DOC 74

The State of Chio)
Cuyahoga County)
IN THE COURT OF COMMON PLEAS

ESTATE OF MARY BROWN,
ADMIN. RAY BROWN, ET AL.

Plaintiff,

vs. Case #

BOOTH MEMORIAL HOSPITAL,
Y.S. HAHN, M.D., ET AL.

Defendant.

Deposition of THOMAS BRALLIAR a witness taken before ANCRE JANIK Motary Public within and for the State of Chio in this cause **on** WEDNESDAY the 26th day APRIL 1989 at 1100 HUNTINGTON ELDG., Cuyahoga County, **Ohio** at 2:11 p.m. Pursuant to **notice** sent to counsel, this **deposition** was tape recorded by Legal **Electronic** Recording, Inc.

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APPEARANCES

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For the **Plaintiff**

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1100 HUNTINGTON BLDG.
Cleveland, Ohio
For the Defendant

THOMAS H. ALLISON, ESQ.
1100 HUNTINGTON BLDG.
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Fur the **Defendant**

ROBERT BUCK, JR. ESQ.
THE LEADER BLDG.
Cleveland, Ohio
For **Bcoth** Memorial

P-R-O-C-E-E-D-I-N-G-S

Dr. Thomas B. Bralliar, of lawful age, a witness herein having first been duly sworn as hereinafter certified, deposes and says as follows:

DEPOSITION OF DR. THOMAS B. BRALLIAR

BY MR. GOLDENSE.

Q For the record, Doctor, would you state your full name and spell your last name, please?

A Thomas B. Bralliar, B-R-A-L-L-I-A-R.

BY MR. GOLDENSE: Dr. Bralliar, my name is David Goldense. We met just briefly a minute ago. As you may or may not know, I represent the estate of Mary Brown, in connection with a medical malpractice claim filed against Dr. Young Hahn, and other parties arising out of some care that Mary Brown received at Booth Memorial Hospital in May of 1985. I'm going to ask you a series of questions today, about anything that I think is relevant in representing my client's interests. If during the course of my questioning, I ask a question that you don't understand because of the way I

phrased it, I want you to stop me, and have me rephrase anything I ask, okay?

BY DR. BRALLIAR: That's fine.

BY MR. GOLDENSE: Make sure that you understand every question that you answer, okay?

BY DR. BRALLIAR: That's fine.

BY MR. GOLDENSE: And also, you're verbalizing your answers, you know that we're recording this deposition. The only way a transcriptionist can somewhere down the road reduce this to writing is if you verbalize all your answers. So you make sure that you answer them all out loud, okay?

BY DR. BRALLIAR: That's fine.

Q For the record, Doctor, your attorney has handed me your curricuium vitae. Have you had a chance to review this CV?

A *Yes,* I have.

Q Is this current?

A Yes, it is.

Q It appears to ne that you have been at the Cleveland Clinic since 1987, is that right?

4 That's right.

Q And you're a staff anesthesiologist there, ccrrect?

A Yes.

Q And it appears that you spent about fifteen (15) years at Huron Road Hospital, where you served as a staff anesthesiologist, prior to taking your appointment at the Cleveland Clinic, Is that correct?

A Yes, that's right.

Q Then you served on a number of committees during your tenure at Huron Road Hospital, is tnat correct?

A Yes, it is.

Q One of the things I sometimes see on curriculum vitaes is publications. Have you published in tne field of anesthesiology that might not be reflected here cn your CV, Doctor?

A NO.

Q Have you ever been deposed before?

A Yes.

Q Approximately how many times have you had your deposition taken?

A Three times.

Q Were any of those three occasions where you were named party to a litigation?

A Yes.

Q How many of those three depositions involved you as a named party?

A One.

Q Tell me, was that case here in Cuyahoga County?

A Yes, it was.

Q Do you remember the name of the case?

A I believe so.

Q What is the name of the case?

A Hanratty was the last name.

Q Of the plaintiff?

A Of the plaintiff.

Q Like H-A-N-R-A-T-T-Y?

A H-A-N-R-A-T-T-Y, as I recall.

Q You indicated that you have been deposed three times. Can you tell me about the other two depositions where you gave testimony? Was either one of those depositions as an expert witness?

A Yes.

Q Which or both of those depositions was as an expert?

A Just one.

Q Tell me about your deposition as an expert.

A What would you like to know?

Q Were you retained by the plaintiff or the defendant?

A Defendant.

Q Who was the defendant in the case?

A I don't recall the name.

Q Do you remember which facility the defendant was providing medical care at?

BY MR. LICATA: Do you mean hospital?

A A hospital in Akron.

Q Who was the defense attorney who retained you in that case, if you recall?

A Cecrge Gore.

Q Cecrge Gore?

A Yes, sir.

Q *Is* he an Akron attorney?

A no, sir.

Q Where are Mr. Gore's offices?

A Cleveland, Arter and Hadden.

Q How long ago was that, Doctor, do you recall?

A A year, year and a half.

Q Do you remember anything about the merits of the case, this case that you testified for Mr. Gore? The merits, what the case was about?

A A bit.

Q Why don't you cell me what you recall with respect to the substance of the case?

BY MR. LICATA: I'm going to object. Can you be more specific? I mean the claims, the facts, the issues.

Q Do you remember the facts of the case?

A A few.

Q Tell me what facts of the case you remember.

A The defendant was innocent.

Q That's a conclusicn. How about a fact?

A That was a fact,

Q Fine. Did it go to trial?

A Yes, sir.

Q There was a verdict?

A Yes, sir,

Q Very good. What was the plaintiff's claim of malpractice in that case, if you recall?

A TMJ.

Q In what field of medicine--strike that.

Were you called to testify as an anesthesiologist?

A Yes.

Q *Was* there surgery in the case?

A Yes.

Q What was the operative procedure that the plaintiff in that case underwent?

A I don't recall,

Q But the plaintiff had a claim of a temporal mandibular joint injury, as a result of malpractice?

A That was a claim.

Q That was the claim, all right. Have you ever:

reviewed, for purposes of expert testimony, a claim of an esophageal intubaticn, prior to this case?

A No.

Q You indicated you have been deposed three times. @ne time was where you were a party to an action, and that was the Hanratty case here in Cuyahoga County, correct?

A Right.

Q You just taiked about the case where you testified for George Gore of this law firm, Arter and Hadden, where we are today, and that was a verdict about eighteen (18) months ago, is that correct?

BY MR. LICATA: Objection.

(... hat correct?

BY MR. LICATA: You can answer the question. I don't want to quibble with the characterization of your question.

EY MR. GOLDENSE: Does George Gore work at Arter and Hadden?

BY MR. LICATA: Yes, he does. But testifying for George Gore in anything, it's fine. You can answer the question if you did provide testimony in that case.

A I testified in that case.

Q And there was a third deposition?

A Yes.

Q Can you tell me, was that a claim that arose out of medical malpractice?

A No.

Q What was the nature of ycur deposition testimony in the third case?

A As respondent to a traffic accident.

Q So, tne motor vehicle accident had nothing to Go with a medical claim as we define it here in Ohio, as a claim arising out of malpractice in the care, management or treatment of a patient, is that correct, in your third deposition?

A No.

BY MR. GOLDENSE: I neglected to give you my business care. We nave moved our address by the way. We are now 920 Terminal Tower.

Q So, your bill for testifying today in that I have requested your deposition testimony, should be sent to me at that address. What hourly rate will you charge my client for the testimony that you will provide today?

A I'm not sure.

Q Who determines chat?

A The Cleveland Clinic.

Q Who at the Cleveland Clinic determines what you charge?

A I don't know.

Q Can you provide me with any assistance whatsoever with respect to what the cost of this deposition, in terms of your appearance will be for my client?

BY MR. LICATA: Let me interject here, the Clinic has a set policy concerning the deposition of any of their doctors. And that is, I think fixed by the legal department there, but I'm not sure. I believe it's about three hundred and fifty dollars ($350.00) per hour, but again, I'm not sure, I wasn't aware of the fact that Dr. Eralliar didn't know what the rate was per hour, and so I didn't check into it for you. I can do that after the deposition. It's no problem. But it's a fixed fee for all their physicians who testify. And that fee is something that's paid basically to the Clinic.

BY MR. BUCK: I videoed an expert over there one time, finished, and said, will you send me your bill, and he said, I

don't testify for money and walked out the door. Go ahead.

BY MR. GOLDENSE: How about a name and address?

BY MR. BUCK: No way.

Q So Dr. Bralliar, your attorney has indicated that the hourly rate will be approximately three hundred and fifty dollars ($350.00). Do you know how many hours of time, other than what we actually spend here this afternoon, you will charge my client for your deposition testimony today, in terms of units of time?

A No, I don't.

Q Did you spend any time preparing your testimony for which my client will be charged at whatever your hourly rate is?

A I don't know.

Q You don't know if you spent any time preparing for this deposition?

BY MR. LICATA: No, I think he doesn't know whether that's going to be charged to your client. Off the record. I mean it can be on the record, but I don't see why it should be.

(OFF THE RECORD)

Q Doctor, what is your current residence address?

A 22089 Shaker Boulevard.

Q What city is that?

A Shaker Heights, 44122.

Q How were you contacted to testify in this case, do you recall?

A As memory serves, Mr. Allison called me.

Q Do you know how Mr. Allison got your name?

A No.

Q That was not disclosed to you at the time of your telephone conversation with him?

A I don't recall.

Q Are you a member of, or a listed member of any expert referral services that are published in various manners in these United States?

A No.

Q Do you remember how George Gore contacted you in connection with the Akron Hospital case where you testified as an expert?

A How he contacted me?

BY MR. LICATA: Objection. I don't think that's relevant. You can answer it if you know.

A I believe he called me.

Q Do you know how he got your name?

BY MR. LICATA: I'm going to note a

continuing objection to any questions about the relationship between Mr. Gore and Mr. Bralliar in a prior case.

Q Do you know how he got your name is the question.

BY MR. LICATA: You can answer his question.

A He knew me from before.

Q How did ne know ycu?

A As before, ne was involved in *my* first malpractice case temporarily.

Q That was the Eanratty case?

A That's right.

Q Were you represented by the law firm of Arter and Hadden in the defense of the Hanratty case?

A For a time.

Q Are you asked *to* review files, short of possibly giving deposition testimony on a regular basis in the field of medical malpractice?

A No.

Q Other **than** these two cases that **you're** talking about, one where you were a party, and one where you were en expert, have ycu ever reviewed any other files, short of giving **deposition** testimony in a medical malpractice claim?

A *Yes.*

Q In your medical career, how many files do you think you have reviewed approximately, if you know?

EY MR. LICATA: If you know.

A I don't know.

Q More than one?

A Yes.

Q More than five?

A Yes.

Q More tnan ten (10)?

A Yes.

Q More than fifteen (15)?

A Maybe.

Q So your yelp threshold starts somewhere over ten (10) files, is that right?

A My yelp threshold?

Q Yelp. It's not that hard, Doctor. The level at which you have some discomfort abouc what you remember as the number of files you have reviewed begins in excess of ten (10) files, is that right?

A No.

Q Where does your discomfort in your recall of tne number of files you have reviewed *begin* to become in doubt in your mind?

BY MR. LICATA: Objection. I'm not sure he has any discomfort. I chink that ne

just can't recall how many at some point.

Q You may answer. I mean I appreciate your attorneys testimony, but you're the one who is testifying today, not your attorney.

BY MR. LICATA: If you know at what point you can't be certain as to the number of files you reviewed, tell him.

A I am not uncomfortable with it. I don't recall the exact number, but I am fairly certain that is more than ten (10).

Q Over how long a period of time would you have reviewed more then ten (10) files?

A Ten (10) years.

Q Were any of those ten (10) files that you reviewed claims on behalf of a plaintiff? One claiming malpractice.

A No.

Q May I then conclude that all ten, at a minimum files that you can recall reviewing over the last ten (10) years were on behalf of the defense to malpractice claims?

