here in Cleveland.
Q. And you have no plans in the near future to go to another city?
A. I think I'm very well settled.
Q. Settled here, all right.
Now, for purposes -- have you reviewed the CV that's given to me?
A. Yes, sir.
Q. And it's correct and up-to-date?
A. Correct.
MR. ALLEN Just go ahead and mark that as Exhibit 1, Plaintiffs' Exhibit 1, and go on from here.
(Thereupon, Plaintiffs' Exhibit 1 to the deposition of Rafal Badri, M.D., was marked for purposes of identification.)
BY MR. ALLEN:
Q. Before you sat down today did you have an opportunity to review the medical records in this case?
A. Yes.
Q. Okay. Tell me, is that what's in front of you what you've reviewed, or you reviewed more records

Page 12

than that?
A. That's basically what I've reviewed.
Q. Are those all the records from the hospitalization on October 17th?
A. Correct.
Q. Were there any medical records from previous hospitalizations of Dewey Jones?
A. I just used this record.
Q. Do you recall going back and looking at other medical records from other hospitalizations before that?
A. I do not recall. Maybe I did at the time of the admission, but at this point in time I did not review --
Q. Not for purposes of today?
A. Correct.
Q. What else have you reviewed for purposes of today other than that hospitalization?
A. Nothing else.
Q. When you reviewed those medical records, did you see anything that struck you as not being accurate?
MR. JONES: well, I'm going to object. First of all, he did not go through every page of this chart, I'll

Page 13

guarantee you that. So -- and what you mean by accurate is untruthful, illegible or just wrong? I don't mean to be difficult, but just so we're clear.
BY MR. ALLEN:
Q. Did you review any of the medical records?
A. I reviewed this record supplied to me by Mr. Jones and concentrated mostly on the part that pertained to my involvement with the case.
Q. And the medical records that you wrote were accurate, correct?
MS. REINKER: Objection.
A. The ones that are shown here in the record are mine.
Q. The medical records that you reviewed other than that, there was nothing that wortched out at you as being an untruth, correct?
A. I'm sorry, I did not review any other medical records but this.
Q. But that?
A. M-hm.
Q. In the hospitalization of 10-17, did you see anything in the hospitalization of 10-17 that you felt was untrue?
A. As far as I recall, no.

Page 14

Q. Okay. Now, did you go and review any medical literature for purposes of today?
A. No.
Q. Did you review any medical literature at the time that you undertook the care of Dewey Jones?
A. No.
Q. I'm a little slow in talking, so let me finish my question sometimes.
A. That's fine, take your time.
Q. I'm just from Georgia.
MR. JONES: we have to give you some allowances, is that what you're telling us?
Q. I don't *drink* coffee a lot of coffee and I do talk slow.
A. You're talking in a very comfortable way.
Q. Did you look at any literature particularly as it relates to the care of Dewey Jones?
A. No, sir.
Q. Now, just some other general background information, Doctor. Have you ever been sued before?
MR. JONES: objection. Go ahead Doctor.
A. I was named in a malpractice case as a witness.

Page 15

Q. When was that?
A. Back in the year 197 -- I'm sorry, '86, 1986.
Q. When you mean you were named, did you have to come in and take a deposition?
A. Yes.
Q. Did you have to go to court and give trial testimony?
A. Yes.
Q. Did the verdict come back against you?
MR. JONES: objection.
A. I was a resident then and I was named as a witness in the case.
Q. The lawsuit was then brought against the hospital in which you were a resident, is that correct?
A. Correct. There were multiple parties involved.
Q. And you just happened to be somebody that was entered into the record caring for that person, correct?
A. Correct.
Q. And when the verdict came back, was it against the hospital?
MR. JONES: Objection.
A. Against the hospital.

Page 16

Q. Now, other than that deposition and that appearance in court, have you ever been deposed or given trial testimony since?
A. Yes.
Q. When is the next time that you gave deposition testimony?
A. I can't remember exactly, but it was around the year 1990, 1991.
Q. And what was the purpose of that deposition?
A. I was working at an urgent care center then and my name was brought up because all the records were reviewed and I happened to have answered a phone call, a questionnaire or a concern that the patient had that she placed to the urgent care center the day after she was seen first.
Q. And you took the phone call; is that correct?
A. Correct.
Q. Did you see her, physically see her?
A. No, I did not.
Q. So you gave a deposition and then did you have to go to trial in that case?
A. No. The case never went to trial.
Q. Were you dropped out of the lawsuit?

Page 17

MR. JONES: I'm not sure he was actually part of the lawsuit.
A. I was not named as part of the lawsuit, it was the urgent care center.
Q. That was named in the lawsuit?
A. Correct.
Q. You were never asked to testify after that point?
A. No. That was it.
Q. How long had you worked at that urgent care center?
A. Maybe for about two years.
Q. Before the dep ?
A. Correct.
Q. How long did you k after that at the urgent care center?
A. I cannot recall. Not long I should say.
Q. Not long?
A. Correct.
Q. Were you working there full time?
A. No, part time.
Q. Was that in the evenings?
A. No, it was during the day.
Q. Why were you working there p ?
A. my

Page 18

Q. What were your general duties in the urgent care facility?
A. As a physician that takes care of the patients that need to be seen there.
Q. During that time frame from, let's say, '89 to '92, what were -- did you have an office at that time away from the urgent care center?
A. I started a practice the year I finished training. I still maintain that same office.
Q. So you had an office during that time?
A. Correct.
Q. And now did you see patients in your office?
A. Then?
Q. Yes, then, between '88 and '92.
A. Yes, I did. I have been seeing patients since the time I started the practice.
Q. In an office setting?
A. Correct. In fact, I have three offices now.

where were you practicing medicine as far as in a hospital setting?
A. I was on staff at more than one hospital.

Page 19

Q. Which ones were those?
A. The main one was the one that I trained at and am still at, which is Meridia Huron.
Q. Now, other than the brief time that you worked at that urgent care center, have you done any other part-time work?
A. No. Actually, I'm sorry, I should say yes. I did do some extra trauma work at one of the downtown hospitals. It was a level one trauma center. Based on my field of specialization, I enjoy doing trauma and I did some night calls in there as the trauma surgeon on call for the hospital.
Q. When was that?
A. That was around the year, probably 1992 to '93 to '94, '95 -- I'm sorry, I cannot recall -- until the program was dismantled based on the financial aspect of it and the hospital electing to drop out. That's when I ended my relationship with that program.
Q. Other than those two instances at the urgent care facility and the trauma unit, did you work in any other capacity part time?
A. No.
Q. What about back when you first, in '81 when you first came to the Cleveland area?
A. Yes, I did do some extra work in the after

Page 20

hours after getting the Ohio license, and I did work in some urgent care centers.
Q. Tell me where those places were, do you recall?
A. I can recall two of them on the east side of Cleveland, one in Willowick and the other one, I think, is in Mentor on 615.
MR. JONES: That would be Mentor probably, yeah.
BY MR. ALLEN
Q. Any other facilities that you recall, sir?
A. And this same urgent care center that was mentioned in the lawsuit on and off prior to that, interrupted periods.
Q. The same law firm defends you in that suit?
A. Correct.
Q. Mark, is he your lawyer?
A. Not at that time.
Q. Now, since 1981 have you ever had your privileges suspended at any hospital?
A. No, sir.
Q. Have you ever been declined staff privileges?
A. No.

Page 21

Q. Have you ever been treated for alcohol, drug abuse?
A. Never.
Q. I want to center the next few questions about your practice today, okay?
A. Yes.
Q. As we sit here today. Tell me, if you could, just walk me through your typical day as it relates today, and if it changes day to day just walk me through your typical week, what you do in your office versus the hospital, et cetera.
A. I usually start at the hospital in the morning and go through rounds and see patients, operate, and I won't leave until afternoon to go and see my patients at the office. Usually I am busy at night. I do get phone calls, and there were times and there are times when I have to go to take care of patients simply because we run a busy trauma unit at Meridia Huron and we do accept complicated cases that need close attention and operative procedures during the middle of the night.
Q. How much time do you spend in your office during each given day?
A. I should say enough time to take care of patients plus some other administrative work,

Page 22

paperwork.
Q. You tell me you have three offices today?
A. The other two offices I see consults only.
Q. Where are those offices?
A. One of them is close to downtown here and the other one is on the near west side.
Q. Now, who calls you in for those consults, what other doctors in the practice?
A. There are many doctors that I get consults from.
Q. In those two locations what's the name of the practice?
A. It's my name, Rafal A. Badri, M.D.
Q. You say you go in as a consult. Maybe I'm --
A. Correct.
Q. So you go in to consult based upon --
A. Referrals.
Q. Referrals that are already made?
A. Correct.
Q. Those people go to that office that's located in different areas of the city, correct?
A. Correct.
Q. Now, what office is your main location?
A. The one 14100 Cedar Road.

Page 23

Q. W, dur..g the day of the week do you have an opportunity to teach residents?
A. Yes.
Q. How long have you been doing that?
A. Since I finished training in 1986.
Q. Tell me h acity you train students doctors.
A. Meridia Huron has an approved general surgery training program. I have involvement with the residents of all capacities. It's a five-year training program, so I get involved with teaching junior and senior residents on rounds, on the floor, patient contact, educational rounds and in the room.
Q. Now, do you ever t in a formal classroom setting surgery?
A. Yes, When I'm asked to give a talk to a group of either medical students or residents from other hospitals in a teaching session, yes, I've had experience with that and still do.
Q. How often have you done that? Monthly?
A. I don't do it on a frequent basis, but I do it when I'm asked to.
Q. Have you done it on a monthly basis, a yearly basis?
A. On a monthly basis I should say.

Page 24

Q. At the request of who?
A. This is beyond Meridia Huron.
Q. Right.
A. At Meridia Huron my involvement is nearly on a daily basis.
Q. But I'm talking about a classroom, formal classroom setting.
A. I should say around a monthly basis.
Q. And those are requested by Meridia Hospital or somebody else?
A. Meridia Hospitals.
Q. And who would ask you to give those talks?
A. It's usually the chief of surgery or one of the attending staff that thinks that there is a subject that is of interest that can be discussed. In general surgery it's usually based on the way I do it or experience basis. It's an informal discussion more than just a didactic setup.
Q. Now, in this informal basis do you find yourself speaking more often on certain surgical techniques than others?
A. Yes, I do.
Q. What are those?
A. Trauma in general, abdominal trauma in specific, and gastrointestinal diseases and

Page 25

gastrointestinal surgery.
Q. How ft h you give talks as it l to c olecystec c nies . g llbladder surgery in gene l?
A. I don't give talks on a routine basis, but we frequently do get involved in discussion of complications related to biliary surgery in particular and gastrointestinal surgery in general.
Q. Wh n the last ime you gave a t on biliary surgery?
A. I do not recall. A formal talk you're asking?
Q. Yes.
A. I do not recall, I'm sorry.
Q. W as it in the l st ye r do you thir ?
A. I don't think.
Q. W as it in the last two ears?
A. Maybe
Q. Now, other than what you just ner oned is th r , personally is there some specialty that you enjoy most in surgery?
A. Abdominal trauma.
Q. Abdominal trauma. And when we're talking abdominal trauma, tell me what we're talking about, give me examples.
A. We're talking about traumatic injury

Page 26

related to the contents of the abdomen, which include the gastrointestinal tract, the hepatobiliary system and the vascular structures.

Q. Other than that, is there any other area that you have specific interest in?

A. That's it.

Q. Have you ever -- I didn't really review your CV that close but have you done any formal writings in medical literature?

A. No.

Q. In neither a textbook nor a periodical setting, correct?

A. No.

Q. Do you have any plans in the near future to put out any writings, studies?

A. I have collected some information pertaining to some areas that I may see some positive [illegible] can [illegible] programs pertaining to maybe management and trauma, but this is something for me to entertain in the future.

Q. Do you have any plans to put any Writings out as it relates to biliary surgery?

A. No, sir.

Q. And when we say biliary surgery, we're

Page 27

talking about gallstone removals and gallbladder removals, correct?

A. I have no intention.

Q. But just to let me clarify the definition, we are talking about gallbladder removal, correct?

A. Correct.

Q. Now, the American Board of Surgery, do you hold any offices on any levels in that group nationally, locally?

A. No.

Q. Have you ever held any offices with that group?

A. No.

Q. Do you have any plans to hold any offices in the future?

A. No.

Q. And that is due to time constraints, or is there some other reason?

A. I usually don't enjoy administrative work. I think I was trained to be a surgeon and still enjoy doing the work of surgery, and I think one good reason why I stayed as a general surgeon was the fact that I do love surgery of the gastrointestinal tract.

Q. So you'd rather be on a hands-on setting than doing administrative paperwork?

Page 28

A. Correct.

Q. Have you ever read an electrocardiogram?

A. Yes. I was taught to read electrocardiograms, but I cannot claim that I am an expert or somebody that could feel very comfortable giving an opinion about looking at an electrocardiogram.

Q. So you don't feel that you could render an opinion as it relates to electrocardiogram, correct?

A. Correct.

Q. Do you feel competent that you could render opinions as it relates to an echocardiogram?

A. No, sir.

Q. Same question as it relates to a chest x-ray and specifically a chest x-ray that is checked for infiltrates versus hyperinflation?

A. I don't feel I'm an

MR. WALTERS: could you read that back?

BY MR. ALLEN

Q. Do you feel competent to testify -- excuse me. Do you feel competent to interpret chest x-rays as it relates to checking the chest x-ray for infiltrates of hyperinflation?

Page 29

A. No.

Q. Do you feel competent or do you consider yourself in any way a cardiologist?

A. No way.

Q. Do you feel that you could categorize yourself as having any expertise in infectious disease?

A. I cannot say an expertise, but I feel comfortable handling some basic infections based on my training and the relation of infectious complications with the practice of surgery, especially the surgery of the gastrointestinal tract.

Q. Okay. So we're talking about peritonitis and infections such as that?

A. Correct.

Q. So you feel confident you could recognize peritonitis, you feel confident that you could administer antibiotics to treat that, correct?

A. Correct.

Q. Any other examples that you could give me that you would feel confident as far as in an infectious disease setting?

A. Not really.

Q. Now, do you feel competent in the areas of pulmunology to interpret studies and hold yourself out as a pulmonology expert?

Page 30

A. I was trained to be a general surgeon, so I cannot claim any expertise in that.
Q. In that area?
A. Correct.
Q. All right. Then as far as internal medicine, do you feel competent to hold yourself out as having any expertise in the field of internal medicine?
A. I was trained to be a physician to begin with and a surgeon second. I feel it's an obligation of any surgeon to be able to understand and handle basic medical problems, but I don't think it is a right thing to do to indulge in management of complicated issues.
Q. Because you don't do that on a regular basis, correct?
A. Correct.
Q. On a regular basis you're a surgeon, correct?
A. Correct.
Q. So you would leave those types of management to --
A. The experts.
Q. -- the experts, internal medicine experts, correct?
A. Correct.

Page 31

Q. Now, as far as pathology, you said your wife was a pathologist. Do you feel you have any extra knowledge in the field of pathology?
MR. JONES: Extra, beyond what?
BY MR. ALLEN:
Q. Beyond what a general surgeon would have.
A. Not beyond what a general surgeon should know and based on what is required of him or her as identified by the American Board of Surgery for a board certified general surgeon in practice.
Q. Okay. So you can't interpret placental pathology slides, correct?
A. Correct.
Q. But you feel confident that you could look at a pathology slide, report, et cetera, of, say, a gallbladder and interpret that?
A. I don't give the interpretation as a formal opinion, I just do it to increase my knowledge. Yes, I do look at slides together with a pathologist, but I never would want to look at a slide by myself and claim expertise or pass an opinion.
Q. And that includes the gallbladder, correct?
A. Correct.

Page 32

Q. Now, have you ever performed oral dissolution therapy for gallstones?
A. No.
Q. Have you ever performed an ESWL shock wave?
A. No.
Q. Do you consider yourself competent to interpret MRI's?
A. No.
Q. What about CT scans, do you feel competent in that area?
A. I feel I have enough training to let myself understand what's going on if I have to read a CT scan in the middle of the night if a radiology opinion is not available, and I reserve this judgment for myself to help me at least get a handle on the case at that time, but not beyond that.
Q. So as an as-needed emergent basis you can interpret CT films, correct?
A. To a limited extent.
Q. To a limited extent. And that limited extent includes what part of the body?
A. The abdomen.
Q. It doesn't include the brain?
A. No.

Page 33

Q. So we're talking the abdomen and the thoracic area?
A. Not really.
Q. Just the abdomen?
A. Correct.
Q. Okay. Do you have any members of your family that practice law?
A. No.
Q. Tell me about Meridia Huron. Am I pronouncing that right?
A. Meridia Huron.
Q. Meridia Huron. Tell me about that hospital. How many beds are in that hospital?
A. I don't recall the exact number, but it's somewhere around 200.
Q. How many OR suites do they have?
A. Eight.
Q. Eight, okay.
A. Major.
Q. Eight major. How many minor ones?
A. One or two.
Q. So ten total?
A. Correct.
Q. How many operations occur in that hospital per year?

