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State of Ohio,                   )  
County of Cuyahoga.         )

Doc 21

— — —

IN THE COURT OF COMMON PLEAS

— — —

DEWEY GLEN JONES, et al. <sub>I</sub>

Plaintiffs,

V.

MERIDIA HURON HOSPITAL,  
et al.,

Defendants.

[illegible]

Case No. 306012  
Judge Lillian Greene

— — —

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

THURSDAY, JANUARY 23, 1997

— — —

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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<p>1 APPEARANCES:</p> <p>2 On behalf of the Plaintiffs:</p> <p>3 CHARLES H. ALLEN, ESQ.</p> <p>4 The Keenan Law Firm</p> <p>5 The Keenan Building</p> <p>6 148 Nassau Street, N.W.</p> <p>7 Atlanta, Georgia 30303</p> <p>8 PAUL GRIECO, ESQ.</p> <p>9 JACK LANDSKRONER, ESQ.</p> <p>10 Landskroner &amp; Phillips Co., L.P.A.</p> <p>11 55 Public Square, Suite 1040</p> <p>12 Cleveland, Ohio 44113-1904</p> <p>13 On behalf of the Defendant Rafal Badri, M.D:</p> <p>14 MARK JONES, ESQ.</p> <p>15 Jacobson, Maynard, Tuschman &amp; Kalur</p> <p>16 1001 Lakeside Avenue</p> <p>17 Suite 1600</p> <p>18 Cleveland, Ohio 44114</p> <p>19 On behalf of the Defendant Beverly O'Neill, M.D:</p> <p>20 WILLIAM MEADOWS, ESQ.</p> <p>21 Reminger &amp; Reminger</p> <p>22 The 113 St. Clair Building</p> <p>23 Cleveland, Ohio 44114</p> <p>24 On behalf of the Defendant Winston Ho, M.D., and</p> <p>25 Lakeland Medical Group:</p> <p>26 STEPHEN WALTERS, ESQ.</p> <p>27 Reminger &amp; Reminger</p> <p>28 The 113 St. Clair Building</p> <p>29 Cleveland, Ohio 44114</p> <p>30 On behalf of the Defendant Meridia Huron Hospital:</p> <p>31 JAMES S. CASEY, ESQ.</p> <p>32 Reminger &amp; Reminger</p> <p>33 The 113 St. Clair Building</p> <p>34 Cleveland, Ohio 44114</p> <p>35 On behalf of the Defendant Peter Adamek, M.D:</p> <p>36 SUSAN REINKER, ESQ.</p> <p>37 Jacobson, Maynard, Tuschman &amp; Kalur</p> <p>38 1001 Lakeside Avenue</p> <p>39 Suite 1600</p> <p>40 Cleveland, Ohio 44114</p> <p>41 ALSO PRESENT: Keith E. McGregor - Videographics</p>	<p>1 MR. JONES: Just for the</p> <p>2 record, the videotape that is here today,</p> <p>3 I'm objecting to its use. There was no</p> <p>4 notice sent when this was finally</p> <p>5 scheduled that this was going to be taken</p> <p>6 by video; therefore, the requirements of</p> <p>7 the civil rules haven't been met.</p> <p>8 However, since the videographer is here</p> <p>9 and set up and since it's past 4:00 and</p> <p>10 we're unlikely to get a judge to make a</p> <p>11 final decision on this, I'm going to allow</p> <p>12 the video to stay, but I'm not waiving my</p> <p>13 objection.</p> <p>14 MR. ALLEN: So noted.</p> <p>15 We're going to take this by agreement</p> <p>16 of counsel, notice and agreement of</p> <p>17 counsel, with just the noted stipulation</p> <p>18 that you have here and waive all</p> <p>19 formalities?</p> <p>20 MR. JONES: With the</p> <p>21 exception of the videotape.</p> <p>22 - - -</p> <p>23 ///</p> <p>24 ///</p> <p>25 ///</p>
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<p>1 INDEX</p> <p>2 PAGES</p> <p>3 CROSS-EXAMINATION BY</p> <p>4 MR. ALLEN 5</p> <p>5 - - -</p> <p>6</p> <p>7</p> <p>8 PLAINTIFFS' EXHIBITS MARKED</p> <p>9 1 11</p> <p>10</p> <p>11</p> <p>12</p> <p>13 OBJECTIONS BY</p> <p>14 MR. JONES 4, 12, 14, 15(2), 43(2), 44,</p> <p>15 55, 56, 57, 59, 60, 62(2), 63, 64, 71(2), 73(2),</p> <p>16 87, 88(3), 105, 115, 147, 161, 162, 166, 169, 170,</p> <p>17 171, 174, 175, 177, 178</p> <p>18 MR. MEADOWS 43(2), 44, 53, 58, 59, 60, 72,</p> <p>19 73, 74(2), 81, 82, 84, 116, 122, 127, 143, 162</p> <p>20 MR. WALTERS 43(2), 46, 62(2), 72, 73, 84,</p> <p>21 104, 147, 171</p> <p>22 MR. CASEY 43, 45, 62, 73, 84</p> <p>23 MS. REINKER 13, 60, 62, 63, 73(2), 84(2),</p> <p>24 115, 118, 133, 162, 165, 169, 174, 175, 182</p> <p>25 - - -</p>	<p>1 RAFAL A BADRI, M.D., F.A.C.S.,</p> <p>2 a Defendant herein, called for examination by the</p> <p>3 Plaintiffs, under the Rules, having been first duly</p> <p>4 sworn, as hereinafter certified, deposed and said as</p> <p>5 follows:</p> <p>6 CROSS-EXAMINATION</p> <p>7 BY MR. ALLEN</p> <p>8 Q. Good afternoon, Dr. Badri. I'm Charles</p> <p>9 Allen. I'm one of the plaintiffs' attorneys.</p> <p>10 I'm going to ask you some questions</p> <p>11 today. If I speak too softly, if I speak in a tone or</p> <p>12 a method in which you cannot understand me, just ask me</p> <p>13 to repeat the question, I'll be happy to repeat it. If</p> <p>14 you need to take a break at any point in the</p> <p>15 deposition, if you need to refer to anything, you do</p> <p>16 so, whatever you want to, just let me know.</p> <p>17 If you need to talk to counsel for any</p> <p>18 reason, need to go to the bathroom, be happy to do</p> <p>19 that, all right? If I ask you a question and you need</p> <p>20 to go to your records, please do so, okay?</p> <p>21 A. Okay.</p> <p>22 Q. If you feel like that's the way that you</p> <p>23 can answer it, I'd rather you do that, okay?</p> <p>24 A. Fine.</p> <p>25 Q. We'll just work through it and maybe we</p>

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1 can get out of here in just a couple hours, okay?

2 A. Yes.

3 Q. Dr. Badri, I'd just like to go into your  
4 background a little bit. You were born and raised in  
5 Iraq; is that correct?

6 A. Correct.

7 Q. When did you leave that country?

8 A. 1978.

9 Q. Now, when did you enter -- when did you  
10 finish your undergrad training? You went to high  
11 school or an equivalence of high school and then you  
12 went to undergraduate school, correct?

13 A. I went to an American Jesuit high school  
14 back in Baghdad, it was a six-year program, and then I  
15 entered a six-year medical school program.

16 Q. How old were you when you finished -- I  
17 didn't mean to interrupt you. How old were you when  
18 you finished high school?

19 A. Eighteen. And I entered the medical  
20 school, it was a six-year program, and I graduated at  
21 the age of 24.

22 Q. And then at 24, what year was that?

23 A. 1976.

24 Q. Two years later you left Iraq?

25 A. Correct. I did one year of internship,

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1 rotating internship in internal medicine, pediatrics,  
2 OB-GYN and general surgery. The second year I did  
3 straight general surgery residency at the Medical City,  
4 which is the teaching hospital affiliated with the  
5 university.

6 Q. Now, were you married over there?

7 A. I got married in the year 1977.

8 Q. '77. So you left and you came to America  
9 in '78; is that correct?

10 A. No. I worked in the Persian Gulf in  
11 Abu Dhabi for three years. I did three years of  
12 surgery, further surgery training hoping to qualify and  
13 finish the requirements for the British boards. I  
14 changed my intentions towards the end of that based on  
15 my friend's recommendation that the surgical training  
16 in the United States is far superior to the British  
17 training.

18 Q. So what did you do then?

19 A. I came to the United States in the year  
20 1981 and started a five-year general surgery residency  
21 training program.

22 Q. Did you have any family that was in  
23 America?

24 A. No.

25 Q. Tell me about your family background. How

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1 many brothers and sisters did you have?

2 A. I come from a family with, both parents  
3 are physicians. My father is a general surgeon, he's  
4 retired now, and my mother is an OB-GYN. I have one  
5 brother that is an engineer.

6 Q. And your family, your mother and father --

7 A. Are still alive, and they're still  
8 residing in Baghdad, Iraq.

9 Q. From '81 you came over here. what year  
10 did you take the F.L.E.X. exam?

11 A. was my to --  
12 me, I'm mixing up. The F.L.E.X. exam is the one for  
13 equivalency?

14 Q. M-hm.

15 A. It was before my arrival to the United  
16 States.

17 Q. Is that on your --

18 MR. JONES: Yes. Unless  
19 it's a memory test, it's all on his CV I  
20 just gave you.

21 MR. ALLEN okay.

22 BY MR. ALLEN:

23 Q. Did you pass that on your first time?

24 A. Yes.

25 Q. And then in that -- let me see where that

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1 is.

2 MR. JONES: Second page  
3 under certifications, third category.

4 BY MR. ALLEN

5 Q. That was in 1982; is that right?

6 A. The equivalency exam --

7 Q. If you'd just re-view that CV.

8 A. The equivalency exam, now that I'm looking  
9 at it, is the E.C.F.M.G. at that time. The name of  
10 those certifications have been changing over the years,  
11 but at that time it was the E.C.F.M.G. The F.L.E.X. is  
12 the medical licensure exam, the federal medical  
13 licensure exam, which I passed during my second year  
14 here, or actually it was during my first year of  
15 training.

16 I took the Georgia boards first that  
17 year and I passed it, and then I went on and got the  
18 Ohio license based on, first, the reciprocity with the  
19 State of Georgia, and Ohio would allow proper licensing  
20 only after two years of training.

21 Q. So when you first came over you came to  
22 Georgia; is that correct?

23 A. No. I came here to Cleveland and stayed  
24 in Cleveland.

25 Q. Tell me what you did after that. That was

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1 '81, correct?  
 2 A. I immediately enrolled in general surgery  
 3 training. I did a year of internship and then four  
 4 years of proper residency to qualify me for the boards.  
 5 Q. And you took the boards in?  
 6 A. 19 --  
 7 Q. 85, '86?  
 8 A. '86 was the written exam.  
 9 Q. Did you pass that on the first attempt?  
 10 A. Yes.  
 11 Q. Where did you take the boards; where did  
 12 you physically sit for the boards?  
 13 A. Philadelphia.  
 14 Q. Now, tell me as far as where you've lived  
 15 since 1981.  
 16 A. I've lived all this time here in  
 17 Cleveland.  
 18 Q. What is the purpose for having licensing  
 19 in Ohio, Michigan, New York, Georgia and Florida?  
 20 A. I was hoping during residency to get all  
 21 my papers straightened out in case I would get a good  
 22 opportunity to practice, and I did not know that I was  
 23 going to settle here in Cleveland. My wife is a  
 24 physician, she's a pathologist, and she was in training  
 25 at the same time when I was. It worked out that she

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

Page 12

1 than that?  
 2 A. That's basically what I've reviewed.  
 3 Q. Are those all the records from the  
 4 hospitalization on October 17th?  
 5 A. Correct.  
 6 Q. Were there any medical records from  
 7 previous hospitalizations of Dewey Jones?  
 8 A. I just used this record.  
 9 Q. Do you recall going back and looking at  
 10 other medical records from other hospitalizations  
 11 before that?  
 12 A. I do not recall. Maybe I did at the time  
 13 of the admission, but at this point in time I did not  
 14 review --  
 15 Q. Not for purposes of today?  
 16 A. Correct.  
 17 Q. What else have you reviewed for purposes  
 18 of today other than that hospitalization?  
 19 A. Nothing else.  
 20 Q. When you reviewed those medical records,  
 21 did you see anything that struck you as not being  
 22 accurate?  
 23 MR. JONES: well, I'm going  
 24 to object. First of all, he did not go  
 25 through every page of this chart, I'll

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



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

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1 Q. When was that?  
2 A. Back in the year 197 -- I'm sorry, '86,  
3 1986.  
4 Q. When you mean you were named, did you have  
5 to come in and take a deposition?  
6 A. Yes.  
7 Q. Did you have to go to court and give trial  
8 testimony?  
9 A. Yes.  
10 Q. Did the verdict come back against you?  
11 MR. JONES: objection.  
12 A. I was a resident then and I was named as a  
13 witness in the case.  
14 Q. The lawsuit was then brought against the  
15 hospital in which you were a resident, is that correct?  
16 A. Correct. There were multiple parties  
17 involved.  
18 Q. And you just happened to be somebody that  
19 was entered into the record caring for that person,  
20 correct?  
21 A. Correct.  
22 Q. And when the verdict came back, was it  
23 against the hospital?  
24 MR. JONES: Objection.  
25 A. Against the hospital.

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

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1 MR. JONES: I'm not sure he  
2 was actually part of the lawsuit.  
3 A. I was not named as part of the lawsuit, it  
4 was the urgent care center.  
5 Q. That was named in the lawsuit?  
6 A. Correct.  
7 Q. You were never asked to testify after that  
8 point?  
9 A. No. That was it.  
10 Q. How long had you worked at that urgent  
11 care center?  
12 A. Maybe for about two years.  
13 Q. Before the deposition?  
14 A. Correct.  
15 Q. How long did you work after that at the  
16 urgent care center?  
17 A. I cannot recall. Not long I should say.  
18 Q. Not long?  
19 A. Correct.  
20 Q. Were you working there full time?  
21 A. No, part time.  
22 Q. Was that in the evenings?  
23 A. No, it was during the day.  
24 Q. Why were you working there part time?  
25 A. My

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1 Q. What were your general duties in the  
2 urgent care facility?

3 A. As a physician that takes care of the  
4 patients that need to be seen there.

5 Q. During that time frame from, let's say,  
6 '89 to '92, what were -- did you have an office at that  
7 time away from the urgent care center?

8 A. I started a practice the year I finished  
9 training. I still maintain that same office.

0 Q. So you had an office during that time?

1 A. Correct.

2 Q. And now did you see patients in your  
3 office?

4 A. Then?

5 Q. Yes, then, between '88 and '92.

6 A. Yes, I did. I have been seeing patients  
7 since the time I started the practice.

8 Q. In an office setting?

9 A. Correct. In fact, I have three offices  
10 now.

13 where were you practicing medicine as far as in a  
14 hospital setting?

15 A. I was on staff at more than one hospital.

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1 Q. Which ones were those?

2 A. The main one was the one that I trained at  
3 and am still at, which is Meridia Huron.

4 Q. Now, other than the brief time that you  
5 worked at that urgent care center, have you done any  
6 other part-time work?

7 A. No. Actually, I'm sorry, I should say  
8 yes. I did do some extra trauma work at one of the  
9 downtown hospitals. It was a level one trauma center.  
0 Based on my field of specialization, I enjoy doing  
1 trauma and I did some night calls in there as the  
2 trauma surgeon on call for the hospital.

3 Q. When was that?

4 A. That was around the year, probably 1992 to  
5 '93 to '94, '95 -- I'm sorry, I cannot recall -- until  
6 the program was dismantled based on the financial  
7 aspect of it and the hospital electing to drop out.  
8 That's when I ended my relationship with that program.

9 Q. Other than those two instances at the  
10 urgent care facility and the trauma unit, did you work  
11 in any other capacity part time?

12 A. No.

13 Q. What about back when you first, in '81  
14 when you first came to the Cleveland area?

15 A. Yes, I did do some extra work in the after

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1 hours after getting the Ohio license, and I did work in  
2 some urgent care centers.

3 Q. Tell me where those places were, do you  
4 recall?

5 A. I can recall two of them on the east side  
6 of Cleveland, one in Willowick and the other one, I  
7 think, is in Mentor on 615.

8 MR. JONES: That would be  
9 Mentor probably, yeah.

10 BY MR. ALLEN

11 Q. Any other facilities that you recall, sir?

12 A. And this same urgent care center that was  
13 mentioned in the lawsuit on and off prior to that,  
14 interrupted periods.

15 Q. The same law firm defends you in that  
16 suit?

17 A. Correct.

18 Q. Mark, is he your lawyer?

19 A. Not at that time.

20 Q. Now, since 1981 have you ever had your  
privileges suspended at any hospital?

A. No, sir.

23 Q. Have you ever been declined staff  
24 privileges?

25 A. No.

Page 21

1 Q. Have you ever been treated for alcohol,  
2 drug abuse?

3 A. Never.

4 Q. I want to center the next few questions  
5 about your practice today, okay?

6 A. Yes.

7 Q. As we sit here today. Tell me, if you  
8 could, just walk me through your typical day as it  
9 relates today, and if it changes day to day just walk  
10 me through your typical week, what you do in your  
11 office versus the hospital, et cetera.

12 A. I usually start at the hospital in the  
13 morning and go through rounds and see patients,  
14 operate, and I won't leave until afternoon to go and  
15 see my patients at the office. Usually I am busy at  
16 night. I do get phone calls, and there were times and  
17 there are times when I have to go to take care of  
18 patients simply because we run a busy trauma unit at  
19 Meridia Huron and we do accept complicated cases that  
20 need close attention and operative procedures during  
21 the middle of the night.

22 Q. How much time do you spend in your office  
23 during each given day?

24 A. I should say enough time to take care of  
25 patients plus some other administrative work,

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1 paperwork.

2 Q. You tell me you have three offices today?

3 A. The other two offices I see consults only.

4 Q. Where are those offices?

5 A. One of them is close to downtown here and  
6 the other one is on the near west side.

7 Q. Now, who calls you in for those consults,  
8 what other doctors in the practice?

9 A. There are many doctors that I get consults  
10 from.

11 Q. In those two locations what's the name of  
12 the practice?

13 A. It's my name, Rafal A. Badri, M.D.

14 Q. You say you go in as a consult. Maybe  
15 I'm --

16 A. Correct.

17 Q. So you go in to consult based upon --

18 A. Referrals.

19 Q. Referrals that are already made?

20 A. Correct.

21 Q. Those people go to that office that's  
22 located in different areas of the city, correct?

23 A. Correct.

24 Q. Now, what office is your main location?

25 A. The one 14100 Cedar Road.

Page 23

1 Q. Now, during the day or the week do you  
2 have an opportunity to teach residents?

3 A. Yes.

4 Q. How long have you been doing that?

5 A. Since I finished training in 1986.

6 Q. Tell me the capacity you train students  
7 doctors.

8 A. Meridia Huron has an approved general  
9 surgery training program. I have involvement with the  
10 residents of all capacities. It's a five-year training  
11 program, so I get involved with teaching junior and  
12 senior residents on rounds, on the floor, patient  
13 contact, educational rounds and in the classroom room.

14 Q. Now, do you ever teach in a formal  
15 classroom setting surgery?

16 A. Yes. When I'm asked to give a talk to a  
17 group of either medical students or residents from  
18 other hospitals in a teaching session, yes, I've had  
19 experience with that and still do.

