In The Matter Of:

ELIZABETH VINCE v.
DINUBHAI C. PATEL, M.D., ET AL

DAVID C. BREWSTER, M.D.
June 23, 1999

Eyal Court Reporting, Inc.
390 Commercial Street
Boston, MA 02109-1007
(800) 322-3925 or (617) 964-4317

Original File 062399C.V1, 61 Pages
Min-U-Script® File ID: 2671699855

Word Index included with this Min-U-Script®

IN THE COURT OF COMMON PLEAS
LORAIN COUNTY, OHIO

NO. 97CV118400

ELIZABETH VINCE, Admrx for the estate of PAUL VINCE, deceased,
Plaintiff,

vs

DINUBHAI C. PATEL, M.D., et al., SUN PACIFIC INTERNATIONAL, INC. and ROBERT FLEMING,
Defendants.

DEPOSITION OF DAVID C. BREWSTER, M.D., taken before Susan F. Lozzi, Certified Shorthand Reporter and Notary Public in and for the Commonwealth of Massachusetts, pursuant to the Ohio Rules of Civil Procedure, at the Massachusetts General Hospital, One Hawthorne Place, Boston, Massachusetts, on Wednesday, June 23, 1999, commencing at 3:10 p.m.

EYAL COURT REPORTING SERVICE, INC.
84 STATE STREET, 2ND FLOOR
BOSTON, MASSACHUSETTS 02109
(800) 322-3925

APPEARANCES:

LAW OFFICES OF ANTHONY P. DAPORE
8039 Broadmoor Road - Suite 11
Mentor, Ohio 44060
(440) 975-9402
For the Plaintiff.
BY: ANTHONY P. DAPORE, ESQ.
(By Telephone)

ARNOLD & ASSOCIATES
115 West Main Street - Suite 200
Columbus, Ohio 43215-5041
(614) 224-1800
For the Defendants.
BY: GAYLE E. ARNOLD, ESQ.

INDEX

Deposition of:
DAVID C. BREWSTER, M.D.

DIRECT

EXHIBITS

Number	Description	Page
(No exhibits were marked.)		

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

DAVID C. BREWSTER, M.D., having been first duly sworn was examined and testified as follows:

DIRECT EXAMINATION BY MR. DAPORE:

Q: Would you state your full name and your professional address, please.

A: David Charles Brewster, and my office address is One Hawthorne Place, Suite 111, Boston, Massachusetts, 02114.

Q: Dr. Brewster, I introduced myself a moment ago. I'm Tony DaPore, and I represent the Vince family. And over the next few minutes, I'm going to be asking you some questions about opinions that you have with regard to care and treatment provided to Mr. Vince.

Before we do get into the questioning, I want to go through a couple of ground rules, particularly since we are on the telephone doing this deposition. Number one, and probably one

of the most important, is allow me to ask my question completely before you start to answer. Otherwise, we're going to be stepping over each other and our court reporter is not going to be able to pick up what we're saying. Okay?
A: Yes.
Q: Likewise, since we're by telephone, and probably the second most important, is if you do not hear me or you do not understand me, stop me and tell me, and I'll repeat it or rephrase it so that you do understand the question. Okay?
A: Yes.
Q: If you provide an answer to a question, it will appear on the transcript as though you did understand the question and provided a response to it as asked. Do you realize that?
A: Yes.
Q: If you need to answer a telephone call or a page or take any kind of a break, please just let me know, and we'll take whatever break is necessary for you.

Okay?
A: Thank you, yes.
Q: If you need to refer to anything to refresh your recollection, please feel free to do so. Just let me know what it is that you're looking at so that I can look at my copy of the records, as well. Okay?
A: All right.
Q: What is your specialty?
A: I'm a vascular surgeon.
Q: How long have you been a vascular surgeon?
A: 24 years I've been practicing after completing my training.
Q: Is your practice a private practice or is it a university academic practice?
A: It functions as a private practice but financially we're all part of one academic group, so all practice revenues get turned over to the hospital. So it's an academic institutional practice in that sense, but it's not that I don't have any patients and I simply supervise

residents.
Q: Is your group a corporation?
A: No. I'm a salaried employee of the Massachusetts General Hospital.
Q: Where did you go to undergraduate school?
A: I went to Trinity College in Hartford, Connecticut.
Q: When did you graduate?
A: 1963.
Q: And where did you go to medical school?
A: Columbia University College of Physicians and Surgeons.
Q: What year did you graduate?
A: 1967.
Q: And did you do an internship?
A: Yes, I did.
Q: And where was that?
A: At the Massachusetts General Hospital here in Boston.
Q: And your residency at the same?
A: Yes, that's right.
Q: What year did you complete your residency?
A: I completed the standard general surgery

residence in 1974; then I did a fellowship in vascular surgery and then I did an additional year as so-called chief resident. That means the single resident that's elected to stay on an additional year and run the entire teaching service.
Q: What years were you in your vascular fellowship?
A: 1974 to 1975.
Q: And then the one additional year was '75, '76?
A: That's right.
Q: Have you had any additional specialized training beyond your fellowship?
A: No.
Q: Are you currently licensed to practice medicine?
A: Yes.
Q: Where?
A: In Massachusetts.
Q: Do you have any other licensures?
A: No. None current. I was licensed for a time in Rhode Island when I was in the

Page 9

Navy, but that has lapsed.
Q: When were you in the Navy?
A: 1969 through 1971.
Q: Where were you stationed?
A: At Quonset Point, Rhode Island.
Q: Were you a general surgeon?
A: Yes.
Q: Have any of your licensures ever been suspended or revoked for any reason?
A: No, they haven't.
Q: I take it, you're board certified?
A: Yes, I am.
Q: In both general surgery and vascular?
A: That's right.
Q: When were you board certified in general surgery?
A: In 1975.
Q: Did you pass the boards on the first try?
A: Yes, I did.
Q: How about with vascular surgery? When were you certified?
A: I was certified the first year they offered the examination, which was in 1983.