Page 34

A. I'm sorry, I don't have the number.
Q. Do you know how many gallbladder surgeries are done in that hospital per year?
A. I actually don't.
Q. Do you know how many surgeons are on staff there?
MR. JONES: General surgeons or just any kind?
MR. ALLEN General surgeons, I'm sorry.
A. I don't know the exact number, but I can tell you that there are surgeons that are there on a regular basis and there are full-time surgeons related to the general surgery training program in there and there are surgeons that show up on a part-time basis that are in practice in the community.
Q. You're on full staff here, right? You spend most of your time at that hospital, correct?
A. I spend most of the time, but I'm in private practice.
Q. So you have no idea how many general surgeons which are equivalent to you would be practicing in that hospital?
A. [illegible] but it does not necessarily mean that all of them are

Page 35

fully active and are operating there on a regular daily basis.
Q. Now, on a regular daily basis do you think it would be half of that, six?
A. I should say the number is around four.
Q. Four?
A. To five.
Q. Including you?
A. Correct.
Q. Now, if you could, Doctor, tell me the number of surgeries, the number of gallbladder surgeries you performed last year.
A. I'm sorry, I did not look at that number.
Q. You don't know?
A. I did not look at the number to be honest.
Q. Excuse me?
A. I did not look at the number, I did not review it, and I did not anticipate there would be a question of such.
Q. Well, just give me an estimation since I kind of --
A. I'm sorry, I cannot come up with a number.
Q. Do you do it on a weekly basis?
A. I could say that, yes.
Q. Do you do it on more than a weekly basis,

Page 36

twice a week?
A. It's very variable. There are times when I may do more than one a week and there are times that I may do less than one a week.
Q. That's fair. So if we were to say 52 times a year you perform gallbladder surgery, would that be a high number, an estimated high number?
A. It may be high.
Q. So if it was less than 40, between 40 and 50? Let me ask you that, between 40 and 50?
A. Maybe less than 40.
Q. Between 30 and 40?
A. I'm sorry, I cannot tell you.
Q. But we're in a close range there, somewhere between 30 and 40?
A. Somewhere.
Q. Now, has that frequency decreased or increased since 1994?
A. Based on the HMO --
MR. WALTERS: what frequency? I don't know what you're talking about.
MR. JONES: The frequency of gallbladder --
A. Are you talking in general or in my practice?

Page 37

Q. Your practice, the frequency of your gallbladder surgeries.
A. Based on the heavier infiltration of the HMO's into this market over the course of the last two years, yes, I have been seeing dwindling numbers.
Q. Now, in 1994 at the time of Dewey's, the year of Dewey's operation, you were performing more than 30 a year?
A. I'm sorry, I cannot recall.
Q. But you were performing more back two years ago than you are today, correct?
A. Correct.
Q. As far as the number of cholecystectomies that you do, what percentage of them are done laparoscopically?
A. I got introduced into the laparoscopic gallbladder surgery around the year 1990 when we started hearing about some surgeons here in the State of Ohio that were doing them, and I did travel to Cincinnati a few times to see how it was performed after I heard about it before I got myself involved in courses and hands-on teaching.
Q. So your first introduction, if I understand, was in 1990 to laparoscope?
A. Correct.

Page 38

Q. Now, in 1994 what percentage of laparoscopic -- of cholecystectomies that you performed were done laparoscopically?

A. Cumulatively I should say it was around maybe 60 laparoscopic, 40 open, but the numbers were rising then. I should say the laparoscopic numbers were rising based on more confidence being built into that procedure.

Q. So in 1994 you roughly had four years experience with laparoscopic procedure, correct?

A. Correct.

Q. So as the years went on you felt more competent to do that procedure, correct?

A. Correct.

Q. So in 1994 you estimated around 60 percent laparoscopic for cholecystectomies, correct?

A. Probably.

Q. Now, in 1996 do you feel that number was greater than 60 percent?

A. Probably.

Q. Seventy, 80 percent?

A. I should say around 70 to 80.

Q. In the national average, about 80 percent laparoscopically cholecystectomies, do you agree with that?

Page 40

saw either an article or written materials on how to be a good witness?

A. No. I've never had any formal introduction to that.

Q. Have you ever attended medical seminars in which that was discussed, that you overheard that?

A. No.

Q. Has no interest at all to you obviously?

A. So far not.

Q. Now, have you ever had the opportunity to give formal talks -- well, scratch that.

Have you ever had an opportunity to give either informal or formal talks to a group of lawyers?

A. No.

Q. How about a group of insurance company people?

A. No.

Q. Now, have you ever had an opportunity to give expert testimony in a medical-legal case?

A. No.

Q. So other than the times that you have given testimony as a fact witness or as a defendant in the case, you've never given deposition testimony before, correct?

Page 39

A. I'm not about this

Q. Sound right?

A. Maybe.

Q. You don't know?

A. I don't.

Q. Now, alternative treatments to cholecystectomy are known, pretty well known in the medical community, correct?

A. Correct.

Q. Have you done any or performed any other procedures for gallbladder surgery other than laparoscopic or laparotomy?

A. No.

Q. [illegible], in the [illegible] have you had an occasion [illegible] ever read any material [illegible] [illegible] it down and give a deposition, you [illegible], be asked [illegible] [illegible] in the setting? Have you ever read an article on how to be deposed?

A. I'm sorry, may I ask you to repeat the question?

Q. Sure. Have you ever read an article that tells you on how to be deposed?

A. No.

Q. Have you ever thumbed through a magazine or been a part of a lecture, medical lecture, that you

Page 41

A. Correct.

Q. Have you ever [illegible] an opportunity to [illegible]ew records at the [illegible] of a lawyer as it relates to either the standard of care or issues of medical-legal?

A. Pertaining to my practice or outside my practice?

Q. Outside practice.

A. No.

Q. Have you ever had the opportunity to review retrospectively care that was given to patients?

A. Yes.

Q. When do you do that.

A. I'm a member of the Quality Assurance Committee at the hospital and we do meet on a regular basis and review the complications and mortalities related to the practice of surgery.

Q. Now, have you had the opportunity to be chief of staff?

A. No.

Q. Have you had the opportunity to hold any sort of an office like that at the hospital there, Meridia?

A. The chief of staff, the only office I held was the director of trauma, which I still do at the hospital.

Page 42

Q. How long have you held that position?
A. Since 1991.
Q. Plans of relinquishing that position any timesoon?
A. No.
Q. Why do you hold that position?
A. It gives me a good opportunity to get myself more involved with trauma. I not only just do my part, but I look at the practice of trauma in general at the hospital. I do review all the admissions, I do look at the quality of care, and I'm assisted with a nurse manager that has expertise in that. I do head the trauma committee meeting, which meets on a regular basis, that has a good part of its duty to review the quality of care delivered to the trauma patients.
Q. Do you find it helpful to be able to retrospectively --
MK. CASEY: Before we get too far into this, I should let you know that in Ohio we have a privilege for any quality review materials, so I just don't want you to go too far with this.
MR. ALLEN: I figured as such. I appreciate it.

Page 43

BY MR. ALLEN:
Q. Now, do you find the opportunity to review -- when you retrospectively look at care in whatever setting you're talking about, do you find it helpful to the medical records retrospectively?
MR CASEY: Object to form.
MR. JONES: objection.
MR. WALTERS: Objection.
MR. MEADOWS: Objection.
Q. Do you find that you can adequately look at the care given to a patient retrospectively through medical records?
MR. MEADOWS: objection.
MR. WALTERS: objection.
MR. JONES: objection.
Q. Can you answer it? You can answer the question if you can understand it.
A. I'm sorry, not really.
Q. Okay.
A. If you want to rephrase it again.
Q. Sure. You review past medical cases in your capacity at the hospital as director of trauma, correct?
A. Correct.
Q. When you do that, you look at medical

Page 44

records, correct?
A. Correct.
Q. Do you find that you can adequately review those cases based upon the medical records alone?
MR. MEADOWS: objection.
MR. JONES: I'm going to object, also. There's been no testimony that that's all they ever look at. If you want to assume that that's all he's looking at, whether he can do it by just looking at records, fine.
BY MR. ALLEN:
Q. Based upon the records, can you adequately review?
A. No. I feel that it's not only the medical records, but listening to the people involved in the care of any particular patients, in addition to the practice of taping or videotaping the management of trauma cases upon arrival in the emergency room, and reviewing that part in videotape was included as part of the job or the duty of the director of trauma. This practice had to stop a couple years ago based on the advice given to us by one of the attorneys after --
MR. JONES: I'm going to

Page 45

have to stop you right there, Doctor. Don't get into what advice you or the hospital got from counsel. If it was stopped, it was stopped on advice of counsel.
A. Simply we were the only --
MR. JONES: That's enough.
BY MR. ALLEN:
Q. Doctor, so if I understand correctly, and we'll move on, you used records, you used interviews with witnesses and people that have performed the care, and at one point you used the capacity of videotape to review these cases, right?
A. Correct.
Q. Other than those *three* aspects, is there anything else that you used in reviewing the care of doctors to patients retrospectively?
A. Well, sitting in also the surgical QA committee and listening to other doctors sitting on that committee passing a judgment does help give you a better insight as to how the management of any individual case went on.
MR. CASEY: objection. Move to trike any erence to lit assurance.

Page 46

BY MR. ALLEN:
Q. But the general discussion and general review of these cases has helped you be a better doctor, would you agree?
A. To some extent I should say.
Q. Now, you had a chance to look at Dewey's records. We're about to get into those records shortly. I just wanted to ask you, besides the medical records -- scratch that.
Doctors use medical records to communicate in, correct? You communicate from doctor to doctor via medical records as one way of communication, correct?
A. One way of communication.
Q. That's true, right, that's one way?
A. Correct.
Q. There are other ways that doctors communicate obviously, right?
A. Correct.
MR. WALTERS: object.
Q. Let's just get our arms around that. You talk to doctors in the hall and communicate about care to a patient, that's not reflected in the medical records, correct?
A. Correct.

Page 47

Q. Do you use nurses to communicate between doctors also?
A. It depends on the kind of communication that you want to establish and the level of care that you think you may need to touch bases with other doctors upon.
Q. But you have found yourself on occasions communicating through nurses to other doctors, correct?
A. On some occasions.
Q. Have you found yourself communicating to another doctor about a specific patient in any other manner besides what we just talked about?
A. Well, if I feel that I need to talk to a doctor based on my concern level, I could go all the way to pick up the phone and page that doctor and wait for him to call back to waiting to see him that day or the next day if I need to.
Q. So you could personally go page him, telephone call him and set up a meeting with him, correct?
A. Correct.
Q. That's what you're talking about there.
Any other way you find yourself reaching out to communicate to other doctors?
A. As far as a specific patient?

Page 48

Q. I mean just in general. Is there any other way to communicate to a doctor besides personally, communication one on one or through a nurse or through a medical record?
A. Well, if I have had some cases that I thought were interesting enough and have had no hundred percent satisfaction with what I have of information on hand, I have used the opportunity, for example, to communicate with other doctors of expertise during attending some seminars in medical or surgical conferences.
Q. Is that more in a retrospective role to say, hey, Doctor, I had this case and this is what happened, what's your opinion, is that what you're talking about?
A. Or listen to a doctor bring his side of the story and discuss his experience with management of a case or cases and then go ahead and discuss some aspect of interest that I have had with his presentation about the management.
Q. So make sure that I understand what you're saying is that if you've got a patient and you want to communicate or find out information as it relates to medical care, you have gone out and sought through -- I'm drawing a blank here -- through seminars, et

Page 49

cetera. other doctors' advices?
A. Correct. And even if I have to pick up a phone and call a friend of mine that I know has some expertise that may five outside this town to try to get some piece of good advice from him about some management.
Q. So we've pretty much got our arms around that, ways to communicate?
A. I guess, unless there's something else that I'm overlooking.
Q. Okay. Is there a way of communication that you rely on more than other ways, doctor to doctor, in your practice?
A. Face-to-face communication.
Q. So you rely on face-to-face communication more than you do the medical records?
A. Correct.
Q. Do you rely on face-to-face communication more than you do information through nurses at the hospital?
A. Correct. Again, I have to individualize, too. If it's a straightforward kind of care process I may not heighten my communication attempt to go looking for a specific doctor or page him and have to wait for an answer at that particular moment.

Page 50

Q. But you like the face-to-face communication the best, correct?
A. I think this is the appropriate way that I rely on.
Q. Is it your job -- scratch that.
What percentage of your job entails consults being called in to consult on a case, how often do you do that a day?
A. That I get called and consult, I should say the majority of my practice because it's mostly referrals.
Q. So what percentage of patients come underneath your care as a primary care doctor?
A. I usually am a general surgeon, so as primary care I don't handle this aspect. If there is a case that may come directly under my care as in one occasion, maybe the patient gets to be admitted directly from the emergency room that may have had no other doctor caring for him or her and I'll have to pick up the slack from there.
Q. So you have routinely admitted patients through the ER, correct?
A. Correct.
Q. Okay. And that usually occurs when that patient in the ER doesn't have a general practice

Page 51

doctor, correct?
A. Correct.
Q. How often do you do that in your practice?
A. I should say maybe around one-third of the time when I can get to take care of a patient that may have had nobody at that particular hospital to take care of him or her.
Q. So a third of the time you'll admit a patient in and you'll be the doctor on record for admitting the patient, correct?
A. Correct.
Q. And when you bring in the patient, do you then turn to an internal medicine guy to then look after his care or that patient's care?
A. Depending on the help that I may need taking care of that particular patient.
Q. So if in your judgment you feel like you need somebody else to be the primary care specialist for a patient that you've admitted to the hospital, then you'll *turn* over that care to another doctor, correct?
A. Correct.
Q. How would you go about g
A.
directly or having the resident doctor communicate with

Page 52

the consultant if I'm not available or put an order in the chart if it's for routine care and have the nurse relay the information to the consultant.
Q. So you would routinely chart whether you were turning over the care to a consultant, primary care, correct?
A. Beyond my surgical involvement with a certain case, correct.
Q. How often do you follow patients after surgery? All the time?
MR. JONES: me you saying right after surgery, I mean, beyond the usual post-op?
BY MR. ALLEN
Q. Until they get out of the hospital.
A. In the immediate postoperative period, yes, it's my responsibility.
Q. To follow the patient?
A. Correct.
Q. And then all the way up until discharge, if you admit that patient, you're responsible for that patient?
A. Correct.
Q. And if you have changed the responsibility of that patient to another consult, you would have

Page 53

noted that in your record, correct?
A. But if I have had some involvement with that patient, I still feel it's my duty to continue following the patient despite the fact that he is or she is on another service.
Q. Okay. So you would feel there would be a joint duty between you and that other consultant?
MR. MEADOWS: Objection.
A. Correct.
Q. Now, does that change when you call in a consultant for a specific problem? Say you want an infectious disease consult based upon you can't understand why an infection is happening with a patient. Would you then, once that consult comes in do you feel there's a mutual role between you and that consult?
A. Correct. The practice of general surgery entails a lot of infections or infectious complications related to the care of a particular patient and we do have or have had certain experience with handling infectious complications, but at times when I feel, for example, the bacteria that are being isolated are just not the kind that I feel comfortable writing the regular daily antibiotics for and I feel that it may need the expertise of somebody who handles this on a

Page 54

more routine basis, yes, I do ask the infectious disease consultant to take over.
Q. And, in general, you would expect that consult to mutually follow that patient along with you, correct?
A. Correct.
Q. Is there any instance in which you would call in a consult and you would feel that the consult should not continually follow the care of a patient that you admitted?
A. Not that I can recall an instance at this point in time.
Q. You would expect that to occur, you would expect him to follow?
A. Correct.
Q. How often in your practice do you refer patients to other physicians?
A. I'm sorry, I cannot give you a percentage, but I do feel that I can only handle as far as my area of expertise or limited expertise, if you may, and the rest is to be handled by people who have had more experience than I do or definitely have more experience than I do in certain aspects of medical management.
Q. So your expertise, if I understand it, is to be a surgeon, correct?

