DOC. 77

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

DIANE M. CARRICK, Executrix
of the Estate of Michael P. Carrick,

Plaintiff,

-vs-

JUDGE KILCOYNE
CASE NO. 185330

THE CLEVELAND CLINIC FOUNDATION, et al.,

Defendants.

- - - -

Deposition of THOMAS A. BROUGHAN, M.D., taken as if upon cross-examination before Sandra L. Mazzola, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Law Offices of Charles Kampinski, 1530 Standard Building, Cleveland, Ohio, at 10:10 a.m. on Wednesday, November 7, 1990, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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ALSO PRESENT:

Gwen Holler.

THOMAS A. BROUGHAN, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF THOMAS A. BROUGHAN, M.D.

BY MR. KAMPINSKI:

Q. Would you state your full name?

A. Thomas A. Broughan, B R O U G H A N.

Q. Okay. And where do you live, Doctor?

A. In Highland Heights.

Q. Your address?

A. 462 Sandhurst.

If Q. Sandhurst?

A. Yes.

Q. I want to ask you a number of questions this morning. If you don't understand any of them, tell me. I'll be happy to rephrase any question you don't understand. When you respond to my questions, please do so verbally. She is going to be taking down everything we say and she can't take down a nod of your head. Okay?

A. Yes.

Q. How old are you, Doctor?

A. Thirty-seven.
Q. All right. I haven't completely absorbed your CV, so why don't you in your own words just run me through your educational background.
A. Went to Wickliffe Senior High School, Allegheny College.
Q. When did you graduate from high school?
A '71.
Q. Go ahead.
A. Allegheny College, a B.S. in chemistry in '75. University of Cincinnati College of Medicine in '79.
Q. And then you did your internship and residency at the Cleveland Clinic between '79 and '84 in surgery?
A. Yes.
Q. Did you specialize at that time in any type of surgery?
A. I did a one-year fellowship following that in hepatobiliary.
Q. And that was also at the Clinic?
A. Yes, although most of the time was spent outside the Clinic.
Q. An exchange type of program?
A. It was actually spent in Pittsburgh and London.

Q. But you were still affiliated with the Clinic?
A. Right, right.
Q. And that was '84, '85?
A. I think so, yeah.
Q. What did you do after that?
A. I came on staff at the Cleveland Clinic.
Q. And have been there since?
A. Yes.
Q. What positions have you held at the Clinic since starting to work for them, I guess it would be what, '85?
A. July '85, I believe. Staff surgeon.
Q. And is your surgery specialized in any area since you've been a staff surgeon?
A. Yeah.
Q. In what?
A. In endocrine and in hepatobiliary.
Q. And what is that, endocrine?
A. Yea. Endocrine deals primarily with thyroid, parathyroid and endocrine pancreas.
Q. And hepatobiliary?
A. Is liver and the bile duets.
Q. Are you Board-certified?
A. Yes.
Q. When were you Board-certified?

A. I think it was '85.
Q. Okay Was that your first time?
A. Yes.
Q. You haven't failed the Board certification test?
A No. There's an oral and written and I passed both the first time.
Q. It lists on here that you're a member or a young surgeon representative of the Ohio Chapter, American College of Surgeons, 1990?
A. *Yes.*
Q. What's a young surgeon?
A. The American College of Surgeons formed an ad hoc committee to try to get young surgeons more involved in the socioeconomic aspects of medicine, and in order to do that, they asked the state chapters to pick what they thought were the cream of the crop of the young surgeons in their chapter and sent them to Chicago to the headquarters of the American College for a program, and I was picked that year. They pick a new person each and every year.
Q. What is the age cutoff, young surgeon versus middle-aged or old?
A. I guess it's all the state of mind. There's no age cutoff as far as I know.

Q. What department are you in?
A. General surgery.
Q. And who is the chairman of the department?
A. Robert Hermann.
Q. And in terms of hierarchy, who would you report to within the department?
A. Hermann. Hermann.
Q. And that's all?
A Yeah.
Q Has that been true since '85, since you've started there?
A Right.
Q How many staff surgeons are in your department?
A It has varied from time to time, but there have been about six to eight.
Q Is Dr. Nakamoto in your department?
A No.
Q What department is he in?
A. Hypertension, nephrology.
Q. Do you know what kind of a physician he is? I mean is he a surgeon?
A. He's a medical internist type.
Q. How is it that you got involved with Mr. Carrick? And any time you need to look at the records, Doctor, feel free to do so. My guess

is you've looked at them before coming here, right?

A. Yes, sir.

Q. And you pretty well know what's in there?

A. I tried to look at the pertinent parts.

Q. But any time you need to refer to it as pertains to any question or answer, go ahead and look at it and just tell me where you are looking.

How did you come to see Mr. Carrick?

A. Dr. Heyka referred him to me.

Q. And where was that?

A. In the office. You want the exact date?

Q. Yes, please.

MR KAMPINSKI Have you numbered the pages of these?

MR. GORE: Yes. I sent you a copy of the numbered pages.

Q. Any time you refer to the record, why don't you refer to the numbered page and then indicate what the page is.

A. Fine. I'll try to do that.

MR. SPISAK: George, we've got that same copy, I assume? I don't have mine with me.

MR. GORE: We did that after the last deposition so you might not have one.

A. April 4, 1989.

MR. GORE: And he is looking at 876.

A. Right.

Q. That's page 876?

A. Page 876, correct.

Q. Are those progress notes?

A. Those are Clinic notes.

Q. And that would be your note?

A. Yes.

Q. And that's the first time you saw him?

A. Yes.

Q. Where did you see him?

A. I saw him in my office.

Q. Which would have been at the Clinic?

A. Right.

Q. You're an employee of the Clinic?

A. Yes, I am.

Q. And what was the reason that he was referred to you?

A. Secondary hyperparathyroidism.

Q. And who made that diagnosis?

A. Dr. Heyka.

Q. How do you make that diagnosis?

A. There are a number of different things that you

look for, an elevated parathyroid hormone level, renal failure, metastatic calcifications, bone and joint pain, ectopic calcifications, certain x-ray findings.

Q. How was it made as it related to Mr. Carrick?

A. Mr. Carrick had chronic renal failure. He had the bone changes. He had severe ectopic calcifications and he had a very elevated parathyroid hormone level.

Q When you said secondary hyperparathyroidism, it was secondary to what?

A Secondary in terms of a response to the chronic renal failure.

Q. And who was treating him for the chronic renal failure?

A. Dr. Heyka.

Q. And how was he treating him?

A. I don't know that I can comment specifically on his treatment plan, not being a nephrologist. He was controlling his blood pressure. He was trying to control some of his bone and joint pain. I think that's as far as I could go.

Q. Did you talk to Dr. Heyka about the referral? I mean did the two of you sit down and discuss Mr. Carrick?

A. We talked by telephone after I had seen Mr. Carrick.
Q. Oh, after you saw him?
A. After I saw him.
Q. All right. How did you know that you were going to be seeing him?
A. I didn't. I just came into the office and it was on the schedule for the morning.
Q. I see. So somehow he had been placed on your schedule?
A. Right.
Q. And you saw him the morning of the 4th, April 4, '89?
A. Correct.
Q. Okay. Why don't you tell me what your findings were on that visitation and then I'll ask you to relate your conversation that you had with Dr. Heyka after the examination. Okay. But start with the examination if you would. And you're referring to what page now?
A. I'm still on 876.
Q. Okay. Go ahead.
A. What I had was I had the notes from his prior Cleveland Clinic hospitalization and his lab values. On physical examination he was a very

uncomfortable, slender man. He was seated in a wheelchair. And he had nothing palpable in his neck.

Q. Is that the extent of the physical exam?

A. Yes.

Q. What lab values did you have that you felt were important in your evaluation?

A. Parathyroid hormone level, calcium phosphates, BUN and creatinine.

Q. Why were those important? And by the way, what dates did you have those for? You said you had his hospital record from a previous hospitalization. Were those tests also, from the previous hospitalization?