20 Q. How often have you done that? Monthly?

21 A. I don't do it on a frequent basis, but I  
22 do it when I'm asked to.

23 Q. Have you done it on a monthly basis, a  
24 yearly basis?

25 A. On a monthly basis I should say.

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1 Q. At the request of who?

2 A. This is beyond Meridia Huron.

3 Q. Right.

4 A. At Meridia Huron my involvement is nearly  
5 on a daily basis.

6 Q. But I'm talking about a classroom, formal  
7 classroom setting.

8 A. I should say around a monthly basis.

9 Q. And those are requested by Meridia  
10 Hospital or somebody else?

11 A. Meridia Hospitals.

12 Q. And who would ask you to give those talks?

13 A. It's usually the chief of surgery or one  
14 of the attending staff that thinks that there is a  
15 subject that is of interest that can be discussed. In  
16 general surgery it's usually based on the way I do it  
17 or experience basis. It's an informal discussion more  
18 than just a didactic setup.

19 Q. Now, in this informal basis do you find  
20 yourself speaking more often on certain surgical  
21 techniques than others?

22 A. Yes, I do.

23 Q. What are those?

24 A. Trauma in general, abdominal trauma in  
25 specific, and gastrointestinal diseases and

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1 gastrointestinal surgery.

2 Q. How often do you give talks as it relates  
3 to cholecystic diseases and gallbladder surgery in general?

4 A. I don't give talks on a routine basis, but  
5 we frequently do get involved in discussion of  
6 complications related to biliary surgery in particular  
7 and gastrointestinal surgery in general.

8 Q. What is the last time you gave a talk on  
9 biliary surgery?

10 A. I do not recall. A formal talk you're  
11 asking?

12 Q. Yes.

13 A. I do not recall, I'm sorry.

14 Q. Was it in the last year do you think?

15 A. I don't think.

16 Q. Was it in the last two years?

17 A. Maybe.

18 Q. Now, other than what you just mentioned  
19 is there, personally is there some specialty that  
20 you enjoy most in surgery?

21 A. Abdominal trauma.

22 Q. Abdominal trauma. And when we're talking  
23 abdominal trauma, tell me what we're talking about,  
24 give me examples.

25 A. We're talking about traumatic injury

g 26

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

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

6 A. That's it.

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

10 A. No.

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

13 A. No.

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

16 A. I have collected some information  
17 pertaining to some areas that I may see some positive  
18 can

19 programs pertaining to maybe management and trauma, but  
20 this is something for me to entertain in the future.

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

23 A. No, sir.

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

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1 talking about gallstone removals and gallbladder  
2 removals, correct?

3 A. I have no intention.

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

6 A. Correct.

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

10 A. No.

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

13 A. No.

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

16 A. No.

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

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

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

1 A. Correct.

2 Q. Have you ever read an electrocardiogram?

3 A. Yes. I was taught to read

4 electrocardiograms, but I cannot claim that I am an  
5 expert or somebody that could feel very comfortable  
6 giving an opinion about looking at an  
7 electrocardiogram.

8 Q. So you don't feel that if you did  
9 render an opinion as it relates to electrocardiogram,  
10 correct?

11 A. Correct.

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

14 A. No, sir.

15 Q. Same question as it relates to a chest  
16 x-ray and say a chest x-ray that is checked  
17 for infiltrate or hyperinflation?

18 A. I don't feel I'm an

19 MR. VALTERS: could you read  
20 that back?

21 BY MR. ALLEN

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

Page 29

1 A. No.

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

4 A. No way.

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

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

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

14 A. Correct.

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

18 A. Correct.

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

22 A. Not really.

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

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1 A. I was trained to be a general surgeon, so  
 2 I cannot claim any expertise in that.  
 3 Q. In that area?  
 4 A. Correct.  
 5 Q. All right. Then as far as internal  
 6 medicine, do you feel competent to hold yourself out as  
 7 having any expertise in the field of internal medicine?  
 8 A. I was trained to be a physician to begin  
 9 with and a surgeon second. I feel it's an obligation  
 10 of any surgeon to be able to understand and handle  
 11 basic medical problems, but I don't think it is a right  
 12 thing to do to indulge in management of complicated  
 13 issues.  
 14 Q. Because you don't do that on a regular  
 15 basis, correct?  
 16 A. Correct.  
 17 Q. On a regular basis you're a surgeon,  
 18 correct?  
 19 A. Correct.  
 20 Q. So you would leave those types of  
 21 management to --  
 22 A. The experts.  
 23 Q. -- the experts, internal medicine experts,  
 24 correct?  
 25 A. Correct.

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

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1 Q. Now, have you ever performed oral  
 2 dissolution therapy for gallstones?  
 3 A. No.  
 4 Q. Have you ever performed an ESWL shock  
 5 wave?  
 6 A. No.  
 7 Q. Do you consider yourself competent to  
 8 interpret MRI's?  
 9 A. No.  
 10 Q. What about CT scans, do you feel competent  
 11 in that area?  
 12 A. I feel I have enough training to let  
 13 myself understand what's going on if I have to read a  
 14 CT scan in the middle of the night if a radiology  
 15 opinion is not available, and I reserve this judgment  
 16 for myself to help me at least get a handle on the case  
 17 at that time, but not beyond that.  
 18 Q. So as an as-needed emergent basis you can  
 19 interpret CT films, correct?  
 20 A. To a limited extent.  
 21 Q. To a limited extent. And that limited  
 22 extent includes what part of the body?  
 23 A. The abdomen.  
 24 Q. It doesn't include the brain?  
 25 A. No.

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1 Q. So we're talking the abdomen and the  
 2 thoracic area?  
 3 A. Not really.  
 4 Q. Just the abdomen?  
 5 A. Correct.  
 6 Q. Okay. Do you have any members of your  
 7 family that practice law?  
 8 A. No.  
 9 Q. Tell me about Meridia Huron. Am I  
 10 pronouncing that right?  
 11 A. Meridia Huron.  
 12 Q. Meridia Huron. Tell me about that  
 13 hospital. How many beds are in that hospital?  
 14 A. I don't recall the exact number, but it's  
 15 somewhere around 200.  
 16 Q. How many OR suites do they have?  
 17 A. Eight.  
 18 Q. Eight, okay.  
 19 A. Major.  
 20 Q. Eight major. How many minor ones?  
 21 A. One or two.  
 22 Q. So ten total?  
 23 A. Correct.  
 24 Q. How many operations occur in that hospital  
 25 per year?



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1 A. I'm sorry, I don't have the number.  
 2 Q. Do you know how many gallbladder surgeries  
 3 are done in that hospital per year?  
 4 A. I actually don't.  
 5 Q. Do you know how many surgeons are on staff  
 6 there?  
 7 MR. JONES: General  
 8 surgeons or just any kind?  
 9 MR. ALLEN General  
 10 surgeons, I'm sorry.  
 11 A. I don't know the exact number, but I can  
 12 tell you that there are surgeons that are there on a  
 13 regular basis and there are full-time surgeons related  
 14 to the general surgery training program in there and  
 15 there are surgeons that show up on a part-time basis  
 16 that are in practice in the community.  
 17 Q. You're on full staff here, right? You  
 18 spend most of your time at that hospital, correct?  
 19 A. I spend most of the time, but I'm in  
 20 private practice.  
 21 Q. So you have no idea how many general  
 22 surgeons which are equivalent to you would be  
 23 practicing in that hospital?  
 24 I don't know how many of them are staff.  
 25 but it does not necessarily mean that all of them are

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1 fully active and are operating there on a regular daily  
 2 basis.  
 3 Q. Now, on a regular daily basis do you think  
 4 it would be half of that, six?  
 5 A. I should say the number is around four.  
 6 Q. Four?  
 7 A. To five.  
 8 Q. Including you?  
 9 A. Correct.  
 10 Q. Now, if you could, Doctor, tell me the  
 11 number of surgeries, the number of gallbladder  
 12 surgeries you performed last year.  
 13 A. I'm sorry, I did not look at that number.  
 14 Q. You don't know?  
 15 A. I did not look at the number to be honest.  
 16 Q. Excuse me?  
 17 A. I did not look at the number, I did not  
 18 review it, and I did not anticipate there would be a  
 19 question of such.  
 20 Q. Well, just give me an estimation since I  
 21 kind of --  
 22 A. I'm sorry, I cannot come up with a number.  
 23 Q. Do you do it on a weekly basis?  
 24 A. I could say that, yes.  
 25 Q. Do you do it on more than a weekly basis,

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1 twice a week?  
 2 A. It's very variable. There are times when  
 3 I may do more than one a week and there are times that  
 4 I may do less than one a week.  
 5 Q. That's fair. So if we were to say 52  
 6 times a year you perform gallbladder surgery, would  
 7 that be a high number, an estimated high number?  
 8 A. It may be high.  
 9 Q. So if it was less than 40, between 40 and  
 10 50? Let me ask you that, between 40 and 50?  
 11 A. Maybe less than 40.  
 12 Q. Between 30 and 40?  
 13 A. I'm sorry, I cannot tell you.  
 14 Q. But we're in a close range there,  
 15 somewhere between 30 and 40?  
 16 A. Somewhere.  
 17 Q. Now, has that frequency decreased or  
 18 increased since 1994?  
 19 A. Based on the HMO --  
 20 MR. WALTERS: what frequency?  
 21 I don't know what you're talking about.  
 22 MR. JONES: The frequency  
 23 of gallbladder --  
 24 A. Are you talking in general or in my  
 25 practice?

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

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

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

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

11 **A. Correct.**

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

14 **A. Correct.**

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

17 **A. Probably.**

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

20 **A. Probably.**

21 Q. Seventy, 80 percent?

22 **A. I should say around 70 to 80.**

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

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1 **A. I'm not about this**

2 Q. Sound about right?

3 **A. Maybe.**

4 Q. You don't know?

5 **A. I don't.**

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

9 **A. Correct.**

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

13 **A. No.**

14 Q. Now, in the past have you had an occasion  
15 to ever read any material on how to do it down and give  
16 a deposition, you know, be asked questions in the  
17 setting? Have you ever read an article on how to be  
18 deposed?

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

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

23 **A. No.**

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

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

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

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

7 **A. No.**

8 Q. Has no interest at all to you obviously?

9 **A. So far not.**

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

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

15 **A. No.**

16 Q. How about a group of insurance company  
17 people?

18 **A. No.**

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

21 **A. No.**

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

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1 **A. Correct.**

2 Q. Have you ever had an opportunity to review  
3 records at the request of a lawyer as it relates to  
4 either the standard of care or issues of medical-legal?

5 **A. Pertaining to my practice or outside my**  
6 **practice?**

7 Q. Outside practice.

8 **A. No.**

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

11 **A. Yes.**

12 Q. When do you do that?

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

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

19 **A. No.**

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

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



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1 Q. How long have you held that position?

2 A. Since 1991.

3 Q. Plans of relinquishing that position any  
4 timesoon?

5 A. No.

6 Q. Why do you hold that position?

7 A. It gives me a good opportunity to get  
8 myself more involved with trauma. I not only just do  
9 my part, but I look at the practice of trauma in  
10 general at the hospital. I do review all the  
11 admissions, I do look at the quality of care, and I'm  
12 assisted with a nurse manager that has expertise in  
13 that. I do head the trauma committee meeting, which  
14 meets on a regular basis, that has a good part of its  
15 duty to review the quality of care delivered to the  
16 trauma patients.

17 Q. Do you find it helpful to be able to  
18 retrospectively --

19 MK. CASEY Before we get  
20 too far into this, I should let you know  
21 that in Ohio we have a privilege for any  
22 quality review materials, so I just don't  
23 want you to go too far with this.

24 MR. ALLEN: I figured as  
25 such. I appreciate it.

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1 BY MR. ALLEN:

2 Q. Now, do you find the opportunity to  
3 review -- when you retrospectively look at care in  
4 whatever setting you're talking about, do you find it  
5 helpful to the medical records retrospectively?

6 MR CASEY Object to form.

7 MR. JONES: objection.

8 MR. WALTERS: Objection.

9 MR. MEADOWS: Objection.

0 Q. Do you find that you can adequately look  
1 at the care given to a patient retrospectively through  
2 medical records?

3 MR. MEADOWS: objection.

4 MR. WALTERS: objection.

5 MR. JONES: objection.

6 Q. Can you answer it? You can answer the  
7 question if you can understand it.

8 A. I'm sorry, not really.

9 Q. Okay.

0 A. If you want to rephrase it again.

1 Q. Sure. You review past medical cases in  
2 your capacity at the hospital as director of trauma,  
B correct?

4 A. Correct.

5 Q. When you do that, you look at medical

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1 records, correct?

2 A. Correct.

3 Q. Do you find that you can adequately review  
4 those cases based upon the medical records alone?

5 MR. MEADOWS: objection.

6 MR. JONES: I'm going to  
7 object, also. There's been no testimony  
8 that that's all they ever look at. If you  
9 want to assume that that's all he's  
10 looking at, whether he can do it by just  
11 looking at records, fine.

12 BY MR. ALLEN:

13 Q. Based upon the records, can you adequately  
14 review?

15 A. No. I feel that it's not only the medical  
16 records, but listening to the people involved in the  
17 care of any particular patients, in addition to the  
18 practice of taping or videotaping the management of  
19 trauma cases upon arrival in the emergency room, and  
20 reviewing that part in videotape was included as part  
21 of the job or the duty of the director of trauma.

22 This practice had to stop a couple  
23 years ago based on the advice given to us by one of the  
24 attorneys after --

25 MR. JONES: I'm going to

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1 have to stop you right there, Doctor.

2 Don't get into what advice you or the  
3 hospital got from counsel. If it was  
4 stopped, it was stopped on advice of  
5 counsel.

6 A. Simply we were the only --

7 MR. JONES: That's enough.

8 BY MR. ALLEN:

9 Q. Doctor, so if I understand correctly, and  
10 we'll move on, you used records, you used interviews  
11 with witnesses and people that have performed the care,  
12 and at one point you used the capacity of videotape to  
13 review these cases, right?

14 A. Correct.

15 Q. Other than those *three* aspects, is there  
16 anything else that you used in reviewing the care of  
17 doctors to patients retrospectively?

18 A. Well, sitting in also the surgical QA  
19 committee and listening to other doctors sitting on  
20 that committee passing a judgment does help give you a  
21 better insight as to how the management of any  
22 individual case went on.

23 MR. CASEY objection.

24 Move to trike any erence to lit  
assurance.

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Page 48

1 BY MR. ALLEN:

2 Q. But the general discussion and general  
3 review of these cases has helped you be a better  
4 doctor, would you agree?

5 A. To some extent I should say.

6 Q. Now, you had a chance to look at Dewey's  
7 records. We're about to get into those records  
8 shortly. I just wanted to ask you, besides the medical  
9 records -- scratch that.

10 Doctors use medical records to  
11 communicate in, correct? You communicate from doctor  
12 to doctor via medical records as one way of  
13 communication, correct?

14 A. One way of communication.

15 Q. That's true, right, that's one way?

16 A. Correct.

17 Q. There are other ways that doctors  
18 communicate obviously, right?

19 A. Correct.

20 MR. WALTERS: object.

21 Q. Let's just get our arms around that. You  
22 talk to doctors in the hall and communicate about care  
23 to a patient, that's not reflected in the medical  
24 records, correct?

25 A. Correct.

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1 Q. Do you use nurses to communicate between  
2 doctors also?

3 A. It depends on the kind of communication  
4 that you want to establish and the level of care that  
5 you think you may need to touch bases with other  
6 doctors upon.

7 Q. But you have found yourself on occasions  
8 communicating through nurses to other doctors, correct?

9 A. On some occasions.

10 Q. Have you found yourself communicating to  
11 another doctor about a specific patient in any other  
12 manner besides what we just talked about?

13 A. Well, if I feel that I need to talk to a  
14 doctor based on my concern level, I could go all the  
15 way to pick up the phone and page that doctor and wait  
16 for him to call back to waiting to see him that day or  
17 the next day if I need to.

18 Q. So you could personally go page him,  
19 telephone call him and set up a meeting with him,  
20 correct?

21 A. Correct.

22 Q. That's what you're talking about there.

23 Any other way you find yourself reaching  
24 out to communicate to other doctors?

25 A. As far as a specific patient?

1 Q. I mean just in general. Is there any  
2 other way to communicate to a doctor besides  
3 personally, communication one on one or through a nurse  
4 or through a medical record?

5 A. Well, if I have had some cases that I  
6 thought were interesting enough and have had no hundred  
7 percent satisfaction with what I have of information on  
8 hand, I have used the opportunity, for example, to  
9 communicate with other doctors of expertise during  
10 attending some seminars in medical or surgical  
11 conferences.

12 Q. Is that more in a retrospective role to  
13 say, hey, Doctor, I had this case and this is what  
14 happened, what's your opinion, is that what you're  
15 talking about?

16 A. Or listen to a doctor bring his side of  
17 the story and discuss his experience with management of  
18 a case or cases and then go ahead and discuss some  
19 aspect of interest that I have had with his  
20 presentation about the management.

21 Q. So make sure that I understand what you're  
22 saying is that if you've got a patient and you want to  
23 communicate or find out information as it relates to  
24 medical care, you have gone out and sought through --  
25 I'm drawing a blank here -- through seminars, et

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1 cetera. other doctors' advices?

2 A. Correct. And even if I have to pick up a  
3 phone and call a friend of mine that I know has some  
4 expertise that may live outside this town to try to get  
5 some piece of good advice from him about some  
6 management.

7 Q. So we've pretty much got our arms around  
8 that, ways to communicate?

9 A. I guess, unless there's something else  
10 that I'm overlooking.

11 Q. Okay. Is there a way of communication  
12 that you rely on more than other ways, doctor to  
13 doctor, in your practice?

14 A. Face-to-face communication.

15 Q. So you rely on face-to-face communication  
16 more than you do the medical records?

17 A. Correct.

18 Q. Do you rely on face-to-face communication  
19 more than you do information through nurses at the  
20 hospital?

21 A. Correct. Again, I have to individualize,  
22 too. If it's a straightforward kind of care process I  
23 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.

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1 Q. But you like the face-to-face  
2 communication the best, correct?

3 A. I think this is the appropriate way that I  
4 rely on.

5 Q. Is it your job -- scratch that.

6 What percentage of your job entails  
7 consults being called in to consult on a case, how  
8 often do you do that a day?

9 A. That I get called and consult, I should  
10 say the majority of my practice because it's mostly  
11 referrals.

12 Q. So what percentage of patients come  
13 underneath your care as a primary care doctor?

14 A. I usually am a general surgeon, so as  
15 primary care I don't handle this aspect. If there is a  
16 case that may come directly under my care as in one  
17 occasion, maybe the patient gets to be admitted  
18 directly from the emergency room that may have had no  
19 other doctor caring for him or her and I'll have to  
20 pick up the slack from there.

21 Q. So you have routinely admitted patients  
22 through the ER, correct?

23 A. Correct.

24 Q. Okay. And that usually occurs when that  
25 patient in the ER doesn't have a general practice

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1 doctor, correct?

2 A. Correct.

3 Q. How often do you do that in your practice?

4 A. I should say maybe around one-third of the  
5 time when I can get to take care of a patient that may  
6 have had nobody at that particular hospital to take  
7 care of him or her.

8 Q. So a third of the time you'll admit a  
9 patient in and you'll be the doctor on record for  
10 admitting the patient, correct?

11 A. Correct.

12 Q. And when you bring in the patient, do you  
13 then turn to an internal medicine guy to then look  
14 after his care or that patient's care?

