IN THE COURT OF COMMON PLEAS

IN THE STATE OF OHIO

ANTHONY ARACHIKAVITZ, et al, Plaintiff, vs. AKRON GENERAL MEDICAL CENTER, et al, Defendants.	)	No. 2002-06-3349

Videotaped Deposition of:

ANGELO E. CANONICO, M.D.

Taken on behalf of the Plaintiffs

JUNE 18, 2004

APPEARANCES:

For the Plaintiff:	Mr. Howard D. Mishkind, Esq. Becker & Mishkind Co., L.P.A. Skylight Office Tower 1660 W. 2nd Avenue St., Suite 660 Cleveland, OH 44113
For the Defendant, Akron General, by Telephone:	Ms. Janis Small, Esq. Roetzel & Andress 222 S. Main Street Akron, OH 44308
For the Defendant, Dr. Loboda:	Mr. Ronald M. Wilt Buckingham, Doolittle & Burroughs, LLP 1375 E. 9th Street, Ste. 1700 Cleveland, OH 44114
For the Defendant, Dr. Papouras:	Mr. Andrew D. Jamison Reminger & Reminger 200 Courtyard Square 80 South Summit Street Akron, OH 44308
Videographer:	Jim Davis, CLVS

I N D E X

E X H I B I T S

The deposition of ANGELO E. CANONICO, M.D. was taken by counsel for the Plaintiffs, pursuant to notice, at the offices of ANGELO E. CANONICO, M.D., St. Thomas Medical Plaza, 4230 Harding Road, Suite 400, Nashville, Tennessee, on June 18, 2004, for all purposes under the Ohio Rules of Civil Procedure.

The formalities as to notice, caption, certificate, et cetera, are waived. All objections, except as to the form of the questions, are reserved to the hearing.

It is agreed that Florence Kulbaba, being a court reporter and notary public for the State of Tennessee, may swear the witness, and that the reading and signing of the completed deposition by the witness are not waived.

* * *

ANGELO E. CANONICO, M.D.

was called as a witness, and after having been first duly sworn, testified as follows:

(Document marked Exhibit No. 1.)

VIDEOGRAPHER: On the record at 9:45:52

DIRECT EXAMINATION

QUESTIONS BY MR. MISHKIND:

Q. Would you please state your name for the record?

A. Angelo Canonico.

09:45:53 Q. Dr. Canonico, my name is Howard Mishkind. I
09:45:56 represent the plaintiffs in connection with the lawsuit
09:45:59 that has been filed against Dr. Loboda and Akron
09:46:03 General and Dr. Papouras.

09:46:03 You have been identified by Mr. Wilt as an
09:46:08 expert on behalf of Dr. Loboda, and that's why I'm here
09:46:11 today to talk to you about the opinions that you will
09:46:13 be providing when you testify at the trial of this
09:46:15 matter. Okay?

09:46:16 A. Nice to meet you.

09:46:17 Q. Nice to meet you, sir.

09:46:18 Tell me, first, what your business address is?

09:46:20 A. 4230 Harding Road, H-a-r-d-i-n-g, Suite 400,
09:46:28 Nashville, Tennessee, 37205.

09:46:32 Q. Doctor, I have marked for identification as
09:46:36 Plaintiff's Exhibit No. 1 the document which is 11 --
09:46:43 11 or 12 pages. It ends with page 11. There must have

09:46:52 been a cover page when it was faxed to me, but I
09:46:54 believe it's 11 pages and it says, "Updated March
09:46:58 2,'04." Is this a current copy of your C.V., sir?
09:47:02 A. My C.V., it needs to be updated additionally
09:47:06 from this.
09:47:08 Q. Do you have a current copy of your C.V.?
09:47:11 A. No. We can get that to you.
09:47:12 Q. There's one physically prepared?
09:47:14 A. No. It needs to be updated.
09:47:17 Q. Okay. So, in other words, you would have to
09:47:19 sit down and physically input --
09:47:22 A. Yes.
09:47:22 Q. -- information in? Okay.
09:47:24 A. Yes.
09:47:24 Q. So the March -- the one that we're looking at
09:47:26 is the most current one that has been disseminated and
09:47:30 given to people, correct?
09:47:31 A. Correct, but there are -- I can go over some
09:47:34 quick changes here, just to let you know.
09:47:36 Q. Sure. Go right ahead. Why don't you do that?
09:47:37 A. I'm board certified in critical care medicine.
09:47:40 That's on page two. And then I have been re-certified
09:47:44 in pulmonary medicine, which we have to do every ten
09:47:48 years. These are the quick changes I notice looking
09:47:53 through this. And on page six I have another patent,

