DOC. 24

STATE OF OHIO)
) SS:
STARK COUNTY)

IN THE COURT OF COMMON PLEA

CASE NO. CV89-1305

NATHANIEL DOCKERY,

PLAINTIFF,

VS.

MASSILLON COMMUNITY HOSPITAL, ET AL,

DEFENDANTS.

VIDEOTAPE DEPOSITION

OF

DR. ARNOLD M. BASKIES

JUDGE

VIDEOTAPE DEPOSITION taken before Fred Palc a Notary Public within and for the State of Ohio, pursuant to Notice, and as taken on January 30, 1991 at the U.S. Air Club, Philadelphia Airport, Philadelphia, Pennsylvania. Said depositi taken of Dr. Arnold M. Baskies is to be used as evidence on behalf of the defendants in the aforesaid cause of action, pending in the Court of Common Pleas, within and for the County of Stark, for the State of Ohio.

APPEARANCES:

MR. PATRICK HART,

On Behalf of the Plaintiff,

MR. GARY BANAS,

On Behalf of the Defendants, Dr. Kofol, Dr. Tolez, & Dr. Alborn,

MR. RICHARD REICHEL,

On Behalf of the Defendant, Massillon Community Hospital.

MVS #

OPERATOR: We're on the record. Doctor, raise your right hand, please. Do you swear or affirm that the testimony you are about to give to be the truth, the whole truth, and nothing but the truth?

DR. BASKIES: I do.

MR. BANAS: Let the record reflect that this deposition is being taken pursuant to the rules of Civil Procedure of the State of Ohio, the Rules of Superintendence of the State of Ohio, as well as Notice. Is there any problem with the Notice, Pat?

MR. HART: No, I have no objection as to Notice.

DURING DIRECT EXAMINATION BY MR. GARY BANAS:

Q Doctor, give us your name and business address?

A My name is Arnold M. Baskies. My business address is 1000 Salem Road, Willingboro, New Jersey.

Q What is Willingboro near?

A Willingboro is a suburb of Philadelphia.

Q And, we are in the U.S. Air Club in the Philadelphia Airport taking this deposition?

A Correct.

Q Now, Doctor, have you reviewed some materials at my request?

A I have.

Q And, just generally tell the jury what materials you have reviewed and then we'll talk about your credentials.

A I have reviewed the depositions of the physicians involved in this matter and I have reviewed the medical records pertaining to Mary Dockery.

Q All right. Now, Doctor, so the jury will know, tell us what your training and education has been from the time you went to undergraduate school until you started your active practice of general surgery?

A I am a native of Boston. I matriculated through college at Boston University College of

Liberal Arts from 1967 through 1971. I majored in biology. From 1971 through 1975 I attended Boston University School of Medicine. From 1975 through 1977 I was a resident at Boston University Medical Center. There is a real Boston flavor to my training.

Q And, a slight Boston accent,

A And, a slight Boston accent even though I live in Philadelphia. From 1977 through 1979 I was a fellow in surgical oncology at The National Cancer Institute in Bethesda, Maryland. From 1979 through 1982 I completed my residency at Boston University Medical School.

Q Doctor, are you board certified?

A I am board certified, yes.

Q In what field?

A I am certified by The American Board of Surgery and General Surgery.

Q And, general surgery includes what, sir?

A General surgery is the treatment of patients who have disorders pertaining to the skin, metabolic organs, chest, and abdomen and peripheral vascular problems.

Q Does this include the small bowel and stomach?

A Yes.

Q Now, Doctor, after your training, did you then commence the active practice of general surgery?

A Yes. In 1982 I went into the practice of general surgery.

Q Have you remained in the practice since then?

A Yes. I am in a private practice. I also have a teaching appointment at Robert Johnson Medical School. I am an assistant clinical professor of surgery and radiology.

Q Do you teach within that confine or perhaps in some of the hospitals where you have privileges?

A Yes.

Q Tell the jury briefly what your teaching responsibilities are.

A Well, the majority of my time is spent taking care of patients. I am called upon to give lectures at the medical school and I serve on several committees and have helped develop protocols at the medical school for the treatment of various malignancies. In that regard I am also active and have helped put together the

Cooperative Oncology Group of New Jersey under those hospices.

Q Do you have a subspecialty within the field of general surgery?

A Yes. I am a surgical oncologist.

Q And, oncology means?

A Oncology means the treatment of cancer, I have special training, if you will, in the treatment of malignancies in general surgical oncology.

Q Doctor, is more than 75 percent of your time either within the field of teaching or the field of general surgery?

A Most of my time. ..I would say over 90 percent of my time is involved in the practice of general surgery.

Q Doctor, have you written for the literature

A Yes.

Q And, just generally can you tell me roughly how many articles or chapters or whatever your contributions have been?

A I have written over 20 publications of book chapters...it includes book chapters and articles dealing with various aspects of immunology and surgery.

Q And, Doctor, are you the member of some of the surgical groups?

A I am a member of a number of different societies, yes.

Q All right. And, are you on the staff of any hospital or hospitals?

A Yes.

Q And, just generally which ones?

A I am on the staff of several hospitals within this area. They happen to be Rancocas Valley Hospital, Memorial Hospital of Burlington (Phonic) County, Zurburg Hospital, and Cooper Hospital which is part of the University of Medicine and Dentistry of New Jersey.

Q Handing you what I have marked as Defendant's Exhibit "1", is that a current curriculum vitae that talks about your educational and professional accomplishments?

A Yes.

Q Is that current?

A Yes.

Q All right. Now, Doctor, earlier I asked you about various items that you have reviewed. You have reviewed the depositions, I believe, of Drs. Kofol and Briones?

A I did review those depositions, yes.

Q And, I believe you have seen the hospital records for an emergency room, as well as the in patient record of Miss Dockery that goes back to March of 1988?

A Yes.

Q And, have you also seen a copy of the coroner's report or the post mortem?

A Yes, I have reviewed that also. In addition, to make the record complete, I also reviewed the slides that were referred to me earlier this week.

Q All right. After the discovery deposition of Mr. Hart I mailed you the slides and you have looked at them....

A Yes.

Q ...and returned them to me?

A Yes, sir.

Q All right. Now, Doctor, as you know, I represent Dr. Kofol in this case and I believe his partner Dr. Tolez was also sued, and I also represent Alborn; recognizing that Drs. Kofol and Tolez are general surgeons and Dr. Alborn is a general internist. Is that what you have deduced from the records?

A Yes.

Q All right. Now, Doctor, I'm going to ask you a broad question and then we'll break it down and talk about individual parts of it. Doctor, having reviewed the records that you have indicated and based upon reasonable medical probability, do you have an opinion as to whether or not Dr. Kofol and Dr. Alborn met the standard of care of reasonably prudent physicians as they cared for Mary Dockery as shown in the records from the Massillon Community Hospital Emergency Room and the in patient record of March 3, 1988? First of all, sir, do you have an opinion?

A Yes.

Q And, your opinion is?

A My opinion is that the physicians tha- you have referred to met the standard of care in taking care of this patient.

Q Now, Doctor, before we go any further, could you tell us what significant history...past history you find in the records for Mary Dockery which may have some bearing on your opinions?

A Well, it mentioned in several areas of her medical record the fact that she had undergone a major abdominal procedure in the past; that being

removal of a large portion of her stomach with what is referred to generally as a Billroth II reconstruction which means that essentially the stomach was sutured or anastomosed to the small intestine to restore her gastrointestinal continuity. So, she had a large operation in the past performed for what was thought...what was peptic ulcer disease.

Q Okay. Was there anything else?

A To the best of my knowledge, I believe that is the only intra-abdominal procedure that was referred to.

Q All right.

A She may have had an umbilical hernia repair. I'm sorry.

Q All right. Now, I believe also the records indicate that she was a diabetic?

A Yes.

Q And, that she had what was called a dumping syndrome?

A Yes.

Q I think we all know what diabetes is, but tell us what a dumping syndrome is?

A A dumping syndrome is one of the syndromes or one of the sequela or one of the things that

happens to a person in a small percentage of patients who have a portion of their stomach removed. Dumping, quote, unquote, "Dumping Syndrome," in layman's terms very simply is after a person has had a portion of their stomach removed, their stomach is then sewn to another portion of the G.I. tract. What happens is basically the symptoms that a patient complains of is there is a sudden feeling of sweating, of diarrhea, of loose stools, and general abdominal discomfort because what happens is is that the stomach...because the normal continuity of the stomach has been altered by surgery, that food moves so quickly through the stomach with its carbohydrate load that fluid is probably sucked in with it and then there is a sudden feeling of a very bad intra-abdominal feeling that the patient describes. Some patients describe a feeling of being flushed, of feeling faint, of feeling abdominal pain, nausea, vomiting, diarrhea, and it can be a very difficult problem to deal with for a patient with this syndrome. It is one of the unfortunate side effect of gastric surgery and it is a known complication of that problem.

Q Now, Doctor, have you treated patients who have had some sort of a small bowel obstruction'

A Yes, many times.

Q All right. Is that part of your practice?

A Yes.

Q All right. Now, Doctor, having seen, first of all, the emergency room record when the patient came in to the Massillon Community Hospital at 4:10 a.m. with a complaint of abdominal pain, nausea, and recurrent vomiting, were you able to determine what the diagnosis was either by the emergency room physician or shortly thereafter?

A From what I gleaned from the record, it appears that the physicians thought that she most likely had a partial or early small bowel obstruction.

Q And, the tests that were run were what, sir? Do you remember?

A Yes. She had an X-ray taken of the abdomen. She had some basic blood studies taken, including what we call a C.B.C. which is a complete blood count, an amylase level was drawn, a set of electrolytes measuring her sodium and potassium and chloride and cardon dioxide content of the blood, her B.U.N. which is a

measure of her kidney function, her blood sugar was taken and, as I mentioned, the all important X-rays of the abdomen which is focusing in on what they felt to be her main area of complaint which was in her abdomen.

Q Well, Doctor, let me read from Dr. Briones' admitting history and physical, and keeping in mind all of the tests and the results, and you have seen the results of these tests from the records that we have just discussed?

A I reviewed all the test results, yes.

Q All right. Now, take into account the following; that she is admitted to Massillon Community Hospital via the emergency room at this time with complaints of recurrent nausea and vomiting and diffuse abdominal pain. The patient was apparently doing well until the evening prior to admission. The patient had a heavy meal at 8:00 p.m. and had another snack at about 1:00 a.m. prior to admission. Following these two heavy meals the patient started having recurrent nausea and vomiting and vomiting profusely initially about three times at home and recurrent gagging and vomiting while she was in the emergency room with bilious materials being noted. This was

preceeded by diffuse abdominal pain. Now, Doctor, assuming the records that I have read...and incidentally, have you seen that in the records?

A Yes.

Q All right. Assuming that history and assuming the tests that were done while she was in the emergency room and shortly thereafter, do you have an opinion based upon reasonable medical probability what the presumptive diagnosis was of Mary Dockery at this point? First of all, sir, do you have an opinion?

A Yes, I have an opinion.

Q And, what is your opinion?

A My opinion is based on what I have been told, and that is the record that you read, that the most likely diagnosis in this instance was that she had a partial small bowel obstruction secondary to the surgery that she had had most likely in the past.

Q All right. Now, what is the treatment; the generally accepted treatment for small bowel obstruction?

A For small bowel obstruction.....

Q Like this.