A. Yes, right.

Q. All right. Did you perform additional tests --

A. Nos

Q. What days were the test levels from? And once again, when you find them refer to the page.

A. Okay. Fage 437, March 29.

Q. '89?

A. Pes. Sorry. 1989. Page 443. They were from March 28, March 29, March 30.

Q. Is that it?

A. Yes.

Q. What were the levels that were important to you, Doctor? You said calcium phasphate -- I'm sorry. BUN?

A. Calcium was 7.8 milligrams per deciliter. Phosphorus was 9.7 milligrams per deciliter.

Q. You are reading from what, sir, which page?

a. 443. BUN of 150 milligrams per deciliter. Creatinine of 7.4 milligrams per deciliter. The other thing I throw in there is alkaline phosphatase, which is on the same page, of 302 international units per liter.

Q. Which of those were abnormal, sir?

A. All of them.

Q. And what did these mean to you, either all together or individually, as it related to how you were going to approach the care of Mr. Carrick?

A. To me it confirmed Dr. Heyka's diagnosis.

Q. Of secondary hyperthyroidism?

A Of secondary hyperthyroidism.

Q. All right. How do you treat that? Well, I'm sorry. Did we finish your examination and meeting with Mr. Carrick on the 4th?

A. I don't know.

Q. Well, why don't you look at your notes.

A Well, I've completed what I had in my note.
Q Well, I mean did you talk to him about anything further on that occasion?
A Oh, sure. We had a discussion of -- that I agreed with Dr. Heyka and what the surgery would entail.
Q Okay. So there was a discussion about a surgical procedure with Mr. Carrick?
A Yes, yes.
Q Whose decision was it to have Mr. Carrick undergo surgery? Was it yours, Dr. Heyka's or a joint decision?
A Joint,
Q And just so I understand, when you say joint decision, for example, if one of you didn't agree that surgery should go forward, would that be effectively a veto of the other one's decision to do it?
A. Yeah.
Q. Okay. So it would require both of you to agree in order for a surgery such as this to go forward?
A Yes.
Q Are there ways to treat secondary hyperparathyroidism absent surgery?

A. I think it depends on the severity as to what the possibilities of treatment are going to be.

Q. Okay. Why don't you give me the range of possibilities then.

A. Okay. I really have to speak as a nonexpert on the medical treatment of secondary hyperparathyroidism because it's not something that I do.

Q. In other words, it can be treated nonsurgically, that is medically, but if it were treated in such a fashion, that wouldn't be done by yourself?

A. It wouldn't be done by myself, no.

Q. You are a surgeon, you operate.

A. The only reason that I would see such a patient would be they had either failed medical therapy or had gone too far for medical therapy.

Q. Well, what if you saw a patient who had, for example, not even undergone medical therapy? Would you be an appropriate person, even though you're a surgeon, to say to the medical doctor, Why don't you try medical therapy as opposed to, Let's go in and have the surgery at this time?

A. What I'd do if somebody came into my office is I would have them see one of our medical people

and allow then to make their own decision on that.

Q Do I assume correctly then by virtue of the fact that he had been referred to you by Dr. Heyka, that is, one of your medical people, did you assume that the prospect of treating him medically had already been considered by Dr. Heyka and rejected?

A Yeah.

Q. Did you ever consider that possibility yourself?

A. Well, sure. You wonder if, you know, has this gone so far that it's not going to be remediable with medical therapy.

Q. And did you make that decision?

A. Yes.

Q. What was your decision?

A. That it had gone too far.

Q. And what is it that led you to believe that?

A He really was in excruciating pain. He was quite uncomfortable, unable to really move around much, and he had extensive ectopic calcium depositian, not only in his soft tissues but in a number of blood vessels, and I think that easily tipped the balances toward surgery.

Q. Were there any serious risks regarding such a

surgery that concerned you as it related to the lab values that you've read to me?

A. No. These are pretty typical of renal failure patients with secondary hyperparathyroidism.

Q. What's the danger of a BUN in excess of a hundred?

A. I don't think there's any particular danger.

Q. Is there a bleeding risk?

A. There's always a bleeding risk in a uremic patient.

Q. Uremia being defined by you as someone who's BUN is elevated?

A. Someone who's BUN and creatinine are elevated. Whether on dialysis or not, that bleeding risk is unchanged.

Q. Well, does dialysis cause BUN to decrease?

A. Yes, usually does.

Q. Did you have any discussions with Mr. Carrick -- by the way, was he by himself when you met with him?

A. I don't believe so.

Q. Do you recall who he was with?

A. Not exactly, no.

Q. Were there any discussions about possibly dialyzing him to reduce his BUN before

subjecting him to surgery?
A. I didn't have any conversation about dialysis with Mr. Carrick.
Q. All right. Tell me what you recall the conversation being with Mr. Carrick on that occasion and whoever it is that was with him.
A. The best I can remember I simply related to the fact that I agreed with Dr. Heyka, he did have secondary hyperparathyroidism and would best be treated surgically for it.
Q. Okay. Now, the surgical treatment that you were referring to was not going to take care of his uremia problem, was it?
A. No.
Q. And that would still presumably be attended to by Dr. Heyka?
A. Or one of the members of the department of hypertension and nephrology.
Q. Okay. How long did that meeting take, by the way, that you had with Mr. Carrick, do you recall?
A I really can't recall.
a. If you had to guess, what would you say?
A. I'm not even sure I could. I try to spend as much time as the patient or the family requires

in terms of answering all questions and being sure that they're comfortable with what we've discussed and what we've planned. So I really couldn't accurately say.

Q. Okay. How long after that meeting -- well, was surgery scheduled right then and there?

A. Now, that I don't remember, if it was scheduled right then and there or we called and let him know later when surgery was scheduled.

Q. Okay. Were you at that time, April of '89, the youngest member of the surgical department?

A Yes.

Q. Is there a reason that you received this referral?

A. There are two of us in the department that do endocrine surgery, and the referrals are mixed between the two of us.

Q. Who was the other one?

A. Caldwell Esselstyn, Jr.

Q. Can you spell the last name?

A. E S S E L S T Y N, Jr.

Q. And what's the extent of Dr. Esselstyn's experience? How long has he been at the Clinic, do you know?

A. Been there 25 years, I believe.

Q. Had you ever seen a case --
A. Of secondary parathyroidism?
Q. Yes.
A. Yes.
Q. How many?
A. I'd probably seen about five to seven before then.
Q. Did you mention to either Mr. Carrick or whoever it is that was with him your level of experience with secondary hyperparathyroidism?
A. Na.
Q. You never said that you've never seen anything like that before?
A. Oh, I'd seen something Pike it before, sure.
Q. My question is did you ever say that to them?
A. That I had seen something like that before?
Q. That you had never seen something like that before.
A. But I had seen something like that before.
Q. I understand your answer. My question is did you ever say to Mr. Carrick or to whoever it is that was with him that you had never seen anything like it before? Maybe the question answers itself based upon the fact that you had told me that you had seen something like it.

A. Yeah.
Q. Had they all been at the Clinic?
A. Yes.
Q. Had you treated them all surgically?
A. Yes, because I'm in the surgical department, so those would be the cases that I would see.
Q. Okay. Any of them die?
A. No, not that I can recall.
Q. Were any of them on dialysis -- or were any of them not on dialysis prior to your performing surgery on them?
A. That I couldn't recall.
Q. When did you speak to Dr. Heyka then after you saw Mr. Carrick?
A I don't remember exactly at what point, if I was there in the office when I called him, if it was later in the day or when.
Q All right. Is that conversation memorialized somewhere?
A No.
Q. All right. So this is something that you recall by memory?
a. *Yes.*
Q. All right. Tell me what was said both by him and by yourself.

A Yeah. I'm not sure if I can recall all of it. I think part of it dealt with the severity of his ectopic calcifications and his pain, his bone pain, the condition of his kidneys and the timing of surgery, I would imagine.
Q Okay. Those are the general areas that you dealt with?
A. Just generally, I would think, yes.
Q. What specifics were talked about regarding those general areas? I mean the degree, for example, as to the severity of the calcifications.
A Yes.
Q As well as the pain that he was in?
A That was obvious.
Q Okay. And what about the condition of his kidneys?
A It was Dr. Heyka's opinion that he would eventually need dialysis. It was just a question of when.
Q All right. And I take it that that's something you would have left up to him?
A. Yeah.
Q. Well, did you discuss with him or did you raise a concern with him of operating on Mr. Carrick with a BUN in the area of 150?

