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

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Word Index included with this Min-U-Script®

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Vs is [7] DINUBHAIC PATEL, MD, et al., [9] EXHIBITS [9] SUM PACIFC INTERNATIONAL, INC. [11] (No exhibits were marked.) [9] Detendents. [11] (No exhibits were marked.) [11] DEPOSITION OF DAVID C. BREWSTER, M.D., [12] [11] DEPOSITION OF DAVID C. BREWSTER, M.D., [13] [12] Eaken before schwarbs. [16] [13] Shornhard Reporter and Notary Fubic in [16] [14] and for the Commonwealth of [16] [15] Massacrussets, pursuant to the Ohio Fulues [16] [16] Botori, Massacrussets, onthereday, June [27] [17] OPERATING BL, Che Hawthorne Place, [28] [18] Botori, Massacrussets, onthereday, June [28] [19] E.YAL COURT REPORTING SERVICE, INC. [28] [20] BOSTON, MASSACHUSETTS 02109 [20] [20] BOSTON, MASSACHUSETTS 02109 [20] [21] APPEARANCES: [21] [22] P.R-O-C-E-E-D-I-N-G-S [23] [24] [24] Marker, Che Add00 [36] [36] [37] DAVID C. BREWSTER, M.D., having		
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 [3] LAW OFFICES OF ANTHONY P. DAPORE 8039 Broadmoor Road - Suite 11 [4] Mentor, Ohio 44060 (440) 975-9402 [5] For the Plaintiff. BY: ANTHONY P. DAPORE, ESQ. [6] (By Telephone) [7] DIRECT EXAMINATION BY MR. DAPORE: BY: ANTHONY P. DAPORE, ESQ. [8] Q: Would you state your full name and your [9] professional address, please. [9] A: David Charles Brewster, and my office [10] A: David Charles Brewster, and my office [11] West Main Street - Suite 200 Columbus, Ohio 43215-5041 [12] 111, Boston, Massachusetts, 02114. [13] Q: Dr. Brewster, I introduced myself a [14] moment ago. I'm Tony DaPore, and I [15] represent the Vince family. And over the [16] next few minutes, I'm going to be asking [17] you some questions about opinions that [18] you have with regard to care and [19] treatment provided to Mr. Vince. 		
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 Mentor, Ohio 44060 (440) 975-9402 For the Plaintiff, BY: ANTHONY P. DAPORE, ESQ. (B) Telephone) (B) Telephone) (C) DIRECT EXAMINATION BY MR, DAPORE: (B) URECT EXAMINATION BY MR, DAPORE: (C) DIRECT EXAMINATION BY MR, DAPORE: (C) DIRECT		
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non Before me do get into the		
[17] [21] questioning, I want to go through a		
[18] [22] couple of ground rules, particularly		
[19] [23] since we are on the telephone doing this		
[20] [24] deposition. Number one, and probably one		
[21]	······	
[24]		

Page 5	Page 7
[1] of the most important, is allow me to ask	m residents.
[2] my question completely before you start	[2] Q: Is your group a corporation?
131 to answer. Otherwise, we're going to be	[3] A: No. I'm a salaried employee of the
(4) stepping over each other and our court	14) Massachusetts General Hospital.
[5] reporter is not going to be able to pick	[5] Q: Where did you go to undergraduate school?
[6] up what we're saying. Okay?	A: I went to Trinity College in Hartford,
[7] A: Yes.	丙 Connecticut.
[B] Q: Likewise, since we're by telephone, and	[8] Q: When did you graduate?
[9] probably the second most important, is if	[9] A: 1963.
[10] you do not hear me or you do not	[10] Q : And where did you go to medical school?
[11] understand me, stop me and tell me, and	The second se
[12] I'll repeat it or rephrase it so that you	
13] do understand the question. Okay?	(iz) and Surgeons.
	(13) Q: What year did you graduate?
[14] A: Yes.	[14] A: 1967.
[15] Q : If you provide an answer to a question,	[15] Q: And did you do an internship?
[16] it will appear on the transcript as	[16] A: Yes, I did.
[17] though you did understand the question	[17] Q: And where was that?
[18] and provided a response to it as asked.	(18) A: At the Massachusetts General Hospital
[19] Do you realize that?	[19] here in Boston.
[20] A: Yes.	[20] Q: And your residency at the same?
[21] Q: If you need to answer a telephone call or	[21] A: Yes, that's right.