A No.

Q If they are not plaintiff and they are not defendant, I'm not sure what other optrons are available

for me. Why don't you tell me if you weren't reviewing for a defendant in a malpractice claim, who else you would be referring for.

A The PIE Mutual Insurance Company.

Q And I see from your CV that you served on their board of directors from 1979 to 1987, is that correct?

A Yes.

Q Were any of your reviews--strike that.

How many of the reviews that you recall conducting were done as a member of the board of directors for the PIE Mutual Insurance Company?

A I'm sorry.

Q I'm trying to find out what percentage of the files you have reviewed with claims of malpractice were done while you were wearing the hat as a member of the board of directors of the PIE Mutual Insurance Company.

BY MR. LICATA: When you say percentage, I assume that you're referring to the more than ten (10) that he has identified?

BY MR. GOLDENSE: Yes, exactly.

A Eight.

BY MR. LICATA: Doctor, when you say eight, are you referring to eight being eight out of ten (10), eighty percent

(80%), or eight of however many?

BY DR. BRALLIAR: Eight out of the nine or ten that were mentioned.

Q And the others--strike chat.

Where you were reviewing claims as a member of the board of directors for PIE Mutua!., were all of those reviews done on behalf of physicians against whom claims of malpractice have been lodged in one form or another?

A Yes.

Q That leaves a couple of other files that you--a couple other cases that you have reviewed. Were those other reviews done on behalf of physicians against whom claims of malpractice were lodged?

A One.

Q Was that other claim referred to you by en attorney for review?

A Yes.

Q Who was the attorney who reviewed that other claim to your consideration?

A Mr. Gore.

Q I take it that other one by Mr. Gore, you did not actually have to testify under deposition, is that correct?

a No, sir.

Q You did testify?

A I am referring to the case that I previously mentioned.

Q And that's the Akron Hospital case?

A Yes, sir.

Q In any of these reviews that we have discussed, whether by way of deposition testimony or reviews when you were on the board of directors at PIE, have you reviewed any claims where the plaintiff's claim was that there was a problem with the intubation of an anesthesized patient?

BY MR. LICATA: Objection. I think he has already testified to that.

BY MR. GOLDENSE: I didn't get to the other reviews.

BY MR. LICATA: I thought you had asked him earlier if he had ever been involved in a case involving esophageal intubation, but go ahead, you can answer.

A Not that I recall.

Q Let me just make sure that I'm clear in that question and the answer, because Mr. Licata's interjection may have caused some confusion. Either as an expert to whom a claim has been referred, where you testified, or where you worked as a member of the board

of directors at PIE Mutual, or in any other capacity where your services have been sought as a consulting expert witness in a medical malpractice claim, which I now intend to have included your entire professional career, have you ever consulted on a case where there was a claim of an esophageal intubation during general anesthesia?

BY MR. LICATA: Objection. You may answer.

A Not that I recall.

Q Doctor, do you have a copy of your February 17th letter addressed to Mr. Licata in front of you there?

A Yes, I do.

Q For the record, I am referring to a letter addressed to Louis Licata, dated February 17th, 1988, which appears to have Dr. Bralliar's signature. Doctor, my question is, reviewing this letter, you indicate that you have reviewed the following, one, Booth Memorial Hospital records for Mary Lou Brown, covering her admission on May 16th, '85. Number two, the autopsy protocol on Mary Lou Brown. Three, the deposition testimony of the operating surgeon, Dr. Kamahl L. Humshari, M.D. Number four, the deposition testimony of the anesthesiologist, Young S. Hahn, M.D. Number five, the deposition testimony of C.R.N.A., Judy N. Doss. And

that obviously would have been reviewed by you prior to signing this letter on February 17th, 1988, is that correct?

A Yes.

Q Since February 17th, 1988, what other records have you had the opportunity to review as they relate to this lawsuit?

A Dr. Kopsch's deposition and report, a second deposition by Dr. Alhamshari.

BY NR. LICATA: Doctor, did ycu have a chance to review Dr. Alhamshari's records, medical records, charts?

BY DR. BRALLIAR: No, I did not.

BY MR. LLCATA: I wasn't sure, I wanted to make sure that if he was giver. the list that we had that at least,

Q Can I see what you just read here, Doctor? For the record, the doctcr is handing me a piece of yellow paper. Where are these records tnat you reviewed, Doctor, prior to testifying today? The five that are set forth in your February 17th, 1988 letter, and the deposition and report of Dr. Kopsch, and the second deposition by Dr. Alhamshari.

A At home.

EY MR. LICATA: We nave extras here,

David, if you want us to get them for you.

Q How about correspondence between you and Mr. Licata? Has Mr. Licata had occasion to correspond with you with respect to this case?

A Your question, sir?

Q Has Mr. Licata had occasion to correspond with you with respect to this case?

A He may have.

Q Where would his correspondence be now, Doctor?

A At home.

Q I want to see the correspondence.

BY MR. LICATA: Why don't you see what you can find in the correspondence?

BY MR. ALLISON: It's privileged.

BY MR. GOLDENSE: It wasn't privileged for Kopsch, how is it going to be privileged for him?

BY MR. LICATA: He hasn't turned it over to us yet either.

BY MR. GOLDENSE: You saw it all at his house.

BY MR. LICATA: We will show it to you. It's no big deal.

BY MR. ALLISON: It will take me a couple

of minutes to find all of the letters to Dr. Bralliar in this correspondence.

BY MR. GOLDENSE: Let the record reflect then that Mr. Allison is making due diligent efforts to obtain copies of correspondence to Dr. Bralliar.

Q Dr. Bralliar, I would like you to make available for my inspection for photocopying, all of the records that you have at your home in connection with your review of this case.

BY MR. LICATA: I'm going to object. He'll make available to you anything he has at home that has not--that you don't have, which--I mean you have the deposition transcripts, and the medical records, and all of that, and so there is no reason for him to drag those records out for you when you already have those records. If he has anything other than--I mean he has told you everything he has reviewed, and everything that he has reviewed, you should have, David. And the only thing we are trying to dig out for you now is this correspondence.

BY MR. GOLDENSE: What I am asking is that the doctor produce for me all of the correspondence between you and him, related to this litigation.

BY MR. ALLISON: Just Licata and Dr. Bralliar?

BY MR. GOLDENSE: Or you, Mr. Allison, Between the law firm of Arter and Hadden and Dr. Bralliar.

BY MR. LICATA: All right. We will produce that. That is something I'm not too concerned about. Although I assume that Dr. Kopsch is going to produce copies of his correspondence for us, then, too.

BY MR. GOLDENSE: To my understanding, you sew his whole notebook at the time of his deposition.

BY MR. LICATA: I want copies.

Q Since you don't have **that** correspondence with you, Doctor, let me ask some questions about this February 17th, 1988 letter, How many such letters have you had occasion to write in your professional career to attorneys on whose behalf you review medical malpractice claims?

A One or two.

Q Have you ever written a letter that goes into greater detail as to the basis for the conclusions you reach upon ycur review? Specifically, in this particular letter, all that is concluded is, it is my professional opinion that their care, referring to Judy N. Doss and Young S. Hahn, in *ne* way, directly or indirectly contributed to tne complications which occurred to the patient cn Nay 6th, 1985, ultimately resuiting in her death. A bald conclusory statement, obviously. Have you...

EY MR. LICATA: Objection.

Q Have you ever prcvided written analysis as to tne basis upon which such a conclusion was written in your other letter reviews?

BY MR. LICATA: Objection. You can answer.

A No.

Q Then the purpose of my deposition today is to try and find **out** the grounds upon which you reached that conclusion, fair enough?

BY MR. LICATA: That's why he's here.

Q That's why you're here. Do you believe that Mary Lou Brown was intubated in the trachea during her surgery in May of 1985?

A Yes.

Q Good, that's a good place to start. Upon what evidence to you draw your conclusion that this was a tracheal intubation?

BY MR. LICATA: Objection. Specifically..

BY MR. GOLDENSE: Yes.

BY MR. LICATA: ...or generally? I'm going to object because there is a lot of evidence in this file that he...

BY MR. GOLDENSE: Let's get to it, then, Lou.

BY MR. LICATA: Right, but I am not going to put him in a position where he has to draw from memory absolutely every fact and detail of the medical chart, and of all the depositions, and of everything he has reviewed in response to that question. So, I object.

Q With your attorney's objection, you can go ahead and start to answer the question, Doctor. Upon what basis do you believe that this was a tracheal intubation?

BY MR. LICATA: If you can give him all the facts that you can recall at your fingertips, go ahead.

A Based upon my review of the records which have been mentioned, and my own background, training and experience.

Q And you, of course, have read the testimony of Dr. Alhamshari, not only his first deposition, but his, what you call in your note here, this trial testimony, right? You have read that?

A Yes.

Q Are you familiar, without having to reread the whole deposition, that he believes that there was an esophageal intubation in this case? Do you recall that fact? That's Dr. Alhamshari's belief?

A That's his opinion.

Q Do you disagree with his conclusion that this was an esophageal incubation?

A *Yes.*

Q Upon what basis do you disagree with Dr. Alhamshari?

BY MR. LICATA: The same objection as I raised before, about all of the things he has to try to recall at his fingertips, but again, if you can tell him the things that you recall, based on your review, tell him why you disagree with Alhamshari's position.

A My answer is the same as the previous answer.

Q The general answer that your background, training, experience, and your review of the records, is chat it?

A That's not a general answer.

Q Dc you know what sinographen is, Dr. Bralliar?

A *Yes.*

Q What is sinographen?

A A radiographic dye.

Q Do you know in this case whether it was a water based or an oil based sinographen?

A Yes.

Q What was it?

A It's a water based,

Q Have you had experience with gynecological procedures in your training and background?

A Yes.

Q Where sinographen have been used as a contrast medium?

A Yes.

Q Have you ever observed an anaphylactic shock reaction in your personal experience to the induction of sinographen?

A No.

Q Do you beiieve that Mary Lou Brown suffered an anaphylactic shock reaction from the induction of

sinographen on May 6th, 1985?

A Anaphylactic shock or anaphylactoid?

Q Wait. Is your answer yes, you do believe that she had such a reaction?

BY MR. LICATA: I think he is trying to clarify your question, that's all.

Q Okay.

A I believe she suffered either an anaphylactic or an anaphylactoid reaction.

BY MR. ALLISON: Spell the last one for me, please.

BY DR. BRALLIAR: A-N-A-P-Y-H-L-A-C-T-C-I-D.

Q Since you have used two different terms, why don't you define them both for me? What is an anaphylactic reaction?

A An immunologically mediated reaction to a foreign subsrance, an antigen antibody reaction.

Q What is an anaphylactoid reaceion?

A A nonimmunologically mediated reaction to a foreign substance.

Q What is an immunologic reaction?

A A reaction mediated by the immune system of the body.

Q Then what is a nonimmunologic reaction?

A Your prior question . . . the immunologic reaction is mediated by IGE antibodies.

Q Taking an anaphylactic reaction first, how long does that take--how does it take for that to manifest itself, subsequent to an induction of sinographen?

A If it's from sinographen, it may manifest itself within seconds to minutes.

Q And if it's an anaphylactoid reaction, how long would it take to manifest itself subsequent to the induction of sinographen?

A Just as rapidly.

Q Now, I believe it's your testimony that you have never personally witnessed one of these reactions in your career, is that correct?

A No.

Q You have witnessed one of these reactions? I'll ask the question in the affirmative. Sometimes I ask questions in the negative, and it gets confusing. I asked earlier whether or not you have ever witnessed an anaphylactic reaction in a patient subsequent to the induction of sinographen, and your answer to that question is, have you or' have you not?

A No, I haven't.

Q Have you ever witnessed an anaphylactoid reaction in a patient, subsequent to the induction of

sinographen?

A No.

Q Upon what basis have you drawn the conclusion that Mary Lou Ercwn suffered either an anaphylactic or an anaphylactoid reaction, subsequent to the induction of sinographen in May of 1985?