A. No.
Q. And the possibility of putting him on dialysis to reduce the BUN before operating on him?
A. No.
Q. Why not?
A. Because I don't see the BUN of over a hundred being significant as far as his care.
Q. Was there any attempt to treat. the hyperparathyroidism medically to your knowledge?
A. I don't honestly know. That would be a question for Dr. Heyka.
Q. Did you have any additional discussions with either Mr. Carrick or Dr. Heyka regarding the upcoming surgery?
A. No. Aa I can remember, that office visit was my only conversation with Dr. Carrick as I can remember.
Q. You mean Mr. Carrick?
A. Mr. Carrick. I'm sorry.
Q. Or Dr. Heyka?
A. Dr. Heyka, that one call.
Q. Okay. Was your next contact then with Mr. Carrick the surgery itself?
A. I probably saw him -- I believe he was admitted the night before and so I probably stopped by

and saw him the night before.

Q. Which would have been what?

A. April 10.

Q. Were any additional lab tests run on him the night before to provide you with any additional information prior to surgery?

A. Yes, I believe he had lab tests run the night before.

Q. Okay. Why don't you tell me what the results of those were, sir.

A. I can give you part of the SMA. This is page 602. Total protein, 4.2. Grams per deciliter, albumin, 2.1. Grams per deciliter calcium, 8.1. Milligrams per deciliter phosphate, 9.3. Milligrams per deciliter uric acid, 11.7. Total bilirubin, 0.4 milligrams per deciliter. Glucose, 98 milligrams per deciliter.

This is page 603. Sodium 121. Milliequivalents per liter potassium, 5.5. Chloride, 88 milliequivalents per liter. CO2, 12 milliequivalents per liter. BUN 224 milligrams per deciliter. Creatinine 6.2 milligrams per deciliter.

Q. What does it mean if you have a BUN of 224, sir?

A. You're getting close to needing dialysis.

Q. Haven't you gone way past the poinc *of* needing dialyxis at 224?
A. No, not necessarily. I think, you know, you would have to ask the nephrologists as to whaC the indications for dialysis are officially because they're the experts and have the answers.

But just in simple terms for me, if the electrolytes are reasonable and the patient is not fluid overloaded, I don't feel that they have to have dialysis before surgery.
Q. What electrolytes are you talking about?
A. Things like sodium and potassium particularly.
Q. Okay. And I'm sorry. You read those numbers to me, didn't you?
A. Right.
Q. And what were they?
A. They were 121 and 5.5.
Q. And are those normal?
A. No. He had labs the following morning, however.
Q. Well, let's deal with those for a second. I'll get to the others. Are they high?
A. No. Well, the sodium is low and the potassium is high.
Q. And what does that tell, you as a surgeon?

A. That he's got chronic renal failure,
Q. Okay. You said if the electrolytes were reasonable and the patient was not fluid overloaded?
A. Right.
Q. How do you determine if the patient is fluid overloaded?
A. Clinical exam.
Q. How do you look?
A. You're looking for evidence of congestive heart failure.
Q And I take it you found none?
A No.
Q You said more tests were taken the next morning?
A Yes, were taken the next morning.
Q Prior to surgery?
A Yes.
Q And the reason for that was what?
A I wanted to see if those numbers were real that were reported the night before and if they were trending one direction or another.
Q. Okay. Was he provided any treatment or medication the previous evening that would have affected any of the laboratory values in any way?

A Yes. He was started on I.V. hydration.
Q And that would have assisted the potential fluid overload situation os the electrolyte balance?
A It would have Refped with the electrolyte balance.
Q Okay. What was he getting through the I.V.?
A It says here D-5 one-quarter normal -- one-half normal saline and 20 milliequivalents of potassium at 125.
Q That's pretty standard isn't it?
A. Yeah.
MR. GORE: That was from 670.
A I'm sorry.
Q Page 670. What was that, the order sheet from the night before?
A Pes, it's an order sheet,
Q. Anything else?
A No.
Q. All right. SO basically he was just given, what would you call it, the normal, typical I.V. prior *to* surgery?
A. Yes.
Q. All right. That would have potentially affected wkat, his potassium and his sodium?
A. Sodium.

Q. Both of which were not normal the night before?
A. Correct.
Q. What did you test the next morning? I'm sorry. Did you make the order for that or is that just a standard order?
A. It's actually done by the junior resident at night.
Q. And that would be just standard on his part?
A. They actually handwrite it out.
Q. Yes, but I mean the order itself would be a standard order for someone undergoing surgery the next morning?
A. Yes.
Q. What were the tests the next morning?
A. We're on page 603. The sodium had risen to 127 and the potassium had decreased to 4.8.
Q. Okay. And how were those?
A. Better. Better.
Q. Still abnormal though?
A. The potassium was now normal and the sodium was almost normal.
Q. Did you attribute that to the fact that he was getting those substances through the I.V*?
A. I think the hydration helped him a little bit, yes.

Q. What other tests results did you get?

MR. GORE: That morning?

Q. Yes.

A. That morning. Just the completion of that SMA, which we're again on page 603. Chloride was 96 milliequivalents per liter. CO2 was 13.8. BUN was 214, and creatinine was 5.8.

Q. Once again, the BUN didn't concern you in terms of his being a candidate for surgery?

A. Pretty much all the renal failure patients run high BUNS. It's not uncommon.

Q. So is the answer to my question it did not concern you?

A. Right.

Q. How did the surgery go?

A. Fine.

Q. You removed his parathyroid gland?

A. Glands. Four.

Q. Glands. Where are those?

A. They're called parathyroid because they're adjacent to the thyroid in most cases. That's the bow tie shaped gland below your Adam's apple in your neck, and these four parathyroid glands usually sit in close proximity to it, two on each side.

Q. So you don't remove the thyroid gland?
A. By and large no, although there are some circumstances under which you would.
Q. I mean you didn't?
A. No.
Q. So you removed the adjacent glands to the thyroid?
A. Yes.
Q. And the reason you do that is what?
A. The parathyroid glands make a substance called parathyroid hormone, or parathormone shortened, that's responsible for a fair degree of the body's calcium metabolism.
Q. And by removing those what was your hoped for result?
A. What you do is you decrease the drive to bring calcium out of the bone.
Q. Okay. And that's where his problem was?
A. Yes.
Q. That is, he was losing calcium out of the bone?
A. Yes.
Q. And you felt that by removing the parathyroid glands it would assist his body in not losing calcium out of the bones?
A. And probably allowing it to even remineralize.

Q. Were there any complications intsaoperatively?
A. Not that I recall, no.
Q. Okay. How long did the operation take approximately?
A. I have to look at the operative record, I don't know. Pes, that wouldn't say it there. It would be on the anesthesia record.
Q. Anesthesia record?
A. If I can read these things. I don't know. If I'm reading this correctly, and I'm not sure that I am -- and I'm on page 1418. It looks like from one to four-fifteen.
Q. Did you have anybody assist you?
A. Yes
Q. Who was that?
A. I'm sorry. Was that the right one? According to page 1427 of the operative record it was Drs. Kline and Hall.
Q. And who were they?
A. Residents on the service.
Q. you do the operation or did they?
A elieve I did the operation.
Q Do you know?
A Not for sure. I mean I need help from all the assistants, so you know, we all play differen

roles, but --

Q. Well, I take it part of the process of training residents is sometimes to allow them to do it. They've got to become doctors and go out into the world and do these things?

A. They may -- you know, I can't remember. But we do have residents. We are a teaching service. I always keep very tight supervision no matter what they're doing. But their role may have been nothing more than just to tie knots as I put them on.

Q. You just don't recall?

A. I just don't recall.

Q. Are they still there, by the way?

A. Dr. Kline is not. I'm looking at this Dr. Hall and I'm not sure I remember which Dr. Hall this was. We've had a number of Dr. Halls.

Q. Why is Dr. Kline no longer there, do you know?

A. Oh, he finished his training.

Q. Do you know where he went?

A. Initially. I don't know where he is this year.

Q. Where did he go?

A. He went to a research fellowship in New Orleans last year.

Q. Who was the anesthesiologist?

A The record says Dr. Brallier.