15 A. Depending on the help that I may need  
16 taking care of that particular patient.

17 Q. So if in your judgment you feel like you  
18 need somebody else to be the primary care specialist  
19 for a patient that you've admitted to the hospital,  
20 then you'll turn over that care to another doctor,  
21 correct?

22 A. Correct.

23 Q. How would you go about going to

24 A.

25 directly or having the resident doctor communicate with

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1 the consultant if I'm not available or put an order in  
2 the chart if it's for routine care and have the nurse  
3 relay the information to the consultant.

4 Q. So you would routinely chart whether you  
5 were turning over the care to a consultant, primary  
6 care, correct?

7 A. Beyond my surgical involvement with a  
8 certain case, correct.

9 Q. How often do you follow patients after  
10 surgery? All the time?

11 MR. JONES: me you saying  
12 right after surgery, I mean, beyond the  
13 usual post-op?

14 BY MR. ALLEN

15 Q. Until they get out of the hospital.

16 A. In the immediate postoperative period,  
17 yes, it's my responsibility.

18 Q. To follow the patient?

19 A. Correct.

20 Q. And then all the way up until discharge,  
21 if you admit that patient, you're responsible for that  
22 patient?

23 A. Correct.

24 Q. And if you have changed the responsibility  
25 of that patient to another consult, you would have

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1 noted that in your record, correct?

2 A. But if I have had some involvement with  
3 that patient, I still feel it's my duty to continue  
4 following the patient despite the fact that he is or  
5 she is on another service.

6 Q. Okay. So you would feel there would be a  
7 joint duty between you and that other consultant?

8 MR. MEADOWS: Objection.

9 A. Correct.

10 Q. Now, does that change when you call in a  
11 consultant for a specific problem? Say you want an  
12 infectious disease consult based upon you can't  
13 understand why an infection is happening with a  
14 patient. Would you then, once that consult comes in do  
15 you feel there's a mutual role between you and that  
16 consult?

17 A. Correct. The practice of general surgery  
18 entails a lot of infections or infectious complications  
19 related to the care of a particular patient and we do  
20 have or have had certain experience with handling  
21 infectious complications, but at times when I feel, for  
22 example, the bacteria that are being isolated are just  
23 not the kind that I feel comfortable writing the  
24 regular daily antibiotics for and I feel that it may  
25 need the expertise of somebody who handles this on a

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

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1 A. A general surgeon.  
 2 Q. A general surgeon?  
 3 A. Correct.  
 4 Q. So your expertise isn't to run a  
 5 diagnostic test, but it's to cut and be a general  
 6 surgeon, correct?  
 7 A. Well, it's to recognize the disease and be  
 8 able to manage the disease in an operative and  
 9 certainly in an inoperative fashion, too, and be able  
 10 to handle the complications, if any, following any  
 11 certain operative procedure and handle all the care  
 12 pertaining to that particular procedure until the  
 13 patient is discharged from the hospital.  
 14 Q. Anything else?  
 15 A. No, sir.  
 16 Q. Have you followed patients that have  
 17 suffered from sleep apnea syndrome?  
 18 A. No.  
 19 Q. Have you ever -- you've never encountered  
 20 a patient with sleep apnea syndrome?  
 21 MR. JONES: I'm going to  
 22 object. Did you ask him whether he's  
 23 treated patients for sleep apnea or if  
 24 he's ever seen a patient --  
 25 MR. ALLEN: Did I say

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1 treated?  
 2 MR. JONES: I don't know.  
 3 MR. ALLEN: I thought I  
 4 said, have you ever seen patients that  
 5 have had sleep apnea syndrome.  
 6 MR. JONES: well, then I'm  
 7 objecting because what have you ever seen,  
 8 I'm not sure exactly what you mean. He  
 9 may have seen somebody at a cocktail party  
 10 who has sleep apnea.  
 11 BY MR. ALLEN:  
 12 Q. Have you followed patients and one of the  
 13 complications that they had was sleep apnea syndrome?  
 14 A. No, I don't follow patients that have  
 15 sleep apnea, but I have had an idea about it based on  
 16 somebody else's experience having listened to it  
 17 discussed in medical conferences.  
 18 Q. What is your understanding of sleep apnea  
 19 syndrome?  
 20 A. I should say it's limited.  
 21 Q. Tell me what limited understanding you  
 22 have, please.  
 23 A. It's usually a problem that more often an  
 24 overweight person may encounter. It's a breathing  
 25 irregularity based on inhibition of certain mechanisms

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1 that do control the breathing process and some onsets  
 2 of interruption of the regular breathing pattern maybe  
 3 and/or the depth of it to some extent causing cessation  
 4 of breathing or the effort of breathing and thereby  
 5 creating the physiological derangements that the body  
 6 in general may incur based on the alteration of the  
 7 normal breathing pattern.  
 8 Q. Are you aware that sometimes that can be a  
 9 fatal complication of an obese person, to have sleep  
 10 apnea syndrome?  
 11 A. Yes, I'm aware of that.  
 12 Q. So you're aware that one of the symptoms  
 13 of it is a history of loud snoring?  
 14 A. I really am not an expert to say. It may  
 15 be, but I'm not sure.  
 16 Q. You're not aware that that's one of the  
 17 symptoms?  
 18 MR. JONES: I'm going to  
 19 object. I've never heard of a history  
 20 being a symptom, but be that as it may.  
 21 He's already tried to answer it.  
 22 A. It may. I actually don't know. It may  
 23 be.  
 24 Q. It may be?  
 25 A. Yes.

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

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

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1 Q. But that patient with sleep apnea syndrome  
2 is at a risk postoperatively to have respiratory  
3 distress, true?  
4 MR. MEADOWS: Objection to  
5 form.  
6 MS. REINKER: objection.  
7 MR. JONES: I've already  
8 been objecting.  
9 Doctor, if you can answer his question,  
10 go ahead. If you don't know, just tell  
11 him you don't know.  
12 A. Not necessarily. If the airway was  
13 managed appropriately and if there was enough  
14 anticipation of how the progress of the postoperative  
15 recovery has been going on, I don't think that this can  
16 hold true.  
17 Q. Do you know that the only way to confirm  
18 sleep apnea syndrome is a sleep somniography, have you  
19 ever heard of that?  
20 A. I don't know anything about that.  
21 Q. Have you handled patients that have had  
22 OHS? Do you know what that is?  
23 A. No.  
24 Q. Obesity hypoventilation syndrome.  
25 A. you me I some of

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1 those?  
2 Q. Yes. Have you cut on a patient that's had  
3 that syndrome?  
4 A. I have had many patients that were  
5 morbidly obese that I've operated on. In fact, I have  
6 had good exposure to morbid obesity patients. When I  
7 was in training the chief of surgery then had special  
8 interest in bariatric surgery or surgery for morbid  
9 obesity, and he was operating on an average of a case a  
10 day stapling those people's stomach.  
11 MR. JONES: Doctor, all he  
12 asked you is if you were familiar with  
13 obesity hypotension something.  
14 BY MR. ALLEN  
15 Q. Let me re-ask the question.  
16 A. I'm not aware of the syndrome.  
17 Q. Let me re-ask the question. Obesity  
18 hypoventilation syndrome?  
19 A. Not this syndrome.  
20 Q. You've never had a patient with that? I  
21 just want to make sure you understand the question.  
22 You've never had a patient with that?  
23 A. can say I not  
24 in-depth knowledge to go and look specifically for that  
25 syndrome.



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1 Q. Okay.

2 A. It might have been listed in the chart or  
3 mentioned somewhere in front of me, but, again, that is  
4 not anything for me to indulge in in further care  
5 delivery, I should say, as far as my specialty is  
6 concerned.

7 Q. Would you expect if you had a patient like  
8 that that it would be brought to your attention, that  
9 had that syndrome?

10 MR. WALTERS: I'm going to  
11 object to form.

12 MS. REINKER: objection.

13 MR. JONES: objection.

14 BY MR. ALLEN

15 Q. Would you expect to be aware of the fact  
16 that a patient had OHS?

17 MR. CASEY: objection to  
18 form.

19 MR. JONES: I'm going to  
20 object. He said he doesn't have a  
21 familiarity with the syndrome, so how can  
22 he have any expectations regarding that?

23 MR. WALTERS: And I'll show  
24 my objection. You're talking about a  
25 hypothetical patient and some abnormal

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1 situation that we're totally unaware. Go  
2 ahead.

3 BY MR. ALLEN:

4 Q. Okay, Doctor.

5 A. I was not made aware at any time that  
6 there was something thrown at me with this specific  
7 description that you gave it. Forgive me, give it to  
8 me again.

9 Q. Obesity hypoventilation syndrome.

10 A. But again, if the case comes out, I'm sure  
11 my level of awareness is going to be altered.

12 Q. Thank you, Doctor.

13 Staying on the track of the obese  
14 patient, Doctor. With your history of obese patients,  
15 you've seen or you're aware of the difficulty that can  
16 be expected when you intubate an obese patient,  
17 correct?

18 A. I have witnessed morbidly obese patients  
19 being intubated and I can say it's not the easiest  
20 intubation that one would encounter.

21 Q. And these patients are difficult to  
22 monitor intraoperatively, correct?

23 MS. REINKER: Objection.

24 MR. MEADOWS: what patients?

25 MR. JONES: Objection.

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1 From a general surgeon's point of view or  
2 an anesthesiology point of view?

3 BY MR. ALLEN:

4 Q. In your opinion, Doctor, are these  
5 patients difficult to monitor intraoperatively?

6 MR. JONES: what kind of  
7 monitoring are we talking about? I'm  
8 objecting to this question as unclear.

9 A. I think it depends on the type of surgery  
10 and the other associated co-morbid medical problems  
11 that may dictate the level of the intensity of  
12 intraoperative monitoring.

13 Q. Sure. How often have you ordered a  
14 Swan-Ganz catheter placed on a patient that you've  
15 operated on?

16 MR. JONES: In his entire  
17 career how many times has he ordered a  
18 Swan-Ganz catheter, is that the question?

19 Q. Is that frequent?

20 A. I can say I've had good training inserting  
21 Swan-Ganz catheters and being able to interpret the  
22 information collected from those catheters. In my  
23 practice nowadays I'm more and more involved with  
24 specialists, and since I find myself needing or  
25 requesting help from other specialists to be involved

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1 in the care of a particular patient, I'm finding myself  
2 ordering the placement of Swan-Ganz catheter less and  
3 less.

4 Q. On a percentage of patients that you see  
5 yearly, is it something that you do more than ten  
6 percent of the time?

7 A. I'm sorry, can I ask you to go a little  
8 bit more specific? Is it my involvement as far as  
9 putting the Swan-Ganz in or ordering it to be inserted?

10 Q. Either way. Let's just leave it very  
11 broad. Either you doing it or ordering it.

12 A. It's getting less and less.

13 Q. Does that less and less mean less than ten  
14 percent of your patients you would order it or do it  
15 the Swan-Ganz?

16 A. I really cannot give you a certain figure  
17 because the degree of other maybe co-morbid problems  
18 that are associated with some of the patients that I  
19 operate on are so variable that I really cannot be very  
20 specific about this.

21 MR. CASEY: Did I miss  
22 something? Did he say he orders Swans?

23 BY MR. ALLEN.

24 Q. So overall a Swan-Ganz catheter you would  
25 expect it to be seen rarely in a patient that you

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1 perform?

2 A. Not necessarily.

3 Q. Do you see it often; do you place it or  
4 order it often?

5 A. I don't think the trend is on the rise or  
6 on the decline more than it's related to the medical  
7 condition of the surgical patient that I was going to  
8 handle or will be handling.

9 Q. Let me narrow it down. How about an obese  
10 patient, what percentage of obese patients do you order  
11 a Swan-Ganz catheter for or insert a Swan-Ganz  
12 catheter?

13 A. Again, nowadays it's mostly the word of  
14 the other specialists that are involved in the care of  
15 that patient more than my word or my liking or my  
16 decision to insert a Swan-Ganz catheter.

17 Q. So you would rely on another specialist to  
18 tell you whether there should be a Swan-Ganz placed,  
19 correct?

20 A. Correct. But by the same token, if it was  
21 a patient of mine, for example, a trauma patient, a  
22 healthy man from the street that got shot and got into  
23 some postoperative complication and I need to sort out  
24 what exactly is going on, yes, I can resort to the  
25 Swan-Ganz catheter to help me get a little bit better

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1 insight as to what may be going on.

2 Q. Well, in 1994 were you relying on  
3 consultations if they were available for a patient in  
4 ordering or placing a Swan-Ganz?

5 A. Correct.

6 Q. Now, a Swan-Ganz gives you the ability --  
7 scratch that.

8 A Swan-Ganz gives a doctor the ability  
9 to intraoperatively assess volume mass and the volume  
10 status of the patient, correct?

11 A. It's a tool that can help generate some  
12 data that a physician may use to delineate certain path  
13 of management of a certain patient.

14 Q. What information does that tool give you,  
15 does that Swan-Ganz catheter give a physician?

16 A. I usually think of the Swan-Ganz catheter  
17 as a tool to help me get more information to correlate  
18 with the ongoing information that gets generated on a  
19 regular basis during the management of a critically-ill  
20 patient that usually needs the Swan-Ganz.

21 Q. Ongoing information, give me an example of  
22 that ongoing information that you would get from a  
23 Swan-Ganz catheter.

24 A. Well, it could tell me, for example, if a  
25 patient is hemodynamically unstable and is this

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1 instability arising from an occult source of infection  
2 versus decompensation of his or her cardiovascular  
3 system. It helps to some extent give me an idea about  
4 the amount of fluid that is on board.

5 It does help give an idea about the  
6 cardiac performance of a patient and some pressure  
7 figures or numbers that can be generated that help  
8 understand the amount of, for example, pulmonary  
9 circulation pressure or systemic circulation pressure  
10 and resistance.

11 Q. Can you think of any other tool that you  
12 can use intraoperatively that would give you the same  
13 amount of information?

14 A. Again, I'm a surgeon, but if I were  
15 requesting some information or detailed information as  
16 to what is going on -- and I usually do not handle the  
17 intraoperative management of Swan-Ganz, but again, if I  
18 were to get involved looking at some information  
19 generated out of Swan-Ganz readings, for example, in  
20 the intensive care unit, which is the usual setting,  
21 yes, I would understand or may have good in-depth  
22 knowledge as to the degree of physiological changes  
23 that are occurring in that particular patient.

24 Q. Now, who would you -- one other quick  
25 question.

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1 MR. A do you want to  
2 take a break?

3 MR. JONES: I have to.

4 It's obviously going to go longer than we  
5 thought. I need to make a personal call.  
6 But go ahead and finish this area if you  
7 want to.

8 MR. ALLEN: Last question  
9 in this area and then we can move on to  
10 another t

11 MR. ALLEN:

12 ( Wl would you expect -- who would you rely  
13 on to monitor information on a Ganz  
14 intraoperatively?

15 A. Intraoperatively?

16 Q. M-hm.

17 A. It's usually the anesthesiologist.

18 MR. ALLEN: We can take a  
19 break.

20 MR. JONES: Let's just take  
21 a quick break. I do have to make a call.  
22 (Thereupon, there was a brief recess.)

23 Q. Doctor, do you hold yourself as to having  
24 any expertise in the area of anesthesiology?

25 A. No.



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1 Q. So when it comes to issues of  
2 anesthesiology, you rely on the anesthesiologist to  
3 perform his duties properly?  
4 **A. Correct.**  
5 Q. Now, as far as a surgeon, before you go  
6 under the knife with somebody or cut on somebody that  
7 you've admitted to the hospital, I want to ask you a  
8 few questions about before the operation. You've  
9 admitted this patient to the hospital. Can you order  
10 any diagnostic study that you feel like you should  
11 order to evaluate the baseline health of that patient?  
12 **A. If there is a diagnostic test that I could**  
13 **or I do feel may help me out as far as my management of**  
14 **that particular surgical problem is.**  
15 Q. So if you feel that there's a diagnostic  
16 test that would help you in your knowledge to order,  
17 you would order it, correct?  
18 **A. Correct.**  
19 Q. Okay. If it was a diagnostic test that  
20 you felt was outside your field, you would then ask for  
21 a consult, correct?  
22 **A. Correct.**  
23 Q. And you would expect that consult to then  
24 perform the appropriate diagnostic tests in his or her  
25 consult area, correct?

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

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1 system, or are we talking about an  
2 admission of Dewey Jones? Is this just  
3 like a huge, broad category of any patient  
4 what can he order, what do his privileges  
5 provide that he can order?  
6 THE WITNESS: I was going to  
7 ask for a clarification.  
8 MR. JONES: wait a minute.  
9 I want a clarification before you try to  
10 answer it, Doctor.  
11 THE WITNESS: I'm asking for  
12 a clarification, too.  
13 MR. JONES: well, I've  
14 already asked for it, so let's just wait  
15 for it.  
16 MR. ALLEN Do you want me  
17 to talk now?  
18 MR. JONES: yes.  
19 BY MR. ALLEN  
20 Q. Doctor, what -- listen to the question --  
21 what tests do you feel that you can run and evaluate  
22 cardiovascularwise to a patient you've admitted before  
23 you go into surgery?  
24 MR. WALTERS: Objection.  
25 MR. MEADOWS: objection.

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1 MR. CASEY: Objection.  
2 MS. REINKER Objection.  
3 MR. JONES: objection.  
4 Go ahead, Doctor, if you can answer  
5 that question.  
6 **A. Are we talking in general or anything**  
7 **specific?**  
8 Q. Whatever you feel you can comfortably  
9 order a diagnostic test and evaluate cardiovascular  
10 systems based upon that test, tell me which ones you're  
11 comfortable ordering.  
12 MR. WALTERS: Objection.  
13 MR. MEADOWS: objection  
14 MS. REINKER: objection.  
15 MR. JONES: objection.  
16 **A. I don't truly feel that there is a good**  
17 **number of tests that I feel comfortable ordering.**  
18 Q. That's fine.  
19 **A. I have the privilege of being surrounded**  
20 **by people of different expertise that can go ahead and**  
21 **order that.**  
22 Q. So as far as evaluating the cardiovascular  
23 system, if you felt it needed to be evaluated, you  
24 would call in a cardiologist, correct?  
25 **A. Correct.**

1 Q. As far as evaluating pulmonary systems,  
2 would you feel comfortable about ordering any  
3 diagnostic tests it relates to pulmonary systems?

4 A. Not really. I would ask a pulmonologist  
5 to get involved in handling this kind of a case.

6 Q. And then you would proceed based upon the  
7 clearance and the judgment of a pulmonologist?

8 A. Correct.

9 MR. MEADOWS: objection.

10 BY MR. ALLEN:

11 Q. I'm sorry, did you say correct?

12 A. I would strongly consider the input from a  
13 pulmonologist that has been asked on consultation.

14 Q. And you would rely on his expertise in the  
15 area of pulmonology as to whether or not the pulmonary  
16 system of any given patient is healthy enough to  
17 proceed with your surgery, correct?

18 MR. MEADOWS: objection.

19 Q. Is that true?

20 A. Correct.

21 Q. Do you have any experience, Doctor,  
22 evaluating patients with hypertension?

23 A. Limited.

24 Q. Tell me about the limited experience you  
25 have in treating patients with hypertension.

1 somebody that I feel is competent enough in his or her  
2 period of expertise to handle that.

3 Q. And in a patient that you are the  
4 admitting primary care doctor, you feel competent to  
5 recognize what hypertension is, true?