Page 55

A. A general surgeon.
Q. A general surgeon?
A. Correct.
Q. So your expertise isn't to run a diagnostic test, but it's to cut and be a general surgeon, correct?
A. Well, it's to recognize the disease and be able to manage the disease in an operative and certainly in an inoperative fashion, too, and be able to handle the complications, if any, following any certain operative procedure and handle all the care pertaining to that particular procedure until the patient is discharged from the hospital.
Q. Anything else?
A. No, sir.
Q. Have you followed patients that have suffered from sleep apnea syndrome?
A. No.
Q. Have you ever -- you've never encountered a patient with sleep apnea syndrome?
MR. JONES: I'm going to object. Did you ask him whether he's treated patients for sleep apnea or if he's ever seen a patient --
MR. ALLEN: Did I say

Page 56

treated?
MR. JONES: I don't know.
MR. ALLEN I thought I said, have you ever seen patients that have had sleep apnea syndrome.
MR. JONES: well, then I'm objecting because what have you ever seen, I'm not sure exactly what you mean. He may have seen somebody at a cocktail party who has sleep apnea.
BY MR. ALLEN:
Q. Have you followed patients and one of the complications that they had was sleep apnea syndrome?
A. No, I don't follow patients that have sleep apnea, but I have had an idea about it based on somebody else's experience having listened to it discussed in medical conferences.
Q. What is your understanding of sleep apnea syndrome?
A. I should say it's limited.
Q. Tell me what limited understanding you have, please.
A. It's usually a problem that more often an overweight person may encounter. It's a breathing irregularity based on inhibition of certain mechanisms

Page 57

that do control the breathing process and some onsets of interruption of the regular breathing pattern maybe and/or the depth of it to some extent causing cessation of breathing or the effort of breathing and thereby creating the physiological derangements that the body in general may incur based on the alteration of the normal breathing pattern.
Q. Are you aware that sometimes that can be a fatal complication of an obese person, to have sleep apnea syndrome?
A. Yes, I'm aware of that.
Q. So you're aware that one of the symptoms of it is a history of loud snoring?
A. I really am not an expert to say. It may be, but I'm not sure.
Q. You're not aware that that's one of the symptoms?
MR. JONES: I'm going to object. I've never heard of a history being a symptom, but be that as it may. He's already tried to answer it.
A. It may. I actually don't know. It may be.
Q. It may be?
A. Yes.

Page 58

Q. A history of loud snoring may be a symptom of sleep apnea syndrome, correct?
A. Maybe.
Q. Okay. And another symptom could be frequent nocturnal awakenings?
MR. WALTERS: Frequent nocturnal what?
MR. ALLEN: Awakenings.
BY MR. ALLEN:
Q. The patient wakes up frequently at night, and usually that's complicated with shortness of breath, are you aware of that?
MR. MEADOWS: Object to form.
A. Based on my understanding of how the normal physiological mechanisms of the body go on, yes, it may be. But again, I don't have that in-depth knowledge of this disease to be able to tell you the exact information that you're looking for.
Q. I'm just trying to find your medical knowledge, that's all. If you know, you know; if you don't, you don't; if you're not quite sure, just tell me. I'm not trying to be hard to get along with, I'm just trying to find out your knowledge.
But are you aware that a person with sleep apnea syndrome can be at risk for acute upper

Page 59

airway obstruction?
A. May I ask you to -- can I hear the question again?
Q. Let me finish. Are you aware that a person with sleep apnea syndrome can be at risk for acute upper airway obstruction?
A. Again, I truly do have limited knowledge about this disease, so I really cannot tell you if it's absolutely correct, but I guess from having to understand the physiology of the body it may be.
Q. And it's that acute upper airway obstruction and/or respiratory arrest is more likely to occur after an operation under general anesthesia; isn't that correct?
MR. MEADOWS: Objection to form.
MR. JONES: I'm going to object. He's already said he doesn't have the knowledge to answer this question.
Go ahead, Doctor, you can answer.
A. upper airway obstruction. I think it's a physiological obstruction, if you may, more than just a mechanical or obturator obstruction in the upper or lower airway, per se.

Page 60

Q. But that patient with sleep apnea syndrome is at a risk postoperatively to have respiratory distress, true?
MR. MEADOWS: Objection to form.
MS. REINKER: objection.
MR. JONES: I've already been objecting.
Doctor, if you can answer his question, go ahead. If you don't know, just tell him you don't know.
A. Not necessarily. If the airway was managed appropriately and if there was enough anticipation of how the progress of the postoperative recovery has been going on, I don't think that this can hold true.
Q. Do you know that the only way to confirm sleep apnea syndrome is a sleep somniography, have you ever heard of that?
A. I don't know anything about that.
Q. Have you handled patients that have had OHS? Do you know what that is?
A. No.
Q. Obesity hypoventilation syndrome.
A. you me I some of

Page 61

those?
Q. Yes. Have you cut on a patient that's had that syndrome?
A. I have had many patients that were morbidly obese that I've operated on. In fact, I have had good exposure to morbid obesity patients. When I was in training the chief of surgery then had special interest in bariatric surgery or surgery for morbid obesity, and he was operating on an average of a case a day stapling those people's stomach.
MR. JONES: Doctor, all he asked you is if you were familiar with obesity hypotension something.
BY MR. ALLEN
Q. Let me re-ask the question.
A. I'm not aware of the syndrome.
Q. Let me re-ask the question. Obesity hypoventilation syndrome?
A. Not this syndrome.
Q. You've never had a patient with that? I just want to make sure you understand the question. You've never had a patient with that?
A. can say I not in-depth knowledge to go and look specifically for that syndrome.

Page 62

Q. Okay.
A. It might have been listed in the chart or mentioned somewhere in front of me, but, again, that is not anything for me to indulge in in further care delivery, I should say, as far as my specialty is concerned.
Q. Would you expect if you had a patient like that that it would be brought to your attention, that had that syndrome?
MR. WALTERS: I'm going to object to form.
MS. REINKER: objection.
MR. JONES: objection.
BY MR. ALLEN
Q. Would you expect to be aware of the fact that a patient had OHS?
MR. CASEY: objection to form.
MR. JONES: I'm going to object. He said he doesn't have a familiarity with the syndrome, so how can he have any expectations regarding that?
MR. WALTERS: And I'll show my objection. You're talking about a hypothetical patient and some abnormal

Page 63

situation that we're totally unaware. Go ahead.
BY MR. ALLEN:
Q. Okay, Doctor.
A. I was not made aware at any time that there was something thrown at me with this specific description that you gave it. Forgive me, give it to me again.
Q. Obesity hypoventilation syndrome.
A. But again, if the case comes out, I'm sure my level of awareness is going to be altered.
Q. Thank you, Doctor.
Staying on the track of the obese patient, Doctor. With your history of obese patients, you've seen or you're aware of the difficulty that can be expected when you intubate an obese patient, correct?
A. I have witnessed morbidly obese patients being intubated and I can say it's not the easiest intubation that one would encounter.
Q. And these patients are difficult to monitor intraoperatively, correct?
MS. REINKER: Objection.
MR. MEADOWS: what patients?
MR. JONES: Objection.

Page 64

From a general surgeon's point of view or an anesthesiology point of view?
BY MR. ALLEN:
Q. In your opinion, Doctor, are these patients difficult to monitor intraoperatively?
MR. JONES: what kind of monitoring are we talking about? I'm objecting to this question as unclear.
A. I think it depends on the type of surgery and the other associated co-morbid medical problems that may dictate the level of the intensity of intraoperative monitoring.
Q. Sure. How often have you ordered a Swan-Ganz catheter placed on a patient that you've operated on?
MR. JONES: In his entire career how many times has he ordered a Swan-Ganz catheter, is that the question?
Q. Is that frequent?
A. I can say I've had good training inserting Swan-Ganz catheters and being able to interpret the information collected from those catheters. In my practice nowadays I'm more and more involved with specialists, and since I find myself needing or requesting help from other specialists to be involved

Page 65

in the care of a particular patient, I'm finding myself ordering the placement of Swan-Ganz catheter less and less.
Q. On a percentage of patients that you see yearly, is it something that you do more than ten percent of the time?
A. I'm sorry, can I ask you to go a little bit more specific? Is it my involvement as far as putting the Swan-Ganz in or ordering it to be inserted?
Q. Either way. Let's just leave it very broad. Either you doing it or ordering it.
A. It's getting less and less.
Q. Does that less and less mean less than ten percent of your patients you would order it or do it the Swan-Ganz?
A. I really cannot give you a certain figure because the degree of other maybe co-morbid problems that are associated with some of the patients that I operate on are so variable that I really cannot be very specific about this.
MR. CASEY: Did I miss something? Did he say he orders Swans?
BY MR. ALLEN.
Q. So overall a Swan-Ganz catheter you would expect it to be seen rarely in a patient that you

Page 66

perform?
A. Not necessarily.
Q. Do you see it often; do you place it or order it often?
A. I don't think the trend is on the rise or on the decline more than it's related to the medical condition of the surgical patient that I was going to handle or will be handling.
Q. Let me narrow it down. How about an obese patient, what percentage of obese patients do you order a Swan-Ganz catheter for or insert a Swan-Ganz catheter?
A. Again, nowadays it's mostly the word of the other specialists that are involved in the care of that patient more than my word or my liking or my decision to insert a Swan-Ganz catheter.
Q. So you would rely on another specialist to tell you whether there should be a Swan-Ganz placed, correct?
A. Correct. But by the same token, if it was a patient of mine, for example, a trauma patient, a healthy man from the street that got shot and got into some postoperative complication and I need to sort out what exactly is going on, yes, I can resort to the Swan-Ganz catheter to help me get a little bit better

Page 67

insight as to what may be going on.
Q. Well, in 1994 were you relying on consultations if they were available for a patient in ordering or placing a Swan-Ganz?
A. Correct.
Q. Now, a Swan-Ganz gives you the ability -- scratch that.
A Swan-Ganz gives a doctor the ability to intraoperatively assess volume mass and the volume status of the patient, correct?
A. It's a tool that can help generate some data that a physician may use to delineate certain path of management of a certain patient.
Q. What information does that tool give you, does that Swan-Ganz catheter give a physician?
A. I usually think of the Swan-Ganz catheter as a tool to help me get more information to correlate with the ongoing information that gets generated on a regular basis during the management of a critically-ill patient that usually needs the Swan-Ganz.
Q. Ongoing information, give me an example of that ongoing information that you would get from a Swan-Ganz catheter.
A. Well, it could tell me, for example, if a patient is hemodynamically unstable and is this

Page 68

instability arising from an occult source of infection versus decompensation of his or her cardiovascular system. It helps to some extent give me an idea about the amount of fluid that is on board.
It does help give an idea about the cardiac performance of a patient and some pressure figures or numbers that can be generated that help understand the amount of, for example, pulmonary circulation pressure or systemic circulation pressure and resistance.
Q. Can you think of any other tool that you can use intraoperativelythat would give you the same amount of information?
A. Again, I'm a surgeon, but if I were requesting some information or detailed information as to what is going on -- and I usually do not handle the intraoperative management of Swan-Ganz, but again, if I were to get involved looking at some information generated out of Swan-Ganz readings, for example, in the intensive care unit, which is the usual setting, yes, I would understand or may have good in-depth knowledge as to the degree of physiological changes that are occurring in that particular patient.
Q. Now, who would you -- one other quick question.

Page 69

MR. A)o you want to take a break?
MR. JONES: I have to. It's obviously going to go longer than we thought. I need to make a personal call. But go ahead and finish this area if you want to.
MR. ALLEN: Last question in this area and then we can move on to .nother t
MR. ALLEN:
(Wl would you expect -- who would ' ou rely on to mon information on a Ganz intraoperatively?
A. Intraoperatively?
Q. M-hm.
A. It's usually the anesthesiologist.
MR. ALLEN: We can take a break.
MR. JONES: Let's just take a quick break. I do have to make a call.
(Thereupon, there was a brief recess.)
Q. Doctor, do you hold yourself as to having any expertise in the area of anesthesiology?
A. No.

Page 70

Q. So when it comes to issues of anesthesiology, you rely on the anesthesiologist to perform his duties properly?
A. Correct.
Q. Now, as far as a surgeon, before you go under the knife with somebody or cut on somebody that you've admitted to the hospital, I want to ask you a few questions about before the operation. You've admitted this patient to the hospital. Can you order any diagnostic study that you feel like you should order to evaluate the baseline health of that patient?
A. If there is a diagnostic test that I could or I do feel may help me out as far as my management of that particular surgical problem is.
Q. So if you feel that there's a diagnostic test that would help you in your knowledge to order, you would order it, correct?
A. Correct.
Q. Okay. If it was a diagnostic test that you felt was outside your field, you would then ask for a consult, correct?
A. Correct.
Q. And you would expect that consult to then perform the appropriate diagnostic tests in his or her consult area, correct?

Page 71

A. Correct.
Q. So when you get into the OR, you're the person that's in control of who is in the OR; is that correct?
MR. JONES: I'm going to object. What do you mean, he's in control of what particular individuals are in the OR, does he make that decision?
A. As far as the surgical team is concerned, but I have no control on, for example, the anesthesia group or the nursing staff that may have been assigned to that room.
Q. So you have control over the specialties that you feel you need to have with you, correct, but not the specialists themselves, correct?
A. Correct.
Q. These next questions are back before we get into the OR. You've admitted the patient. Tell me all the diagnostic tests that you feel comfortable ordering as it relates to the cardiovascular system in which you can order and you can read it before surgery.
MR. JONES: wait a minute. I'm going to object. We're talking about any class of patients what tests he can order relevant to the cardiovascular

Page 72

system, or are we talking about an admission of Dewey Jones? Is this just like a huge, broad category of any patient what can he order, what do his privileges provide that he can order?
THE WITNESS: I was going to ask for a clarification.
MR. JONES: wait a minute. I want a clarification before you try to answer it, Doctor.
THE WITNESS: I'm asking for a clarification, too.
MR. JONES: well, I've already asked for it, so let's just wait for it.
MR. ALLEN Do you want me to talk now?
MR. JONES: yes.
BY MR. ALLEN
Q. Doctor, what -- listen to the question -- what tests do you feel that you can run and evaluate cardiovascularwise to a patient you've admitted before you go into surgery?
MR. WALTERS: Objection.
MR. MEADOWS: objection.

Page 73

MR. CASEY: Objection.
MS. REINKER Objection.
MR. JONES: objection. Go ahead, Doctor, if you can answer that question.
A. Are we talking in general or anything specific?
Q. Whatever you feel you can comfortably order a diagnostic test and evaluate cardiovascular systems based upon that test, tell me which ones you're comfortable ordering.
MR. WALTERS: Objection.
MR. MEADOWS: objection
MS. REINKER: objection.
MR. JONES: objection.
A. I don't truly feel that there is a good number of tests that I feel comfortable ordering.
Q. That's fine.
A. I have the privilege of being surrounded by people of different expertise that can go ahead and order that.
Q. So as far as evaluating the cardiovascular system, if you felt it needed to be evaluated, you would call in a cardiologist, correct?
A. Correct.

Page 74

Q. As far as evaluating pulmonary systems, would you feel comfortable about ordering any diagnostic as as it relates c pulmon ry systems?
A. Not really. I would ask a pulmonologist to get involved in handling this kind of a case.
Q. And then you would proceed based upon the clearance and the judgment of a pulmonologist?
A. Correct.
MR. MEADOWS: objection.
BY MR. ALLEN:
Q. I'm sorry, did you say correct?
A. I would strongly consider the input from a pulmonologist that has been asked on consultation.
Q. And you would rely on his expertise in the area of pulmonology as to whether or not the pulmonary system of any given patient is healthy enough to proceed with your surgery, correct?
MR. MEADOWS: objection.
Q. Is that true?
A. Correct.
Q. Do you have any experience, Doctor, evaluating patients with hypertension?
A. Limited.
Q. Tell me about the limited experience you have in treating patients with hypertension.

Page 75

MR. JONES: Are we asking about treating patients for hypertension or treating patients surgically who happen to have hypertension? Which are we talking about? I want a clarification before he answers. He will not answer the question as it is posed to him at this time. I want a clarification.
MR. ALLEN: Good.
BY MR. ALLEN:
Q. Now, as far as your limited experience with patients that have hypertension, correct?
A. Correct.
Q. Are youwithme?
A. Yes.
Q. You tell me what area of limited experience you have with these patients. If it's in the realm of surgery, tell me about the realm of surgery; if it's in the realm of diagnostic, tell me about the realm of diagnostic. You understand my question, correct?
A. Yes. If we're handling a patient that is in the hospital with hypertension and a surgical problem that I have some involvement with, I usually defer anything that pertains to hypertension to

Page 76

somebody that I feel is competent enough in his or her period of expertise to handle that.
Q. And in a patient that you are the admitting primary care doctor, you feel competent to recognize what hypertension is, true?
A. Forgive me, rephrase the question.
Q. Do you feel competent to recognize what hypertension is in a patient?
A. Based on what a physician in general should understand about hypertension, and I think this is basic.
Q. Based on what you're presented with in front of you, you feel that you can tell whether the patient is hypertensive, correct?
A. Correct.
Q. How many patients have you operated on would you estimate that have severe hypertension?
A. I'm sorry, I cannot put a number on it.
Q. Is that often, is that a lot of patients?
A. It is often, yes.
Q. A lot of people have hypertension, right?
A. Especially in this country.
Q. A good many of patients have severe hypertension that you operate on?
A. Yes.

Page 77

Q. Now, before you operate on that patient you oversee what medication that patient is receiving, correct?
A. Usually in association with another consultant who has more in-depth knowledge about this condition.
Q. So you and a consult would be looking over the hypertensive medications administered to any given patient, correct?
A. Correct.
Q. Do you feel that the patient should stay on his medical therapy up to the day of surgery?
A. Correct.
Q. Why is that, Doctor?
A. It's imperative to maintain stability of the cardiovascular system for optimal postoperative results.
Q. And it's important to maintain that stability because patients with hypertension intraoperatively are at risk for precipitous falls of blood pressure, correct?
A. I should say fluctuation.
Q. Fluctuation?
A. Of blood pressure.
Q. That's true, correct?