O I'm sorry. Can you spell that?

A. I think I can if I can find it.

B R A L L I E R

Q. Okay. And just so everybody is on the same page here --

A. I'm sorry. Yeah, here. 1418. I didn't see the page number there.

MR. KAMPINSKI: All right. Les and John, we've scheduled the depositions of Dr. Brallier and Nakamoto for November 20th at 10:00. They couldn't be done today. And that will be at the Clinic.

MR. GORE: I'll let you know what conference room.

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(Thereupon, a discussion was had off the record.)

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Q. Doctor, you were the attending physician during the hospitalization that started on April 10, is that correct.?

A. Yes.

Q. And what does it mean to be the attending physician?

A. As much as anything, you're the one that is responsible for the administrative details of admission and discharge. You're also responsible for arranging their medical care.
Q. Okay. While they're in the hospital?
A. While they're in the hospital.
Q. All right. So if a consult was required, I mean it would be up to *you* to get that consult?
A Right.
Q And you would be responsible then for his post-op care as well, would that be correct?
A As far as taking care of the wound and the immediate effects of the operation.
Q Well, I mean you would ultimately be responsible for all aspects of the post-op, wouldn't you? Whether or' not you got referrals or not, it would be up to you?
A Correct. But in terms of I couldn't be responsible for what a consultant recommended or did.
Q. I see what you're saying. Did you call in any consultants in the post-op care?
A Yes.
Q And who was that?
A I called in a number. I called in the

rheumatology service,

Q. And give me specific names, if you would

A. If I can.

Q. All right.

A. I believe the first rheumatologist to see Mr. Carrick in the hospital was Anna Koo, K O O.

Q. Whex was that?

A. Page 892, April 12.

Q. And why did you call her in?

A. Because he had the previous bone and joint pain and I believe had been seen by the department of rheumatology before.

Q. All right. So there was nothing specific in terms of a post-op complication that caused you to call her?

A. Correct.

Q. Okay. I'm sorry. Go ahead.

A. The renal service, of course, was secondary and I guess it was Dr. Nakamoto who was covering for Dr. Heyka in the hospital.

Q. When you say the renal service was secondary, what does that mean?

A. When you look at the sheet, the patient was admitted Broughan, Heyka, which meant that there were two services that saw the patient from the

get-go.

Q Okay. Was Dr. Nakamoto called in by you for any specific reason or this was just part of the overall care that he was getting while he was in the hospital?

A. That was preplanned, that the nephrology service, whoever was the staff physician on service, would pick up Mr. Carrick's care when he came into the hospital for his operation.

Q. Okay. I'm sorry. Go ahead.

MR. SPISAK: About other services?

MR. KAMPINSKI: Yes.

A. It's going to take me a while. On page 920, April 16, Dr. David Longworth from infectious disease.

Q Why was he called in?

A He was called in because of Mr. Carrick's pneumonia.

Q. Why did he develop pneumonia, Doctor?

A. I don't know.

Q Did the fact that he was uremic and had not been dialyzed contribute to his contracting pneumonia?

A No. I think uremia, whether or not they've been dialyzed alone might contribute to his

immunosuppressed state and cause him to be more susceptible, but the chronic renal failure, period, whether he's been dialyzed on not dialyzed, I don't believe has anything to do with that.

Q. Well, didn't you just say something inconsistent? I mean if in fact it causes a reduced immunosuppressed state, then doesn't that contribute to pneumonia?

A But just because you're dialyzing a patient doesn't change that. In other words, they're still immunosuppressed from chronic renal failure whether or not they're on dialysis. And just because you dialyzed someone doesn't change that immunosuppressed state.

Q. Do you have any opinion as to what the course of Mr. Carrick would have been had he been dialyzed and had a correction of his uremic state for a period of let's say six months prior to undergoing surgery?

A. I don't think it would have been any different. I don't think Mr. Carriek would have been able to carry on for six months to reach that point in time.

Q And why is that?

A. The severity of his bone disease.
Q. And do you have an opinion as to why his bone disease got that severe in light of the fact that he had been treating for years with a person who held himself out as a nephrologist?
MR. SPISAK: Note my objection. Go ahead, Doctor.
MR. GORE: You can answer.
A. I think his secondary hyperparathyroidism was more advanced than we would prefer to see our patients for surgical treatment.
Q. And when you say more advanced, is it your opinion that it should been recognized at some point prior to when in fact it was?
A. Yes.
Q. By the physician who had been treating him?
A. Yes.
Q. And had it been recognized in a timely fashion, do you have any opinion to a reasonable degree of medical certainty as to what the probable outcome would have been in the treatment and care of Mr. Carrick by someone qualified such as yourself?
A. You confused me a little bit. The only thing that I can comment about Mr. Carrick's care is

the treatment -- is the surgical treatment of his hyperparathyroidism.

Q. Okay. I didn't mean to confuse you. Let me try it again.

Had his hyperparathyroidism been recognized in a timely fashion, unlike the way it was, do you have an opinion under those circumstances what the probable outcome would have been for Mr. Carrick?

A. That's difficult to know. I'm not sure that I can say that. You know, surgical experience of treating secondary hyperparathyroidism as reported in the literature is a fairly low morbidity, low mortality procedure. So I'm not sure enough information is really available to say, you know, at what point a difference would have been made.

Q. Well, is it your opinion that it had progressed to the point where no matter what you did, nothing would have made a difference?

A. I think his bone disease was very severe. I think it's one of the reasons why he should have been operated on earlier rather than later in his -- in that current circumstance.

Q. And had he been operated on earlier do you

believe then that the low morbidity and mortality figures that you've just suggested exist for this type of a surgery would have been more applicable to him?

A. That's pure judgment and speculation.

Q. Well, yeah, but you're the doctor. And you know, listen, if you don't have an opinion on these things, tell me. But when we as lawyers ask you for opinions, we're asking you as to what probably would have happened. Obviously you can't say to a certainty because he's not here for you to do it in a timely fashion.

And my question is what probably would have happened had you been able to do so in a timely fashion, the probability being defined as 51 percent or more?

A. I think he would have been in better shape.

Q. And that's as far as you go?

A. Yes.

Q When you say better shape, better shape in terms of a candidate for surgery and ultimate recovery?

A A candidate in terms of the extent and degree of his bone disease, the amount of pain he was in as a result of it.

Q. Well, okay. And in terms of the recovery from that, I mean would he have been in better shape for that then?
A. I think so, yeah.
Q. What complications other than pneumonia did Mr. Carrick suffer from postoperatively? Well, you know what? Let me withdraw that. I don't want to stop you in the middle of answering another question, which was which consults did you get. You got me up to Dr. Longworth.
A. Okay. On that same day Dr. Zaccaro was consulted for colonoscopy.
Q. Zaccaro?
A. Z A C C A R O, from gastroenterology.
Q. And why was that consult made?
A. Mr. Carrick had developed a distended abdomen and a dilated cecum.
Q. What was the reason for that?
A. Probably because he was sick with his pneumonia.
Q. Well, was Mr. Carrick receiving Dialume?
A. Yes, I believe he was.
Q. And what is Dialume, Doctor?
A. Dialume, if I remember correctly, is a phosphate binder.
Q. Who put him on that?

A He was probably placed on that in our postoperative orders.

MR. GORE: 670, something like that.

Q Well, wasn't he put on Dialume when he arrived at the Cleveland Clinic?

A. Correct. But I thought you meant what order got him on it post-op.

Q. Well, was Dialume continued from the time that he entered the Clinic until -- well, throughout the post-op period?

A. It was ordered postoperatively.

Q. Was he on it when he first came in?

A. Yes, I believe he was.

Q. All right. And who put him on it when he first came in?

A. He was already on it when he came in. That was a drug he was already receiving.

Q. Do you know who originally placed him on it?

A. I would assume it would have been the nephrology people.

Q. And what was it being given for?

A. I assume for his high serum phosphate.

Q. What effect does that have -- well, I mean does it cause severe constipation?

A. I think renal failure patients can have constipation just as a result of their chronic renal failure.
Q. Well, but what does the drug eause, sir?
A. Side effects, I'd have to look it up to tell you all the side effects.
Q. Was he given any laxative prior to surgery?
A. Prior to surgery?
Q. Yes, sir.
A. I would not think so.
Q. Is that because that's not something that you would normally give a patient?
A. Correct.
Q. Why is that?
A. There's no benefit.
Q. What did Dr. Zaccaro find when he did the colonoscopy?
A. He found stool.
Q. In your opinion could the problem of the distended abdomen and dilated cecum have been due to the phosphate binder in Mr. Carrick's colon?
A. No. I think this was a bit more severe than that. It's a different name, Ogilvie's syndrome.