Page 10

Q: Did you pass the first time?
A: Yes. And I've been recertified in vascular surgery in 1992.
Q: Are you due for recertification in the next year?
A: Not to my knowledge, no.
Q: Has your board certification ever been suspended or revoked for any reason?
A: No.
THE WITNESS: Mr. DaPore, could I take a break? I think I've got a page from the operating room. Okay?
MR. DAPORE: Very good.
(A short break was taken.)
Q: Dr. Brewster, where do you have privileges?
A: I have privileges at the Massachusetts General Hospital, and I also still have privileges for the Mount Auburn Hospital in Cambridge, Massachusetts, but I haven't done anything there probably in 15 years.
Q: Have your privileges ever been suspended or revoked for any reason?

Page 11

A: No.
Q: Do you have any publications dealing with the issues of chronic mesenteric ischemia and/or acute mesenteric ischemia?
A: I've written a great deal about aortic surgery, and I've got some publications both in peer review journals and also book chapters related to ischemic bowel complications at aortic surgery.
But I don't have any specific publications, I don't recall, related strictly to chronic mesenteric ischemia or the treatment thereof, no.
Q: Do you have any current teaching responsibilities?
A: Yes, I do.
Q: And what are those responsibilities?
A: I'm a professor of surgery at Harvard Medical School. Most of my teaching responsibilities relate to training residents in vascular surgery here at the Massachusetts General Hospital, but I am involved some with Harvard medical students teaching physical diagnosis,

Page 12

giving some lectures regarding basic surgery, introduction to surgery, but principal teaching relates to training residents here at Mass. General.
Q: Could you describe for me your current practice, if you can by using percentages or however is easiest for you to break it down?
A: You mean, how I spend my time?
Q: Let's start with that. How do you spend your time?
A: They're estimates, of course, but I probably spend 75 percent of time in direct patient care, seeing patients in the office; performing surgery three to four days per week; taking care of in-hospital patients; seeing in-hospital consultations.
I probably spend 10 percent of my time on administrative matters related to the — I am director of endovascular surgery for our division of vascular surgery. I have some responsibilities to our noninvasive vascular laboratory, and

Page 13

I probably spend 15 percent of my time with either teaching, speaking or writing obligations. I think that adds up to a hundred.

Q: Okay. Does the noninvasive vascular lab perform the duplex ultrasound of the mesentery vessels?

A: That lab might do it or vascular radiology might do it. Both departments do duplex scans of various blood vessels or organs.

Q: Do you currently perform endovascular procedures yourself?

A: Yes, I do.

Q: What ones do you perform?

A: We do quite a bit of endovascular stent graft repair of aortic aneurysms, and I perform some angioplasty or stenting of iliac or femoral occlusive disease.

Q: How long have you been doing those endovascular procedures?

A: About five years.

Q: Have you had any experience with angioplasty of the superior mesentery

Page 14

artery or interior mesentery artery or iliac axis?

A: I have no personal experience with that, although, obviously, I've taken care of patients where it might have been considered.

To my recollection, there may have been one patient that underwent angioplasty and stenting, one of my patients, by the vascular radiologist, but I don't personally perform that procedure, no.

Q: Have you ever been a defendant before in a medical malpractice case?

A: A defendant?

Q: Yes.

A: Yes.

Q: On how many occasions?

A: I've never had to appear in court. There was one case when I was a resident that was settled; that related to leaving an instrument in the abdominal cavity after surgery. I was in a case that was mainly an anesthesia problem where a wire was

Page 15

left in the vena cava. I was simply the surgeon, and I was eventually dropped from that case.

There was one case, I'm not sure I even recall the nature of the case, but it went to a tribunal and was dismissed for inadequate evidence. And I think there's two cases currently pending now against me.

Q: Do either of those cases involve chronic mesenteric ischemia?

A: No.

Q: Do either one of them involve acute mesenteric ischemia?

A: No. Rather than get all the questions, one of them, somebody came down with lung cancer four years after I operated on them, and they claim there was an abnormality on the admission chest x-ray four years previously that should have been noted. That case is ongoing.

And there's another case where there was a ureteral injury during aortic surgery and that case is ongoing.

Page 16

Q: When did you first start reviewing cases as a medical expert?

A: I'm going to estimate somewhere around 1980.

Q: And how many cases do you review on average in a year?

A: I think it's fair to say probably ten to 12. Somewhere about, perhaps, one case a month.

Q: How long has that been true?

A: That's been true for at least ten to 15 years.

Q: Are you currently working on any other cases that involve issues of chronic mesenteric ischemia or acute mesenteric ischemia?

A: No.

Q: Have you ever testified on behalf of a plaintiff in such a case, either chronic or acute mesenteric ischemia?

A: No.