BY MR. LICATA: Objection. The same basis as before.

Q Upon what evidence have you drawn that conclusion?

A The clinical records, and testimony.

Q Do you have a copy of the clinical record available to you, or can you make one available to him, Mr. Licata? Where in the clinical records do you find evidence of an anaphylactic or anaphylactoid reaction? Clinical records, by the way, do you mean anything other than the Booth Memorial Hospital records?

BY MR. LICATA: Or the autopsy. Is the autopsy protocol part of those records?

BY MR. GOLDENSE: That's exactly what my question is going to.

Q Doctor, this is not a hidden bail game. You said clinicai records. In this case, clinical records, obviously to all of commonly mean the chart fron Booth Memorial Hospital, which you have right in front of you. Do you need any other records to look at, in order to

give me the indication of the evidence upon which you have reached this conclusion of anaphylactic or anaphylactoid reaction?

A I include not only the clinical records, but the depositions and the autopsy report.

Q Do you have the autopsy report handy?

BY MR. ALLISON: I don't think he does, no.

Q I have an autopsy report, but it's the only one I have. Where, in either the Cleveland Memorial Hospital records, which you have in front of you, or the autopsy records that you have in front of you, do you find evidence of an anaphylactic or anaphylactoid reaction to the sinographen?

A The evidence is a clinical diagnosis.

Q Where is that manifested in the records?

A It's manifested in the records by the documentation of an immediate cardiovascular collapse of the patient, which immediately followed the injection of the srnographen into the patient.

Q Is there anything in the autopsy protocol, or any of the records from the Cuyahoga County Coroner's Office that support your conclusion of an anaphylactic or anaphylactoid reaction?

A In the sense that -- he -- he? -- exclude other

diagnoses.

Q Looking at those records, what other diagnoses are excluded?

A In my opinion, esophageal...

BY MR. LICATA: When you say these records, you're talking about the autopsy report?

BY MR. GOLDENSE: Yes.

A In my opinion, the esophageal incubation.

Q How was that ruled out in the autopsy records?

A I would expect with an esophageal incubation to see evidence of trauma to the esophagus, if that in fact would have occurred.

Q You have got the record right there in frons of you, Doctor, and it's not that long. Can you show me where the evidence of nontrauma to the esophagus is present in the coroner's report?

A On page 1, under gastrointestinal tract, quote, the esophagus and stomach are grossly unremarkable.

Q What you called page 1, Doctor, can I see the page 1 you are referring to?

BY MR. LICATA: I think it's marked at the bottom of the page as page 1, that's why. It's actually on the copy.

BY MR. GOLDENSE: I see. You have a

reduced copy. That's what...

Q Other than the clinical records, which you--I don't mean to cut you off. Is there anything else in the--while we're on it, the record of the Cuyahoga County Coroner's Office that lead you to conclude that this was a--shall we call it an adverse, and I'll mean adverse reaction, meaning either anaphylactic or anaphylactoid, for the purpose of not having to repeat those every question. In terms of reaching your conclusion to an adverse reaction to the sinographen, is there anything else in the Cuyahoga County Coroner's records that supports that conclusion?

A Possibly.

Q What else might possibly support your conclusion, Doctor?

A The lungs are very heavy.

BY MR. BUCK: Are very what?

BY MR. GOLDENSE: Beavy.

A Markedly congested and edematous. The heart, as a whole is very flabby and dilated.

Q Anything else that you choose to draw on to find support for your conclusion that this was an adverse reaction to the sinographen from the coroner's records?

A The fact that there are no other demonstrable causes.

Q What is it about the lungs being heavy, that possibly--and you used the word possibly to support your conclusion, so I'm going to repeat it, and maybe that's not fair. If it isn't, you correct me. You indicated that you possibly might find support for your conclusion in the fact that the lungs were heavy. What about heavy lungs supports your conclusion chat this was an adverse reaction to sinographen?

A I had mentioned chat the lungs were heavy, markedly congested, and edematous.

Q I was going to break those down into three different questions. I started with heavy.

A I include ail three of things together. Those are findings that might occur witn an anaphylactic or an anaphylactoid reaction.

Q What else could cause heavy, congested, and edematous lungs, other than an anaphylactic or anaphylactoid reaction?

A I'm sure there are numerous things.

Q You've had a chance to review wnat happened to this patient on the operating table, didn't you?

A Yes.

Q Would the length and duration of her resuscitive efforts be a potential cause for heavy congested, and edematous lungs?

A Yes.

Q What other causes that we can specify to Mary Lou Brown's case, with the history that she had prior to coming to the coroner's office, cause heavy, congested, and edematous lungs? Rather than trying to answer that question in the whole world of medicine.

A In this case, none that I can think of right now.

Q So we have two potential causes that you can think of for the findings in the lungs, either the adverse reaction to the sinographen, or the efforts to resuscitate her, is that correct?

A There is a third possibility.

Q What would the other third possibility be?

A Myocardial event.

Q Is there any indication in the Booth Memorial records that she had a myocardia event?

A Could you clarify that?

Q Did you just say myocardia event?

A Myocardial event, a cardiac event,

Q Is there any indication in the record that Mary Lou Brown had some sort of myocardial event during the time that she was being resuscitated, or the time that she was at Booth Memorial Hospital?

A Yes.

Q And of course we know that her heart stopped on the

operating table, is that right?

A Yes.

Q Is that a myocardial event, the way you have defined it?

A Certainly.

Q So now, we can think of three reasons for the heavy, congested, and edematous lungs, is that correct?

A That I can think of right now.

Q Are there any other reasons that you can think that Mary Lou Brown had heavy, congested, and edematous lungs in the autopsy?

A Not right now.

Q Are certified nurse anesthetist routinely used in your experience to administer general anesthesia?

A No.

Q What circumstances in your experiences, and I'll call them CRNA's, if I may. Under what circumstances in your experience are CRNA's used?

A When they are available.

Q Are they available at the Cleveland Clinic Foundation?

A Yes, they are.

Q Were they available at Huron Road Hospital when you worked there?

A Part of the time.

Q Was it a scheduling phenomenon strictly that determined their availability?

A No.

Q What determined the availability of CRNA's in your experience at Huron Road Hospital?

A The need for trained professionals to provide the service that was necessary for surgical anesthesia.

Q Do you have any criticism in this case of the use of a CRNA, in terms of administering the anesthesia to Mary Lou Ercwn?

A No.

Q From the standpoint of her being a CRNA rather than a board certified anesthesiologist.

A No.

Q Is it your opinion, based upon a reasonable degree of medical certainty, that the use of a CRNA at Booth Memorial Hospital in May of 1985 was within the standard of care to which Mary Lou Ercwn was entitled? Use of a C--for the record, you lock like you didn't understand the question. 1'11 rephrase it.

A Right.

BY MR. BUCK: Acceptable standards, I think would clear it up.

BY MR. COLDENSE: Thanks.

Q Was it within the acceptable standards of care for

Booth Memorial Hospital and Dr. Hahn, in his anesthesia group, to employ a CRNA at Booth Memorial Hospital in May of 1985?

BY MR. BUCK: Show an objection.

BY MR. LICATA: Objection.

BY MR. BUCK: You're implying that CRNA was an employee of Booth Hospital.

BY MR. GOLDENSE: That's another question I'll be getting to.

BY MR. BUCK: Okay, you'll get there.

Q You can answer the question if you understand it.

BY MR. LICATA: You can answer it if you remember it and understand it.

A Yes.

Q Explain to me the role that the anesthesiologist plays in supervising a CRNA during surgery. How do they interact with one another?

A You asked two questions there.

Q Explain to me the role of an anesthesiologist in providing general anesthesia, where there is a CRNA working with the anesthesiologist.

A The anesthesiologist's role is to medically direct the anesthetic for that case.

Q What is the role of the CRMA?

A To act as a competent trained professional in

working with the physician, to provide that anesthesia care.

Q What is the scope of delivering anesthesia that falls within the realm of a CRNA?

BY MR. LICATA: Objection. What do you mean by scope? I mean really.

BY MR. GOLDENSE: Lou, you have this incredible habit of, every time you don't like my question, you have a way of telling your witness.

Q If you don't understand my question, Doctor, you ask me to repnrase it.

BY MR. GOLDENSE: Lou, I would appreciate it if you wouldn't ask ne to rephrase every question I've asked, If the doctor can't answer my question, *he's* already indicated that he knows now to stop me.

BY MR. LICATA: All right.

BY MR. GCLDENSE: I would appreciate if you didn't every time.

BY MR. LICATA: Yes, that is fair. I'm going to object, however, because I think the question is unfair., I mean, what is the scope of anesthetic

practice.

BY MR. GOLDENSE: No, I didn't ask what the scope of anesthetic practice was.

BY MR. LICATA: You asked what the scope of a CRNA's role in administering anesthesia.

BY MR. GOLDENSE: Yes, what's so hard about that?

BY MR. LICATA: I think it's broad and vague, and I'm not sure it necessarily...

BY MR. GOLDENSE: But you're not the witness. He's the witness.

BY MR. LICATA: I know that, and I'm trying to protect the record, so that the question...

BY MR. GOLDENSE: No, you're not trying to protect the record. You're trying to protect your witness, and that's what's offensive about it.

EY MR. LICATA: That's your...

BY MR. GOLDENSE: If he has a question about one of my questions, he's free to ask ne. The man is a doctor. He knows how to read and write the English

language. He has no questions about what I'm asking. If he does, he can ask me. But I'm tired of, every time I ask a question, you interjecting and saying you don't understand it.

BY MR. LICATA: I think it's important that I understand the question from a legal perspective, David.

BY MR. GOLDENSE: Then you can object.

BY MR. LICATA: And I did.

BY MR. GOLDENSE: But when you object, you don't have to then tell him what the nature of your objection is so that he understands what not to say.

BY MR. LICATA: I'm going to tell you what the nature of my objection is, that's all.

BY MR. GOLDENSE: I don't need to hear it. That's for the judge.

BY MR. LICATA: If you can answer the question, Doctor, go ahead.

Q The question quite simply is this, Doctor. What is the scope of a CRNA's duties in providing the delivery of anesthesia during a general anesthesia operation?

BY MR. LICATA: Objection.

A It varies.

Q In this case, where there was a hysterosalpinogram, with a D and C ordered and planned for May 6th, 1985, and Judy N. Doss was in the OR as a CRNA with Dr. Hahn as an anesthesiologist, what was the scope of her function in providing general anesthesia to Mary Lou Brown on May 6th, 1985?

BY MR. LICATA: Objection. You can answer.

A What she and Dr. Hahn had decided, with him as the medical director.

Q Does that include administering anesthetic gases?

A Yes.

Q We know in this case, and I'm sure you've read it in Dr. Kopsch's deposition, that there was a lengthy analysis of the anesthetic gases that were delivered to Mary Lou Brown. Do you recall that testimony?

A What is your question specifically?

Q Do you recall the testimony in the deposition of Dr. Kopsch as to the anesthetic gases that were delivered to Mary Lou Brown?

A Not specifically.

Q Why don't you turn, then, to the chart, and it is page--I have it numbered page 23 in the upper right-hand corner. Yes, you're on the same page I am, Page 23, and

we're referring to the Booth Memorial chart. Can you tell me what gases were administered to Mary Lou Brown on May 6th, 1985?

A The gases that I see on this record are oxygen, nitrous oxide, ethylene.

Q I understand that there were some intravenous medications administered, is that correct?

a The record snows that.

Q Whar record--and what intravenous medicines were administered to Mary Lou Brown?

A Not necessarily in order are shown atropine sulfate, Vesprin, Anectine, DTC.

9 Dc you Know what DTC stands for?

A Detubocurare, Phentonil, and Penathol.

Q What is Sucocolin?

A Succinylcholine?

Q Succinylcholine, what is it?

A It's a depolarizing muscle relaxant.

Q Was it administered, from your review of this anesthesia record?

A Yes.