A ...as you have described it at this stage

of the game?

Q Right.

A Okay. The general treatment that I believe should be instituted would be to put an I.V. in the patient to hydrate them and, obviously because you are not going to feed them and, assuming that their bowel is twisted or kinked or obstructed in some way by adhesions, one could try to deal with that in an indirect way. The way that surgeons or internists typically deal with that problem is to...and this sounds a little barbaric, but this is very commonly done...is to put a tube in the nose, down the esophagus, and into the stomach and do an intubation, what we call an intubation of the stomach with a nasogastric tube. That decompresses the stomach, sucks the fluids out that the patient is vomiting, and puts the G.I. tract, quote, unquote, "at rest" and therefore you relieve the pressure intra-abdominally, you relieve some the patient's symptoms sometimes, but more importantly you are doing something active to take care of the patient and that is what is instituted in this particular instance.

Q Did the doctors who were treating this

patient do what you have just described?

A Yes.

Q Doctor, what is the expected follow up on a patient who has a partial small bowel obstruction? Assuming we have a patient like Mary Dockery, they've done an x-ray of the bowel. When would you expect, normally, you would do a repeat x-ray...a flat plate?

A Well, I can tell you what my routine is, is after seeing the patient and feeling that this is an early process, I'll order an x-ray for the next morning.

Q All right. Was that done in this case?

A I believe it was, yes.

Q Now, doctor, let's now skip to the end and then we'll pick it up in the beginning. Do you know the reason for Mary Dockery's untimely demise?

A Yes.

Q And that is what?

A Mary Dockery succumbed to the sequelae as what's referred to as mesenteric venous thrombosis.

Q All right. Now, for those of us who don't understand that, if you can tell us in lay terms, first of all, what the mesentery is. And then tell us what mesenter venous thrombosis is. And then how this all hooks together

A Okay, well basically, think of the small intestine as a long long hollow tube...that has...sort of...

like an empty snake...

...Okay.. .

...With nothing...just a long hollow tube, sort of like a slinky, a solid slinky.,.

...All right.. .

...That is a living thing so it requires a blood supply and so the mesentery is this sheet of tissue that connects to the slinky and it contains an in-flow for blood coming into the bowel and an out-flow for blood going out of the bowel. The in-flow of blood comes via the mesenteric arteries.. .

...Okay.. .

...The out-flow of blood from this hollow tube, the small intestine, goes out through the mesenteric veins. Now, just like you can have a blood clot in an artery in the leg, or an artery in the neck, or an artery in the hand, you can have a blood clot in an artery that feeds the bowel., And just like you can have phlebitis, for instance, of the lower extremity that's caused by a blood clot in the veins of the leg, you can have a blood clot that develops in the veins that feed the bowel.

Q Okay, so she had what you call a venous...

A She had massive venous thrombosis of the. ..she didn't have just a little blood clot in one portion of the vein feeding this long hollow tube. All the veins feeding

her bowel were clotted according to the coroners report. So this was not just mesenteric venous thrombosis, this was massive mesenteric venous thrombosis.

Q What happens when you have a massive venous thrombosis of the mesentery?

A Almost all those patients die...virtually all of them.

Q And why?

A The...very simply, the bowel is a very frail organ, just like the brain and many of our organs are very frail. And if you have compromised the entire venous circulation of the small bowel, that's a...then the entire small bowel dies. When that happens, that's a situation that really is almost consistent with 100% mortality.

Q Doctor, was there anything in the signs or symptoms that Miss Dockery exhibited, or any of the tests that were done, that would have pointed to a reasonably prudent physician that this was a mesenteric venous thrombosis? Or an infarction of the bowel perhaps is another way of putting it?

A No, I've there before with this...in the battlefields with this problem. And I can tell you that unfortunately.. .the unfortunate.. .the tragic part of this case is that this woman manifested none of the symptoms

of mesenteric...none of the findings that would point to that diagnosis as the likelihood. She didn't come into, the emergency room with a sign pointing to her saying I have mesenteric venous thrombosis. In fact, this is probably the rarest surgical emergency involving the abdomen. If you look at the...if you look at the series of publications that have been done regarding this...there is a series, for instance, from Copenhagen that was done between 1972 and 1973, you see that they say this represents .01% of all the admissions in that particular city. That's 1 in 1,000 admissions...

MR. HART: Objection.

...had that particular diagnosis of mesenteric venous thrombosis. If you look at any of the series published in this country. The one that I happen to sort of look at is the one that was published by Dr. Rledman at Martha field (phonic) Hospital many years ago. I'm sorry, Scott Boley, who works with Kledman. Scott Boley is a recognizee authority in this particular area. His conclusion was about the same, it represented .01% of all the admissions. So this is a particularly rare event.

Q How about a 32-year-old woman?

A I would say in a 32-year-old woman with no previous history, this problem...it would be probably the last diagnosis that I would make. I think if you brought

100 surgeons in the room to see this woman at that particular point in time, all 100 wouldn't come to the conclusion...none of them would come to the conclusion that this woman had mesenteric venous thrombsis. It's such a rare event with these symptoms presenting and all of the negative tests she had, that you would not be led to that conclusion.

Q What are the signs or symptoms that lead a reasonably prudent physician to a diagnosis of venous mesenteric thrombosis, or an infarction of the bowel?

A Okay, well...well let's go through the physical findings first and then I can get to the laboratory tests..

...All right..

...The...if this is the problem that you're considering, mesenteric venous thrombosis, you're looking for a diffuse abdominal tenderness. Looking for pain that is diffuse way out of proportion to physical findings. On x-ray, you're looking for a, not just an ileus pattern, but any indication to what we call an ileus pattern or dilated bowel, which is a very very nondiscript finding. You're looking for something called thumb printing or thickening of the bowel loops.

Q Was that read by the radiologist in this case?

A The x-rays were read by the radiologist.

Q Was that finding found?

A No, the radiologist read the x-rays as showing a probable early small bowel obstruction.

Q Okay, go ahead, proceed.

A There was no suggestion on the part of the radiologist...I mean, and this is a test that we really need help for from the radiologist. There was no suggestion on the part of the radiologist that the physicians were dealing with a mesenteric venous thrombosis. So, what you look for in the laboratory tests are what we call hemoconcentration, for instance. Where the blood count, the hematocrit, or the red blood cells, is very high. Hers was not...hers were normal. You look for acidosis, signs of acidosis on the blood studies. In other words, a high acid level if you will, in the blood. A low acid... a high acid level, but a low pH if you will, that was normal in her. You look for a high BUN, that was normal in her. You look for blood sugar way out of wack in a diabetic, that was not way out of wack in her. So the... and amylase, although it is not usually elevated, if it is, points to that problem, that was also normal. So none, unfortunately, none of the physical findings, and unfortunately in her case, none of the tests that were done suggested that this woman had mesenteric venous thrombosis. In fact anybody that would have reached that conclusion at this point, I would really wonder how they

ever would have reached that conclusion if they thought she had it. I can't imagine reaching that conclusion.

Q Well doctor, I heard the term arterial mesenteric thrombosis used in this case. First of all, do you have an opinion...first of all are you familiar with that?

A Yes, very familiar.

Q What...is there any difference in, for instance, generally the way a patient reacts to either a venous or an arterial mesenteric thrombosis?

A Yes.

Q All right, just briefly describe that.

A A person who has a mesenteric arterial thrombosis or embolism, let's look at it as an embolic phenomenon, is usually...it can be a sudden event. It generally is more sudden in terms of its presentation. The patient will not infrequently have a bloody bowel movement. And the pain is usually located periumbilical around the umbilicus, And it's really impressive pain. When you see it, you never forget it, because the pain is excruciating, it's much worse than almost any other pain that you see in a patient. It's what we call mesenteric vascular accident. And when a sur...I've seen it in several occasions and I've known immediately what that problem was. Just clinically I suspected it and worked the patient up very quickly. So, that's mesenteric arterial occlusion.

Q All right. Let's now shift our gears a bit and first of all, how serious is a mesenteric venous thrombosis?

A Well this is a...it's a very serious problem for several reasons.

Q What's the nature consequence of it, generally?

A Well, unless it's picked up early, which is rarely done, in fact it's done because someones operating usually for another reason, not suspecting it. It goes on and the problem is that veins tend to clot very easily. And once that clotting process has begun, it can spread throughout all the veins of the bowel. And it occurs very quickly. And the problem is that even if it's in one segment of the bowel and you are lucky enough to make that diagnosis and lucky enough to do this limited resection, you very often have to go back in 24 hours and remove more dead bowel, because the process goes on. Whatever is the inciting cause for it, and very often we don't know what's causing it, continues, And there are multiple complication5 of that, in fact we sometimes have to anticoagulate these patients. And now you're giving a person a blood thinner right after you've done surgery and have the complications of that problem. So it's a very very very difficult problem to deal with surgically.

Q Now doctor, the post mortem in this case indicates the extent of the small bowel infarction or death?

A Yes.

Q And how much of the small bowel was involved?

A The coroners report described the entire small bowel as having been involved.

Q Knowing that, and knowing the symptoms that she ha and when they started. Can you tell us, again based upon reasonable medical probability, how long, approximately, after the beginning of the symptoms, does a reasonably prudent surgeon have before, in essence, the patient become virtually inoperable? First of all sir, do you have an opinion?

A Yes.

Q And your opinion is?

A My opinion is that you have roughly about two hours to make a major impact from the time of the symptoms ...from the time the occlusion occurs.

Q All right, now keeping in mind what I read from the records at the beginning of this deposition, the history as taken by Dr. Brionus. Knowing that prior to the time she came in, she had vomiting, nausea and pain and she enters the emergency room at Massillon Community Hospital at approximately 4:10 a.m. in the morning, How long would a physician have, regardless of whether he's an internist making a diagnosis or a surgeon making a diagnosis, have before it, in essence, becomes inpossible

to save a person's life whose small bowel is completely infarcted?

A Okay. Lets take go.. .take one step back.. .

...All right.. .

She came to the emergency room before 10 a.m., I have no way of knowing what time she actually awoke. But she awoke in the history that I have.. .the doctors document that she awoke with abdominal pain. That's when this process started, when she awoke, that's awakened her from sleep was the occlusion of her mesenteric veins.

Q You have two hours from then?

A Two hours from the time of the symptoms, not two hours from the time she got to the E.R...

...All right.. .

...So, at 4:10, this was already an ongoing process. Unfortunately and tragically, without any...giving any evidence or any signs, that that's what she had. At 4:10 in the morning, assuming that she awoke with...lets say she awoke an hour before just for the sake of argument, you have roughly an hour to get the whole operating room together, plunge in and get started trying to save this woman's life. But again, that would be the last thing,.. if I'd been called in to see her at 4:10 in the morning and I saw her at 4:10 in the morning, that isn't what I would have done for this lady. I would have done exactly

what these physicians did. There was no reason to have suspected that she had this ongoing problem. And that's the whole problem with mesenteric vein thrombosis. It's an insidious disease. It sneaks up on the patient and it sneaks up on the doctor and that's one of the reasons why we've had very little in the way of any improvement in survival rate with this disease over the last 20 years. Because there is no good way of making the diagnosis.

Q Let me add to that. Now lets assume that we have a patient who has had previous abdominal surgery because she has had a peptic ulcer. That she has diabetes. That she has a dumping syndrome. And she comes into the E.R. with the symptoms that we've discussed, And again, based upon reasonable medical probability, is there anything about that history which should in some way warn or alert either an internist or a general surgeon that she is more likely to have a venous...or mesenteric venous thrombosis or small bowel infarction?

