IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

John M. Karaba, Administrator of the Estate of Rita A. Karaba, Deceased, Plaintiff, vs. Parma Community General Hospital, et al., Defendants.	Case No. 408025

VIDEOTAPED DEPOSITION

of FRANCIS E. BARNES, M.D.

Taken at the offices of
BARNES SURGERY
3360 Tremont Road
Columbus, Ohio 43221-2111

on June 4, 2001, at 10:11 a.m.

Reported by: Dawn M. Morrison

-=0=-

APPEARANCES:

John B. Robertson
WESTEN HURD FALLON PAISLEY & HOWLEY LLP
2500 Terminal Tower
50 Public Square
Cleveland, Ohio 44113-2241
(216) 607-3304

on behalf of the Defendant,
Parma Community General Hospital

Harry E. Guion
PARMA LAW CENTER
5566 Pearl Road
Parma, Ohio 44129
(440) 886-7089

on behalf of the Plaintiff,
John M. Karaba

JAMES M. Kelley III
REMINGER & REMINGER
113 St. Clair Avenue
Suite 700
Cleveland, Ohio 44114
(216) 687-1311

on behalf of the Defendant,
Emergency Physicians, **Inc.**,
and Dr. Gordon

ALSO PRESENT:

Gary Burgard, Videographer

-=0=-

STIPULATIONS

It is stipulated by and among counsel for the respective parties that the deposition of FRANCIS E. BARNES, M.D., the witness herein, called by the Defendant under the applicable Rules of Civil Procedure, may be taken at this time by the notary by agreement of counsel; that said deposition may be reduced to writing in stenotypy by the notary, whose notes thereafter may be transcribed out of the presence of the witness; and that the proof of the official character and qualification of the notary is waived.

--=0=-

INDEX OF EXAMINATION

INDEX OF EXHIBITS

-=O=-

(Deposition Exhibit 1 marked.)

-=O=-

THE VIDEOGRAPHER: This is the videotaped deposition of Dr. Francis E. Barnes, taken by the defendant in the matter of John M. Karaba, administrator of the estate of Rita A. Karaba, deceased, versus Parma Community General Hospital, et al., in the Court of Common Pleas, Cuyahoga County, Ohio; Case Number 408025, held at the offices of Barnes Surgery, 3360 Tremont Road, Columbus, Ohio, on Monday, June 4th, 2001, at approximately 10:11 a.m.

The court reporter is Dawn Morrison; the videographer is Gary Burgard, both with the firm of Professional Reporters, Inc.

Counsel will now introduce themselves for the record.

MR. ROBERTSON: Go ahead.

MR. GUION: My name is Harry Guion, and I represent the estate of Rita Karaba.

MR. ROBERTSON: I'm John Robertson, and I represent Parma Community General

Hospital, and I will be taking the deposition of Dr. Barnes under direct examination this morning.

MR. KELLEY: My name is Jay Kelley. I represent Dr. Gordon and his employer, Community Emergency Physicians.

THE VIDEOGRAPHER: The court reporter will now swear the witness.

FRANCIS E. BARNES. M.D.

being first duly sworn, as hereinafter certified, deposes and says as follows:

EXAMINATION

BY MR. ROBERTSON:

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

A. Francis Edward Barnes.

Q. And what is your professional address?

A. 3360 Tremont Road, Columbus, Ohio.

Q. What is your profession or calling?

A. I'm a general surgeon.

Q. Doctor, I have had marked as an exhibit to your deposition Exhibit 1, a copy of your CV. Would you take a look at

that --

A. Sure.

Q. -- and tell us whether it is both accurate and current.

A. Yes, it is.

Q. Thank you. Do you currently hold a license to practice medicine in Ohio?

A. Yes, sir.

Q. How much of your professional time is devoted to the clinical practice of medicine, or as teaching in connection with an accredited medical school?

A. Approximately 60 percent.

Q. Doctor, tell the Court and jury about your professional education, beginning with undergraduate school.

A. I was born and raised in Canada, and I went to medical school and premedicine at the University of Western Ontario in London, Canada. I had an internship -- rotating internship in London, Ontario; that is to say, a little bit of everything, not too much of anything.

Then I came to Columbus, where I had

a surgical internship at Grant Hospital. Following that I had a surgical residency at Marquette University in Milwaukee, Wisconsin. I stayed there for an extra year. Nowadays they would call it a fellowship year; we used to call it a chief year, but it was as an attending. And during that year, 1967, I also got my American Board of Surgery certification.

Q. What does it mean to be board certified, Doctor?

A. To be board certified -- board certification is sort of like getting a driver's license; you have to show people that you know what it is to be a surgical specialist. You have to write an exam, you have to take orals after you have completed an accredited training program.

Q. At what hospitals do you currently enjoy privileges?

A. Well, in 1967 I came to Columbus, and in 1971, I believe it was, I became a fellow of the American College of Surgeons. I've been in private practice ever since.

I'm affiliated with Grant, Mount Carmel, and St. Ann's. I have a teaching position with the Ohio State University Department of Surgery as a clinical instructor. I'm also on the faculty of the Mount Carmel surgical residency here in town.

My practice has been -- changed over the years. I started out in practice doing a lot of vascular surgery. Vascular was not a subspecialty in those days; it was a component of general surgery.

Q. Could you define for us the present scope and nature of your practice?

A. Sure. And 1 was just going to mention that I also started the Grant Hospital Trauma Program, which is a level one trauma center here in central Ohio. I think it's probably the best one in Ohio.

But I did trauma surgery for 13 years. I stopped doing trauma in 1994. I stopped doing vascular surgery about the same time, because I had a hip replacement.

I still do general surgery. My

current practice consists of approximately 25 percent breast disease, 25 percent gallbladder and biliary disease, 25 percent hernias of various types, and 25 percent would be intestinal surgery, such as colon cancer, that sort of thing, thyroids.

Q. Doctor, in how many cases of colon cancer have you been involved over the years of your practice as a general surgeon?

A. Oh, hundreds.

Q. To what professional associations do you currently belong?

A. Well, the usual ones: The County Medical Society, the State Medical Society, the State Surgical Society. That's the Ohio chapter of the American College of Surgeons. I am a fellow of the American College of Surgeons and I regularly attend their meetings.

I also belong to a couple of specialty ones. One is the American Hernia Society, of which I'm a charter member, and you'll notice that there's a Hungarian Medical Association of America. Due to my

heritage, I joined that. It's a great meeting, by the way. It's in Sarasota, Florida, every year. People usually ask me about it, so I thought I'd preempt you on it.

Those are the societies that I belong to. I also belong to the Society of Laparoscopic Surgeons.

Q. Doctor, have I personally ever engaged your services as an expert medical witness before?

A. No.

Q. You have, however, I believe, been engaged by my firm?

A. Right. I worked with Mr. Jeffries in your firm.

Q. How many times has our firm retained you as an expert?

A. Twice.

Q. All right. When were you first contacted by my office about the case of Rita Karaba?

A. About a year ago.

Q. And with what materials were you

subsequently furnished?

A. I was given this booklet, which contains the hospitalizations at Parma Community General Hospital on 4-27-98, 4-30-98, 11-23-98.

It also has Rita Karaba's autopsy, the -- that was performed on November 24, 1998. This also had opinion letters from both plaintiff's experts, who were Dr. Richard Braen -- is that the way you pronounce it -- B-R-A-E-N; Dr. Booth has also given. I was given defense expert opinions, by Dr. Lewis Horowitz, and Dr. David Woodruff.

Q. All right. Did you then review those materials and provide a report to me dated February 21st?

A. Yes, I did.

Q. Did I subsequently provide you with some additional materials?

A. Yes, you did.

Q. And what were they?

A. I received, in addition, a report from a Dr. Charles Emmerman, Dr. Armand

Green -- let's see -- Dr. William Schermer, as well as depositions of Frank Booth, Ronald Gordon, and Richard Braen.

Q. Did any of the materials that I provided to you after your report of February 21st change any of the opinions you expressed in that report?

A. Not at all.

Q. Doctor, as you know, this case revolves around the unfortunate death of Rita Karaba on November 23rd of 1998.

A. Yes, sir.

Q. After your review of the materials with which I provided you, do you have an opinion, based upon your years of experience and training and the materials that you've looked at, to a reasonable degree of medical probability, as to the cause of death of Rita Karaba?

A. Yes, sir, I do.

Q. And what is that opinion?

A. My opinion, this woman died of pulmonary edema -- that is fluid in the lungs -- secondary to sepsis.

Q. Is there another name for pulmonary edema?

A. Well, there is another name for this particular situation; it's called adult respiratory distress syndrome.

Q. What is that, Doctor?

A. Well, you can have fluid in the lungs from various conditions. Heart failure is a very common one. The fluid in this situation is not due to any problem of the heart. The fluid in the lung in this situation is due to simply the leakage of fluid from your blood vessels into the space between the air sacs. That's what pulmonary edema is.

Now, the reason for it happening is not entirely clear. There's lots of literature on this, but it's pretty obvious that it has to do -- one of the main causes for this situation is sepsis, trauma is another, pancreatitis is another.

Q. What is sepsis?

A. Sepsis is the -- is the term that we use to describe the body reactions to

infection.

Clearly, this woman was infected. She came in with fever. She had an unbelievably high white count. 61,400 white cell count is extremely high. She had a perforation.

The autopsy is very clear that she had a perforated bowel. Also describes -- I can read it to you from the autopsy. The anatomical diagnoses include acute purulent peritonitis. That is, purulent means it's infected; that it has bacteria in it.

Peritonitis is an inflammation of the lining of the abdomen. Now, in all fairness, it wasn't all over the place. It was in the left side of her abdomen where the tumor was perforated.

There's other indicators that this woman had -- had this septic phenomenon, both on the chest x-ray that was done before her CAT scan, as well as the CAT scan. There are lung changes which are indicative of ARDS. We call these streaking or infiltrates.

A very important feature also has to do with this leakage of the fluid from the blood into the lungs, and on her microscopic examination, the prosector described intra-alveolar fibrin.

Q. What is fibrin?

A. Fibrin is a -- is a protein that comes from plasma protein called fibrinogen. It is sort of the -- the mesh that is made by the body in order to trap blood cells to form a blood clot. Blood cells, blood platelets get hung up. It's almost like a little screen effect. It's -- that's the purpose of the fibrin, is to trap things in order to -- now, that's in order if you get cut and you have to heal the thing.

The fact that there's fibrin in the lung is very significant to me, because that is a hallmark of ARDS.

She also had intervascular granulocytosis. Now, that's a big, fancy word for a lot of blood cells, a lot of white cells.

Sepsis can -- can affect not only

the lung, it can affect other organs. It can affect your -- your ability to -- for your kidneys to work properly. Eventually it can affect your heart; in fact, the end stage of sepsis is what we call multiple organ failure; in other words, everything's affected.

Q. In this case, Doctor, do you believe that Rita Karaba -- or do you have an opinion based upon a reasonable degree of medical probability as to whether or not Rita Karaba was suffering from a severe case of peritonitis?

A. Let me answer it this way: There is no question that she had peritonitis. I think the autopsy bears that out, and my -- I don't want to sound like President Clinton, but it's a question of what is severe. Severe, to me, is where you have a generalized case of peritonitis, where you might have bowel content all over the place, ruptured intestine and so forth.

I would describe this woman's peritonitis as maybe not being severe, but

significant. She had a perforation. She had dying and dead tissue.

The autopsy is very clear about the so-called necrosis, and it also supports her clinical findings, which I'm sure you'll ask me about later, but the -- the fact that she had a lot of swelling in the area of the tumor on the CAT scan and at autopsy, the fact that there were changes in the surface of the colon; she describes -- and I apologize for these big words, but they're hers not mine -- fibrinopurulent serositis with polymorphic bacterial colonies.

Well, all that means is that there is infectious material there due to bacteria from the bowel. And the serositis is the same as peritonitis, except it's on the surface of the bowel as opposed to the lining of the abdomen. There's inflammation there; lots of inflammation there. There's sepsis there, there's infection there. And, so, yes, she had peritonitis.

Q. Do you have an opinion based upon a reasonable degree of medical probability,

Doctor, as to whether or not Rita Karaba was dehydrated when she presented at the emergency room?

A. Yes; I believe she was dehydrated.

Q. To what extent do you believe she was dehydrated?

A. Well, it's a little confusing, because there's more than just one factor at work here, but let's look at her facts.

The fact is that her blood pressure dropped to some degree when they put her from a flat position to an upright position. That gives us a clue that she is dehydrated, say, 10 percent.

Her white count was high, but I think it was high because of infection, slightly higher because of the concentration of the blood.

How much was she concentrated? Well, let's look at this. Her hemoglobin was listed as 16.9 grams, and her hematocrit 49.9 percent. This would also be in keeping with about a ten-percent dehydration.

Interestingly enough, though, of her

laboratory values, the BUN -- that's blood, urea, nitrogen -- which is a prime indicator of where you are as far as not only hydration but kidney is concerned, was 20, and normal at Parma is 6 to 19, so that's barely -- barely above normal.

Creatinine, which is another kidney test, which is also an indicator of dehydration, was 1.2. The normal there is up to 0.9. So, clearly, both of these are slightly elevated, but not wildly elevated.

The amylase level was 24. That's less than normal, which is fascinating to me, because some of her laboratory values are elevated and some of them are not.

Well, if you were to say what degree of dehydration -- mild, moderate, severe; 5 percent, 10 percent, 15 percent -- I would say that she was certainly no more than 10 percent dehydrated.

Q. And what factors in the evidence before you do you point to to justify the conclusion that it was no more than a 10-percent dehydration?

A. Well, as I mentioned, her laboratory values plus the fact that she was alert and talking and awake.

There is -- you know, you have to put the entire clinical picture together. The lady was sick for a couple of days, no question about that. She came to the emergency room with a two-day history of pain, and then she vomited. She had one episode of vomiting.

Now, while she was there, she also had some diarrhea, so clearly she lost some fluids, or, on the other hand, we don't know -- there's no way of telling how much fluid she did not take in before coming to the hospital, but I don't think anybody's going to argue that -- you know, with the fact that she was slightly dehydrated.

Were some of these blood pressure readings affected by sepsis? It's a good question. They can be. Your heart can be affected by sepsis, but that would be speculative on my part. I have no indication in the record one way or the

other.

Q. Doctor, the records at Parma Community Hospital on November 23rd include a number of measured blood pressures between the time that this lady first came to the hospital --

A. Yes, sir, they do.

Q. -- and the time she was taken down to the CT scan area.

A. Yes.

Q. Is there anything about those readings that informs you as to whether or not this lady's blood pressure was low?

A. Yeah. Yeah. The blood pressure was low.

Q. All right. What about those readings gives you that information?

A. Well, when she came into the emergency room, her blood pressure was 116/86 at -- I'm a little confused by the writing whether it was 7:10 or 7:18 that they took it. She was booked in at 7:15, so let's not quibble. A little after 7:00 her blood pressure was listed as 116/86, flat on

the gurney; 104/82 upright. So that's referred to as a tilt test. It's also an indication as to whether or not you have enough circulating, what we call, blood volume, and part of what makes up blood volume are your blood cells. The rest of it is fluid.

Now, later, at the CT scanner, she had a blood pressure of 100/50, and that was taken sometime between 9:05 and 9:15. 100/50 is decidedly low.