Q: Have you ever testified on behalf of a defendant before involving chronic mesenteric ischemia or acute mesenteric

Page 17

ischemia?
A: I think I have. As I say, I've written a good deal about bowel ischemia after aortic surgery.
And I think over the years there's been one or two cases usually of colonic ischemia following aortic surgery that I've testified about. As I recall, I think both of them were defendant cases.
Q: What is the percentage breakdown of your reviews for plaintiff versus defendant?
A: Again, I would be estimating, but I would say probably two-thirds defendant and perhaps a third plaintiff.
Q: What is your charge per hour for review of cases?
A: $400 per hour to review; $500 per hour for deposition or court testimony.
Q: Do you have any sense of the number of depositions you've given over the years?
A: Not really. I would say only a handful of cases get to that point every year, so it might be, I don't know, I would say

Page 18

half a dozen depositions a year. And that would probably be true over the last ten years; something like that.
Q: And how about testimony at trial, either live or by videotape?
A: That's even more infrequent. I'm going to guess at three times a year.
Q: Again, over the last ten years?
A: Yes.
Q: Did you do any medical research prior to preparing for your deposition today?
A: I rereviewed all the records, but I didn't do any research, no.
Q: In the report that I have a copy of that you authored in February of this year, there's a listing of eight items that you reviewed for your report. Have you reviewed anything in addition since then?
A: Yes. Last night I spent about three hours reviewing the deposition transcript of Dr. Flanigan.
Q: Do you know Dr. Flanigan?
A: Yes, I do.
Q: Is he a well-respected vascular surgeon?

Page 19

A: Yes.
Q: Is he a reasonable vascular surgeon?
MR. ARNOLD: Objection.
A: You would have to define that for me.
Q: In your encounters with him, does he appear to be reasonable in his thoughts about vascular surgery?
MR. ARNOLD: Objection. You may answer.
A: I respect Dr. Flanigan, yes, so I would say in that context, he's reasonable.
Q: Have you read any of the depositions from the physicians at the Cleveland Clinic?
A: No, I haven't.
Q: Have you asked to see any of those depos?
A: No, I haven't.
Q: Have you prepared any other written reports other than the one that's dated February 22nd of 1999?
A: No, I haven't.
Q: Is there anything that you reviewed in Dr. Flanigan's deposition that has changed your opinions in any way as expressed in your letter of February

Page 20

22nd?
A: Could you repeat that for me, Mr. DaPore?
Q: Sure. Is there anything in the deposition that you reviewed for Dr. Flanigan that changes any of your opinions that you have expressed in your letter of February 22nd, 1999?
A: No. Nothing that I read in Dr. Flanigan's deposition would change my prior opinions.
Q: Do you intend to do anymore research or review in this case before coming to testify at trial?
A: Not that I anticipate at this time. I feel I'm knowledgeable and capable of testifying based on my own training and experience.
Q: If there is anything that you do review for this case that changes your opinions or gives rise to new opinions, will you tell either Mr. Arnold or Mr. Welch so that they can let me know and we can reconvene the deposition if we need to to

Page 21

explore those opinions?
A: Yes, I will.
Q: Can you tell me what the signs and symptoms of chronic mesenteric ischemia are?
A: Typically, there would be abdominal pain, usually related to eating, and weight loss.
Q: Is diarrhea frequently seen?
A: It can be, but I think it's — in my own experience, the change in bowel function or bowel frequency is often quite variable.
Some patients seem to have constipation, although probably more commonly diarrhea may be an issue, but I wouldn't regard either one as a hallmark of the clinical signs or symptoms of chronic mesenteric ischemia.
Q: How about aversion to food?
A: Yes. I mean, it's classically described as fear of food and so that would be a part of the typical clinical presentation or syndrome.

Page 22

Q: When Mr. Vince was admitted to Elyria Memorial Hospital in January of 1996, did he give a history of having postprandial pain?
A: I think he may have mentioned that to the emergency room physician, but I didn't see it in any of the other admitting history and physical examinations.
Q: Would Dr. Patel as a consulting physician be obligated to review the medical records of what had been done for Mr. Vince prior to his involvement in any histories obtained by other physicians?
A: I don't think he would be legally obligated. Obviously, any doctor wants to get as much information as possible, but I don't think I would classify it as an obligation.
Q: When you go in to consult on a patient, do you review prior histories from other physicians who have seen the patient before you?
MR. ARNOLD: Objection. You may answer.

Page 23

A: Sometimes. But often I prefer simply to get my own history.
Q: When Mr. Vince was in Elyria Memorial Hospital in January of 1996, did he give a history of weight loss?
A: I think he gave a history of about ten pounds of weight loss, yes.
Q: Did Mr. Vince give a history of an aversion to food in January of 1996?
A: Not that I recall, no.
Q: Did he give a history of some foods causing more pain and discomfort after eating than other types?
A: Not that I can recall, no.
Q: If he gave a list of solid foods causing more difficulty than liquid foods, would that be an indication of a food aversion?
A: When you say "more difficulty," what do you mean?
Q: More pain. The pain lasts longer.
A: Would it be indicative of food aversion? No, I don't think so.
Q: Would you agree with me that there are multiple reasons for delay in diagnosis

Page 24

of chronic mesenteric ischemia?
A: Yes, I would.
Q: Would one of them be a patient failing to seek care for several months after the onset of symptoms?
A: That's a common — common reason for delay, yes.
Q: Would another reason be that the patient goes to a general practitioner or family practitioner for a time before there is a referral to a gastroenterologist for further evaluation and workup?
A: That's a possible reason. I guess you're inferring that the general practitioner would be less likely to make a diagnosis than a gastroenterologist?
Q: Well, is that your experience?
A: I would say that's — that's a reasonable assumption, that it would be more common.
Q: What would be more common?
A: For the general practitioner to — the general practitioner would be less likely to arrive at the correct diagnosis than a gastroenterologist.