09:48:05 and I don't know the official name of that patent but
09:48:11 there is a second patent in there.
09:48:13 Q. Anything else by way of publications,
09:48:16 abstracts, book chapters that would be in addition to
09:48:21 what's on Exhibit No. 1?
09:48:23 A. I don't think so, unless under the abstracts,
09:48:26 Number 15 has been published, and I don't know if
09:48:29 that's been published yet or not. It's a 24 Ambulatory
09:48:33 Pulse Asymmetry Abstract.
09:48:37 Q. I was actually going to ask you about that
09:48:39 because in looking in Respiratory Care 2002, I couldn't
09:48:40 find this article at all.
09:48:46 A. That's probably part of the abstract. So it
09:48:49 would be under Abstracts in there, which we can get
09:48:51 that for you.
09:48:52 Q. Okay.
09:48:53 A. It may not be published yet.
09:48:55 Q. If you do have the abstract -- if you have the
09:49:01 abstract, if you would provide it to Mr. Wilt and then
09:49:05 I'm sure he'll provide me with a copy of it.
09:49:08 A. Sure.
09:49:08 Q. Okay. The exhibit that is Exhibit No. 1 shows
09:49:14 that you are board eligible in critical care medicine.
09:49:20 Had you sat for the critical care board previously?
09:49:25 A. That was one of the changes I mentioned

09:49:28 earlier. I'm board certified.
09:49:29 Q. Right. How many attempts?
09:49:30 A. Oh, first.
09:49:31 Q. Okay. First time through?
09:49:33 A. Right.
09:49:33 Q. Was it a written and an oral board?
09:49:35 A. Written.
09:49:37 Q. Written. And you passed the written boards
09:49:40 the first time through?
09:49:41 A. Yes.
09:49:41 Q. Okay. Thank you.
09:49:52 I've had a chance before the deposition
09:49:53 started to look through the material that has been
09:49:58 provided to you by Mr. Wilt, and it appears as if you
09:50:03 have received a number of depositions as well as
09:50:07 medical records concerning Anthony from Akron General
09:50:12 Medical Center; is that a fair statement?
09:50:13 A. Yes.
09:50:14 Q. And have you read all of the depositions that
09:50:16 have been provided to you?
09:50:17 A. As far as I know, I have read them all. There
09:50:19 are a lot.
09:50:20 Q. You also have notes which we're going to have
09:50:23 the court reporter mark as an exhibit in a moment, but
09:50:26 when you read the depositions did you make notes on the

paper that's to your right?
A. Yes.
Q. So that the notes would reflect all of the depositions that you have reviewed, correct?
A. No, not necessarily. When I read the deposition or went through the medical records I'll occasionally scribble down a note. If I read a deposition, I may or may not write down a note.
Q. If there aren't notes on the deposition is it fair to say, and correct me if I'm wrong, that the deposition, as far as your opinions, wasn't terribly relevant?
A. No, I wouldn't say that. It was just -- when I read the depositions and the notes sometimes it makes me think of something, and if it does, and I sometimes write it down. I don't think it necessarily has any bearing on the relevance or irrelevance of the deposition.
Q. Do you know whether there have been any depositions taken that have not been provided to you by Mr. Wilt?
A. I don't know.
Q. And the reason I say that, obviously you had a chance to meet with Mr. Wilt before the deposition and I'm sure you've talked to him as this case has been

progressing, correct?

A. Correct.

Q. And I don't want to belabor the record to go through all of the depositions that are here, but to your understanding have you been provided with all of the depositions or do you have an understanding that there may have been a deposition taken that Mr. Wilt, for whatever reason, chose not to send to you?

MR. WILT: Objection.

BY MR. MISHKIND:

Q. Go ahead.

A. You know, there may be other depositions. This is what I have. I don't know if I'm supposed to be receiving more or not.

Q. Fair enough. Do you intend to do any additional work other than perhaps reviewing some additional depositions that may be coming or may be taken in this case between now and the time that the trial takes place?

A. Such as?

Q. Research?

MR. WILT: Objection.

THE WITNESS: When I go through depositions, if I need to look something up I would look it up. So I would look at that as part of my

09:52:34 deposition review if I do research on it.
BY MR. MISHKIND:
09:52:36 Q. When you say research, I'm assuming literature
09:52:38 search, things like that?
09:52:41 A. Yes, sir.
09:52:41 Q. The notes that you have that are paper
09:52:44 clipped, is that the extent of the written notes that
09:52:47 you have prepared in connection with this case?
09:52:49 A. Yes. Well, I do want to say these written
09:52:53 notes weren't necessarily prepared for the case,
09:52:56 they're just -- me, as I read things, write stuff down.
09:52:59 So they're not a formal preparation. I was just
09:53:02 requested to bring everything I had.
09:53:05 Q. Sure. Simply put, what's in your handwriting
09:53:08 on the notes that we're going to have marked as
09:53:10 exhibits are notes that you made as you looked at
09:53:14 various depositions or looked at various medical
09:53:17 records in this case, is that correct?
09:53:19 A. That's correct.
09:53:20 Q. Those notes don't reflect anything unrelated
09:53:24 to this case, do they?
09:53:25 A. They shouldn't, unless I -- you know, by
09:53:28 chance, as I write something else, that's independent
09:53:31 of this on this sheet. These are on my desk. So as I
09:53:34 read through things there may be little written things