How low is low? Well, if her normal blood pressure would have been normal, 120/80, that wouldn't have been *too* low, but we know from her previous hospitalizations that she did have some element of high blood pressure, so for her, this was lower than it should be.

Q. Without regard to the information from the prior hospitalizations of April 27 and April 30, was it possible for Dr. Gordon to make the determination that this lady was suffering from low blood pressure?

A. Well, again, it's a question of

what -- you know, how low is low. One of the definitions of shock is that the blood pressure has to drop by at least 30 millimeters of mercury. And looking at this prospectively -- you know, in retrospect, it's easy to say that yeah, she had a high blood pressure, and when she came in, it was low.

But let's look at it in Dr. Gordon's perspective. He sees a lady that's sick, and he takes these -- looks at these blood pressures, and, you know, 116/860, that's normal. That's normal for a nonhypertensive person. So could you fault this man for not considering that -- that this was a decent blood pressure? The answer is no, of course not. You can't fault him for that.

Even with the drop in the tilt, now, she went from 116 to 104, from 86 to 82. Significant? Yeah. Wildly out of line? No. That's not that much of a drop. Just the raw pressure itself, 104/82. 82 -- 82, the diastolic pressure is normal if you are dealing with a, you know, nonhypertensive

person.

I don't know whether the doctor asked her about her past history and asked her -- I'm assuming he did; a very thorough write-up in here in the record.

I don't have any criticism of Dr. Gordon in his examination, but once again, the record does not refle'ctwhether or not the issue of her previous hypertension was even brought up.

Normally speaking, you say, you know, what other illnesses do you have? Well, the only one that was listed was endometriosis. And I think Dr. -- obviously, he was asking the questions, but whether that specific issue of the blood pressure was discussed, we'll never know.

Endometriosis, if you remember, is how she described the pain. She said that the pain that I have is similar to the endometriosis that I used to have. So she was focused on that. Whether she volunteered if she had any hypertension or not, it's not reflected in the record.

Q. Assuming that a request for records -- prior records has been made, is it there any standard of care in the industry, Doctor, as to how long it should take a hospital record room to come up with prior hospital records?

A. Well, I don't -- I'm not an expert on medical rooms' standard of care. They don't call them record rooms anymore. Now they're called information centers, but whatever you call them, in general, you can expect to have records in, say, an hour.

I don't know what Parma General's employment situation is, whether they have somebody in the record room at nighttime. You know, somebody gets a request for records at 7:15 in the morning, is there anybody even there to look it up at 7:15 in the morning? I don't know. I don't know.

At our hospitals, if -- you know, if you need the records right now, there's -- you know, if you have a life-threatening emergency or something, apparently there's a way to get them. I don't know what that is

because I've never had to go over and get them myself. But --

Q. Was this a life-threatening emergency as it presented to Dr. Gordon that morning?

A. No, sir; it was not. No. I think this whole -- what Dr. Gordon was presented with was a very ill person, but he had no reason to believe in his examination at 8:00 in the morning that this was a life-threatening emergency. It's a far cry from a gunshot wound to the abdomen or a ruptured aortic aneurysm or a myocardial infarction. No; that's not in the cards.

This woman was sick, yes. There's no question that she was sick. But, again, looking at this prospectively, I don't believe that he had any reason to believe that this was life-threatening at that point.

But let's just say for the sake of argument he put in a record request and the records came back whenever they did, an hour later. I don't consider that to be

unusually -- an unusual delay.

Q. Doctor, the records suggest that following his physical examination of the patient, Dr. Gordon requested a number of lab studies and other tests be done.

A. Yeah, he did. He ordered a bunch of stuff, which -- which is what -- what you would expect him to do.

Q. Were the tests as ordered, in your opinion, to a reasonable degree of medical probability, appropriate tests to request?

A. Oh, sure. Sure. He ordered chemistries, he ordered a blood count, he ordered a urine -- well, there's two urine tests. I'm convinced there was only one urine, but there were two tests on it. One is where they just dip a dip stick into and look at the color indicators; the other is where they take it to the lab and actually spin it down and look to see if there's any -- to get a little more accurate assessment of it.

He also ordered some liver enzymes and the amylase and lipase that we mentioned

earlier. He ordered a chest x-ray, and he ordered a CT scan of the abdomen.

Q. You've looked at both the interpretations of the chest x-ray and the CT scan, I take it?

A. Yes, sir.

Q. Was it appropriate, in your view, for Dr. Gordon to have requested a chest x-ray and a CT scan?

A. Sure. Sure, it was. Because a chest x-ray is part of the examination of abdominal pain.

This woman comes in with severe abdominal pain. Do we want to call it acute abdomen? You can call it anything you want, but what you do is you get x-rays of the abdomen and the chest, because you're looking for free air under the diaphragm on a chest x-ray. That's the best way to look for a perforated viscous.

Q. What about the CT scan?

A. Oh, sure. He felt a palpable mass. He felt a palpable mass. I mean, that, right off the bat, you have to know what

that mass entails.

Now, the doctor, on the basis of his examination, he believed that this woman had a tender abdomen with a palpable mass, but he did not have generalized peritonitis. There was no guarding, there was no rebound tenderness. And as a surgeon of 34 years, I can tell you that the key indicators of generalized peritonitis is whether or not you have guarding, rigidity and rebound tenderness.

Rebound tenderness is a specific examination that tells you that that person is not only tender, but when you let go, the percussion of the lining of the abdomen against itself elicits more pain. Another way you can do it is what we call percussion, by just tapping on the belly like this. (Indicates.) If that person complains when you do that, that's rebound tenderness.

But the fact of the matter is, he did not have that. And based on the autopsy findings, that's not surprising, because she

did not have generalized peritonitis, but she had a palpable mass.

Now, why -- why the difference? If she would have had generalized peritonitis plus an abdominal mass, that represents more of a surgical emergency than nonperitonitis with a palpable mass. And he did the very thing that all of us would have done under those circumstances. I can tell you 100 percent, if I would have been at Parma General walking around, making my rounds, and he would have called me and said, I need a consultation; I've got a woman with a palpable mass in the left lower quadrant, one of my first reactions would be, get a CAT scan, because we have to know where the heck this thing is located, what's it doing, is there fluid, is this in the colon, is it in the ovary, is it -- what the heck is it.

I mean, the differential on a abdominal mass, I mean, we could be here till 9:00 tonight talking about a differential, on what it could be, but the test that you use, you know, the gold

standard, if you want to call it that, is a CT scan, and he ordered that, and that's appropriate.

Now, it didn't get done right away because of some delays, delays because the lady had to go to the bathroom a couple of times because she had loose bowel movements.

Q. Also, Doctor, there's **a** notation on one of the pages of the nurse's notes. At 8:10 it says one cup oral contrast was given.

A. Right.

Q. Do you know how long after oral contrast is given to a patient before one normally attempts to do a CT scan?

A. Generally, about half an hour.

Q. All right. Does the record tell us anything about what else was going on in the CT scan department that morning in terms of what other cases may have been in line before this lady?

A. No.

Q. Was the CT scan ordered on an emergent basis; that is, put this ahead of

all other cases?

A. I don't remember seeing anything that said emergent, but, clearly, they did it right away. I mean, you know, he ordered the thing at 8:00, and she was over there at 9:00, so that's pretty good. I mean, considering travel time and so forth, that's pretty good.

Q. Okay. In this case, Doctor, you believe that her death was caused by adult respiratory distress syndrome?

A. Yes, sir.

Q. But she was dead by 9:55 in the morning.

A. Yeah.

Q. Does adult respiratory distress syndrome produce death that rapidly?

A. Well, it depends on what mediators you have and it depends on the scope of the disease. This woman complained of two days' worth of pain. She had lots of necrosis on her autopsy.

Q. What is necrosis?

A. Dead tissue. She -- what happens

with these tumors is -- and there's some tremendous research that was done by one of our boys here in Columbus. He's at the Harvard Mass General; his name is Fulpin. But Judah Fulpin has shown that in tumors, the blood supply to a tumor is such that tumor cells only can grow six layers away from its blood supply.

And what happens with -- and this is fairly characteristic of colon cancer -- it grows like a cauliflower, and then the center part actually goes rotten because it gets too far away from its blood supply. It just literally dies, because it doesn't have any blood supply.

The periphery of the tumor keeps growing and, so, the center part is where the hole came from. This is where it penetrated the bowel initially, but then the tumor kept growing.

What's interesting about this tumor is it was an eight-centimeter tumor, but four centimeters, or nearly two inches of this tumor, was already outside of the

bowel. So it tells us that, number one, this thing has been there for a while. But that's an awful lot of growth outside of the bowel already.

Okay. The -- you'll have to excuse me. I lost my train of thought.

Q. I asked whether it was possible for adult respiratory distress syndrome to produce death this quickly.

A. Yeah. Oh, sure. Okay. Of the various mediators -- let me go back to the beginning.

Adult respiratory distress syndrome usually takes a couple of days to develop. She had symptoms for a couple of days. She had tumor necrosis for more than a couple of days. I mean, this is just the way -- it has to have been there for a long time, because that's how you get the hole in the bowel. You have to rot your way through the bowel in the first place.

But in the second place, she had this two inches of tumor outside, so she's been rotting away at this tumor for quite

some time. The necrosis here did not completely occur during the last hours of her death, although there were symptoms there where she is writhing around on the gurney. That tells me that she was having further necrosis, because the type of pain she was experiencing there is very characteristic of what we call ischemic pain or the pain of an organ where it lacks blood supply, such as with a heart attack, such as with an occluded blood vessel to the leg, such as where you have with infarcted bowel.

But getting back to the ARDS, so she's had this for a couple of days. How long has this sepsis been going on? Long enough to cause changes in the lungs. Right from the very get-go, the very first chest x-ray is indicative of coarse interstitial pattern in the lungs, particularly in the lower lungs; in fact, he says, 1 can't rule out a viral pneumonia. So there's significant changes in the lungs.

The doctor did not hear very much on his initial examination. Later on they

described some stuff in the lungs, but what I'm getting at is, that there are some tumor mediators. There are -- tumor necrosis factor is one. There's another factor called C5A. C5A has a -- is an interesting little protein that is produced under sepsis, and if you inject that into somebody, they go into allergic shock. It's got a fancy name, anaphylatoxin or anaphylactic toxin.

Anaphylaxis is the collapse that you go through with severe allergic reactions. The guy that has the bee stings many, many times, then a bee stings him and he drops over, that's anaphylaxis.

Okay. So we know from the literature -- and by the way, I have presented -- I have a bibliography for you folks. But there's a couple of articles in there on ARDS which is fully supportive of what this woman is -- went through.

The initial phase, hours; secondary phase, couple of days; third and fourth phase, it depends largely on whether or not

you survive and whether or not it's adequately treated.

By the time you get into the fourth phase of ARDS, your chances of survival are next to none. In my opinion, this woman was in definite phase two, possibly even early phase three of ARDS. But it's not proper --

Q. At what point in time?

A. Excuse me?

Q. At what point in time?

A. At the time that she was -- well, between 8:00 and 9:00 in the morning. I mean, the lady came in; she's talking, she is able to give a history, she is able to lie still for a, you know, a pelvic and a rectal and get all that stuff done.

Then she starts getting a little sicker. She starts writhing around in pain on the cart. She has a couple of loose stools that she has to go to be bathroom for. I don't know if you need the exact times, but I got them here. 8:40, she went and had a stool, and 8:55, so that goes to what she went to the CAT scanner. Because

Most people can't go to the CAT scanner if they're in the bathroom

So let's put the issue of the CAT scan to bed. The CAT scan was done appropriately and it was done quickly

Now, this woman, first has, on the record -- the first -- the first indication that she has real problems with her lungs is not until she's in the CAT scan room, and specifically it's listed at 9:05 She complained of shortness of breath

They used a pulse oximeter. What's a little device that's put on your finger or your ear to indicate how much oxygen saturation you have Hers was 97 percent, which is normal But they still gave her three liters of oxygen in order to support some treatment for her shortness of breath

The oxygen was maintained, but she then basically went into -- started getting into some real problems. started getting sweaty, the blood pressure was listed as 100/50, which we all now agree was a little low. It was low. Pulse was 137

respiration ratels 32.

Now, let's go back to when she first came into the emergency room. Trying to find her respiration rate, and I don't see it.

Q. Doctor, on --

A. Here it is, 13.

Q. It's 18, I believe, Doctor. You're looking at the line that says 7-18?

A. Yeah.

Q. Yeah.

A. Is that it?

Q. I believe it's 18?

A. Let's make it 18. 18 is still not bad. It's either 13 or 18, but if you tell me it's 18, it's 18. 18 is still a heck of a lot better than 32, so --

Q. And you see the reading at 8:45, it says 24?

A. Okay. Well, what we're witnessing here is the deterioration of this woman, and she -- and you have to ask yourself, what in the blue heaven could possibly cause this woman to go off the end of the earth in such

a short period of time? Because, basically, this woman died within about an hour and a half.

I mean, when you take -- if you take from the time Gordon does his exam at 8:00, she's in full arrest at 9:30, and they couldn't get her back. So the time of death is 9:55, but she was basically dying or dead at 9:30.

What on earth could cause such a -- you know, how do you drop off the end of the earth that quickly? Well, dehydration alone won't do that to you. Sepsis will; pulmonary edema will. If you can't breathe, you can't get oxygen. If you can't get oxygen, all your organs start starving, and you literally start going down the slippery slope.

The autopsy is very clear about that. Her lungs were noncrepitant -- noncrepitant.

Q. What does that mean?

A. Well, the lungs are filled with air, and it's like -- let's see, what's the best

way of describing crepitus? It's like when you have -- when you squeeze crepe paper. It has that sort of crackly feel to it; it's soft but it sort of crackles a little bit. Well, those are the little air sacs when you squeeze the lung. When it's full of fluid, there's no air; therefore, nothing ruptures when you squeeze the lung to make it feel or sound like the crepe paper.

The lungs were noncrepitant, and the reason they were noncrepitant was because of what you see on the x-ray, what you see on the CAT scan interpretation of the lungs, and this that there's infiltrates. There's fluid there.

The fluid was there before she went into the shock. I mean, the shock meaning the last 15 minutes of her life. She -- the fluid was definitely in the lungs before, so we can't say that this was something that happened as a terminal event; it takes time to have pulmonary edema. And I got to remind you that they find fibrin in the lung, which tells me that it's been like

that for some time.

You don't get fibrin in the lung from ARDS within a matter *of* an hour, no. It's been there for a while.

Q. Doctor, do you have an opinion based upon an opinion *of* medical probability whether or not any of the nursing staff from the Parma General Hospital departed from accepted standards of care in their treatment *of* Patient Rita Karaba?

A. I don't think they did. I think there's one area of dispute here that I read in the record; I read in the depositions. IV fluids were ordered at 150 an hour, and somebody wrote down, "Administered at 100 an hour." Was that a clerical error or did she actually goof it up?

Well, the question is, what would be the more reasonable thing to believe? The more reasonable thing to believe is that if you see an order at 150 an hour, you try to make it 150 an hour. 1 don't know of any nurses that take an order of mine and say, I don't think I'm going to agree with this,

I'm only going to give two/thirds of that.