Page 78

A. Correct.
Q. Those patients are also a higher risk for myocardial ischemia and cerebral ischemia intraoperatively, true?
A. To some extent, yes, but I don't have exact in-depth knowledge about that.
Q. Now, how many patients have you had the opportunity to operate on that have had congestive heart failure?
A. I should say many, but I cannot give you a number.
Q. It's something that you're familiar with, a patient presenting to you with congestive heart
a
A. To some extent.
Q. And you would -- would you automatically with a patient with congestive heart failure ask for a cardiology consult?
A. Yes.
Q. Pardonme?
A. Yes.
Q. Yes, you would. And why would you do that?
A. I believe that this kind of patient is at higher risk of getting into problems, whether it be

Page 79

intraoperative or postoperative, based on this condition.
Q. And you would want that consultant's judgment based upon the cardiovascular health of that patient, correct?
A. Correct.
Q. With that consultant available, do you feel that that would lessen the likelihood of mortality or morbidity for you, for your patient, having a consult available as opposed to just you handling the patient alone?
A. That is correct.
Q. Just in general though, you see the benefit and the reduction of the chance of death or morbidity in a patient with congestive heart failure for calling in a consult, correct?
A. Correct.
Q. Now, surgery in obese patients -- if I can just get your mind to think in that area, okay, Doctor. You have concerns when you face a patient that is obese for surgery, correct?
A. Correct.
Q. Would it be fair to say a consensus of surge. is have tl ose concerns, too?
A.

Page 80

Q. One of the concerns is pulmonary edema, correct?
A. I can't put it on top of the list. I think there may be other problems that may take priority on top of that.
Q. What would they be?
A. Inadequate breathing effort postoperatively that may precipitate atelectasis or lung collapse. The pain, especially abdominal surgical pain, that may diminish the effort of breathing and precipitate the retention of secretions, whether it be infected or just physiological secretions, can cause a higher chance of retention and subsequent pulmonary complications.
Q. Anything else that you can put on the list of concerns for an obese patient above pulmonary edema?
A. Are we talking about the pulmonary system alone or in general?
Q. In general.
A. No. There are a lot of complications or a lot of considerations that the surgeon has to understand that pertains to almost every system in that morbidly obese patient's body stemming from the efficiency of the cardiovascular system, the mobility of the patient that may enhance the development of

Page 81

blood clots or postoperative DVT, or deep venous thrombosis, in addition to the skin complications related to inactivity and pressure sores and hygienic issues related to that.
Q. And pulmonary embolism, DVT's, that's sometl ng that you're trying to guard aga st, correct?
A. Correct.
Q. Would that be something that you would order a test for yourself, or would you rely on a pulmonology expert to do that for you if he was consulted?
MR. MEADOWS: under what circumstances? Object to form.
A. Are we talking about the preoperatively, the perioperative period? There are some variations.
Q. Does it matter? Should I ask you in the different realms?
A. I think we need it a little bit more specifically.
Q. Okay. So if you have a pulmonology consult available to you, a pulmonologist that has consulted with you on a patient, would you rely on him to do the PT test. the PTT test. to evaluate --
A. I can tell you if --
MR. WALTERS: Are we talking

Page 82

about --
MR. MEADOWS: me-op,
post-op?
MR. WALTERS: -- hematology
tests now?
BY MR. ALLEN
Q. Do you unc : my question, I :t
MR. MEADOWS: show an
objection to form.
Q. Do you understand my question?
A. To some extent.
Q. Okay.
MR. JONES: I don't want
you answering a question to some extent
that you understand. Make sure you
understand his question, Doctor.
A. I need to ask you to clarify again. Are we talking about a patient that presents to me without the previous or preexisting DVT versus somebody that I anticipate that's going to develop DVT after surgery, and my approach to those patients is a little bit different.
Q. I n your concern. Maybe this will be a ple way and we can cut all this off. Is \ r or t development of DVT' is t something that

Page 83

you feel you should evaluate without a consultation from a pulmonologist?
A. DVT is usually a disease that we get struck with after surgery.
Q. Right.
A. Unfortunately books have been written on it and each surgical meeting that I attend has a topic that tackles DVT and the prevention of DVT. Dealing with DVT after the fact is something more of a standard or more well delineated, but having to prevent DVT and even instituting the prophylaxis for DVT is prone to failure even in some surgeons' hands who have in-depth or high level of suspicion or anticipation.
Q. Thank you, Doctor. I want to ask you, again, is that something that you feel as a general surgeon postoperatively to follow in a patient?
A. I'm sorry, I didn't get it right. Diagnosing or managing?
Q. Managing, diagnosing. You follow patients postoperatively, correct?
A. Correct.
Q. If you were concerned with a patient being at high risk for DVT's and this patient has already been consulted with a pulmonologist, is it a joint duty between you and the pulmonologist to look after that

Page 84

patient?
MR. CASEY objection.
MR. MEADOWS: objection.
MR. WALTERS: Objection.
MS. REINKER: objection. For
DVT?
A. To an extent.
Q. To an extent there's a joint duty between you and the pulmonologist?
A. Correct.
Q. Now, as far as pulmonary edema, my understanding of pulmonary edema is -- scratch that.
Is it true that pulmonary edema, when patients die of pulmonary edema it's like they drown in the fluid in their lungs, is that what happens?
MS. REINKER. Objection.
A. That's a simple explanation.
Q. Can you give me any simpler explanation than that?
A. I think in laymen's terms you've done it perfect.
Q. In medical terms what happens physiologywise to cause death due to pulmonary edema.
A. The air sacs and the air spaces which are oxygen are

Page 85

diffused through the capillary wall from the blood displacing air and oxygen away from those air sacs and air spaces ending up in inadequate amount of oxygenation of the blood coming out of the lung.
Q. A patient that presents with a history of myocardial infarction, that's a pre-op predictor of a patient at risk for cardiovascular complications during surgery, correct?
A. I'm sorry, previous myocardial infarction?
Q. Yes, a history of -- say within the last six months the patient presents with a history of myocardial infarction.
A. There has been some variation in the literature as to the time of myocardial infarction and the timing of surgery.
Q. Do you hold an opinion as to any timing that would increase the risk of intraoperative complications?
A. To the best of my recollection, based on the surgical literature that I've reviewed, the figure was six months.
Q. What about a patient that has a history of congestive heart failure, that patient is also at a risk of perioperatively in the operation room developing cardiovascular complications, correct?

Page 86

A. At a risk, yes.
Q. And there's an increased risk over a patient that doesn't have CHF, correct?
A. It is somewhat of a higher risk than somebody who does not have CHF.
Q. And a patient with a history of CHF also is at higher risk postoperatively of developing cardiovascular complications, correct?
A. We need to be a little bit more specific about that. If the patient was -- a patient with CHF who was well monitored and taken care of preoperatively and intraoperatively may not necessarily get into trouble in the postoperative period with CHF.
Q. What would you want to see preoperatively to monitor that patient With CHF to reduce the risk of cardiovascular complications postoperatively?
A. I think we're getting into a little bit more complex cardiac or cardiology information as to the degree of cardiac impairment that did precipitate that CHF and the extent of this cardiac impairment that will dictate the degree of CHF or how badly CHF may be and how it may inflict problems in the perioperative period.
Q. Do you feel a cardiologist would be better suited at talking about those risk factors,

Page 87

perioperative and intraoperative management of a patient with CHF?
A. Again, we have -- I think we're dealing with a wide or a spectrum of CHF which could be, on the one hand, very mild and, on the other extreme, severe enough to warrant closer care, I should say, or higher level of alertness.
Q. So in your history of reviewing literature and your general knowledge, can you tell me if there are studies out there that you've reviewed that you're familiar with that divide the risk factors for CHF and complications due to cardiovascular complications postoperative, preoperative, intraoperatively?
MR. JONES: Object to form.
A. I'm sorry, I cannot indulge on this.
Q. So you don't have any -- you can't point me to any literature or medical knowledge out there that divides the degree of CHF --
A. No, I can't.
Q. Let me just finish my question.
A. I'm sorry.
Q. -- divides the degree of CHF and the degree of the higher risk of complications, cardiac complications, you can't lead me to that?
A. I cannot pinpoint to a study that I'm

Page 88

aware of.
Q. Do you feel a cardiologist would be able to tell me that --
MR. JONES: objection.
BY MR. ALLEN
Q. -- more than you would be able to tell me that?
MR. JONES: objection.
Q. He would have more knowledge in that area than you?
MR. JONES. Objection.
A. Maybe even an internist or a family practitioner may give you a better in-depth than I am.
Q. Now, do you hold any opinion as to whether preoperative arterial blood gas values give any assurance as to the adequacy of pulmonary reserve for a patient during surgery?
A. I'm sorry, give me the question again.
Q. Do you hold any opinions as to whether preoperative ABG's, arterial blood gas values, gives any assurance of adequacy of pulmonary reserve during surgery?
A. I cannot use the word "assurance," but maybe some understanding or in-depth understanding better than the word "assurance."

Page 89

Q. So ABG's can give you some understanding of the pulmonary reserve of a patient intraoperatively, true?
A. True.
Q. In your knowledge, what are some predisposing factors of cardiac dysrhythmia postoperatively?
A. I think this is a little bit of an in-depth question. I could just -- based on my limited knowledge of that, it could be electrolyte imbalance, it could be instability of the cardiovascular system itself. Coagulopathy, again, outside the issue of the cardiovascular system itself, which may pertain to hematological disorders, can precipitate dysrhythmias or arythmias. Even temperature variations can predispose to that.
Q. And when you talk about cardiovascular instability, you're talking cardiac disease within that, correct?
A. Correct. But there are diseases of the blood vessels or the stability of the blood vessels themselves maintaining the pressure at the particular time that can precipitate that.
Q. Including hypertension?
A. Correct.

Page 90

Q. Can you as a general surgeon give me some -- let me just ask you to save some time. Do you agree with the next statement or two, just true or false, and I'll ask you. The following risk factors are for increased -- the following are risk factors for increased morbidity due to respiratory problems intraoperatively. Okay, these are the following risk factors.

Do you believe the site of the surgery has any correlations to that as being an increased risk for respiratory morbidity?

MS. REINKER: Excuse me, I couldn't hear the last part of your question.

MR. ALLEN what part did you not hear?

MR. WALTERS: Read it back.

(Thereupon, the question was read back.)

MR. ALLEN: Let me rephrase that question if it's okay with everybody.

BY MR. ALLEN:

Q. Does the site of the surgery increase the risk --

A. The site or the size?

Q. The site, the area of the site.

Page 91

Does the site of the surgery increase the **risk** intraoperatively or postoperatively for respiratory morbidity?

A. With abdominal surgery, yes. Upper abdominal surgeries have higher chance of complications or respiratory complications versus lower abdominal surgeries.

Q. And what about the length of the surgery, does that have -- does that increase the risk factor for respiratory complications?

A. I'm not quite aware of a study that I have come across that tells me if a procedure that's taking two hours versus three hours may definitely bring out a higher percentage of complications.

Q. What about age, would age be a factor that would increase the possibility of respiratory complications?

A. Age, per se, may not. It's more of the co-morbid factors.

Q. Such as obesity, that would increase risk factor of respiratory complications, correct?

A. Correct.

Q. What about the presence of a patient that's suffering from dyspnea, would that increase the complications, respiratory complications, risk of

Page 92

respiratory complications?

A. Dyspnea, per se, is a difficult thing to point down. And again, are we talking about dyspnea that is related to maybe a cardiovascular disease versus an endogenous pulmonary disease?

Q. Take it pulmonary disease. The fact that they have a pulmonary disease that would cause dyspnea, that would increase the risk factors?

A. To some extent.

Q. What about cardiac? If the underlying cause was cardiac disease that caused the dyspnea, would that change the risk factors for respiratory complications due to surgery?

A. Again, dyspnea is a symptom. It's more related to the kind of underlying cardiovascular disease that would dictate the chance of complication.

Q. So the patient with that dyspnea, that symptom, is there -- a patient with dyspnea, the symptom of dyspnea, is that an indicator at all that there could be cardiac or could be -- scratch that -- respiratory complications due to surgery?

A. I'm sorry, repeat the question again.

Q. We'll read it again.

MR. ALLEN change the tape, go ahead and change the tape.

Page 93

(Thereupon, there was a brief recess.)

BY MR. ALLEN:

Q. I'll try that question again, Doctor.

Just the presence of dyspnea, would that increase, cause you to believe that the patient would be at an increased risk for respiratory complications due to surgery?

A. Yes.

Q. Now, the risk of respiratory complications increase after an upper abdominal surgery, correct?

A. Correct.

Q. That's due to the splitting incisions in the upper part of the --

A. It's the diminished respiratory or inspiratory effort secondary to the pain that gets generated from the abdominal, upper abdominal incision.

Q. So it's the pain that the patient goes through trying to breathe that causes the complication?

A. That causes them to decrease their inspiratory effort and the complications that might follow whatever comes out of the decreased inspiratory effort.

Q. They can inspire in less capacity due to the pain?

A. Correct.

Page 94

Q. So when they're breathing in less volume you, thus, have complications --
A. Correct.
Q. -- flowing from that? That's why when you have an obese patient you try a transverse incision?
A. Not necessarily.
Q. Tell me why not.
A. There has been no study that I'm aware of that tells me that a transverse incision in an upper abdominal operation versus an up and down or longitudinal incision can dramatically or significantly change the outcome.
Q. Do you hold any habit or opinion as to which way you should cut on an obese patient?
A. It depends on the kind of surgery that I usually am doing and the organ that I'm tackling during that operative procedure.
Q. So if it's an upper abdominal procedure it would depend upon what organ you're going after?
A. Correct.
Q. So just in gallbladder surgery, laparotomy, would you more likely do a transverse incision?
A. In a gallbladder it's more likely a transverse or an oblique incision. But it is well

Page 95

known that one of the approaches for a gallbladder could be an up and down incision, too, or a longitudinal incision. There are some factors that the surgeon has to understand or factor in to make that or decision.
Q. Based upon the patient in front of him?
A. Based on the patient's habitus and maybe, more specifically, the degree of the subxiphoid angle and the amount of rib spread, I should say, or the rib cage. The lower ribs confluence creating a narrow or a wide subxiphoid angle.
Q. Does anything else come into play?
A. Sometimes some surgeon may resort to a different incision based on their judgment that they may do it faster and get in and out in an emergency trying to cut down on the operative time.
Q. What are the symptoms of biliary colic -- excuse me, scratch that.
Biliary colic is caused by intermittent obstruction of the cystic duct by gallstones; is that a true statement?
A. Correct.
Q. Episodes of biliary colic would include upper gastric and right upper quadrant pain; is that a correct statement?

Page 96

A. Upper abdominal epigastric pain, not necessarily right. It can occur on the left side, too.
Q. It can occur on the left side.
Is it more likely to occur in the right upper quadrant?
A. More likely.
Q. And it's more likely that that pain would radiate to the back?
A. More likely.
Q. Okay. That patient would also present on physical exam more likely with fever?
A. Not necessarily.
Q. What percentage of patients that you diagnose -- scratch that.
Do you diagnose patients with biliary colic?
A. Yes.
Q. What percentage of patients do you think that you diagnose with biliary colic that present without fever?
A. Well, if fever ensues we're beyond the stage of biliary colic. It is a more advanced and, I should say, slightly longer occurring process of obstruction that precipitated the infection versus the intermittent, short lasting biliary colic.

Page 97

Q. Now, you wouldn't expect to see the WBC elevated in biliary colic, would you?
A. It may occur.
Q. But you wouldn't expect with biliary colic for biliary colic to cause the WBC to increase?
A. It can happen.
Q. It [illegible]
A. Yes.
Q. But not very often?
A. very was short lasting.
Q. Short lasting, are we talking symptoms of one to four hours?
A. Yes, to some extent.
Q. And you would expect to see nausea in a patient with biliary colic?
A. Yes, in a good percentage of those patients.
Q. And you'd expect to see vomiting in a patient with biliary colic?
A. Yes, but a slightly lower percentage than nausea.
Q. All right. Now, acute cholecystitis is very similar to biliary colic, correct; is that true?
A. I can't say similar. I think it's a

Page 98

different ballpark, if you may.
Q. What makes acute cholecystitis a different ballpark?
A. It's persistent obstruction of the cystic duct precipitating retention of bile, and subsequent infection ensues in that bile stagnant or trapped in that gallbladder.
Q. You would expect to see a patient with acute cholecystitis present with a low-grade fever, true?
A. In the early stages.
Q. You'd expect to see that patient with acute cholecystitis present with chills, true?
A. If the obstruction has been ongoing for some time good enough to have precipitated infection that was invasive enough to have spread to the bloodstream.
Q. And you would expect to see a patient with acute cholecystitis present with leukocytosis?
A. Yes.
Q. A mild elevation in bilirubin would be another symptom of acute cholecystitis?
A. It will be a finding.
Q. Finding, pulmonary finding, correct?
A. Correct.