Page 25

Q: Would another cause be simply malpractice on the part of a physician failing to diagnose the condition?
MR. ARNOLD: Objection.
A: The question, as I remember it, relates to possible reasons for delay in diagnosis.
Q: Right.
A: So you're saying that one of the reasons for delay would be malpractice —
Q: Correct.
A: — in failing to arrive — I don't really follow your question.
Q: Let me restate it then. Would one of the reasons for delay in diagnosis of chronic mesenteric ischemia be malpractice on the part of a physician for failure to investigate it?
MR. ARNOLD: Objection.
A: It depends at what time frame you're speaking of. If the signs and symptoms have been going on for a long period and diagnostic evidence is accumulated to a point where the diagnosis should be made,

Page 26

I would acknowledge that at that point it's possible that failure to make a diagnosis might represent a standard of care below accepted levels.
But, certainly, I don't feel that's the case here with Dr. Patel, if that's what you're trying to get me to say.
Q: I'm not trying to get you to say anything. I'm just asking you what your thoughts are.
A: Well, I tried to answer your question. To me, it's a vague question.
Q: If a patient came to you who was 57 years old, is a male, with risk factors for arthrosclerotic disease being that he's a smoker for 30 years, non-insulin dependent diabetic, hypercholesterolemia, has a positive family history for coronary artery disease and the patient has been having post-triennial pain and a 30-pound weight loss over a four-month period of time, would you consider the diagnosis of chronic mesenteric ischemia

Page 27

in your differential?
MR. ARNOLD: Objection.
A: I think that it might be something that one physician would consider on their list of differential diagnoses.
It's hard for me to answer that question from personal experience because I just don't see those patients in that context.
Nobody is going to come to me as a vascular surgeon with just a complaint of weight loss and abdominal pain. They're going to be referred, usually, to me if there's a question of mesenteric ischemia, if you follow my point.
Q: Is the diagnosis strongly suspected in most of the patients that you receive upon referral?
A: Yes. In other words, I don't start from point zero with a patient with abdominal pain and have to rule out gallbladder disease, rule out pancreatic disease, rule out ulcer disease, rule out an

Page 28

ileocolitis. My practice isn't that sort of practice. But, certainly, I see these sorts of patients, and I'm quite familiar with the typical story, the typical means of evaluation; how long it takes to arrive at this diagnosis; how the diagnosis is usually or finally made and then what the proper therapies are.
Q: Is there any evidence in the records that you reviewed that Dr. Patel even considered chronic mesenteric ischemia in his evaluation of Mr. Vince?
A: I don't recall anything specifically noted in the records that would — where Dr. Patel wrote down that diagnosis or clearly indicated he was considering it, no.
Q: If a duplex ultrasound had been performed between January of 1996 and June 15th of 1996, would it have shown significant mesenteric vessel disease?
A: It's possible. But in my experience, the visceral artery duplex scan is a very difficult exam to technically get correct

Page 29

and, therefore, again in my experience, and it's based on review of reported experiences in the literature and our own experience here in our noninvasive vascular lab, the reliability or accuracy of duplex scanning for this purpose is not very good.

Q: Doesn't it have a greater than 95 percent positive predictive value?

A: Maybe in a few reports from various — from very experienced laboratories who do this a lot, but I would strongly disagree with that as a valid statement for the vast majority of hospitals, departments of radiology or vascular laboratories.

Q: If I understand your opinion, you would disagree with anyone who says that the probability is that a duplex ultrasound performed between January of '96 and the middle of June '96 would have shown significant mesenteric vessel disease?

A: I'm just saying that I'm not accepting that this is a simple highly accurate test. I would strongly disagree with

Page 30

that. It's possible that it would have shown disease, but the point I'm trying to make, I don't know what the facilities are like at Elyria Memorial Hospital, but unless they have a very experienced technologist or radiologist doing the study, it's a highly technical, difficult study that in our own experience here we have very disappointing results and accuracy with it, so I'm not going to agree that it would definitely have shown 95 percent accuracy in showing disease.

It's possible it would have shown disease. I don't think anybody would accept it as a definitive test, however.

Q: I'm not saying that it is a definitive test. The screening accuracy of the test more likely than not would have shown significant disease in Mr. Vince in that time frame, wouldn't it?

A: Again, I think you have to talk about what laboratory you're speaking about. Some labs or institutions that have

Page 31

written about this have a great interest in it, but I think even they would be the first to acknowledge that there are many difficulties with this, and this is based on our own experience. I don't regard it as a particularly useful modality.

Q: Has anyone in your vascular lab or the other lab that you mentioned that performs this study written anything in the medical literature saying that you have poor results with a duplex ultrasound?

A: I don't believe anybody has published that, no.

Q: You, yourself, have not published anything of that nature?

A: That's right.

Q: Do you feel that any of the treatment at the Cleveland Clinic and workup and plan for surgery for Mr. Vince fell below accepted standards of care?