Q Do you recall Dr. Kopsch's testimony with regard to the administration of some of these medications and gases, with respect to a criticism that he might have had with respect *to* the amount of the dosage of Vesprin?

A Yes.

Q Do you agree with Dr. Kopsch's conclusion that a one milligram dose would have been indicated for this patient?

A No.

Q You don't recall that testimony, or you disagree with his conclusion?

A I recall the testimony. I disagree with his conclusion.

Q Do you agree that a two milligram dosage of Vesprin was indicated and proper within the standard of care for Mary Lou Brown within this procedure?

A I would agree with Dr. Hahn's decision to have that dosage administered in this patient.

Q With respect to page 23 of the anesthesia record that you have in front of you, it appears that there were changes made in the record, changes defined as something having been written down, and then crossed out and new notes made. I would like to go over those with you. You see, in the middle of the page on the right, two diagonal lines, if I may just point to this note right here. And it appears that extubated in OR, R-E-S-P would be what, respirations, or respiratory something? That's it, extubated in OR, and can you read what else is written underneath those two lines?

A It says resp. not done.

Q Extubated in OR means that the endotracheal tube would have been removed in the operating room, is that correct?

A Yes.

Q Prior testimony indicates in the case that that's Judy Doss' handwriting. My question is, is it common to have notations written on an anesthesia record about things that are anticipated before they are actually done?

A I would not be surprised.

Q Is it common?

BY MR. LICATA: Objection.

A What do you mean by common?

Q Do you ever do it?

A Not as a practice.

Q Let's skip on down to appearance then, Underneath appearance it says start and finish, and in both cases, it appears that a G was circled, and then the finish was crossed off, and below that it says, air, and we know from prior testimony that it's Judy Doss' handwritten initial, okay?

A Yes.

Q We know that. Do you write the finishing appearance of a patient before you complete an

anesthesia management?

A No.

Q Is it unusual, in your experience, that this would have had to have been crossed off, because it is obviously not a factually correct statement when trouble intervened?

BY MR. LICATA: Objection.

Q In your experience, is that an unusual phenomenon.

A You had several questions in that.

Q No, I have one question. Is it unusual that this would have to be crossed off when, as we obviously know today, trouble intervened?

A Whenever an error is made on a record, it is always--it should be crossed and initialed, regardless of whether trouble intervenes or not,

Q Is it unusual that the finishing appearance of the patient would be recorded before the anesthesia management was completed?

A Not necessarily.

Q In administering general anesthesia, is there a frequency of problems with esophageal intubation that you can quantify in your experience as an anesthesiologist?

A No.

Q Is esophageal intubation a well known risk of

general anesthesia in your community?

BY MR. LICATA: in *tine* community?

a Gf anesthesiologists.

A What do you mean by well known risk?

Q I mean a risk that is anticipated as a potential problem in administering general! anesrhesia.

A I wouldn't say anticipated.

Q What would you say?

A I would *say* it's **a** recognized potential occurrence.

Q Thank you. So, we agree that esophageal intubation is a recognized potential occurrence?

A Yes.

Q What means are available to an anesthesiologist or **a** nurse anesthetist **to** recognize esophageal intubation?

BY MR. LICATA: Today?

Q Today.

A A variety.

Q Give me the laundry list cf the variety of means that **allow** you to detect esophageal intubation today.

A One of the best is endtidal *CG2* monitoring.

Q I am sorry, Doctor, **wnat?**

A Endtidal carbon dioxide monitoring.

Q Was carbon dioxide monitoring entitled?

A End, E-N-D, tidal, T-I-0-A-L.

Q Endtidal carbon dioxide monitoring, got you, thank

you. Was that available in May of 1985?

A Not routinely.

Q Where was it available in May of 1985?

A I can't say.

Q Was it available at Huron Road Hospital in May of 1985, when you were working there?

A I believe so.

Q Is it available at the Cleveland Clinic today--or strike that.

Is it available at the Cleveland Clinic since you have been there since 1987, endtidal--carbon monoxide?

A Dioxide.

Q Carbon dioxide monitoring.

A Yes.

Q Any other ways to detect esophageal intubation today?

A Esophageal or tracheal?

Q I'm asking for esophageal.

A I beg your pardon then, because...

Q A potential risk that I am discussing with you now is esophageal intubation.

A Then I may have misspoke, because the endtidal CO2 monitoring is to confirm tracheal intubation.

Q Doesn't that inferentially rule out an esophageal intubation?

A Yes, but you were saying that you wanted tests used to detect esophageal incubation.

Q Yes.

A We don't use tests to detect esophageal intubation, we use tests to detect tracheal intubation.

Q And if you have intubated the trachea, is it fair for me to conclude that you have effectively ruled out the potential for esophageal intubation?

A Yes.

Q How else can you confirm tracheal intubation today, other than endtidal?

A The second equally good, or second best technique is direct visualization of the endotracheal tube, going through the vocal cords, into the trachea.

Q How is that visualized?

A Visually.

Q With any instrument assisting the anesthesiologist?

A Usually using a laryngoscope to lift the anatomical structures into position. You can then directly visualize, with your own eyes, the vocal cords, and watch the endotracheal tube go between the vocal cords, into the trachea. Which some consider the gold standard of tracheal intubation.

BY MR. BUCK: What was the name of the scope?

BY DR. BRALLIAR: Laryngoscope.

Q How else can one confirm today tracheal intubation. Strike that.

Was this visualization with the laryngoscope available commonly in administering general anesthesia in May of 1985?

A Yes.

Q Laryngoscopes have been around a long time, haven't they?

A *Yes.*

Q Routinely used by all general anesthesiology performing medical personnel for a long time, is that right? Laryngoscopes.

A Routinely?

Q *Yes.*

A Not in every case.

Q Were they routinely available in May of 1985, laryngoscopes?

A Yes.

Q So we talked about two ways to confirm tracheal intubation. How about a third way?

A There are a variety of other clinical observations that are available, not as good as the two I have mentioned, all of which help to confirm, including auscultation with the stethoscope.

Q And that's listening to the lung fields?

A Yes Observation, ventilation, cnest wall motion in some cases, the feel of the beg when one is ventilating the patient.

Q And that's a manual bag that is squeezed by the anesthesiologist, or the nurse anesthetist?

A By the anesthesia personnel involved. Condensation of expired gases on the endotracheal Lube help.

Q Before you get all the way through this list, hold on to the list. I'm going to come back to the other items on the list, but let me ask a couple of questions about the bagging. Was Mary Lou Brown bagged prior to trouble intervening, according to your review of these records?

BY MR. LICATA: Objection.

A At a moment in time, yes.

Q Do you know at what moment in time she was being bagged by Judy Doss? I mean the evidence in this case is clear that Judy Doss is the one who was administering the anesthesia. That's not a hidden ball trick. Do ycu know when, at what point in the procedure, Judy Doss was bagging Mary Lou Erown?

A Prior to incubation. I believe immediately after intubation, Perhaps prior to removing the endotracheal tube.

Q The first endotracheal tube?

A Yes. Probably after insertion of the second endotracheal tube. Perhaps, I don't know, between the two.

Q What is it about the bagging that helps make a clinical judgment confirming tracheal intubation possible?

A The fee, of the bag, as far as the gases exiting and entering.

Q Does that feel change between an esophageal intubation and a tracheal intubation, that feel of the bag that you're describing?

A It certainly can.

Q Does it routinely change? Strike that.

Can you tell from bagging a patient, with your training and experience, whether the esophagus or trachea has been intubated?

A In most cases, I would expect to.

Q So now, I would like to finish the other ways that a clinical determination can be made which confirms a tracheal intubation.

A We haven't finished this question of how do I fee- with the bag, as far as whether or not the tube is in the trachea or in the esophagus.

Q I'm sorry. I thought you had finished the answer to

my question. I thought I had asked, could you tell the difference, and I thought ycur answer was yes.

A I would expect to, but there are other things that i am aware of, other than just the feel of the bag with the gases exiting and entering.

Q Then please, I don't mean to cut you off. How else, other than the entering and exiting gases in the bag could you tell the difference between an esophageal and a tracheai intubation?

A I would oftentimes expect to have a difference in air sound, as far as a leak with an esophageal intubation. I would expect to oftentimes hear a difference in the tonal quality of the air sounds.

Q The tonal quality?

A Tonal, T-O-N-A-L. And I might expect to feel a difference in the resistance of a good tracheal intubation versus a nontracheal placement of the tube.

Q Which would provide greater resistance? A tracheai intubation or some other intubation?

A It depends.

Q Now you have lost me. Is there a consistent degree of resistance in a tracheal intubation that you could palpate with the bag?

A There is a distinct feel.

Q And you're looking for chat feel with a tracheal

intubation on the bag, is thae it?

A That's one of the things, yes.

Q Now was there anything else you wanted to explain to me about Sagging a patient that confirms tracheal intubation?

A It doesn't confirm. it's jusr one of the facts tnat helps...

Q Form the clinical judgment.

A The judgment.

Q I understand tnat.

A Your question now?

Q Is there anything else that you wanted to explain to ne, I didn't mean tc cut you off, about tne feel of a bag confirming, or tending to corroborate?

A Not as far as the feel, no.

Q What other means of detection, and we have talked about cine feel *of* the bag, and the auscultation in tne endtidal carbon dioxide monitoring device, and the visualization through the laryngoscope. Those are the four ways ycu have described so far of confirming tracheal incubation, right?

BY MR. LICATA: Did we have four? There was something else. Condensation on the.. .

BY MR. GOLDENSE: Condensation of

expired gases and observation of ventilation, such as chest wall motion.

A That's correct.

Q And auscultation?

A Right.

Q Is there anything else you would care to add to the list?

A Yes.

Q Please do.

A A technique that may be used is to actually compress the chest, and to feel the air coming out through the endotracheal tube.

Q What is that procedure called, or how would you term that?

A I would call that a chest compression.

Q If that's what you want to call it, that's fine. And by compressing the chest, you can then see what happens to the gases that are being delivered through the anesthesia, is that the idea?

A No, what I hear is it's tantamount to a Heimlich maneuver. By pressing on the chest, I get air exiting through the endotracheal tube from the lungs. I can hear and/or feel the air.

Q Do you put the stethoscope on the endotracheal tube, or how do you hear it?

A I put my ear right at the exit of the endotracheal tube.

Q Right down next to the patient's mouth, where the endotracheal tube is...

A Next to the endotracheal tube itself.

Q Running back to you: anesthesia gas machines?

A Before I hook them up to the tubes or anything else.

BY MR. ALLISON: Your first one was endtidal C02 monitor. Your second one was direct visualization of the tube going through the vocai cords and into the trachea. Thirdly, you said there was variety of other clinical observations, such as auscultation with a stethoscope, observatron of ventilation, like chest wall motion, the feel of the bag as you ventilate the patient with the bag, condensation of expired gases in the tube, chest compression.

Q is. there anything else tnat you would like to add to what I'm calling your laundry list of ways to detect--I'm sorry, to confirm and corroborate tracheal intubation.

BY MR. LICATA: Objection. You can answer.

A I'm sure there are others. The absence of a leak.

Q A leak where?

A On inspiration, around eke endotracheal tube, out into the oral pharynx. Auscultation over tne stomach.

Q How, by ausculating the stomach--by ausculating, you're talking about using a stethoscope to listen to sounds arcund the stomach?

A Yes.

Q How does that work? Explain that to me.

A I would, on an esophageal intubation, expect to hear a distinct sound of air in tne stomach witn ventilation, Whereas I would, witn a tracheal intubation, not hear.,.

Q Any sound.

A Vesicular breach sounds. You might near some transmitted sound, but it would be distinctly different.

Q With your trained ear, as it were, you would recognize whether or not the gases were passing right inuo tne stomach, or if they were these transmitted sounds from the lung fields, is that the idea?

A Hopefully.

Q How many of these methods do you routinely use, Doctor, in your practice?

A Currently?

Q Yes.