Q I'm sorry. Ogilvie's?
A Ogilvie's syndrome.
Q. And what is that?
A It's called pseudo obstructions of the colon and it's seen in patients who are ill for other reasons, and it's not believed to be due to an obstructive process, but perhaps more to a motility problem in the colon, and gas tends to collect in the cecum because it's the part of the bowel that has the largest diameter and therefore the least resistance to dilatation.
Q Who made that diagnosis?
A Dr. Zaccaro and I agreed with that, I think.
Q Well, is this something that you can point to a specific finding or a test or something that he saw through the colonoscope that would lead you to conclude that?
A No. This is more of a clinical diagnosis.
Q What other consults did you order?
A He was placed in the surgical intensive care unit.
Q This was after he contracted the pneumonia?
A Right.
Q Where had he been?
A On a regular nursing floor.

Q. Okay. When was he put into the SSU?
A. April 16.
Q. And when did he contract pneumonia?
A. April 15.
Q. Okay. I'm sorry. Go ahead.
A. At that point when a patient enters the surgical intensive care unit, the intensivist assumes technically half responsibility for the patient. The surgeons address their particular aspects of the case and the intensivists manage the others. And I don't know for you who was the intensivist at that time.
Q. The record doesn't reflect that?
A. No.
Q. How long was he in the SSU?
A. Until April 24.
Q. And you don't know who took care of him between the 16th and the 24th?
A. They have a system where they rotate a couple of guys and it depends on who is on call that day. So that it changes hands.
Q. So nobody had primary care for him for that eight-day period?
A. Correct. The guy on call assumes that responsibility for his time on call.

Q. Did you call in any other consults then from that point on?
A. Yes. Well, he was seen by Dr. Slugg from the pharmacology service as part of his antibiotic monitoring, and that continued through much of his hospital stay. He was seen by a member of our peripheral vascular disease, and I'm trying to find the person's name. And I think I'll come to it. He was also seen by one of the neurologists. And then he was finally seen by Dr. Marks from orthopedics.
Q. Did you call Dr. -- I'm sorry. What did you say, Shag?
A. Slugg.
Q. I'm sorry. Slugg. Spelled just the way it sounds?
A. S L U G G.
Q. Did you call him in or was that routine for somebody receiving antibiotics?
A. It's pretty much routine when you've got antibiotics like that running.
Q. Okay. How about the peripheral vascular disease physician, whoever that might have been?
A. Yeah. We asked for them to come by and see him.
Q. And the reason for that was what?

A. He was in some respiratory distress which was abrupt in onset, and the concern was that since he was relatively immobile, that he might have had a pulmonary embolus.
Q. And when was that, Doctor?
A. April 27.
Q. And their conclusions were what?
A. Their conclusion was to put him on Heparin and do angiograms in the morning and transfer him back to the intensive care unit.
Q. Where was he at the time they saw him?
A. Regular nursing floor.
Q. When was he transferred from SICU back to the floor?
A. If I recall correctly, it was the 24th.
Q. All right. Was he then transferred back to the SICU?
A. Yes.
Q. And when was that?
A. 27th.
Q. And the reason for that was what?
A. His respiratory distress.
Q. When did you call the neurologist or neurologists in or did you?
A. Yes. I believe it was the 27th.

Q. And the reason you did that was what?
A. He had slurred speech.
Q. And what did they find? I mean what was their diagnosis in terns of their belief as to the cause of the slurred speech?
A. They asked that we reconsult them when he was extubated and stable for evaluation.
Q. Was that done?
A I believe so.
MR GORE He was just looking at 1021.
MR KAMPINSKI: For the neurology consult?
MR. GORE Yes
THE WITNESS: Oh, I'm sorry.
MR. GORE: That's okay. I'm just putting the page number in the record.
A Yes, neurology. I have a note here on page 1039 on April 28. So those are the two notes, the 27th and then back to the 28th.
Q. What did they find as a reason for his slursed speech, if anything?
A I have to look for it, but if I remember correctly, it was felt that he had some decreased hearing.

Q. That was due to the antibiotics?
A. Yes.
Q. And then Dr. Marks, the orthopod.
A. Right.
Q. When did he see Mr. Carrick?
A. I'm looking for that.
Q. By the way, as you're looking for that, was it recognized that the decreased hearing was due to the antibiotics at that time?
A. I don't know. I don't know if I can tell you.
Q. I mean is there anything in the record suggesting that that is in fact the cause of the decreased hearing?
A. No. I can't even find the specific point where they say that. That's simply what I recall from having reviewed the record before.
Q. When you say before, recently?
A. Yes. Dr. Marks. I have a note from Dr. Marks' service -- I saw one before that. I'm sorry The first time that the neurologist was called to see Mr. Carrick was April 26 is the first note. And Dr. Marks' note is from April 26.
Q. Why was he called in?
A. There was a right femur fracture.
Q. How did that happen?

A. Probably was the decreased bone density.
Q. What activity was going on that caused that to occur, do you know?
A. As far as I know, there was no activity that could be directly related to the fracture. It had been noted -- right thigh swelling had been noted before and a prior plane film had not shown a fracture, and then when it was pursued with a CT scan, the fracture was detected.
Q. When was the swelling first noted?
A. April 21.
Q. That's while he was in the SSCU?
A. Yes, page 978.
Q. And plane film would have been done the same day?
A. I don't know the date of that plane film. There's an x-ray report on page 189. And I'm not sure that was -- no. That wasn't it. I'm sorry That's not it. That was the CT scan.
Q. What was the date of the CT scan?
A. The 25th.
Q. April 25th?
A. Yes.
Q. And then orthopedics was in the next day to see him?

A. I think orthopedics was probably there the same day but the staff note was the following day.
Q. Okay.
A. Would you like me to keep looking for this? Here it is. No, it's not here. Should I keep looking for this?
Q. Please. Well, presumably it's before April 25?
A. Yeah, but it's not in order here entirely. April 18, page 1400.
Q. 1400?
A. Yes. It says portable, right femur. Examination of the femur again reveals no intrinsic bone abnormality. However, soft tissue extensive calcification.
Q. Okay. And the CT scan did show it on April 25?
A. Yes.
Q. Was that taken because there was continued swelling?
A. The swelling persisted and we couldn't explain it. It was of some concern that it might have resulted from, I think it's dialysis or something.
Q. When was he started on dialysis?
A. His first dialysis was I believe April 14.
Q. And who started him on that?

A The renal service.
Q Do you know which doctor?
A I think it was Dr. Nakamoto covering it at that time.
Q. Do you know why?
A. The note here from their service, his sodium was down and his BUN had continued to go higher. And he had developed more of an acidosis and -- yes, as best I can tell.
Q. Well, what was his sodium and what was the BUN that caused them to gut him on dialysis?
A His sodium was down to 119. His CO2 was down to 10.6 and his BUN was a hundred. And his creatinine was 6.2. And the other thing was that he hadn't corrected with giving him more sodium chloride, so they were unable to correct him medically.

MR. GORE: Page 899.

Q. What's a friction rub?
A. Friction rub is a sound that one can hear through a stethoscope.
Q. And what does it indicate to you as a physician if you hear a friction rub? Make that a cardiac friction rub. I don't know that there are others.

A You would have to ask a cardiologist.
Q You don't use stethoscopes?
A Don't listen to the heart much. I have a real problem hearing.
Q Well, you indicated to me before that one of the things that you were concerned with prior to the surgery was any evidence of congestive heart failure.