A: No.

Q: In a patient like Mr. Vince who has significant arthrosclerotic disease in

Page 32

the mesenteric vessels and the lower segment of the aorta, the most frequent cause of vessel occlusion by thrombus is from a ruptured plaque causing the vessel to clot off?

A: I'm not sure. We can speculate about plaque rupture, but I think the generally accepted mechanism of bowel infarction in those circumstances is progressive critical stenosis of the vessel leading to slow flow and thrombosis.

I don't know if — plaque rupture may be a factor in some cases, but I think nobody knows about that. Certainly, there's been no clinical study in that regard.

Q: Do you have an opinion as to whether the transient decrease in blood pressure in the recovery phase of the dobutamine stress test had anything to do with the acute occlusion of the superior mesenteric artery?

MR. ARNOLD: Objection. Go ahead. You may answer.

Page 33

A: Again, we're speculating, but I think since I don't have an alternative explanation, I think it may be a significant factor.

In these circumstances, there's a very delicate balance between metabolic needs and very tenuous borderline blood supply to the bowel.

And I think a typical cause of a final thrombotic event and bowel infarction is a period of hypotension or a period of dehydration, things of this nature.

So although I certainly can't be sure, I think this may be an important factor. I have no other explanation why on the evening of July 26th this situation acutely deteriorated as it did.

Q: How long would there have to be a decrease in blood pressure to cause the low flow state?

A: I'm not sure we're speaking about a low flow state. My idea of the possible mechanism here would be severe stenosis,

Page 34

a preexisting low flow state through — because of this critical origin or osteo stenosis and, therefore, a period — a relatively brief period of hypotension might be enough to cause — to lead to thrombosis.

It wouldn't be an ongoing low flow state. It would be the transition from severe stenosis and very poor flow to actual thrombosis and total occlusion, so I think it's possible that a matter of, you know, a few minutes might be sufficient to cause that.

Q: What do you mean by "a few minutes"?

A: Three to five minutes.

Q: Is the risk of a failed graft after revascularization of the mesentery a greater risk after acute ischemia and bowel infarction than elective procedure with a chronic ischemia?

A: You're speaking strictly of the risk of graft failure?

Q: Correct.

A: It might be slightly higher if extensive

Page 35

resection of the bowel had to be carried out because the so-called runoff vascular bed that a bypass graft would have might be less if extensive amounts of bowel had to be resected.

But other than that, I don't think that infarction, itself, would alter or impact the anticipated patency of a bypass graft.

Q: What would you consider to be extensive amounts of bowel resection?

A: You know, two-thirds or three-quarters of the bowel resected.

Q: How would that — how long would that be in centimeters?

A: I have no idea, to be honest with you. I can't answer that question. I don't really resect bowel very often, so I can't put it in terms of centimeters. We would be talking feet, though, rather than centimeters.

Q: How many feet?

A: Well, I don't know. If I think back to medical school, maybe there's — I think

Page 36

there's some amazing figure like 30 feet of bowel, so I'm going to say 8 or 10 feet of bowel.

That sounds like a lot, but you're causing me to really speculate, and I don't really want to do that, so I'm guessing here.

Q: Did you see in Mr. Vince's records at the Cleveland Clinic that there was an increasing white blood cell count with a corresponding increase in platelet count starting from August 1st through August the 13th and 14th and 15th?

A: I have some recollection of that but not in great detail.

Q: Would that be suggestive of a patient with peritonitis and/or possible sepsis?

A: A rising white blood cell count might be compatible with sepsis, certainly, but I think just in the course of normal — the postoperative state, peoples' white blood cell count often rises to some degree.

Q: Have you ever heard of a delayed necrosis of the bowel occurring after an abdominal

Page 37

vascular surgery as late as 17 to 18 days post-op?
A: A delayed necrosis?
Q: Yes.
A: Well, certainly, I think the diagnosis of further bowel ischemia is often delayed and can be made as late as seven to ten days. I've not really seen or heard of cases with a delay that long, though, 17 or 18 days, no.
Q: Would you expect there to be extensive adhesions in the abdominal cavity at the time of autopsy of Mr. Vince if the peritonitis that was found at the time of the third surgery began on August 13th and he died on August 17th?
A: Would I expect extensive adhesions?
Q: Correct.
A: Not really.
Q: Why not?
A: You're talking about, as I understand your question, an interval of four days and adhesions I don't think occur or form to any degree in four days.

Page 38

Q: How long would it take for extensive adhesions to develop as a result of peritonitis?
A: The adhesions that I think you're speaking of I would say would take weeks to months to form, but I'm not sure I'm really following your question.
Q: If Mr. Vince had been your patient, would you have ordered a duplex ultrasound in May of 1996 when he had continued abdominal pain on the right lower quadrant, the weight loss of 30 pounds, he had a history of negative colonoscopy in January, a negative IVP in February of '96, a negative CT scan of the abdomen and pelvis in January of '96; that there was a negative upper G.I. performed in May of '96 showing only a small sliding hiatal hernia, and the gallbladder and ultrasound was negative?
MR. ARNOLD: Objection.
A: You're asking me if I would have performed a duplex scan?
Q: Correct.