[22] a page or take any kind of a break,	[22] Q: What year did you complete your
[23] please just let me know, and we'll take	[23] residency?
[24] whatever break is necessary for you.	^[24] A: I completed the standard general surgery
Page 6	Page 8
and a second	(i) residence in 1974; then I did a
	[2] fellowship in vascular surgery and then I
[3] Q : If you need to refer to anything to	3) did an additional year as so-called chief
[4] refresh your recollection, please feel	[4] resident. That means the single resident
157 free to do so. Just let me know what it	151 that's elected to stay on an additional
[6] is that you're looking at so that I can	
[7] look at my copy of the records, as well.	6 year and run the entire teaching
[a] Okay?	77 service.
jøj A: All right.	[7] service.[8] Q: What years were you in your vascular
	 [7] service. [8] Q: What years were you in your vascular [9] fellowship?
[10] Q : What is your specialty?	[7] service.[8] Q: What years were you in your vascular
III A: I'm a vascular surgeon.	 [7] service. [8] Q: What years were you in your vascular [9] fellowship?
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Page 9	Page 11
11) Navy, but that has lapsed.	n A: No.
[2] Q : When were you in the Navy?	[2] Q : Do you have any publications dealing with
[3] A: 1969 through 1971.	3) the issues of chronic mesenteric ischemia
[4] Q: Where were you stationed?	(4) and/or acute mesenteric ischemia?
151 A: At Quonset Point, Rhode Island.	(5) A: I've written a great deal about aortic
[6] Q: Were you a general surgeon?	[6] surgery, and I've got some publications
[7] A: Yes.	7 both in peer review journals and also
[8] Q: Have any of your licensures ever been	(8) book chapters related to ischemic bowel
^[9] suspended or revoked for any reason?	m complications at aortic surgery.
no A: No, they haven't.	[10] But I don't have any specific
[11] Q : I take it, you're board certified?	[11] publications, I don't recall, related
[12] A: Yes, I am.	[12] strictly to chronic mesenteric ischemia
[13] Q : In both general surgery and vascular?	[13] of the treatment thereof, no.
[14] A: That's right.	[14] Q: Do you have any current teaching
[15] Q: When were you board certified in general	[15] responsibilities?
(16) surgery?	[16] Â: Yes, I do.
[17] A: In 1975.	[17] Q: And what are those responsibilities?
[18] Q : Did you pass the boards on the first try?	[16] A: I'm a professor of surgery at Harvard
[19] A: Yes, I did.	19 Medical School. Most of my teaching
[20] Q : How about with vascular surgery? When	[20] responsibilities relate to training
[21] were you certified?	211 residents in vascular surgery here at the
[22] A: I was certified the first year they	[22] Massachusetts General Hospital, but I am
23) offered the examination, which was in	[23] involved some with Harvard medical
[24] 1983.	124) students teaching physical diagnosis,
Page 10	Page 12
[1] Q : Did you pass the first time?	n giving some lectures regarding basic
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in I probably spend 15 percent of my time	in left in the vena cava. I was simply the
[2] with either teaching, speaking or writing	[2] surgeon, and I was eventually dropped
(3) obligations. I think that adds up to a	jøj from that case.
0 hundred.	^[4] There was one case, I'm not
[5] Q: Okay. Does the noninvasive vascular lab	s sure I even recall the nature of the
[6] perform the duplex ultrasound of the	[6] case, but it went to a tribunal and was
[6] perform the duplex unfusioned of the	 [6] Case, but it went to a tribunar and was [7] dismissed for inadequate evidence. And I
(8) A: That lab might do it or vascular	[8] think there's two cases currently pending
19) radiology might do it. Both departments	ø now against me.
ion do duplex scans of various blood vessels	[10] Q: Do either of those cases involve chronic
[11] OF OFGANS.	[11] mesenteric ischemia?
[12] Q : Do you currently perform endovascular	[12] A: No.
[13] procedures yourself?	[13] Q : Do either one of them involve acute
[14] A: Yes, I do.	[14] mesenteric ischemia?
[15] Q : What ones do you perform?	ns A: No. Rather than get all the questions,
[16] A: We do quite a bit of endovascular stent	(16) one of them, somebody came down with lung
177, graft repair of aortic aneurysms, and I	[17] cancer four years after I operated on
[18] perform some angioplasty or stenting of	[18] them, and they claim there was an
[19] iliac or femoral occlusive disease.	[19] abnormality on the admission chest x-ray
[20] Q : How long have you been doing those	[20] four years previously that should have
[21] endovascular procedures?	[21] been noted. That case is ongoing.