A There is absolutely nothing in her history that would make one suspect that this woman came in with one of the rarest of all surgical problems.

Q Doctor, lets assume, lets take it one step further, lets assume that somehow late in the afternoon, because we know that Dr. Kofol comes in at, I believe, 2:30, Dr. Kofol here. Lets assume....and. is there any

failure to meet the standard of care because he didn't show up until 2:30 in the afternoon after an order was put on by Dr. Brionus at roughly 7 to 8 o'clock in the morning?

A No. I can tell you from my own practice and the practice of almost every surgeon I know, that unless someone calls you as a stat or an emergency, that one will see a consultation on the patient sometime during that day. And certainly, that's a very...that may even have been in the middle of the man's office hours. So, I mean, it's a very reasonable time to see a patient who you don't suspect has a...you have no reason to suspect has a major surgical problem.

Q All right, lets assume Dr. Kofol is *so* perceptive that he says "Ah ha, this may be a mesenteric venous thrombosis or a small bowel infarction". He mobilized the team, they take this patient to the O.R. Based upon reasonable medical probability, could he have saved her had he done that?

A Are you talking about 2:30 when she (sic) saw her?

Q 2:30 in the afternoon.

A Let me just go through this again so I understand what you're saying. The patient awoke sometime in the early hours of the morning...

...Right..

...Seen in the emergency at 4:10...

...a.m....

...a.m., then Dr. Kofol sees the patient at 2:30 in the afternoon...

...Right.. .

...and mobilized the O.R. team?...

...Right.. .

...It doesn't matter at that point whether he operated on her or didn't operate on her, the result would have been the same.

Q Lets assume you open up the patient and see what is essentially a dead small bowel, have you ever had that?

A Oh yes, unfortunately I have-

Q What does...

MR. HART: Objection.

...What does a reasonable prudent surgeon do generally?

A Well it's a really tough problem I can tell you. The.. .in an older patient, many surgeons will just open and close the patient because you're talking about taking out the whole small bowel. If you're dealing with an older patient, they're not going to tolerate that very well. So I've been in that in that position and I can tell you that I told the patient and the family ahead of time what I'm expecting. And when they hear that, many of them opt eithe not to have the surgery or to just explore them to try to make sure it isn't something else. But a younger patient,

much more difficult problem to decide what to do. One could elect to take out the whole small bowel and then sew the stomach to the colon. You now have a person.. . that's a situation, by the way, that's incompatible with life, to have just the stomach with no small bowel. It's a very difficult problem because now you have...now the pancreating juices have no where to go except into the colon. You have a situation that's devastating. The only way around that is now to put in, what we call a hyper-alimentation line or an IV that the patient now gets nutrition through. And that's a horrible existence. You'v got a person who will never be able to eat again. Who will have multiple problems from the gastric secretions having no where to go except into the bowel. They'll be in the toilet 24 hours...bath room 24 hours a day having bowel movements. It's a short...it's the ultimate short gut syndrome, what we call short gut syndrome. And it's...and in a diabetic, especially in a diabetic, you're talking about a situation that's going to.. .that has a very.. .I believe the patient would die from just the consequences of having that kind of a preparation performed on them. As well as being on life time hyperalimentation.

Q One or two more brief questions. I want you to assume, as the records reflect, that a Dr. Alborn stops and sees the patient...I'm sorry, is called at 5:30, told c

the patient's status and in essence says to the nurses call Dr. Kofol, Alborne being the internist, Kofol being the general surgeon. Dr. Kofol is called and he orders some additional Demerol and he's told in essence the same things that Dr. Alborne is told. Again, do you have an opinion based on reasonable medical probability whether the internist, Dr. Alborne, met the standard of care?

A I think Dr. Alborne did what any.. .what most internists will do. They will you ...the internist will tell the nurse to call the surgeon and see what he wants to do. And at that point in time, I think the... unfortunately for her, the die was cast. She had a, what I think, was an incurable problem, a problem that's associated with an extremely high, if not 100% mortality rate. In the perioperative period especially. And I think at 5:30 in the afternoon, or 2:30 in the afternoor it didn't matter. This woman, I think, was destined, unfortunately to succumb to a devastating surgical problem.

Q One last question. Is there anything that either Dr. Alborne or Dr. Kofol could have done, based upon reasonable medical probability, which would have saved Miss Dockery's life?

A I don't believe so. I think that again, the

tra...this is a tragic death. This is a 32-year-old woman that passed away. I mean I don't know the woman I never met the woman I don't know her family. This is an unexpected death. It's a 32-year-old woman who passe away. But it's a 32-year-old woman who passed away from one of the rarest of all problems that we see in practice. And it's a problem that's almost impossible to deal with on a successful basis, It's almost like a malignant problem. It's a devastating problem, it's something, I think, that nobody could have corrected. Whether she went to the world's greatest surgeon who could have made this diagnosis at 6 o'clock in the morning, unlikely to have occurred. Or whether she went to Dr. Alborne or Dr. Brionus. I think if you brought one-hundred surgeons in that room they would hav come to the same conclusions that they did.

That's all I have- You may cross examine.

OPERATOR: We're off the record.

OPERATOR: We're on the record,

DURING **CROSS** EXAMINATION BY MR. PAT HART:

Q Dr. Baskies, my name is Pat Hart and I represen the Dockery family with respect to this case...the estat of Mary Dockery...which is in Common Pleas Court of Stark County. And I would like to ask you some question: based on your testimony this morning. First of all,

Dr. Baskies, there was one question asked at the end of your direct examination by Mr. Banas about had this patient been opened up at 2:30 by Dr, Kofol and the determination been made that this small bowel was dead, what does a surgeon generally do or frequently do. And I think your answer was something along the lines that it's not uncommon that they will close the patient back up. Is that correct?

A That's correct.. .

That's correct...in an older patient.

Q In an older patient?

A In a younger patient it's a much more difficult problem, mainly because in that situation you take... let's just assume you've taken this woman to the operating room. Probably, if it was me, I wouldn't have suspected that she had this problem. That would have not been what I suspected.

Q 1 understand, we're going to get to that in a minute.

A If she had been in the operating room for snother reason, let's say I suspected that she had infarcted bowel on the basis of a small bowel obstructio and I now discovered that her entire small bowel was dead. I'm in a very difficulty position, that's surgeon is in a very difficult position. As well as the

patient being in a difficult position.

Q One point that you've just indicated is there is a difference between an older patient and a younger patient as to what you're going to do as a surgeon, correct?

A Right.

Q This patient, being a 32-year-old woman was a younger patient, correct?

A Correct.

Q All right. And by all of this testimony you're not suggesting, are you, to the jury that at 2:30 in the afternoon this woman's small bowel was dead, are you?

A Oh no, I'm saying at 2:30...yes I am saying that. I'm saying at 2:30 in the afternoon, this small.. this woman's small bowel was dead...dead dead,

Q Dead, dead?

A Dead, dead.

Q All right. In the consult note of Dr. Kofol's have you read that?

A Yes.

Q And that was when he saw her at 2:30, is that correct?

A Yes.

Q All right. Do you recall him indicating in

the consult note that there were bowel sounds noted?

A Yes.

Q All right. And bowel sounds would indicate to you that the bowels are moving.

A The large bowel also makes sounds. You're.. . the problem with your interpretation of the record is you don't understand it. The stomach makes sounds, the large bowel makes sounds. A number of bowels, different bowels, make sounds.

Q What does the record say on that? It says "bowel sounds are present but diminished".

A Correct.

Q So he's not saying small bowel or large bowel is he?

A Well you can't tell large bowel from small bowel when you listen.

Q Exactly. But you have assumed that the small bowel is dead, even though this record says bowel sounds are present but diminished.

A I'm not assuming that the small bowel is dead, I know that the small bowel is dead at 2:30 in the afternoon.

Q You know the small bowel is dead.

A I know, based on experimental data, based on what I know about this disease. Yes, I think the small

bowel was dead at 2:30 in the afternoon. Bowel sounds being present doesn't change my opinion at all. Because they're diminished, so she may have had 1 cm or 2 cm of bowel...small bowel that was making these sounds. Her stomach may have been making the sounds. And, in fact, her large bowel may have been making those sounds, since the large bowel was alive, So the presence of bowel sounds doesn't really mean anything to me at this point.

Q Could mean though, small bowel. That inscription could have meant...

A It could mean small bowel, yes.

Q All right. And we know from the autopsy report...by the way, when was the autopsy done?

A After she died.

Q Okay, so it was the next day, correct?

A I'm not sure of the date of the autopsy.

Q All right. But that's where we find that the small bowel...extensive small bowel infarction, correct? That's where there's a documentation of small bowel... extensive small bowel infarction?

A Actually at the autopsy that's the first time anybody has even thought...known that that's the case.

Q If you'd answer my question doctor.

A Right.

Q That is when it is documentated that there is

extensive small bowel infarction?

A Yes, it's documented at her postmortem examination.

Q Exactly, and that is some number of hours after she has died, correct?

A Yes.

Q And would you indicate for the record when that was done?

A When the postmortem exam was done?

Q When the postmortem was done.

A Could you...do you know when it was done becaus I can't. The postmortem was done.. .okay, it was begun at 2:15 on the tenth of March 1988.

Q 2:15 p.m.?

A Correct.

Q All right. Now, let's look at Dr, Kofol's other physical findings that he found and documented when he saw her at 2:30 in the afternoon on the ninth of March. Do you have his consult chart there?

A Yes.

Q Okay. Now, he finds, does he not, that...if I'm reading this correctly, that the abdomen appears slightly distended.

A Correct.

Q Is that consistent with a total small bowel

infarction, or small bowel being totally dead dead as you've indicated?

A Oh yes, that's very consistent with that. If you want me to explain why I say that I'd be glad to.

Q I'll let you explain that in a second doctor. Let's continue with this physicial finding. Does he say anything about whether this abdomen is tender?

A He makes no mention of that in his note.

Q Now, has there been mentioned previously in the chart when, in the emergency room and in her initial examination, her admitting examination by Dr. Brionus, as to the status of the tenderness of her stomach?

A Dr. Brionus says there is no rebound present. And he says the bowel sounds are silent, there are no bowel sounds at all.

Q No my question was tenderness.

A I'm sorry, tenderness. He describes no tenderness. Actually let me just...if I can read from the record. He says, "the abdomen is distended and soft wit diffuse abdominal tenderness". He said the abdomen was tender, I'm sorry.

Q Okay. Now, if you'll...and that's his dictated physical findings some time on the ninth of March, correct?

A Yes, he...Dr. Brionus, from what I gather,

examined the patient and dictated this note.

Q All right, Now, when the patient initially comes into the hospital, the work up is done right there in the emergency room, correct, by nurses?

A The work up in the emergency room was done by the emergency room physician.

Q All right. And there are nurses there assistin correct?

A I assume there were nurses in the emergency room, yes.

Q And there are handwritten notes documenting what they found, correct?

A Yes.

Q And on the issue of tenderness, what do they find in handwritten notes when she first arrives in the emergency room?

A In handwritten notes I'll read you what's here, if I can, this is not the greatest handwriting, but...

Q Well I'm really interested...instead of reading the whole chart, the issue of tenderness of the abdomen.