You have to respond verbally. You were shaking your head yes and I just want to make sure --

A I didn't realize it.
Q You were shaking your head yes and I just want to make sure the record reflected correctly what you stated. You were in fact looking for any evidence of congestive heart failure before that?
A Repeat that
Q Yes. You were checking for any evidence of congestive heart failure prior to your conducting the surgery on Mr. Carrick?
A Correct
Q. Had you reviewed any of the records from the previous hospitalization at Lakewood Hospital?
A. I don't know that I had those available to me.

Q If there had been evidence of a cardiac friction rub having been found in the examination of Mr. Carrick, would that have affected you one way or another in terms of your decision to subject him to surgery?

A No.

Q. Why not?

A Because in that circumstance it probably would have meant something to do with his, say like a uremia, pericarditis or something like that. And I don't know. That's kind of beyond me medically in terms of an internal medicine type question.

Q Well, but aren't those the questions that you specifically have to involve yourself in in terms of clearing somebody for surgery?

A A lot of that I have to rely on the medical man to reassure me that the patient is medically all right.

Q All right. So when you said before it was a joint decision between you and Dr. Heyka, you assumed that he had gone over whatever had to be gone over from the medical standpoint?

A Correct.

Q Any other consults post-op?

A. Not that I can remember.
Q. Did you continue to see Mr. Carrick while he remained hospitalized?
A. Yes.
Q. Did you provide any treatment or this was just going in to see how he was and what was going on?
A. I really was a clearing house in terms of getting consultants in and, you know, the intensivist would manage his day-to-day, moment-to-moment care.
Q. And we don't know who that is?
A. No. I don't know for sure. There are a couple of their signatures in here.
Q. Why did he die?
A. He was intubated, and according to the note, he bit through the cuff of his endotracheal tube resulting in a large air leak, and he was reintubated. They thought they had good breath sounds bilaterally but he remained hypoxic and blue. The endotracheal tube was removed and replaced twice, both times with good breath sounds heard, but the patient failed to improve with a further drop in blood pressure and heart rate.

Q. Well, you're reading from something.
A. Yes, I'm reading from the note, page 1208.
Q. Is that your note?
A. No.
Q. Whose note is it?
A. Dandau, D A N D A U.
Q. Who is that?
A. I would think he was one of the fellows on call that night in the surgical intensive care unit.
Q. All right. I guess my question was really very poorly phrased. You're reading the terminal note, I guess.
A. Right.
Q. At the time when he died.
A. Right.
Q. What I really wanted to ask you, and I did so very inartfully, was what is it that caused him to die as opposed to the actual moment of death?
MR. SPISAK: Note an objection. Go ahead.
Q. In your opinion.
A. His persistent pneumonia and the requirement for intubation put him into a position whereby this kind of event with his endotracheal tube could happen.

Q. And when you say this kind of event, are you talking about biting through the cuff?
A Or having a complication with the tube where the tube develops an air leak, and they can do that for a number of different reasons, and then trying to reestablish an endotracheal tube afterwards.
Q. Well, when was he intubated, Doctor?
A. I don't know that I can tell you that accurately without completely rereading the section from April 27 until his time of expiration. I'm not sure if they were ever able to get his endotracheal tube out or not during that stay in SICU.
Q. All right. Was he intubated when he was put back into SICU on the 27th?
A. Yes. He was reintubated.
Q. When you say intubated, what does that mean?
A. Oh, it means you put a tube into the trachea to breathe for the patient.
Q. Okay. And that's hooked up to a machine?
A. Yes.
Q. Do you have to change that tube every so often?
A. I don't know.
Q. Was it changed?

A. I don't know.
Q. And this would have been up to whoever was on call on that particular day --
A. It would have been up to the intensivists. They run that exclusively.
Q. And you were reading from page 1208, Dandau's note. Now, was he indicating what was occurring on this particular day or was that a recitation of what had occurred throughout the period of time that he was in the SICU?
A. That was simply the terminal event.
Q. Okay. What day was that?
A. May 16.
Q. And does he indicate -- well, I apologize. I stopped you in the middle of reading the note. Why don't you go ahead and finish it.
A. It says, Resuscitation with Dopamine, Atropine and Epinephrine was attempted but failed. In compliance with the family's wishes of no cardiac compressions, none were performed, and the patient expired at 11:35 p.m. on May 16, 1989.
Q. Okay. Can you tell how long was he without assistance through intubation from the time that they found that he had bit through the cuff and

attempted reintubation? Can you tell that?
A. I don't know.
Q. How was he being treated for his pneumonia?
A. Dr. Longworth was handling that. He was being treated with antibiotics.
Q. Do you know what kind?
A. Not specifically, no.
Q. In the condition that he was in subsequent to the operation, were you ever able to determine whether or not the surgery that you did to remove the parathyroid glands had any effect on the calcium deposits in the bone, or would that be unrealistic to even think about under these circumstances?
A. Under these circumstances that would be unrealistic.
Q. That would take some period of time for you to be able to assess that?
A. Yeah And so much else was going on.
Q. Was Mr. Carrick's serum aluminum ever checked while he was in the hospital?
A. I don't know. I don't know if it was or it wasn't.
Q. Well, I think you can determine from the record if it was.

A. I can start searching.
Q. Well, would that be in the lab tests?
A. Yeah.
MR. GORE: 608, something like that.
MR. KAMPINSKI: While the doctor is looking, John, what I'd like if possible is Dr. Riley's personnel record as well as his admission applications and the rulings on those and what privileges he had at the hospital. I'll put a request for production in.
MR. BAKER: And I'll tell Dierdre, you know. I'm in and out of this today.
MR. KAMPINSKI: I understand. But I'll put a request together, but this at least can give you some head start. Chris will put a request together.
Q. I'll suggest to you, Doctor, that I was unable to find it.
A. Yes. No, I don't find it either.
Q. Was there a reason that it wasn't checked?
A. I think it wouldn't be of any clinical relevance in this case.
Q. Why was Mr. Carrick intubated to begin with? What was it that caused him to require a machine

to breathe for him?
A. He was unable to breathe for himself.
Q. Why?
A. The pneumonia.
Q. So that was a decision made by --
A. The intensive care people.
Q. Intensive care people or Dr. -- I'm sorry. Didn't you call somebody in for the pneumonia specifically?
A. Dr. Longworth, you mean?
Q. Yes.
A. The infectious disease. No. That would have been an intensive care decision.
Q. Why is it that we can't determine the names of the intensivists?
A. Well, I mean I've seen two signatures. I've seen Dr. McHugh.
Q. How do you spell that?
A. M C capital H U G H. And Lockren, L O C K R E N.
Q. And they are?
A. Intensivists.
Q. And where have you seen their signatures?
A. In the record.
Q. What days are we talking, or just interspersed

throughout --

A. Interspersed throughout.

Q. And it's your understanding then that there would be a different person on duty each day?

A. Yes. Usually they rotate. If I understand their system correctly, they rotate daily call as to who is responsible that day for the patients in the unit.

Q. Are these physicians specifically intensive care physicians?

A. Yes.

Q. Okay. So they're not from other departments covering ICU?

A. No. That's their job. That's what they're hired for.

MR. KAMPINSKI: Can we get a list, George, of the intensive care physicians who treated Mr. Carrick?

MR. GORE: I'll see what I can do. I can tell you Lockren is in charge of SICU.

MR. KAMPINSKI: All right. So if I wanted to know who these people were that saw him, he probably would be the best person to depose and he could go through the record and just point out who was who.

MR. GORE: Sure. I'll try to get you a list ahead of time, but yes, he is the one in charge of the SSCU and McHugh works with him.

Q. Do you know Dr. Riley?

A No.

Q Did you ever talk to him, meet him?

A No.

Q Ever have any discussions with him about the surgery prior to the surgery, during the surgery or after the surgery?

A No.

Q Never reported to him anything that --

A I sent him a letter.

Q Okay. When was that?

MR. GORE: 1633

A How about 1236.

MR GORE: 1236? Geez, I wasn't even close.

A April 18 is the date that it was typed. It was dictated before then.

MR. GORE: I'd like the record the to show I had the digits right, just in the wrong order.