A I basically use all of them if possible. And I would use other findings if the patient were on mechanical ventilation.

Q Was this patient on mechanical ventilation?

A In my opinion.

Q Yes. Was Mary Lou Brown on mechanical ventilation in your opinion?

A At a moment in time, *yes.*

Q Once a patient is on mechanical ventilation, what other methods would you employ to confirm or corroborate tracheal intubation?

A I would still do the same observational evaluations that I do when I bag the patient. I would also look to see how the bellows of the ventilator are responding.

Q Anything else you would do with a mechanically ventilated patient *to* confirm or corroborate tracheal intubation?

A Not particularly.

Q What is capnography?

A Capnography is the measurement of the expired carbon dioxide.

Q Is that a measurement that is part or what you call the endtidal carbon dioxide monitoring device?

A Yes.

Q So you have accounted for what was discussed in Dr. Kopsch's discussion as capnography as a relatively modern method, is that correct? For corroborating tracheal intubation.

A I would have to look at what he said.

Q You had seen his deposition. Do you recall that testimony at all?

A In part.

Q Do you recall the testimony about the capnography?

A Not specifically.

Q All I'm trying to do is categorize it on this, laundry list. I'm trying to categorize where capnography fits on the laundry list that you have just given me, and it would fit under the category of the endtidal carbon dioxide monitoring devices, is that correct?

A *Yes.*

BY MR. COLDENSE: Can you make a copy of Dr. Alhamshari's trial testimony deposition available to the witness? I only have the one copy here.

(OFF THE RECORD)

Q Doctor, I have asked your attorneys to make available to you a photocopy of the trial testimony of,

Dr. Alhamshari that was taken July 20th, 1988. Doctor, why don't you start by turning to page 29?

A Yes.

Q Starring at line 17, the question was asked of the doctor, what he did when she, Judy Doss, said "bradycardia", and skipping from lines 18 to 25, he indicates some initial things that he did, and I want to direct your attention specifically now to page 30, line 13. If you read along here, you'll get the text of where we were in the procedure when this line of questioning was being asked, Picking up at line 13, my specific question is, when asked, what did you then do, the doctor, Alhamshari responded that he said, quote, I went to the chest of the patient, i took a stethoscope from one of the nurses, and I listened to breathing sounds on both sides of the chest. I could not hear adequate breathing, All I could hear is fine wheezing. Skipping .then--I'm almost done with the testimony here. Skipping then through the rest of the pages you see some clarification, tnen at the top of page 31, some said bradycardia, yes, someone said asystole, after that yes, and then skipping down to the last three lines of the page, starting on page 23, again the doctor was asked, what did you do then?

A Page 23?

Q I'm sorry, line 23, I beg your pardon. He said, I listened to the chest, both sides of the chest. I could nor hear adequate air entry, and all I could hear is fine wheezing. With chat testimony in mind, Doctor, here is my question. Is the testimony of Dr. Alhamshari indicative of having heard a fine wheezing, consistent or inconsistent with a tracheai intubation of this patient during this procedure?

A Consistent...?

Q Is fine wheezing what you expect to hear when you ausculate a lung field of a tracheally intubated patient?

A No.

Q Now I an confused. Why is it not whar you hear when you ausculate the lung fields — let me see if I car, ask a question that describes my confusion. Having heard fine wheezing in the lung fields, Dr. Alhamshari draws the conclusion thac the patient was improperly intubated, is that a correct statement?

A A correct statement, or a correct conclusion?

Q Have I correctly characterized Dr. Alhamshari's thought process, as set forth in his testimony that where he heard fine wheezing, he concluded that that was an improperly placed endotracheal tube?

BY MR. LICATA: Objection. You can

answer.

A What I read here is that he ausculated and heard fine wheezing.

BY MR. BUCK: To save time, why don't you hypothecate it?

BY MR. GOLDENSE: I'm trying to find. There is a specific...

Q Page 37. Starting at line 5. The question was asked, Doctor, based upon your skill and care as a physician, and based upon the preadmission tests of Mary Brown, and based upon the events which occurred in the operating room on May 6th, 1985, do you have an opinion to a reasonable degree of medical certainty as to what was the cause of Mary Brown's death. Objection. Answer, In my opinion, the endotracheal tube was inserted not into the trachea, but into the esophagus. Question, And how is it that that caused her death? Objection. The answer was, The anesthesia gases and oxygen, rather than going into the lungs to go into the bloodstream, they were going into the stomach. And assume for purposes of my question that the testimony in the trial testimony of Dr. Alhamshari was to the effect that he based that opinion on what he heard when he ausculated the lung fields, when he was advised that bradycardia had intervened, the testimony we just read. Do you have an

opinion, based upon a reasonable degree of medical certainty as to whether or not Dr. Alhamshari properly diagnosed the cause of Mary Brown's death?

A Yes.

Q What is your opinion?

A He is in error.

Q Upon what basis have you drawn the conclusion that Dr. Alhamshari was in error?

BY MR. LICATA: Objection.

A All of the clinical information, review of the records, and my own training, experience, and expertise.

Q What significance, if any, do you attach to the finding of Dr. Alhamshari that he heard fine wheezing and not good air entry, which is his testimony when he ausculated the lung fields?

A I believe it's significant.

Q What significance does it have?

A I believe it has significance, one, that it tends to confirm endotracheal intubation.

Q It tends to confirm esophageal incubation, is that what you said?

A In my opinion. At least to the degree that it is in the trachea, perhaps further down, but still in the airway. Two, I think the wheezing that is mentioned could also give confirmation to the presence of an

anaphylactic and/or anaphylactoid reaction.

Q I'm sorry. Give me that again. The presence of the wheezing confirms...

A It could help confirm...

Q Ai: anaphylactic.

A ...or support.

Q An adverse reaction to the sinographen?

a It would be one of the supportive findings that one might see in an anaphylactic or anaphylactoid reaction.

Q 30 you have an opinion, based upon a reasonable degree of medical certainty as to the cause of Mary Lou Brown's death on May 6th, 1985?

A Yes, I do.

Q What is your opinion?

A I believe she had an anaphylactic or anaphylactoid reaction to sinographen.

Q I asked you earlier what you hear when you ausculate lung fields when you intubate a patient in the airway, and you said that you don't Rear fine wheezing, is that correct?

A That wasn't your question.

BY MR. LICATA: Objection.

Q I'm going to try to get to this. When you ausculate a patient's lung fields, foilowing intubation in the airway, what do you hear?

A It depends on the patient.

Q Okay. What about the patient causes different reactions, different sounds?

A It depends on the reactivity of their airways. It depends upon ehe placement of the endotracheal tube in their airway.

Q Under what circumstances if any do you hear fine wheezing when you ausculate the lung fields of a properly intubated patient?

A The circumstances, is an individual patient circumstance, the facr thae the placement of the tube initiates a physiologic response, causing bronchial or constriction, which then results in the wheeze.

Q Doctor, you also have available to you the chart from Booth Memorial. It's over there on you: right. Do you recall reviewing in this chart an x-ray--I believe it's page 16. An x-ray of the chest, which had findings of gaseous distention of the stomach, the last line of that x-ray report?

A I'm looking at it.

Q Do you remember seeing that before today, Doctor?

A The record?

Q *Yes.*

A Yes.

Q Do you remember ehe finding of gaseous distention

of the stomach?

A The report, yes.

Q Do you recall the testimony of Dr. Alhamshari in his trial testimony, and assume that I properly read his testimony. He drew two grounds for drawing his conclusion of an esophageal intubation here. One was what he heard when he ausculated the lung fields, which we just went over, and the other was this x-ray finding of gaseous distension of the stomach. My question to you is whether or not you place significance--strike that.

My question is, what significance do you attribute to gaseous distension of a patient's stomach, as found by x-ray following the difficulty in the surgery?

A In this case, none.

Q In placing no significance to that finding of gaseous distension in the stomach, does your analysis flow from your original conclusion that she was, in fact, intubated in the airway, the trachea?

A Let me restate my answer to the last question before we get to this.

Q Feel free.

A I may have misspoke myself when I said I placed no significance in the finding. The fact that there is gaseous distention reported on the x-ray does not

surprise me. Whether as a significant implication or not is another speculation.

Q Try me again on that. How is it speculative?

A What I am saying is, I misspoke myself when I said I placed no significance on the finding. I do place significance on the finding.

Q What significance do you attach to the finding of gaseous distention of the stomach?

A In this situation, in this case, to me it implies that this patient may have been difficult to maintain an airway without some gas entry into the stomach, when they ventilated by mask, and/or she may have been an aerophageic.

Q What is an--spell aerophageic for me.

A A-E-R-O-P-H-A-G-E-I-C, I believe.

Q What is an aerophageic?

A An air swallower, or air eater,

Q And that would account potentially for gas distention in the stomach, is that the idea?

A It could.

Q Is there any indication in the record that this patient was aerophageic?

A Not to my knowledge.

Q So to try to understand your analysis of Dr. Alhamshari's conclusion, you reject as significant

gaseous distention of the stomach as proof of an esophageal intubation, correct?

A By itself in this case, absolutely.

Q In this case, on these facts, with these records, how else would you account for gaseous distention of this patient's stomach, other than the potential for her being aerophageic?

A As I just told you, in a short, obese lady, I would not be surprised that some air entered the stomach when they were ventilating by mask, prior to the first intubation.

Q Enough air so that it would show up on the x-ray report, subsequent to the trouble that she experienced?

A Absolutely.

Q Would there be any other causes for this patient, on these records, with these facts, for a finding of gaseous distention of the stomach?

A Other than what I have mentioned, I can't think of any.

Q The thought I had to share with you was that maybe there was something in the efforts to resuscitate her that might have caused the gasecus distention in her stomach. And you, of course, are aware that this woman underwent cardiopulmonary resuscitation for a long cine, the better part of two hours, when she was on *the*

operating table.

BY MR. LICATA: Objection.

Q You are aware of that fact, right?

BY MR. LICATA: Objection.

A I don't know what the time relationship is between the CPR and the chest x-ray.

Q Yes, the chest x-ray doesn't tell us what time it was taken, does it? Okay, fair enough. Is there anything about the efforts to resuscitate her that might have caused the gaseous distention in her stomach?

A If she were ventilated by mask between the first intubation into the trachea and the second.

Q Going back to now the deposition again of Dr. Alhamshari.

A Which one?

Q Dr. Alhamshari, the one that's right there in front of you, the July 20, 1988 deposition. There was a cross-examination conducted by Mr. Licata of Dr. Alhamshari. Do you recall reading it?

A Not specifically.

Q Let me characterize it for you a little bit, if I may. Rather than have you sit here and read it all again. He had some questions about whether or not Dr. Alhamshari should have visualized cyanosis in the peritoneum, specifically the area around the cervix,

when he was doing a PAP smear, and then later opening the cervix to enter the--to inject the sinographen into the uterus. Do you recall that testimony, that line of questioning?

A Vaguely.

Q Here is my question specifically, is it your opinion, based upon a reasonable degree of medical certainty, that Dr. Alhamshari should have diagnosed cyanosis in this woman's peritoneal cavity at the time that he was performing his operative procedures?

BY MR. LICATA: Objection. Diagnosed?

Q Observed. Observed cyanosis.

BY MR. ALLISON: Peritoneal cavity?

BY MR. GOLDENSE: Yes. I mean he is working at the cervix.

BY MR. ALLISON: That's like within the...

BY MR. GOLDENSE: I understand. I'm using a broad phrase.

A Peritoneal cavity?

Q Doctor, we know that this surgeon was performing a D and C and a hysterosalpingography, is that correct?

A No, sir.

Q We know that chat was his intended plan, is that right?

A That's what the record says.

Q Very good, Doctor. So understanding that that's what the record says, and none of us were there, and we're relying on the records to determine that that's what was underway, is it fair to conclude that Dr. Alhamshari had an opportunity to observe cyanosis, if any, in this patient?

A I would need further clarification.