09:53:38 about a phone call I got that has nothing to do with
09:53:40 this case. But as far as I know, the substance of this
09:53:43 has to do with the case.
09:53:44 Q. Fair enough. Are there any other notes that
09:53:48 are stored anywhere else other than on the notes that
09:53:54 are to your right?
09:53:55 A. No.
09:53:56 Q. Anything on the computer that you generated?
09:53:59 A. No.
09:53:59 Q. Have you e-mailed anything to Mr. Wilt with
09:54:02 regard to any of the opinions that you hold in this
09:54:05 case?
09:54:05 A. No.
09:54:06 Q. Have you written any reports or any letters to
09:54:10 Mr. Wilt?
09:54:10 A. No.
09:54:11 Q. There are cover letters with a number of the
09:54:15 depositions as I have gone through them, "Enclosed
09:54:19 please find the deposition." Some of them are
09:54:22 chronologically arranged, some of them are right on top
09:54:26 of the depositions, others are scattered about. But
09:54:29 have you received any other correspondence from
09:54:33 Mr. Wilt that you haven't brought with you today that
09:54:36 in any way describes this case in terms of the medical
09:54:39 subject matter of it?

09:54:40 A. Not that I know of. I think at the very
09:54:43 beginning I may have received a letter from Mr. Wilt.
09:54:46 I probably threw it out. That probably requested me to
09:54:50 review it, but I probably threw that out. So there are
09:54:53 no other communications.
09:54:55 Q. All right. During your preparation today or
09:54:58 in discussions with Mr. Wilt prior to today were you
09:55:01 requested not to bring anything with you by way of
09:55:05 letters or research that pertains to this case?
09:55:09 A. No.
09:55:10 Q. Is there anything back in your office
09:55:13 concerning Anthony's case that, for whatever reason,
09:55:16 you didn't bring in with you today?
09:55:18 A. No.
09:55:18 Q. I don't see any films, any actual radiology
09:55:23 films. Have you actually looked at any of the films?
09:55:28 A. No.
09:55:28 Q. So you have relied on interpretations,
09:55:31 radiological interpretations in reviewing this case, is
09:55:34 that a fair statement?
09:55:36 A. Yes.
09:55:36 Q. You've not reviewed any of the records past
09:55:38 Akron General Medical Center, at least from what I can
09:55:41 tell; is that correct, also?
09:55:42 A. The medical records?

09:55:43 Q. Yes.
09:55:43 A. I have not.
09:55:45 Q. You've reviewed depositions that talk about
09:55:49 Anthony's condition, I presume, from some of these
09:55:53 depositions, but you haven't actually looked at any
09:55:58 records for any of his treatment for his condition in
09:56:01 Las Vegas, have you?
09:56:02 A. I reviewed one deposition, not depositions.
09:56:05 Q. Which deposition would that have been?
09:56:07 A. I think it was Saxena.
09:56:09 Q. And was Dr. Saxena's deposition relevant to
09:56:12 you as it relates to any of the opinions that you hold
09:56:16 in this case?
09:56:19 A. No.
09:56:19 Q. In reviewing your C.V., it appears that you
09:56:24 have an interest in cystic fibrosis, is that correct?
09:56:27 A. Past interest. I was the -- I founded -- I
09:56:33 established the Adult Cystic Fibrosis Center at
09:56:37 Vanderbilt, when I was at Vanderbilt.
09:56:39 Q. That was a number of years ago, correct?
09:56:41 A. That was a number of years ago, yes.
09:56:43 Q. It also appears that you have some interest in
09:56:46 gene therapy?
09:56:47 A. Again, it's -- my academic career was in gene
09:56:51 therapy.

09:56:52 Q. Does gene therapy have anything to do with the
09:56:56 opinions you hold in this case?
09:56:57 A. No.
09:56:57 Q. And I presume cystic fibrosis is not a subject
09:57:01 matter that is terribly relevant to the opinions that
09:57:03 you hold in this case?
09:57:04 A. It is not.
09:57:05 Q. Is there any sub-specialty or area within
09:57:10 pulmonary medicine, critical care or internal medicine
09:57:15 that you have a special interest in?
09:57:19 A. Well, historically, it was cystic fibrosis and
09:57:24 then I did -- my research with gene therapy also
09:57:28 focused with Alpha1 antitrypsin deficiency and in
09:57:32 sepsis.
09:57:32 Q. Okay.
09:57:34 A. But now it's no one focal area of pulmonary
09:57:39 medicine, pulmonary critical care medicine.
09:57:42 Q. We're at -- is it St. Thomas Medical Center?
09:57:47 A. Yes.
09:57:48 Q. Is this your one and only office, or do you
09:57:50 have another office?
09:57:51 A. My one and only.
09:57:53 Q. Doctor, in looking at your C.V. are there any
09:57:59 articles or abstracts that you believe to be relevant
09:58:04 to any of the opinions that you hold in this case, and