Q. So this would have been before his death?

A Yes.
Q Did you send any letters after that?
A I don't think I did.
MR. GORE: To Dr. Riley?
MR. KAMPINSKI: Yes.
Q Let me take a look at that one letter to the doctor. Did you write any other letters to -- I'm sorry. I see one here that you wrote to Mrs. Carrick on June 11. Did you write any other letters?
A Not that I recall.
Q All right. The letter that you wrote to Dr. Riley on April 18 indicates that --
A I didn't write it on April 18.
Q Dictated at some point in time --
A Some point before then.
Q You signed it -- oh, signed in your absence. Where were you?
A I was probably out of town.
Q Where?
A I was at a meeting of the American Association of Endocrine Surgeons.
Q. Where was that?
A. At Chapel Hill, North Carolina.
Q. When did you go?

A. April 17 through 18, it says.
Q. Was that your schedule for those two months of --
A. No. These are my out dates for the year.
Q. Can I see that?

MR. KAMPINSKI: Can we get a copy of this, George? I can copy it here, right?

A. You can have it if you want.

MR KAMPINSKI: Did you guys want copies of this?

MR. SPISAK: Yes.

MR. BAKER: Yes.

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

Q The other document that you've pulled out that you were looking at was what?

MR. GORE: Let me see.

Q What is it, Doctor?
A It's a response to a survey by the American Endocrine Surgeons that asks the total number of thyroid and parathyroid cases treated over a two-year period, surgically treated over a two-year period, and I thought maybe if you were

going to ask what my recent operative experience with parathyroid or thyroid disease was, I could provide you something actual.

Q. Okay. You filled out this survey in response to a --

A Well, it's a thing by the society to try to gain more leverage in some of the other national societies.

Q. Where in these different categories would Mr Carrick's surgery fall?

A The 28th.

Q I'm sorry?

A The 28th.

Q And that is parathyroidectomy?

A Right.

Q Or exploration of parathyroid?

A Right.

Q. Okay. If there were a subcategory that would have been set forth here, what would you characterize Mr. Carrick's surgery in terms of a subcategory? I mean you told me before, for example, that you had had or had seen six or seven cases of secondary hyperthyroidism. I mean it doesn't say that on here.

A. No, no. Because pretty much that's accepted as

being just one of the manifestations of parathyroid disease. It's not set aside as a special subcategory. Because it's handled with the basic principles that you handle any of those cases.

Q. And surgically?

A. Surgically, yes. I'm sorry.

Q. Sure. I guess want a copy of this, too.

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

Q. In the letter that was sent on April 18 to Dr. Riley it indicates that your patient was doing well. That's not true, is it?

A. Well, it was true when it was dictated.

Q. When was it dictated?

A. It was probably dictated either the 12th or the 13th. I try to be fairly prompt getting those letters out.

Q. Why did you send the letter to Dr. Riley? Was this just from checking through the chart you were aware of the fact that he had been the previous treating physician?

A. When somebody gets referred their name goes

into the computer bank and you get it spit out -- for example, here it is, a printout, and it comes to your office and it says this is the referring doctor, so you automatically send them a note to be polite.

MR. GORE: Page 841.

Q It's a matter of courtesy?

A That's right.

Q Did you have any discussions with Mrs. Carrick, Mr. Carrick or any members of their family subsequent to the operation in terms of his condition, the cause of the condition, the treatment, anything of that nature?

A Oh, I'm sure we had many conversations.

Q Do you recall any specifically?

A No, not any specific.

Q Do you have any recollection of any specific discussions with Mrs. Carrick as to why her husband's condition was what it was prior to his death?

A No, I don't.

Q Did you have any discussions with her after he died in terms of your belief as to the reason for his death?

A No. After -- my only -- if I recall correctly,

the only contact I had with Mrs. Carrick after his death was the letter that I sent to her.

Q. Had you ever met Mr. Carrick or any members of his family before?

A. No.

Q. Have had any discussions or meetings with Dr. Riley since treating Mr. Carrick?

A. No.

Q. Have you had any discussions or conversations with Dr. Heyka, Dr. Nakamoto or any of the physicians who treated Mr. Carrick since his death?

A. Yes.

Q. When?

A. Yesterday.

Q. And who did you meet with?

A. I didn't meet with them. I called them on the telephone.

Q. Who did you call?

A. Dr. Heyka and Dr. Brallier.

Q. Who is he?

A. The anesthesiologist.

Q. And what did you discuss with them?

A. Just the portions of the case as to I had read his deposition and asked him how it went, what

he saw as the pertinent points of the case.
Q. What did he say?
A. He said, you know, the real question was whether or not he should have been dialyzed preoperatively, but he still didn't think so.
Q. What did Dr. Brallier say?
A. We talked about the status of the patient prior to surgery that morning and, you know, related that we didn't think there was any problem with his electrolyte status vis-a-vis, you know, risk for surgery.
Q. Why did you make the call?
A. Just as part of preparation, just like I read, you know, the chart and looked at some literature. I was just trying to totally prepare myself.
Q. Did you talk to any of the other physicians?
A. No.
Q. At any time. I mean not just yesterday, but at any time after Mr. Carrick's death as to how he died, what he died from, the cause of death?
A. You know, we talked as his case went along but not since that time.
Q. Was it presented in any fashion after his death in terms of a department meeting or anything of

that nature?

A. It wouldn't have been presented at a department meeting. It was probably recorded in our Saturday morning M. and M.

Q When you say recorded, what do you mean?

A What we do is we go through the morbidity and mortality department on a weekly basis.

Q And would the reasons for the mortality have been discussed in that meeting?

A. Pes.

Q. And which department would that be?

A. General surgery.

Q. And is that a permanent record kept by general surgery then?

A. No. We don't keep a written -- we keep a record that the case was presented perhaps, but we don't keep a record of any discussion.

Q. It's not transcribed or recorded in any fashion?

A No, no,

Q Well, what record is there then?

A. It's just a cellophane sheet that puts up the patient's initials and the complication and the date of surgery.

Q Did you see Mr. Carrick as an outpatient prior to the surgery?

A. Yes.
Q. When was that?
A. That was the first date I saw him.
Q. Oh, I'm sorry.
MR. GORE: April 4.
Q. On the 4th. Did you see him again as an outpatient?
A. I don't see any record of that, no.
Q. Do you remember what you told Mr. Carrick and whoever it is that was with him of the risks of the surgery that he was about to undergo?
A. I can't remember that particular conversation specifically, but I know the things that I cover in general.
Q. Well, is there an informed consent signed by Mr. Carrick or anybody else in the file?
A. No.
Q. Why not?
A. We don't use signed informed consent. It's discussed and I report that I discussed the operation and indications and risks.
Q. Where did you see that?
A. In the April 4 note.
Q. But there's nothing signed by Mr. Carrick though to confirm that?

A. No.
Q. Well, what risks did you tell him and whoever it is that were there with him existed in this operation?
A. I would have told him that --
Q. You're telling me this in terms of what you normally tell me as opposed to a specific recollection you have?
A. That's right. I can't tell you a specific recollection.
Q. Okay. I'm sorry. Go ahead.
A. All right. It would be the risk of anesthesia, it would be the risk of bleeding which is possible any time surgery is performed. In this particular situation it would have been the risk of injury to the recurrent laryngeal nerves, the nerves to the voice box which are adjacent, and also that there would be a need for calcium, perhaps a lot of calcium postoperatively.
Q. Did you make it appear as though this was a minor operation, Doctor?
A. I don't know that I can assess that. The operation has a history of a low morbidity and mortality. But I, you know, state the risks pretty straighforwardly and answer any questions

about them the patient or the family has.
Q. Was there a fat embolism associated with the hip fracture in Mr. Carrick?
A. He had a femur fracture.
Q. I'm sorry.
A. And I believe there was a test there for fat and I didn't see any.
Q. All right. So that was never confirmed?
A. Right.
Q. And that was just a suspicion that needed to be ruled out?
A. Correct.
Q. And was it ruled out?
A. Correct.
Q. In your opinion was Mr. Carrick septic before he died?
A. Septic. How would you mean septic?
Q. Well, how would you mean septic?
A. Septic, I would mean as showing clinical and hemodynamic characteristics of infection.
Q. Was he?
A. Yes.
Q. How do you street sepsis?
A. Antibiotics.
Q. And he was receiving antibiotics?