Q Let's go to the operative note then. Page 25. The third paragraph, where it starts out with the word Procedure, colon, okay?

A Yes.

Q Starting then with about the third sentence, where it says PAP smear was taken, and then reading the next sentence, then preparation of the operation area was done with Butadiene, including intravaginal prep, and the operation area was *draped* in the usual manner. A vaginal speculum was inserted into the vagina, and the PAP smear was taken. This was done before the Betadine preparation. Then after the Betadine preparation, interior lip of the cervix was grasper! with a tenaculum forceps, and the cervical canal *was* gauged with uterine sound, and then slightly dilated with Hagar dilators with the first two sizes. Then ten (10) cubic centimeters srnographen **was** injected **into** the uterine

cavity, and preparation was done to have an x-ray of the pelvis. But before the x-ray was the patient was done, the patient developed bradycardia, period.

BY MR. LICATA: I'm going to object.

Q And then cardiac arrest, period.

BY MR. LICATA: Okay.

Q Taking that segment of time, beginning with the PAP smear was taken, until the injection of the sinographen, did Dr. Alhamshari have an opportunity to observe cyanosis around the area of the cervix, where he was beginning his operative procedure?

A It there were cyanosis.

Q Is there any indication anywhere in this record, or anywhere in the autopsy report, or protocol from the Cuyahoga County Coroner's Office that there was cyanosis of this patient?

A No.

Q Do you have an opinion, based upon your training, experience, and understanding of this case, as to whether or not this patient would have had cyanosis in the area around her cervix, where the PAP smear was taken, and then the sinographen was injected? Do you have an opinion?

BY MR. LICATA: Objection. Under what circumstances?

BY MR. GOLDENSE: Under these circumstances that I just read.

BY MR. ALLISON: At what point?

BY MR. GOLDENSE: At the point in time that I just read, from the time of the PAP smear until the sinographen was injected.

BY MR. LICATA: Assuming that she had an endotracheal intubation, assuming she had an esophageal intubation?

BY MR. GOLDENSE: He has already testified...

BY MR. LICATA: Assuming how many minutes into the procedure? That's the only reason I am objecting here.

BY MR. GOLDENSE: Wait a minute. He has testified already that it's his opinion, based upon a reasonable degree of medical certainty, that this was an endotracheal intubation.

BY MR. LICATA: Right.

BY MR. GOLDENSE: Okay?

BY MR. LICATA: Okay.

BY MR. GOLDENSE: So I'm taking that into account.

BY MR. LICATA: Right. So there wouldn't be any cyanosis.

BY MR. GOLDENSE: I want to hear it from him.

BY MR. LICATA: I know that. I understand. I thought that your question, though, was to determine under what circumstances Dr. Alhamshari would have seen cyanosis. That's the only reason I raised the objection, and if you want to ask it the way you did, fine.

Q From the time the PAP smear was taken, until the sinographen was injected, according to the operative report, under what circumstances if any would Dr. Alhamshari have seen or could he have seen cyanosis in the area around her cervix?

A Arcund and/or on?

Q Yes, both, arcund and/or on, in the area of her cervix.

A If she were cyanotic.

Q Under what circumstances could he have seen evidence of cyanosis?

A If she were cyanotic.

Q That's rather question begging, Doctor. Obviously,

what would cause her to be cyanotic?

A A variety of things could.

Q How large a universe of variety are we talking about?

A Five grams reduced hemoglobin.

Q What causes a five gram reduction in hemoglobin?

A A variety of things.

Q My question is how many things? Are we talking about two things, or two hundred (200) things, for this patient, under this procedure?

A I cannot assume that, because there, as you said, is nothing to indicate cyanosis, You're asking me to assume something that I can't assume. All I can tell you is thar if cyanosis were present, I would have expected, under the parameters that ycu gave me, for Dr. Alhamshari to have recognized it.

Q I'll come at it another way. Upon your review of this chart, the evidence that you have seen by way of deposition testimony, do you have any particular criticism of the care and management that Dr. Alhamshari provided to Mary Lou Brown on May 6th, 1985?

BY MR. LICATA: Objection. You can answer. I mean that's not why he was retained, but go ahead and answer If you know the answer.

A Yes, I do.

Q What are the areas of your criticism of Dr. Alhamshari?

A I think that Dr. Alhamshari, according to his deposition, did not respond in an appropriately speedy manner after the cardiovascular collapse of the patient, following the sinographen injection.

Q In the variety of things that cause cyanosis for Mary Lou Brown, in the area on or around her cervix, is cardiac collapse one of those variables causing cyanosis?

A The cardiac collapse, as I understand it, occurred after the injection of the sinographen.

Q Absolutely correct.

A Which would then have occurred when Dr. Alhamshari was not visually inspecting the vaginal vault or the cervix.

Q Do I take your criticism to mean that he did not respond as quickly to the emergency that he was faced with as he should have under the circumstances?

A I don't believe he responded appropriately.

Q What was inappropriate about the response that he undertook?

A According to his deposition, I think there was an inappropriate delay in the cardiac massage being

instituted. I also think that he should *have* considered the possibility under the clinical circumstances that occurred of anaphylactic or anaphylactoid reaction and instituted appropriate treatment.

Q Let's get to that. You testified earlier that you have never seen an adverso reaction defined as anaphylactic or anaphylactoid, to the induction of sinographen in your experience, is that right?

A Yes.

Q From whence do you have information about the existence of anaphylactic or acaphylactoid reaction *eo* the induction of sinographen?

A From my background, training, end experience, I know the distinct possibility of such an occurrence.

Q Have you done any particular research intc this area since being retained to testify in this case? The area being the adverse reaction to sinographen?

A I did make an inquiry of a colleague.

Q in what field of medicine was your colleague engaged?

A Anesthesiology.

Q As a result of your inquiry, what did you learn?

A Ee gave me a report documenting an anaphylactic reaction to sinographen.

Q Where is that report?

A At home.

Q Can you tell me about the report? Where is it published? Where can I find it?

A I don't have that right now.

BY MR. GOLDENSE: Mr. Licata, on your list of things that I would like the doctor to provide for me, I would like a copy of the report that he got from his colleague, upon which he provided us testimony today, setting forth the adverse reaction, anaphylactic or anaphylactoid to sinographen. Would you make that available for my inspection and copying?

BY MR. LICATA: I don't see why not. I'll let you know if there is a problem.

Q Tell me about the report. Is it in a regular journal, or was it a particular study? Can you tell me anything about the report?

A I did not see the report per se. He did a search on his computer.

BY MR. LICATA: Doctor, do you have a copy of that report, or was it just something you discussed with him after the search?

BY DR. BRALLIAR: He sent me a note with some information that I can't say specifically what it was, but I can provide it.

Q In addition to talking to the colleague, and in addition to relying on your background and training, do you have any other sources for your knowledge of the existence of the risk of adverse reaction to sinographen?

A Information as to the adverse reaction to radiographic dyes, in general.

Q Now, is there a difference between water based dyes, and oil based dyes, as it pertains to the risk of adverse reaction?

A Yes.

Q Is it a correct statement that there is a much lower incidence of adverse reaction with water based dyes than oil based dyes?

A What type of adverse incidents?

Q I'm sorry. Earlier, I told you that we were going to define adverse reactions as anaphylactic shock or anaphylactoid shock, so I didn't have to repeat that twenty (20) times. Is there a difference between the oil and the water based contrast mediums?

A Not that I know.

Q What other adverse reactions go with sinographen, according to the research, and the review that you have conducted, as far as adverse reactions?

A I didn't do research, and I didn't do review of the literature.

Q You've read no literature at all about sinographen preparatory to today's deposition?

A No.

Q Other than this report from your colleague?

BY MR. LICATA: Which he didn't read.

A I did not read the report. That's true.

Q Can you cite me, out of your training, your educational training and background, to any text or any writing that you're familiar with, supporting the relationship of anaphylactic or anaphylactoid reaction to induction of sinographen?

A I can only refer you to what I said, as far as the potential anaphylactic or anaphylactoid reaction to radiographic dyes, which I mentioned.

Q Now radiographic dyes generically is a much larger--is a large category, of which sinographen is one particular subset, is that the idea?

A In my opinion.

Q There are all kinds of radio opaque contrast mediums that are used by the medical community to inject

into the human body to take x-rays, is that right?

A There are a variety.

Q If I understand the limitation in your testimony, or how you limited your answer, your answer is that you know that the general category of radio opaque contrast mediums has with them a risk of anaphylactic or anaphylactoid shock, correct?

A Among other things.

Q Yes. Your testimony in this case is that's what Mary Lou Brown had, an anaphylactic or anaphylactoid shock reaction, correct?

A That's my opinion.

Q Now if I understand you, then what you did was with that general piece of knowledge, which you had with you for presumably a long time, is that the Idea?

A I don't know what you mean by a long time.

Q The fifteen (15) years, since you *have* been practicing since 1972 at Huron Road Hospital, let's just take that period of time, you were aware during the 197--what was it? '72, that you started at Huron Road?

A Yes. As a staff.

Q '72 to '85, the thirteen (13) years prior to this treatment, you were aware, while you were on staff *at* Huron Road, that there could be these adverse reactions, anaphylactic or anaphylactoid, to contrast medium, is

that correct?

A Yes.

Q Prior to this case, the case that you have been retained on for the defense, had you ever in your training or background, run across knowledge that sinographen, as a particular type of radio opaque contrast medium, could, having been induced in a patient, result in anaphylactic or anaphylactoid shock?

A Only in the sense that any foreign substance can. But it was not excluded.

Q You say it was not excluded. The flip side of that, was it included in your specific knowledge, sinographen...

BY MR. LICATA: I object.

Q ...as a cause of anaphylactic or anaphylactoid shock?

BY MR. LICATA: I object to that, and I think he's indicated to you that they are all included unless they are excluded. That's the way I understand it, but...

BY MR. GOLDENSE: That's what I was asking.

A That's what I just said, as I understand it.

Q So what you went to your colleague with was a

question, how about sinographen as a competent producing cause of an anaphylactic or anaphylactoid shock reaction. Was that the question you asked him?

BY MR. LICATA: Objection.

A Not specifically that I recall.

Q What was your reason in consulting with a colleague?

A I asked him if he had any awareness of any reports of anaphylactic reactions under anesthesia to sinographen or radiologic dyes.

Q And the report that he produced for you, was it a report where sinographen was the contrast dye?

A I did not see the report.

Q What did you see?

A He sent me a note with a printout from his computer, and it's my belief that it mentioned sinographen specifically, but I would have to look to be sure.

Q What you're going to produce for me, then, is this computer printout from your colleague that he got from his computer search?

A That's my understanding.

Q I want to make sure that I have developed all the sources of your information for the basis for your testimony today. You have this computer search printout

from your computer. Your testimony was that you did not literature research intc sinographen per se, as a competent producing cause of adverse reaction *to* sinographen, correct?

BY MR. LICATA: No, there is...

A I don't have a computer.

BY MR. LICATA: No, there is an independent research.

BY MR. GOLDENSE: Yes, exactly.

Q Yes, going to the library or doing--you do research all the time, don't you, Doctor?

A No.

Q You don't? God bless you. Okay. You have relied on your training, and background, and experience with sinographen and other contrast medium as a basis for your opinion today, is that correct?

A No.

BY MR. LICATA: As the basis for his opinion with respect to sinograpnen causing anaphylactic or anaphylactoid reaction.

BY MR. GOLDENSE: Yes.

BY MR. LICATA: The only reason he said based on your opinion today, and he has expressed a lot of opinions, that's all.

Q Your opinion that I am referring to is your key opinion, as far as I'm concerned, that this woman died of an adverse reaction, either anaphylactic or anaphylactoid, after the induction of sinographen, okay?

A Yes.

Q That's the opinion to which I refer.

BY MR. LICATA: There are several opinions he has regarding this case. So I just...