Q. By the way, is that order timed, Doctor, the order for the IV?

A. Hang on a second here. Sure it is, but you're going to have to help me find it. Hang on a second.

Started by Kathy Schaefer, and I suppose --

Q. Her notations are timed, but is the doctor's order; would that be timed?

A. Oh, the doctor's order is -- my impression was that all that stuff was ordered at 8:00.

Q. Okay. You will note --

A. 7:45 --

Q. Yes, in nurse's notes.

A. -- in nurse's notes, it says, "Left hand number 18 saline lock. 8:10, D-5, normal saline, 100 per hour, by Kathy Schaefer." And Kathy Schaefer took off the 150 an hour over here.

Q. All right. Now, if she began the insertion of that saline lock at 7:45 --

A. Right.

Q. -- then that would have been done even before the doctor ordered any infusion of fluids, correct?

A. Right.

Q. Okay. Is it -- but how does the number 18 catheter compare in size to catheters generally for the infusion of fluids?

A. Well, you know, needles vary anywhere from 27 gauge, which is like a filament of hair almost -- plastic surgeons like to use those because that's part of their mystique -- all the way up to -- you can -- you know, you can have needles that are up to 16 gauge. They make them bigger than that, but none of us use any bigger than that.

18 is a good-sized needle. With an 18-gauge needle, you can administer a lot of fluid -- a lot of fluid. Especially if you put up a pressure pump or something, you can get a lot of fluid through an 18 needle, if you need it.

Q. There has been testimony in this

case, Doctor, from experts for the plaintiff, that the plaintiff was suffering from hypovolemic shock. Do you have an opinion on the subject of whether or not Rita Karaba suffered from hypovolemic shock, to a reasonable agree of medical probability?

A. I think they're half right. I think they're half right. I do agree that this woman was dehydrated, that she was, in a word, hypovolemic, but I don't think that her degree of hypovolemia would have put her into a shocked state absent the infection.

I mean, to me, it's crystal clear that the sepsis had more to do with this than the mere fact that she was dehydrated.

Q. And what produced the sepsis?

A. Her perforated cancer of the colon and its necrosis; the perforation, the localized peritonitis, which has been there -- well, if you listen to her, the terminal event on this thing was going on for a couple of days.

We know from the fact that she had

80-percent growth around the circumference of the colon that that tumor had to have been there for a minimum of a year, a year and a half.

She had an ultrasound done on one of her previous hospitalizations, which didn't really show much in the pelvis. Maybe they didn't scan the area; on the other hand, maybe it just wasn't that visible. But we know from the natural history of colon cancer that it takes about six months to fill one quadrant.

So this thing was there for at least a year. We know that the thing was penetrated outside of the bowel quite a ways. But I think that somewhere along the line -- and what's telling us what's happening here is the fact that she's writhing around in pain on that gurney. This thing is rotting right in front of our eyes. This thing is -- this tumor is literally disintegrating right in front of our eyes, and part of that disintegration took place prior to the time she came to the

emergency room, a goodly part of it did.

On the CAT scan, there was a little bit of fluid back there. It was described as being roughly two inches by two inches, which is not a lot of fluid. The doctor made the conclusion that this might be perforated diverticulitis, a very reasonable conclusion under these circumstances.

Well, it doesn't matter a damn why you're perforated. Once you're perforated, you're perforated. And that -- it's no longer the bowel that takes first precedent here; it's the effect of the perforation, the sepsis.

There is some question as to whether or not, you know, this woman should have had immediate surgery. There's no way in hell that anybody would have operated on this woman right from the emergency room. I can tell you, within reasonable medical certainty, a surgeon would have gone down and the first thing the surgeon would have wanted was a CAT scan to try to delineate the problem. And the next thing he would do

was put this person into the hospital, into intensive care or surgical intensive care, a critical care unit of some sort, and get her, what we call, tuned up, you know.

Now, she could have had ten surgeons standing around her bedside and she would not have survived this under these circumstances. The thing about it is that a goodly number of these people die; not everybody survives. And under the circumstances of Rita Karaba, you could have had every surgical professor in the country standing there, and they would not have saved this woman.

MR. KELLEY: Objection.

Q. Doctor, subsequent to my receipt of your opinion letter on February 21 --

A. Right.

Q. -- following your review of the materials I had given you, did I request your opinion as to the likelihood that Rita Karaba would have survived surgery to remove that perforating colon tumor, had such surgery been initiated within a

reasonable period of time after its detection?

A. Let's define --

MR. GUION: Objection to this, and let me put on the record a continuing objection to any reference from this point on regarding the cancer.

Q. Go ahead, Doctor. Go ahead, Doctor.

A. Again, it depends on what you consider a reasonable period of time. A reasonable period of time of a person who has a perforation, a localized perforation of the colon, who is -- who has some dehydration, who has to have some antibiotic coverage; in fact, some bowel prep for the colon, a reasonable period of time on this would be 24 to 48 hours.

It would be unreasonable to go directly from the emergency room to the operating room, which we do when we have a life-threatening emergency.

I was a trauma surgeon for 13 years. We took gunshot wounds to the abdomen directly to the operating room. We took

stab wounds of the abdomen directly to the operating room. Where you can get a CT scan in a nonlife-threatening situation, you have immense amount of information that you need.

The way this lady presented, and her problems up until about 9:00, were not life threatening at that point, When she started to go down was -- the first indicator was the shortness of breath at 9:05, and all of a sudden, my goodness, within 25 minutes, she's arrested. And this is not some feeble person who's got myocardial disease, that's heart disease, or anything like that. This is a fairly robust, fairly healthy woman.

That's -- you know, in the Air Force, they say crash and burn. I mean, this is -- this is absolutely astounding that somebody goes down this quickly. And you can't go down that quickly on the usual slow processes. Dehydration is not a real rapid process, but allergic reactions, abnormal things like ARDS, those can be fast.

Q. Did I also request, Doctor, whether

you had an opinion as to the life expectancy of Rita Karaba had she survived abdominal surgery to remove colon cancer following its detection?

A. Sure.

MR. GUION: Again, let me first state a continuing objection to anything having to do with an answer here that is in reference to the cancer.

A. Can I answer?

Q. You may respond. Do you have an opinion, first?

A. Yeah; I sure do.

Q. And what is the opinion?

A. Well, her life expectancy would have been quite low. First of all, with perforated cancers, the mortality rate is somewhere around 20 to 25 percent just from the operation. That's standard in the literature. And I have references here for -- for -- that deal with that.

Secondly, the two factors that are most important in the longtime survival of colon cancer is the depth of the tumor and

whether or not lymph nodes were involved.

The more shallow the tumor, that is to say, if it is just restricted to the lining, if it's just to the lining itself, the inside lining of the bowel, you can expect over 90-percent survival

Once it's through the outer surface, the overall survival rate of penetrated tumors is only about 25 percent

Q What do the records in this case tell us about the degree of penetration of Rita Karabas's tumor?

A. There's horrendous penetration. The colon, on the autopsy, is described -- it says, 'On opening the colon, there is a fungating, necrotic, gray, pink, and tan solid mass, mucosal mass, involving approximately 80 percent of the circumference, measuring 10 by 8 centimeters, and extends intraluminally approximately 4 centimeters

Then it says, 'The mass appears to extend through the underlying bowel wall The pericolonic tissue is dull, fibrotic,

pink-red." And listen to this, "The pericolonic fibrosis involves the left uterine adnexa and the dome of the urinary bladder.

So this thing has not only penetrated, but it's stuck to the bladder and the neighboring tissues. All right. so --

Q. What's the significance of that?

A. Well, two things. First of all, just the raw statistics. Just the raw statistics. The raw statistics on colon cancer haven't changed for decades. Out of every 100 people that have colon cancer, 25 of them will have distant involvement in the liver and so-called distant metastases, making them unresectable for cure.

Of the 75 percent that are resectable for cure, approximately one-third of them will be penetrated with nodes; about half will be confined to the bowel wall itself. So if you can resect for cure, that is to say --

Q. What does that term mean?

A. Well, that means that you're removing the tumor and you have -- you are -- are doing this with the idea that you're extirpating all of the disease as opposed to leaving some behind, which is called palliative; or where it's spread elsewhere, which is what we call metastatic.

Now, that has to do with all tumors, all comers. The depth of the tumor in this thing, in my opinion, within reasonable medical certainty --

MR. GUION: Objection, again.

Q. Go ahead, Doctor.

A. -- is that there must have been lymph nodes involved.

You see, Claude Welsh, who is one of the great authors of Massachusetts General, pointed out that even if the nodes aren't involved, if it's already stuck to its neighbors like this one was, the -- the survival rate on this thing is no more than 40 percent, but if the nodes are involved and you have a free perforation, the survival rate on perforated cancers of the

colon can be as little as 7 percent.

So where do you go in the middle? Well, the literature -- and one of these papers has a summary of the literature. The literature will tell you that the --

MR. GUION: Objection.

A. -- survival rate is around 25 percent. The autopsy did not describe any lymph nodes. It would have been helpful to know that, but in my opinion, within reasonable medical certainty, the extent of this tumor is such that the lymph nodes had to have been involved.

Q. So if I understand you correctly, Doctor, then, had the person who performed the autopsy removed the lymph nodes and put the tissue under microscope and found cancerous tissue there --

A. Right.

Q. -- that would be proof positive that the lymph nodes were involved, correct?

A. Sure.

Q. But in the absence of having that --

A. Right.

Q. -- you still are able to form an opinion to a reasonable degree of medical probability that those lymph nodes would have been involved in this case?

MR. GUION: Objection.

A. Sure. But there are two reasons why I'm basing my opinion on that. Number one is that the extent of the tumor, my experience tells me that lymph nodes would be involved, but -- but, even if we accept the premise that the lymph nodes weren't involved, under the modification of the Aston Collier classification of colon cancers, Dr. Welsh would have called this a B-3, which is -- which is into its neighbors.

And even if it's into the neighbors, without lymph nodes, you still have a -- more likely than not, you're not going to survive five years.

Q. Do you have an opinion, Doctor, based on a reasonable degree of medical probability, as to whether there was anything that could or should have been done

for Rita Karaba at Parma Community General Hospital on the morning of November 23rd that would have prevented her death?

A. No. No. I think this woman was doomed from the get-go because of her disease.

MR. ROBERTSON: Thank you. I have no more questions.

MR. KELLEY: Can we take a break before you start?

MR. GUION: Yeah. Let's take a break. I'd like to look at those records.

THE VIDEOGRAPHER: Off the record at 11:12 a.m.

(Pause in proceedings.)

THE VIDEOGRAPHER: On the record at 11:17.

EXAMINATION

BY MR. GUION:

Q. Doctor, my name is Harry Guion. We met just briefly a little while ago.

A. Sure.

Q. And I've got some questions. First thing I'd like to do, Doctor, is just go

over some general concepts, and I just need a yes-or-no, agree-or-disagree type of answer, okay?

A. Okay.

Q. Is that fair?

A. If I can.

Q. Yeah. If you can't, you can say, obviously, you don't understand the question or you can tell me you can't answer it. Fair enough?

A. Sure.

Q. Dehydration would be a loss of body water; is that true?

A. Yes, sir.

Q. Dehydration can lead to shock; is that correct?

A. Yes, sir.

Q. Okay. Patients with severe dehydration will have intravascular hypovolemia?

A. Yes, sir.

Q. Okay. I'll just mark this out here.

Patients may experience an increase in hematocrit as they develop shock?

A. Are we talking about hypovolemic shock?

Q. Yes.

A. Yes.

Q. The response to a substantial blood loss is hypotension?

A. Sure.

Q. Patients with severe hypovolemia are often pale and diaphoretic?

A. Can be.

Q. Patients with a 20-to-40 percent blood volume deficit are at risk for death if their intravascular volume remains unrestored?

A. Of course.

Q. Despite many reports that tachycardia is a reliable indicator of the presence and severity *of* shock, hypovolemic shock, the pulse rate has been consistently found to be neither sensitive nor specific for differentiating injured patients in shock from those not in shock; true or not true?

A. I don't believe that. There's a lot

of gray area in that answer.

Q. An increment of more than 30 beats per minute in hypovolemic individuals after postural changes is reported to be a sensitive indicator of hyper -- hypovolemia?

A. Can be.

Q. Septic shock is the most serious clinical problem and exists if a patient has severe sepsis, is resuscitated appropriately with intravenous fluid infusion and remains in shock; do you agree or disagree?

A. Yes. Yeah, I agree.

Q. The treatment of septic shock begins with prompt treatment of the infection site. Antibiotics play an essential role in treating septic shock. Do you agree or disagree?

A. Yes, certainly.

Q. The resuscitation of most patients in septic shock begins with the intravenous infusion of isotonic fluid, normal saline or Ringer's lactate, for the purpose of expanding the intravascular volume; is that true?

A. True.

Q. Enormous volumes of fluids may be required to resuscitate patients in septic shock?

A. True.

Q. The amount of fluid can exceed 10 percent of the body weight, true?

A. True.

Q. Radiographic contrast agents may cause acute renal failure?

A. Sometimes.

Q. Generally, patients with abdominal pain requiring surgical treatment experience the pain before vomiting occurs, generally?

A. Yes.

Q. Peritonitis causes hypovolemia as plasma volume leaves the intravascular space?

A. Well, of course, it depends on the amount of peritonitis, but --

Q. In general?

A. -- the answer -- the general -- let's start all over again. The answer to that general statement is yes.

Q. Okay. Doctor, you have reviewed, among other things, Dr. Braen's deposition, correct?

A. Yes, sir.

Q. And do you agree that Rita Karaba came into the hospital with fever, number one?

A. Yes, sir.

Q. Abdominal tenderness?

A. Yes, sir.

Q. Hypotensive?

A. It turns out that way.

Q. Evidence of dehydration?

A. Yes, sir.

Q. And would be in what we call early shock?

A. Yes.

Q. Dr. Braen has stated that -- in agreement, that the CAT scan was an appropriate diagnostic test, but his caveat is that she first should have been adequately fluid resuscitated. Do you agree or disagree with that statement?

A. I disagree.

Q. Okay. Her orthostatic pulse went from 92 to 94 up to the 130s, which is almost 44 percent. Is that an indicator of dehydration?

A. Yes, sir.

Q. Okay. Plus she had vomiting; is that true?

A. Yes, sir.

Q. Plus a fever; is that true?

A, Yes, sir.

Q. Are those also indications for dehydration?

A. Not necessarily.

Q. Can they be?

A. They can be part and parcel of the same complex, yes.

Q. And if you put all three together, does that increase the likelihood of a need to consider dehydration as being present in the same patient at the same time?

A. Sometimes.

Q. Dr. Braen has stated that the standard of care would have been to give -- to start with a bolus of 500cc of fluid. Do

you agree or disagree with that statement?

A. Well, retrospectively, yeah, I would agree.

Q. But what you knew at the time -- what Dr. Gordon knew at the time, would you still agree or disagree that 500 bolus of cc should have been started based on what Dr. Gordon knew or should have known?

A. No. In my opinion, the examination that was done at 8:00 in the morning, even with the postural changes, the amount of fluid that was ordered, 150cc's per hour, which is more than maintenance, was a good start.

The doctor had no indication whatsoever at 8:00 in the morning that this person was -- was about to go off the deep end.