A There are two documentations regarding pain and tenderness. One, is documentation which I assume is by a physician, who describes the abdomen is soft without tenderness. At the same time, she asked the nurse for a pain shot, requesting Demerol by name. So, she obviousl

was having pain way out of proportion to her physical findings.

Q But above that, it indicates, "abdomen soft, no tenderness", correct?

A Correct.

Q And that is something that a clinical physician with a patient coming in and complaining of abdominal pain, that's something that's significant, isn't it? Tenderness and...

A The finding of tenderness is a significant event, yes.

Q And the firmness or softness of the abdomen is also important?

A That's important in the context of what else the patient is telling you.

Q Absolutely. But these are important clinicaly perceptions on behalf of the doctor or nurse.

A Yes.

Q And the amount of distention of the abdomen is also important, isn't it?

A Correct.

Q Now, you, in direct examination, made reference to her symptoms and also some tests that were done in the emergen...as she was hospitalized on the ninth and the tenth. And I want to take these and make sure that

...in chronological order, and make sure we understand. When she appeared in the emergency room, we're talking 4:10 a.m. on the ninth of March, correct?

A Correct.

Q And she's in the emergency room for about three and one-half hours, until about 7:40, is that right?

A Correct.

Q Okay. Now let's just talk for a moment about her symptoms in the emergency room when she first presen Now you've already indicated that this handwritten chart indicates, "abdomen soft, no tenderness", correct.

A Correct.

Q And I think it was in the emergency room that this x-ray was ordered that we've talked about or you mentioned to Mr. Banas, correct?

A The x-ray.. .there was an x-ray ordered and done while she was in attendance in the emergency room.

Q That's correct. Now, was there.. .before we move on.. .was there any other x-rays done at any other time during the hospitalization that you're aware of?

A Not that I'm aware of, no.

Q Okay. So that the x-ray findings that you referred to on direct examination were done at the very beginning of her hospitalization when she was in the emergency room between 4:10 a.m. and 7:40, correct?

A Correct.

Q And, in fact, the x-ray report, if you have it there, documents that it was done at 5:47 in the morning right?

A If you want me to...do you want me to confirm what you said?

Q Yes. How about if you look at that report and then referring to the top here. Would you agree that that shows that this report was at least dictated and read...or at least taken at 5:47 in the morning?

A Well the...it says time: 5:47, I'm not, I don' practice at this hospital, so I don't whether that...to be honest with you...whether that's 5:47 a.m., 5:47 p.m 5:47 a.m. that the film was taken or 5:47 that the dictation was made. It just says 0547.. .

...All right. ..

...If you want, I'll assume that the x-ray was taken at 5:47 a.m.

Q Well let's, for the purposes of this discussio: I think it's fine if we assume it was taken during her emergency room stay.

A Right.

Q All right. And you also referred on direct examination to lab tests that were done, correct?

A Correct.

Q And that they were not consistent, I think, if I understood you correctly, they were not consistent with a mesentery venous thrombosis.. .the lab findings? Did I understand that correctly?

A No, let me tell you how I want you to understand what I said. The problem with the lab findings in this disease are very often they are not classic...

...Nonspecific...

...very often, they are nonspecific. There is no test or one test that can be performed easily that points to this diagnosis and that's the problem with the disease.

Q I understand that doctor, but it was your testimony that said these lab tests wouldn't point you to mesenteric venous thrombosis, you said that, correct?

A Well what I said was that the.. .that if you had the findings the you would like to see for the disease then you have a good indication as to what's going on. The problem is is that very often most often, we don't have the findings that we like to see to point us in that direction, So none of the tests that she had done, in my estimation, gave anyone the cause to believe that this woman had mesenteric venous thrombosis.

Q I understand that, but let's agree, can we, that these are nonspecific tests, these are nonspecific lab tests that we are talking about, correct?

A I don't think that I would agree with you that they are nonspecific. The term nonspecific means that the results can be specific, the tests are tests that we generally run to try to help us make a diagnosis. In this particular instance, those tests pointed towards a small bowel obstruction rather than mesenteric vascular occlusion.

Q Well they can point to a lot of things, can't they? Not just to a small bowel obstruction. Those tests and those readings could mean a lot of things to a clinical doctor.

A Not really, no, the absence of positive finding in this particular instance, leads one to believe that she doesn't have mesenteric venous thrombosis.

Q And maybe she didn't.

A Oh no, she definitely did, we know from the postmortem exam she had that.

Q Well she did at postmortem, the next day, after she's dead. But in the emergency room between 4 and 7 in the morning, maybe she didn't,

A Are you telling me she had another disease othe than mesenteric vein thrombosis that brought her to the emergency room?

A These findings, these lab findings, can mean a lot of things to a clinical doctor, do you agree with

that. They're not pointing to one diagnosis and that is. You see the problem...

...Do you agree with that?

A No. You see the problem with your thinking is, you're thinking more like an attorney than like a physician. You see...

...I'm trying to be objective...

...I know. A physician who saw this patient, and the only evidence I have as to what these physicians thought is what's in the chart. All of these physicians were led to believe that she had, including the radiologist who didn't even see the patient, who saw the x-rays. If I could read the radiology report.

Q Please, if you would.

A He read, "this could represent the early or incomplete small bowel obstruction". Nowhere at all does he tell us that he thinks this could also be mesenteric vein thrombosis. Nor does her physical examination show you that. Nor does any of her laboratory tests show you that she had that. So they...on physical exam and on.. .what you're calling nonspecific tests, is...that is not a good term. What I'm looking for in this particular instance, if I thought she had the disease, would be something that told me, "hey, think about this as a diagnosis, look at her BUN is it

elevated, look at her blood time, is it elevated". None of the tests that were done, unfortunately, showed that that's what she had, but we know that she had mesenteric vein thrombosis.

Q We know that she had it at 2:15 the next day in the afternoon.

A No, that's not right, if you look at coroners...

Q Well no, excuse me...

...Oh, I'm sorry.

...Do you believe that when she died that Dr. Kofol knew what she had?

A No.

Q He didn't?

A I don't think anybody knew until the post was done.

Q Okay. Now, let's look at this x-ray finding again. It states, "this could represent", it doesn't say "this represents", it says this "could represent an early or incomplete small bowel obstruction", doesn't it?

A Oorrect.

Q Then it goes on to say, "a severe ileus could also give the same pattern".

A Right.

Q And then it says, doesn't it doctor, "clinical

correlation is necessary".

A Right.

Q So even the readiologist is saying at, I believe 5:47 in the morning, but sometime when she is in the emergency room, "pay attention to her clinical picture". True?

A That the radiology...yes, he's saying that.

Q All right. So that the radiologist is not pointing the finger in any one direction, but he's laying out some possibilities here. Is that a fair assessment of...

A I think if you want to know what the radiologis thought, the best thing to do would be to actually ask him.. .

...Yes, I agree.. .

...Because in my reading of this x-ray report, what he's telling me, is he thinks this patient probably has early or incomplete small bowel obstruction. He doesn't say any other pathologic diagnosis mentioned here, He doesn' say this could represent an early or incomplete small bowel obstruction, and also think about mesenteric vein thrombosis. He doesn't say that here. He says, "this could represent an early or incomplete small bowel obstruction. A severe ileus could also give a similar pattern". I can tell you I see a lot of these kind of

reports. I've seen x-rays up the wazoo, of patient's who have the same picture as this and that's what a radiologist will always say. And clinical correleation is necessary is a standard line that's put in the end of every single dictation that a radiologist does. Because it's a way of telling you, "think about something else". But he's telling us here, I think, that...and it's in black and white.

Q It says what it says and we have to...

A Right. My interpretation of this is that he specifically mentions one particular entity as.. .

...Something it could be. ...

...as, he says, yeah, it could represent an early or incomplete small bowel obstruction. That's what he says here.

Q And he also.. .he mentions also a severe ileus.

A yeah, an ileus, yeah.. .

...All right. ..okay. ..

...But he doesn't say any other things that it could reperesent. And I don't think that was on his list of diagnoses, if that's what you're trying to say. He's not telling us this could be mesenteric vein thrombosis, he doesn't see any of the classic findings that you see with mesenteric vein thrombosis. He doesn't see thumb printing, he doesn't see thickened bowel.

Q But he does say apparently he's not clear enough so that he says clinical correlation is necessary Is that right, is that what that says there? Clinical correlation is necessary.

A It does say clinical correlation is necessary

Q All right, let's talk about the clinical signs and symptoms then. When this x-ray is done in the emergency room, she is showing apparently, according to this chart, no tenderness, right?

A I'm sor , whose note are you reading fr ?

Q I'm looking at the handwritten x-ray or the handwritten emergency room chart.

A X says, 'no tenderness', correct.

Q Abdomen soft, correct?

A Soft, yes.

Q Do you agree that monitoring this patient closely was important with her situation?

A Yes.

Q Okay. Do you also agree that the x-ray has limited value in her situation...in this patient's situation?

A I'm sorry...

Q Xas ..I'll say, less value diagnostically than monitoring her clinical course?

A No, I wouldn't say that at all.

Q Would ou agree with the radiologist that the clinical correlation needs to be followed here?

A Yes.

Q All right, now let's follow then, the clinical correlation or the clinical course. Does her abdomen continue to be soft through the course of this day?

A Well she was seen by three separate physicians that day. Three separate physical exams were done on #is patient.

Q And she was seen by nurses too?

A Yes...

...Okay.. .

...But they ...I'm not sure they examined her.

Q Well, my question to you is...

A ...In fact I'm sure they didn't examine her, but the physicians who examined her, I'll read from thei notes.

Q Are you saying the nurses didn't examine her?

A I don't know that they did or not?

Q Should the nurses examine a patient like this?

A Usually not, no, most nurses don't examine patients.

Q Well let's. ..what do you mean by examine? Shouldn't the nursed be cognizant of changing signs in a patient?

A Well what do you call a physical examination? I don't know what you're referring to when you say a nurse should examine a patient.

Q Well should...are you saying that a nurse shoul not document whether an abdomen is soft or hard? That that's not something a nurse should do?

A Well, you know, in what situation?

Q In this situation.

A I would say that unless she had reason in her own opinion, to examine the patient or she had been directed to do it. It's been my experience that most nurses don't examine patients.

Q Now we're getting hung up on the word examine. I'm strictly talking about whether a patient's abdomen i tender or whether it's soft or hard. Is that something nurses can document in charts...or should document in charts, with a patient who has abdominal pain?

A Not necessariiy, no.

Q Okay, go ahead.

A You're asking a lot of a nurse to...most nurses ...are you talking about LPNs, are you talking abour RNs are you talking about nurses aids, are you talking about complete physical exam...

Q Let's get off the hypothetical, let me ask you in this case, did the nurses check this woman's abdomen?

A At what time of the day?

Q At any time of the day.

A Well I'll have to take a minute to look through all the nurses notes.

Q I'm getting to my first question, I guess we've broken it down in a bunch of ways, but is there any documentation as to whether this abdomen remained soft through the day?

A Well let me read you the notes that I have, okay. In the emergency room her abdomen was described as being soft...

Right...

...with no tenderness, although she did ask for pain medicine. On Dr, Kofol's note, at 2:30 in the afternoon, his physical examination showed that the patient was crying, he showed that the abdomen was distended with a large amount of voluntary guarding, which means, I'm not sure...do you want me to explain that, or? She had tenderness when he pressed on her abdominal cavity. Bowel sounds were present, but diminished.