Page 39

A: It's hard to say. I think if your point is would I have considered the diagnosis of mesenteric ischemia, I think it might — it's not unreasonable to start thinking about in the circumstances you outline.
As I've already explained to you, I'm not much of a believer in duplex scans so from my own practice perspective or patient-management perspective, I would perhaps have considered an arteriogram at some point to address that possible diagnosis.
Q: When would you have considered getting an arteriogram?
MR. ARNOLD: Objection.
A: You know, I really can't answer that question because this is an evolving story. I can't look back at these records and say on May 21st I would have definitely considered it.
I think it would be reasonable to start thinking about it on your list of differential diagnoses, a list which

Page 40

is extensive. And although tests that you indicated had been performed, there were lots of other possibilities still remaining.
Q: What were the other possibilities remaining?
A: Whether or not there was any malignant disease; whether or not there was pancreatic disease. I'm not a gastroenterologist. You know, I think they were puzzled.
Q: Well, would a chemistry profile, a full chemistry profile rule out pancreatic disease?
A: It might rule out pancreatitis but not necessarily rule out chronic pancreatitis or pancreatic cancer; things of that nature.
Q: So if the pancreas was normal by CT scan, would that rule that out?
A: It certainly makes it a lot less likely, yes. He had had a colonoscopy, a biopsy that was read, I believe, as consistent with nonspecific chronic colitis, so I

Page 41

think Dr. Patel was considering inflammatory bowel disease. That's a hard diagnosis to make, I believe. Although, again, I can't speak with experience of evaluating and managing patients of that nature.

Q: Do patients with diarrhea of two, three, four times a day that has been persisting for several weeks have microscopic inflammatory changes such as were seen in Mr. Vince?

A: I can't answer that. I don't know the answer to that question.

Q: Many of the reports that I have seen defend Dr. Patel by making a comment that the diagnosis made at the Cleveland Clinic in July of 1996 was made because of the negative studies that Dr. Patel had obtained prior to Mr. Vince going to the Cleveland Clinic. Do you share that opinion?

A: I think that's a very important and valid point, so I would share that opinion.

Q: Didn't Dr. Patel, however, have all of

Page 42

that same information in June of 1996, himself?

A: Yes, he did. And I think it's very likely that Dr. Patel would have started thinking along the lines of alternative possibilities such as mesenteric ischemia, but Mr. Vince elected to leave Dr. Patel's care and go to the Cleveland Clinic.

Q: Is there anywhere in the medical records that Dr. Patel was considering chronic mesenteric ischemia as a differential?

A: No. As I've already stated, I don't believe it's documented anywhere in the records.

But let's not forget Mr. Vince went to the Cleveland Clinic for his initial visit, and the diagnosis — I don't see any documentation there, either, that they considered the diagnosis.

Q: Do you know what kind of physician Dr. Horvath is?

A: I believe he's an internist.

Page 43

Q: In your hospital, patients coming in for general physical examinations by internists, are they typically done by senior residents?

A: You're saying if a patient came here to have an overall medical evaluation?

Q: Correct. As a new patient.

A: No. I don't think they would be seen by a senior resident, no.

Q: Who would they be seen by?

A: One of the staff internists.

Q: Do you know if Dr. Horvath was a staff internist or a resident?

A: I don't know.

Q: Do you think it was appropriate for Dr. Patel to tell Mr. Vince to come back in three months when he last saw him on June 4th, given no diagnosis for his condition?

A: I'm not familiar with that advice.

Q: Would that have been appropriate assuming that that's what Dr. Patel told Mr. Vince? We'll see you in three months unless something else comes up in the

Page 44

meantime, given the complaints, given the amount of weight loss and given that there was no diagnosis for his condition?

MR. ARNOLD: Objection.

Q: Would that be appropriate?

MR. ARNOLD: Objection.

A: I don't think that would be particularly good advice, no.

Q: Why not?

A: For the reasons you've already outlined. You don't have a diagnosis, and he had had considerable weight loss by that time.

Q: In your report of February 22nd, on page two, the second paragraph, you're speaking of the March 4th office visit.

A: Yes.

Q: You indicate that Dr. Patel's office notes at that time clearly indicate there was no history of abdominal pain or complaints of weight loss, correct?

A: That's what the report says, yes.

Q: In looking at the records of Dr. Patel for March 4th, did you review the record

Page 45

that is labeled at the top with family history and then an examination and then a second page that starts with — a preprinted page that starts with symptoms and then goes through — I'm sorry — systems and then goes through each of the systems?

A: I'll have to get the records out, if you want me to do that.

Q: Sure.

A: And you're speaking now of March 4th?

Q: Correct.

A: I've got the April 16th entry. I'm just trying to find March 4th here.

(Reviewing documents.)

A: Okay. I've got March 4th now. Where did you want me to look?

Q: Do you see the preprinted form?

A: Family history?

Q: Starts with family history.

A: Yes.

Q: Is there a weight recorded there?

A: Weight is 182 pounds.

Q: Is that a weight loss from the

Page 46

hospitalization in January of '96?

A: I don't know. I would have to look through the hospital records. I don't have — I don't have that information on the tip of my tongue, Mr. DaPore.

Q: Okay. Do you recall his weight when he entered the hospital to be about 187 pounds?

A: That's possible. I don't actually recall what it was, but I'll accept that if that's what you say.

Q: On the portion of the record that starts at the top with systems, if you go down to gastrointestinal, —

A: Yes.

Q: — it indicates that the patient has abdominal cramps with diarrhea.

A: Then it says no pain.

Q: After eating.

A: My record just says no pain.