Q. Okay. Arterial blood gas study was not done; is that correct?

A. That's correct.

Q. An arterial blood gas study might have provided useful information as to whether or not she was in a shock state; is

that true?

A. Well --

Q. Yes or no.

A. Yes. Sure.

Q. Would it have helped in this case to know exactly what her pH level was --

A. No.

Q. -- when she arrived?

A. No.

Q. Do you agree or disagree that at 8:45, Dr. Gordon should have reexamined her at that point and should have done an abdominal exam at 8:45?

A. 8:45 was when she was --

Q. Writhing in pain.

A. -- writhing in pain, with spasmodic pain, which was, in my opinion, was ischemic pain.

Q. Yeah. My question is, Doctor, do you agree or disagree with that?

.A. Optimally, yeah, it would have been a good idea, but I don't think it was necessary.

Q. Okay. In terms of specific gravity

of the urine, the specific gravity was listed at 1.048 by the lab, right?

A. By the laboratory, that's correct.

Q. Is that indicative of dehydration?

A. Yes, it is.

Q. Dr. Braen, in his deposition, has made the statement, "Early in the game his responsibi1ity" -- referring to Dr. Gordon -- "his responsibility was *to* fluid resuscitate her, and that is where he fell down on his care of this patient."

Do you agree or disagree with that statement?

MR. ROBERTSON: Objection.

A. I disagree.

Q. Okay. Dr. Braen has said, "Given the fact that she was in impending shock, she was febrile, she had abdominal pain, she had an abdominal mass, she was dehydrated, that antibiotic therapy should have been considered early on." Do you agree or disagree with that?

A. Sure.

Q. Dr. Braen has said -- the question

was asked: "Do you believe she should have been bolussed with 500ccs?"

And his answer was: "Right. She should have been -- she should have been closely monitored. If she didn't improve, she should have been rebolussed as many times as necessary."

Do you agree or disagree with that?

A. Sure.

Q. The one thing that you do know is she should have kept getting fluids until her vitals came up. Do you agree or disagree with that statement?

A. Sure; she needed fluid.

Q. Dr. Braen has stated that the standard of care required a large-bore IV and he should have been able to get 500cc's into her within 8 to 10 minutes. Do you agree or disagree with that?

A. I'm going to disagree that -- that anything larger than an 18-gauge needle was obvious at 8:00 in the morning.

Q. Okay. Well, forgetting about the large-bore IV, would you agree that they

should have been able to get 500cc's into her within 8 to 10 ten minutes?

A. You can do that with an 18-gauge needle.

Q. Okay. Which is what she had, 18-gauge?

A. Yes, sir.

Q. Elevated respirations, we talked about that --

A. Right.

Q. -- and up to 34. That is also consistent -- that is also consistent with increased acid in your system; is it true, consistent?

A. Acidosis.

Q. Acidosis.

A. Can be.

Q. It's also consistent with being in shock; isn't that true?

A. Of course.

Q. Do you agree that pulse rate changes are more sensitive than blood pressure changes?

A. Yes, sir.

Q. Now, her respiration rate kept increasing. It went from 18 at 7:18, to 24 at 8:45, to 32 at 9:05; is that correct?

A. That's correct.

Q. And does that indicate continuing increasing dehydration?

A. No.

Q. Can it?

A. No. No. What -- what --

Q. All right. Yes or no is all I'm asking you, Doctor. If you don't believe it can, then fine.

Would you agree with this statement: That the degree of her dehydration was probably fairly great, given her specific gravity on the dip stick originally was 1.030, and we know that is as high as the dip stick reading will go.

Would you agree that will indicate that?

A. Sure.

Q. Dehydration can be caused by vomiting, correct?

A. Yes.

Q. It can be caused by poor fluid intake, correct?

A. Yes.

Q. And it can be caused by sepsis, correct?

A. Yes.

Q. And Rita Karaba had all three of those things, correct?

A. Yes.

Q. Dr. Braen has stated, "This is a patient that needed a large volume -- that needed large volumes of fluid, 500ccs initially, followed by reevaluation, followed by more fluid as required. 100cc's doesn't cut it."

Do you agree or disagree with that statement?

A. Well, of course, I agree. In retrospect, I agree wholeheartedly.

Q. Do you agree that arterial blood gas studies should have been obtained by at least 8:45 a.m.?

A. No.

Q. Should it have been obtained at all?

A. Yeah.

Q. Do you believe that the nurses at 8:45, when the writhing-in-pain on the cart was taking place, should have notified the doctor of this change in the patient's status?

A. Not necessarily.

Q. Okay. Would you agree with Dr. Braen that you're not going to send a patient to a CAT scan until you have their blood pressure and pulse stabilized?

A. Not necessarily.

Q. Dr. Braen has stated that by 8:45 Dr. Gordon should have come in, reexamined the patient, and within a few minutes contacted a surgeon.

A. No; I don't agree with that.

Q. He has said that to keep her afloat she needed two things: She needed IV antibiotics and IV fluid. Do you agree or disagree with that?

A. I agree with half of that statement.

Q. Which -- do you agree with the antibiotics, or that --

A. No. Antibiotics --

Q. -- she needed the fluid?

A. Antibiotics in an hour period of time would have done nothing.

Q. So you agree with the fluid part of the thing?

A. Fluid would have helped --

Q. Okay.

A. -- to some degree.

Q. Okay. Dr. Braen has said, "I believe that without the adequate resuscitation, namely the fluid resuscitation, she had a very high chance of going into irreversible shock and dying, which is exactly what happened."

Do you agree or disagree with that statement?

A. I don't agree with that.

Q. Okay. Doctor, do you know when she was given the IV contrast that she was given -- what time it was given?

A. The IV contrast?

Q. Uh-huh. She was given an IV contrast as well as the -- were you aware of

that?

A. Well, let's see. I only see a cup of oral contrast given at 8:10.

Q. Uh-huh.

A. Now, if I'm missing something, I'm -- I would hope that you'd point it out to me.

Q. Well, she did receive a IV contrast dye. She received three types *of* -- three types *of* -- of contrast. She received the oral, *of* course; you know that, right?

A. Yeah.

Q. And she received the rectal; you know that?

A. Uh-huh.

Q. She also received an IV contrast. You were totally unaware of that up to this moment?

A. Yes, sir. I don't see it on the record. I'm sorry.

Q. IV contrast can be very dangerous to a patient that's dehydrated; do you agree or disagree with that?

A. I disagree.

Q. Do you believe that IV contrast is totally nondangerous?

A. Oh, no. No. If you have an iodine allergy, it can kill you.

Q. What if you're dehydrated?

A. Well, certainly, there is an affect on the kidney if you are severely dehydrated -- severely dehydrated.

Q. Okay.

A. And I suppose that's where we're getting down to here. She had no -- in my opinion, her renal function studies were normal enough, even in the face of this dehydration that she exhibited, that it was --

Q. Okay, Doctor, that's fine.

A. Well, but --

Q. I'm just asking you --

A. I'd like to answer the --

MR. ROBERTSON: And I object and I request that you let the doctor finish answering the question that you asked.

MR. GUION: I asked him only -- you already answered my question.

THE WITNESS: All right.

MR. KELLEY: In reality, you can move to strike it, thought, but we have to put the answer on the record.

MR. GUION: 1 just don't want it to pile up here.

THE WITNESS: Okay. All right.

MR. GUION: You'll still have an opportunity to answer anything more in front of the Court when you get to Mr. --

A. What was the original question? Because I don't agree, okay?

Q. Do you agree, Doctor, that a patient that is in shock will continue to get worse until such time as they are fluid resuscitated?

A. Of course.

Q. Now, Dr. Booth has stated that Dr. Gordon should have given Rita Karaba at least a liter of fluid in 30 minutes or so as an initial first step. Do you agree or disagree with that?

A. I disagree.

Q. Do you agree with this statement:

If you come into the hospital with a colon perforation and you are in your 40s, agewise, your mortality rate should be 10 percent or less?

A. No. Absolutely disagree.

Q. Dr. Booth has said that the chance of her surviving this operation, Rita Karaba of surviving, would have been at least 90 percent survivor rate, and that more likely than not she's going to be in the **ICU** a couple of days, out of the hospital 10 or 12 days, depending on what's done.

Do you agree or disagree with that assessment?

A. I disagree with most of it.

Q. What do you agree with?

A. I agree that she'd be in the hospital 10 to 12 days.

Q. Okay. Doctor, let's take a look at your report.

A. Okay.

Q. Your report -- your -- actually, you've written two reports, a report and a supplement to the report?

A. Yes, sir.

Q. Your first report was written February 21st, 2001; is that correct?

A. Yeah, but --

Q. And take your time to find it.

A. That's my problem, where is it? Have you got mine there?

Q. No, I don't have yours, I have my own.

A. Well, where are mine?

Q. I don't have it.

MR. ROBERTSON: (Hands.) There's a copy you can use, Doctor.

MR. GUION: I gave you back everything that was here. I've got my own copy.

THE WITNESS: Let me just look here.

MR. ROBERTSON: That's both of them.

THE WITNESS: Here we go. Yeah. I've got my original for the supplemental report but I still don't have my original report.

MR. GUION: Take your time and find it.

MR. ROBERTSON: That is the original there, Doctor, the February 21. That's the supplement. The original is right there, the one you have your right hand on.

THE WITNESS: This is a copy.

MR. ROBERTSON: I understand that, but --

THE WITNESS: So where is my original?

MR. GUION: I don't have it.

MR. ROBERTSON: I probably stole it.

MR. GUION: Off the record.

THE VIDEOGRAPHER: Off the record at 11:40.

(Discussion off the record.)

THE VIDEOGRAPHER: On the record at 11:42.

Q. Doctor, I'm going to first refer to your report of February 21st, 2001.

A. Yes, sir.

Q. Okay. Let's go through it step-by-step.

A. Sure.

Q. First of all, she had two days of

left lower quadrant pain; isn't that correct?

A. That's correct.

Q. She was vomiting the morning of her admission; is that correct?

A. That's correct.

Q. Now, you mentioned in your report she had a mild temperature elevation. I'm focusing on this word "mild." At 7:18, her temperature was 101.3, and at 7:30, it was 103.7 rectally.

Do you consider that to be a mild temperature elevation?

A. When she came in, it was 101.3, and that is mild, in my opinion.

Q. You consider that mild, 101.3?

A. Yes, sir.

Q. You have -- consider that to be something -- anything above 101 where you'd want to rule out sepsis; is that correct?

A. Sure.

Q. Once it goes above 101, you want to rule out sepsis, because sepsis is a concern with a temperature of over 101, correct?

A. It depends if you have a fever, but, in general, yes; over 101, you start worrying about infection elements. Yes, of course.

Q. You certainly wouldn't use the term "mild" to describe her temperature a few minutes later, when it went to 103.7, would you?

A. 103.7 is no longer mild. Yes.

Q. And that was only a few minutes afterwards, about 12 minutes later; is that correct?

A. Yes.

Q. So her temperature climbed quite a bit in that 12-minute period, correct?

A. Yes, apparently.

Q. Is that significant?

A. Maybe it is; maybe it isn't.

Q. Would that be something you'd look into further?

A. Well, that's the whole point, isn't it?

Q. Yeah. Would that be something you would consider possibly being something

produced by dehydration?

A. You would do exactly what has to be done and what was done in this situation. You do a history, you do a physical, you do a thorough exam, you get some laboratory studies, you get some x-rays, and then you start putting all this together.

Q. Okay. That's a fine answer, Doctor.

MR. KELLEY: I'm going to object to cutting off the witness.

THE WITNESS: Do I get a grade?

BY MR. GUION:

Q. By the way, you never mentioned the actual temperatures of 101.3 and 103.7 in your report, did you?

A. Well, it's a report, after all. It's not regurgitation of the entire chart.

Q. But those actual figures were not mentioned, were they?

A. No.

Q. Okay. You mentioned, going further, that she had a normal blood pressure but elevated pulse while supine.

A. Right.

Q. And that pulse was 92; is that correct?

A. That's correct.

Q. But that wasn't mentioned in the report at that point, either, was it?

A. No.

Q. And a pulse of 132 upright, correct?

A. That's correct.

Q. **Now,** without putting in the number 92, it would be difficult to compare that 92 to the 132 upright; is that correct?

A. Just have to look at the chart.

Q. Okay. And that's an increase of 40 beats; is that correct?

A. Yes, sir.

Q. That's an increase of about 43 percent, is that correct, assuming the math is right?

A. Doing the math -- sure.

Q. And anything more than 30 beats increase after postural changes is a sensitive indicator of hypovolemia; is that correct?

A. Can be.

Q. She showed an elevated white count of 61,000, of which 54 percent were neutrophils and 28 bands; is that correct?

A. That is correct.

Q. Okay. And nowhere in your report do you state what those figures actually mean, the 61,000 elevated white count and the 54 and the 28. There's nowhere in your report where you've mentioned the significance of that, is there?

A. Not in so many words, no, but any doctor can look at this and they'll tell you that that's pretty significant.

Q. Okay. And, actually, that means she that -- has a serious infection, doesn't it?

A. Yes, sir.

Q. It means that with a shift to the left of 82 percent she has a very high percentage of inflammatory cells?

A. That's correct.

Q. Okay. It means she has an acute abdomen; would that be another way of putting it?

A. No. No.

Q. But she did have an acute abdomen, didn't she?

A. Well, acute abdomen can be interpreted in many different ways. The general interpretation of an acute abdomen is one where you have signs and symptoms of peritonitis. This woman did not have the signs and symptoms of peritonitis. She did not have the rigidity, the distension, the rebound tenderness that I mentioned before; she even had bowel sounds.

Q. But earlier --

A. So --

Q. But earlier in your testimony, on your direct examination, you mentioned that this could -- what she had could be called an acute abdomen, or whatever you call it?

A. Yeah. The fact that she's vomiting, the fact that she has got pain, the fact that she's got tenderness. But it depends on where in the spectrum you put her, and there's a difference between somebody that has all of those features that I mentioned before, which would put her more into the --

over more toward the life-threatening stage as opposed to the semiurgent stage that she was in.

Q. Now, in this particular type patient, would you order a stat CBC; would that be ordered by you?

A. Of course.

Q. Yeah. Urinalysis?

A. Sure.

Q. And serum amylase?

A. Oh, sure.

Q. And those are the three things you would get when you're faced with an acute abdomen; is that correct?

A. Right.

Q. What would you be looking for in the urinalysis? You'd be looking for going into those high figures again, like the 1030 we're talking about and the 1048?

A. Well, you know, the one thing about our business is that you run the -- a lot of risk if you take one piece of glass out of a stained glass window and try and make too much of it.