Q Does he state whether the abdomen was hard or firm or soft?

A He makes no.. .he says.. .he doesn't make-my...

Q He doesn't make a notation?

A He doesn't make a notation as to whether the

abdomen is soft or hard, but he does say there is a larg amount of voluntary guarding.

Q All right. Continue on.

A There is a note from Dr. Brionus who, I believe examined the patient also, correct?...

MR. BANAS: That was earlier. ...That was earlier in the day, right. And Dr. Brionus note...so first it was the E.R. note, then it was Dr. Brionus note which showed that the abdomen was distended soft, with diffuse tenderness. So we have three differe physical exams with three different sets of findings.

END OF TAPE ONE:

Q The emergency room says, abdomen soft.

A Correct.

Q Dr. Brionus is...so we understand and the jury understands, that's the physical done at the time of admission.

A Correct, that was...

Q So leaving the emergency room and being admitted in the hospital.

A I would assume...I don't know when he did the physical exam, it may have been when she was in the emergency room...or when she was on the floor, but it would have been some time after 6 o'clock in the mornin

...All right...

...Okay, so I would guess it was sometime in the morning that he did the (VO) ...

Q And he says the abdomen is soft.

A No, he says...yes, he says it's soft, but he says that there is diffuse tenderness throughout the whole abdomen.

Q well we're going to talk about tenderness in a minute, let's talk about abdomen is soft.

A Right...

...Okay...

...yes.

Q And then, and that's when she is admitted to the hospital.

A Correct.

Q Okay, now, let's turn to the nurses notes for a moment, before we move on to your ...Dr. Kofol's examination. Do you see an indication at 9 o'clock in the morning on this subject?

A From the nurses notes you mean?

...Right..

.... MR. BANAS: I have all this pulled out so it's much simpler, unless you want to have him...

...You see, this chart as given to me doesn't have notations as to where the nurses notes are, so I have tc

look through these pages.

Q Well, I'll get it for you.

A Thank you.

MR. BANAS: It's much easier this way.

Q That's your summary Gary, just a moment let's just look at the chart directly...

MR. BANAS: It was done by the hospita ...This is not that large a chart, here we are...9 a.m. on March 9, do you see that?

A Yes.

Q What's that say with respect to her abdomen?

A It says expelling flatus, abdomen soft.

Q What's expelling flatus mean?

A She had gas from the rectum.

Q Okay. Let's look at then, at...where...does anywhere in the chart does it indicate that the abdomen is hard?

A No.

Q Nowhere in the chart?

A I don't know of any place where it says in thos specific words "abdomen is hard".

Q How about "abdomen very firm", is that that the same thing as hard?

A That's such a generic term that I can't comment on that. I never use the term "abdomen firm".

Q Okay. You use hard?

A No.

Q What do you use?

A I describe what I find, I don't describe...hard of firm.

Q When you want to say the abdomen is not soft, how do you describe it?

A How do I write a physical?

Q How do you write on that point?

A I describe whether there is guarding or no guarding, whether there is rebound tenderness or no rebound tenderness, whether there is a positive Rovsing sign or negative Rovsing sign.

Q Whether the abdomen is hard or soft?

A Those are terms that I don't use.

Q You don't use those terms?

A Correct.

Q Is the...whether the abdomen is getting hard ar more distended, isn't that a significant clinical findir

A It can be.

Q In this kind of situation, in this kind of patient who is complaining of abdominal pain, if the abdomen is becoming more distended or hard, isn't that important?

A It can be very important, yes. The problem wit

once the abdomen is very firm in that situation, the patient is almost dead. So, it is of some importance.

Q Well that's why we monitor the situation closely or the doctors try to monitor them closely, don't they? Because you're looking for this problem developing.

A If you're.. .no, you're not looking for mesenteric...in this particular instance, I don't think the physicians were looking to see if she had mesenteric vein thrombosis.

Q That's not my question...

OPERATOR: We're off the record.

OPERATOR: We're on the record, Dr. Baskies, we had a slight interruption, and we, in fact, changed locations, so that if the jury sees a different background, we've had to change rooms. Let me pick up with where we left off if I can recall. I think we were talking about the symptoms of abdomen.. . I'm going to call it for lack of a better term...softnes And I think that's how we went down the road with a line of questioning. But the central thrust to my question relates, and I'm trying to find out, isn't that a fact that that is domething you look for clinically as a clinician when you are examining a patient who has been complaining of abdominal pain and you're hospitaliz ing?

A The physician will generally look to see what the physical findings are of the abdomen and that includes what you're referring to as a soft finding or a hard finding. You used the word symptoms earlier, the softness or hardness of the abdomen isn't a symptom.

Q Is that a sign?

A It's a physical finding.

Q Okay. But in any event, it's pertinent?

A Yes.

Q And in this particular patient, would you agree that the chart showed a progressive deterioration with respect to that pertinent physical finding?

A Yes.

Q So that the diagnosis made by the radiologist in looking simply at the x-rays indicating that partial bowel obstruction could be the problem here, was that x-ray was done at a time when she was exhibiting a soft abdomen.

A That's correct.

Q Okay. And we were in agreement, I can't recall whether I asked it before on break and the changing of rooms, but we are in agreement that no other x-rays were done after that x-ray in the emergency room?

A To the best of my knowledge she had no further x-rays ordered for that day.. .or done that day.

Q All right. And you mentioned in direct examination, that the lab tests that were done, those and ordered were done/in the emergency room as well?

A Correct.

Q There were no other lab tests...follow up lab tests done at any other time during the course of her hospitalization at Massillon Community Hospital.. . correct?

A She had other tests performed, yes. What you said was not correct, she did have other things done during her time in the hospital.

Q Were there any follow up tests done on the reading for amylase levels?

A No.

Q And BUN?

A No.

a Sodium potassium, electrolytes?

A She had no further blood studies done except for blood gases.

Q Okay. And those are studies that you, on direct examination, related to us were essentially norma were done...or at least samples were taken...when she was in the emergency room per the order of the emergency room physician?

A She had numerous studies done in the emergency

room that I discussed before. Her blood sugar was elevated, but to the best of my knowledge...

Q Well those that I just indicated, the BUN, the electrolytes, the amylase, those were taken.. .that blood study was taken in the emergency room?

A Those blood studies were taken in the emergency room. Her potassium, however, as I remember was low. Her blood sugar was a little high. But I thought you said they were normal, they weren't totally normal. And her x-rays were abnormal.

Q Would you agree that this patient progressively deteriorated during the course of her stay at Massillon Community Hospital?

A Yes.

Q Would it be appropriate standard practice for a clinician to monitor this patient closely based on her history and the physical findings upon examination that were determined in the emergency room?

A Yes.

Q Other than her examination at the time of admission, would you state to the jury how many physical examinations she had, or how many examination...or how many times she was seen by a physician after 8 a.m. when she was admitted to the floor?

A To my way of thinking, she had two physical

examination performed after she was admitted to the hopsital. She had one done by.. ..

Q My question is after she's admitted onto the floor, not the examination in the emergency room. We know she was examined in the emergency room.

A Right.

Q She was admitted onto the floor. After that point in time, how many times is she seen by the doctor?

A Well again, I don't know when Dr. Brionus did his physical exam, whether it was in the emergency room or on the floor. I assume it was...he saw her...

Q Let's assume for purposes of this question that it's approximately 8 a.m. when she is admitted to the floor....or sometime prior to her admission.

A Okay. She was seen by.. .again, she was seen by Dr. Brionus, that could have been when she...after she was quote, unquote, "admitted from the emergency or before she was admitted from the emergency room", so I think she was seen twice. I think she was seen by Dr. brionus after she was admitted, and I believe she was seen by Dr. Kofol after she was admitted.

Q Why do you say that she was seen by Dr. Brionus after she was admitted? Why do you say that? Show me on the record where he saw her.. .

A Well Dr. Brionus admitted her, so he.. .

Q He admitted her subsequent to his examination, did he not?

MR. BANAS: Well I'll object, he said he doesn't know whther it was in the E.R. or on the floor. He said that two or three times.

A He may have...I don't know whether Dr. Brionus told the doctor in the emergency to admit her and then did his formal work up or whether he did the work up after she had been admitted. Do you follow me? So I have no way of knowing when Dr. Brionus did his complete physical examination. He may have seen her in the emergency room and then completed his physical exam on the floor, instead of...so she was either seen twice or she was seen once. It was either once or twice after she came out of the emergency room.

Q Did you review Dr. Brionus deposition?

A Yes I did.

Q In his deposition did he say that he did his examination of Mary Dockery at approximately 7 a.m.?

A I don't know what time he said it, I did.. .if he said he did it at 7 a.m., then that was probably before she got to the floor,

Q Well let's assume that then...

...Okay...

Let's assume then and get back to my original question. After she is admitted to the floor, how many times was she seen by a doctor...

MR. BANAS: Object, he just said once a minute ago.

A She was seen one time by Dr. Kofol.

Q Okay....in your review of the chart, did you determine that there were a number of request by the nurse for the doctor to see her?

A I'll have to refer to the nurses notes, you'll have to give me a moment here.. .

MR. BANAS: I'll object, I don't think there is anything like that in the nurses notes.

..How would. ..I don't know quite how to answer how many times the nurses called Dr. Kofol.

Q How many times did the nurses call Dr. Kofol?

A I don't know, I mean I don't have any way of knowing that. The nurses may have documented that in their notes. But if they...I'll have to go through the notes to find out how many times.. .if, in fact, they called him and if, in fact...

Q - - Are you aware as we sit here today, that they did indeed call him?

A Yes.

Q Okay, you're just not familiar with how many times?

A Yes, I didn't count up how many times they called Dr. Kofol, there's four pages of nurses notes here.

Q Does Dr. Kofol's consultation note indicate to you that there has been some progression or deterioratic of this patient?

A From the time that she was in the emergency room, is that what you're saying?...

...Right..

...Well Dr. Kofol, the first time Dr. Kofol saw the patient was at 2:30. In order for him to know whether the patient deteriorated I assume he would have spoken to the doctor in the emergency room or whatever. But he doesn't make any...I don't believe he makes any notation in his note that says that the patient has deteriorated between 4 a.m. and 2:30 p.m.

Q Does not he indicate that she appeared in the emergency room with upper abdominal pain and since that time it has progressed and developed into the lower abdomen as well? Doesn't he make that reference in his chart?

A He stated that her pain complaint was constant, altough the episodes were sometimes worse. She has

since that time, developed some pain in the lower abdomen as well.

Q Okay. And he notes as we mentioned before that the bowel sounds were present, but diminished in his physical findings.

A Correct.

Q Now, would it be your opinion that the standard of care would require that this patient be examined more frequently by the treating physicians if she was undergoing changes clinically?

A No.

Q I took your deposition about three weeks ago, is that correct?

A Correct.

Q And when I asked you a question on that subject, and I'll refer to page 29, of your deposition. I think we were talking about...let me see if I can find this. On page 29, we are discussing what you would have done in your practice if the patient had presented in a similar fashion. And you had indicated in your answer at the top of 29, Answer: "It depends on where you are in the obstructive process, this was a very early, or at least I'm led to believe that the physicians here felt that was early on in her small bowel obstruction. So in my practice I see the patient when I'm originally con-

sulted unless I have reason to believe that things are not...unless I have reason to believe that things are changing, I would examine the patient again within 24 hours.. .