6 A. Forgive me, rephrase the question.

7 Q. Do you feel competent to recognize what  
8 hypertension is in a patient?

9 A. Based on what a physician in general  
10 should understand about hypertension, and I think this  
11 is basic.

12 Q. Based on what you're presented with in  
13 front of you, you feel that you can tell whether the  
14 patient is hypertensive, correct?

15 A. Correct.

16 Q. How many patients have you operated on  
17 would you estimate that have severe hypertension?

18 A. I'm sorry, I cannot put a number on it.

19 Q. Is that often, is that a lot of patients?

20 A. It is often, yes.

21 Q. A lot of people have hypertension, right?

22 A. Especially in this country.

23 Q. A good many of patients have severe  
24 hypertension that you operate on?

25 A. Yes.

1 MR. JONES: Are we asking  
2 about treating patients for hypertension  
3 or treating patients surgically who happen  
4 to have hypertension? Which are we  
5 talking about? I want a clarification  
6 before he answers. He will not answer the  
7 question as it is posed to him at this  
8 time. I want a clarification.

9 MR. ALLEN: Good.

10 BY MR. ALLEN:

11 Q. Now, as far as your limited experience  
12 with patients that have hypertension, correct?

13 A. Correct.

14 Q. Are you with me?

15 A. Yes.

16 Q. You tell me what area of limited  
17 experience you have with these patients. If it's in  
18 the realm of surgery, tell me about the realm of  
19 surgery; if it's in the realm of diagnostic, tell me  
20 about the realm of diagnostic. You understand my  
21 question, correct?

22 A. Yes. If we're handling a patient that is  
23 in the hospital with hypertension and a surgical  
24 problem that I have some involvement with, I usually  
25 defer anything that pertains to hypertension to

1 Q. Now, before you operate on that patient  
2 you oversee what medication that patient is receiving,  
3 correct?

4 A. Usually in association with another  
5 consultant who has more in-depth knowledge about this  
6 condition.

7 Q. So you and a consultant would be looking over  
8 the hypertensive medications administered to any given  
9 patient, correct?

10 A. Correct.

11 Q. Do you feel that the patient should stay  
12 on his medical therapy up to the day of surgery?

13 A. Correct.

14 Q. Why is that, Doctor?

15 A. It's imperative to maintain stability of  
16 the cardiovascular system for optimal postoperative  
17 results.

18 Q. And it's important to maintain that  
19 stability because patients with hypertension  
20 intraoperatively are at risk for precipitous falls of  
21 blood pressure, correct?

22 A. I should say fluctuation.

23 Q. Fluctuation?

24 A. Of blood pressure.

25 Q. That's true, correct?

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1 A. Correct.

2 Q. Those patients are also a higher risk for

3 myocardial ischemia and cerebral ischemia

4 intraoperatively, true?

5 A. To some extent, yes, but I don't have

6 exact in-depth knowledge about that.

7 Q. Now, how many patients have you had the

8 opportunity to operate on that have had congestive

9 heart failure?

10 A. I should say many, but I cannot give you a

11 number.

12 Q. It's something that you're familiar with,

13 a patient presenting to you with congestive heart

14 failure?

15 A. To some extent.

16 Q. And you would -- would you automatically

17 with a patient with congestive heart failure ask for a

18 cardiology consult?

19 A. Yes.

20 Q. Pardon me?

21 A. Yes.

22 Q. Yes, you would. And why would you do

23 that?

24 A. I believe that this kind of patient is at

25 higher risk of getting into problems, whether it be

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1 intraoperative or postoperative, based on this

2 condition.

3 Q. And you would want that consultant's

4 judgment based upon the cardiovascular health of that

5 patient, correct?

6 A. Correct.

7 Q. With that consultant available, do you

8 feel that that would lessen the likelihood of mortality

9 or morbidity for you, for your patient, having a

10 consult available as opposed to just you handling the

11 patient alone?

12 A. That is correct.

13 Q. Just in general though, you see the

14 benefit and the reduction of the chance of death or

15 morbidity in a patient with congestive heart failure

16 for calling in a consult, correct?

17 A. Correct.

18 Q. Now, surgery in obese patients -- if I can

19 just get your mind to think in that area, okay, Doctor.

20 You have concerns when you face a patient that is obese

21 for surgery, correct?

22 A. Correct.

23 Q. Would it be fair to say a consensus of

24 surgeons have those concerns, too?

25 A. --

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1 Q. One of the concerns is pulmonary edema,

2 correct?

3 A. I can't put it on top of the list. I

4 think there may be other problems that may take

5 priority on top of that.

6 Q. What would they be?

7 A. Inadequate breathing effort

8 postoperatively that may precipitate atelectasis or

9 lung collapse. The pain, especially abdominal surgical

10 pain, that may diminish the effort of breathing and

11 precipitate the retention of secretions, whether it be

12 infected or just physiological secretions, can cause a

13 higher chance of retention and subsequent pulmonary

14 complications.

15 Q. Anything else that you can put on the list

16 of concerns for an obese patient above pulmonary edema?

17 A. Are we talking about the pulmonary system

18 alone or in general?

19 Q. In general.

20 A. No. There are a lot of complications or a

21 lot of considerations that the surgeon has to

22 understand that pertains to almost every system in that

23 morbidly obese patient's body stemming from the

24 efficiency of the cardiovascular system, the mobility

25 of the patient that may enhance the development of

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1 blood clots or postoperative DVT, or deep venous

2 thrombosis, in addition to the skin complications

3 related to inactivity and pressure sores and hygienic

4 issues related to that.

5 Q. And pulmonary embolism, DVT's, that's

6 something that you're trying to guard against, correct?

7 A. Correct.

8 Q. Would that be something that you would

9 order a test for yourself, or would you rely on a

10 pulmonology expert to do that for you if he was

11 consulted?

12 MR. MEADOWS: Under what

13 circumstances? Object to form.

14 A. Are we talking about the preoperatively,

15 the perioperative period? There are some variations.

16 Q. Does it matter? Should I ask you in the

17 different realms?

18 A. I think we need it a little bit more

19 specifically.

20 Q. Okay. So if you have a pulmonology

21 consult available to you, a pulmonologist that has

22 consulted with you on a patient, would you rely on him

23 to do the PT test, the PTT test, to evaluate --

24 A. I can tell you if --

25 MR. WALTERS: Are we talking

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1 about --  
 2 MR. MEADOWS: me-op,  
 3 post-op?  
 4 MR. WALTERS: -- hematology  
 5 tests now?  
 6 BY MR. ALLEN  
 7 Q Do you understand my question, I think  
 8 MR. MEADOWS: show an  
 9 objection to form.  
 10 Q. Do you understand my question?  
 11 A. To some extent.  
 12 Q. Okay.  
 13 MR. JONES: I don't want  
 14 you answering a question to some extent  
 15 that you understand. Make sure you  
 16 understand his question, Doctor.  
 17 A. I need to ask you to clarify again. Are  
 18 we talking about a patient that presents to me without  
 19 the previous or preexisting DVT versus somebody that I  
 20 anticipate that's going to develop DVT after surgery,  
 21 and my approach to those patients is a little bit  
 22 different.  
 23 Q. I understand your concern. Maybe this  
 24 will be a simpler way and we can cut all this off. Is  
 25 the development of DVT is something that

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

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1 patient?  
 2 MR. CASEY objection.  
 3 MR. MEADOWS: objection.  
 4 MR. WALTERS: Objection.  
 5 MS. REINKER: objection. For  
 6 DVT?  
 7 A. To an extent.  
 8 Q. To an extent there's a joint duty between  
 9 you and the pulmonologist?  
 10 A. Correct.  
 11 Q. Now, as far as pulmonary edema, my  
 12 understanding of pulmonary edema is -- scratch that.  
 13 Is it true that pulmonary edema, when  
 14 patients die of pulmonary edema it's like they drown in  
 15 the fluid in their lungs, is that what happens?  
 16 MS. REINKER. Objection.  
 17 A. That's a simple explanation.  
 18 Q. Can you give me any simpler explanation  
 19 than that?  
 20 A. I think in laymen's terms you've done it  
 21 perfect.  
 22 Q. In medical terms what happens  
 23 physiologywise to cause death due to pulmonary edema.  
 24 A. The air sacs and the air spaces within the  
 25 oxygen are

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

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1 A. At a risk, yes.

2 Q. And there's an increased risk over a  
3 patient if it doesn't have CHF, correct?

4 A. It is somewhat of a higher risk than  
5 somebody who does not have CHF.

6 Q. And a patient with a history of CHF also  
7 is at higher risk postoperatively of developing  
8 cardiovascular complications, correct?

9 A. We need to be a little bit more specific  
10 about that. If the patient was -- a patient with CHF  
11 who was well monitored and taken care of preoperatively  
12 and intraoperatively may not necessarily get into  
13 trouble in the postoperative period with CHF.

14 Q. What would you want to see preoperatively  
15 to monitor that patient With CHF to reduce the risk of  
16 cardiovascular complications postoperatively?

17 A. I think we're getting into a little bit  
18 more complex cardiac or cardiology information as to  
19 the degree of cardiac impairment that did precipitate  
20 that CHF and the extent of this cardiac impairment that  
21 will dictate the degree of CHF or how badly CHF may be  
22 and how it may inflict problems in the perioperative  
23 period.

24 Q. Do you feel a cardiologist would be better  
25 suited at talking about those risk factors,

1 aware of.

2 Q. Do you feel a cardiologist would be able  
3 to tell me that --

4 MR. JONES: objection.

5 BY MR. ALLEN

6 Q. -- more than you would be able to tell me  
7 that?

8 MR. JONES: objection.

9 Q. He would have more knowledge in that area  
10 than you?

11 MR. JONES: Objection.

12 A. Maybe even an internist or a family  
13 practitioner may give you a better in-depth than I am.

14 Q. Now, do you hold any opinion as to whether  
15 preoperative arterial blood gas values give any  
16 assurance as to the adequacy of pulmonary reserve for a  
17 patient during surgery?

18 A. I'm sorry, give me the question again.

19 Q. Do you hold any opinions as to whether  
20 preoperative ABG's, arterial blood gas values, gives  
21 any assurance of adequacy of pulmonary reserve during  
22 surgery?

23 A. I cannot use the word "assurance," but  
24 maybe some understanding or in-depth understanding  
25 better than the word "assurance."

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1 perioperative and intraoperative management of a  
2 patient with CHF?

3 A. Again, we have -- I think we're dealing  
4 with a wide or a spectrum of CHF which could be, on the  
5 one hand, very mild and, on the other extreme, severe  
6 enough to warrant closer care, I should say, or higher  
7 level of alertness.

8 Q. So in your history of reviewing literature  
9 and your general knowledge, can you tell me if there  
10 are studies out there that you've reviewed that you're  
11 familiar with that divide the risk factors for CHF and  
12 complications due to cardiovascular complications  
13 postoperative, preoperative, intraoperatively?

14 MR. JONES: Object to form.

15 A. I'm sorry, I cannot indulge on this.

16 Q. So you don't have any -- you can't point  
17 me to any literature or medical knowledge out there  
18 that divides the degree of CHF --

19 A. No, I can't.

20 Q. Let me just finish my question.

21 A. I'm sorry.

22 Q. -- divides the degree of CHF and the  
23 degree of the higher risk of complications, cardiac  
24 complications, you can't lead me to that?

25 A. I cannot pinpoint to a study that I'm

1 Q. So ABG's can give you some understanding  
2 of the pulmonary reserve of a patient intraoperatively,  
3 true?

4 A. True.

5 Q. In your knowledge, what are some  
6 predisposing factors of cardiac dysrhythmia  
7 postoperatively?

8 A. I think this is a little bit of an  
9 in-depth question. I could just -- based on my limited  
10 knowledge of that, it could be electrolyte imbalance,  
11 it could be instability of the cardiovascular system  
12 itself. Coagulopathy, again, outside the issue of the  
13 cardiovascular system itself, which may pertain to  
14 hematological disorders, can precipitate dysrhythmias  
15 or arrhythmias. Even temperature variations can  
16 predispose to that.

17 Q. And when you talk about cardiovascular  
18 instability, you're talking cardiac disease within  
19 that, correct?

20 A. Correct. But there are diseases of the  
21 blood vessels or the stability of the blood vessels  
22 themselves maintaining the pressure at the particular  
23 time that can precipitate that.

24 Q. Including hypertension?

25 A. Correct.



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

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

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

5 MR. ALLEN what part did  
6 you not hear?

7 MR. WALTERS: Read it back.  
8 (Thereupon, the question was read back.)

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

21 BY MR. ALLEN:

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

24 A. The site or the size?

25 Q. The site, the area of the site.

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1 Does the site of the surgery increase  
2 the risk intraoperatively or postoperatively for  
3 respiratory morbidity?

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

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

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

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

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

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

22 A. Correct.

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

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1 respiratory complications?

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

6 Q. Take it pulmonary disease. The fact th t  
7 they ha a ary disease at a cause dyspnea,  
8 that would increase the risk factors?

9 A. To some extent.

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

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

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

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

23 Q. We'll read it again.

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

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1 (Thereupon, there was a brief recess.)

2 BY MR. ALLEN:

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

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

8 A. Yes.

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

11 A. Correct.

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

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

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

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

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

25 A. Correct.

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1 Q. So when they're breathing in less volume  
2 you, thus, have complications --

3 A. Correct.

4 Q. -- flowing from that? That's why when you  
5 have an obese patient you try a transverse incision?

6 A. Not necessarily.

7 Q. Tell me why not.

8 A. There has been no study that I'm aware of  
9 that tells me that a transverse incision in an upper  
10 abdominal operation versus an up and down or  
11 longitudinal incision can dramatically or significantly  
12 change the outcome.

13 Q. Do you hold any habit or opinion as to  
14 which way you should cut on an obese patient?

15 A. It depends on the kind of surgery that I  
16 usually am doing and the organ that I'm tackling during  
17 that operative procedure.

18 Q. So if it's an upper abdominal procedure it  
19 would depend upon what organ you're going after?

20 A. Correct.

21 Q. So just in gallbladder surgery,  
22 laparotomy, would you more likely do a transverse  
23 incision?

24 A. In a gallbladder it's more likely a  
25 transverse or an oblique incision. But it is well

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1 known that one of the approaches for a gallbladder  
2 could be an up and down incision, too, or a  
3 longitudinal incision. There are some factors that the  
4 surgeon has to understand or factor in to make that  
5 or decision.

6 Q. Based upon the patient in front of him?

7 A. Based on the patient's habitus and maybe,  
8 more specifically, the degree of the subxiphoid angle  
9 and the amount of rib spread, I should say, or the rib  
10 cage. The lower ribs confluence creating a narrow or a  
11 wide subxiphoid angle.

12 Q. Does anything else come into play?

13 A. Sometimes some surgeon may resort to a  
14 different incision based on their judgment that they  
15 may do it faster and get in and out in an emergency  
16 trying to cut down on the operative time.

17 Q. What are the symptoms of biliary colic --  
18 excuse me, scratch that.

19 Biliary colic is caused by intermittent  
20 obstruction of the cystic duct by gallstones; is that a  
21 true statement?

22 A. Correct.

23 Q. Episodes of biliary colic would include  
24 upper gastric and right upper quadrant pain; is that a  
25 correct statement?

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1 A. Upper abdominal epigastric pain, not  
2 necessarily right. It can occur on the left side, too.

3 Q. It can occur on the left side.

4 Is it more likely to occur in the right  
5 upper quadrant?

6 A. More likely.

7 Q. And it's more likely that that pain would  
8 radiate to the back?

9 A. More likely.

10 Q. Okay. That patient would also present on  
11 physical exam more likely with fever?

12 A. Not necessarily.

13 Q. What percentage of patients that you  
14 diagnose -- scratch that.

15 Do you diagnose patients with biliary  
16 colic?

17 A. Yes.

18 Q. What percentage of patients do you think  
19 that you diagnose with biliary colic that present  
20 without fever?

21 A. Well, if fever ensues we're beyond the  
22 stage of biliary colic. It is a more advanced and, I  
23 should say, slightly longer occurring process of  
24 obstruction that precipitated the infection versus the  
25 intermittent, short lasting biliary colic.

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1 Q. Now, you wouldn't expect to see the WBC  
2 elevated in biliary colic, would you?

3 A. It may occur.

4 Q. But you wouldn't expect with biliary colic  
5 for biliary colic to cause the WBC to increase?

6 A. It can happen.

7 Q. It can happen.

8 A. Yes.

9 Q. But not very often?

10 A. very was  
11 short lasting.

12 Q. Short lasting, are we talking symptoms of  
13 one to four hours?

14 A. Yes, to some extent.

15 Q. And you would expect to see nausea in a  
16 patient with biliary colic?

17 A. Yes, in a good percentage of those  
18 patients.

19 Q. And you'd expect to see vomiting in a  
20 patient with biliary colic?

21 A. Yes, but a slightly lower percentage than  
22 nausea.

23 Q. All right. Now, acute cholecystitis is  
24 very similar to biliary colic, correct; is that true?

25 A. I can't say similar. I think it's a



1 different ballpark, if you may.

2 Q. What makes acute cholecystitis a different  
3 ballpark?

4 A. It's persistent obstruction of the cystic  
5 duct precipitating retention of bile, and subsequent  
6 infection ensues in that bile stagnant or trapped in  
7 that gallbladder.

8 Q. You would expect to see a patient with  
9 acute cholecystitis present with a low-grade fever,  
0 true?

1 A. In the early stages.

2 Q. You'd expect to see that patient with  
13 acute cholecystitis present with chills, true?

14 A. If the obstruction has been ongoing for  
15 some time good enough to have precipitated infection  
16 that was invasive enough to have spread to the  
17 bloodstream.

18 Q. And you would expect to see a patient with  
9 acute cholecystitis present with leukocytosis?

0 A. Yes.

11 Q. A mild elevation in bilirubin would be  
12 another symptom of acute cholecystitis?

13 A. It will be a finding.

14 Q. Finding, pulmonary finding, correct?

25 A. Correct.

1 Q. , levels would you  
2 expect that?

3 A. To some extent. Not the high percentage  
4 if we're dealing with acute cholecystitis, per se.

5 Q. But the history of acute cholecystitis, it  
6 usually starts off with biliary colic and then  
7 progressively gets worse; is that a true statement?

8 A. Correct.

9 Q. And the pain is more generalized with  
0 acute cholecystitis than that with biliary colic; is  
1 that true?

2 A. Generalized as generalized abdominal pain?

3 Q. Right.

4 A. It's possible.

5 Q. So you'd expect to see three things with  
6 an acute cholecystitis. One would be the sudden onset  
7 of right upper quadrant tenderness, two would be fever,  
8 and three would be leukocytosis; is that true?

9 A. Forgive me, I'm not trying to play smart,  
10 but right upper abdominal pain. Tenderness is a  
11 finding, is a sign.

12 Q. Okay. So you'd expect to see right upper  
13 quadrant pain?

14 A. Pain.

15 Q. Not tenderness?

1 A. Tenderness is a finding on exam.

2 Q. So on exam you'd expect to see tenderness  
3 in the patient?

4 A. Find tenderness, correct.

5 Q. But then the fever, you'd expect fever and  
6 leukocytosis?

7 A. Correct. But it's not a hundred percent  
8 finding, or the three findings are not present in 100  
9 percent of cases of cholecystitis or even early  
10 cholecystitis I should say.

11 Q. Sure. But wouldn't you agree that the  
12 general literature states that's a triad for diagnosing  
13 acute cholecystitis?

14 A. I can't say a triad, but it's a common  
15 finding.

16 Q. Those three things are a common finding in  
17 acute cholecystitis?

18 A. Correct.

19 Q. Now, I think you said this, but  
20 cholecystitis occurs when stones become lodged in the  
21 cystic duct and then block the flow of bile and that  
22 causes inflammation of the gallbladder; is that true?