Q. Exactly.

A. The idea is to put the whole picture together, and then you can appreciate the hands of God.

Q. Right. So in this case with Rita what you want to do --

A. So what you're looking for is not only specific gravity, which is an indicator of whether or not we have urinary concentration, which she clearly had, but you're also looking for the level of ketones; you're looking for whether or not there is protein loss, which would indicate there's some problem with the kidney and so on. So you're looking for reds cells, white cells. I mean, you're --

Q. I understand --

A. Yeah. Okay.

Q. -- you're looking for more things, Doctor.

A. Oh, Sure. You know --

Q. Now, the hemoglobin was 16.9, and the hematocrit was 49.9 percent; is that correct?

A. That's correct. Uh-huh.
Q. This was an increase over her previous reading on April 30th, wasn't it?
A. Yes, sir.
Q. April 30th, it was 13.3 and 38.6, correct?
A. That's correct.
Q. That change could also indicate significant dehydration, couldn't it?
A. Oh, of course.
Q. And, again, nowhere in your report did you state what the 16.9 and the 14 -- 49.49 meant, did you? You didn't state anywhere in your report what that actually -- the significance of that, did you?
A. Well, I did state in my discussion that she was dehydrated.
Q. 1 believe you used the word "mildly," correct?
A. Slightly.
Q. Or slightly, okay.
A. And, you know, I'll correct that to moderately, if you wish, but, you know, as I

indicated in my direct testimony, you know --

Q. Her C02 level was -- again, you used the word "slightly" decreased to 19.

A. That's right.

Q. Now, Dr. Gordon says that this means the patient is displaying acidosis.

Do you agree with Dr. Gordon's assessment of that?

A. Sure.

Q. Now, the BUN was 20, and the --

A. Let's call it B-U-N, so we all know what it is.

Q. The BUN was 20, and the creatinine was 10, correct?

A. That's correct, sir.

Q. Now, actually, when you look at those two figures, you can take them separately, but you can also put them as a ratio; is that correct?

A. You can.

Q. And a ratio for normal is about 10 to 1 or 1 to 10, whichever way you want to flip that ratio, correct?

A. Sure.

Q. And if it goes above that ratio, that's a significant thing to look at depending on how much?

A. Again, we're picking out pieces of glass.

Q. I understand, but we put these little pieces together and they cost a composite.

A. Yes.

Q. And that's how you evaluate a patient.

A. Right. A BUN of 20 is virtually normal.

Q. Okay. But when you put the 20 with the 1.2, that gives us the ratio of 1 to 17, instead of 1 to 10, correct?

A. That's not significant enough to -- to forget about the rest of the things. It is a fact. It is a piece of information.

Q. And what does that piece of information tell you?

A. Well, it tells us right now that her kidneys are working pretty well, because her

BUN is only 20, and her creatinine is only 1.2, which is mildly elevated.

Q. So a ratio of 1 to 17, In your opinion?

A. I don't go by that. You go by the entire picture.

Q. Okay. But in and of itself, that ratio indicates that there's dehydration there, doesn't it?

A. Well, on the face of it, sure. Sure.

Q. Okay. Okay. An IV was started at 7:45 at -- it was ordered, I believe, at 7:45, and it was run around 8:00; is that correct? Is that when it began to be run at 100cc per hour?

A. I read the record to state -- to say that it was started at 7:45.

Q. The drip was started at 7:45?

A. Well, it says, "7:45, left hand, number 18, saline lock, by Kathy Schaefer." I think that's her signature. There's a second note at 0810, where it indicates at D-5 a normal saline at 100 an hour was

initiated by Kathy Schaefer.

Q. You make no mention in your report as to your opinion of the amount of fluid resuscitation she received.

A. Right.

Q. Okay. Now 100cc's, is that the equivalent -- so the jury would understand, is that the equivalent of about three ounces?

A. Yeah, a little better than three ounces -- three and one-third ounces.

Q. So this is 211-pound woman receiving three ounces of fluid --

A. Right.

Q. -- over an hour period when she's dehydrated.

A. If that's what she got.

Q. Uh-huh. In your opinion, is that adequate?

A. No.

Q. Okay. Dr. Gordon states she received about an hour worth of fluid, so about 3 percent, okay. And you knew she weighed about 210, 211 pounds?

A. Yes, sir.
Q. That's something you factored in?
A. Sure.
Q. All right. At 8:00 she's described as again writhing in pain.
A. Right.
Q. To your knowledge, did the nurse report that to Dr. Gordon, or did she not report that to Dr. Gordon?
A. I have no way of knowing from the records. I have no way of knowing whether it was reported or not.
Q. At 9:05 she's complaining of shortness of breath, correct?
A. That is -- that is correct.
Q. She's now in the CAT scan room. She has not actually -- they have not started the CAT scan yet, because we know that starts at approximately around 9:20, is that correct, based on looking at the actual radiographs themselves; 9:18, around that time?
A. Around that time, yeah.
Q. Okay. So prior to that time she's

diophoretic, which is sweaty, correct, and pale? You left the word "pale" out of your report, but it is in the nurse's notes that she was pale.

A. It is in the nurse's notes, you're right.

Q. Okay. So she's pale and diaphoretic.

A. Hold on a minute, Counselor.

Q. Yeah. This is prior to getting the CAT scan?

A. Yeah. She was pale.

Q. She has a blood pressure of 100/50 --

A. Right.

Q. -- which is low, correct?

A. Right.

Q. She has a pulse of 136, which is high, correct?

A. Correct.

Q. She has a respiratory rate of 32, which is very high, correct?

A. Yes, sir.

Q. And she has difficulty breathing,

correct?

A. Yes, sir.

Q. And with all that going on, the nurse does not contact the doctor, correct, as far as we know?

A. As far as -- it's not on the record one way or the other. I have -- I have no idea whether she did or not.

Q. In your opinion, should the nurse have contacted the doctor, with Rita in that shape, before she put her into the CAT scan?

A. Well, they were there for the CAT scan, and the CAT scan takes, what, 20 minutes?

Q. Uh-huh.

A. I think, ideally -- ideally, it should have been reported, but I can also understand if it wasn't, simply because of the expediency of getting the study done.

Q. So the expediency of getting the study done overrode the safety and the -- as you put it, before the terribly debilitating condition of this patient; you felt -- you feel it was more important that she get a

CAT scan than that her life be saved; is that what you're saying?

A. No. No. No. That's ridiculous. I never said that.

Q. I thought you said earlier she was ~~in~~ a deteriorating state.

A. She was deteriorating. From 9:15 on she was deteriorating. There's no question about that.

Q. Okay. So in that deteriorating state, you feel that's it's more important that she would get a diagnostic test than that her life would be saved, or attempt to save her life, or that she would see a doctor?

A. There's only one way to answer that question.

Q. Okay. I'm tying to understand.

A. You know the answer to that before you even asked it.

Q. I would like to hear the answer.

A. Of course, you have to worry about saving her life. Of course, you do. But I can also -- I can also understand,

prospectively, when somebody is sitting there and they're saying, gee, this woman is having more difficulty breathing and she's getting a little pale, she's starting to sweat a little bit; do we automatically stop studies? No. Do we automatically cancel studies? No. It depends on what -- you have to take the situation one at a time.

A lot of people go to CAT scanners in shock. A lot of people go to CAT scanners sweaty and diophoretic and short of breath and so forth, because one of the reasons why you're in the CAT scanner is to try to figure out what the heck is going on.

I mean, what -- one element of this is, what could have been done to save this woman's life?

Q. Well, let's not get into that long discussion. I just wanted you to answer my question.

You mentioned before that you felt that she was not in a life-threating situation, correct?

A. Absolutely not.

Q. The CAT scan could have waited a little longer, couldn't it have?

A. Well, it could, sure, but --

Q. This woman is in dire straits by all of these vital signs --

A. Uh-huh.

Q. -- and you feel it is still appropriate to continue on for the next 20 minutes putting her through the CAT scan before a doctor is consulted in this case; is that your testimony?

A. No. No. Ideally -- ideally, it would be -- it would be preferable to, you know, cancel the study and have it done, but as I mentioned before, that's ideally. I can also understand why they continued doing the study, because it was integral to try to figure out what was going on with her.

Q. But it wouldn't do much good, as we know in fact happened, to find out later what was going on with her after she was already dead; is that a logical statement?

A. That's one -- one way of looking at it.

Q. Another way is, we know, in fact, the CAT scan results didn't come down until after 10:30, and she was already dead over an hour by that time.

A. Okay. But a third way of looking at it is, what if? What if they would have cancelled the CAT scan? What if they would have taken her back to the emergency room? What if they would have pounded a bunch of fluids into her? At that point, would it have changed things? In my opinion, no.

Q. And the answer is, we will never know the answer to that.

A. My opinion is that it would not.

Q. That's fine. That's your opinion, then.

A. Well, that's what we're here to find out.

Q. That's fine, Doctor. That's what we're here for, right.

A. Sure.

Q. Patients with severe hypovolemia are often pale and diaphoretic, aren't they?

A. Sure.

Q. By the time they rushed her back to the emergency room, her pulse was now up to 170?

A. That is correct.

Q. And she also had a bowel movement on herself. She became incontinent on the way back; is that correct also?

A. Yes. There is -- let me see my notes here real quick. The bowel movement was after she had returned from the CT scan.

Q. Yeah. On the way back, right, to the emergency, or back at the emergency room?

A. Sir, it's my opinion that she had the bowel movement after she was already in attendance by Dr. Gordon at 9:30.

Q. Okay. And she was also gasping for breath, correct?

A. Yes, sir.

Q. So, in other words, from the time she came out of that CAT scan, she was just constantly going downhill; is that a reasonable statement?

A. And I think the record shows that

over about a 15-minute period, that's true. Okay.

Q. Okay. Let's take -- that takes care of that.

THE WITNESS: Could we stop for a moment?

MR. GUION: Sure.

THE VIDEOGRAPHER: Off the record at 12:00.

(Pause in proceedings.)

THE VIDEOGRAPHER: On the record at 12:08.

BY MR. GUION:

Q. Doctor, a few more questions and I will be finished.

A. Sure.

Q. Doctor, how many times a year do you give depositions such as this one?

A. The last four years, I've been in trial about four times per year, and I've given about 13 to 14 depositions per year.

Q. 13 or 14. 13, did you say, or 14 depositions per year?

A. Yes, sir.

Q. And how many times do you represent the plaintiff and the defendant; what's the breakdown there?

A. On case reviews, it's about 75 percent for plaintiffs and 25 percent for defendants. Of my active files, I've only got about 5 or 6 defendants' cases right now, and as far as those depositions and so forth are concerned, I've only given two or three depositions for defendants in the last couple of years.

Q. And how many for plaintiffs?

A. The rest.

Q. And that would be how many?

A. About 13 a year.

Q. For plaintiffs?

A. Yes, sir.

Q. And are those cases that you actually write reports on?

A. Well, not always. I mean, sometimes they want reports, sometimes they don't, but --

Q. Well, those 13 -- did you say 13 a year for plaintiffs; is that correct?

A. Yeah, because I don't -- I don't do very many defense depositions.

Q. Okay.

A. And the reason is because -- well, the reason is that, the same way with plaintiffs' cases, most of them, I don't feel there's a problem with them, and on defense cases sometimes I'll tell them that I can't help you, so --

Q. How many of your plaintiffs' depositions go on to a -- where a deposition is actually taken; where you accept a case, not necessarily a trial deposition, but at least a discovery deposition?

A. Sure.

Q. How many of those?

A. For every case that goes to deposition, I will review 2 or 3 more, so 1 will review somewhere in the neighborhood of 40 to 50 cases a year.

Q. So, in other words, these 13 depositions are discovery depositions --

A. Right.

Q. -- that were taken by plaintiff?

A. Right.

Q. Where you represent the plaintiff?

A. Sure. This is kind of an unusual situation here, because, normally speaking for me, my experience has been that there would be a discovery deposition and later there would be a trial, the testimony.

Q. Right. Sometimes there isn't a trial, just a discovery deposition.

A. Well, but, of course, sometimes the cases are dismissed or -- or settled or whatever.

Q. Right. So the 13 depositions that you take on behalf of plaintiffs --

A. Right.

Q. -- that's per year, did you say, or --

A. Yeah. For the last four years, that's a consistent number.

Q. So in the last four years, from 19 -- I'm just trying to get this straight -- from 1996 to the present, about 4 times, so about 50 times you have testified that the doctors were negligent

and -- and doctors and/or hospital were negligent on behalf of the plaintiff?

A. Yes, sir.

Q. Okay. About 50 times in the last four years?

A. Yes, sir.

Q. And of those 50 times where you felt doctors were negligent --

A. Right.

Q. -- and had caused the patients harm or death --

A. Right.

Q. -- about how many of those 50 actually ended up going to trial?

A. Well, about a third of them.

Q. So maybe 15 times you ended up --

A. Yeah. About --

Q. -- speaking to --

A. -- four trials a year is what I'm averaging.

Q. So about -- okay. All right. What do you charge, Doctor, for these depositions?

A. $750 an hour.

Q. $750 per hour?

A. Yes, sir.

Q. Would you agree that Rita Karaba should not have been sent -- should not have been sent to the radiology department, to the CAT scan, with no one with her who was capable of writing orders?

A. No.

Q. You would not agree with that?

A. No.

Q. You have mentioned in the past textbooks that you consider reliable and informative sources. What textbooks do you consider reliable?

A. Well, the textbooks that we would like to see the student use is Sabiston's *Textbook of Surgery.* That's my personal favorite. It's out of Duke University, and most everything out of Duke is quality.

Q. How about authoring articles, have you written very many articles yourself?

A. Two. I didn't include them in my curriculum vitae because they're two little dinky ones. One was on the laparoscopic

diagnosis of traumatic rupture of the diaphragm. It has nothing to do with this. And the other one was on intestinal injuries due to seat belts.

In 1990 we had an exhibit at the American College of Surgeons in San Francisco, and that was followed up with a little paper that went into one of the little journals, and I don't consider those to be -- you know, to me, a paper is one that comes out in the big four, you know: *Annals of Surgery,* what used to be called *SGNO* is now called the *Journal of the American College of Surgeons, Archives of Surgery,* that sort of thing.

Q. And you've never written articles for those journals?

A. No; I have not.

Q. Okay. Now, Doctor, you've given some opinions on direct examination regarding Rita Karaba's carcinoma, correct --

A. Yes, sir.

Q. -- carcinoma?

A. Yes.

Q. You're not an oncologist, are you?

A. No.

Q. Do you have any training as a oncologist?

A. And I didn't sleep at a Holiday Inn. I'm just kidding. I have had training in cancer surgery.

Q. How many years ago?

A. Well, all my life. I mean, we don't stop learning just because we finish our training.

Q. Are you -- well, when you say, "training in cancer surgery," have you ever followed up with a cancer patient after you've done the surgery --

A. Of course.

Q. -- as a cancer expert?

A. Well, let's define what a cancer expert is.

Q. Okay. The first --

A. I don't do chemotherapy, let's put it that way.

Q. Okay. So, in other words, you are

not a doctor who is called upon to treat the cancer after the patient has had surgery, are you?

A. No. That's a medical oncologist. I'm a surgeon.

Q. Okay.

A. Now, there is a division of surgery, called surgical oncology, where people choose to do nothing but treat cancer.

Q. Uh-huh.

A. That is a minority number of general surgeons.

Q. And you are not one of those?

A. No, sir. No, sir, because I do other things.

Q. So, basically, your opinions are based upon a search of the literature; would that be a fair statement?

A. And my personal experience. You know, I've dealt with a lot of cancers of the colon and I've dealt with a lot of perforated cancers of the colon. It's -- I'm not ignorant of the experience of handling these patients.

Q. All right. You've read Dr. Gordon's deposition, correct?

A. Yes, sir.

Q. And you're aware that he has stated in his deposition that during that period of time when she was at the CAT scan, that even though he would have been told that she was pale and diaphoretic, that her blood pressure was 100/50, that her pulse was 136, and her respiration was 32, that he would not have done anything differently than he did do. You're aware of that, aren't you?