MR. BANAS: Object. Go ahead and answer.

...Do you recall giving that answer?

A Yes.

Q And my question to you is in this case, in this clinical picture, is there reason to believe that things are changing?

A At a point in time during this case, things are changing, yes. But the question you asked me when.. .in this deposition was different than the question you just asked me. So, I mean, the answer to your question is, generally if things are...a physician is lead to believe that things are changing, then a physician generally will examine the patient.

Q Well my question is what you believe the standard is, and that is, is this case was the condition changing. Was this patient's condition changing?

A Yes.

Q And should she. ..should that condition been followed more closely by the doctor in your opinion?

A No.

Q Do you believe that this patient showed clinical changes in the amount of pain that she was undergoing?

A Yes.

Q It got worse as the day went on, is that...

A During the evening it got worse, yes.

Q During the afternoon it was worse as well, was it not?

A Well worse than when, worse than in the morning worse than when Dr. Kofol saw the patient?

Q Worse than when she was seen in the emergency room.

A It probably was worse, yes. I'm led to believe however you can measure pain, that probably her sensatic of pain was probably getting worse.

Q Well, let's look for a moment at the nurses notes. At four in the afternoon, just an hour and one-half after Dr. Kofol saw her, are you with me?

A Are you referring to the nurses notes?

Q Nurses notes at four in the afternoon.

A This is in military time.. .

Q Let's start at the emergency room-

A I mean the nurses notes are in military time, so 4 p.m. is 1600, okay. Okay I have where you are.

Q All right, it reads crying and sobbing with

abdominal pain. Is that correct?

A Yes.

Q Why don't you just read the rest of it there.

A "NG intact and patent of brown liquid. IV infusion in right arm without signs of redness or swelling. Abdomen distended and very firm. Sitting up at bedside, states pain meds not helping."

Q Okay. Now let's go back in time and let's go to 11:20 in the morning. This is almost five hours before that 4 o'clock inscription. And what does it say at 11:20 in the morning, which is three hours before Dr. Kofol sees her?

A "Inquiring what medicine she was given, saying it wasn't strong enough. Holding abdomen sitting between rails and getting in and out of bed, IV pulled out, IV therapy notified, IV restarted."

Q Okay, and at 10:25 in the morning, an hour even before that, they medicated her with Demerol, is that correct?

A Correct.

Q Now in the emergency room, am I correct in Dr. Brionus's notation of this patient not being in distress?

A Did he use the word "no distress" somewhere?

Q "The patient is a well-developed, fairly

nourished, thin". ..

A But not in distress, right.

Q Okay, so we would agree that based on the clinical chart, she is showing signs of progressively getting worse in terms of manifestations of pain and problems with pain, correct?

A I would be led to believe that between the time Dr. Brionus ....between the time in the emergency room an the time that Dr. Kofol saw her that she had increasing pain, yes.

Q Is restlessness also a sign or symptom that is of significance in a patient who is progressively deteriorating?

A Restlessness is *a* very nonspecific finding, or nonspecific complaint of *a* patient or an observation. Restlessness in and of itself doesn't have much meaning in this patient. I'm not sure what it meant. It may have been a reaction to the Demerol that she had. It may have been increasing abdominal pain. It may have been anything ...any number of different things. *So* I don't know what to make out of restlessness.

Q Do you believe that the nurses employed at Massillon Community Hospital, adequately and appropriate communicated all the information necessary for Dr. Kofol and Dr. Alborne to make a good clinical judgment of this

woman's condition at the times that the nurses called them?

A You know I really don't think I can make any determination as to the answer to that question. Only because I read Dr. Kofol's deposition and I've read what's in the nurses chart. It's hard to determine what was said exactly, because the nurses don't document exactly what they said during their entire conversation, it's sort of little dribs and drabs of what they told Dr. Kofol. Dr. Kofol's testimony says that he had inadequate information that made him come in himself. It's hearsay that you're asking me to comment on between what the nurse told the doctor, what the doctor told the nurse. So, I'm not sure that I can give any expert testimony as to that.. .the answer to the question.

Q What should the nurse have told the doctor based on this patient's clinical picture?

MR. REICHEL: Objection.

A I think the nurse should describe the vital signs and what her observations are.

Q Should she have told him the condition of pain the patient is in?

A Yes.

Q Did I understand you to say earlier that the

nurses should not be, or generally don't determine the softness or hardness of an abdomen in a case like this?

A It varies from nurse to nurse and, you know, I've had many patients in the hospital and rarely have ...has a nurse described a physical finding to me, I'm not sure how reliable those are, only because many nurses aren't trained to do...they're held to a different standard of care than a physician is. Their ability to do physical examination is different than mine. I'm not saying it's better or worse, but it's different. So, a nurse is...what most nurses will do under those circumstances, in my experience, will be to describe what they see, They may describe something in terms of what they can observe. But putting together actual physical findings with your hand and telling you on the phone what they're finding can sometimes be a sticky wicket, in terms of trying to determine what the meaning of that is. So what a nurse should or shouldn't do you might want to speak to what their criteria are in that particular hospital. I can't tell you what that is. I go to three or four different hospitals and I get three or four different nursing observations. I car! tell you what the doctors standard of care is, but what a nurses standard of care is is a different issue.

Q Doctor, when the doctor is not at the hospital,

and a patient is deteriorating and the nurse decides to call the doctor because of the patient's condition. What should the nurse tell the doctor?

MR. REICHED: Objection, that's been asked and answered.

A Do you want me to repeat what I just told you? Basically.. .

Q What should the nurse have told the doctor in this case?

A What her observations were regarding the patien

Q Did she do that, do you know? Did the nurses do that?

A What nurse?

Q The nurse at 5:30 when she called Dr. Alborn.

A At 5:30 in the afternoon?. . .

Right....

...That's...what time is that in miliary time?. ..

...1730...

A Okay.. .

MR. BANAS: You can tell who has and who hasn't been in the service -..Actually I was in the Navy, but it was a long time ago, I'm too old for that. "Notified", it says, "doctor Alborn called, notified of status of pain".

Q All right. You've told us what the chart says,

shauld the nurse have related anything more than that in your opinion?

A No.

Q How about at 5:45 when the nurse calls Dr. Kofol? Same answer?

A Dr. Kofol...do you want me to read what it says

Q If you would please.

A "Dr. Kofol notified of status of pain. Orders obtained". I don't know basically what status of pain means. Does that mean that she told him that the pain is colicky, did she tell him that...nurses notes are not like physicians notes, they are usually very terse.

Q I understand doctor, but at 4 o'clock let's go right above...at 4 o'clock, a nurse is saying that this patient's abdomen is distended and very firm, isn't that written at 4 o'clock?

A Yes, that's what she wrote.

Q Now assuming that the abdomen remains distended and very firm, an hour and one-half later at 5:30, should that have been reported to Dr. Alborn?

A You want me to assume that her abdomen remained firm, is that what you're saying? Because I don't know if it did or not. It doesn't say anything about that in the nurses.. ..

Q Well what do you think, do you think it got

soft and went back.

A Well we have three different physical findings in the morning all of which were....(VO).

Q Well what do you think at this time, do you think at 5:30 it went down and became soft?

A Well the patient had been medicated with Demerol, so at that point in time it's hard to tell whether the physical findings were getting worse or not.

Q do you think at 5:30 her abdomen got soft and went back down?

A probably not.

Q Okay, so then if, let's assume then, that if it did not go back down and get soft and remained distended and very firm as noted at 4 o'clock, should the nurse have reported that to the doctor?

MR. REICHEL: Objection.

A I don't know that I, I don't know what you're asking of this particular nurse. Most nurses wouldn't reexamine the abdomenm most nurses wouldn't examine the abdomen to begin with. I think she thought the patient was having pain. I mean you're asking me to put myself in the position of a nurse, I'm not a nurse. So again, if you want to know what the nurse thought and what she did, the best person to ask would be the nurse. But...

Q Well you agree, don't you doctor...

A ...Let me finish the answer to my question. She told the doctor that the patient was having pain. Her communcation with Dr. Alborn at that time...what ever else she said, I don't know that the nurse...this is also, I believe an LPN, who's doing this, has less training than an R.N. and a different standard of care than an R.N. as far as I'm concerned. And I can't, I'm not an expert in telling you what an R.N. should or what an LPN should or shouldn't do, so I'd rather not get into what she should or shouldn't do. It's just not my level of expertise to tell you what a nurse should or shouldn't do.

Q Should a nurse call a doctor...

...*Yes*...

...if she feels thatthere is something going wrong with the patient?

A Yes, she should call the doctor to tell if there is something wrong with the patient.,.

...Okay. ..

...But you're asking the nurse to do a complete physical assessment on the patient, some of them don't know how to do that.

Q No, that's not my question.. .my question is simply this. Should she have communicated what was goin on in terms of the distention of this abdomen and its

hardness.

MR. **REICHEL:** Objection, there's no evidence in the record what the condition of the abdomen was at that time.

MR. BANAS: Objection, if you can answer the question, answer it.

A Well nurses notes, it's been my 15 years of experience, are very terse. She may well have had an opinion as to what was going on. She does...this note just says she called the doctor, she notified the doctor of the status of pain. So, I don't know what she told the doctor and there is no way of knowing that much.

Q My question is, should...regardless of what was said, do you believe she should have communicated that if she was aware of it and if it was present?

A I'm sorry, she should have communicated what?

Q That the abdomen was distended and very firm. Is that something that should have been communicated to the doctor...

MR. **REICHEL:** Objection.

...If it was present at 5:30.

A It's very hard to say what she should have told the doctor or what she did tell the doctor. I

this is an appropriate note from an LPN or from any nurse that she called the doctor and she told him what the status of pain was.

Q All right, let's assume that Dr. Kofol's deposition testimony is accurate and he wasn't given this information. Do you believe he should have been given the information?

A I'm sorry, what information?

Q That the abdomen is distended and very firm

MR. BANAS: Assuming that's the case.

Assuming that's the case at 5:30?

A He probably should have been told what she observed. Now she may not have observed that. In her opinion, it may have changed. I have no way of knowing that. She should have told him what she observed at the time.

Q Well is the nurse whose noting at 5:30 and 5:45 these calls to Dr. Alborn and Dr. Kofol, in fact, the very same nurse that's making the notation at 4 o'clock, "abdomen distended and very firm", does that appear to you to be the same signature; Powell?

A Yeah I believe it is, yes.

Q All right. So let's assume that she has noted that, noticed it. Should she communicate it to the

doctor?

A Probably should tell him what she thinks is going on with the patient, yes. If that's an observatio that she made, she should tell. him that. She should tell him any observations that she has.

Q Is there any indication in the calls to Dr. Alborn at 5:30 and the call to Dr. Kofol at 5:45 that vital signs were taken and communicated to either doctor

A There is no mention made either of those two time slots that the nurse told the doctor what the vital signs were.

Q Are you aware as to whether or not Mary Dockery mother wanted to talk to the doctors to request them to come in and examine and look at her daughter?

A I'm not sure whether she asked that or not. There is reference made to that in the deposition given by Dr. Kofol, but Dr. Kofol denied knowing that the moth had asked that he come in. That's to the best of my knowledge. There may be something in the nurses notes, is that what you're referring to?

Q I'm just referring to generally, if you were aware that Mrs. Dockery, Mary Dockery's mother, requeste that the doctor come in to see her daughter,

A I'm not aware that that's a fact in this case.