23 A. Correct.

24 Q. And basically cholelithiasis is just the  
25 finding of gallstones in the gallbladder?

1 A. Correct.

2 Q. What is your definition of fever? Give it  
3 to me in Celsius and Fahrenheit. What would you say a  
4 fever would start, at what degree?

5 A. I can say there is something that I can  
6 call low-grade fever and there's high-grade fever. The  
7 low-grade fever is something -- Celsius I'm more aware  
8 of -- something that goes above 37.5.

9 Q. And Fahrenheit, what is that?

10 A. Forgive me. Maybe I should say above a  
11 hundred or 99.8, if you may. I'm not exact about that.

12 Q. 99.8, 100 would be a low-grade fever?

13 A. Yes.

14 Q. And then a high-grade fever in Celsius?

15 A. I consider that anything above 38.5, 38.4.

16 Q. Which would be what, 101?

17 A. Forgive me, I'm not -- maybe around 101,  
18 even higher.

19 Q. In obesity you would consider a patient  
20 obese with greater than 20 percent of their ideal body  
21 weight?

22 A. To a good extent.

23 Q. That's a true statement in your opinion?

24 A. That is true.

25 Q. And morbidly obese you would classify as

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1 somebody with twice the body weight --  
 2 A. 200 percent.  
 3 Q. 200 percent, twice?  
 4 A. Yes.  
 5 Q. And dyspnea -- we talked about it  
 6 earlier -- that's just shortness of breath?  
 7 A. Correct.  
 8 Q. And gallbladder surgery, that's an upper  
 9 abdominal surgery, correct?  
 10 A. Correct.  
 11 Q. Now, obesity, that can cause reduced  
 12 oxygenation in a patient, can it not?  
 13 A. Depending on the degree of obesity.  
 14 Q. And depending on the degree of obesity, it  
 15 could cause pulmonary hypoxemia, true?  
 16 A. Correct.  
 17 Q. It could cause that, correct?  
 18 A. Yes.  
 19 Q. All right. Now, as far as cholecystitis,  
 20 would you agree that -- scratch that.  
 21 Free perforation of gallbladder is rare  
 22 in cholecystitis, true?  
 23 MR. WALTERS: I'm sorry, I  
 24 didn't understand that. Free --  
 25 MR. JONES: Perforation.

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1 MR. ALLEN: Free  
 2 perforation of gallbladder.  
 3 A. It is a known complication, but it is  
 4 infrequent. It's a late stage of ongoing  
 5 cholecystitis.  
 6 Q. Now, spreading peritonitis is a rare  
 7 complication of cholecystitis, true?  
 8 A. Correct.  
 9 Q. Emergency laparotomies are rarely  
 10 performed for cholecystitis, true?  
 11 A. Emergency surgery for cholecystitis, if  
 12 you may. I cannot say rarely, but it is not -- again,  
 13 I should say you have to individualize.  
 14 Q. When was the last time you performed an  
 15 emergency laparotomy for a cholecystitis?  
 16 A. Two weeks ago.  
 17 Q. When was the last time you did it before  
 18 that?  
 19 A. Before what?  
 20 Q. Before two weeks ago when was the last  
 21 time?  
 22 A. I can't remember that.  
 23 Q. Was it in the last year?  
 24 A. Less than that.  
 25 Q. Does it happen two or three times a year?

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1 A. It's possible.  
 2 Q. To you?  
 3 A. Yes.  
 4 Q. Two or three times?  
 5 A. Yes.  
 6 Q. More than that?  
 7 A. No.  
 8 Q. So that's pretty rare for your practice as  
 9 far as gallbladder surgery, true?  
 10 A. Thanks to the care and advancement in  
 11 medical practice.  
 12 Q. But that's a true statement about your  
 13 practice?  
 14 A. Correct.  
 15 Q. Is there, in your opinion, a medical  
 16 controversy regarding the need to get rid of  
 17 gallstones?  
 18 MR. WALTERS: object to the  
 19 form. I don't understand "controversy."  
 20 A. There are a lot of people or a certain  
 21 percentage of people that can go to the grave without  
 22 knowing that they have gallstones. On the other hand,  
 23 once a person is struck with a disease process related  
 24 to the gallstones, whether it be cholecystitis or  
 25 common bile duct stone or gallstone pancreatitis, the

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

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1 Q. Patients with diabetes mellitus, are they  
2 more susceptible to septic complications during  
3 surgery?

4 A. That's absolutely correct.

5 Q. And then talking about cholelithiasis,  
6 gallstones, diabetes, patients that are diabetic are at  
7 greater risk for forming complications of  
8 cholelithiasis, correct? Not cholecystitis, just  
9 cholelithiasis.

10 A. I'm sorry. Rephrase it again to me.

11 Q. Sure, be happy to, Doctor. Patients that  
12 are diabetics that have cholelithiasis, they're at  
13 greater risk for complications due to the  
14 cholelithiasis, true?

15 A. Correct.

16 Q. And that's because of their cardial,  
17 pulmonary and renal status?

18 A. But mainly because of the diabetes process  
19 itself, which doctors say is related to in itself to a  
20 lower immune or suboptimal immune response, per se.

21 Q. Per se. And that usually manifests itself  
22 in cardiovascular and reduced renal status?

23 A. Correct.

24 Q. Obesity, that's a risk factor for  
25 developing cholelithiasis, true?

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1 A. To some extent. I cannot give you  
2 figures.

3 Q. And on the flip side, patients with very  
4 low calorie, rapid weight loss diets or prolonged  
5 fastings, they're also at risk for developing  
6 cholelithiasis, true?

7 A. I'm not aware of an exact specific study  
8 about that, but I could tell you, with patients that I  
9 handled with surgery for morbid obesity, yes, they have  
10 been at a higher risk of developing gallstones  
11 following rapid weight loss.

12 Q. But wouldn't you agree that it's not  
13 really clear that there's a proven correlation between  
14 diet and development of gallstones, formation of  
15 gallstones?

16 A. There is some correlation between the kind  
17 of diet consumed plus-minus other factors that may  
18 precipitate to gallstone formation.

19 Q. So it's diet plus other factors?

20 A. Plus-minus.

21 Q. What are some of the plus factors that  
22 would increase the risk of gallstone formation along  
23 with diet?

24 A. Hypercholesterolemia is one example; some  
25 other diseases related to the gastrointestinal tract,

1 for example, diseases of the ilium; some medications  
2 that the patient may consume or some diet that may be  
3 high in content of some elements that may precipitate  
4 higher stone formation.

5 Q. High cholesterol?

6 A. Cholesterol plus other factors that I  
7 cannot recall at this point in time.

8 Q. Is it a true statement that women between  
9 20 and 60 are twice as more likely to develop  
10 gallstones than men?

11 MR. JONES: okay, now,  
12 we've been real patient. It's now quarter  
13 to 7:00 and it's been two and a half at  
14 least or more than two and a half hours,  
15 two and a half hours. You're now asking  
16 questions about women being at increased  
17 risk for gallbladder disease, Could we  
18 possibly, so that I can take care of  
19 obligations other than this, get to  
20 relevant questions? I would appreciate  
21 it. I'm sure the doctor would. I think  
22 everybody else would.

23 MR. WALTERS: I would.

24 MS. REINKER: Agreed.

25 MR. JONES: This deposition

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1 will not go all night. I will call an end  
2 to it and I'm telling you I'll do it. I  
3 don't care if you're from Georgia or not.  
4 This is not going to go the rest of the  
5 evening. This is not a marathon. I want  
6 relevant questions and we'll go. We've  
7 been real patient with a lot of  
8 irrelevancies. So my lecture is over.

9 MR. ALLEN: Thank you.

10 MR. JONES: Now, he's got a  
11 question about women developing  
12 gallstones.

13 BY MR. ALLEN:

14 Q. Can you answer that question, risk  
15 factors?

16 A. I can say higher, but I cannot say twice  
17 as much.

18 Q. Let's talk about oral dissolution therapy.  
19 That was a possibility for Dewey, was it not?

20 A. I am aware of this approach of handling  
21 gallstones. It has not been successful. The published  
22 results in this country are not encouraging.

23 Q. It's possible you could attempt that with  
24 Dewey Jones, true?

25 THE WITNESS: Counsel?

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

5 A. Yes.

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

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

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

14 A. I did.

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

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

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

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

7 Q. So I I you : mmend th t Dewey was a  
8 candidate to do that ESWL?

9 A. I would not recommend it.

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

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

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

21 A. Correct.

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

24 A. Correct. But that is a minor variation.

25 We're talking about how the gallbladder is extracted

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

3 MR. WALTERS: It certainly  
4 was close to that.

5 MR. ALLEN was it close to  
6 that?

7 MS. REINKER: That's what I  
8 heard.

9 BY MR. ALLEN:

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

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

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

21 A. Correct.

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

25 A. more

1 versus whether or not to remove the gallbladder.

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

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

6 A. Correct.

7 Q. Why did that attempted surgery fail?

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

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

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

24 Q. You discussed it i the  
25 anesthesiologist and you disusse l this itl Dewey

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1 Was everybody present; is that true?

2 A. I cannot recall who was present, but I  
3 always discuss the fact that there could be a good  
4 chance of the open procedure, whether it be at the time  
5 of the laparoscopic procedure or even before that.

6 I did consider laparoscopic surgery  
7 with Mr. Jones prior to the day of surgery simply for  
8 the feasibility and factoring the issue that we may be  
9 able to get Mr. Jones out of the acute phase, maybe  
10 into the less acute phase, into a more optimal  
11 situation before I could safely and comfortably tell  
12 Mr. Jones that this is the right, most practical  
13 procedure for you.

4 Q. You discussed with Dewey and you decided  
5 to do the laparotomy, that decision was made the day of  
6 surgery?

7 A. Correct.

8 Q. And you just said you discussed it with  
9 the anesthesiologist. Did you discuss it with anybody  
0 other than Dewey, you know, another doctor besides an  
1 anesthesiologist?

2 A. No.

3 Q. What was the anesthesiologist's name that  
4 you discussed it with? Adamek?

5 A. I cannot remember.

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1 I tell you, anesthesiologists always  
2 favor open procedures because it's less of an operative  
3 time and less chance of pulmonary complications with  
4 insufflation of the abdomen by gas.

5 Q. I understand.

6 Now, you didn't discuss with the  
7 anesthesiologist different methods in the initiation of  
8 anesthesia before you operated on Dewey?

9 A. No.

0 Q. We're moving right along. It may look  
1 like a lot, but it's not.

2 MR. WALTERS: could you keep  
3 your voice up a little?

4 MR. JONES: I think you  
5 talked a lot, the two of you. Your voices  
6 are getting lower and lower and lower, and  
7 we've had trains going by and stuff.

8 BY MR. ALLEN

9 Q. When you're in the OR, you're the captain  
0 of the ship of the OR, true?

1 MR. JONES: objection.

2 MS. REINKER: Objection.

3 A. As far as the --

4 MS. WINKER: My objection is  
5 based on your, perhaps, lack of knowledge

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1 of Ohio law. Ohio law does not recognize  
2 and never has a captain of the ship  
3 doctrine in the operating suite.

4 MR. ALLEN Thank you.

5 BY MR. ALLEN

6 Q. What would you categorize -- would you  
7 categorize yourself as the captain of the ship?

8 MS. REINKER: I'm sorry, I  
9 didn't hear the question, please. Could  
10 you read --

11 MR. ALLEN I asked the  
12 same question, but I thought we waived all  
13 formalities and were objecting to the  
14 question at the time of use early on. Can  
15 I not ask that question?

16 MS. REINKER: well, I  
17 couldn't hear the question this time  
18 around.

19 MR. MEADOWS: I don't know if  
20 I agreed to that waiver of formalities.  
21 That's not what I understood any waiver up  
22 front to include. I'm objecting to not only  
23 form, but basis, as well, and reserving  
24 other objections at the same time.

25 MR. ALLEN: Ok;

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1 MS. REINKER: And I,  
2 don't let the doctor answer  
3 questions that relate to the legal issues  
4 He does not have the right of the law in  
5 Ohio.

6 MR. JONES: If the doctor  
7 uses that term, I mean, if that's what  
8 you're asking him, Doctor, do you say that  
9 you are the captain of the ship. If you  
10 use that term, Doctor, tell him. If you  
11 don't use that term, tell him you don't  
12 use that term.

13 A. I don't consider myself the captain of the  
14 ship as far as the OR environment. I may be the  
15 limited captain in the sense that I do make the final  
16 judgment as to my part of the operative procedure, but  
17 I do not have control on other personnel or specialists  
18 or other physicians in the operating room.

19 Q. So you're just part of the team, you're  
20 part of a team?

21 A. My surgical team?

22 Q. Right.

23 A. Correct.

24 Q. Dewey was a non-smoker, true?

25 A. I cannot recall.



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1 Q. According to your review of the records,  
2 did you see where Dewey Jones was a smoker?  
3 MR. JONES: we'll stipulate  
4 that the record says he was not a smoker.  
5 Whether, in fact, he was a smoker or not,  
6 God only knows, or maybe his brother or  
7 somebody knows and we'll find that out  
8 when we depose them.  
9 BY MR. ALLEN:  
10 Q. To your knowledge, Doctor, in your review  
11 of the records, was Dewey Jones a non-smoker?  
12 A. If the record says he's non-smoker, he's  
13 non-smoker.  
14 Q. He was also a non-drinker, true?  
15 MS. REINKER: Objection.  
16 A. If the records states such. But again,  
17 non-drinker in that period of time of our encounter or  
18 as a period of time before we even knew him?  
19 Q. According to the records and your  
20 knowledge of Dewey, your histories that you took of  
21 Dewey, your conversations with Dewey, Dewey was, in  
22 your knowledge, a non drinker, true?  
23 A. At that point in time. I am not aware of  
24 or cannot recall, I should say, of a possibility of  
25 previous history of alcohol consumption to a variable

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

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1 MR. JONES: Fine with me.  
2 BY MR. ALLEN  
3 Q. Now, Dewey presented to you in your  
4 history, according to the past records and your  
5 knowledge, he was -- you would have to categorize him  
6 as a noncompliant patient as it relates to his  
7 medication, true?  
8 MR. WALTERS: I'm sorry, and  
9 I apologize. Categorize him as a  
10 noncompliant patient?  
11 MR. ALLEN. M-hm.  
12 A. I don't think I could pass this judgment  
13 myself. I have not had that kind of long interaction  
14 with him, and I have to rely on the records of other  
15 physicians that were involved.  
16 Q. Doctor, are you aware of Dewey's mental  
17 health evaluations? He had two previous psychologic  
18 evaluations and hospitalizations.  
19 A. Mental health?  
20 Q. M-hm. Were you aware of that?  
21 A. I cannot recall that.  
22 Q. Do you recall him giving a history of  
23 having prior, having gunshot, being shot, multiple  
24 gunshots?  
25 A. Yes, there was such a history.

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1 Q. Whether or not you had knowledge of  
2 Dewey's previous psychological evaluations, that  
3 wouldn't have made any difference in the medical care  
4 that you gave to Dewey, true?  
5 A. No, sir.  
6 Q. When were you aware of the fact that he  
7 had a history of hypertrophic cardiomyopathy? Was it  
8 before surgery?  
9 A. Before surgery.  
10 MR. CASEY Before we get  
11 off the psychological stuff, I'm going to  
12 want to know when those admissions  
13 occurred and where they occurred. I don't  
14 think we know that yet.  
15 MR. ALLEN Okay, sure.  
16 Whatever that procedure is.  
17 MR. CASEY: Just let me  
18 know.  
19 MR. ALLEN: If that's  
20 procedure, we can sit down right now and  
21 we can give them to you. I'm sorry.  
22 BY MR. ALLEN:  
23 Q. You were aware of hypertrophic  
24 cardiomyopathy?  
25 A. Preoperatively, correct.

1 Q. What about his history of hypertension,  
2 you were aware of that before surgery, true?  
3 A. **Correct.**  
4 Q. His history of congestive heart failure  
5 dating back to like 1987, were you aware of that before  
6 surgery?  
7 A. **I'm aware of congestive heart failure; I**  
8 **cannot specify timing.**  
9 Q. The time that he presented with a history  
10 of it. But you're aware that he had CHF before you  
11 operated on him, or a history?  
12 A. **Correct.**  
13 Q. And that in Dewey's case was hand in hand  
14 with his obesity, his congestive heart failure was due  
15 to his obesity; is that true?  
16 MR. MEADOWS: what was that?  
17 I'm having a hard time hearing you.  
18 MR. ALLEN I'm trying.  
19 I'm sucking on a --  
20 MR. MEADOWS: If you could,  
21 repeat it.  
22 A. **Rephrase the question again, please. I**  
23 **didn't pick up all parts of it.**  
24 **(Thereupon, the question was read back.)**  
25 MR. MEADOWS: Objection to

1 **form.**  
2 A. **I was aware that the patient had**  
3 **congestive heart failure and he was morbidly obese.**  
4 Q. But you never put the correlations  
5 together in your medical opinion?  
6 A. **There is some correlations, yes.**  
7 Q. There is correlations in general.  
8 So more than likely the correlation  
9 between the congestive heart failure and Dewey's  
10 obesity --  
11 A. **May be related.**  
12 Q. When were you aware that Dewey had a  
13 history of sleep apnea?  
14 A. **During that admission.**  
15 Q. Before the surgery?  
16 A. **Correct.**  
17 Q. Were you aware that he had a history of  
18 TIA before surgery?  
19 A. **No.**  
20 Q. Were you aware in 1993 presentations to  
21 hospitals for history of chest pains?  
22 A. **I'm aware that he had consulted medical**  
23 **people for some other problems, but I'm not aware if it**  
24 **was specifically chest pain.**  
25 Q. You're you aware he had consulted for

1 cardiology problems, correct; is that what you're  
2 saying?  
3 A. **Cardiac problems?**  
4 Q. Yes.  
5 A. **Correct.**  
6 Q. Were you aware before the surgery that he  
7 had a history of multiple chest x-rays that showed  
8 cardiomegalia?  
9 A. **I'm aware of that.**  
10 Q. And you were aware of that before the  
11 surgery, true?  
12 A. **True.**  
13 Q. And you were aware that he had EKG's that  
14 were abnormal before surgery, true? You're aware that  
15 he had a history of EKG's that were abnormal before you  
16 operated on him, true?  
17 A. **I cannot recall what the EKG was or the**  
18 **report on the EKG. I'll have to refer to the chart.**  
19 Q. Excuse me?  
20 A. **I'll have to refer to the chart.**  
21 Q. Can you do that for me right now?  
22 MR. CASEY while you're  
23 looking, Doctor, I might as well put this  
24 on the record, too. As I recall the  
25 answers to interrogatories in this case,

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



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

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1 candidate, true?  
 2 MR. WALTERS: could you  
 3 read -- I'm sorry, could you repeat the  
 4 question, please?  
 5 Q. You were aware that Dewey Jones was a poor  
 6 surgical candidate going into this surgery --  
 7 MR. MEADOWS: objection to  
 8 form.  
 9 Q. -- that you performed, true?  
 10 A. I can say that he was at a higher risk of  
 11 getting into problems than somebody else.  
 12 Q. And he was at a higher risk for getting  
 13 into problems such as cardiopulmonary complications,  
 14 true?  
 15 A. Correct.  
 16 Q. When he presented on 10-17-94, he  
 17 presented to the ER via EMT With a history of one day  
 18 of abdominal pain. You were aware of that, true? You  
 19 can look at the record --  
 20 A. Correct.  
 21 Q. -- the ER record if you want to.  
 22 A. A day or two. I'm not very specific about  
 23 that.  
 24 Q. You were aware of the fact that he  
 25 presented with a history of nausea and headache?