[22] A: About five years.	[22] And there's another case where
	비행 이렇게 이렇게 되는 것 같은 것 같
	253 there was a ureteral injury during aortic
[24] angioplasty of the superior mesentery	[24] surgery and that case is ongoing.
Page 14	0
Page 14 [1] artery or interior mesentery artery or	Page 16 [1] Q: When did you first start reviewing cases
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[1] artery or interior mesentery artery or	 [1] Q: When did you first start reviewing cases [2] as a medical expert?
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j ischemia?	III A: Yes.
A: I think I have. As I say, I've written a	[2] Q: Is he a reasonable vascular surgeon?
good deal about bowel ischemia after a aortic surgery.	[3] MR. ARNOLD: Objection.
	 [4] A: You would have to define that for me. [5] Q: In your encounters with him, does he
And I think over the years there's been one or two cases usually of	[5] Q: In your encounters with him, does he [6] appear to be reasonable in his thoughts
colonic ischemia following aortic surgery	about vascular surgery?
that I've testified about. As I recall,	
I think both of them were defendant	[8] MR. ARNOLD: Objection. You [9] [9] may answer.
a cases.	
Q: What is the percentage breakdown of your	 A: I respect Dr. Flanigan, yes, so I would say in that context, he's reasonable.
reviews for plaintiff versus defendant?	[12] Q: Have you read any of the depositions from
A: Again, I would be estimating, but I would	[13] the physicians at the Cleveland Clinic?
a say probably two-thirds defendant and	[14] A: No, I haven't.
perhaps a third plaintiff.	[15] Q: Have you asked to see any of those depos?
Q : What is your charge per hour for review	[16] A: No, I haven't.
y of cases?	[17] Q: Have you prepared any other written
g A: \$400 per hour to review; \$500 per hour	[18] reports other than the one that's dated
for deposition or court testimony.	(19) February 22nd of 1999?
Q : Do you have any sense of the number of	[20] A: No, I haven't.
depositions you've given over the years?	[21] Q : Is there anything that you reviewed in
A: Not really. I would say only a handful	[22] Dr. Flanigan's deposition that has
of cases get to that point every year, so	^[23] changed your opinions in any way as
n it might be, I don't know, I would say	[24] expressed in your letter of February
Dege 19	
Page 18	Page
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Page 21		Page 23
[1] explore those opinions?		A: Sometimes. But often I prefer simply to
[2] A: Yes, I will.	1 ···	get my own history.
 Q: Can you tell me what the signs and symptoms of chronic mesenteric ischemia 	[3]	Q: When Mr. Vince was in Elyria Memorial
		Hospital in January of 1996, did he give
[5] are?	[5]	a history of weight loss?
[6] A: Typically, there would be abdominal pain,	[6]	A: I think he gave a history of about ten
Justice of the string and weight	: 1	pounds of weight loss, yes.
(a) loss.	[8]	Q: Did Mr. Vince give a history of an
[9] Q: Is diarrhea frequently seen?	. t	aversion to food in January of 1996?
10] A: It can be, but I think it's — in my own	[10]	
(1) experience, the change in bowel function	[11]	Q: Did he give a history of some foods
1121 or bowel frequency is often quite		causing more pain and discomfort after
is variable.		eating than other types?
[14] Some patients seem to have	1	A: Not that I can recall, no.
(15) constipation, although probably more	[15]	Q: If he gave a list of solid foods causing
[16] commonly diarrhea may be an issue, but I		more difficulty than liquid foods, would
in wouldn't regard either one as a hallmark	1	that be an indication of a food aversion?
118] of the clinical signs or symptoms of	[18]	
กๆ chronic mesenteric ischemia.	1	you mean?
[20] Q : How about aversion to food?	[20]	Q: More pain. The pain lasts longer.
[21] A: Yes I mean, it's classically described	[[21]	ししか しかし レート しんしゃ かかいたかい たわか からから ション ブルム しゅうかい おうしか 日本 熱発気 読ん () 後後後
[22] as fear of food and so that would be a	- L -	No, I don't think so.