A. Yeah.

Q. Are you in agreement with that?

A. Yeah, I am. I am. I think the CAT scan had to be done.

MR. GUION: Okay. Doctor, I have no further questions. Thank you.

EXAMINATION

BY MR. KELLEY:

Q. Dr. Barnes, my name is Jay Kelley. We met this morning.

A. Yes, sir.

Q. I'm going to ask you several

questions. Just so you're aware, I represent Dr. Gordon and his emergency group in this case --

A. Okay.

Q. -- okay?

A. Sure.

Q. If I ask you a question that for some reason doesn't make sense to you or that you don't understand for sure, let me know, and I'll be happy to repeat it or rephrase it, okay?

A. Sure. Certainly.

Q. What I'm going to try to do here is not repeat a lot of the questions that have already been asked, but try to add a little context and perspective to some of the medical principles that have been raised by plaintiff's counsel, okay?

A. Sure.

Q. First, you do have involvement in your practice on a regular basis with patients and physicians generated from the emergency room, correct?

A. Sure.

Q. And in that situation you're consulted in to determine whether or not someone is or is not a surgical candidate, right?

A. That's correct.

Q. So patients such as this, and the issues of whether or not someone is a surgical candidate and what tests are required are within your day-to-day practice, correct?

A. Yes, sir.

Q. Now, obviously, in this case, when it comes to you, you have some benefits that some of the physicians who are there that are on the front line that day do not have. Primarily, you know the outcome by way of the autopsy, right?

A. That's correct.

Q. And you will agree that medicine would be a lot easier to practice if we knew the diagnosis before we started providing treatment?

A. Well, that's the tough part about doing these things. I mean, hindsight is

always 20/20, but I try to review cases with the idea of looking at it prospectively, following the case as it came in and try to put myself in the shoes of the people who were confronted at that particular circumstance, because there's no question that once you know all the questions, you may well have done a lot of things differently.

Q. I'm going to from time to time be asking you some questions about the care and treatment of my client, Dr. Gordon.

A. Sure.

Q. And whether or not he complied with the standard of care, which is kind of a phrase generated by lawyers.

A. Well, standard of care refers to what a reasonable physician would do under the same circumstances. I can give you answers from a general surgeon's perspective. I am not board certified in emergency medicine.

I have worked with emergency doctors all my career. 13 years in trauma, you

know, you're elbow to elbow with them, so -- so I will -- I will give you the -- my answers as best I can from my perspective.

Q. And let me start with following up on 'ananswer that you gave earlier. I think you described that if yourself and an entire surgical team were called in to consult for this patient, you do not believe the outcome could have been different, correct?

A. Well, I don't, no. **I** sure don't, because I think this person's -- I think this person -- the course of this lady was virtually cast in stone from approximately 8:30 on.

Q. And there has been some discussion in this case about the underlying tumor --

A. Right.

Q. -- that this patient had.

A. Right.

Q. But my understanding is this is an 8-by-10 centimeter tumor that she had in the left lower quadrant of her belly.

A. Yeah. Bigger than my fist.

Q. And when we talk about perforating

and invasive carcinoma such as this, what you mean is, this tumor has actually gone through the bowel wall?

A. Yeah; that's correct.

Q. And that, in your experience as a surgeon, is a sign that has negative consequences for the patient, correct?

A. It is of -- of very important prognostic significance, but it's also indicative of a grave prognosis.

MR. GUION: I'm going to again object to this whole line of questioning regarding the cancer.

BY MR. KELLEY:

Q. Mr. Guion asked you a question about whether or not you agree that patients in their 40s who present to the hospital for surgery for a colonic mass only have a ten-percent mortality.

A. No.

Q. You disagree with that, correct?

A. I disagree. I disagree.

Q. What I want to do is put context on that medical statement that he asked you

about.

A. Okay.

Q. This patient, knowing that her mass is 8-by-10 centimeters, goes through the bowel wall and actually attaches or comes in contact with the dome of her bladder --

A. Right.

Q. -- would that patient, as Mr. Guion asked you, have a ten-percent mortality or morbidity rate?

MR. GUION: Again, objection to this line of questioning.

A. The extent of the cancer certainly has a material bearing on the amount of surgery that's done, but the reason that people die is not necessarily from the amount of surgery that's done; it's from the other factors. Is there a sepsis? Is there hemorrhage? Is there renal failure? Is there myocardial infarction? And so on.

I think Dr. Booth mentioned it that being younger this woman had a better prognosis and, in general, that's true. I mean, I don't know of any surgeon that

wouldn't rather operate on young people rather than older people, just as a matter of course.

But each one of these -- you can -- while you can generalize, when you get down to specifics, the individual's extent of the disease and the -- and the -- and the consequence of the disease on that particular person is what's important.

I think -- I think that the literature is very clear on this. And the literature very clearly states that the mortality rate is about 20 percent, and that's -- we can argue until the cows come home whether or not a woman like this, who is 40 years old, but, hey, she's obese, okay? Now there's one factor right there. She -- now we know that she also had hypertension. There's another factor right there, you see. So it wasn't like this woman was pristine.

So, you know, we can argue as to whether or not it would be a little less than 20 or whatever, sure. Sure. There's

no question that age has something to do with it.

I notice on her autopsy she had a good heart. That's a big plus. That's a big plus, but it's not -- you know, again, we're getting off on little tangents here when you have to consider, look what happened to her.

I mean, look what happened to her. You know, you go into sepsis, it doesn't matter how old you are, you're going to be sicker than a dog, and a lot of people don't survive.

Q. Looking at the care and treatment provided, there were some questions asked first regarding the adequacy of history, and specifically hypertension.

A. Right.

Q. You do see that they took medical history from this patient, including the fact that she had: endometriosis --

A. Right.

Q. -- 13 years ago?

A. Right. She did. Uh-huh.

Q. You see in the chart that they asked what medications she was on prior to coming to the hospital, and she said none.

A. Right.

Q. You see that they asked about allergies that the patient had, and she said none?

A. That's correct.

Q. You see that they got a description of the immediate signs and symptoms that prompted this episodic visit?

A. They did.

Q. And that included the two-day course and, also, the similarity in presentation between what she came that day to the endometriosis.

A. To the endometriosis, that's correct.

Q. Okay. So do you agree that the history as taken represents a thorough and adequate history in compliance with the standard of care?

A. I believe it was.

Q. Okay. Obviously, history is only

one part of what a clinician can do in trying to figure out what is wrong.

A. Absolutely.

Q. And, so the jury recalls, we're talking about this case knowing the outcome. Dr. Gordon didn't know the outcome that day.

A. That's right. He didn't have a clue. How could he?

Q. In fact, he's the first person who found this mass, which had obviously been present for quite some time, correct?

A. That is correct.

Q. Now, another part of what a physician does in conjunction with the history is they perform physical examination?

A. That's correct.

Q. And that's where the physician actually puts his hand on the patient, right?

A. Yes.

Q. And if we look at this -- and I don't want to go through each step, because that would take quite some time -- but,

Dr. Gordon's chart shows that he did a head-to-toe, literal, physical examination of this patient, correct?

A. Yes, he did.

Q. He checked head and neck all the way down to the lower extremities, right?

A. That's correct.

Q. And one of the things that you described is that in looking at an abdominal presentation, you look at that physical abdominal exam, right?

A. Yes, sir.

Q. And you look for things like rebound tenderness?

A. Well, specific to the abdomen, yes.

Q. Specific to the abdomen?

A. Yes. That's correct.

Q. And the reason that you know this patient did not have rebound tenderness, still had bowel sounds present, was because he did that thorough examination, correct?

A. He says he -- and he specifically mentions it. He says there was no rebound involved or any guarding, which is

another -- guarding is simply when you start pushing on somebody, they stiffen up because they don't want you to push anymore.

Q. And this was a patient who was alert and oriented, correct?

A. Right.

Q. Whose vital signs at the time were not markedly abnormal or critical in any regard of Dr. Gordon's examination, correct?

A. Well, her vital signs were normal. Certainly, she -- you know, she came to the emergency room because she was ill.

Her temperature was 103.7 rectally at the time that he dictated this. She had an elevated pulse. We know that she had an elevated respiration rate. Certainly, the woman was -- had indications that she was ill.

Q. These vital signs, though, are not a contraindication to performing certain laboratory tests, as were taken, correct?

A. Well, look, the key whenever you have somebody is to find out what is going on. That is called a diagnosis. And every

medical student will tell you, because we drill it into their heads, is that a diagnosis is made upon a thorough history, a complete physical examination, and intelligent use of laboratory and x-ray findings. Putting all of the pieces of that mosaic together, then you finally get the picture.

Hopefully, not always -- not always. Sometimes we have to guess, but without doing those four components, you are not only doing a disservice to your patient, but you're -- you're -- you're running a risk that you're not going to find out what's going on -- big risk.

Q. And, obviously, when we talk about that mosaic, what you're trying to do is from piece -- by piece of information by piece of information, put together an intelligent picture?

A. Of course.

Q. One of the things that was done was a chest x-ray --

A. Right.

Q. -- which raised the question of a viral pneumonia.

A. Well, yes, it did.

Q. Okay. What is viral pneumonia; is that fluid in the lungs?

A. It is inflammation of lung tissue and the interior of the lung due to inflammation from the virus. It's different than pulmonary edema, which is fluid between the air sacs where the blood vessels are.

Q. And pulmonary edema, that is actually fluid in the lungs that makes it more difficult for the body to exchange oxygen and carbon dioxide, correct?

A. Oh, yeah. Sure.

Q. And what it is, in essence, some people have described it as, you almost drown within yourself from that fluid?

A. That's, of course --

Q. That's a layman's --

A. -- that's a very vivid description, because that's a lot different than drowning. Drowning is where you can't get air in --

Q. Sure.

A. -- because you've got water in your throat and in your windpipe. But what it does, is it impairs -- I mean, you have a very fine balance there of air sacs and a few cells and blood vessels on the other side, and without getting biblical, this is a -- this is one of the reasons why I don't think we came from amoebas -- there's oxygen goes across this little membrane, and it's picked up by the red blood cells, the iron pigment called hemoglobin. At the same time they drop off, they use stuff, the carbon dioxide, and this happens every time you breathe. It's really amazing.

Now, that little space, that little, teeny space that you have between air that you actually breathe and blood that's circulating in your body is only a few cells thick. If you get fluid in there -- and what fluid does is simply widen the gap. It widens the gap and, therefore, you don't have the exchange as well. And that's why the oxygen saturations go down and all of

the nasty things happen with -- that are reflective of lack of oxygen; lack of being able to properly breathe.

It's the same as that wall. I mean, that wall was paper thin until they just redid it. We could all hear what they were saying on the other side of the wall. They fixed up the wall, they put in some insulation, they made it thicker. Now we can't hear them and they can't hear us. Not as much fun, but that's basically the same principle.

The principle is the -- is the -- the -- the how thick -- how thin is that delicate little membrane.

Q. When an emergency physician questions a surgical cause or things of that type, sometimes they call you, a surgeon, in, correct?

A. Sure.

Q. If you were called in, I think you testified earlier, that you would have wanted a CT scan?

A. Oh, sure. Absolutely.

Q. Because that's information vital for you to determine what type of surgery and the extent ***of*** surgery for the patient, correct?

A. I -- I can categorically tell you this person would not have gone to surgery by a practicing surgeon. A surgeon who practices abdominal surgery would not have taken this person to the operating room without a CT scan.

Because, as I testified before, we do go from ER to OR. We do go from emergency room to operating room because the circumstances dictate it. I've taken people to the operating room with a gunshot wound to the heart. We didn't stop for x-rays or anything else. We didn't even stop or anything.

But in this particular circumstance, as this lady presented, a CT scan was not only appropriate, but it would have been ordered by the surgical consultant. I'm convinced of that.

Q. Now, looking at the care and

treatment of Dr. Gordon prospectively --

A. Uh-huh.

Q. -- and I know you were asked some questions by plaintiff's counsel about retrospective and prospective opinions.

A. Sure.

Q. Do you believe the care and treatment he provided was reasonable and in accordance with the standards of care?

A. I do. I think it was reasonable, sure.

Q. And based upon the information that he had available, do you believe that the laboratories, the fluids, and the CT scan which was ordered, were all appropriate and in accordance with the standard of care?

A. Well, I conceded to counsel that a little more fluid would have been better than less fluid. Having said that, what we're talking about here is about an hour of life.

Looking at it another way, let's say that she got that 500cc bolus instead of the 150 an hour that was ordered.

MR. GUION: Objection. It was 100.

THE WITNESS: Sir, I think it was 150 that was ordered.

MR. GUION: That was ordered, okay.

A. Yeah. So -- okay. 350cc's is not even as much fluid as in this Coke container, and you wonder, is that the difference between life and death in a 200-pound woman? I can't believe that. I don't believe that, which is why I don't believe this woman died of dehydration. This woman died of sepsis.

I think there's some agreement with that with some of the consultants, but the fact of the matter is that it wasn't just the fluid alone that would make the difference in one hour on this thing.

I think the doctor ordered the 150 an hour. 150 an hour is not a great amount of fluid, but it's more than maintenance. Maintenance is about 100 an hour.

So -- so, you know, I don't think that Dr. Gordon erred in what he did, because at the time that he assessed this

patient, he had some facts at his fingertips that said, 1 have a sick lady with an abdominal mass with fever. I mean, at that point, he didn't even know what her white count was.

I'm sure the -- the 61,000 must have caused him to catch his breath, because that's a lot. That's an unbelievable amount, which indicates that there's something really, really metabolically wrong with this woman. Can you get 61,000 just from dehydration? Of course not. No. No.

Again, looking at the big picture, looking at the stained glass window, you put all these pieces together. Was she dehydrated? Yes; she was dehydrated. Did she have infectious process going on? Yes; she had infectious process going on. Was she septic? Yes; she was septic. Was it mild, moderate, or severe? I called it fulminating in my report because I believe that.

This woman went down like a stone, and when you look at her autopsy, she should

not have gone down like a stone. She -- she doesn't have a bunch of bad organs.

So when you have good organs and you go down like a stone, it tells us that there's something going on in there, some little toxin or some blood component or something that has basically poisoned this woman, for lack of a better word. I truly believe that.

I think that this woman died of sepsis, and I think she died because of the mechanism of the disease brought on by her perforated colon.

Now, you're asking me, you know, would -- would -- would -- what Dr. Gordon did was appropriate? I think it was. I think it was. Dr. Gordon is not a surgeon, number one. Number two, he's an ER doc. His job is to figure out, roughly, what's going on, get some treatment initiated, and then, once he's got his facts together, call for help.

If this lady had not crashed on the return from the CT scan, his next step would

have been to get those reports together and get a surgical consultation. This person would have been admitted to the hospital. I don't know about Parma General, but in my hospitals, emergency room doctors can't admit patients; it has to be done by a consultant. So -- so, you know, did he do his job? I think he did.

MR. KELLEY: Okay. I don't have any further questions for you. Thank you very much.

FURTHER EXAMINATION

BY MR. ROBERTSON:

Q. Doctor, in response to a great many questions by counsel for the plaintiff about various signs and symptoms which the chart contains that pertain to Rita Karaba on November 23rd, are any of those factors that plaintiff's counsel elicited from the chart such that they change your opinions in this case?