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1 A. I'm aware of a history of nausea; I cannot  
 2 be sure of headache.  
 3 Q. You performed your initial examination of  
 4 Dewey Jones on what date, Dr. Badri, 10-17.  
 5 A. 10-18.  
 6 Q. On your initial examination of Dewey would  
 7 you categorize him as having severe hypertension?  
 8 A. I cannot recall that I labeled him as  
 9 such.  
 10 Q. Would you refer to your chart of your  
 11 physical, history and physical examination that you  
 12 first performed?  
 13 MR. JONES: The 18th you  
 14 said?  
 15 A. I cannot recall that we had to label him  
 16 as severe hypertension.  
 17 Q. Pardon me? I didn't catch it.  
 18 A. I cannot recall that we had to label him  
 19 as, quote/unquote, severe hypertension, but he was  
 20 hypertension.  
 21 Q. Would you label him as severe  
 22 hypertensive?  
 23 A. Again, I'll have to look at more details  
 24 of the chart, but, yes, he was hypertensive. I cannot  
 25 say it was severe, no.

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

1 A. Correct.  
 2 Q. Did you note an enlargement of his liver?  
 3 A. No.  
 4 Q. Did you note that he had pitting edema of  
 5 the legs on your initial --  
 6 A. He did have a mild degree of pitting  
 7 edema.  
 8 Q. His initial WBC was normal, was it not,  
 9 Doctor?  
 10 A. If that's what the record states.  
 11 Q. If it's 5.7 on the initial WBC, that is  
 12 normal, true?  
 13 A. Was there a differential count for that?  
 14 MR. JONES: It's probably  
 15 in this second volume.

16 we have a  
 17 white count of 5.7 and a differential count which was  
 18 normal.

19 Q. Okay. So it was normal? What WBC  
 20 normal?  
 21 A. Correct.  
 22 Q. The initial serum bilirubin was slightly  
 23 elevated at 2.1, true?  
 24 A. Correct.  
 25 Q. Based upon those symptoms, that's

1 I had the plan upon admission to get him over the acute  
 2 phase and not to operate during this hospital  
 3 admission.  
 4 Q. And tell me what the acute phase of  
 5 Dewey's presentation was.  
 6 A. It was abdominal pain with nausea and  
 7 vomiting with the presence of gallstones in there,  
 8 which may add up to beginning of biliary colic, plus a  
 9 history of previous attacks, which may put him at a  
 10 ballpark of being labeled as chronic cholecystitis, and  
 11 between those two ballparks there is the park of acute  
 12 cholecystitis, which I was fearful of.  
 13 Q. So you're in several different ballparks  
 14 at this point and you're not definite which one it is,  
 15 true?

16 I was fearful of a patient who has or who came to me with biliary  
 17 cholecystitis who has or who came to me with biliary  
 18 colic. I was not sure if we were dealing with acute  
 19 cholecystitis at that point in time.

20 Q. When were you sure that you had acute  
 21 cholecystitis?  
 22 A. I was more concerned about the elevation  
 23 of his liver function tests, i.e., his serum bilirubin  
 24 and the alkaline phosphatase, which increased my level  
 25 of anxiety as to whether I'm going to be able to get

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

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

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1 Q. Now, the accelerated bilirubin and the  
2 alkaline phosphorus in his case, at what degree would  
3 you state -- the serum bilirubin was 2.1 on  
4 admission. Did it continue to go up?

5 A. Yes.

6 Q. What was the highest point that it was?

7 A. 3.2.

8 Q. And was it when it reached 3.2 that you  
9 decided to perform a cholecystectomy on Mr. Jones?

10 A. It was based on additional doctors of the  
11 absence of the sense of well being. Mr. Jones  
12 to me  
13 he ~~did~~ not feel better, and when we even tried to offer  
14 him some liquids he had ongoing nausea and he could not  
15 tolerate that.

16 Q. So we had the ongoing nausea and  
17 complaints by you of being uncomfortable, plus the  
18 bilirubin, that was when you decided to --

19 A. Intervene.

20 Q. -- intervene.

21 Is there anything else that I'm missing  
22 out of the equation as to what made you decide to  
23 intervene?

24 A. I think I've stated that to you.

25 Q. Thank you.

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1 THE WITNESS: Is it possible  
2 that I can take a two-minute break?

3 MR. JONES: Absolutely.

4 MR. ALLEN: Sure.

5 (Thereupon, there was a discussion off the  
6 record.)

7 BY MR. ALLEN:

8 Q. Doctor, when we left we were talking about  
9 the 3.2 bilirubin, and that was leading you to evaluate  
10 his condition as a **risk** of inadequate liver function;  
11 is that correct?

12 A. As a risk of biliary obstruction.

13 Q. Biliary obstruction.

14 So your concern is that there is some  
15 stone lodged in his bile duct, correct?

16 A. Or that the obstruction within the  
17 gallbladder had gotten good enough to have caused  
18 pressure on the common bile duct by the virtue of  
19 vicinity of an extensive inflammatory process going on  
20 in the gallbladder sitting next to the common bile duct  
21 that can cause pinching or obstruction.

22 Q. That inflammation, would you expect to see  
23 that produce an elevated temperature or WBC?

24 A. Yes. Not consistently though.

25 Q. But you'd expect to see an elevated WBC

1 along with that, correct?

2 A. Correct.

3 Q. At what point is the bilirubin count  
4 you're looking at -- it was 2.1 on admission and it's  
5 3.2 when you made your decision, but at what point were  
6 you becoming concerned about the liver function?

7 A. I was concerned from the beginning with a  
8 bilirubin of 2.1, which is high. I mean, I would have  
9 felt better if it was below 1.1 or 1, which is the  
10 maximum normal, and here I am faced with a patient that  
11 has twice that amount that jumped to 3.2 the next day.  
12 That got me more concerned.

13 Q. Now, at the point that you made your  
14 decision, you weighed the 3.2 and the complaints of  
15 Dewey with his health condition at that time before you  
16 decided to proceed with surgery, correct?

17 A. I was concerned that further delay or me  
18 waiting or procrastinating any further could bring a  
19 good chance of more complications related to the  
20 biliary process or the inflammatory process going on in  
21 the biliary tract that may increase the chances of  
22 morbidity related to that disease process and increase  
23 the chance of morbidity in general to the patient if I  
24 wanted to intervene at a later time.

25 Q. So the complications that you talked, you

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1 I were worried about -- what complications of the  
2 obstruction were you worried would occur with Dewey  
3 Jones?

4 A. I was afraid that the gallbladder may  
5 undergo necrosis and subsequent perforation, or there  
6 might have been biliary obstruction, which there was,  
7 that could precipitate subsequent infection in the  
8 common bile duct that will throw him in a different  
9 ballpark called acute cholangitis, which is a more  
10 lethal disease than simple acute cholecystitis.

11 Q. But he didn't have that when you operated  
12 on him, true?

13 A. True.

14 Q. He didn't have it before you operated on  
15 him, true?

16 A. I cannot say that, no.

17 Q. You didn't diagnose him with acute  
18 cholangiosis, did you?

19 A. Well, he was covered with antibiotic and I  
20 did not want to reach a **stage** where I have a full blown  
21 picture of acute cholangitis on my hand before I **start**  
22 doing something about it.

23 Q. So that concern weighed against Dewey's  
24 health condition led you to conduct the surgery on  
25 Dewey Jones on that morning, true?

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

8 Q. So morning of 20. October 1994 we had  
9 reached a point in your mind that there was an  
10 emergency laparotomy necessitated; is that true?

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

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

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

17 Q. Okay. You had time to make all the  
18 things that were necessary before surgery, true?

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

21 Q. That was what you did you needed to do  
22 before his emergency laparotomy  
23 cholecystectomy on Dewey Jones, true?

24 A. Correct.

25 Q. You had the time to call a cardiologist

1 consult, true?

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

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

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

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

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

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

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

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

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

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

1 you read it?

2 A. No.

3 Q. Would it have been Dr. Ho?

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

6 Q. Do you know him?

7 A. Yes.

8 Q. Is he a cardiologist?

9 A. Yes.

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

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

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

16 A. I cannot recall.

17 Q. You don't recall ordering the EKG, true?

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

23 Q. If you didn't read the EKG, who did you  
24 expect to read the EKG and tell you the findings on the  
25 EKG?

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

4 ( So expected the  
5 to report to you the findings on the EKG, true?

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

8 MR. BASE, Allen, I

9 think you're getting into confusion over  
10 the term "read." You interpret "read" as  
11 he interprets and he interprets it

12 as --

13 MR. BASE, I'm wall

14 that road, thanks

15 BY MR. ALLEN:

16 Q. Did you have knowledge of the fact that  
17 that EKG before you operated was abnormal?

18 A. Yes.

19 Q. And it was your decision in the face of  
20 that abnormal EKG and the rest of the presentation  
21 to operate, true?

22 A. No.

23 Q. Whose decision was it?

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

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P 1

1 candidate for surgery, especially suitable.

2 Q. Do I understand that you look at the EKG  
3 and the report that was given to you and your knowledge  
4 that it was abnormal and you put that into the equation  
5 with everything else that you knew about Dewey Jones  
6 and then you decided to do the surgery, true?

7 A. There are other people that are involved  
8 in the decision making of labeling a patient a  
9 candidate or a poor candidate or an unsuitable  
10 candidate for surgery.

11 Q. Those people that you consulted with were  
12 Dr. O'Neill and Dr. Ho?

13 A. Correct.

14 Q. Was there anybody else besides  
15 Dr. O'Neill, Dr. Ho and yourself that decided whether  
16 Dewey Jones was a candidate?

17 A. Anesthesia service.

18 Q. And anesthesia service. Anybody else?

19 A. Well, it was, again, my decision as far as  
20 the biliary disease is concerned, but I had to go with  
21 what the rest of the nonsurgeons' decisions was of  
22 whether I was allowed to operate on Mr. Jones at that  
23 particular day.

24 Q. So to do the bilirubin surgery you  
25 considered, did you not -- did you not consider a

1 Q. Was there any equipment that was not  
2 that.

3 Was there any diagnostic tests that you  
4 wanted to run in which there was not equipment  
5 available to you when you evaluated Dewey Jones before  
6 surgery?

7 A. Related to his surgical problem or in  
8 general?

9 Q. Let's talk about first in general. As you  
10 were in your decision whether he was a candidate  
11 for surgery and you wanted to run any diagnostic test,  
12 was there ever a problem with any of the equipment, the  
13 availability of equipment to you?

14 A. I reached a point where I felt that as far  
15 as I'm concerned that I could not afford to wait any  
16 longer and I had to abide by what other physicians or  
17 consultants involved --

18 MR. JONES: Doctor, we're  
19 trying to get to the point. He just asked  
20 you if any diagnostic test you wanted to  
21 run, was there ever an instance where you  
22 wanted to run a test and the equipment  
23 wasn't available for you to run the test.

24 A. No.

25 MR. ALLEN: Thank you.

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1 cardiologist's consult before operation?

2 A. Again, it's in the hands of the doctors  
3 that are more knowledgeable about the degree of a  
4 disease process, if you may, that can say the patient  
5 does need a cardiologist or not.

6 Q. If I understand correctly, were you then  
7 relying on Dr. O'Neill and Dr. Ho to --

8 A. And anesthesia.

9 Q. -- and anesthesia to inform you whether a  
10 cardiology consult was needed?

11 A. Correct.

12 MR. MEADOWS: t  
13 BY MR. ALLEN

14 Q. Dr. Rizk never became involved in the case  
15 before Dewey was operated, true?

16 A. Forgive me?

17 Q. Dr. Rizk.

18 A. Rizk.

19 Q. Dr. Rizk was never involved in this case  
20 before Dewey was operated?

21 A. Correct.

22 Q. And you never saw Dr. Rizk in the  
23 emergency room doctor, after the patient was admitted  
24 to the hospital, true?

25 A. True.

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1 MR. CASEY Thanks, Mark.

2 MR. JONES: No problem.

3 BY MR. ALLEN:

4 Q. What about an echocardiogram, when was an  
5 echo ordered in this case?

6 A. It was ordered preoperatively.

7 Q. Who reviewed the echocardiogram?

8 A. I'll have to look.

9 Q. While you're looking for that -- never  
10 mind.

11 A. There is a report of an echo in the chart,  
12 but I'm aware that there is an echo that was done  
13 preoperatively.

14 Q. You're aware that it was done  
15 preoperatively. Did you review the report before you  
16 operated on Dewey?

17 A. I cannot remember that I reviewed the  
18 report, but I remember discussing --

19 Q. Who did you discuss --

20 A. -- discussing the findings of the report  
21 or discussing the findings of the procedure, if you  
22 may, the echocardiogram.

23 Q. Who did you discuss that with?

24 A. I discussed it with the resident staff and  
25 I remember discussing it with anesthesia, and I read



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

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1 A. Correct.  
 2 Q. And that would have been part of --  
 3 hypertension did not come into your -- come into  
 4 your -- you looked at Dr. Ho to evaluate Dewey's  
 5 hypertension based upon his consult, and you weren't  
 6 independently going to clear or not clear Dewey for  
 7 surgery based on hypertension alone. true?  
 8 MR. WALTERS: Object to form.  
 9 MR. JONES: I'll object  
 10 it.  
 11 If you can, answer the question,  
 12 Doctor.  
 13 A. I don't independently clear the patient  
 14 for surgery, especially somebody like this particular  
 15 with medical  
 16 Q. That evaluation of hypertension did  
 17 not come into your consideration before you operated on  
 18 Dewey Jones. true?  
 19 A. I'm sorry, repeat the  
 20 Q. Hypertension never entered into your mind  
 21 as a consideration of whether or not to operate on  
 22 Dewey Jones. true?  
 23 A. It is a consideration that any physician  
 24 has to take. Somebody with hypertension is somebody  
 25 that is, to some extent, if it's there and it has

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

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1 note, was that based upon your order to that --  
 2 A. It is the usual protocol for anybody who  
 3 is to undergo any operative procedure under anesthesia,  
 4 to go NPO the night before.  
 5 Q. What is the protocol for patients that are  
 6 hypertensive, under hypertensive medication? Should  
 7 they go NPO?  
 8 A. I'm not aware of a specific protocol, but  
 9 patients, hypertensive patients can either take a pill  
 10 or a water or can a  
 11 antihypertensive medication.  
 12 Q. Are you aware of that Dewey was given  
 13 his hypertension medication after midnight?  
 14 A. Yes.  
 15 Q. Are you aware that after midnight his  
 16 oxygen saturations decreased to 87 percent while he was  
 17 sleeping?  
 18 A. I cannot recall that.  
 19 Q. You weren't aware of that before surgery,  
 20 were you?  
 21 A. I cannot recall if I was aware of it or  
 22 not.  
 23 Q. You weren't aware of whether or not Dewey  
 24 woke that night with dyspnea, can you?  
 25 A. Yes.

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1 Q. You don't know whether or not that that  
2 it before surgery whether he suffered from  
3 edema of the legs, edematous of the legs, can you?

4 A. I'm not aware that his edema had gotten  
5 worse the night before.

6 Q. You were aware that 8:30 in the morning  
7 they put him on oxygen therapy? The surgeon, weren't  
8 you?

9 A. I cannot recall that I specifically was  
10 aware of that for a specific reason, meaning the oxygen  
11 therapy.

12 Q. Did you have ordered the oxygen therapy  
13 for him?

14 A. No.

15 Q. Who would have ordered the oxygen therapy?

16 A. It could be a possibility that any of the  
17 resident staff that was involved with his care or any  
18 of the consultants that were asked to intervene on the  
19 case.

20 Q. Can you turn to the morning of 10-19 in  
21 the physician's order and tell me who ordered the  
22 oxygen therapy? Precede that question, can a nurse  
23 give oxygen therapy based upon her own --

24 A. Not without an order.

25 Q. Not without an order, okay.

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1 A. On the 19th?

2 Q. Well, it was the morning of surgery.  
3 Wasn't that the 19th? The 20th, I'm sorry.

4 A. You want me to go to the 20th then?

5 Q. Yes. The morning of the 20th, around 8:30  
6 is when the oxygen therapy began.

7 A. I cannot identify an order for oxygen in  
8 here on the 19th.

9 Q. So you don't know who ordered oxygen  
10 therapy that morning, true?

11 A. True.

12 Q. And you can't tell me today whether you  
13 were aware of the oxygen therapy before to be proceeded  
14 on the surgery that morning?

15 A. Correct.

16 Q. You wrote an op report in this case, true?

17 A. I signed a dictated operative report by  
18 the senior resident who was with me on the case.

19 Q. By the fact that you signed it, you  
20 acknowledged that the above was true and correct?

21 A. Correct.

22 Q. If I could take your attention to the op  
23 report, the typed op report that was dictated and  
24 typed, typed on 10-21-94.

25 A. It was dictated on the 20th and typed on

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1 the 21st.

2 Q. Until did you agree that there was  
3 a mildly inflamed yet friable gallbladder with multiple  
4 gallbladder stones? Is that true?

5 A. Correct, that's what the report says.

6 Q. You stated in your report that you  
7 that prior to 48 hours prior to his admission he  
8 was complaining of colicky right upper  
9 abdominal pain. That would have been something  
10 you were aware of, true?

11 A. Correct.

12 Q. I noticed that a transverse incision was  
13 done in this case. Is that because of your concern for  
14 Dewey's obesity?

15 A. No. I thought it was the most practical  
16 approach to that gallbladder in such a heavyset person.

17 Q. Did you not do it because you were  
18 weighting the factor that he could use respirator  
19 complications if you did the incision any other way,  
20 wasn't that part of it?

21 A. I did not consider making a longitudinal  
22 incision simply because the patient was morbidly obese,  
23 and if I had made an up and down incision I would have  
24 been anatomically away from the gallbladder site that  
25 would have complicated the operative procedure as far

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1 as exposure

2 Q. You saw no signs of infection in the  
3 peritoneum, true?

4 A. There was no generalized peritoneal  
5 infection, correct.

6 Q. And you stated in your op report -- and I  
7 just want to ask you if you still hold this true  
8 today -- that while the patient awoke from general  
9 anesthesia, he was noted to become hypoxic,  
10 bradycardic, and pulses lost. Is that still -- was  
11 that correct then, is that still correct today?

12 A. This report was dictated by Dr. Zelis, and  
13 the time when this incident did occur I was not in the  
14 operating room.

15 Q. So you're basing those facts on Dr. Zelis'  
16 view of the occurrence, true?

17 A. Correct.

18 Q. And where were you at the time, Doctor?

19 A. The operative procedure was close to  
20 completion. We were just left with the closure of the  
21 skin layer, which I delegated to Dr. Zelis to complete  
22 while I had to go out and talk to the mother because I  
23 felt that we had spent close to, a little bit over two  
24 hours probably, and I just needed to talk to the mother  
25 and let her know that everything went okay.

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1 Q. A little over two hours, that's ,in your  
2 mind, long for this procedure?

3 A. I said a little bit over two hours. I  
4 cannot be very specific about the time. But it took a  
5 little bit longer than it should simply because of  
6 technicality and exposing the gallbladder, removing the  
7 adhesions around the gallbladder and taking out the  
8 gallbladder.