Page 99

Q [illegible] levels would you expect that?
A. To some extent. Not the high percentage if we're dealing with acute cholecystitis, per se.
Q. But the history of acute cholecystitis, it usually starts off with biliary colic and then progressively gets worse; is that a true statement?
A. Correct.
Q. And the pain is more generalized with acute cholecystitis than that with biliary colic; is that true?
A. Generalized as generalized abdominal pain?
Q. Right.
A. It's possible.
Q. So you'd expect to see three things with an acute cholecystitis. One would be the sudden onset of right upper quadrant tenderness, two would be fever, and three would be leukocytosis; is that true?
A. Forgive me, I'm not trying to play smart, but right upper abdominal pain. Tenderness is a finding, is a sign.
Q. Okay. So you'd expect to see right upper quadrant pain?
A. Pain.
Q. Not tenderness?

Page 100

A. Tenderness is a finding on exam.
Q. So on exam you'd expect to see tenderness in the patient?
A. Find tenderness, correct.
Q. But then the fever, you'd expect fever and leukocytosis?
A. Correct. But it's not a hundred percent finding, or the three findings are not present in 100 percent of cases of cholecystitis or even early cholecystitis I should say.
Q. Sure. But wouldn't you agree that the general literature states that's a triad for diagnosing acute cholecystitis?
A. I can't say a triad, but it's a common finding.
Q. Those three things are a common finding in acute cholecystitis?
A. Correct.
Q. Now, I think you said this, but cholecystitis occurs when stones become lodged in the cystic duct and then block the flow of bile and that causes inflammation of the gallbladder; is that true?
A. Correct.
Q. And basically cholelithiasis is just the finding of gallstones in the gallbladder?

Page 101

A. Correct.
Q. What is your definition of fever? Give it to me in Celsius and Fahrenheit. What would you say a fever would start, at what degree?
A. I can say there is something that I can call low-grade fever and there's high-grade fever. The low-grade fever is something -- Celsius I'm more aware of -- something that goes above 37.5.
Q. And Fahrenheit, what is that?
A. Forgive me. Maybe I should say above a hundred or 99.8, if you may. I'm not exact about that.
Q. 99.8, 100 would be a low-grade fever?
A. Yes.
Q. And then a high-grade fever in Celsius?
A. I consider that anything above 38.5, 38.4.
Q. Which would be what, 101?
A. Forgive me, I'm not -- maybe around 101, even higher.
Q. In obesity you would consider a patient obese with greater than 20 percent of their ideal body weight?
A. To a good extent.
Q. That's a true statement in your opinion?
A. That is true.
Q. And morbidly obese you would classify as

Page 102

somebody with twice the body weight --
A. 200 percent.
Q. 200 percent, twice?
A. Yes.
Q. And dyspnea -- we talked about it earlier -- that's just shortness of breath?
A. Correct.
Q. And gallbladder surgery, that's an upper abdominal surgery, correct?
A. Correct.
Q. Now, obesity, that can cause reduced oxygenation in a patient, can it not?
A. Depending on the degree of obesity.
Q. And depending on the degree of obesity, it could cause pulmonary hypoxemia, true?
A. Correct.
Q. It could cause that, correct?
A. Yes.
Q. All right. Now, as far as cholecystitis, would you agree that -- scratch that.
Free perforation of gallbladder is rare in cholecystitis, true?
MR. WALTERS: I'm sorry, I didn't understand that. Free --
MR. JONES: Perforation.

Page 103

MR. ALLEN: Free perforation of gallbladder.
A. It is a known complication, but it is infrequent. It's a late stage of ongoing cholecystitis.
Q. Now, spreading peritonitis is a rare complication of cholecystitis, true?
A. Correct.
Q. Emergency laparotomies are rarely performed for cholecystitis, true?
A. Emergency surgery for cholecystitis, if you may. I cannot say rarely, but it is not -- again, I should say you have to individualize.
Q. When was the last time you performed an emergency laparotomy for a cholecystitis?
A. Two weeks ago.
Q. When was the last time you did it before that?
A. Before what?
Q. Before two weeks ago when was the last time?
A. I can't remember that.
Q. Was it in the last year?
A. Less than that.
Q. Does it happen two or three times a year?

Page 104

A. It's possible.
Q. To you?
A. Yes.
Q. Two or three times?
A. Yes.
Q. More than that?
A. No.
Q. So that's pretty rare for your practice as far as gallbladder surgery, true?
A. Thanks to the care and advancement in medical practice.
Q. But that's a true statement about your practice?
A. Correct.
Q. Is there, in your opinion, a medical controversy regarding the need to get rid of gallstones?
MR. WALTERS: object to the form. I don't understand "controversy."
A. There are a lot of people or a certain percentage of people that can go to the grave without knowing that they have gallstones. On the other hand, once a person is struck with a disease process related to the gallstones, whether it be cholecystitis or common bile duct stone or gallstone pancreatitis, the

Page 105

chances are that they are going to get into trouble again and again.
Q. Do you form any opinion as to whether there's controversy in the medical literature or medical knowledge, general knowledge throughout this country, as to the need to get rid of gallstones?
MR. JONES: I'm going to object. Under what circumstances? He's just explained there are different circumstances. You've just asked the question, he gave you more than you needed for your response. I mean, are we talking about symptomatic patients, not symptomatic patients?
A. I could rephrase my answer in saying that, yes, there is controversy in those people who have cholelithiasis or gallstones without having had symptoms at all, but I think there is less of controversy in those who have gotten into some kind of a problem or have become symptomatic related to their gallstones.
Q. So once a patient becomes symptomatic with gallstones, there's not much controversy as to the need to remove the gallbladder?
A. Correct.

Page 106

Q. Patients with diabetes mellitus, are they more susceptible to septic complications during surgery?
A. That's absolutely correct.
Q. And then talking about cholelithiasis, gallstones, diabetes, patients that are diabetic are at greater risk for forming complications of cholelithiasis, correct? Not cholecystitis, just cholelithiasis.
A. I'm sorry. Rephrase it again to me.
Q. Sure, be happy to, Doctor. Patients that are diabetics that have cholelithiasis, they're at greater risk for complications due to the cholelithiasis, true?
A. Correct.
Q. And that's because of their cardial, pulmonary and renal status?
A. But mainly because of the diabetes process itself, which doctors say is related to in itself to a lower immune or suboptimal immune response, per se.
Q. Per se. And that usually manifests itself in cardiovascular and reduced renal status?
A. Correct.
Q. Obesity, that's a risk factor for developing cholelithiasis, true?

Page 107

A. To some extent. I cannot give you figures.
Q. And on the flip side, patients with very low calorie, rapid weight loss diets or prolonged fastings, they're also at risk for developing cholelithiasis, true?
A. I'm not aware of an exact specific study about that, but I could tell you, with patients that I handled with surgery for morbid obesity, yes, they have been at a higher risk of developing gallstones following rapid weight loss.
Q. But wouldn't you agree that it's not really clear that there's a proven correlation between diet and development of gallstones, formation of gallstones?
A. There is some correlation between the kind of diet consumed plus-minus other factors that may precipitate to gallstone formation.
Q. So it's diet plus other factors?
A. Plus-minus.
Q. What are some of the plus factors that would increase the risk of gallstone formation along with diet?
A. Hypercholesterolemia is one example; some other diseases related to the gastrointestinal tract, for example, diseases of the ilium; some medications that the patient may consume or some diet that may be high in content of some elements that may precipitate higher stone formation.

Page 108

Q. High cholesterol?
A. Cholesterol plus other factors that I cannot recall at this point in time.
Q. Is it a true statement that women between 20 and 60 are twice as more likely to develop gallstones than men?
MR. JONES: okay, now, we've been real patient. It's now quarter to 7:00 and it's been two and a half at least or more than two and a half hours, two and a half hours. You're now asking questions about women being at increased risk for gallbladder disease, Could we possibly, so that I can take care of obligations other than this, get to relevant questions? I would appreciate it. I'm sure the doctor would. I think everybody else would.
MR. WALTERS: I would.
MS. REINKER: Agreed.
MR. JONES: This deposition

Page 109

will not go all night. I will call an end to it and I'm telling you I'll do it. I don't care if you're from Georgia or not. This is not going to go the rest of the evening. This is not a marathon. 1want relevant questions and we'll go. We've been real patient with a lot of irrelevancies. So my lecture is over.
MR. ALLEN: Thank you.
MR. JONES: Now, he's got a question about women developing gallstones.
BY MR. ALLEN:
Q. Can you answer that question, risk factors?
A. I can say higher, but I cannot say twice as much.
Q. Let's talk about oral dissolution therapy. That was a possibility for Dewey, was it not?
A. I am aware of this approach of handling gallstones. It has not been successful. The published results in this country are not encouraging.
Q. It's possible you could attempt that with Dewey Jones, true?
THE WITNESS: Counsel?

Page 110

MR. JONES: Is it within the realm of human possibility to have treated Dewey Jones with oral dissolution therapy?

A. Yes.

Q. There was nothing in Dewey to indicate that he was not a candidate for oral dissolution therapy, true?

A. I cannot say at this point that he is not or is a candidate. There are other factors that we have to factor in before I could tell you he is or is not a candidate.

Q. You took care of him, did you not, Doctor?

A. I did.

Q. You still don't ***think*** you have relevant knowledge as to answer that question?

MR. JONES: He's answered in relevant knowledge. He doesn't feel that the published reports regarding oral dissolution therapy have shown that it is successful.

MR. ALLEN: Is that what he said, or is that what you're testifying to? I didn't hear that out of his mouth, but I could have misheard him.

Page 111

MR. JONES: If I misstated it, I apologize.

MR. WALTERS: It certainly was close to that.

MR. ALLEN was it close to that?

MS. REINKER: That's what I heard.

BY MR. ALLEN:

Q. Could you repeat your answer, Doctor? Maybe I misheard it. If I misspoke, I apologize.

A. Based on my knowledge of oral dissolution of gallstones and the published results in this country, I feel that the published success results are not good.

Q. And as far as Dewey being a candidate for that, it's not the factor of your knowledge of Dewey, but it's the knowledge of the oral dissolution therapy that gives you reservation as to say whether he's a candidate or not; is that true?

A. Correct.

Q. Would the same hold true for electroshock wave ESWL therapy, or do you have more knowledge in that area?

A. more

Page 112

rates are very high. The experience in the whole United States is very limited, especially for gallstones, and the specificity of Mr. Jones' disease having multiple small stones versus the published inclusion criteria for patients to undergo shock wave lithotripsy conflicts itself.

Q. So I [illegible] you [illegible] mmend th t Dewey was a candidate to do that ESWL?

A. I would not recommend it.

Q. Would you recommend him as a candidate for endoscopy sphincterotomy?

A. He is not a candidate simply because he does not fall into the criteria of whether he would be considered for endoscopic sphincterotomy because we are dealing with a gallbladder disease more than, quote/unquote, obstruction of the common bile duct to an extent that will necessitate endoscopic sphincterotomy.

Q. So the fact that we're dealing with a disease versus an obstruction?

A. Correct.

Q. And laparoscopy, you recommended Dewey for a laparoscopy or attempted laparoscopy, correct?

A. Correct. But that is a minor variation. We're talking about how the gallbladder is extracted

Page 113

versus whether or not to remove the gallbladder.

Q. Let me just change so I give you a good transition there.

You recommended Dewey as a possible candidate for laparoscopy surgery, true?

A. Correct.

Q. Why did that attempted surgery fail?

A. I had to consider other factors, which included the operative time, the practicality of this procedure in a heavyset patient, and the presence of technical issues related to the area or the anatomical area around the gallbladder and the gallbladder itself for the degree of inflammation that may be factored in as to what the surgeon may elect to do.

Q. So you elected not to do the laparoscopy on Dewey Jones when you were in the OR; is that true?

A. No, even before we got started. I discussed the issue again with the patient and did discuss it with the anesthesia personnel there and reconsidered the issue of the operative time with the patient's body habitus and the feasibility of this procedure in somebody like him and the outcome versus the open procedure.

Q. You discussed th [illegible] i the anesthesiologist and you discussed this [illegible] itl Dewey

Page 114

Was everybody present; is that true?
A. I cannot recall who was present, but I always discuss the fact that there could be a good chance of the open procedure, whether it be at the time of the laparoscopic procedure or even before that. I did consider laparoscopic surgery with Mr. Jones prior to the day of surgery simply for the feasibility and factoring the issue that we may be able to get Mr. Jones out of the acute phase, maybe into the less acute phase, into a more optimal situation before I could safely and comfortably tell Mr. Jones that this is the right, most practical procedure for you.
Q. You discussed with Dewey and you decided to do the laparotomy, that decision was made the day of surgery?
A. Correct.
Q. And you just said you discussed it with the anesthesiologist. Did you discuss it with anybody other than Dewey, you know, another doctor besides an anesthesiologist?
A. No.
Q. What was the anesthesiologist's name that you discussed it with? Adamek?
A. I cannot remember.

Page 115

I tell you, anesthesiologists always favor open procedures because it's less of an operative time and less chance of pulmonary complications with insufflation of the abdomen by gas.
Q. Iunderstand.
Now, you didn't discuss with the anesthesiologist different methods in the initiation of anesthesia before you operated on Dewey?
A. No.
Q. We're moving right along. It may look like a lot, but it's not.
MR. WALTERS: could you keep your voice up a little?
MR. JONES: I think you talked a lot, the two of you. Your voices are getting lower and lower and lower, and we've had trains going by and stuff.
BY MR. ALLEN
Q. When you're in the OR, you're the captain of the ship of the OR, true?
MR. JONES: objection.
MS. REINKER: Objection.
A. As far as the --
MS. WINKER: My objection is based on your, perhaps, lack of knowledge

Page 116

of Ohio law. Ohio law does not recognize and never has a captain of the ship doctrine in the operating suite.
MR. ALLEN Thank you.
BY MR. ALLEN
Q. What would you categorize -- would you categorize yourself as the captain of the ship?
MS. REINKER: I'm sorry, I didn't hear the question, please. Could you read --
MR. ALLEN I asked the same question, but I thought we waived all formalities and were objecting to the question at the time of use early on. Can I not ask that question?
MS. REINKER: well, I couldn't hear the question this time around.
MR. MEADOWS: I don't know if I agreed to that waiver of formalities. That's not what I understood any waiver up front to include. I'm objecting to not only form, but basis, as well, and reserving other obiections at the same time.
MR ALLEN: Oka

Page 117

MS. REINKER: And , I don't ll the doctor ɔı b: wering questions that relate to the legal issues He does not have ge of the law in Ohio.
MR. JONES: If the doctor uses that term, I mean, if that's what you're asking him, Doctor, do you say that you are the captain of the ship. If you use that term, Doctor, tell him. If you don't use that term, tell him you don't use that term.
A. I don't consider myself the captain of the ship as far as the OR environment. I may be the limited captain in the sense that I do make the final judgment as to my part of the operative procedure, but I do not have control on other personnel or specialists or other physicians in the operating room.
Q. So you just part of the , you' e part of a team?
A. My surgical team?
Q. Right.
A. Correct.
Q. Dewey was a non-smoker, true?
A. I cannot recall.

Page 118

Q. According to your review of the records, did you see where Dewey Jones was a smoker?
MR. JONES: we'll stipulate that the record says he was not a smoker. Whether, in fact, he was a smoker or not, God only knows, or maybe his brother or somebody knows and we'll find that out when we depose them.
BY MR. ALLEN:
Q. To your knowledge, Doctor, in your review of the records, was Dewey Jones a non-smoker?
A. If the record says he's non-smoker, he's non-smoker.
Q. He was also a non-drinker, true?
MS. REINKER: Objection.
A. If the records states such. But again, non-drinker in that period of time of our encounter or as a period of time before we even knew him?
Q. According to the records and your knowledge of Dewey, your histories that you took of Dewey, your conversations with Dewey, Dewey was, in your knowledge, a non drinker, true?
A. At that point in time. I am not aware of or cannot recall, I should say, of a possibility of previous history of alcohol consumption to a variable

Page 119

degree.
Q. Let me rephrase the next question. There's no evidence to indicate that there was a history of drug abuse for Dewey Jones, true?
A. Based on my recollection reviewing the chart, I could not find any evidence of that.
Q. There's no evidence in his history that he gave you or the records that you reviewed or your knowledge that he had a history of diabetes mellitus, true?
A. Forgive me, I cannot remember.
Q. But you would rely on the records for the accuracy of that statement?
A. Correct.
Q. When Dewey presented to you -- and you're welcome to go to any part of the record that you want to, Doctor. It's not a memory test.
When Dewey presented to you, his serum cholesterol levels were normal, true?
A. I'll have to look at the records.
MR. ALLEN I'll tell you what, I'm just going to circle that for saving some time, and if I feel I need to come back to it, we will. How's that; is that a good compromise?