Q Yes, that's the opinion I'm talking about right now for the purpose of my next question. In reaching that conclusion, your sources of authority are your training, background, and experience, and just this one computer search that a colleague did at your request, from which he gave you a note from his computer search, is that correct?

A No.

Q What other sources of authority have you relied on to reach the conclusion that sinographen caused an anaphylactic or anaphylactoid reaction in Mary Lou Brown on May 6th, 1985?

A As I said, the readings I have undertaken include radiographic dyes. they did not exclude sinographen. All substances, including all radiographic dyes are potential causes.

BY MR. LICATA: And when you're asking him for what he has based his opinion on, you're not intending to exclude him from relying on the depositions in the chart. I mean I assume you're referring strictly to the...

BY MR. GOLDENSE: No, no. I'm talking about outside research.

BY MR. LICATA: That's fine.

Q Extrinsic to this evidence is what I am trying to inquire into now. According to this reading that you have told me you've done, about the incidence of adverse reactions, anaphylactic or anaphylactoid to the induction of radio opaque dye, what is the frequency in the literature, from your reading, of the incidence of anaphylactic or anaphylactoid shock? I'm trying to get a percentage chance of this occurring.

BY MR. LICATA: Objection. I don't think he...

BY MR. GOLDENSE: If he knows, he knows.

BY MR. LICATA: But what you asked him is based on the research and the literature, and I think he said he didn't look at any research in the literature.

BY MR. GOLDENSE: He said that about--wait.

Q You did read about contrast dyes, did you not?

A No.

Q What did you just tell me about: your reading about the general category of contrast dye mediums?

A I said that in my reading of anaphylactic or anaphylactoid reactions, that they could occur as a result of the injection of any foreign substance. in this category, radiographic dyes are mentioned as a frequent cause of this occurrence. There were no specific exciusions or' sinographen, and there were no percentages mentioned.

Q So the answer to my question is, you cannot ascribe a frequency for me on a percentage basis?

A No.

Q And you testified, you have never see it yourself?

A Seen what?

Q An adverse reaction to the induction of a contrast dye medium, anaphylactic or anaphylactoid, in your experience.

A That's not true.

Q Oh, you have never seen it with respect to sinographen, an adverse--you have never seen an adverse reaction to sinographen in your experience, is that

right?

A I have never seen an anaphylactic or anaphylactoid reaction to sinographen in my experience.

Q Have you ever seen an anaphylactic or anaphylactoid reaction to any other contrast dye medium in your experience?

A No.

Q Okay. What would be your best estimate, and obviously it can only be an estimate, as to the number of occasions in your professional life, where you have been involved in an anesthesia management situation, where sinographen was used as a contrast medium?

BY MR. LICATA: Objection.

Q It's an estimate, I understand that.

A I can't give you an estimate.

Q Is it more than fifty (50)?

A I have no idea.

Q You don't know if it's--have you ever seen it? Have you ever been an anesthesia management situation, where sinographen has been used by a surgeon, or someone such as Dr. Alhamshari in this case, for a contrast medium?

A I can't say for sure.

Q Can you say for sure that you have been involved in anesthesia management of patients, where contrast medium

have been induced into their body?

A Yes.

Q Can you give me an estimate as to how many occasions you have been in such cases in your professional career?

A My best guess would be several hundred.

Q Go back to the question, in those several hundred, and we understand it's only an estimate, in those several hundred procedures, you have never witnessed an anaphylactic or anaphylactoid shock reaction in any of those cases?

BY MR. LICATA: Objection. That's not what he said.

BY MR. GOLDENSE: That's what I'm asking.

Q Have you ever, in those several hundred cases, seen a patient sustain an anaphylactic or anaphylactoid reaction, after the induction of a contrast medium?

A Possibly.

Q It's hard for you to recall, is that it? When you say possibly.

A No.

Q Do you have a specific case in mind?

A I have seen reactions to the dye. I can't say that they were necessarily anaphylactic or anaphylactoid.

Q In any of those cases where there was a reaction,

was there cardiac arrest and death?

A No.

Q In any of those cases, do you recall the patient developing bradycardia?

A Perhaps.

Q Why do you qualify your answer? Because you cannot recall, or because you cannot recall if bradycardia was the reaction?

A Because I'm sure that of all those patients I've done, that during the anesthetic course, there have been episodes of bradycardia, not necessarily associated with tee dye.

Q Fair enough. In your criticism of Dr. Alhamshari, if I understood you, you thought that he had responded inappropriately to the emergency that he was presented with, including his failure to consider the possibility of an adverse reaction to sinographen, is that a correct characterization of what you said?

A That was one of the things, yes.

Q How would having considered an adverse reaction to the sinographen, as the cause of the patient's distress, lead him to manage her in a different fashion?

A You have to diagnose the condition in order to treat it. If you don't diagnose it or think of it, you can't institute treatment.

Q Of course.

A I think that his treatment would have been much ncre aggressive with volume expansion, adminis...

Q Volume expansion of what, Doctor?

A Volume expansion of the intravascular circulating volume. I think he would have been more aggressive with the administration of epinephrine. I think he would have been more aggressive with the immediate institution of cardiac massage, according to his testimony, and I think he would have been more alert to the administration of other drugs.

Q For instance?

A Steroids perhaps.

Q What would steroids have done for this patient?

a I don't know. She never received them.

Q Good, right. Why would you have suggested or considered steroids for this patient?

A They are part of the treatment in allergic reactions.

Q What do they do? What function to they perform?

A They perform a function of anti-inflammatory response. They reduce sone of the effects or' tne allergic reaction. He would have probably also, in the course of his treatment, if the patient survived, added some antihistamines. But the primary things that he

would have done is volume expansion and adrenalin and cardiac massage.

Q Now which of those criticisms also apply to Dr. Hahn?

A None.

Q Was he not a anesthesiologist called in to the management of this case, as soon as the circulating nurse could get him to the operating room?

A He was called in to help.

Q Is he not responsible for helping reach a diagnosis as to what's wrong with this patient?

A He was not there when the diagnosis had to be made.

Q Where do you draw that conclusion?

A As I understand it, Dr. Hahn was not in the room at the moment that Dr. Alhamshari injected the sinographen.

Q True, but...

A And as I also said...

Q Wait, in fairness, though, isn't Dr. Hahn within the room, clearly from his testimony and the deposition testimony of Judy Doss, within a few minutes after the code was called?

BY MR. LICATA: True.

A Yes.

Q Then why--is he exonerated from having to reach a diagnosis as to what was wrong with this patient,

whether it be an anaphylactic shock or an anaphylactoid shock reaction?

A Are you assuming he's responsible?

Q No, I'm asking you. You're the expert. I'm just a lawyer.

A You asked me if he was exonerated. I haven't established that he was responsible.

Q Wait a minute, Doctor. Now you're splitting hairs with me. You're exonerating him in your letter, saying--I mean you're under oath today, and you're written a letter. You've said, it's my professional opinion that their care, referring to Doss and Hahn, in no way directly or indirectly contributed to the complications with occurred to the patient on May 6th, 1985, ultimately resulting in her death. So you're the one who has exonerated these people.

BY MR. LICATA: Objection.

Q Now my question is, does Dr. Hahn have any responsibility at the moment when he is in the emergency situation in the operating room, to reach a diagnosis as to what happened to this patient?

BY MR. LICATA: Objection.

Q Does he have a responsibility to diagnose what was wrong with this patient in the operating room? That's my question.

A No.

Q Why not?

A That's such a broad inclusive category.

Q What's broad?

A Dr. Hahn does have responsibilities. But his responsibilities don't include being the diagnostician for every possible intraoperative event that could occur.

Q You are a board certified anesthesiologist, right?

A Right.

Q Dr. Hahn is an anesthesiologist, and whether or not he is board certified isn't relative to my question. You have made a determination diagnostically as to what happened to this patient, as an anesthesiologist, based on what happened intraoperatively. Why are you sitting here today in any different position than Dr. Hahn was in the operating room, immediately after the code was called? What's different between you and him?

BY MR. LICATA: Objection to that question.

A What do you mean what's different?

Q Why can you take responsibility for determining what caused Mary Brown's death and diagnosing it today, on a review, and Dr. Hahn, according to you, has no responsibility for reaching the same diagnosis, when he

was there in the operating room?

BY MR. LICATA: Are we talking about the anesthetic care and management, are we talking about hindsight, are we talking about the events and circumstances as Dr. Hahn faced them after the bradycardia occurred, and she went into cardiac arrest? I mean I object to that question.

BY MR. GOLDENSE: We're talking about the circumstances of the bradycardia and the cardiac arrest that Dr. Hahn faced when he walked into the operating room. He has criticized Alhamshari for not responding speedily.

BY MR. LICATA: In his capacity as the general surgeon, responsible for the surgery.

BY MR. GOLDENSE: Wait a minute now. Don't dare suggest the answer to your witness again...

BY MR. LICATA: I'm not.

BY MR. GOLDENSE: ...on a critical issue.

BY MR. LICATA: I am not suggesting...

BY MR. GOLDENSE: It is a suggestion.

BY MR. LICATA: No, it isn't.

BY MR. GOLDENSE: You're telling the man exactly what the answer has to be.

BY MR. LICATA: No, I'm not.

BY MR. GOLDENSE: Louis, please.

BY MR. LICATA: He said that Dr. Hahn had responsibilities. He never said that Dr. Hahn didn't have responsibilities. You've got two sections of inquiry here, and you're trying to merge them together.

BY MR. GOLDENSE: And if they are not to be merged, let me hear it from the witness, and not from you, please.

BY MR. LICATA: I think he has said that.

BY MR. GOLDENSE: No, he has not. You want him to, and he will now.

BY MR. LICATA: The record will speak for itself, because he has said that.

Q What exactly are the responsibilities of the anesthesiologist called in to a code--strike that.

What were the responsibilities for Dr. Hahn on May 6th, 1985, when the code was called, and he showed up in the operating room? What were his responsibilities at that moment in time?

A To help in any way that he could, for the best outcome of the patient.

Q Fine, does that assistance, which is his responsibility, including reaching a diagnosis as to what caused this emergency situation?

A No.

Q You're putting that entirely on the surgeon, because it happened intraoperatively, is that correct?

A No.

Q Where does the responsibility fall for diagnosing what happened to Mary Lou Brown, at the moment that the code was called, and Hahn and Alhamshari were in the room?

A As I understand it, Alhamshari was in the room when Dr. Hahn was not in the room. Dr. Alhamshari injected the sinographen as part of the surgical procedure. It was immediately after that injection that the patient has this catastrophic cardiovascular collapse, before Dr. Hahn was anywhere around. As I said before, in my opinion, it was the responsibility of Dr. Alhamshari, knowing that he had just injected the sinographen, and that the patient immediately, temporally, after the injection, had cardiovascular collapse, to me it's standard of care for him to consider in his diagnosis, based upon the clinical temporal relationship that

occurred, that this patient could have had an anaphylactic or anaphylactoid reaction, and responded immediately. As I said before, this can occur within seconds to minutes, and as a matter of fact, this patient with an anaphylactic or anaphylactoid reaction, can actually die within minutes. So this could have all been an issue that happened when Dr. Alhamshari was there, before Dr. Hahn even arrived, within a few minutes. It could have been too late.

Q In your experience and training, how long a window of opportunity exists for the physician in the OR to save the patient's life after the anaphylactic or anaphylactoid reaction occurs?

BY MR. LICATA: Objection.

Q How big a window of opportunity do you have to save the patient?

BY MR. LICATA: Objection. When you say physician, you're referring to the general surgeon?

BY MR. GOLDENSE: Yes.

A As I said, this could be, to save the patient, a matter of minutes, or a matter of a longer period of time.

Q What determines the length of the window of opportunity to save the patient's life?

A The individual response at that moment is an individual variability that can't be predicted, except to say that if you are going to be successful, speed is of the essence, and appropriate treatment is of the essence, if you wish that opportunity.

Q And you cannot answer how long the window lasts before the patient is gone irretrievably, is that the answer?

BY MR. LICATA: Objection. I think he said it varied on the patient.