Q Have you studied the nurses notes in this chart

A I've gone over the nurses notes, yes.

Q Are you convinced that this patient went through a significant amount of pain after, or during... progressive amount of pain over the course of the day that she was in this hospital?

A I would say that her pain progressed over the time she was in the hospital.

Q When is the first time that the vital signs are communicated to the doctor of this patient after she is admitted to the floor?

A The...I don't know when the first time they told the doctor what the vital signs were only because the nurses notes do not reflect that. That doesn't necessarily mean that she didn't tell the doctor what the vital signs were, but it's just the...the place where the nurses writes her notes up is called pertinent information. I don't know whether that's pertinent to the patient, pertinent to her or pertinent to the doctor or pertinent to all three of them. So she may have told the doctor what the vital signs were, she may not have. She may have told him and not documented that she told him. But the fact that she didn't document it, doesn't mean that she didn't tell him. The fact is, is that she doesn't mention...there's no mention...there's very few mentions made here as to whether or not she told the doctor.

Q Well that's the purpose of the chart though, to document what is going on, isn't it doctor?

A The purpose of the chart is to document what's going on with the patient, yes.

Q Absolutely, and if you're a doctor and you want to find out what's going on with this patient, you'll read the chart.

A And speak to the nurses, yes.. .

And speak to the nurses.. ..

...And examine the patient. All those three things should be done, but again, you're looking at the nurses notes as if ...

Q Oh, I'm not looking at the nurses...I'm looking at the chart. And I'm asking you when the nurses communicated the vital signs to the doctor.. .

MR. BANAS: Object, he already answered.

...Do you see an inscription of the vital signs at midnight. ..in the nurses notes?

A Midnight is what time?. ..

...2400 ...

...2400, there is a mention made of the vital signs, yes

Q All right. And the vital signs, of course, as far as pulse, blood pressure, particularly blood pressure pretty ominous, isn't it?

A Yes her blood pressure was low at that point.

Q Do you see in the nurses notes any other communication, or at least charting of the vital signs of this patient prior to midnight?

A Yes, there's a number of ...see, you're looking in the wrong place for the vital signs I believe.

Q No, I'm going to get to that, but my question is the nurses notes, first of all.

A Well we have here, where they documented her blood pressure.

Q I know, I'm leading up to another question... ...Okay... ...Do you see it in the nurses notes?

A I believe that's the only place in the nurses notes where they wrote down the blood pressure, right.

Q Now, do you see anywhere in the nurses notes where the documentation that you've referred to just in the previous question where it's recorded...the vital signs are recorded elsewhere in the chart, where it was communicated to the doctor? Dr. Alborn or Dr. Kofol?

A No.

Q Now, let's change subjects for a moment, Dr. Baskies. On your direct examination you indicated that this patient presented in the emergency room with symptoms of vomiting, nausea, abdominal pain, correct?

A Correct.

Q Would you agree that these are generally symptoms of many abdominal problems?

A Yes.

Q And, so that the jury understands the expressio differential diagnosis, what is, just in layman's terms, if you could explain what the term differential diagnosi means.

A The term differential diagnosis refers to the thought process really of the physicians who are seeing the patient. When a person comes in with a whole assortment of different symptoms, the physician has to order in his mind what the most likely diagnosis is and the least likely diagnosis is. And so the differential diagnosis is a way of formulation a game plan in terms of what the thinking is in that particular case. So the first diagnosis in the differential diagnosis would be the most likely diagnosis. And then less likely, less likely, less likely, less likely to least likely.. .

...Okay.. .

...So the differential diagnosis is just a list of different diagnoses that could fit the picture that you're seeing.

Q All right. You indicated on direct examination you talked about mesenteric venous thrombosis and that

it's a rare phenomenon-

A Yes.

Q Isn't it a fact though, Dr. Baskies, that is indeed the concern of the clinical doctor if he believes the patient is suffering from small bowel obstruction that it can lead to small bowel infarction?

A If the patient has small bowel obstruction, it can lead to small bowel infarction, but not usually from mesenteric vein thrombosis. It's usually from a twisting of the bowel.

Q But the end result is the infarction of the small bowel?

A Usually a small area of the small bowel, a small area, not usually the entire small bowel.

Q But that is the concern of the physician.

A That is a concern, yes.

Q And it is not uncommon that when the small bowel obstruction, or a diagnosis of small bowel obstruction progresses, that that is the difficulty you run into?

A Correct.

Q Are you aware that a pathologist retained by the-hospital to look at this chart has found that it was not small bowel...or venous thrombosis, but an arterial thrombosis, mesenteric arterial thrombosis?

A There is a report from a outside pathologist who reviewed, I believe, just 12 slides that he wrote in the note that the patient had mesenteric arterial thrombosis.

Q *yes,* which is the opposite of what you had indicated, mesenteric venous thrombosis.

A It's a...yes, it's a different diagnosis.

Q And that opinion on his behalf, on his part, was in part at least, prior to reviewing the slides that you reviewed?

A Correct. I came to just the opposite conclusion, however, after looking at the slides, I believe the patient.. .and going over the chart, that the patient had mesenteric vein thrombosis. I agree with the corone report.

Q You accept that different physicians can render, in their own medical judgment, different opinions OR the same issue?

A Correct.

Q You indicated, Dr. Baskies, that I think you touched on the subject of the mortality rate of mesenter venous thrombosis.

A Correct.

Q And I think you said it's darn near 100% mortality?

A No, what I'm trying to say is if you have an infarction of the entire small bowel that that's pretty close to being 100%.

Q And that's the case when you have venous thrombosis ...mesenteric venous thrombosis.

A When you see a patient with complete mesenteric venous thrombosis that is the case, yes.

Q I have read some literature on the subject since we talked that last time and I've made a copy and I'd like you to review it and see if you agree with the statement. It reads, "overall the mortality" if you could read that underlined on the bottom.

A Excuse me, where is this from?

Q Well I don't have the face page, I made a copy of the pertinent sections if you'd turn to the first page you'll see that it deals with, what's that title there?

A It says Syndromes Resulting from Vascular Occlusion.

Q Okay.

MR. BANAS: Where does this come from?

A That's what I don't know.

Q I don't have the title of the book and I can get it. It's ...I made a copy of it and...

A And what do you want me to do with this?

Q The part I have underlined here reviews ...and you can check it for my understanding, but reviews the mortality for patients with mesenteric venous thrombosis as opposed to mesenteric arterial thrombosis. And the statement here states overall the mortality for patients operated on with venous thrombosis is 21% in contrast to about a 66% mortality for patients with arterial thrombosis. My first question to you doctor, did I read that accurately?

A You read that accurately.

Q My second question to you is, do you disagree with the statement that I just made or read from that literature?

A Yes I do.

Q Okay. Now, with respect to mesenteric venous thrombosis, Dr Baskies, do you agree that it's a slower process than mesenteric arterial thrombosis?

A You'll have to be a little more complete when you say slower process.

Q Slower in the process of debilitating the small intestines?

A The. ..what do you mean by debilitating? I'm just trying to be specific. Are you talking about slow in terms of presenting with symptoms, slow in terms of

the pathological findings that you see. There are changes in mesenteric vein thrombosis that occur within ten minutes of the vein being obstructed. The layers of the bowel start to get edematous, the layers start to separate and the process progresses at a variable rate from one patient to another. Mesenteric arterial occlusion is a different entity, but...and it presents in a different way.

Q Is it the, as far as the patient is concern, in striking the patient down, or just debilitating the small intestines a more sudden event because it occludes the entire mesentery artery?

A Mesenteric arterial occlusion is a much more sudden event, yes.

Q Okay. Could we go off the record one moment.

OPERATOR: We're off the record.

OPERATOR: We're on the record.

...Dr. Baskies, I just have a few more questions for yoc and I appreciate your patience. Number one, are you critical of...in any way, of the prescription of Demerol for this patient over the course of the day, or course of her hospitalization?

A Would you define what you mean by critical a little further?

Q Would you have given this patient Demerol?

A I probably.. .I don't think I probably would have given her Demerol.

Q Demerol masks symptoms, doesn't it, it has that effect?

A It can mask symptoms, yes.

Q Do you have an opinion or are you critical in any respect, Dr. Baskies, of the hospitals care of this patient, and I should define that further? The nurses efforts in communicating to the doctors, Dr. Alborn and Dr. Kofol, this patient's course after Dr. Kofol saw her at 2:30 p.m.?

A From what I've seen in the chart, I'm not critical on the nurses only because I don't think anything that could have or would have been done after the patient would have made any difference to the outcome in this particular case, as I stated before. I think the nurses.. .the nurses I think treated a patient who was having abdominal pain and I think they think they did the right thing.

Q Well that's ...I'm not sure you're answering my question. Let's talk ...we'll talk about. There will be plenty of testimony over whether or not this patient would have survived and so forth and so on...

MR. BANAS: Move to strike.

...I want to ask you whether or not you feel the nurses

appropriately communicated in your opinion, all of the information that was manifest to them after Dr. Kofol saw the patient at 2:30 p.m.?

MR. REICHEL: Objection, asked and answered.

Q I think I went over this material earlier in the deposition. As far as I can tell the nurses reporte what they saw, what they felt they needed to report to the doctor. There is a list of things that the nurses at various times called the doctor about. And I don't think that those nuses notes are as complete as they may be or as they could have been because they're not designed to be anymore complete. All I can say is is from what I see, I think the nurses reported what they observed to the physicians and I really can't comment any further. What I see there is adequate reporting to the physician.

Q Except for the...I think you earlier said the nurse who noted at 4 p.m. a distended and very firm abdomen. If she didn't report it at 5:30 and if the abdomen remained distended and very firm, I think you indicated that probably should have been communicated.

A That particular point, if she noted it, probably should have been communicated. I don't know that it wasn't communicated only because the nurses

notes are. If a nurse stopped to write down every singl thing that she observed or that she told the physician during a phone call, she would never get to see her patients. She would just be writing all.evening.

Q I understand that doctor, but you were the one in your answer referring to the nurses notes, I'm not referring to the nurses notes. Let's go to Dr. Kofol's deposition where it says "I was not.. .I wasn't given that information", let's assume that hypothetically that is his position...

A Okay.

Q Would you be critical of the nurses for not giving him the information?

A I'd like the nurse to give me whatever information she thought was important in any particular point in time. And if she didn't give me the information that she thought was important, then I would be critical of the nurse, yes.

Q Okay. And is the distention and very firm abdomen information that is important?

A Yes.

Q Okay. And do you feel that it's all the responsibility of the nurse or do you feel that a doctor, who is aware of a patient and has seen the patient himself. And who gets a call once, or twice or

three times in the course of an evening about the patien relating to pain. That there is some responsibility on the part of the physician to ask questions about, you know, nurse Powell, for instance, nurse Powell, what is the situation with her abdomen, can you tell me? Is there any responsibility on the physician to inquire on those subjects, in your opinion, if the physician obviously is not at the hospital?

A Well the...that's such a general question I car only answer it in this way. I would.. .if a nurse calls me with the description of the patient, I listen. If I have any reason to believe from what she's told me and how she's told me it. A nurse can say, for instance, this patient's abdomen is rigid and firm, or she might so, you know the abdomen is rigid, it's firm, but I don't make much out of it. An abdomen.. .abdominal examination.. .you know, studies have been done comparinc physician examining a patient and a nurse examining a patient, they can be totally different, very often. In fact, physician to physician physical examinations vary. So, going just by what's written in the chart really...you really have to get the flavor of how the nurse described the thing to the physician or a partica finding to the physician. But, I don't think you can make a general statement, in my expert opinion, as to

what a physician should ask and what he shouldn't ask in a particular instance. I think if the nurse noted something and it was of importance to her, then she is under an obligation to tell the physician what she's found. I don't think I can answer the question any more completely than that.