A. Yes.
Q. And you indicated earlier, I mean that wouldn't be within your area of expertise, that you left up to the infectious disease physician?
A. That's correct.
Q. Does Indocin have an effect on calcium metabolism?
A. I can't answer that.
Q. Okay. If you just give me one moment, I think I'll be done in a second.

Is there anything else that we have not talked about to this point, Doctor, which you believe had an impact on Mr. Carrick's illness and/or death?
A. I'm not sure what you're looking for.
Q. Well, I'm looking for whatever it is that you're aware of, either through going through the file, looking at records, looking at deposition testimony, that you believe impacted Mr. Carrick in terms of his illness and/or death that we haven't talked about.

In other words, this is discovery, okay. The purpose of this is for me to understand what it is you're going to testify to when you get up on the stand so that neither you nor I are

surprised. And if there are things that you are aware of that you believe have an impact on his care, his treatment, his condition, I'd like to know them at this time.

A. I can't think of anything right offhand.

Q. Just so I understand, what you reviewed before the deposition was what, the medical record, Dr. Heyka's deposition, anything else?

A. Summary of Dr. Riley's deposition.

Q. Okay.

A. Literature.

Q. What literature did you look at?

A. Literature on secondary hyperparathyroidism.

Q. Specifically what articles or what books?

A. It would have been articles summarized in selected readings in General Surgery.

Q. In the volume or in the publication, General Surgery? Well, I'll tell you what. Rather than have you sit here and try to do this by memory, do you have them with you?

A. No.

Q. Where are they?

A. My office.

Q. Can you put together a list of those things that you reviewed?

A. Sure.
Q. And provide them to Mr. Gore?
MR. KAMPINSKI: And I'd ask that you give them to me.
A. Sure.
MR. GORE: Fine, will do.
MR. SPISAK: And I would ask for a copy of those as well.
MR. GORE: No, you can't have them.
MR. BAKER: Send me his.
Q. Other than the articles, a summary of Dr. Riley's deposition, Dr. Heyka's deposition, the medical records, anything else? Did you look at the Lakewood records, for example?
A. I browsed through them but I didn't really look at them seriously.
MR. GORE: There are some portions of the Lakewood records in the chart.
MR. KAMPINSKI: That were sent over to the Clinic?
MR. GORE: Yes.
Q How about Dr. Riley's office records, did you look at those?
A. NO.
Q. Anything else that you can think of that you

looked at?

A. No.

MR. KAMPINSKI: Okay. Doctor, that's all I have. The other attorneys may or may not have some questions of you.

MR. GORE: Mr. Spisak?

MR. SPISAK: I'm not going to ask any questions today, Doctor. I'll reserve my right, if necessary, which I don't anticipate.

MR. BAKER: We'll do the same.

MR. KAMPINSKI: Okay. Thanks, Doctor.

THOMAS A. BROUGHAN, M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Sandra L. Mazzola, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named THOMAS A. BROUGHAN, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 __.

_____
Sandra L. Mazzola, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires January 6, 1992

CURRICULUM VITAE

Thomas A. Broughan, M.D. Social Security No. 273-48-7726

Born: Cleveland, Ohio, December 3, 1952

B.S. Allegheny College (cum laude), 1975
Alden Scholar

M.D. University of Cincinnati College of Medicine, 1979

Intern, Surgery - Cleveland Clinic Foundation, 1979-1980
Resident, Surgery - Cleveland Clinic Foundation, 1980-1983
Chief Resident - Cleveland Clinic Foundation, 1983-1984

Fellowship, Gastrointestinal and Hepatic Surgery
Cleveland Clinic Foundation, July 1984 - June 1985

Visitor, University of Pittsburgh, December 1984 - February 1985

Visitor, University of London
Royal Postgraduate Medical School, April 1985 - June 1985

Assistant to the Director of the General Surgery Residency Program
Cleveland Clinic Foundation, July 1984 - June 1985

Associate Director, General Surgery Residency Program,
Cleveland Clinic Foundation, 1985 - 1988

Director, General Surgery Residency Program,
Cleveland Clinic Foundation, 1988 to present

Associate Staff, Cleveland Clinic Foundation, 1985

Staff, Cleveland Clinic Foundation, 1986 - present

Honorary Medical Societies

Alpha Omega Alpha, 1979

Professional eties

Diplomate, National Board of Medical Examiners, 1980
Ohio State Medical Association, 1984
Diplomate, American Board of Surgery, 1985
American Medical Association, 1985
Cleveland Academy of Medicine, 1985
Cleveland Surgical Society, 1986
Northeast Ohio Transplant Society, 1986

Professional Societies (continued)

Pancreas Club, 1986
American Association of Endocrine Surgeons, 1988
Fellow, American College of Surgeons, 1988
American Association for the Study of Liver Diseases, 1989
Young Surgeon Representative, Ohio Chapter, American College of Surgeons, 1990
Society for Surgery of the Alimentary Tract, 1990

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Return in enclosed envelope to:

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VETERANS ADMINISTRATION MEDICAL CENTER
1201 N.W. 16th STREET
MIAMI FLA *33125*

PROCEBURE	CPT CODE	# PATIENTS *24* Months (June 1,1988-June 30,1990)
Parathyroidectomy or exploration of parathyroid(s)	60500	28
Parathyroidectomy, re-exploration	60502	
Parathyroidectomy with mediastinal exploration, sternal split or transthoracic approach	*60505*	
Parathyroid	TOTAL:	28
Adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal (separate procedure), unilateral.	*60540*	1
Adrenalectomy with excision of adjacent retroperitoneal tumor	*60545*	
Adrenalectomy, bilateral, one stage	60550	
Adrenolectomy	TOTAL:	1
Excision of cyst or adenoma of thyroid, or transection of isthumus	*60200*	
Total thyroid lobectomy, unilateral	*60220*	13
Total thyroid lobectomy with contralateral subtotal lobectomy including isthumus	*60225*	14
Thyroidectomy, total or complete	*60240*	9
Thyroidectomy, subtotal or partial	*60245*	7
Thyroidectomy, subtotal with removal of substernal thyroid gland, cervical approach	*60246*	
Thyroidectomy, total or subtotal for malignancy; with limited neck dissection	*60252*	1
Thyroidectomy, total or subtotal for malignancy; with radical neck dissection	*60254*	
Thyroidectomy, secondary, unilateral	*60260*	
Thyroidectomy, secondary, bilateral	*60261*	
Thyroidectomy, including substernal thyroid, sternal split or transthoracic approach	*60270*	
Thyroid	TOTAL:	45

Sign **Thomas A. Broughan, M.D.** City **Cleveland** State OH

THOMAS A. BROUGHAN, M.D.

Meetings Attended

Date	Organization	Location	Presentation	CME/Cat
Feb. 16-17	Assoc. of Program Directors in Surgery	Salt Lake, UT		17.5/1
Feb. 18	Ohio Solid Organ Transplantation Consortium	Columbus, OH	Speaker	
Mar. 2-4	Regulation of Phy. Training Programs	Coral Gables, FL		
Apr. 17-18	Amer. Assoc. of Endocrine Surgeons	Chapel Hill, NC		
May 12-13	Ohio Chapter Am. College of Surgeons	Cincinnati, OH		12/1
May 14-17	Digestive Disease Week The Society for Surgery of the Alimentary Tract	Washington, DC.		13/1
	Pancreas Club, Inc.			
Oct 15-18	1989 Clinical Congress, ACS,	Atlanta, GA		

.gr Course

Date		
Apr. 13-14	General Surgury	Speaker

S ng Engagements

May 27	Fairview General Hospital Resident Grand Rounds "Update on Peptic Ulcer"
Aug 12	St. Joseph Riverside Hospita, Warren, Ohio " "
Sept. 9	Fairview General Hospital Resident Grand Rounds "Management of Gallstones with Lithotripsy"

Clinic Business/Residents' Program

Apr. 5	Oakland General Hospital Madison Hts., MI
May 2	Grant Hospital, Columbus
Aug 4	Children's Hospital, Dayton
Sept 5-6	CCF Florida, Review Colorectal Resident Program
Sept 7	Research Day - Poster "Conservative Surgery for Gastric Ulcer"
Sept 18-22	Professionals In Management Course