Q: Well, then your record is cut off because there's additional history. No pain after eating.

A: Mine must be cut off because it doesn't

Page 47

show that. This is — you're saying that this is something the patient filled out?

Q: The patient — Dr. Patel filled it out when he was questioning the patient.

A: Mh-hmm.

Q: Would that be evidence that he was still having abdominal complaints on March 4th when he complained of abdominal cramps with diarrhea and having diarrhea three times a day?

A: Well, it doesn't say three times a day, but I was referring more here to the written note of Dr. Patel. He says specifically no abdominal pain, no diarrhea, no constipation.

Q: Does that seem to be in contravention to what's written in the review of systems? Does that appear to be contrary to what is written in the review of systems with the patient?

A: It's a puzzling difference, yes.

Q: Would you find it unusual for a patient to go to see a gastroenterologist that

Page 48

he's been seeing in the past for abdominal complaints to go see that physician for a sore testicle when he has had a primary care physician for several years?

MR. ARNOLD: Objection.

A: I think it's somewhat surprising, but Dr. Vinwanath seems to kind of have disappeared, at least from the records I see at this point.

And many patients, many gastroenterologists do function in the capacity of primary care givers, so perhaps Mr. Vince assumed at this point that Dr. Patel was doing it.

I don't — I don't know. I don't think it's a very important point, but can I explain why? No, I can't.

Q: What is "Ascid"?

A: What is what?

Q: "Ascid."

A: I'm not sure. I think it's a medication related to acid peptic disease, but I'm not actually sure. I never prescribe it,

Page 49

and I'm not really familiar with it.
Q: Is it given to patients who have epigastric discomfort after eating?
A: I think it is used as an antacid for complaints of that sort. But, again, I'm not very sure about that.
Q: What is your understanding as to when the decision was made that Mr. Vince was going to be going to the Cleveland Clinic for further evaluation?
A: According to my recollection and my notes, after the visit of June 4th with Dr. Patel, they informed him that they wanted to — that the patient's wife had called and wished — they wished to go to the Cleveland Clinic for further care, and I believe this was indicated also in Dr. Patel's deposition.
Q: Did you read Mrs. Vince's deposition?
A: Yes, I did.
Q: Do you recall what her testimony was as to when that conversation took place with Dr. Patel?
A: I don't recall a specific date. I

Page 50

certainly recall that according to her testimony there was a lot of frustration and difficulty getting a referral there or getting connected with proper people at the Cleveland Clinic, but I don't recall a specific date, no.
Q: In your institution, if a patient were to call and ask for an appointment to see you or anyone in your practice as a vascular surgeon, how long would it take to get an appointment?
A: It can be problematic. It may take a couple of weeks. That's certainly possible. Depends obviously on the nature of the complaint and what the urgency of the problem seems to be.
If it's a routine matter, kind of a general checkup or chronic problem that somebody wants evaluated, it may be a wait of several weeks.
Q: If a physician calls you directly, somebody that you know from the community, and says, Dr. Brewster, I would like you to see this patient, and

Page 51

the patient gives you the patient's complaints, does that expedite entry into your office to see a patient?
A: Yes, it certainly could do that, yes.
Q: And with that kind of a call and intervention, how long is the wait for the patient?
A: If it seems to be a bona fide, pressing or urgent matter, you might see — I might see the patient immediately?
Q: Well, if a call came in, we've got this patient, 30, 40-pound weight loss over the past five months and he's having this abdominal pain that I cannot find an answer for, all my studies are negative, and he continues to have the pain, how long would it take?
MR. ARNOLD: Objection.
A: I think in those circumstances, I would assume the patient's had this problem for months. Although it sounds like it's something significant, I wouldn't detect any — put any sense of urgency on it. And I would try — if I was responding to

Page 52

a physician's call who said that they simply were out of possible explanations for this, I would try to see him within the next week or two, probably.
Q: If Mr. Vince had been worked up in June of 1996 and operated on by early July of 1996, would he have survived?
A: I think more likely than not he would have, yes.
Q: Had Mr. Vince survived, do you have any opinions as to what his life expectancy would have been?
A: Well, he had very extensive arteriosclerotic disease. I'm not an actuarial expert, but I would say patients such as he with this amount of disease, coronary disease, mesenteric disease, aortic disease, their life expectancy, as a rule, I would say would be ten to 15 years less than the general population.
Q: Is that assuming that there's no surgical intervention for the coronary disease?
A: You know, I'm not a public health expert,

Page 53

but I think once you have that amount of disease, that your life expectancy no matter what therapies are done is considerably less than the average person.

Q: So at age 57, would you give him a ten-year life expectancy had he survived?

MR. ARNOLD: Objection.

A: I would be guessing, but I would say that's not unreasonable, yes.

Q: Would 15 be unreasonable?

A: You're starting to stretch it now, so you're saying he's going to get up to 72. You know, I think that's less likely.

Q: Is it still within the realm of probability that he would live to another 15 years?

MR. ARNOLD: Objection.

A: Instead of probability, I'll say realm of possibility. It's not out of the question.

Q: Do you have any criticisms of any other health care providers that they were

Page 54

negligent in treating Mr. Vince?

A: I don't have any criticism in terms of in the legal sense or negligence. I think it's instructive and important to recognize that Mr. Vince was evaluated over the course of four weeks at the Cleveland Clinic.