That's all the questions I have for you at this time Dr. Baskies, thank you.

DURING CROSS EXAMINATION BY MR. RICHARD REICHEL:

Q Doctor, my name is Richard Reichel, we've met previously and as you know, I'm the attorney for Massillon Community Hospital in this case,

MR. HART: Excuse me Dick, let me interrupt you for a minute, and let me put on the record here, note my objection. There has been some discussion at the pretrial of this case that there is a conflict interest between the various defendants. And as I understand it the defense attorneys were going to consult with their client and insurance companies and see if there is any objection to that proceeding since they are now

members of the same firm. As I understand it, they have decided that there is not a conflict, or at least that there is a unity of interest in this case and they are going to present their defense in such a fashion. That being the case, I am objecting to any cross examination or enquiry by attorney Reichel on behalf of the hospital, because I think the.. .and has a right to cross examine the doctor as a witness on behalf of both parties who have a unity of intere

..Doctor, at various times Mr. Hart asked you about pertinent findings in Mary Dockery. And my question would be, when a person has a fatal illness, as compared with a patient who has an illness that if it's properly treated, will recover. Can those findings with the patient that can be treated, the findings might be pertinent, whereas with the patient that has the terminal illness, those findings are really not pertinen

A In dealing with a fatal illness which, parenthetically, I think this patient had. Physical findings, I'm not sure what...for instance, let's take a

different example. Let's say a patient has...you know has complete mesenteric infarction from the ligament of Trietz, which is the beginning of the small intestine, all the way around to the large intestine. That to me is a fatal illness. To me, it doesn't matter what findings you have, that patient is going to die. There is just not anything that modern medicine can do to prevent that from happening, especially in a person who is diabetic, which this patient was. So, the pertinent findings, the clinical pertinent findings, whether the abdomen was rigid or whether it was soft, whether the blood pressure was 100, whether it was 80, this woman had a fatal illness, it's like being hit by a train. This woman was going to die, I feel, unfortunately and tragically based on her disease process, not on what these physicians did or didn't do. Therefore, whatever physical findings they had, unfortunately, doesn't matter, that's the whole point here. In my opinion, it doesn't matter whether her abdomen was soft or hard, whether there were bowel sounds or no bowel sounds. This woman was destined to die from her disease. It's unfortunately a fact in this particular instance. So whether the nurse noted that her abdomen was soft, whether it was hard, whether her blood pressure was 80, whether it was 120 or whether it was 60. At 8 o'clock

or 9 o'clock or 10 o'clock that night, she was going to pass away, unfortunately, from her disease process.

Q Therefore doctor, do you believe that any of the nurses or LPNs in this case did anything that contributed tu the proximate cause of Mary Dockery's death?

MR. HART: Objection.

A Can I answer that question...despite the objection?. ..

...Yes...

...I don't think the physicians or the nurses, LPNs, RNs, technicians, administrators at this hospital, could have impacted on what was going to happen with this patient.

Thank you doctor that's all the questions I have.

OPERATOR: We're off the record.

END OF TAPE TWO.

OPERATOR: We're on the record.

DURING REDIRECT EXAMINATION BY MR. GARY BANAS:'

Q Doctor, just three or four questions. First of all, does the increase in pain along the way as noted in the nurses notes in any way point to the fact that this patient had a small bowel infarction or this mesenteric venous thrombosis? Again, would that show, to a reasonably prudent doctor, that's what was going on

as opposed to a small bowel obstruction?

A No, not necessarily, it could...the progression in pain could be secondary to a ruptured appendix, it could be...her pain complaints could be secondary to a number of different things.

Q Well, is there anything in that increase in pain which would lead a reasonably prudent surgeon to say, "Ah ha we now have necrosis of the small bowel?"

A Not necessarily, no.

Q Secondly, is the fact that Demerol was given, is that below the standard of care?

A That's a very interesting question, I would say that I wouldn't have given the patient Demerol during her hospitalization. Was it below the standard of care, no it isn't, for the simple...in other words is that what a prudent physician would do?

...Yes...

...I don't think a prudent physician would give her Demerol. Is it below the standard of care? No, only because I don't believe that the patient was going to survive her disease and giving her Demerol probably helped her in some way only because she had less pain while she was dying from her...

MR. HART: Objection.

...imminently tragic and fatal illness.

MR. HART: Objection.

Q one other question, and I think the questions of Mr. Hart may suggest this, and I...It has been your opinion that the patient's mesenteric venous thrombosis started back at the time prior to her admission to the emergency room. That is when she first noted pain, sometime immediately or sometime prior to her admission to the E.R., has that been your testimony?

A That's been my testimony.

Q All right, now, let's assume, and I think maybe Mr. Hart is hinting at this, but let's check it out. Let's assume that she has a small bowel obstructio when she comes in. Do you have an opinion, as to whether or not, while she is in the hospital, she then developed a mesenteric venous thrombosis after admission as opposed to starting back prior to her admission to the hospital?

A Well the, again, let me get back to this. I don't believe this patient.. .this patient didn't have small bowel obstruction. She had mesenteric venous occlusion...

...All right.. .

...I believe she had mesenteric venous occlusion when she woke up in the morning and I believe that's also what Dr. Carrari testified to also.

MR. HART: Objection.

She had no symptoms.. .no findings consistent with the disease she had and, unfortunately, had no laboratory tests consistent with her disease process. And so the physicians were led to believe, based on the physical exam and on the basis of the tests that were performed, that she had garden variety early small bowel obstructio Which generally gets better by just putting a naso-gastric tube in and putting an IV in. The unfortunate part of mesenteric venous occlusion then, and what I tried to answer before with the other gentleman's questions, was that this disease is an insidious disease The reason people die from it is that physicians generally don't make the diagnosis early enough to be able to impact on it. Experimental studies have shown that unless something is done within two hours of the time that mesenteric venous occlusion occurs, that prognosis is impacted. So, she woke up in the early hours of the morning and had come in with a sign saying I have mesenteric venous occlusion, that to me is the only way I would have been able to make this diagnosis.

Q You have in front of you the article, we don't know where it's from, or perhaps part of a book, chapter of a book. And you were asked a question about survivability from both venous and arterial mesenteric

thrombosis. Do you have any comment, first of all, the article in general, or part of the chapter. And secondly, as to that specific reference to survivability of surgery after either arterial or venous mesenteric thrombosis?

A Well, I believe it's a little unfair for me to comment on this. First of all I don't know the year that this chapter was published, I don't know the book that it came from, I don't know the author of the book, it's not listed here, nor is it listed as to who wrote this particular chapter or section. This section could have been written by a senior resident who had nothing better to do and was published under the name of his chief of surgery. I don't know, I'm not impuning the integrity of the author, the book, this is a very generic article, it unfortunately I wouldn't use this as a reference to try to answer any of the question in this case.

Q Why?

A The...first of all, it starts out it's saying Syndromes Resulting From Vascular Occlusion and what they are really talking about at the beginning of this is-mesentery artery occlusion, which she didn't have. She had mesenteric venous occlusion in my opinion and in the opinion, I believe, the coroner who did the post-

mortem examination. It then goes on to talk generically about a number of different ways to work up the arterial occlusion. And then suddenly jumps into a discussion of mesenteric venous thrombosis. It says, and I'll quote from the article. "Overall the mortality for patients operated on with venous thrombosis is 21%". Well, what does overall mean? Are they talking overall in patients who are operated on within an hour of making the diagnosis, are they talking overall about patients all comers. I'm not really interested in all comers when I'm talking about Mary Dockery who's 32-year old with this particular problem. I'm interested in a 32-year-old person with mesenteric venous thrombosis. This could include patients who had a history of...a prior history of mesenteric venous occlusion, and so when they come in, you knew that they had it again...

...All right...

...So, I wouldn't recommend anybody using this particular chapter as a reference to make a particular point. Because it's just...unfortunately this reference...my critique of this reference is it's probably pretty good for giving information to a lay person or to a medical student, but not very good in terms of educating a surgical resident or an attending.

Q One last question. Having heard all of the

questions that Mr. Hart has asked you. D you have an opinion based upon reasonable medical probability, whether anything Drs. Kofol or Alborn did that fell below the standard of care that proximally caused Miss Dockery's demise. First of all sir, do you have an opinion?

A Yes.

Q And your opinion is?

MR. HART: Objection.

A My opinion regarding Mary Dockery's ...the facts surrounding this case is that neither Dr. Alborn or Dr. Kofol, the internist and the surgeon involved in thi particular case, nor the nurses in the hospital are responsible for this poor woman's demise.

Thank you very much.

DURING RECROSS BY MR. PAT HART:

Q Just two questions, Dr. Baskies, you'v referred to the mesenteric venous thrombosis as a disease process in this woman's small intestine, correct

A Correct.

Q All right. Just so we understand, you don't believe that she was suffering from this 48 hours before she came to the emergency room, correct?

A Forty-eight hours?. ..

Forty-eight hours.. .

...No, I believe her process started when she woke up ...the morning that she came to the emergency room with the pain.

Q That's when you believe it all started with her

A Yes.

Q The mesenteric venous thrombosis?

A Yes.

Q Not 9 o'clock in the morning when she's in the hospital or 11 in the morning when she's in the hospital or 24 hours before she comes to the hospital, It's when she wakes up?

A I believe what awakened this patient from sleep was abdominal pain secondary to her mesenteric venous thrombosis.

Q All right. And that is from what you based you opinion that this patient couldn't be saved, because that's when you believe the mesenteric venous thrombosis began.

A I believe her mesenteric venous thrombosis started when she awoke from sleep, correct,

Q And, we know she woke from sleep from abdominal pain, she gave that in her history.

A Right.

Q You believe that abdominal pain was secondary to mesenteric venous thrombosis?

A Yes.

Q As opposed to one of the many other types of problems that she could have had?

A Correct.

Q All right. That's all I have for you. Thank you Dr. Baskies.

OPERATOR: We're off the record.

STATE OF OHIO)
) SS:
STARK COUNTY)

IN THE COURT OF COMMON PLEAS

NATHAN DOCKERY,

PLAINTIFF,

VS.

MASSILLON COMMUNITY HOSPITAL,

DEFENDANT.

CASE NO. CV-89-1305
VIDEOTAPE DEPOSITION

OF

ARNOLD M. BASKIES, M.D.

JUPGE

C E R T I F I C A T I O N

I Fred Palcho, a Notary Public within and for the State of Ohio, do hereby certify that the within named witness, Dr. Arnold M. Baskies, was by me first duly sworn to testify ta the truth, the whole truth, and nothing but the truth in the cause aforesaid.

for or related to any of the parties involved in this action nor am I interested in the outcome of this matter. Also, I am an independent videotape reporter, employed on an as needed basis and not in the employ on a regular or full time basis of any of the parties involved in the aforesaid litigation-

IN WITNESS WHEREOF, I have hereunto set my hand

My Commission Expires:
February 4, 1993.

Fred Palcho, Notary Public and
Videotape Reporter

MULTI VIDEO