9 Q. Technicality was due to Dewey's body  
0 makeup?

1 A. In part, but in part due to the adhesions  
2 around the area related to the process of chronic  
3 cholecystitis and the subacute stage that was going on  
4 during this hospital admission.

5 Q. So the adhesions around the gallbladder  
6 made it more difficult to remove --

7 A. To expose the gallbladder in addition to  
8 removing the gallbladder off of its bed.

9 Q. And those adhesions, in your opinion, were  
0 caused by or resulted from the biliary colic and the  
1 cholecystitis?

2 A. They were related to previous attacks of  
3 cholecystitis.

4 Q. And that's consistent with acute  
5 cholecystitis?

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1 A. A resolved attack of acute cholecystitis  
2 compounded by subacute process that I thought was going  
3 on during this hospital admission.

4 Q. Now, Dewey was revived in the operating  
5 room, or were you not there? You weren't there at that  
6 point, true?

7 A. I left at the time when they were closing  
8 the skin incision, and after I talked to the mother and  
9 checked another patient in the preoperative holding  
0 area and I went back to the operating room there was an  
1 ongoing code.

2 Q. So you had another patient that you were  
3 about to proceed with and then you went -- you go visit  
4 that patient, is that what you said?

5 A. Just to check if the patient was ready or  
6 was there in the preoperative holding area.

7 Q. Then you went back in to check on Dewey?

8 A. Correct.

9 Q. And you found out he had coded?

0 A. Correct.

1 Q. No one came to you saying, Dewey's coded?

2 A. No.

3 Q. Were you there when the Swan-Ganz catheter  
4 was placed?

5 A. No.

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1 Q. In your opinion, was this code a result or  
2 a result of pulmonary edema?

3 A. I think it was secondary to some kind of  
4 cardiac event, but I cannot tell you exactly what had  
5 happened simply because I was not there.

7 in this operation, did he perform any other procedures?

8 A. As far as this particular operative  
9 procedure is concerned, yes. He and I were doing it  
10 together. He was the chief resident or, in simple  
11 words, somebody who is ready to go out and practice in  
12 a few months, and he and I were working together as a  
13 surgeon and assistant surgeon.

15 to perform the procedure, true?

16 A. I was there and I was doing the procedure  
17 in part. I mean, I cannot tell you how much I did do  
18 work by myself, but I definitely appreciated and needed  
19 whatever assistance he could offer me then simply  
20 because of the technicality.

21 Q. Sure. But did you feel comfortable enough  
22 with his skills that he could on that date have done  
23 the procedure by himself?

24 A. Yes.

25 Q. So you were there even though you felt he

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1 could comfortably do the procedure, true?

2 A. I'm always there on any major abdominal  
3 surgery or any major surgery on any of my patients.

4 Q. And in this case you made the incision to  
5 open up Dewey? Did you do the incision to open Dewey  
6 up?

7 A. I cannot recall if the strike of the knife  
8 was mine or Dr. Zelis'.

9 Q. And you can't recall whether the strike of  
10 the knife that pulled out Dewey's gallbladder was yours  
11 or Dr. Zelis', true?

12 A. All that I can remember is that it was a  
13 tedious operative procedure. The bottom line is that I  
14 successfully took out the gallbladder without causing  
15 any operative complications in there or injury, I  
16 should say, which is the fear of any surgeon that does  
17 biliary surgery.

18 Q. Did you get a chance to review the path  
19 report?

20 A. Yes.

21 Q. Just in your review of the path report, do  
22 you disagree with the path report in any way?

23 A. Yes. I could tell you that I thought my  
24 operative findings were more seriously descriptive of  
25 the procedure than what the op path finding may

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1 indicate or the path report may indicate.

2 MR. ALLEN: I'm sorry, could  
3 you read that back for me?

4 We're almost finished here, guys.  
5 (Thereupon, the answer was read back.)

6 BY MR. ALLEN:

7 Q. So you believe by saying "more seriously  
8 descriptive" that your op report described the  
9 gallbladder better than the path report done by the  
10 pathologist?

11 A. Well, I can tell you that during surgery I  
12 found areas of what I thought was ischemia of the  
13 gallbladder wall and dissection of bile underneath the  
14 mucosa of the gallbladder. The gallbladder was stained  
15 in parts, which indicated to me that there was more  
16 than just a chronic process going on at that particular  
17 time.

18 Q. More than a chronic process?

19 A. Correct.

20 Q. Meaning acute?

21 A. Meaning acute and subacute.

22 Q. When you mean subacute, you mean it  
23 occurring in less than how long, a day?

24 my knowledge, that it was a chronic process on its way

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1 line and was stopped from turning into a full blown  
2 picture of acute cholecystitis.

3 Q. So you agree with the path report when it  
4 says the findings may represent an early or developing  
5 acute cholecystitis?

6 A. Correct.

7 Q. And you agree with him when he says that  
8 there was mild to moderate chronic inflammation; that's  
9 consistent with what you just said, true?

10 A. Correct.

11 Q. Now, he goes on in his gross  
12 description -- you can turn to the path report. You're  
13 there, Doctor?

14 A. Yes.

15 Q. It says, there is, however, -- do you see  
16 where I am -- no exudate --

17 A. Exudate.

18 Q. -- exudate or adhesions in the vicinity  
19 of these defects.

20 Now, I'm concerned with that statement.  
21 You can read the whole gross description, but is that  
22 consistent with what I saw in Dewey's gallbladder?

23 A. I can tell you, this defect is surgeon  
24 made. It's usually decompression of the gallbladder

1 because it was so distended intraoperatively and it  
2 would have made it easier for us technically to dissect  
3 the gallbladder by decompressing it or removing the  
4 fluid and some of the stones out of its lumen.

5 Q. How many calculi were present?

6 A. I can tell you by remembering how that  
7 sack of the gallbladder felt when I squeezed it after I  
8 got the specimen out of the abdomen. I felt there were  
9 many multiple small stones of variable sizes I could  
10 recall.

11 Q. Variable sizes. So that's consistent with  
12 the gross description in the path report?

13 A. That's what the path report says.

14 Q. So your feel, your squeeze, your look at  
15 the gallbladder is consistent with the gross  
16 description by this pathologist, true?

17 A. It's consistent as far as the stones are  
18 concerned, but I have to agree with what the  
19 pathologist had seen or read.

20 Q. Do you agree with him when he indicates  
21 that there is no inflammation of the ducts?

22 A. When we take out the gallbladder, it's  
23 only the gallbladder and a short stump of the cystic  
24 duct that gets to be removed with the specimen. The  
25 rest of the bile ducts the surgeons fear and try to

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1 stay away from even having the feeling that we're close  
2 to them.

3 Q. But what he saw, he saw no inflammation of  
4 those ducts, true?

5 MR. JONES: I'm going to  
6 object. He either did or he didn't. He  
7 didn't review this path specimen himself  
8 or look at slides or anything else.

9 A. I usually just cut a very small stump, and  
10 I can tell you it's in millimeters next to the  
11 gallbladder. I try to, and every surgeon tries to, cut  
12 the shortest amount of cystic duct close to the  
13 gallbladder, especially when they're dealing with an  
14 acute, a questionable acute or subacute stage, for the  
15 fear of injuring the other major ducts and causing  
16 big-time complication.

17 Q. That path report does not indicate any  
18 inflammation in the part of the duct that you left,  
19 true?

20 A. Can you please help me to the statement or  
21 the sentence that you're referring to?

22 Q. Yeah. He does not indicate that there's  
23 any inflammation in the bile ducts.

24 MR. JONES: He's asking  
25 where is the statement that says there's

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1 no inflammation in the bile ducts.

2 BY MR. ALLEN

3 Q. There is no statement in there, is there,  
4 Doctor?

5 A. I don't see any.

6 Q. There is none. There is no indication  
7 that there was inflammation in the bile duct, true?

8 A. But I don't see any that could have him or  
9 even say no or  
10 there is.

11 Q. But if there was inflammation, that would  
12 be something that would be reflected in the path  
13 report?

14 MR. MEADOWS: objection.

15 MS. REINKER. objection.

16 MR. JONES: I'm going to  
17 object.

18 A. Not necessarily.

19 Q. Not necessarily?

20 A. No. Because, again, we tried to remove  
21 the gallbladder and the gallbladder alone. With acute  
22 cholecystitis or subacute cholecystitis, even with  
23 chronic cholecystitis, the cystic duct, which is a very  
24 short stump or very short duct that connects that sack  
25 or reservoir of gallbladder to the rest of the biliary

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1 ducts, gets so shortened that we try to avoid cutting  
2 as much as we can out of it, even as millimeters if  
3 we're lucky to include with the gallbladder, and leave  
4 the rest intact or leave the rest in there for the fear  
5 of injuring, quote/unquote, the bile ducts.

6 Q. Thanks. I appreciate your clearing me up  
7 on that, Doctor.

8 I'm just turning to your discharge  
9 summary. Discharge was dated 11-21-94 and it was  
10 dictated February 3rd, 1995. Is that pretty consistent  
11 with most discharge summaries by you, Doctor?

12 A. No.

13 Q. Why did this one take two and a half

14 A. Simply because Mr. Jones did stay longer  
15 than he should in the hospital, and it was not until  
16 Dr. Zelis had enough time to sit down and review the  
17 records and put some kind of a pertinent summary that  
18 he felt was appropriate describing in brief the course  
19 of this hospitalization.

20 Q. So due to the month plus long  
21 hospitalization and Dr. Zelis' need to review those  
22 records, that is the reason it took two and a half  
23 months to dictate this discharge summary, correct?

24 A. In part.

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1 Q. Do you know of any other reason why it  
2 took that long?

3 A. Well, I felt it was Dr. Zelis' duty based  
4 on his degree of involvement with the case that he gets  
5 to dictate the discharge summary, and it wasn't until  
6 that time when Dr. Zelis was able to get to the  
7 discharge summary. I may have had --

8 MR. JONES: Doctor, don't  
9 guess. He just asked do you know why it  
10 took that long. If you know, tell him.

11 A. I don't.

12 Q. Are you critical of him as a resident that  
13 you were overseeing for taking two and a half months to  
14 discharge?

15 A. Yes, I would be critical.

16 Q. Were you critical of him in this case?

17 A. I would be critical had I known that it  
18 was dictated after this long.

19 Q. Did you sign this discharge?

20 A. Yes, that's my signature.

21 Q. Did you just not catch the fact that it  
22 took two and a half months to dictate it?

23 A. Even if I did, it was my obligation that  
24 the discharge summary was dictated by Dr. Zelis, and  
25 based on my judgment of Dr. Zelis being a competent

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1 senior resident stating the facts as an independent  
2 body that this holds true.

3 Q. In the discharge summary it stays under  
4 the narrative, refractory hypertension. Define that  
5 for me.

6 MS. REINKER: Are you asking  
7 something about the discharge summary?

8 MR. ALLEN: yeah. In the  
9 discharge summary it says, narrative and  
10 hospital course.

11 MS. REINKER: Objection.

12 This was not dictated by this witness. I  
13 don't think he's the right one to ask what  
14 is meant by the words used.

15 BY MR. ALLEN:

16 Q. Go ahead, Doctor. You had a patient who  
17 has a history of refractory hypertension.

18 A. The discharge summary states that the  
19 patient has history of refractory hypertension.

20 Q. What is refractory hypertension?

21 A. In laymen's term, it is a form of  
22 hypertension that has chronicity associated with some  
23 degree of difficulty controlling it.

24 Q. It goes on down to say that after -- I'm  
25 sorry. As far as -- do you have any criticisms -- did



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1 you review any of the records of University Hospital?

2 A. No, sir.

3 Q. Do you have any criticisms to the nurses  
4 that were involved in the care of Dewey Jones?

5 A. The nurse?

6 Q. The nurses or the nursing help.

7 A. No.

8 Q. Dewey Jones signed a consent for a  
9 laparoscopic cholecystectomy and possible open. I'm  
10 going to give you the consent. Were you there when he  
11 gave that consent?

12 A. No; but he was or he would never have been  
13 asked to sign a consent unless he had been thoroughly  
14 informed about the details of the consent or the  
15 details of the operative procedure.

16 Q. Now, discharge summary, it's your  
17 responsibility to see that the resident dictates this  
18 by whatever time the policy and procedure of the  
19 hospital states, correct?

20 A. Correct.

21 Q. Now, did you enter into any expressed oral  
22 or permission, expressed permission by the family of  
23 Dewey Jones before surgery was completed, undertaken?

24 MR. JONES: I'm going to  
25 object. You don't have to get family

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1 permission for a competent adult to do  
2 surgery. So I'm not sure I understand  
3 your question.

4 BY MR. ALLEN:

5 Q. Did you talk or consult with the family  
6 before?

7 A. I felt that my degree of interaction with  
8 Mr. Jones preoperatively was so good, and he and I were  
9 discussing all aspects promptly, and I thought he had a  
10 full understanding of what was going on, and he never  
11 asked me for any family involvement or any family  
12 permission or request to get any family member  
13 involved.

14 Q. So you never talked to any of the family  
15 before?

16 A. Correct.

17 Q. The first time you talked to a family  
18 member was after when you went out to see the mother?

19 A. Correct.

20 Q. Other than that time, did you have any  
21 other conversations with the family?

22 A. Yes, I did.

23 Q. Tell me about the next conversation that  
24 you had with the family.

25 A. A few days after the operation and after a

1 telephone conversation one family member had requested  
2 a meeting with me with other family members present,  
3 and I respected this request and such a meeting did  
4 occur.

5 Q. Who were the family members there, do you  
6 recall?

7 A. I recall it was the mother, a brother and  
8 possibly a sister or two.

9 Q. And what was discussed, do you recall?

10 A. All aspects of the surgery and Dewey's  
11 condition at that point in time and prognosis.

12 Q. Now, Dewey -- any independent  
13 recollections of the specifics, does anything stand out  
14 in your mind today about that conversation with the  
15 family?

16 A. The mother was calm and contained, and the  
17 brother especially and the sister, if I may recall,  
18 were a little bit out of respect more vocal with their  
19 words and anger.

20 Q. At you?

21 A. At me.

22 Q. What did you tell them was the cause of  
23 Dewey's arrest?

24 A. I told them based on my understanding that  
25 there is a hypoxic brain injury that occurred and at

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1 that point in time I was not qualified to tell them  
2 what the prognosis was, and I told them that I would  
3 get involved -- if I recall, I might have gotten  
4 somebody involved by then as far as a neurosurgeon or a  
5 neurologist especially to get his or her opinion as far  
6 as the prognosis and the outcome.

7 Q. You told them that it was your risk that  
8 caused Dewey to be in that condition, didn't you?

9 MR. JONES: Objection.

10 A. It was what?

11 Q. Because of the risk that you took was the  
12 reason Dewey was in that condition.

13 MS. REINKER: Objection.

14 A. I didn't say -- I didn't mention my risk,  
15 quote/unquote. I didn't mention that word.

16 Q. Your evaluation of the risk, didn't you?

17 A. I cannot recall the specifics, but if you  
18 may just give me the proper way it was related to you  
19 or what was said in that conversation, I could confirm  
20 it or not, but I cannot recall that I did go this  
21 specific mentioning these kind of specific words.

22 Q. You didn't say anything in the line,  
23 you know, that it was because of the surgery that Dewey  
24 was in this condition?

25 A. I cannot say it was because of the

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1 surgery. It was a complication of the operative  
2 procedure that something had happened that caused him  
3 to go into this kind of condition.

4 Q. You would take the same steps that you  
5 took with Dewey today as you did back then, correct?

6 A. As far as?

7 Q. Your entire management and care. Would  
8 you change anything?

9 MR. JONES: wait a minute.

10 With the knowledge of hindsight would he  
11 have changed anything? What does that  
12 mean?

13 BY MR. ALLEN

14 Q. If you were put in that situation today,  
15 would you change anything that you did?

16 MR. JONES: objection.

17 MR. WALTERS: without knowing  
18 the outcome? With knowing the outcome or  
19 not knowing the outcome?

20 MR. JONES: It's a  
21 nonsensical question. If he knew that  
22 this was going to be the outcome for this  
23 particular patient, would he have done  
24 exactly the same thing for this patient if  
25 he had the same patient tomorrow? It

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1 doesn't make any sense.

2 BY MR. ALLEN

3 Q. Do you understand my question?

4 A. I do. But there is a hindsight element in  
5 there. You and I know what the outcome is or has been.  
6 I don't think it's fair for me to answer this question  
7 having been involved in such an issue.

8 Q. Taking away the hindsight, the same  
9 situation?

10 MR. JONES: objection.

11 MR. WALTERS: I'm a little  
12 unclear as to the question at this point.

13 I'll show my objection.

14 A. I cannot, in all fairness, answer this  
15 question appropriately for you.

16 Q. That's fine, Doctor.

17 A. I mean, there is always this hindsight  
18 element that I cannot remove out of the picture.

19 Q. Sure. Have you ever had a patient die  
20 from gallbladder surgery before?

21 A. Not my patient.

22 Q. Have you ever had a patient go into a coma  
23 other than Dewey Jones after a gallbladder surgery?

24 A. Not after a gallbladder surgery.

25 Q. You've never operated on a patient like

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1 Dewey Jones before, have you?

2 A. I have.

3 Q. How many times?

4 A. I cannot recall.

5 Q. When was the last time?

6 A. I'm sorry, I cannot recall.

7 Q. You don't know?

8 A. I'm sorry, I cannot recall.

9 Q. Has it been more than ten times?

10 A. I did encounter many patients during my  
11 training and my practice that were close to Mr. Jones'  
12 condition in one way or the other, but I cannot tell  
13 you in all honesty that it was exactly the same picture  
14 or the same setup, if you may, or same scenario.

15 Q. Sure. Everything is unique, every patient  
16 is unique?

17 A. Possibly to some degree or to some extent.

18 Q. Other than calling in the consults and the  
19 things that we went over today, did you do anything  
20 else that I didn't touch on to investigate Dewey's  
21 condition, consults, you know, diagnostic studies  
22 ordered that I didn't talk about or you didn't talk  
23 about?

24 MS. REINKER: me-op you're  
25 referring to?

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1 MR. ALLEN: yes, pre-op.

2 MS. REINKER: me-op, before  
3 surgery.

4 A. All that I can tell you is that I --

5 MR. JONES: Doctor, before  
6 we go into a long explanation, he just  
7 wants to know whether we've covered all of  
8 the diagnostic tests and consultations you  
9 got and other things you did  
10 preoperatively for Mr. Jones. Either you  
11 have or you haven't.

12 A. It was covered.

13 Q. Now, how did you rely on the communication  
14 between the consulted doctors in this case? Did you  
15 rely on the records or did you rely on in-person  
16 communication?

17 A. I relied on a combination of both.

18 MR. WALTERS: I didn't hear  
19 the answer.

20 MR. JONES: He relied on a  
21 combination of both.

22 BY MR. ALLEN:

23 Q. Do you have any independent recollection  
24 as to the location of the meetings in which you  
25 consulted with these physicians?