Page 120

MR. JONES: Fine with me.
BY MR. ALLEN
Q. Now, Dewey presented to you in your history, according to the past records and your knowledge, he was -- you would have to categorize him as a noncompliant patient as it relates to his medication, true?
MR. WALTERS: I'm *sorry*, and I apologize. Categorize him as a noncompliant patient?
MR. ALLEN. M-hm.
A. I don't think I could pass this judgment myself. I have not had that kind of long interaction with him, and I have to rely on the records of other physicians that were involved.
Q. Doctor, are you aware of Dewey's mental health evaluations? He had two previous psychologic evaluations and hospitalizations.
A. Mental health?
Q. M-hm. Were you aware of that?
A. I cannot recall that.
Q. Do you recall him giving a history of having prior, having gunshot, being shot, multiple gunshots?
A. Yes, there was such a history.

Page 121

Q. Whether or not you had knowledge of Dewey's previous psychological evaluations, that wouldn't have made any difference in the medical care that you gave to Dewey, true?
A. No, sir.
Q. When were you aware of the fact that he had a history of hypertrophic cardiomyopathy? Was it before surgery?
A. Before surgery.
MR. CASEY Before we get off the psychological stuff, I'm going to want to know when those admissions occurred and where they occurred. I don't ***think*** we know that yet.
MR. ALLEN Okay, sure. Whatever that procedure is.
MR. CASEY: Just let me know.
MR. ALLEN: If that's procedure, we can sit down right now and we can give them to you. I'm *sorry*.
BY MR. ALLEN:
Q. You were aware of hypertrophic cardiomyopathy?
A. Preoperatively, correct.

Page 122

Q. What about his history of hypertension, you were aware of that before surgery, true?
A. Correct.
Q. His history of congestive heart failure dating back to like 1987, were you aware of that before surgery?
A. I'm aware of congestive heart failure; I cannot specify timing.
Q. The time that he presented with a history of it. But you're aware that he had CHF before you operated on him, or a history?
A. Correct.
Q. And that in Dewey's case was hand in hand with his obesity, his congestive heart failure was due to his obesity; is that true?
MR. MEADOWS: what was that?
I'm having a hard time hearing you.
MR. ALLEN I'm trying.
I'm sucking on a --
MR. MEADOWS: If you could, repeat it.
A. Rephrase the question again, please. I didn't pick up all parts of it.
(Thereupon, the question was read back.)
MR. MEADOWS: Objection to form.
A. I was aware that the patient had congestive heart failure and he was morbidly obese.
Q. But you never put the correlations together in your medical opinion?
A. There is some correlations, yes.
Q. There is correlations in general.
So more than likely the correlation between the congestive heart failure and Dewey's obesity --
A. May be related.
Q. When were you aware that Dewey had a history of sleep apnea?
A. During that admission.
Q. Before the surgery?
A. Correct.
Q. Were you aware that he had a history of TIA before surgery?
A. No.
Q. Were you aware in 1993 presentations to hospitals for history of chest pains.
A. I'm aware that he had consulted medical people for some other problems, but I'm not aware if it was specifically chest pain.
Q. You're you aware he had consulted for

Page 123

Page 124

cardiology problems, correct; is that what you're saying?
A. Cardiac problems?
Q. Yes.
A. Correct.
Q. Were you aware before the surgery that he had a history of multiple chest x-rays that showed cardiomegalia?
A. I'm aware of that.
Q. And you were aware of that before the surgery, true?
A. True.
Q. And you were aware that he had EKG's that were abnormal before surgery, true? You're aware that he had a history of EKG's that were abnormal before you operated on him, true?
A. I cannot recall what the EKG was or the report on the EKG. I'll have to refer to the chart.
Q. Excuse me?
A. I'll have to refer to the chart.
Q. Can you do that for me right now?
MR. CASEY while you're looking, Doctor, I might as well put this on the record, too. As I recall the answers to interrogatories in this case,

Page 125

I'm not sure that there was a cardiologist identified. If this man had been to a cardiologist prior to 10-18 of '94, I want to know it and I want to know who it is and when. We don't know who his treater was.
A. In reference to your question, there is a copy of the EKG on October 17th done at 1449. The report states, sinus rhythm, intraventricular conduction delay, poor airway progression, diffuse, nonspecific ST and T abnormality. Since 9-18-94 the ST and T abnormality is less.
Q. What you're reading there, Doctor, is an abnormal EKG, true?
A. True.
Q. You're aware of his history of taking treatments of multiple drugs for his hypertension before surgery, true?
A. Correct.
Q. Were you aware of his history of noncompliance as it relates to those hypertensive drugs before surgery?
A. I'm not aware of the issue of noncompliance.
Q. That doesn't play one way or the other

Page 126

into the care and treatment that you gave to Dewey in that hospitalization of October 17th, does it?
A. As far as I'm concerned?
Q. Yes.
A. No.
Q. Before you operated on Dewey -- I'm sorry, if you need to answer that.
A. I don't.
Q. Before the operation of Dewey, were you aware of the 6-24 of 94 echocardiogram report?
A. 6-24-94?
Q. M-hm.
A. I'm not aware of that.
Q. Before you operated on him were you aware that he was hospitalized in August of 1994 at Meridia Huron for congestive heart failure?
A. I am aware that he was hospitalized before for issues related to his cardiovascular system. I cannot recall what details I was aware of.
MR. CASEY: Same request for the 6-24 of '94 echo report. I'd like to know where and when that had occurred.
BY MR. ALLEN:
Q. Now, Doctor, you were aware going into this surgery that Dewey Jones was a poor surgical

Page 127

candidate, true?
MR. WALTERS: could you read -- I'm sorry, could you repeat the question, please?
Q. You were aware that Dewey Jones was a poor surgical candidate going into this surgery --
MR. MEADOWS: objection to form.
Q. -- that you performed, true?
A. I can say that he was at a higher risk of getting into problems than somebody else.
Q. And he was at a higher risk for getting into problems such as cardiopulmonary complications, true?
A. Correct.
Q. When he presented on 10-17-94, he presented to the ER via EMT With a history of one day of abdominal pain. You were aware of that, true? You can look at the record --
A. Correct.
Q. -- the ER record if you want to.
A. A day or two. I'm not very specific about that.
Q. You were aware of the fact that he presented with a history of nausea and headache?

Page 128

A. I'm aware of a history of nausea; I cannot be sure of headache.
Q. You performed your initial examination of Dewey Jones on what date, Dr. Badri, 10-17.
A. 10-18.
Q. On your initial examination of Dewey would you categorize him as having severe hypertension?
A. I cannot recall that I labeled him as such.
Q. Would you refer to your chart of your physical, history and physical examination that you first performed?
MR. JONES: The 18th you said?
A. I cannot recall that we had to label him as severe hypertension.
Q. Pardon me? I didn't catch it.
A. I cannot recall that we had to label him as, quote/unquote, severe hypertension, but he was hypertension.
Q. Would you label him as severe hypertensive?
A. Again, I'll have to look at more details of the chart, but, yes, he was hypertensive. I cannot say it was severe, no.

Page 129

Q. What other details of the chart would you have to look at to tell me whether or not he was hypertensive?
A. I would have to look at more frequent record of his vital signs or blood pressure reading. On the 17th I see a record at 2000 hours of a blood pressure of 182 over 98.
Q. Would that be severe hypertension?
A. No. The 2400 hours of 180 over 100. On 10-18 there is 168 over 90, and at 1600 hours of 10-18 it was 158 over 88. On --
Q. I'll just stop you right there. At that point, at any point along the line there would you categorize him as severe hypertension, as having severe hypertension?
A. No.
Q. Now, when he presented to you, it's true he weighed 308 pounds?
A. If that's what the record states.
Q. That's what the record states.
If he weighs 308 pounds, would you categorize him as morbidly obese?
A. Yes.
Q. And he had right upper quadrant abdominal tenderness on initial examination, true?

Page 130

A. Correct.
Q. Did you note an enlargement of his liver?
A. No.
Q. Did you note that he had pitting edema of the legs on your initial --
A. He did have a mild degree of pitting edema.
Q. His initial WBC was normal, was it not, Doctor?
A. If that's what the record states.
Q. If it's 5.7 on the initial WBC, that is normal, true?
A. Was there a differential count for that?
MR. JONES: It's probably in this second volume.
we a white count of 5.7 and a differential count which was normal.
Q. Okay. So it was normal? Wa t WBC normal?
A. Correct.
Q. The initial serum bilirubin was slightly elevated at 2.1, true?
A. Correct.
Q. Based upon those symptoms, that's

Page 131

consistent with cholelithiasis, true?
A. Correct.
Q. And it's consistent with biliary colic, true?
A. Correct.
Q. The echo -- an echo was performed and that's when -- that's when I believe Dr. Ho found the stones. Did you order the echo or did Dr. Ho?
A. It was ordered in the emergency room.
Q. Okay, it was ordered in the emergency room.
What day did you schedule the cholecystectomy?
A. Initially I had no intention of operating on Mr. Jones.
Q. On your initial examination of 10-18?
A. Again, my goal, and it's not just with Mr. Jones, but to avoid operating on acute cases, and I try to get them over the acute phase in the hope of getting into lesser operative complications and less chance of postoperative complications that are related to the acute phase.
Q. That's what you did in Dewey's case? Is that what you did in Dewey's case?
A. Well, with Mr. Jones' case I elected to or

Page 132

I had the plan upon admission to get him over the acute phase and not to operate during this hospital admission.
Q. And tell me what the acute phase of Dewey's presentation was.
A. It was abdominal pain with nausea and vomiting with the presence of gallstones in there, which may add up to beginning of biliary colic, plus a history of previous attacks, which may put him at a ballpark of being labeled as chronic cholecystitis, and between those two ballparks there is the park of acute cholecystitis, which I was fearful of.
Q. So you're in several different ballparks at this point and you're not definite which one it is, true?
cholecystitis who has or who came to me with biliary colic. I was not sure if we were dealing with acute cholecystitis at that point in time.
Q. When were you sure that you had acute cholecystitis?
A. I was more concerned about the elevation of his liver function tests, i.e., his serum bilirubin and the alkaline phosphatase, which increased my level of anxiety as to whether I'm going to be able to get

Page 133

Mr. Dewey over this, quote/unquote, acute phase.
Q. But can you tell me the point in time when you knew for sure that you had acute cholecystitis before surgery?
MS. REINKER: Objection.
A. I was dealing with a closed abdomen and I was handling abnormal liver function values that would indicate some advanced degree of biliary obstruction. And it's not based on one single value, but it's the further elevation from 117 to 118 that raised my anxiety level.
Q. I understand completely what you said, Doctor, but I just want to know, did you ever in your mind before you operated on Dewey Jones classify him as either acute cholecystitis, chronic cholecystitis, cholelithiasis? Did you have a certain --
A. I would classify him as subacute.
Q. Subacute?
A. Cholecystitis.
Q. You came up with that before you operated on him, correct?
A. I was not certain about that because I was worried about some degree of biliary obstruction that I had to explain to myself with the progressive elevation of serum bilirubin and alkaline phosphatase.

Page 134

Q. Now, the accelerated bilirubin and the alkaline phosphorus in his case, at what degree would you state -- the serum bilirubin was 2.1 on admission. Did it continue to go up?
A. Yes.
Q. What was the highest point that it was?
A. 3.2.
Q. And was it when it reached 3.2 that you decided to perform a cholecystectomy on Mr. Jones?
A. It was based on additional doctors of the absence of the sense of well being. Mr. Jones to me he did not feel better, and when we even tried to offer him some liquids he had ongoing nausea and he could not tolerate that.
Q. So we had the ongoing nausea and complaints by you of being uncomfortable, plus the bilirubin, that was when you decided to --
A. Intervene.
Q. -- intervene.
Is there anything else that I'm missing out of the equation as to what made you decide to intervene?
A. I think I've stated that to you.
Q. Thank you.

Page 135

THE WITNESS: Is it possible that I can take a two-minute break?
MR. JONES: Absolutely.
MR. ALLEN: Sure.
(Thereupon, there was a discussion off the record.)
BY MR. ALLEN:
Q. Doctor, when we left we were talking about the 3.2 bilirubin, and that was leading you to evaluate his condition as a risk of inadequate liver function; is that correct?
A. As a risk of biliary obstruction.
Q. Biliary obstruction.
So your concern is that there is some stone lodged in his bile duct, correct?
A. Or that the obstruction within the gallbladder had gotten good enough to have caused pressure on the common bile duct by the virtue of vicinity of an extensive inflammatory process going on in the gallbladder sitting next to the common bile duct that can cause pinching or obstruction.
Q. That inflammation, would you expect to see that produce an elevated temperature or WBC?
A. Yes. Not consistently though.
Q. But you'd expect to see an elevated WBC

Page 136

along with that, correct?
A. Correct.
Q. At what point is the bilirubin count you're looking at -- it was 2.1 on admission and it's 3.2 when you made your decision, but at what point were you becoming concerned about the liver function?
A. I was concerned from the beginning with a bilirubin of 2.1, which is high. I mean, I would have felt better if it was below 1.1 or 1, which is the maximum normal, and here I am faced with a patient that has twice that amount that jumped to 3.2 the next day. That got me more concerned.
Q. Now, at the point that you made your decision, you weighed the 3.2 and the complaints of Dewey with his health condition at that time before you decided to proceed with surgery, correct?
A. I was concerned that further delay or me waiting or procrastinating any further could bring a good chance of more complications related to the biliary process or the inflammatory process going on in the biliary tract that may increase the chances of morbidity related to that disease process and increase the chance of morbidity in general to the patient if I wanted to intervene at a later time.
Q. So the complications that you talked, you

Page 137

were worried about -- what complications of the obstruction were you worried would occur with Dewey Jones?
A. I was afraid that the gallbladder may undergo necrosis and subsequent perforation, or there might have been biliary obstruction, which there was, that could precipitate subsequent infection in the common bile duct that will throw him in a different ballpark called acute cholangitis, which is a more lethal disease than simple acute cholecystitis.
Q. But he didn't have that when you operated on him, true?
A. True.
Q. He didn't have it before you operated on him, true?
A. I cannot say that, no.
Q. You didn't diagnose him with acute cholangiosis, did you?
A. Well, he was covered with antibiotic and I did not want to reach a stage where I have a full blown picture of acute cholangitis on my hand before I start doing something about it.
Q. So that concern weighed against Dewey's health condition led you to conduct the surgery on Dewey Jones on that morning, true?

Page 138

A. I reached a point where I felt that it was inappropriate for me to wait any longer based on what I was handling with Mr. Jones' biliary problem, and I reached a point where I felt that I truly need to intervene operatively and cannot wait based on the fact that I had related to his biliary condition, per se, or alone, if you may.

Q. So morning of 20. October 1994 we had reached a t in your mind that there w an emergency laparotomy necessitated; is that true?

A. I cannot call it an emergency, but it was an indicated operation at that point in time.

Q. Now, you had time to prepare Dewey for the operation over two days, true?

A. Can I ask you to elaborate on the word "prepare"?

Q. Okay. Y h time to make all c y i h were necessary before surgery, true?

A. I did put in a medical consult and I did put a pulmonary consult preoperatively.

Q. That was what you l you needed t d efor luc y laparotomy cholecystectomy on Dewey Jones, true?

A. Correct.

Q. You h l the time to l i a cardiolog

Page 139

consult, true?

A. I went ahead and ordered an internal medicine consult and I was prepared to act based on the consultant's recommendation.

Q. You felt more comfortable calling in an internal medicine consult on Dewey Jones than a cardiology consult before surgery; is that true?

A. I cannot say felt more comfortable, but it was a judgment call then for me to ask an internist to give me his or her opinion at that point in time.

Q. Did you have an internist in mind for your consult?

A. Since Dr. Ho was involved with the patient before, I felt it was appropriate to bring in Dr. Ho on the case.

Q. Do you feel Dr. Ho had more than adequate knowledge to evaluate Dewey's heart before surgery?

A. I felt that Dr. Ho had enough interaction with the patient and enough exposure to the patient to be able to tell me what the next step would be.

Q. And that exposure included his cardiology history and present condition, true?

A. Exposure in the sense that Dr. Ho did work on the patient at a prior hospital admission.

Q. Now, who read the EKG before surgery? Did

Page 140

you read it?

A. No.

Q. Would it have been Dr. Ho?

A. No. It was read by a physician with the name of Michael S. Grinblatt, M.D.

Q. Do you know him?

A. Yes.

Q. Is he a cardiologist?

A. Yes.

Q. Did you consult him on Dewey's case other than to read the EKG?

A. I did not consult him at all. He happened to have been probably the person assigned to read EKG's that particular day.

Q. Did Dr. Ho order the EKG, not you?

A. I cannot recall.

Q. You don t recall ordering the EKG, true?

A. It's part of the routine admission of having an EKG, even for a routine gallbladder surgery or routine gallbladder, even admission in anticipation for possible unexpected surgery during the hospital course.