So, certainly, those physicians at a wonderful hospital did not put any urgency on the matter even when the diagnosis became quite evident.

Again, there was no urgency about intervention and, unfortunately, that timing simply didn't work out. In other words, he had an infarct of his bowel before corrective therapies were undertaken.

Q: If surgery had been performed in early July or planned for early July, would he have avoided the acute infarction of his bowel that took place in late July?

A: If it had — if he had had surgery in early July?

Q: Correct.

Page 55

A: Well, of course, it would have. He didn't infarct until July 26th. So if he was operated on before that, he would have avoided infarction, so I completely agree with that.

MR. DAPORE: Let me take a break and look at my notes, Doctor. I may be finished. If you need to return any phone calls or check on that patient from the O.R., —

THE WITNESS: Okay.

MR. DAPORE: — please do so.

(A short break was taken.)

Q: In your report on page four, the last paragraph, you state that the patient's ultimate death was not caused by the July 27th bowel infarction, correct?

A: Yes.

Q: What was the cause of his death?

A: The bypass graft that Dr. O'Hara put in to revascularize the bowel thrombosed and this led to reinfarction or more extensive additional infarction of the bowel, and I believe this was the cause

Page 56

of death.

Q: Why did that graft thrombose?

A: I don't think anybody knows that. In vascular surgery, bypass grafts occasionally thrombose, whether it's in the leg or the aorta or the mesenteric artery. We don't always know the cause.

In many cases, there may be failure because of just very extensive disease. In some cases, there may be failure due to technical reasons, but I think in this case, we don't know the reason why it failed.

Q: Do they also fail when they are placed in the presence of acute inflammation from infarction of the bowel?

A: No. I don't think that would be a cause, in my mind, of graft failure. It might result in graft infection, but I don't believe it would promote or accelerate graft thrombosis.

Q: But would infection of the vessel that is used for the bypass of the saphenous vein, if that becomes infected, does that

Page 57

promote thrombosis of the graft?
MR. ARNOLD: Objection.
A: Not in my mind. It promotes possible disruption of the anastomosis or actual disintegration and rupture of the graft, but I don't believe infection, per se, would increase the rate of thrombosis.
Q: Is the rate of graft failure higher in patients who are operated on for acute mesenteric ischemia with infarction versus patients who are operated on electively for chronic mesenteric ischemia?
A: I suspect that that is true. I don't know the actual difference in patencies, but I think in the emergency circumstances of acute infarction, possibly you're doing surgery, as in the case of Mr. Vince, at a difficult time in the middle of the night.
You're tired; maybe you don't have the best help that you might normally have, the circumstances all are adverse, so I think the rate of graft

Page 58

failure in those instances might be higher. And as I've already explained, if extensive resection of bowel is necessary, this may eliminate the runoff or flow through the graft and that might be an additional factor.
Q: Early graft failure is defined as any graft failure that occurs within the first 30 days postoperatively, correct?
A: Yes, that's right.
Q: Had Mr. Vince been operated on prior to the acute event with bowel infarction, would he have been more likely than — would he have more likely than not avoided graft failure?
A: No, I don't — as I explained to you, since I don't think — I think infection — or maybe I'm not following your question. Can you rephrase it for me?
Q: If Mr. Vince had been operated on in early July without an acute infarction of the bowel, would it have been more likely that he would have avoided the graft

Page 59

failure and occlusion that occurred later in the month?
MR. ARNOLD: Objection.
A: Certainly, as I already explained, I think the patency of grafts done in the circumstances, emergency circumstances of acute infarction would probably be a little less, although I don't think there's any hard data on that.
But I think it's logical that it would be a little worse than more elective circumstances, so if I'm following your question, I think if he were operated electively, he would have been more likely to have avoided graft failure, yes.
MR. DAPORE: Okay. That's all the questions I have. I want to thank you for your time.
THE WITNESS: You're welcome.
MR. DAPORE: What do you want to do about signature?
MR. ARNOLD: Doctor, you have a right to review the transcript to verify

Page 60

accuracy. The choice is yours.
THE WITNESS: Yes. I would like to review the transcript.
MR. DAPORE: That's fine.
(Whereupon the deposition concluded at 4:35 p.m.)

COMMONWEALTH OF MASSACHUSETTS

COUNTY OF ESSEX, SS.

I, Susan F. Lozzi, Registered Professional Reporter and Notary Public, duly and qualified in and for the State of Massachusetts do hereby certify there came before me the deponent herein, namely DAVID C. BREWSTER, M.D., who was by me duly sworn to testify to the truth and nothing but the truth concerning the matters in this cause.

I further certify that the foregoing transcript is a true and correct transcript of my original stenographic notes.

I further certify that I am neither an attorney or counsel for, nor related to or employed by any of the parties to the action in which this deposition was taken; and furthermore, that I am neither relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

IN WITNESS WHEREOF, I hereunto set my hand and affixed my Notarial Seal this 28th day of June, 1999.

SUSAN F. LOZZI, CSR,
Notary Public

My commission expires:
April 24, 2003.

PLEASE NOTE
THE FOREGOING CERTIFICATION OF THIS TRANSCRIPT DOES NOT APPLY TO ANY REPRODUCTION AND/OR DISTRIBUTION OF THE SAME BY ANY MEANS UNLESS UNDER THE DIRECT CONTROL AND/OR SUPERVISION OF THE CERTIFYING COURT REPORTER.