A. No. No. I answered truthfully. I answered his questions as they were asked. There's room for debate as to how you put

all this together. The questions he asked were fair, I think, and I answered them, I think, in a fair way. But I don't think that any one of those factors was the single most important thing that dealt with this woman's demise.

Q. A number of his questions dealt with whether or not a particular sign or symptom was, and I quote, consistent with hypovolemia.

A. Right.

Q. And you would say yes, they were?

A. Well, sure.

Q. Were they also consistent with other things?

A. Of course. Of course. I mean, see, that's the beauty of this business we're in, there is no black and white. The fact of the matter is that when you have a rapid pulse, when you have decreased blood pressure, you can have that without any dehydration whatsoever. Ask anybody that's had a coronary. Ask anybody that's got a -- a kidney stone. I mean, there's just so

many things that enter into whether or not your blood pressure is up or down, whether or not your pulse rate is up or down, whether or not your respirations are up or down.

You can take a person with perfectly normal lungs, if you give them a painful stimulus, I can guarantee you that they're going to breathe faster.

So, you know, what he said was true, but again, I really make a strong appeal to put the entire picture together.

Q. Doctor, you said that ideally perhaps it would have been nice if Dr. Gordon had been informed about the fact that the patient was writhing in pain and short of breath. Do you feel that the failure to communicate that information, if indeed it occurred, is a departure from the standard of care for the nurses involved?

MR. GUION: Objection.

A. I don't think it's a departure of the standard of care. But looking at it very pragmatically, it wouldn't have made

any difference, and the doctor said that.

Because, number one, normally speaking, pain medication is not given until they have some idea what's going on. Normally speaking, you don't give pain medication to alleviate pain until you have your surgical consultation, because it changes the perception of your consultant's assessment of the abdomen if the person is narked out on morphine or something.

so -- so he -- you know, I mean, it would have been nice if somebody said she's writhing around in pain. It would have been nice if he'd have gone over and said, how you doing, but it still would not have changed things. He would not have given her anything for pain medication. He still would have wanted to have that CAT scan.

It -- her assessment would have been roughly the same. The autopsy shows that she didn't have a generalized peritonitis, so the examination that he had of her abdomen at 8:00, I don't think would have been any different at all at 8:45.

But what you had was a lady who was in -- in -- in pain and then she was -- of course, she's got a tumor that's giving her the pain, so, you know, that's no big surprise. But it wouldn't have made any difference to Dr. Gordon's what he did, and I don't think what he did was inappropriate. I think what he did was appropriate.

We're talking about whether or not she should have had the CAT scan. I'm telling you right now that the CAT scan was necessary. It was necessary. It was needed. And a surgical consultant -- if I would have been asked to see this lady over the phone, I would have told them to get a CAT scan.

So, you know, I don't think the CAT scan -- I don't think the CAT scan should have been avoided. No, not at all.

MR. ROBERTSON: 1 have no more questions. Thank you, Doctor.

FURTHER EXAMINATION

BY MR. GUION:

Q. Doctor, let's focus now on something

very, very critical here: The difference between diagnosis and treatment, okay?

A. Sure.

Q. We've talked about the CAT scan. The CAT scan is not treatment, is it?

A. That's diagnosis.

Q. It's diagnosis?

A. Yes, sir.

Q. Everything that Dr. Gordon did was diagnosis, correct?

A. Well, that's -- that's right.

Q. In other words, with one exception --

A. Starting an IV.

Q. -- he started an IV?

A. Right.

Q. Now, you have said that it takes 100cc's for maintenance per hour.

A. Right.

Q. In other words, a person just uses up about 100cc's, correct?

A. That's right.

Q. So, in order for them to be getting anything, they'd have to get more than that,

correct?

A. Correct.

Q. Okay. So if that is correct, that she was given 100cc per hour --

A. That's correct.

Q. -- and we know she got about -- she, in effect, received no fluids; is that a reasonable, logical statement based on those numbers?

A. Well, I don't know about no fluids.

Q. If you give her 100 and she needs 100, doesn't that come out to zero?

A. Well, what that tells you is you're not going to gain, you're not going to lose, you're going to stay the same.

Q. In other words, she didn't gain anything?

A. Well, if it was 100 that she got. Now --

Q. She got 100.

A. -- hypothetically, if she got 100 --

Q. She received nothing?

A. -- she gained -- she had no gain in her body water, no.

Q. Okay. Which means from the moment she entered that hospital until she died she received absolutely no treatment whatsoever; is that a correct statement?

A. Well --

MR. KELLEY: Objection.

Q. I'm not talking about diagnosis; treatment.

A. -- let's say beneficial treatment.

Q. No. I'll go beyond that. Let's go with the word "treatment," because I want to know what the treatment was, if you want to say she did receive any.

A. Well, the fact that she got any fluids at all was treatment.

Q. No. Well, wait a minute. Let's go back over it again.

A. Let's go back over that again, because --

Q. All right.

A. -- she came to the emergency room. She was not taking in any fluids at all, so the fact that she was getting any fluids at all, to me, would be a --

Q. Maintenance?

A. -- a change of her status. Now, it might be maintenance level at 100cc's --

Q. Okay.

A. -- but it's still better than nothing.

Q. Well, actually, we're only talking three ounces, aren't we?

A. Well, that's -- (Indicates.)

Q. That can holds 12 ounces, doesn't it?

A. Yeah. Yeah.

Q. So we're talking about giving her one-fourth of that can of fluids, and that's the total treatment she received in that hospital.

A. But the difference between what she got --

Q. Uh-huh.

A. -- and what she was getting before --

Q. Before what?

A. -- before she came to the hospital -- I mean, the reason that this

woman got dehydrated was because she was not taking in fluids of enough level to maintain her hydration status.

Q. Right. We agree with that.

A. Okay. Now, so --

Q. But once she gets in the hospital --

A. -- 100cc's an hour, you and I will agree was not enough to treat this woman's dehydration over the hour and a half or hour or so that they had; I mean, from 7:45 to whatever time. Let's agree that --

Q. We do agree with that. I agree it wasn't enough, completely.

A. (Indicates.) But I'm also going to tell you that if you had given this much more, it would have been a spit in the ocean.

Q. I agree with that, too, but what if we had run a 500 bolus in ten minutes, and then another 500 bolus, and then another 500 bolus, and then another one, until her orthostatic changes came down; wouldn't that have been proper fluid resuscitation, and haven't you, in fact, said so yourself in

the past?

A. If you look at it retrospectively, you would have to agree with that statement.

Q. You would have to agree with it?

A. I would agree with it retrospectively, but looking at what Dr. Gordon was faced with, at 8:00 he does his exam. He orders a bunch of tests that he has -- I mean, he had no idea what the hemoglobin/hematocrit was at 8:00.

Q. Right.

A. He had no idea what the BUN and creatinine were, whatever the ratios were, Counselor. Give the guy a little bit of credit here. He started an IV more -- he ordered the IV more than the usual rate. Usual rate that people get an IV is 100 an hour, which is maintenance fluid.

Q. That's all he got -- that's all she got, was 100 an hour.

A. But I'm going to differentiate that he ordered 150. It says here, 150.

Q. He ordered it, but she didn't receive it --

MR. ROBERTSON: Objection.

A. Sir, I'm not going to argue --

Q. -- according to the records -- according to the records?

MR. KELLEY: I'm just going to object that you won't let him finish an answer.

A. The doctor ordered the 150 an hour.

Q. I understand.

A. Now, what she got --

Q. According to the record.

A. -- according to the record, I don't know what it says, because we don't have a fluid sheet on here -- now wait a minute. Let me try to explain this.

Normally speaking, there's an IV fluid sheet or an intake and output record, and there wasn't one because they didn't have time to compile it. Where the difference is, is that Kathy Schaefer takes off this order 150 an hour --

MR. ROBERTSON: It's Kim Schaefer, Doctor, for the record.

A. Whatever -- yeah -- and then, over

here, she writes 100 an hour. Now, that can either be because she didn't give any more than 100 an hour, or it could have been a clerical error on her part. I don't know how much she got. I know that 150 was ordered. I can't -- I just can't believe, Counselor, that somebody would be so stupid as to take off an order and then -- then only give two-thirds of it. I mean --

Q. But that could have happened, couldn't it?

A. Anything can happen. We could be hit by lightning here.

Q. It's logical to assume that if she's not on another page writing 100cc's, that that's probably what she's going to run, isn't it?

A. I don't know that. I don't know that. I just find in --

Q. In any event --

A. -- it's hard for me to believe that she would do that.

Q. In any event, from the time Rita came into that hospital --

A. Right.

Q. -- until the time she died --

A. Right.

Q. -- you tell me what treatment she received.

A. Okay. She --

Q. Treatment.

A. They didn't get around to treatment. I mean, what they got -- what she got was some IV fluid. We will agree that she got some IV fluid.

Q. We'll agree she got three to five ounces, then, if you want to put it that way.

A. Okay. Sir, that's three to five ounces better than nothing.

Q. Minus the three ounces that was maintenance, meaning she either got no fluids whatsoever, or at the most, she received two ounces, by your own figuring, correct?

A. Okay. We have to define that maintenance is when you give fluid to somebody that has no other source of fluid

Q. Which was the case here, wasn't it?

A. As it turned out. As it turned out. I mean, the woman vomited that morning. She hadn't been vomiting for two days. She vomited that morning. She was -- and we all agree she was dehydrated to some degree. Your consultants say more, I say less, but we all agree that she was dehydrated to some degree.

He started an IV of 150 an hour, which is more than they normally start an IV with -- he ordered the IV. Okay. Now -- then he ordered a battery of tests, including a pregnancy test, which I thought was pretty thorough. He then orders a chest x-ray and CT scan, with the idea that when all of this information comes together and he starts to get a picture of that stained glass window, then he may have some idea.

Q. And then he may start treatment?

MR. KELLEY: Objection to the continued interruption of the witness.

Q. Well, go ahead.

A. But see, I don't think that

Dr. Gordon or any of us are so clairvoyant that we know what to treat in advance. For example, did he know on his examination at 8:00 that this woman should have antibiotics? No. How could he? How could he? He didn't know that, Counselor. He wouldn't have the faintest clue.

This lump that he's feeling down there, was it necessarily perforated diverticulitis? Why couldn't it have been a cancer of the ovary?

You see what I mean? He can't -- you've got to be a little cautious about, you know, shooting from the hip. You can't jump in there and assume certain things until you have some of your diagnostic studies, and it turns out many of these studies didn't come back until after she was already coding. I mean, you mentioned that yourself. The reports of the CT scan didn't come back till later, not to say he couldn't go over and look at it himself.

Q. But he didn't do that, did he?

A. He didn't have time. He didn't have

a chance. As soon as she came back, he was in immediate attendance. That's what it says on the thing, immediate attendance, and she crashed. He had to intubate her.

Q. Okay. Let's go back and talk some more about the fluid.

A. Okay.

Q. She may have got no fluid; she may have got up to two ounces? Other than that, I mean, if she -- assuming he ran it at 150cc, would have been two ounces?

A. That's five ounces.

Q. But minus the maintenance, which is the three ounces.

A. Well, that's one way of looking at it, but, you know, the fluid --

Q. The benefit to her. We're talking about benefit.

A. Okay, therapeutic benefit. Therapeutic benefit would have been 50cc's more, right.

Q. Okay. So two ounces at the most, maybe no ounces.

A, Over an hour and a half would be

75cc's.

Q. Well, he said she received it about an hour, okay? That was his --

A. Okay, about an hour, sure. Sure. Yeah. Okay.

Q. Okay. Other than the fact that she may have gotten a few ounces, at the most a few ounces, this 211 -- of fluid --

A. Right.

Q. -- are you aware of any other treatment that she received while she was in Parma Hospital?

A. Well --

MR. KELLEY: Before the code?

MR. GUION: At any time, from the second she walked in the door.

A. Well, sure.

Q. What treatment?

A. Well, they gave her nasal oxygen. He intubated her so that she could have -- they could assist her in her respiration.

Q. That was when she was dead, or dying, at 9:30.

A. That was at 9:15.

Q. It wasn't at 9:15. They intubated her about 9:30.

MR. ROBERTSON: She was receiving oxygen by nasal cannula.

A. She was intubated at 9:35, okay, but she received oxygen at -- 9:05.

Q. So he put this nasal tube up and then they put some air in her. That's one treatment, right? We'll call that a treatment, if you will.

A. It was oxygen, yeah. Sure.

Q. And other than that, did she receive anything else all the time she was at Parma Hospital --

A. Well, sir --

Q. -- in terms of treatment?

A. -- okay. If we are going to define treatment as not including all of the diagnostic tests that were ordered --

Q. We certainly are going to do that.

A. -- I mean, if you exclude all that --

Q. We certainly are.

A. -- the only treatment she got was

intravenous fluid and oxygen. You're right. Intravenous fluid and oxygen, and some soothing words at the bedside.

Q. Because all those tests are not treatment, are they, they're diagnostic procedures?

A. Well, but, hold it now. I mean, let's go back to what we said before. We don't know what the heck we're treating until we do the four steps.

Q. Okay, I'm not arguing that, Doctor. I'm -- you didn't answer my question.

All of those diagnostic tests, they are not treatment, are they?

A. Not in the strictest sense of the word --

Q. Okay.

A. -- but they are necessary.

Q. I'm not arguing with that.

A. You can't treat until you have a diagnosis.

Q. Oh, but you said quite the opposite a few minutes ago, didn't you?

A. No. No. No. No.

Q. Didn't you tell us about a gunshot wound where you take the person right into surgery?

A. You've got a diagnosis, sir. You've got a hole in the belly and you've got some guy that's hurting like hell. Trust me on this, a gunshot wound of the abdomen is a self-evident diagnosis --

Q. Okay.

A. -- that you don't need to go to the CAT scanner for.

Q. So you don't have to run any tests. So sometimes --

A. Oh, yeah, you do. When you come into my trauma bay, you will get seven tubes of blood drawn on you, whether you like it or not. No matter how quickly we're going up there, we do want to know, and we also get a blood gas, just so you know, but, you know, that's trauma. That's a very specialized art.

Let's look at what this lady had. This lady had a battery of tests ordered. She had some x-rays ordered. The effort

here is to come up with a diagnosis. Once you've got a diagnosis, then you launch into the treatment phase.

Q. But isn't it true that sometimes treatment has to precede diagnostic studies?

A. To some degree, yeah. Sure; I would agree with that, sure, if you know what the process is. I mean, if you know what the process is, of course. Did he know what that mass was? No.

Q. He knew there were plenty signs of dehydration, though, didn't he?

A. Well, he knew that there was some dehydration.

Q. And he knew the woman weighed 211 pounds, correct?

A. Yeah.

Q. And he knew giving her no fluid, or up to two ounces in your best-case scenario, certainly wasn't going to help her any, didn't he?

A. Well, two ounces more than maintenance.

Q. Two ounces more than maintenance was

not going to help her, was it?

A. (Indicates.) And once again, this much more fluid would have been like a spit in the ocean.

Q. How about five times as much; would that help?

A. In the context that it -- the short answer is yes, it would have helped.

What else was going on with this woman during the time that she would have got five times more than this? Would it have abated her pulmonary edema? No. Would it have treated her sepsis? No. Would it have closed the hole in her bowel? No.