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1 A. No, sir.  
 2 Q. You don't know whether it was in Dewey's  
 3 room or in the hall?  
 4 A. **Definitely not in his room.**  
 5 MR. WALTERS: YOU guys are  
 6 talking quieter and quieter. Could you  
 7 just, please.  
 8 MR. MEADOWS: And there's a  
 9 train going by.  
 10 BY MR. ALLEN  
 11 Q. You don't know where it was that you  
 12 communicated?  
 13 A. **Correct.**  
 14 Q. Can you tell me for certain that it didn't  
 15 occur over a telephone?  
 16 A. **I can't be certain.**  
 17 Q. Can you tell me for certain that you  
 18 consulted with Dr. Ho and Dr. Rizk, Dr. Adamek before  
 19 surgery?  
 20 MR. JONES: I'm sorry --  
 21 MS. REXNER objection.  
 22 MR. JONES: objection.  
 23 He's already gone through Dr. -- you keep  
 24 mispronouncing his name, it's Rizk, and he  
 25 already said that Dr. Rizk was not

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1 involved in this in any way before  
 2 surgery.  
 3 MR. ALLEN Did I say Rizk?  
 4 MR. JONES: yes.  
 5 BY MR. ALLEN  
 6 Q. Dr. Ho, Dr. Adamek and Dr. O'Neill.  
 7 MS. REINKER: objection.  
 8 MR. JONES: I'm still going  
 9 to object.  
 10 MS. REINKER: He's already  
 11 said he does not know who he spoke to from  
 12 anesthesia.  
 13 Q. Did you say that?  
 14 ~~Q. Did you say that?~~  
 15 **persons involved from anesthesia in the preoperative or**  
 16 **immediate preoperative or perioperative time.**  
 17 ~~(thereupon, there was a brief recess.)~~  
 18 Q. Doctor, this surgery to Dewey Jones was  
 19 moved up from noon until early in the morning; is that  
 20 true?  
 21 A. ~~If that's what the record states~~  
 22 Q. Do you recall why it was moved up to an  
 23 earlier time?  
 24 A. **I'm not positive about it, but I think**  
 25 **there was a cancellation, either one of my patients or**

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1 **there was an opening in that operative room prior to**  
 2 **Mr. Jones' scheduled procedure.**  
 3 Q. So you just moved him in instead of that  
 4 patient?  
 5 A. **Correct.**  
 6 Q. Cholelithiasis, have you ever had a  
 7 patient die from cholelithiasis?  
 8 A. **Cholelithiasis, per se, alone, no.**  
 9 **Complications --**  
 10 Q. What about cholecystitis?  
 11 A. **Yes.**  
 12 Q. When was that?  
 13 A. **I witnessed somebody die, but I didn't --**  
 14 **I mean, when I was a resident, but I did not have**  
 15 **direct involvement. I was not the attending.**  
 16 Q. Is that the only time that you witnessed  
 17 it?  
 18 A. **There were times when I was a resident.**  
 19 Q. One time?  
 20 A. **Times.**  
 21 Q. Times, okay. How many times?  
 22 A. **I cannot recall.**  
 23 MR. WALTERS: I apologize  
 24 again, I cannot hear you guys. You're  
 25 whispering.

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1 MR. JONES: we've got  
 2 another train.  
 3 BY MR. ALLEN  
 4 Q. Had you ever had a patient -- you  
 5 personally have never had a patient die of  
 6 cholecystitis, true?  
 7 A. **True.**  
 8 Q. What about cholelithiasis, have you ever  
 9 had a patient die of that?  
 10 A. **If it was -- I have to be more specific.**  
 11 **If it was uncomplicated cholelithiasis, no, but if it**  
 12 **was a complicated cholelithiasis, yes.**  
 13 Q. ~~What would that terminology be? Cholelithiasis associated with acute~~  
 14 ~~cholecystitis associated with common bile duct stones~~  
 15 **cholecystitis associated with common bile duct stones**  
 16 **and acute cholangitis or perforation of the gallbladder**  
 17 **secondary to acute unresolved cholecystitis.**  
 18 Q. You had that occur to a patient of yours?  
 19 A. **I did, but it did not progress to that on**  
 20 **a patient of mine.**  
 21 Q. Perforation, but you intervened?  
 22 A. **Correct.**  
 23 Q. How long did you have to intervene?  
 24 MR. JONES: objection.  
 25 ///

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1 BY MR. ALLEN:

2 Q. How much time did you have to intervene in  
3 that?

4 MR. JONES: come on, let's  
5 get on with something relevant here. This  
6 has nothing to do with this case. You  
7 said you had five questions ten questions  
8 ago. This is getting ridiculous. It's  
9 8:30, it's four and a half hours into this  
10 deposition. I have been so patient and  
11 this doctor has been unbelievably patient  
12 with you. Get to the end of this  
13 deposition, now.

14 A. I'm sorry, I cannot recall the specific  
15 timing for you now.

16 Q. Did you have a matter of minutes, did you  
17 have a matter of an hour?

18 MR. JONES: objection.

19 We're done. Let's go.

20 MR. ALLEN I do not feel  
21 that this deposition is done. I feel like  
22 I have not been able to adequately examine  
23 this patient based upon evidence that I  
24 feel is discoverable. Now, I have a few  
25 more questions to ask. We can do it now

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1 or we can reconvene on a judge's orders, I  
2 don't mind.

3 MR. JONES: How many  
4 questions have you got, Mr. Allen?

5 MR. ALLEN I've got this  
6 (indicating), this is it.

7 MR. JONES: You've got five  
8 pages of paper there. How many questions  
9 have you got?

10 MR. ALLEN: It's about five  
11 questions. But if he answers something  
12 that I feel that I need to go into, I  
13 think I have the right to do so.

14 MR. JONES: Look, I am  
15 going to stop --

16 MR. ALLEN: we're spending  
17 more time talking about this, I could have  
18 been done.

19 MR. JONES: well, that's  
20 very unlikely considering an hour ago you  
21 told me -- more than an hour ago you told  
22 me you would be done in half an hour. So  
23 get to the end of the deposition, now.

24 Go!

25 MR. ALLEN: okay.

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1 MR. JONES: I'll tell you,  
2 I've been a lot more patient than I think  
3 that gentleman is going to be tomorrow,  
4 one of these gentlemen is going to be  
5 tomorrow because you're setting a trend  
6 with this doctor with a  
7 four-and-a-half-hour deposition. I'll be  
8 interested to see what happens tomorrow.

9 BY MR. ALLEN:

10 Q. Now, Doctor, do you have any opinions as  
11 to the cause of Dewey's condition today?

12 A. I think this question is very generalized.  
13 Can I ask you to be specific about condition?

14 Q. What caused Dewey to be in a coma today,  
15 what was the event?

16 A. The pathology was anoxic brain damage.

17 Q. Due to what?

18 A. Cardiac arrest.

19 Q. What caused the cardiac arrest?

20 A. I do not know.

21 Q. You don't have any opinion?

22 A. I wasn't there.

23 Q. And you don't expect to form any opinions  
24 before trial, do you?

25 A. I do not want to form an opinion based on

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1 my knowledge alone, and I yet to see what comes out of  
2 other doctors' statements that were involved in close  
3 care at those particular moments around the time when  
4 the cardiac arrest had occurred. I think it's unfair  
5 for me to pass or make a judgment based on what was  
6 going on then while I was not in the room.

7 MR. JONES: I will  
8 represent to you, Mr. Allen, that if he  
9 does, because of additional discovery that  
10 goes on, feel that he is competent to give  
11 such an opinion, I will certainly let you  
12 know that he has opinions, what the  
13 general areas are, and we will respond to  
14 any kind of discovery you want on the  
15 opinions that he then has.

16 MR. ALLEN That's fair.

17 Thank you.

18 BY MR. ALLEN:

19 Q. In particular, you saw no evidence of  
20 sepsis in this patient when you were operating on this  
21 patient, true?

22 A. Gross sepsis.

23 Q. Gross sepsis. Acute or any other form of  
24 sepsis?

25 A. There's microscopic or occult sepsis that

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

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

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

11 Q. I'm just talking in general.

12 A. In general?

13 Q. Yeah. Do you have an opinion?

14 A. Give me the question again, please.

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

19 MS. REINKER: Objection.

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

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

1 MR. CASEY If we can.  
 2 MR. ALLEN: okay.  
 3 Appreciate your abundance of patience.  
 4 MR. JONES: Because of the  
 5 length of this deposition, I have agreed  
 6 that if and when defense counsel wish to  
 7 question Dr. Badri that we will make  
 8 Dr. Badri available at a mutually  
 9 convenient time and place.

10 ---  
 11 (DEPOSITION ADJOURNED)  
 12 ---

15 RAFAL A. BADRI, MD. (Date)  
 16  
 17 ---

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1 Dr. Sullivan?

2 A. Forgive me, I don't know.

3 Q. Do you remember his name?

4 A. I do not.

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

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

12 MR. ALLEN who would be  
 13 the one --

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

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

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

25 MR. ALLEN Great.

1 STATE OF OHIO, )  
 2 COUNTY OF CUYAHOGA. ) SS:  
 3 CERTIFICATE  
 4 I, LAUREN I. ZIGMONT-MILLER, Registered  
 5 Professional Reporter and Notary Public within and for  
 6 the State of Ohio, duly commissioned and qualified, do  
 7 hereby certify that the within-named witness, RAFAL A  
 8 BADRI, M.D., was by me first duly sworn to tell the  
 9 truth, the whole truth and nothing but the truth in the  
 10 cause aforesaid; that the testimony then given by him  
 11 was reduced to stenotypy in the presence of said  
 12 witness, and afterwards transcribed by me through the  
 13 process of computer-aided transcription, and that the  
 14 foregoing is a true and correct transcript of the  
 15 testimony so given by him as aforesaid.

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

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

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

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



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1:47:7	1:47:9		1:57:16	1:63:20	1:68:24	1:180:21	1:180:25	1:181:11
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<b>occur</b> [12]			1:125:25	1:127:17	1:132:14	1:28:13	1:88:19	1:180:10
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1:97:3	1:137:2	1:153:13	1:175:25	1:176:19	1:180:4	1:10:22	1:11:22	1:23:2
1:168:4	1:174:15	1:177:18	1:183:13			1:40:10	1:40:12	1:40:19
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1:68:23	1:96:23	1:158:23	1:67:18	1:67:21	1:67:22	1:77:16	1:114:10	
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<b>october</b> [4]			<b>onset</b> [1]			1:110:7	1:110:19	1:111:12
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1:20:13	1:82:24	1:99:6	<b>open</b> [7]			1:66:10	1:70:9	1:70:11
1:121:11	1:135:5	1:154:18	1:38:5	1:113:23	1:114:4	1:70:16	1:70:17	1:71:21
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<b>offer</b> [3]			1:166:9			1:73:9	1:73:21	1:81:9
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1:22:24	1:41:21	1:41:23	1:141:21	1:142:22	1:147:21	1:131:10	1:139:2	1:145:5
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<b>offices</b> [8]			1:61:5	1:64:15	1:76:16	1:150:15	1:150:21	1:151:9
			1:115:8	1:122:11	1:124:16	1:172:22		
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1:73:17	1:74:2	1:140:17	<b>park</b> [1]	1:62:7	1:62:16	1:62:25
<b>orders</b> [2]			1:132:11	1:63:14	1:63:16	1:64:14
1:65:22	1:179:1		<b>part</b> [27]	1:65:1	1:65:25	1:66:7
<b>organ</b> [2]			1:13:8	1:66:10	1:66:15	1:66:21
1:94:16	1:94:19		1:17:21	1:66:21	1:67:3	1:67:10
<b>otherwise</b> [1]			1:32:22	1:67:13	1:67:20	1:67:25
1:185:19			1:42:14	1:68:6	1:68:23	1:70:9
<b>outcome</b> [8]			1:90:13	1:70:11	1:71:18	1:72:3
1:94:12	1:113:22	1:169:6	1:117:16	1:72:22	1:74:16	1:75:22
1:170:18	1:170:18	1:170:19	1:119:16	1:76:3	1:76:8	1:76:14
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1:41:5	1:41:7	1:49:4	<b>part-time</b> [2]	1:78:24	1:79:5	1:79:9
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<b>overheard</b> [1]			1:25:6	1:83:23	1:84:1	1:85:5
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<b>overlooking</b> [1]			1:55:12	1:85:23	1:86:3	1:86:6
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<b>oversee</b> [1]			1:95:5	1:87:2	1:88:17	1:89:2
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<b>overseeing</b> [1]			1:158:16	1:93:5	1:93:17	1:94:5
1:164:13			1:181:19	1:94:14	1:95:6	1:96:10
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1:150:15	1:150:22	1:150:23	1:56:9	1:139:19	1:139:19	1:139:24
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<b>oxygenation</b> [2]			1:120:12	1:147:15	1:148:10	1:152:22
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<b>pardon</b> [2]			1:51:5	1:79:18	1:82:21	1:83:19
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			1:52:25	1:105:14	1:106:1	1:106:6
			1:53:14	1:106:11	1:107:3	1:107:8
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1:37:7	1:37:10		1:132:24	1:133:25		1:11:5	1:26:14	1:26:22
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1:75:7			1:82:19	1:78:25 1:80:4 1:86:22
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<b>positive</b> [3]			1:155:9 1:155:16 1:175:15	
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1:130:10	1:130:16	1:135:6	1:136:19	1:136:22	1:138:6	1:141:6	1:142:3	1:145:11
1:175:21			1:144:7	1:154:12	1:154:22	1:145:15	1:145:18	1:145:20
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1:46:10	1:46:12	1:46:24	<b>relationship</b> [1]			1:1:20	1:185:4	
1:49:16	1:118:1	1:118:11	1:19:18			<b>reports</b> [1]		
1:118:16	1:118:19	1:119:8	<b>relative</b> [1]			1:110:19		
1:119:12	1:119:20	1:120:4	1:185:18			<b>represent</b> [2]		
1:120:14	1:163:18	1:163:23	<b>relay</b> [1]			1:159:5	1:181:8	
1:166:1	1:173:15		1:52:3			<b>request</b> [4]		
<b>recovery</b> [1]			<b>relevant</b> [6]			1:24:1	1:126:20	1:167:12
1:60:15			1:71:25	1:108:20	1:109:6	1:168:3		
<b>reduce</b> [1]			1:110:15	1:110:18	1:178:5	<b>requested</b> [2]		
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<b>reduced</b> [3]			1:173:17	1:173:20		<b>requesting</b> [2]		
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<b>refer</b> [5]			1:49:12	1:49:15	1:49:18	<b>requirements</b> [2]		
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1:124:20	1:128:10		1:70:2	1:74:14	1:81:9	<b>research</b> [1]		
<b>reference</b> [2]			1:81:22	1:119:12	1:120:14	1:26:18		
1:45:24	1:125:7		1:173:13	1:173:15	1:173:15	<b>reservation</b> [1]		
<b>referrals</b> [3]			<b>relying</b> [2]			1:111:19		
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<b>reflected</b> [2]			1:119:11	1:145:17	1:145:18	<b>reserving</b> [1]		
1:46:23	1:162:12		1:145:25	1:148:9	1:157:12	1:116:23		
<b>refractory</b> [4]			1:183:3			<b>reservoir</b> [1]		
1:165:4	1:165:17	1:165:19	<b>remembering</b> [1]			1:162:25		
1:165:20			1:160:6			<b>residency</b> [4]		
<b>regarding</b> [4]			<b>reminger</b> [6]			1:7:3	1:7:20	1:10:4
1:62:22	1:104:16	1:110:19	1:2:13	1:2:13	1:2:16	1:10:20		
1:146:3			1:2:16	1:2:19	1:2:19	<b>resident</b> [15]		
<b>registered</b> [2]			<b>removal</b> [1]			1:15:12	1:15:15	1:51:25
1:1:19	1:185:3		1:27:5			1:145:24	1:148:16	1:148:18
<b>regular</b> [10]			<b>removals</b> [2]			1:148:20	1:150:17	1:151:18
1:30:14	1:30:17	1:34:13	1:27:1	1:27:2		1:156:10	1:164:12	1:165:1
1:35:1	1:35:3	1:41:14	<b>remove</b> [5]			1:166:17	1:176:14	1:176:18
1:42:14	1:53:24	1:57:2	1:105:24	1:113:1	1:154:16	<b>residents</b> [4]		
1:67:19			1:162:20	1:171:18		1:23:2	1:23:10	1:23:12
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1:2:22	1:3:23	1:13:12	1:160:24			<b>residing</b> [1]		
1:60:6	1:62:12	1:63:23	<b>removing</b> [3]			1:8:8		
1:73:2	1:73:14	1:84:5	1:154:6	1:154:18	1:160:3	<b>resistance</b> [1]		
1:84:16	1:90:12	1:108:24	<b>renal</b> [2]			1:68:10		
1:111:7	1:115:22	1:115:24	1:106:17	1:106:22		<b>resolved</b> [1]		
1:116:8	1:116:16	1:117:1	<b>render</b> [2]			1:155:1		
1:118:15	1:133:5	1:162:15	1:28:9	1:28:13		<b>resort</b> [2]		
1:165:6	1:165:11	1:169:13	<b>repeat</b> [8]			1:66:24	1:95:13	
1:172:24	1:173:2	1:174:21	1:5:13	1:5:13	1:39:19	<b>respect</b> [1]		
1:175:7	1:175:10	1:182:19	1:92:22	1:111:10	1:122:21	1:168:18		
<b>relate</b> [1]			1:127:3	1:147:19		<b>respected</b> [1]		
1:117:3			<b>rephrase</b> [8]			1:168:3		
<b>related</b> [25]			1:43:20	1:76:6	1:90:19	<b>respiratory</b> [17]		
1:25:6	1:26:1	1:34:13	1:105:15	1:106:10	1:119:2	1:59:12	1:60:2	1:90:6
1:41:16	1:53:19	1:66:6	1:122:22	1:182:16				
1:81:3	1:81:4	1:92:4						

1:90:11	1:91:3	1:91:6	1:24:3	1:30:5	1:30:11	<b>sack</b> [2]		
1:91:10	1:91:16	1:91:21	1:33:10	1:34:17	1:39:2	1:160:7	1:162:24	
1:91:25	1:92:1	1:92:12	1:45:1	1:45:13	1:46:15	<b>sacs</b> [2]		
1:92:21	1:93:6	1:93:9	1:46:18	1:52:12	1:76:21	1:84:24	1:85:2	
1:93:14	1:152:18		1:83:5	1:83:17	1:95:24	<b>safely</b> [1]		
<b>espond</b> [1]			1:96:2	1:96:4	1:97:23	1:114:11		
1:181:13			1:99:13	1:99:17	1:99:20	<b>sat</b> [1]		
<b>esponse</b> [2]			1:99:22	1:102:19	1:114:12	1:11:21		
1:105:12	1:106:20		1:115:10	1:117:22	1:121:20	<b>satisfaction</b> [1]		
<b>esponsibility</b> [3]			1:124:21	1:129:12	1:129:24	1:48:7		
1:52:17	1:52:24	1:166:17	1:152:8	1:165:13	1:179:13	<b>saturation</b> [1]		
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1:52:21			<b>ise</b> [1]			<b>save</b> [1]		
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1:54:21	1:109:4	1:141:20	<b>ising</b> [2]			<b>saving</b> [1]		
1:142:21	1:160:25	1:162:25	1:38:6	1:38:7		1:119:23		
1:163:4	1:163:4		<b>isk</b> [47]			<b>saw</b> [7]		
<b>esult</b> [1]			1:58:25	1:59:5	1:60:2	1:40:1	1:153:2	1:159:23
1:156:1			1:77:20	1:78:2	1:78:25	1:161:3	1:161:3	1:181:19
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1:94:10	1:96:24	1:112:4	1:108:23	1:111:3	1:115:12	1:150:25	1:157:14	1:170:17
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1:89:21	1:89:21		1:174:5	1:176:23		1:40:23	1:72:6	1:72:11
<b>via</b> [2]			<b>wants</b> [1]			1:109:25	1:135:1	1:165:12
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