Q. If you didn t read the EKG, who id you expect to read the EKG and tell you the fi lings on the EKG?

Page 141

A. The patient assigned to read the EKG by the hospital based on the Department of Medicine protocols.

Q. So xpected the to report to you the findi g on the EKG, t e?

A. To put his report on the chart on that particular page or EKG strip, if you may.

MR. ASE . Allen, I thinl you're ttin g into confusion over the tern "read." You i "rcad" as l e i pret and he interprets d" as --

MR. I'm wall d that road, thanks

BY MR. ALLEN:

Q. Did you have knowledge of the fact that that EKG before you cperated was abnormal?

A. Yes.

Q. And it was our d cisio i d face of that abnormal EKG and the rest of l presentation to operate, true?

A. No.

Q. Whose decision was it?

A. I cannot make a decision based on an EKG and label the patient as suitable or unsuitable

Page 142

candidate for surgery, especially suitable.
Q. Do I understand that you look at the EKG and the report that was given to you and your knowledge that it was abnormal and you put that into the equation with everything else that you knew about Dewey Jones and then you decided to do the surgery, true?
A. There are other people that are involved in the decision making of labeling a patient a candidate or a poor candidate or an unsuitable candidate for *surgery*.
Q. Those people that you consulted with were Dr. O'Neill and Dr. Ho?
A. Correct.
Q. Was there anybody else besides Dr. O'Neill, Dr. Ho and yourself that decided whether Dewey Jones was a candidate?
A. Anesthesia service.
Q. And anesthesia service. Anybody else?
A. Well, it was, again, my decision as far as the biliary disease is concerned, but I had to go with what the rest of the nonsurgeons' decisions was of whether I was allowed to operate on Mr. Jones at that particular day.
Q. So to do the bilirubin surgery you considered, did you not -- did you not consider a

Page 143

cardiologist's consult before operation?
A. Again, it's in the hands of the doctors that are more knowledgeable about the degree of a disease process, if you may, that can say the patient does need a cardiologist or not.
Q. If I understand correctly, were you then relying on Dr. O'Neill and Dr. Ho to --
A. And anesthesia.
Q. -- and anesthesia to inform you whether a cardiology consult was needed?
A. Correct.
MR. MEADOWS: [illegible]
BY MR. ALLEN
Q. Dr. Rizk never became involved in the case before Dewey was operated, true?
A. Forgive me?
Q. Dr. Rizk.
A. Rizk.
Q. Dr. Rizk was never involved in this case before Dewey was operated?
A. Correct.
Q. And you never [illegible]d Dr. Ozan the emergency room doctor, after the patient was admitted to the hospital, true?
A. True.

Page 144

Q. Was there any equipment that -- that that.
Was there any diagnostic tests that you wanted to run in which there was not equipment available to you when you evaluated Dewey Jones before surgery.
A. Related to his surgical problem or in general?
Q. Let's talk about first in general. As you were in your decision whether he was a candidate for surgery and you wanted to run any diagnostic test, was there ever a problem with any of the equipment, the availability of equipment to you?
A. I reached a point where I felt that as far as I'm concerned that I could not afford to wait any longer and I had to abide by what other physicians or consultants involved --
MR. JONES: Doctor, we're trying to get to the point. He just asked you if any diagnostic test you wanted to run, was there ever an instance where you wanted to run a test and the equipment wasn't available for you to run the test.
A. No.
MR. ALLEN: Thank you.

Page 145

MR. CASEY Thanks, Mark.
MR. JONES: No problem.
BY MR. ALLEN:
Q. What about an echocardiogram, when was an echo ordered in this case?
A. It was ordered preoperatively.
Q. Who reviewed the echocardiogram?
A. I'll have to look.
Q. While you're looking for that -- never mind.
A. There is a report of an echo in the chart, but I'm aware that there is an echo that was done preoperatively.
Q. You're aware that it was done preoperatively. Did you review the report before you operated on Dewey?
A. I cannot remember that I reviewed the report, but I remember discussing --
Q. Who did you discuss --
A. -- discussing the findings of the report or discussing the findings of the procedure, if you may, the echocardiogram.
Q. Who did you discuss that with?
A. I discussed it with the resident staff and I remember discussing it with anesthesia, and I read

Page 146

Dr. Ho's report in the chart about this.
Q. What did Dr. Ho state in his report regarding the echo that you read?
A. It's a long paragraph. I'm sorry, I'm having difficulty reading some of it.
MR. JONES: My copy is not the greatest, I'm afraid.
MR. ALLEN: Probably better than mine.
A. I could tell you the bottom of the report or at the bottom of that note written on 10-19 by Dr. Ho it says he is medically cleared for surgery.
Q. And it's your understanding that that note talks about his evaluation of the echocardiogram?
A. Correct.
Q. And the bottom line is that he cleared for surgery Dewey Jones based upon the echo and everything else?
A. Everything else, correct.
Q. Now, were you looking at Dr. Ho to control or look after Dewey's hypertension?
A. Yes.
Q. So the type of medications given and duration, et cetera, you were looking to Dr. Ho to control that hypertension, true?

Page 147

A. Correct.
Q. And that would have been part of -- hypertension did not come into your -- come into your -- you looked at Dr. Ho to evaluate Dewey's hypertension based upon his consult, and you weren't independently going to clear or not clear Dewey for surgery based on hypertension alone. true?
MR. WALTERS: Object t form.
MR JONES: I'll object
tl
If you can, answer the question, Doctor.
A. I don't independently clear the patient for surgery, especially somebody like this particular with medical
Q. t tl t evaluation of hypertension did not come into your considerati before you operate on Dewey Jones, true?
A. I'm sorry, repeat the
Q. ertension nev entered t your mind as a consideration of whether or not t erate on Dewey Jones. true?
A. It is a consideration that any physician has to take. Somebody with hypertension is somebody that is to some if and it has

Page 148

to be considered in the total decision making.
Q. And you considered that before you operated?
A. Yes.
Q. Were you aware that the night before surgery that he was put on NPO that night?
A. Yes. That's the protocol.
Q. Did you put him on NPO?
A. I can't remember if I placed that order or not. But be as it may, the patient had been anorexic and got nauseated even with sips of liquid the day prior to surgery.
Q. Can you just tell me, look at your 10-18 physicians order and tell me whether you ordered NPO that night, or 10-19.
A. It was the resident doctor that placed him on NPO after midnight on 10-18.
Q. Who was in charge of that resident doctor?
A. I am.
Q. What is that resident doctor's name?
A. Robbie Charri.
Q. Why did he place the NPO?
A. In anticipation for an operative procedure the next day.
Q. The fact that he placed the NPO in that

Page 149

note, was that based upon your order to that --
A. It is the usual protocol for anybody who is to undergo any operative procedure under anesthesia, to go NPO the night before.
Q. What is the protocol for patients that are hypertensive, under hypertensive medication? Should they go NPO?
A. I'm not aware of a specific protocol, but patients, hypertensive patients can either take a pill a water or can a a antihypertensive medication
Q. Are you aware of l Dewey was given his hyper si edic ti after midnight?
Q. Are you are that after midnight his oxy saturations decreased to 87 cer while he was sleeping?
A. I cannot recall that.
Q. Y(eren t aware of tl t before surgery, were you?
A. I cannot recall if I was aware of it or not.
Q. Y('t aware of w her or t Dewey Jo es woke tl night with dyspnea, can you?
A.

Page 150

Q. **You** don't know whether or not that that
it before surgery whether he was suffering from
edema of the legs, edematous of the legs, can you?
A. I'm **not aware that his edema had gotten worse the night before.**
Q. You were aware that 8:30 in the morning they put him on oxygen therapy before surgery, weren't you?
A. **I cannot recall that I specifically was aware of that for a specific reason, meaning the oxygen therapy.**
Q. Did you have ordered the oxygen therapy for him?
A. No.
Q. Who would have ordered the oxygen therapy?
A. **It could be a possibility that any of the resident staff that was involved with his care or any of the consultants that were asked to intervene on the case.**
Q. Can you turn to the morning of 10-19 in the physician's order and tell me who ordered the oxygen therapy? Precede that question, can a nurse give oxygen therapy based upon her own --
A. **Not without an order.**
Q. Not without an order, okay.

Page 151

A. **On the 19th?**
Q. Well, it was the morning of surgery. Wasn't that the 19th? The 20th, I'm sorry.
A. **You want me to go to the 20th then?**
Q. Yes. The morning of the 20th, around 8:30 is when the oxygen therapy began.
A. **I cannot identify an order for oxygen in here on the 19th.**
Q. So you don't know who ordered oxygen therapy that morning, true?
A. **True.**
Q. And you can't tell me today whether you were aware of the oxygen therapy before to be proceeded on the surgery that morning?
A. **Correct.**
Q. You wrote an op report in this case, true?
A. **I signed a dictated operative report by the senior resident who was with me on the case.**
Q. By the fact that you signed it, you acknowledged that the above was true and correct?
A. **Correct.**
Q. If I could take your attention to the op report, the typed op report that was dictated and typed, typed on 10-21-94.
A. **It was dictated on the 20th and typed on**

Page 152

the 21st.
Q. Do you agree that there was a mildly inflamed yet friable gallbladder with multiple gallstones, is that true?
A. **Correct, that's what the report says.**
Q. You stated in your report that you first noted 48 hours prior to his admission he was complaining of colicky right upper abdominal pain. That would have been something you were aware of, true?
A. **Correct.**
Q. I noticed that a transverse incision was done in the case. Is that because of your concern of Dewey's obesity?
A. **No. I thought it was the most practical approach to that gallbladder in such a heavyset person.**
Q. Did you not do it because you were weighting the factor that he could have respiratory complications if you did the incision any other way, wasn't that **part** of it?
A. **I did not consider making a longitudinal incision simply because the patient was morbidly obese, and if I had made an up and down incision I would have been anatomically away from the gallbladder site that would have complicated the operative procedure as far**

Page 153

as exposure.
Q. You saw no signs of infection in the peritoneum, true?
A. **There was no generalized peritoneal infection, correct.**
Q. And you stated in your op report -- and I just want to ask you if you still hold this *true* today -- that while the patient awoke from general anesthesia, he was noted to become hypoxic, bradycardic, and pulses lost. Is that still -- was that correct then, is that still correct today?
A. **This report was dictated by Dr. Zelis, and the time when this incident did occur I was not in the operating room.**
Q. So you're basing those facts on Dr. Zelis' view of the occurrence, true?
A. **Correct.**
Q. And where were you at the time, Doctor?
A. **The operative procedure was close to completion. We were just left with *the* closure of the skin layer, which I delegated to Dr. Zelis to complete while I had to go out and talk to the mother because I felt that we had spent close to, a little bit over two hours probably, and I just needed to talk to the mother and let her know that everything went okay.**

Page 154

Q. A little over two hours, that's ,in your mind, long for this procedure?
A. I said a little bit over two hours. I cannot be very specific about the time. But it took a little bit longer than it should simply because of technicality and exposing the gallbladder, removing the adhesions around the gallbladder and taking out the gallbladder.
Q. Technicality was due to Dewey's body makeup?
A. In part, but in part due to the adhesions around the area related to the process of chronic cholecystitis and the subacute stage that was going on during this hospital admission.
Q. So the adhesions around the gallbladder made it more difficult to remove --
A. To expose the gallbladder in addition to removing the gallbladder off of its bed.
Q. And those adhesions, in your opinion, were caused by or resulted from the biliary colic and the cholecystitis?
A. They were related to previous attacks of cholecystitis.
Q. And that's consistent with acute cholecystitis?

Page 155

A. A resolved attack of acute cholecystitis compounded by subacute process that I thought was going on during this hospital admission.
Q. Now, Dewey was revived in the operating room, or were you not there? You weren't there at that point, true?
A. I left at the time when they were closing the skin incision, and after I talked to the mother and checked another patient in the preoperative holding area and I went back to the operating room there was an ongoing code.
Q. So you had another patient that you were about to proceed with and then you went -- you go visit that patient, is that what you said?
A. Just to check if the patient was ready or was there in the preoperative holding area.
Q. Then you went back in to check on Dewey?
A. Correct.
Q. And you found out he had coded?
A. Correct.
Q. No one came to you saying, Dewey's coded?
A. No.
Q. Were you there when the Swan-Ganz catheter was placed?
A. No.

Page 156

Q. In your opinion, was this code a result or [illegible] pulmonary edema?
A. I think it was secondary to some kind of cardiac event, but I cannot tell you exactly what had happened simply because I was not there.
in this operation, did he perform any other procedures?
A. As far as this particular operative procedure is concerned, yes. He and I were doing it together. He was the chief resident or, in simple words, somebody who is ready to go out and practice in a few months, and he and I were working together as a surgeon and assistant surgeon.
to perform the procedure, true?
A. I was there and I was doing the procedure in part. I mean, I cannot tell you how much I did do work by myself, but I definitely appreciated and needed whatever assistance he could offer me then simply because of the technicality.
Q. Sure. But did you feel comfortable enough with his skills that he could on that date have done the procedure by himself?
A. Yes.
Q. So you were there even though you felt he

Page 157

could comfortably do the procedure, true?
A. I'm always there on any major abdominal surgery or any major surgery on any of my patients.
Q. And in this case you made the incision to open up Dewey? Did you do the incision to open Dewey up?
A. I cannot recall if the strike of the knife was mine or Dr. Zelis'.
Q. And you can't recall whether the strike of the knife that pulled out Dewey's gallbladder was yours or Dr. Zelis', true?
A. All that I can remember is that it was a tedious operative procedure. The bottom line is that I successfully took out the gallbladder without causing any operative complications in there or injury, I should say, which is the fear of any surgeon that does biliary surgery.
Q. Did you get a chance to review the path report?
A. Yes.
Q. Just in your review of the path report, do you disagree with the path report in any way?
A. Yes. I could tell you that I thought my operative findings were more seriously descriptive of the procedure than what the op path finding may

Page 158

indicate or the path report may indicate.
MR. ALLEN: I'm *sorry*, could you read that back for me?
We're almost finished here, guys.
(Thereupon, the answer was read back.)
BY MR. ALLEN:
Q. So you believe by saying "more seriously descriptive" that your op report described the gallbladder better than the path report done by the pathologist?
A. Well, I can tell you that during surgery I found areas of what I thought was ischemia of the gallbladder wall and dissection of bile underneath the mucosa of the gallbladder. The gallbladder was stained in parts, which indicated to me that there was more than just a chronic process going on at that particular time.
Q. More than a chronic process.
A. Correct.
Q. Meaning acute?
A. Meaning acute and subacute.
Q. When you mean subacute, you mean it occurring in less than how long, a day?
my knowledge, that it was a chronic process on its way

Page 159

line and was stopped from turning into a full blown picture of acute cholecystitis.
Q. So you agree with the path report when it says the findings may represent an early or developing acute cholecystitis?
A. Correct.
Q. And you agree with him when he says that there was mild to moderate chronic inflammation; that's consistent with what you just said, true?
A. Correct.
Q. Now, he goes on in his gross description -- you can turn to the path report. You're there Doctor?
A. Yes.
Q. It says, there is, however, -- do you see where I am -- no exudate --
A. Exudate.
Q. -- exudate or adhesions in the vicinity of these defects.
Now, I'm concerned with that statement. You can read the whole gross description, but is that consistent with what you saw in Dewey's gallbladder?
A. I can tell you, this defect is surgeon made. It's usually decompression of the gallbladder

Page 160

because it was so distended intraoperatively and it would have made it easier for us technically to dissect the gallbladder by decompressing it or removing the fluid and some of the stones out of its lumen.
Q. ... you know how many calculi were present?
A. I can tell you by remembering how that sack of the gallbladder felt when I squeezed it after I got the specimen out of the abdomen. I felt there were many multiple small stones of variable sizes I could recall.
Q. Variable sizes. So that's consistent with the gross description in the path report?
A. That's what the path report says.
Q. So your feel, your squeeze, your look at the gallbladder is consistent with the gross description by this pathologist, true?
A. It's consistent as far as the stones are concerned, but I have to agree with what the pathologist had seen or read.
Q. Do you agree with him when he indicates that there is no inflammation of the ducts?
A. When we take out the gallbladder, it's only the gallbladder and a short stump of the cystic duct that gets to be removed with the specimen. The rest of the bile ducts the surgeons fear and try to

Page 161

stay away from even having the feeling that we're close to them.
Q. But what he saw, he saw no inflammation of those ducts, true?
MR. JONES: I'm going to object. He either did or he didn't. He didn't review this path specimen himself or look at slides or anything else.
A. I usually just cut a very small stump, and I can tell you it's in millimeters next to the gallbladder. I try to, and every surgeon tries to, cut the shortest amount of cystic duct close to the gallbladder, especially when they're dealing with an acute, a questionable acute or subacute stage, for the fear of injuring the other major duets and causing big-time complication.
Q. That path report does not indicate any inflammation in the part of the duct that you left, true?
A. Can you please help me to the statement or the sentence that you're referring to?
Q. Yeah. He does not indicate that there's any inflammation in the bile ducts.
MR. JONES: He's asking where is the statement that says there's

Page 162

no inflammation in the bile ducts.
BY MR. ALLEN
Q. There is no statement in there, is there, Doctor?
A. I don't see any.
Q. There is none. There is no indication that there was inflammation in the bile duct, true?
A. But I don't see any that could have him or even say no or there is.
Q. But if there was inflammation, that would be something that would be reflected in the path report?
MR. MEADOWS: objection.
MS. REINKER. objection.
MR. JONES: I'm going to object.
A. Not necessarily.
Q. Not necessarily?
A. No. Because, again, we tried to remove the gallbladder and the gallbladder alone. With acute cholecystitis or subacute cholecystitis, even with chronic cholecystitis, the cystic duct, which is a very short stump or very short duct that connects that sack or reservoir of gallbladder to the rest of the biliary

Page 163

ducts, gets so shortened that we try to avoid cutting as much as we can out of it, even as millimeters if we're lucky to include with the gallbladder, and leave the rest intact or leave the rest in there for the fear of injuring, quote/unquote, the bile ducts.
Q. Thanks. I appreciate your clearing me up on that, Doctor.
I'm just turning to your discharge summary. Discharge was dated 11-21-94 and it was dictated February 3rd, 1995. Is that pretty consistent with most discharge summaries by you, Doctor?
A. No.
Q. Why did this one take two and a half

A. Simply because Mr. Jones did stay longer than he should in the hospital, and it was not until Dr. Zelis had enough time to sit down and review the records and put some kind of a pertinent summary that he felt was appropriate describing in brief the course of this hospitalization.
Q. So due to the month plus long hospitalization and Dr. Zelis' need to review those records, that is the reason it took two and a half months to dictate this discharge summary, correct?
A. In part.