[23] part of the typical clinical presentation	[23]	
[24] or syndrome.	[24]	multiple reasons for delay in diagnosis
Page 22		Page 24
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 (1) Q: When Mr. Vince was admitted to Elyria [2] Memorial Hospital in January of 1996, did [3] he give a history of having postprandial [4] pain? [5] A: I think he may have mentioned that to the [6] emergency room physician, but I didn't [7] see it in any of the other admitting [8] history and physical examinations. [9] Q: Would Dr. Patel as a consulting physician [10] be obligated to review the medical [11] records of what had been done for Mr. [12] Vince prior to his involvement in any [13] histories obtained by other physicians? [14] A: I don't think he would be legally [15] obligated. Obviously, any doctor wants [16] to get as much information as possible, [17] but I don't think I would classify it as [18] an obligation. [19] Q: When you go in to consult on a patient, [20] do you review prior histories from other [21] physicians who have seen the patient 	[1] [2] [3] [4] [5] [6] [6] [7] [8] [9] [10] [11] [12] [14] [14] [14] [14] [14] [14] [14] [15] [14] [15] [14] [15] [15] [15] [15] [15] [15] [15] [15	 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

Page 25	Page 27
q Q: Would another cause be simply malpractice	(1) in your differential?
n on the part of a physician failing to	[2] MR. ARNOLD: Objection.
a diagnose the condition?	p) A: I think that it might be something that
MR. ARNOLD: Objection.	[4] one physician would consider on their
A: The question, as I remember it, relates	15) list of differential diagnoses.
s) to possible reasons for delay in	[6] It's hard for me to answer that
n diagnosis.	p question from personal experience because
a) Q : Right.	19 I just don't see those patients in that
A: So you're saying that one of the reasons	(9) CONTEXT.
n for delay would be malpractice —	101 Nobody is going to come to me
n Q : Correct.	[11] as a vascular surgeon with just a
A: — in failing to arrive — I don't really	iz complaint of weight loss and abdominal
a follow your question.	[13] pain. They're going to be referred,
Q: Let me restate it then. Would one of the	[14] usually, to me if there's a question of
5] reasons for delay in diagnosis of chronic	15 mesenteric ischemia, if you follow my
mesenteric ischemia be malpractice on the	ties point.
n part of a physician for failure to	Q: Is the diagnosis strongly suspected in
aj investigate it?	[18] most of the patients that you receive
MR. ARNOLD: Objection.	[19] upon referral?
of A: It depends at what time frame you're	[20] A: Yes. In other words, I don't start from
n speaking of. If the signs and symptoms	21 point zero with a patient with abdominal
2) have been going on for a long period and	[22] pain and have to rule out gallbladder
a) diagnostic evidence is accumulated to a	23) disease, rule out pancreatic disease,
4) point where the diagnosis should be made,	1241 rule out ulcer disease, rule out an
	(
	r .
Page 26	Page 2
I would acknowledge that at that point	(i) ileocolitis. My practice isn't that sort
-	[1] ileocolitis. My practice isn't that sort[2] of practice. But, certainly, I see these
 i) I would acknowledge that at that point 2) it's possible that failure to make a 3) diagnosis might represent a standard of 	 [1] ileocolitis. My practice isn't that sort [2] of practice. But, certainly, I see these [3] sorts of patients, and I'm quite familiar
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 1 I would acknowledge that at that point 2 it's possible that failure to make a 3 diagnosis might represent a standard of 4 care below accepted levels. 	 [1] ileocolitis. My practice isn't that sort [2] of practice. But, certainly, I see these [3] sorts of patients, and I'm quite familiar
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Page 29	Page 3
) and, therefore, again in my experience,	in written about this have a great interest
and it's based on review of reported	121 in it, but I think even they would be the
experiences in the literature and our own	(3) first to acknowledge that there are many
experience here in our noninvasive	[4] difficulties with this, and this is based
n vascular lab, the reliability or accuracy	[5] on our own experience. I don't regard it
of duplex scanning for this purpose is	s a particularly useful modality.
η not very good.	[7] Q: Has anyone in your vascular lab or the
Q : Doesn't it have a greater than 95 percent	[8] other lab that you mentioned that
positive predictive value?	[9] performs this study written anything in
A: Maybe in a few reports from various —	[10] the medical literature saying that you
from very experienced laboratories who do	[11] have poor results with a duplex
h this a lot, but I would strongly disagree	[12] ultrasound?
	[13] A: I don't believe anybody has published
y vast majority of hospitals, departments	[14] that, no.