Q What is your testimony, Doctor? Is there any way for you to put a number on the window?

A I know that it can be a very short period of time.

Q How short?

A I already told you.

Q You said seconds or minutes. Can you be any more precise than that?

A Seconds to minutes for the onset. The patient can die within minutes, or a longer period.

Q What's the fewest number of minutes that the patient could die? What's the worst case scenario?

A The fewest number?

Q Yes.

A I can't say.

Q And on the best case scenario, how long could a

patient survive an anaphylactic reaction, before the institution of the treatment that you suggested?

A It depends upon the severity of the anaphylactic or anaphylactoid reaction.

Q My only question is, how long can it be?

A Before what?

Q Before--how long can it be for the general surgeon to delay those modes of treatment that you earlier suggested that Dr. Alhamshari should have? I'll withdraw the question.

We know from Judy Doss' testimony that she was in the operating room throughout the period of time when the sinographen was injected and this reaction, according to your testimony developed, is that correct? We know that from her testimony.

A Yes.

Q What responsibilities did Judy Doss, as a CRNA have in the care and management of Mary Lou Brown, once the bradycardia was developed and was known, and signaled by her to Dr. Alhamshari?

A To do exactly as she did.

Q What exactly did she do?

A To notify Dr. Alhamshari, to have the nurse call for Dr. Hahn, to reassess the adequacy of ventilation.

Q Is it your testimony that she did all of those

things in a manner thae was within the standard--within the acceptable standard of care that applied to her under those circumstances?

A I don?know that ~hereare standards specifically listed, but it's my opinion that she responded in a professional, competent and appropriate manner in this situation.

Q Other than checking the airway, and calling for Dr. Bahn to respond, and advising Dr. Alhamshari of the patient's condition, the three things which you said she did, was there anything else that she should have done when the bradycardia developed during the surgical procedure?

EY MR. LICATA: Objection. I'm not sure he said checking the airway.

Q Didn't you say checking the airway?

A Reassess.

BY MR. LLCATA: Reassess.

A Adequacy of ventilation.

BY MR. LICATA: Reassessing adequacy of ventilation [redacted] different. That's why I objected.

Q Other than those three things, reassessing the airway, and calling the doctor, and telling Dr. Alhamshari what happened, is there anything else that

you believe she should have done?

A Yes.

Q That she should have done? What else should she have done?

A Exactly what she did.

Q What else did she do?

A She turned off the anesthetic agents and turned on oxygen.

Q And you believe that was done in a speedy manner by her?

A Absolutely.

Q Absolutely. That's your response, absolutely, she did do that in a speedy manner?

A My answer is absolutely to your question.

Q Is there anything else that she should have done at that point in time?

A There are other things that could have been done at that time, but I would not hold her to be responsible to think of them as a physician might.

Q Because as a CRNA, you're not going to hold her to the same standards that you would hold a physician, is that correct? A physician anesthesiologist.

A Yes.

BY MR. GOLDENSE: Subject to having Dr. Brallier produce for my inspection this

whatever it is, computer search note,from his colleague and all of the correspondence between your office, whether it be from you or Mr. Allison, or paralegals, or anybody else, related to the Mary Lou Brown case, I have no further questions at this time.

BY MR. LICATA: I'm going to state for the record right now, we have no intentions of producing Dr. Bralliar again without a court order. So if you have any questions. I can show you the four letters that we sent to him, if you would like to look at those letters. Just show it to him. As long as he doesn't mark on it, we can always give him a copy after the deposition.

BY MR. GOLDENSE: These are in some sort of chronological order?

BY MR. ALLISON: Reverse chronological at the moment, I believe.

(OFF THE RECORD)

BY MR. GOLDENSE: For the record, at my request, Mr. Licata has produced from his file, correspondence under cover of

November 2, 1987, correspondence of November 11, 1987, again on Arter and Hadden letterhead, November 28, 1987, again on Arter and Hadden letterhead, and August 29, 1988 on Arter and Hadden letterhead.

Q Doctor, the only question that occurs to me is, other than this one letter that your attorney--that defense counsel has provided to me that I am showing you here, Doctor, have you written any other letters to Mr. Licata arising out of your analysis of this case?

A No.

Q This is the only letter you have ever authored?

A Yes.

Q This letter being the February 17, 1988 letter, correct?

A Correct.

BY MR. GOLDENSE: I'm not going to request a waiver of signature.

BY MR. LICATA: We won't waive anyway.

BY MR. GOLDENSE: I was going to render it moot. I have no further questions. Thank you, Doctor.

BY DR. ERALLIAR: Thank you.

(END OF DEPOSITION)

I have read the foregoing page 1 through page 105 and note the following corrections:

PAGE	LINE	CORRECTION

THOMAS BRALLIAR

CERTIFICATE

The State of Ohio) ss
County of Cuyahoga)

I, MARC EPPLER, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the abovenamed THOMAS BRALLIAR, was first duly sworn to testify the truth; that the testimony then given by him was tape recorded and reduced to writing; that said deposition was taken and that it was completed without adjournment; that I am not a relative or counsel of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office in Cleveland, Ohio this 28th day of JULY, A.D., 1989.

MARC ZPDLER
Notary Public
State of Ohio
My commission expires
10-4-93

THE CLEVELAND CLINIC FOUNDATION
9500 Euclid Avenue Cleveland, Ohio 44106
A National Referral Center .in international Health Resource

DIVISION OF ANESTHESIOLOGY
216/444 6339

February 17, 1988

Mr. Lewis J. Licata
Arter & Hadden
1100 Huntington Bldg.
Cleveland, Ohio 44115

RE: Curtis Ray Brown, et al versus
Kamal El Hamshari, M.D., et al
Cuyahoga County Common Pleas Court
Case $98756

Dear Mr. Licata:

I have reviewed the following:

1. The Booth Memorial Hospital records for Mary Lou Brown covering her admission and surgery on May 6, 1985;

2. The autopsy protocol on Mary Lou Brown;

3. The deposition, testimony of the operating surgeon Kamal El Hamshari, M.D.;

4. The deposition, testimony of the anesthesiologist Young S. Hahn, M.D.; and

5. The deposition, testimony of the C.R.N.A. Judy Ann Daus.

After reviewing the above material, it is my professional opinion that the anesthesiologist Young S. Hahn, M.D., and the C.R.N.A. Judy Ann Daus, provided anesthesia care for Mary Lou Brown's surgery on May 6, 1985, which was well within the acceptable standard of care. Furthermore, it is my professional opinion that their care in no way, directly or indirectly, contributed to the complications which occurred to the patient on May 6, 1985, ultimately resulting in the her death.

Sincerely yours,

Thomas B. Bralliar, M.D.
Staff Anesthesiologist
Department of General Anesthesiology
Cleveland Clinic Foundation

CURRICULUM VITAE

Thomas B. Bralliar, M.D.
22089 Shaker Blvd.
Shaker Heights, OH 44122

I. PERSONAL DATA

Date of Birth: November 10, 1941
Place of Birth: Wickenburg, Arizona

II. EDUCATION

	DEGREE	DATES
Undergraduate School University of Tennessee Knoxville, Tennessee	B.S.	1959-1963
Graduate School University of Arizona Tucson, Arizona		1963-1965
Medical School University of Tennessee Memphis, Tennessee	M.D.	1965-1968

III. HOSPITAL TRAINING

Internship
Huron Road Hospital
Cleveland, Ohio — 1969

Residency in Anesthesiology
Huron Road Hospital
Cleveland, Ohio — 1970-1971

IV. PROFESSIONAL APPOINTMENTS

Cleveland Clinic Foundation — 1987-Present
Department of General Anesthesiology
Cleveland, Ohio
Staff Anesthesiologist

Member
Education Committee / 1988 - to present
Academic Committee, Chairman / 1988 to present
Education Governing Group / 1980 to present
Anesthesiology Division Committee / 1989 to present
Committee for the Review of the Chairman of the Division of Education 1989

Huron Road Hospital 1972-1987
Department of Anesthesiology
Cleveland, Ohio
Staff Anesthesiologist

Member
Clinical Competence Committee, Chairman / 1972-1987
Quality Assurance Committee / 1972-1987
Resident Selection Committee / 1972-1987

Director of Residency Education / 1976-1987
Duties entailed responsibility for determining and assigning all departmental academic activities and ensuring that all residents receive sufficient, academic, and clinical instruction to become "boarded." I prepared approximately 11 examinations and 52 lectures and/or conferences per year.

Associate Chairman / 1984-1987

Vice President - H.R. Anesthesia Service Inc. / 1984-1987
In addition to administrative responsibilities within the department, I was primarily responsible for organizing and implementing the financial considerations within the corporation.

Case Western Reserve University Hospitals 1982-Present
Department of Anesthesiology
Cleveland, Ohio
Clinical Instructor

V. PROFESSIONAL ACTIVITIES AND HONORS

Phillips Award - "Outstanding Intern" 1969
Whitacre Award - "outstanding Resident" 1971
Anesthesia Teacher of the Year (Huron Road Hospital) 1987

Fellow - The American College of Anesthesiologists 1971
Diplomate - The American Board of Anesthesiology 1974

Cleveland Academy of Medicine
Medical Practice and Service Committee 1975-1976

Cleveland Society of Anesthesiologists
Secretary 1976-1978
Vice-President 1978-1979
President 1979-1980
Board of Directors 1980-1982

Ohio Society of Anesthesiologists
Public Relations Committee - Chairman 1982-1985
Education Committee 1982-1984
Alternate Delegate (District 4) to the American Society of Anesthesiologists 1982-Present
Delegate (District 4) to the A.S.A. 1989
Nominating Committee 1989-90

American Society of Anesthesiologists
Surgical Anesthesia Committee 1990-1993

Society for Education in Anesthesia
Committee on CA-3 Curriculum Development 1989-Present

Invited Member: Citizen Ambassador Program: Regional
Anesthesia Delegation to the People's Republic of China 1990

PIE Mutual Insurance Company
Board of Directors 1979-1987

Univeristy of Tennessee Medical School
Fund Raising - Class Agent 1970-Present

Civic Award
"Good Citizen Award 1980
University Heights, Ohio

VI. MEMBERSHIPS

American Medical Association
Ohio State Medical Association
Cleveland Academy of Medicine
American Society of Anesthesiologists
Ohio Society of Anesthesiologists
Cleveland Society of Anesthesiologists

Critical Care Society
International Anesthesia Research Society
Regional Anesthesia Society
Society of Cardiovascular Anesthesiologists
Society of Ambulatory Anesthesia
Society for Education in Anesthesia

VII. COMMITTEES

Cleveland Clinic Foundation
- Division of Anesthesiology Education Committee, 1988-Present
- Division of Anesthesiology Academic Committee, Chairman, 1988-Present
  - Subcommittee In-Training Exam, Chairman, 1989-Present
  - Subcommittee Monday Anesthesia Conference 1989-Present
  - Subcommittee Journal Club, 1989
  - Subcommittee Clinical Correlation Conference, 1989-Present
  - Subcommittee Mock Oral Examination, 1989-Present
- Division of Education Governing Group, 1989-Present
  - Subcommittee Finance, 1990
- Committee for the Review of the Chairman of the Division of Education, 1989
- Search Committee for the Director of the School of Nurse Anesthesia, Chairman 1989
- Committee to Review School of Nurse Anesthesia, Chairman, 1989
- Anesthesiology Division Committee, 1989
- Division of Anesthesiology Finance Committee, 1989-topresent; Chairman, 1990
- Anesthesia Record Review Committee 1988-1989
- Division of Anesthesiology Brochure Committee, 1989

Huron Road Hospital
- Blood Utilization Committee
- CPR Committee
- Development and Fund Raising Committee
- Infection Control Committee
- Medical Staff Nominating Committee - Chairman
- Professional Library Committee - Chairman
- Public Relations Committee
- Resident Training Committee
- Transportation Committee - Chairman

TBB:sad *7/6/90*