Page 164

Q. Do you know of any other reason why it took that long?
A. Well, I felt it was Dr. Zelis' duty based on his degree of involvement with the case that he gets to dictate the discharge summary, and it wasn't until that time when Dr. Zelis was able to get to the discharge summary. I may have had --
MR. JONES: Doctor, don't guess. He just asked do you know why it took that long. If you know, tell him.
A. I don't.
Q. Are you critical of him as a resident that you were overseeing for taking two and a half months to discharge?
A. Yes, I would be critical.
Q. Were you critical of him in this case?
A. I would be critical had I known that it was dictated after this long.
Q. Did you sign this discharge?
A. Yes, that's my signature.
Q. Did you just not catch the fact that it took two and a half months to dictate it?
A. Even if I did, it was my obligation that the discharge summary was dictated by Dr. Zelis, and based on my judgment of Dr. Zelis being a competent

Page 165

senior resident stating the facts as an independent body that this holds true.
Q. In the discharge *summary* it stays under the narrative, refractory hypertension. Define that for me.
MS. REINKER: Are you asking something about the discharge *summary?*
MR. ALLEN: yeah. In the discharge summary it says, narrative and hospital course.
MS. REINKER: Objection. This was not dictated by this witness. I don't think he's the right one to ask what is meant by the words used.
BY MR. ALLEN:
Q. Go ahead, Doctor. You had a patient who has a history of refractory hypertension.
A. The discharge summary states that the patient has history of refractory hypertension.
Q. What is refractory hypertension?
A. In laymen's term, it is a form of hypertension that has chronicity associated with some degree of difficulty controlling it.
Q. It goes on down to say that after -- I'm *sorry.* As far as -- do you have any criticisms -- did

Page 166

you review any of the records of University Hospital?
A. No, sir.
Q. Do you have any criticisms to the nurses that were involved in the care of Dewey Jones?
A. The nurse?
Q. The nurses or the nursing help.
A. No.
Q. Dewey Jones signed a consent for a laparoscopic cholecystectomy and possible open. I'm going to give you the consent. Were you there when he gave that consent?
A. No; but he was or he would never have been asked to sign a consent unless he had been thoroughly informed about the details of the consent or the details of the operative procedure.
Q. Now, discharge *summary*, it's your responsibility to see that the resident dictates this by whatever time the policy and procedure of the hospital states, correct?
A. Correct.
Q. Now, did you enter into any expressed oral or permission, expressed permission by the family of Dewey Jones before surgery was completed, undertaken?
MR. JONES: I'm going to object. You don't have to get family

Page 167

permission for a competent adult to do surgery. So I'm not sure I understand your question.
BY MR. ALLEN:
Q. Did you talk or consult with the family before?
A. I felt that my degree of interaction with Mr. Jones preoperatively was so good, and he and I were discussing all aspects promptly, and I thought he had a full understanding of what was going on, and he never asked me for any family involvement or any family permission or request to get any family member involved.
Q. So you never talked to any of the family before?
A. Correct.
Q. The first time you talked to a family member was after when you went out to see the mother?
A. Correct.
Q. Other than that time, did you have any other conversations with the family?
A. Yes, I did.
Q. Tell me about the next conversation that you had with the family.
A. A few days after the operation and after a

Page 168

telephone conversation one family member had requested a meeting with me with other family members present, and I respected this request and such a meeting did occur.
Q. Who were the family members there, do you recall?
A. I recall it was the mother, a brother and possibly a sister or two.
Q. And what was discussed, do you recall?
A. All aspects of the *surgery* and Dewey's condition at that point in time and prognosis.
Q. Now, Dewey -- any independent recollections of the specifics, does anything stand out in your mind today about that conversation with the family?
A. The mother was calm and contained, and the brother especially and the sister, if I may recall, were a little bit out of respect more vocal With their words and anger.
Q. At you?
A. At me.
Q. What did you tell them was the cause of Dewey's arrest?
A. I told them based on my understanding that there is a hypoxic brain injury that occurred and at

Page 169

that point in time I was not qualified to tell them what the prognosis was, and I told them that I would get involved -- if I recall, I might have gotten somebody involved by then as far as a neurosurgeon or a neurologist especially to get his or her opinion as far as the prognosis and the outcome.
Q. You told them that it was your risk that caused Dewey to be in that condition, didn't you?
MR. JONES: Objection.
A. It was what?
Q. Because of the risk that you took was the reason Dewey was in that condition.
MS. REINKER: Objection.
A. I didn't say -- I didn't mention my risk, quote/unquote. I didn't mention that word.
Q. Your evaluation of the risk, didn't you?
A. I cannot recall the specifics, but if you may just give me the proper way it was related to you or what was said in that conversation, I could confirm it or not, but I cannot recall that I did go this specific mentioning these kind of specific words.
Q. You didn't say anything in the line, you know, that it was because of the surgery that Dewey was in this condition?
A. I cannot say it was because of the

Page 170

surgery. It was a complication of the operative procedure that something had happened that caused him to go into this kind of condition.
Q. You would take the same steps that you took with Dewey today as you did back then, correct?
A. As far as?
Q. Your entire management and care. Would you change anything?
MR. JONES: wait a minute.
With the knowledge of hindsight would he have changed anything? What does that mean?
BY MR. ALLEN
Q. If you were put in that situation today, would you change anything that you did?
MR. JONES: objection.
MR. WALTERS: without knowing the outcome? With knowing the outcome or not knowing the outcome?
MR. JONES: It's a nonsensible question. If he knew that this was going to be the outcome for this particular patient, would he have done exactly the same thing for this patient if he had the same patient tomorrow? It

Page 171

doesn't make any sense.
BY MR. ALLEN
Q. Do you understand my question?
A. I do. But there is a hindsight element in there. You and I know what the outcome is or has been. I don't think it's fair for me to answer this question having been involved in such an issue.
Q. Taking away the hindsight, the same situation?
MR. JONES: objection.
MR. WALTERS: I'm a little unclear as to the question at this point.
I'll show my objection.
A. I cannot, in all fairness, answer this question appropriately for you.
Q. That's fine, Doctor.
A. I mean, there is always this hindsight element that I cannot remove out of the picture.
Q. Sure. Have you ever had a patient die from gallbladder surgery before?
A. Not my patient.
Q. Have you ever had a patient go into a coma other than Dewey Jones after a gallbladder surgery?
A. Not after a gallbladder surgery.
Q. You've never operated on a patient like

Page 172

Dewey Jones before, have you?
A. I have.
Q. How many times?
A. I cannot recall.
Q. When was the last time?
A. I'm sorry, I cannot recall.
Q. You don't know?
A. I'm sorry, I cannot recall.
Q. Has it been more than ten times?
A. I did encounter many patients during my training and my practice that were close to Mr. Jones' condition in one way or the other, but I cannot tell you in all honesty that it was exactly the same picture or the same setup, if you may, or same scenario.
Q. Sure. Everything is unique, every patient is unique?
A. Possibly to some degree or to some extent.
Q. Other than calling in the consults and the things that we went over today, did you do anything else that I didn't touch on to investigate Dewey's condition, consults, you know, diagnostic studies ordered that I didn't talk about or you didn't talk about?
MS. REINKER: me-op you're referring to?

Page 173

MR. ALLEN: yes, pre-op.
MS. REINKER: me-op, before surgery.
A. All that I can tell you is that I --
MR. JONES: Doctor, before we go into a long explanation, he just wants to know whether we've covered all of the diagnostic tests and consultations you got and other things you did preoperatively for Mr. Jones. Either you have or you haven't.
A. It was covered.
Q. Now, how did you rely on the communication between the consulted doctors in this case? Did you rely on the records or did you rely on in-person communication?
A. I relied on a combination of both.
MR. WALTERS: I didn't hear the answer.
MR. JONES: He relied on a combination of both.
BY MR. ALLEN:
Q. Do you have any independent recollection as to the location of the meetings in which you consulted with these physicians?

Page 174

A. No, sir.
Q. You don't know whether it was in Dewey's room or in the hall?
A. Definitely not in his room.
MR. WALTERS: YOU guys are talking quieter and quieter. Could you just, please.
MR. MEADOWS: And there's a train going by.
BY MR. ALLEN
Q. You don't know where it was that you communicated?
A. Correct.
Q. Can you tell me for certain that it didn't occur over a telephone?
A. I can't be certain.
Q. Can you tell me for certain that you consulted with Dr. Ho and Dr. Rizk, Dr. Adamek before surgery?
MR. JONES: I'm sorry --
MS. REXNKER objection.
MR. JONES: objection.
He's already gone through Dr. -- you keep mispronouncing his name, it's Rizk, and he already said that Dr. Rizk was not

Page 175

involved in this in any way before surgery.
MR. ALLEN Did I say Rizk?
MR. JONES: yes.
BY MR. ALLEN
Q. Dr. Ho, Dr. Adamek and Dr. O'Neill.
MS. REINKER: objection.
MR. JONES: I'm still going to object.
MS. REINKER: He's already said he does not know who he spoke to from anesthesia.
Q. Did you say that?
persons involved from anesthesia in the preoperative or immediate preoperative or perioperative time.
(Thereupon, there was a brief recess.)
Q. Doctor, this surgery to Dewey Jones was moved up from noon until early in the morning; is that true?
A. If that's what the record states
Q. Do you recall why it was moved up to an earlier time?
A. I'm not positive about it, but I think there was a cancellation, either one of my patients or

Page 176

there was an opening in that operative room prior to Mr. Jones' scheduled procedure.
Q. So you just moved him in instead of that patient?
A. Correct.
Q. Cholelithiasis, have you ever had a patient die from cholelithiasis?
A. Cholelithiasis, per se, alone, no. Complications --
Q. What about cholecystitis?
A. Yes.
Q. When was that?
A. I witnessed somebody die, but I didn't -- I mean, when I was a resident, but I did not have direct involvement. I was not the attending.
Q. Is that the only time that you witnessed it?
A. There were times when I was a resident.
Q. One time?
A. Times.
Q. Times, okay. How many times?
A. I cannot recall.
MR. WALTERS: I apologize again, I cannot hear you guys. You're whispering.

Page 177

MR. JONES: we've got another train.
BY MR. ALLEN
Q. Had you ever had a patient -- you personally have never had a patient die of cholecystitis, true?
A. True.
Q. What about cholelithiasis, have you ever had a patient die of that?
A. If it was -- I have to be more specific. If it was uncomplicated cholelithiasis, no, but if it was a complicated cholelithiasis, yes.
Q. What would the terminology be? Cholecystitis associated with common bile duct stones and acute cholangitis or perforation of the gallbladder secondary to acute unresolved cholecystitis.
Q. You had that occur to a patient of yours
A. I did, but it did not progress to that on a patient of mine.
Q. Perforation, but you intervened?
A. Correct.
Q. How long did you have to intervene?
MR. JONES: objection.
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Page 178

BY MR. ALLEN:
Q. How much time did you have to intervene in that?
MR. JONES: come on, let's get on with something relevant here. This has nothing to do with this case. You said you had five questions ten questions ago. This is getting ridiculous. It's 8:30, it's four and a half hours into this deposition. I have been so patient and this doctor has been unbelievably patient with you. Get to the end of this deposition, now.
A. I'm sorry, I cannot recall the specific timing for you now.
Q. Did you have a matter of minutes, did you have a matter of an hour?
MR. JONES: objection. We're done. Let's go.
MR. ALLEN I do not feel that this deposition is done. I feel like I have not been able to adequately examine this patient based upon evidence that I feel is discoverable. Now, I have a few more questions to ask. We can do it now

Page 179

or we can reconvene on a judge's orders, I don't mind.
MR. JONES: How many questions have you got, Mi-. Allen?
MR. ALLEN I've got this (indicating), this is it.
MR. JONES: You've got five pages of paper there. How many questions have you got?
MR. ALLEN: It's about five questions. But if he answers something that I feel that I need to go into, I think I have the right to do so.
MR. JONES: Look, I am going to stop --
MR. ALLEN: we're spending more time talking about this, I could have been done.
MR. JONES: well, that's very unlikely considering an hour ago you told me -- more than an hour ago you told me you would be done in half an hour. So get to the end of the deposition, now. Go!
MR. ALLEN: okay.

Page 180

MR. JONES: I'll tell you, I've been a lot more patient than I think that gentleman is going to be tomorrow, one of these gentlemen is going to be tomorrow because you're setting a trend with this doctor with a four-and-a-half-hour deposition. I'll be interested to see what happens tomorrow.
BY MR. ALLEN:
Q. Now, Doctor, do you have any opinions as to the cause of Dewey s condition today?
A. I think this question is very generalized. Can I ask you to be specific about condition?
Q. What caused Dewey to be in a coma today, what was the event?
A. The pathology was anoxic brain damage.
Q. Due to what?
A. Cardiac arrest.
Q. What caused the cardiac arrest?
A. I do not know.
Q. You don't have any opinion?
A. I wasn't there.
Q. And you don't expect to form any opinions before trial, do you?
A. I do not want to form an opinion based on

Page 181

my knowledge alone, and I yet to see what comes out of other doctors' statements that were involved in close care at those particular moments around the time when the cardiac arrest had occurred. I think it's unfair for me to pass or make a judgment based on what was going on then while I was not in the room.
MR. JONES: I will represent to you, Mr. Allen, that if he does, because of additional discovery that goes on, feel that he is competent to give such an opinion, I will certainly let you know that he has opinions, what the general areas are, and we will respond to any kind of discovery you want on the opinions that he then has.
MR. ALLEN That's fair. Thank you.
BY MR. ALLEN:
Q. In particular, you saw no evidence of sepsis in this patient when you were operating on this patient, true?
A. Gross sepsis.
Q. Gross sepsis. Acute or any other form of sepsis?
A. There's microscopic or occult sepsis that

Page 182

on. to see *gross* pus. But a gallbladder that's chronically inflamed that has harbored stones for years or for some time is definitely contaminated or infested or infected to some degree or to some extent with bacteria.

Q. Do you agree that the leading cause of death from laparotomy cholecystectomy is due to cardiovascular disease?

A. To be honest -- I mean, are we talking about this specific case?

Q. I'm just talking in general.

A. In general?

Q. Yeah. Do you have an opinion?

A. Give me the question again, please.

Q. Do you have an opinion that the majority of deaths -- excuse me, let me rephrase it. The leading cause of death from laparotomy cholecystectomy is due to cardiovascular disease, do you agree?

MS. REINKER: Objection.

A. I cannot say the leading cause. I'm not sure if it is the leading cause, you may be right, but it is a statement that is *good* to a good extent or correct to a good extent.

Q. I don't want to go through the chart, but I saw the name of a Dr. Sullivan in the chart. Who is

Page 183

Dr. Sullivan?

A. Forgive me, I don't know.

Q. Do you remember his name?

A. I do not.

MR. ALLEN I just have some questions as to who people, signatures were. Can I address that to you at some other time?

MR. JONES: YOU can send any question and we will identify anybody for you.

MR. ALLEN who would be the one --

MR. CASEY: If you go through the chart and you mark a page with a signature and send it to me, I will send it off to the hospital people and identify signatures for you.

MR. ALLEN: I've got parts of the chart which I can't interpret, if I just highlighted it --

MR. CASEY Just highlight it and send it to me. I'll send it off and we'll get you the names.

MR. ALLEN Great.

Page 184

MR. CASEY If we can.

MR. ALLEN: okay. Appreciate your abundance of patience.

MR. JONES: Because of the length of this deposition, I have agreed that if and when defense counsel wish to question Dr. Badri that we will *make* Dr. Badri available at a mutually convenient time and place.

(DEPOSITION ADJOURNED)

RAFAL A. BADRI, M.D. (Date)

Page 185

STATE OF OHIO,)
COUNTY OF CUYAHOGA.) SS:
CERTIFICATE

I, LAUREN I. ZIGMONT-MILLER, Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, RAFAL A BADRI, M.D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, and afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

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

IN WITNESS WHEREOF. I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 19th day of February 1997.

Lauren I. Zigmont-Miller, RPR and Notary Public in and for the State of Ohio.