5) of radiology or vascular laboratories.	[15] Q: You, yourself, have not published
9 Q: If I understand your opinion, you would	[16] anything of that nature?
n disagree with anyone who says that the	[17] A: That's right.
probability is that a duplex ultrasound	[18] Q : Do you feel that any of the treatment at
performed between January of '96 and the	[19] the Cleveland Clinic and workup and plan
middle of June '96 would have shown	[20] for surgery for Mr. Vince fell below
significant mesenteric vessel disease?	[21] accepted standards of care?
a i'm just saying that I'm not accepting	[22] A : No.
that this is a simple highly accurate	
4 test. I would strongly disagree with	[23] Q: In a patient like Mr. Vince who has [24] significant arthrosclerotic disease in
Page 30	
ij that. It's possible that it would have	Page 3
ij that. It's possible that it would have ij shown disease, but the point I'm trying	[1] the mesenteric vessels and the lower[2] segment of the aorta, the most frequent
ıj that. It's possible that it would have zj shown disease, but the point I'm trying aj to make, I don't know what the facilities	 [1] the mesenteric vessels and the lower [2] segment of the aorta, the most frequent [3] cause of vessel occlusion by thrombus is
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Page 33	Page 38
n A: Again, we're speculating, but I think	in resection of the bowel had to be carried
zj since I don't have an alternative	2 out because the so-called runoff vascular
3) explanation, I think it may be a	3 bed that a bypass graft would have might
4) significant factor.	14] be less if extensive amounts of bowel had
51 In these circumstances, there's	is to be resected.
6) a very delicate balance between metabolic	M But other than that, I don't
needs and very tenuous borderline blood	7] think that infarction, itself, would
[8] supply to the bowel.	in alter or impact the anticipated patency
9 And I think a typical cause of	19 of a bypass graft.
oj a final thrombotic event and bowel	[10] Q: What would you consider to be extensive
in infarction is a period of hypotension or	[11] amounts of bowel resection?
27 a period of dehydration, things of this	[12] A: You know, two-thirds or three-quarters of
isj nature.	[13] the bowel resected.
So although I certainly can't	[14] Q: How would that — how long would that be
isj be sure, I think this may be an important	[15] in centimeters?
a factor. I have no other explanation why	[16] A: I have no idea, to be honest with you. I
7 on the evening of July 26th this	177 can't answer that question. I don't
isj situation acutely deteriorated as it did.	[16] really resect bowel very often, so I
9 Q: How long would there have to be a	(19) can't put it in terms of centimeters. We
decrease in blood pressure to cause the	[20] would be talking feet, though, rather
low flow state?	[21] than centimeters.
A: I'm not sure we're speaking about a low	[22] Q: How many feet?
rai flow state. My idea of the possible	[23] A: Well, I don't know. If I think back to
24) mechanism here would be severe stenosis,	[24] medical school, maybe there's — I think
Page 34	Page 3
in a preexisting low flow state through -	Page 3 (1) there's some amazing figure like 30 feet
(1) a preexisting low flow state through — [2] because of this critical origin or osteo	Page 3 (1) there's some amazing figure like 30 feet [2] of bowel, so I'm going to say 8 or 10
 (1) a preexisting low flow state through — (2) because of this critical origin or osteo (3) stenosis and, therefore, a period — a 	Page 3 (1) there's some amazing figure like 30 feet
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 [1] a preexisting low flow state through — [2] because of this critical origin or osteo [3] stenosis and, therefore, a period — a [4] relatively brief period of hypotension [5] might be enough to cause — to lead to [6] thrombosis. [7] It wouldn't be an ongoing low 	Page 3 (1) there's some amazing figure like 30 feet [2] of bowel, so I'm going to say 8 or 10 [3] feet of bowel. [4] That sounds like a lot, but [5] you're causing me to really speculate, [6] and I don't really want to do that, so [7] I'm guessing here.
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INUBRAI C. PAIEL, M.D., EI AL	June 23, 199
Page 37	Page 35
y vascular surgery as late as 17 to 18 days	(i) A: It's hard to say. I think if your point
zj post-op?	[2] is would I have considered the diagnosis
A: A delayed necrosis?	jo of mesenteric ischemia, I think it
η Q: Yes.	[4] might — it's not unreasonable to start
ny ana amin'ny faritr'o amin'ny tanàna mandritry dia kaominina dia kaominina mandritry dia kaominina dia	[5] thinking about in the circumstances you
 A: Well, certainly, I think the diagnosis of b) further bowel ischemia is often delayed 	6) outline.
n and can be made as late as seven to ten	π As I've already explained to
8) days. I've not really seen or heard of	[6] you, I'm not much of a believer in duplex
9) cases with a delay that long, though, 17	19 scans so from my own practice perspective
oj or 18 days, no.	100 or patient-management perspective, I
1) Q : Would you expect there to be extensive	[11] would perhaps have considered an
adhesions in the abdominal cavity at the	[12] arteriogram at some point to address that
3) time of autopsy of Mr. Vince if the	(13) possible diagnosis.