So even had she got that more fluid, Counselor, I'm absolutely convinced that this woman would have gone down the slippery slope.

Q. And you're well aware that Dr. Braen and Dr. Booth are of the opinion that had she gotten 'chat fluid, it would have kept her alive and would have allowed her then to have further diagnostic testing and would have allowed her to get to surgery

eventually down the road, and she would have lived. You're aware of their opinions, aren't you?

A. I'm aware of their opinions, and I -- you know, it's almost worth a trip to Buffalo. I'd love to talk to these guys.

Q. I'm sure they'd love to talk to you.

A. Because I just don't agree with that. I just don't agree with that.

Q. Uh-huh.

A. As a practicing surgeon, I can tell you that this woman would not have gone to surgery without getting tuned up, without correcting, without doing all the necessary things -- electrocardiograms, all that good stuff -- but when you've got pulmonary edema, that she didn't have when she walked in -- her chest was clear when he checked her over when he first examined her.

The initial chest x-ray showed some element of disease, the CAT scan showed more element of disease, and now we've got an autopsy that shows a lot of element of the disease. What does that tell us? That

tells us that this woman was going down like a stone.

Q. So all the while she's in the hospital, she is deteriorating, and all the while she's in the hospital, she's receiving no treatment; is that an accurate statement? Yes.

A. No. No. I -- I -- well --

Q. Other than the oxygen and the two ounces, at the most, of fluid, correct?

A. Okay. Let me just -- you know, I don't want to be argumentative, Counsel.

Q. I'm just trying to --

A. **I** want to --

Q. For the record, I'm trying to make clear the difference between diagnosis and treatment.

A. Well, but that's the point. The point of it is, in order to treat, you have to diagnose.

Now, there are some things that are self-evident. Yes. Could they have done a little better job on the dehydration? Sure. Sure. I mean, you know -- I mean, could

they have said, hey, this lady is dry, maybe we ought to give her more fluid? I'll agree that that is a possibility, a possibility, but would that have abated her pulmonary edema due to sepsis? Absolutely not.

Q. But she would have lived.

A. They never had a chance to treat her sepsis because they didn't know that it was there.

Q. They never had a chance to treat her sepsis because she died of dehydration.

A. No. No, sir.

Q. That's the opinion of my experts.

A. Well, but, in all due respect, sir, they're wrong. They're wrong --

Q. Well --

MR. KELLEY: Objection.

A. -- because she died of sepsis. She died of sepsis. She died of sepsis, and further, I'm saying that she had a specific type of sepsis called ARDS. But I will agree with your -- with your consultants that she died of sepsis.

Now, let's say, hypothetically, that

when she walked in the door, Dr. Gordon said, you know something, you look septic to me; I'm going to start a great big IV on you and I'm going to pour in some antibiotics. In one hour, hour and a half, two-hour period of time, sir, that wouldn't have made any difference. I mean, you've got to have a little time to treat these things.

Q. What about pouring in some fluids?

A. Well, the fluid would have treated her dehydration to some degree, but it would not have aborted her sepsis.

The sepsis was, in my opinion, cast in stone from the minute she walked in. She had a perforated carcinoma of the colon. She had necrosis of the tumor. She had some degree of localized peritonitis. She had a little bit of fluid there on that CAT scan, which is not surprising, a little bit of localized fluid. This woman had fibrin in her lung, in her -- on her microscopic. She had noncrepitant lungs. She had pulmonary edema.

And you can see from the -- from

the -- and this is the paradox. This -- this is the thing that's fascinating about this. As dry as you think she was, she still dumped fluid into her lungs, the fluid that came from her blood, so --

Q. Which would have dehydrated her even more, correct?

A. Well, but, you see --

Q. Is that true?

A. Well, but, if you can't breathe -- see, if you have a choice between being well oxygenated and having a low blood pressure, as opposed to having no oxygen and having a normal blood pressure, take the first one, because without oxygen, you're not going to last very long.

Q. Then based on what you're saying, it would have been very smart to have intubated her long before she was on the -- on her death bed.

A. Well, it would have been smart to intubate her at the time that it was indicated.

Q. And that was long before 9:30,

wasn't it?

A. Well, how much longer? At 9:05, according to the record, when she complained of shortness of breath, her pulse oximeter showed a 97-percent saturation on room air, and they gave her oxygen in regard to that. I mean, if my pulse oximeter is 97 percent, why do I need oxygen?

Q. That's a good question.

A. That's a good question. Somebody gave it to her empirically because they thought it might help her breathing some. Totally off the wall, nonscientific. Who did that? One of the nurses did that. I don't see any order from the doctor that he did that. One of the nurses did that, because I guess that's what they do.

But the fact of the matter is the -- the -- the deterioration here, where the -- where the -- from the time that she started exhibiting shortness of breath, where she got the nasal oxygen at 9:05, to the time that she was intubated is only 30 minutes. That is -- that doesn't give you much lead

time. Doesn't give you much lead time, and she was not in full arrest at the time that he intubated her.

It doesn't have any readings on the record. I'm assuming that when they intubated her they gave her oxygen under pressure with some kind of a ventilator or with a Ambu-bag, but most -- most -- and the other thing that intubation does is it helps pulmonary edema to some degree.

But here's the point, the point of it is that, you know, the course of this lady, I mean, it's as if she stepped on a banana peal. I mean, this woman went down, and she went down just like that.

Q. Right. So when they started the fluids at 7:45, they had an hour and 15 minutes until 9:00, until this precipitous decline, correct, to give her fluids, if they had wanted to?

A. Sir, I don't see in the record where that -- that delay materially changed things. Her blood pressure, which we now know, in retrospect, was lower than it was

back in April, only went lower by a little bit more. Her mental capacity was still there: She's still awake, alert, conversing, doing all those things.

Between 8:30 and 9:00, she made two trips to the bathroom. I mean, it doesn't say there that they had to lift her with some lifting device to go into the bathroom. At some point she was able to still be mobile to some degree.

So what I'm having a tough time with is putting this woman into the, you know, ultra, ultra sick category. I mean -- and further, here's somebody standing off to the side, and they're looking at this woman; they're saying yeah, she's got fever; yeah, she's short of breath; yeah, she's hurting. But look at this: She's still talking, she's awake, she's alert, she's oriented, she's able to go to the bathroom.

Q. Okay.

A. How sick -- how sick is she? This is -- I mean, you know, I think we can argue about that, Counselor.

MR. GUION: Yeah, we could. Okay. I have no further questions.

MR. KELLEY: No questions.

MR. ROBERTSON: Nothing further. Doctor, by point of procedures here, secondly, you have a right to review the transcript of this deposition to make sure it was accurately transcribed. Of course, it's on videotape, so you have the right to say whether you'll waive that requirement under the circumstances.

THE WITNESS: I'd like to review it if a copy -- if a copy could be made available to me.

MR. ROBERTSON: All right. We'll do that, but we've got to do it quickly, because the trial is next week.

THE WITNESS: Oh, okay. I'm pretty confident that the answers that I gave were -- are not going to be changed, so if I don't get it, okay. I always like to review it, because I sometimes feel that I don't understand some of these questions, and I wouldn't want to mislead anybody.

MR. GUION: By the way, this is the book you looked at.

THE WITNESS: Where did you get the little, cheap version?

MR. GUION: This is the cheap version?

THE WITNESS: Are you off the record?

THE VIDEOGRAPHER: Not yet. I'm sorry. This is the end of the videotape deposition of Dr. Francis E. Barnes, taken Monday, June 4th, 2001, consisting of two VHS formatted tapes. We're off the record at 1:02 p.m.

(Off the record discussion.)

MR. ROBERTSON: Can we agree before the court reporter here that I can retain the original of the tape before the trial and we don't have to file it, the abridged version.

-=O=-

(Deposition Exhibit 2 marked.)

-=O=-

Thereupon, the testimony of

June 4, 2001, was concluded at 1:05 p.m.

-=O=-

*Attach to the deposition of Dr. Francis Barnes

John M. Karaba vs. Parma Community General Hospital
Case No. 408025

STATE OF OHIO: SS:

COUNTY OF _____

I, Dr. Francis Barnes, do hereby certify that I have read the foregoing transcript of my deposition given on June 4, 2001; that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

_____

I do hereby certify that the foregoing transcript of Dr. Francis Barnes was submitted for reading and signing; that after it was stated to the undersigned Notary Public that the deponent read and examined the deposition, the deponent signed the same in my presence on the _____ day of _____, 2001.

_____
NOTARY PUBLIC
My commission expires:

CERTIFICATE

STATE OF OHIO
SS:
COUNTY OF FRANKLIN :

I, Dawn M. Morrison, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named Dr. Francis Barnes was first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced to stenotypy in the presence of said witness, afterwards transcribed; that the foregoing is a true and correct transcript of the testimony; and that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee, or attorney of any of the parties hereto, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

In witness whereof, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this 6th day of May, 2001.

Dawn M Morrison

Dawn M. Morrison
Notary Public, State of Ohio

My commission expires: 02-16-2005

FRANCIS E. BARNES. M.D.. F.A.C.S
GENERAL SURGERY

3360 TREMONT RD. COLUMBUS. OHIO 43221

TELEPHONE 442-8801
FAX 442-8803

CURRICULUM VITAE OF FRANCIS E. BARNES, M.D., F.A.C.S.

BORN - Tillsonburg, Ontario, Canada 1938

PRIMARY EDUCATION - Aylmer, Ontario, Canada 1944 - 1954

PREMEDICAL EDUCATION - University of Western Ontario 1954 - 1956

MEDICAL SCHOOL - University of ,Western Ontario 1956 - 1960 M.D.

INTERNSHIP - 1960 - 1961 - Rotating - Victoria Hospital, London, Ontario
1961 - 1962 - Surgical - Grant Hospital, Columbus, Ohio

RESIDENCY - Marquette University - combined Surgical Residency Program 1962 - 1966
Chief Resident - Milwaukee, Wisconsin 1966 - 1967

BOARD CERTIFIED - American Board of Surgery 1967
American College of Surgeons 1971 Fellow - F.A.C.S.

PRACTICE - Columbus, Ohio 1967 to present
300 E. Town Street General & Peripheral Vascular Surgery

LICENSED - Ohio, Wisconsin, Ontario

HOSPITAL APPOINTMENTS -
Active Staff - Grant Hospital, Columbus, Ohio
Active Staff - Mt. Carmel Hospital, Columbus, Ohio
Active Staff - St. Ann's Hospital, Westerville, Ohio
Courtesy Staff - Ohio State University Hospital, Columbus, Ohio

FACULTY APPOINTMENTS -
Clinical Instructor in Surgery, Marquette University 1966 - 1967
Clinical Instructor in Surgery, Ohio State University 1972 to present

PROFESSIONAL SOCIETIES -
Academy of Medicine of Columbus & Franklin County
Columbus Surgical Society, President - 1989
Ohio State Medical Association
American College of Surgeons
American College of Surgeons, Ohio Chapter
American Society of Outpatient Surgeons
Society of Laparoscopic Surgeons
Hungarian Medical Association of America
American Hernia Society - Charter Member

EXHIBIT
BARNES #1
6-4-01

CURRICULUM VITAE OF FRANCIS E. BARNES, M.D., F.A.C.S.

COUNCIL APPOINTMENTS - PAST
Council Member - Academy of Medicine
Council Member - Columbus Surgical Society

COMMITTEE APPOINTMENTS - PAST
Grant Hospital: Chairman, Department of Surgery
Grant Hospital: Surgical Care Appraisal Committee
Grant Hospital: Chairman, Utilization Review Committee
Grant Hospital: Emergency Room Committee
Grant Hospital: Executive Committee
Grant Hospital: Joint Conference Committee
Grant Hospital: Chairman, Operating Room Committee
Grant Hospital: Medical Forms Committee
Grant Hospital: President, Medical Staff
Grant Hospital: Chairman, Trauma Committee
Grant Hospital: Director, Trauma Services
Grant Hospital: Director, Utilization Review
Grant Hospital: Quality Assurance Committee
Mt. Carmel Hospitals: Surgical Care Appraisal Committee
Mt. Carmel Hospitals: Utilization Review Committee
Mt. Carmel Hospitals: Emergency Room Committee
St. Ann's Hospital: Utilization Review Committee
St. Ann's Hospital: Quality Assurance Committee
Ohio Health Choice Plan: Medical Advisory Board

BIBLIOGRAPHY

1> MALIGNANT LESIONS OF THE COLON, RECTUM, AND ANUS
Timothy Yeatman, M.D., Kirby I. Bland, M.D., Edward M. Copeland III, M.D.
Surgical Treatment of Digestive Disease, Second Edition, Chapter 46.

2> THE SURGICAL MANAGEMENT OF OBSTRUCTION AND PERFORATION OF THE LEFT COLON
J. R. McGregor, M.D., P. J. O'Dwyer, MCH
Surgery,' Gynecology & Obstetrics, Auy. 1993, Volume 177, pg. 203-210

3> PERFORATED COLONIC CANCER. EVOLUTION AND PROGNOSIS
F. Alcobendas, R. Jorba, I. Poves, J. Busquets, A. Engel, and E Jaurrieta
[1130-0108 (2000) 92:5 pp 330-3331, Revista Espanola De Enfermedades Digestivas.

4> OBSTRUCTIVE AND PERFORATIVE COLONIC CARCIONOMA: PATTERNS OF FAILURE
Christopher Willett, Joel Tepper, Alfred Cohen, Erica Orlow, Claude Welch
Journal of Clinical Oncology, Vol 3, No 3, March 1985, pp 379-384.

5> OBSTRUCTION AND PERFORATION COMPLICATING COLORECTAO CARCINOMA
Lauri Kyllonen
Acta Chir Seand 153: 607-614, 1987

6> PENETRATING, OBSTRUCTING, AND PERFORATING CARCINOMAS OF THE COLON AND RECTUM
William Kelley, Jr., M.D., Peter Brown, M.D., Walter Lawrence, Jr., M.D., Jose Terz, M.D.
Archives of Surgery, Vol 116, April 1981, pp 381-384.

7> PERFORATION OF COLONIC NEOPLASMS
J. Badia, A. Sitges-Serra, J. Pla, J. Marti Rague, F. Foqueta, A. Sitges-Creus
Colorectal Disease, International Journal, 1987 2:187-189

8> OUTCOME AFTER EMERGENCY SURGERY FOR CANCER OF THE LARGE INTESTINE
N. Runke, P. Schiag, V. Schwarz, C. Herfarth
Journal of Surgery, 1991, Vol. 78, February, 183-188

9> ADULT RESPIRATORY DISTRESS SYNDROME: CURRENT CONCEPTS
Robert Demling, M.D.
New Horizons, Vol. 1, No. 3, pp 388-401

10> ADULT RESPIRATORY DISTRESS SYNDROME: A DISORDER IN NEED OF IMPROVED OUTCOME
Robert Brandstetter, M.D., Kailash Sharma, M.D., Maryanne DellaBadia, RN, Lorie Cabreros, M.D., Gary Kabinoff, M.D.
Heart & Lung, Vol. 26, No. 1, pp 3-14.

EXHIBIT
BARNES #2
6-4-01 Dm