4] peritonitis that was found at the time of	[14] Q: When would you have considered getting an
5] the third surgery began on August 13th	[15] arteriogram?
and he died on August 17th?	[16] MR. ARNOLD: Objection.
7 A: Would I expect extensive adhesions?	[17] A: You know, I really can't answer that
a Q: Correct.	[18] question because this is an evolving
	[19] story. I can't look back at these
oj Q: Why not?	[20] records and say on May 21st I would have
A: You're talking about, as I understand	[21] definitely considered it.
2) your question, an interval of four days	[22] I think it would be reasonable
a and adhesions I don't think occur or form	[23] to start thinking about it on your list
4) to any degree in four days.	[24] of differential diagnoses, a list which
Page 38	Page 4
Q: How long would it take for extensive	in is extensive. And although tests that
Q: How long would it take for extensive	 is extensive. And although tests that you indicated had been performed, there
Q: How long would it take for extensive adhesions to develop as a result of peritonitis?	 [1] is extensive. And although tests that [2] you indicated had been performed, there [3] were lots of other possibilities still
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DAVID C. BREWSTER, M.D.

June 23, 1999

DINUBHAI C. PATEL, M.D., ET AL

Page 41	Page 43
in think Dr. Patel was considering	(1) Q: In your hospital, patients coming in for
21 inflammatory bowel disease. That's a	2) general physical examinations by
[3] hard diagnosis to make, I believe.	[3] internists, are they typically done by
[4] Although, again, I can't speak with	[4] senior residents?
(5) experience of evaluating and managing	(5) A: You're saying if a patient came here to
[6] patients of that nature.	16) have an overall medical evaluation?
[7] Q : Do patients with diarrhea of two, three,	7] Q: Correct. As a new patient.
[8] four times a day that has been persisting	(a) A: No. I don't think they would be seen by
9 for several weeks have microscopic	19) a senior resident, no.
inflammatory changes such as were seen in	[10] Q: Who would they be seen by?
[11] Mr. Vince?	A: One of the staff internists.
[12] A: I can't answer that. I don't know the	[12] Q : Do you know if Dr. Horvath was a staff
[13] answer to that question.	na internist or a resident?
	[14] A: I don't know.
[15] defend Dr. Patel by making a comment that	[15] Q : Do you think it was appropriate for Dr.
16) the diagnosis made at the Cleveland	[16] Patel to tell Mr. Vince to come back in
	(17) three months when he last saw him on June
	[18] 4th, given no diagnosis for his [19] condition?
[19] had obtained prior to Mr. Vince going to	
[20] the Cleveland Clinic. Do you share that	[20] A: I'm not familiar with that advice.
[21] opinion?	[21] Q : Would that have been appropriate assuming
[22] A: I think that's a very important and valid	[22] that that's what Dr. Patel told Mr.
[23] point, so I would share that opinion.	[23] Vince? We'll see you in three months
[24] Q: Didn't Dr. Patel, however, have all of	[24] unless something else comes up in the
Page 42	Page 44
(1) that same information in June of 1996,	11 meantime, given the complaints, given the
11 that same information in June of 1996, 22 himself?	[1] meantime, given the complaints, given the[2] amount of weight loss and given that
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n that is labeled at the top with family	[1] show that. This is — you're saying that
2) history and then an examination and then	2 this is something the patient filled
a second page that starts with $-a$	isj out?
4 preprinted page that starts with symptoms	[4] Q: The patient — Dr. Patel filled it out
5] and then goes through — I'm sorry —	[5] when he was questioning the patient.
ej systems and then goes through each of the	روم A: Mh-hmm.
7) systems?	7) Q: Would that be evidence that he was still
B) A: I'll have to get the records out, if you	B) having abdominal complaints on March 4th
e want me to do that	(9) when he complained of abdominal cramps
oj Q: Sure.	[10] with diarrhea and having diarrhea three
1) A: And you're speaking now of March 4th?	[11] times a day?
2) Q: Correct.	[12] A: Well, it doesn't say three times a day,
31 A: I've got the April 16th entry. I'm just	113 but I was referring more here to the
4) trying to find March 4th here.	[14] written note of Dr. Patel. He says
sj (Reviewing documents.)	115) specifically no abdominal pain, no
6] A: Okay, I've got March 4th now. Where did	(16) diarrhea, no constipation.
7) you want me to look?	[17] Q: Does that seem to be in contravention to
a] Q: Do you see the preprinted form?	[18] what's written in the review of systems?
s A: Family history?	[19] Does that appear to be contrary to what
20] Q: Starts with family history.	[20] is written in the review of systems with
an A: Yes.	[21] the patient?
Q: Is there a weight recorded there?	A: It's a puzzling difference, yes.
A: Weight is 182 pounds.	[23] Q: Would you find it unusual for a patient
Q: Is that a weight loss from the	[24] to go to see a gastroenterologist that
Page 46	
(1) hospitalization in January of '96?	11 he's been seeing in the past for
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(i) and I'm not really familiar with it.	In the patient gives you the patient's
[2] Q: Is it given to patients who have	[2] complaints, does that expedite entry into
(a) epigastric discomfort after eating?	B) your office to see a patient?
A: I think it is used as an antacid for	[4] A: Yes, it certainly could do that, yes.
[5] complaints of that sort. But, again, I'm	[5] Q: And with that kind of a call and
[6] not very sure about that.	[6] intervention, how long is the wait for
7 Q: What is your understanding as to when the	[7] the patient?
18] decision was made that Mr. Vince was	[8] A: If it seems to be a bona fide, pressing
9 going to be going to the Cleveland Clinic	9 or urgent matter, you might see — I
10] for further evaluation?	(10) might see the patient immediately?
A: According to my recollection and my	[11] Q: Well, if a call came in, we've got this
12] notes, after the visit of June 4th with	[12] patient, 30, 40-pound weight loss over
13] Dr. Patel, they informed him that they	[13] the past five months and he's having this
14] wanted to — that the patient's wife had	[14] abdominal pain that I cannot find an
15] called and wished — they wished to go to	[15] answer for, all my studies are negative,
16] the Cleveland Clinic for further care,	[16] and he continues to have the pain, how
in and I believe this was indicated also in	(17) long would it take?
iej Dr. Patel's deposition.	[18] MR. ARNOLD: Objection.
19] Q: Did you read Mrs. Vince's deposition?	(19) A: I think in those circumstances, I would
A: Yes, I did.	[20] assume the patient's had this problem for
Q : Do you recall what her testimony was as	[21] months. Although it sounds like it's
²² to when that conversation took place with	[22] something significant, I wouldn't detect
23] Dr. Patel?	22) something significant, I wouldn't detect 23) any — put any sense of urgency on it.
A: I don't recall a specific date. I	24 And I would try — if I was responding to
Page 50	Page 52
(i) certainly recall that according to her	i) a physician's call who said that they
(i) certainly recall that according to her izj testimony there was a lot of frustration	[1] a physician's call who said that they[2] simply were out of possible explanations
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Page 53	Page 55
but I think once you have that amount of	1) A: Well, of course, it would have. He
 isease, that your life expectancy no matter what therapies are done is 	[2] didn't infarct until July 26th. So if he
4 considerably less than the average	is was operated on before that, he would
	[4] have avoided infarction, so I completely
 [6] person. [6] Q: So at age 57, would you give him a 	 [5] agree with that. [6] MR. DAPORE: Let me take a
7) ten-year life expectancy had he survived?	6 MR. DAPORE: Let me take a 7 break and look at my notes, Doctor. I
MR. ARNOLD: Objection.	[8] may be finished. If you need to return
9 A: I would be guessing, but I would say	[9] any phone calls or check on that patient
of that's not unreasonable, yes.	[10] from the O.R., —
Q: Would 15 be unreasonable?	[11] THE WITNESS: Okay.
A: You're starting to stretch it now, so	[12] MR. DAPORE: — please do so.
31 you're saying he's going to get up to	[13] (A short break was taken.)
4) 72. You know, I think that's less	[14] Q: In your report on page four, the last
5] likely.	[15] paragraph, you state that the patient's
Q: Is it still within the realm of	[16] ultimate death was not caused by the July
7 probability that he would live to another	[17] 27th bowel infarction, correct?
B 15 years?	[16] A: Yes.
MR. ARNOLD: Objection.	[19] Q: What was the cause of his death?
هز A: Instead of probability, I'll say realm of	[20] A: The bypass graft that Dr. O'Hara put in
n possibility. It's not out of the	[21] to revascularize the bowel thrombosed and
29 question.	[22] this led to reinfarction or more
Q: Do you have any criticisms of any other	[23] extensive additional infarction of the
24] health care providers that they were	[24] bowel, and I believe this was the cause
Page 54	Page 56
n negligent in treating Mr. Vince?	In of death.
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Page 57	
ij promote thrombosis of the graft?	Page 59 [1] failure and occlusion that occurred later
[2] MR. ARNOLD: Objection.	[2] in the month?
A: Not in my mind. It promotes possible	(a) MR. ARNOLD: Objection:
[4] disruption of the anastomosis or actual	A: Certainly, as I already explained, I
(5) disintegration and rupture of the graft,	is think the patency of grafts done in the
i but I don't believe infection, per se;	6 circumstances, emergency circumstances of
y would increase the rate of thrombosis.	acute infarction would probably be a
[8] Q: Is the rate of graft failure higher in	 in active infarction would probably be a in little less, although I don't think
p) patients who are operated on for acute	(9) there's any hard data on that.
[10] mesenteric ischemia with infarction	[10] But I think it's logical that
[11] versus patients who are operated on	[11] it would be a little worse than more
[12] electively for chronic mesenteric	[12] elective circumstances, so if I'm
riaj ischemia?	[13] following your question, I think if he
A: I suspect that that is true. I don't	[14] were operated electively, he would have
15 know the actual difference in patencies.	(15) been more likely to have avoided graft
16 but I think in the emergency	[16] failure, yes.
117 circumstances of acute infarction,	[17] MR. DAPORE: Okay. That's all
18 possibly you're doing surgery, as in the	[18] the questions I have. I want to thank
(19) case of Mr. Vince, at a difficult time in	[19] you for your time.
(20) the middle of the night.	^[20] THE WITNESS: You're welcome.
[21] You're tired; maybe you don't	[21] MR. DAPORE: What do you want
[22] have the best help that you might	[22] to do about signature?
[23] normally have, the circumstances all are	^[23] MR. ARNOLD: Doctor, you have a
124 adverse, so I think the rate of graft	[24] right to review the transcript to verify
	is a serie to review the transcript to verify

 Page 58 [1] failure in those instances might be [2] higher. And as I've already explained, [3] if extensive resection of bowel is [4] necessary, this may eliminate the runoff [5] or flow through the graft and that might [6] be an additional factor. [7] Q: Early graft failure is defined as any [8] graft failure that occurs within the [9] first 30 days postoperatively, correct? [10] A: Yes, that's right. [11] Q: Had Mr. Vince been operated on prior to [12] the acute event with bowel infarction, [13] would he have been more likely than — [14] would he have more likely than not [15] avoided graft failure? [16] A: No, I don't — as I explained to you, [17] since I don't think — I think [18] infection — or maybe I'm not following [19] your question. Can you rephrase it for [20] me? [21] Q: If Mr. Vince had been operated on in [22] early July without an acute infarction of [23] the bowel, would it have been more likely 	Page 60 [1] accuracy.The choice is yours. [2] THE WITNESS: Yes. I would [3] like to review the transcript. [4] MR.DAPORE: That's fine. [5] (Whereupon the deposition [6] concluded at 4:35 p.m.) [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] [19] [20] [21] [22] [23] [24]
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[2]		
	COUNTY OF ESSEX, SS.	
[3]		
	I, Susan F. Lozzi, Registered	
[4]	Professional Reporter and Notary Public,	
	duly and qualified in and for the State	
(5)	of Massachusetts do hereby certily there	
	came before me the deponent herein,	
[6]	namely DAVID C. BREWSTER, M.D., who was	
	by me duly sworn to testify to the truth	
[7]	and nothing but the truth concerning the	
	matters in this cause.	
[8]		
	I further certify that the foregoing	
[9]	transcript is a true and correct	
	transcript of my original stenographic	
	notes.	
[11]	I further certify that I am neither an	
	attorney or counsel for, nor related to	
[12]	or employed by any of the parties to the	
1401	action in which this deposition was taken; and furthermore, that I am neither	
្រែ	relative or employee of any attorney or	
(4.4)	counsel employed by the parties hereto or	
[14]	financially interested in the action.	
[15]		
[(~]	IN WITNESS WHEREOF, I hereunto set my	
[16]	hand and affixed my Notarial Seal this	
£ · · · 2	28th day of June, 1999.	
[17]		
[18]		
	Notary Public	
[19]		
	My commission expires:	
[20]	April 24, 2003.	
[21]		
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