09:58:11 I'll certainly --
09:58:12 A. No -- yeah, I'm not quite sure -- are there
09:58:15 any articles that I have written that specifically
09:58:18 affect my opinion on this?
09:58:20 Q. That you draw into the mix in terms of your
09:58:25 knowledge, training, experience in the writings that in
09:58:29 some way supports the opinions that we are going to be
09:58:33 talking about in this case?
09:58:36 A. I have written -- I have written chapters on
09:58:40 sepsis and, you know, I did some research with gene
09:58:44 therapy in sepsis. I view them as I would other
09:58:47 literature as part of my knowledge base.
09:59:03 Q. It looks like the last article that you wrote
09:59:07 on sepsis would have been back in 1994 in Current
09:59:14 Perspectives In Pathophysiology?
09:59:17 A. No. There should be one after that. I wrote
09:59:19 one for --
09:59:20 MR. WILT: Why don't you give him back
09:59:22 his C.V.?
09:59:24 THE WITNESS: Yeah.
09:59:24 MR. MISHKIND: I think you have a copy
09:59:25 also with you. You can use that exhibit.
09:59:35 THE WITNESS: Sure. Under, "Book
09:59:37 Chapters" on page 9, number 6 is "Biology of Acute Lung
09:59:42 Injury." That's 1997.

09:59:43 BY MR. MISHKIND:
09:59:43 Q. Okay. On your C.V. it indicates that you were
10:00:07 a member of the clinical quality committee at St.
10:00:12 Thomas Health Service in the year 2002?
10:00:14 A. As president-elect of the medical staff, part
10:00:18 of the responsibility is to be chair of the clinical
10:00:25 quality committee.
10:00:25 Q. What's involved in that, sir?
10:00:27 A. The way the structure is here, clinical
10:00:32 quality issues of the hospital go through the clinical
10:00:34 quality control -- clinical quality committee. So
10:00:39 issues that deal with patient safety, quality control,
10:00:43 those type of topics with respect to hospital care will
10:00:48 funnel through that committee. And then that committee
10:00:53 answers to our medical executive committee which then
10:00:57 answers to the board.
10:01:05 Q. You do teaching as well, don't you?
10:01:08 A. We have house staff here. We do -- yes.
10:01:12 Q. Do you do teaching at the medical school?
10:01:15 A. No. Do clinical teaching here.
10:01:19 Q. What textbooks do you regularly refer to as
10:01:22 far as your practice or in terms of teaching positions?
10:01:30 A. You know, there's a lot of pulmonary critical
10:01:34 care textbooks that I use. The ones that come to mind
10:01:37 would be Murray and Nadel, West, Fraser, and Pare,

10:01:42 Shoemaker in critical care medicine and then, you know,
10:01:47 obviously the whole -- we try to refer to the whole
10:01:50 database that we have out there on Medline, up to date.
10:01:55 Q. Do you still refer to the critical care book
10:01:57 by Marini and Wheeler?
10:02:01 A. Uh-huh. I do.
10:02:02 Q. Consider that to be a fairly reliable source
10:02:04 of information as it relates to critical care medicine?
10:02:07 A. It's a source I use.
10:02:09 Q. And also the one by Fishman, as well?
10:02:12 A. It's a source I use at times.
10:02:15 Q. Okay. You consider it to be a reliable source
10:02:17 for information in the area of critical care medicine?
10:02:20 A. I consider it a source that I will use.
10:02:23 Q. Okay. It's a reasonable source, is it not?
10:02:26 A. It's a fine source.
10:02:27 Q. Okay. What about Murray and Nadel on the
10:02:33 lung, do you refer to that from time to time as well?
10:02:36 A. I do.
10:02:36 Q. And you consider that to be a finer, or
10:02:38 reasonable source of information in the area of the
10:02:43 pulmonary --
10:02:43 A. Again, as part of the whole library of medical
10:02:45 literature, I refer to it as one I would use.
10:02:48 Q. What peer review journals in pulmonary

10:02:55 medicine or critical care do you subscribe to?
10:02:55 A. Chest, American Journal of Respiratory and
10:02:56 Critical Care Medicine, Intensive Care Medicine. Our
10:03:06 office gets Journal of Intensive Care Medicine. I
10:03:10 don't have my own subscription to that. New England
10:03:16 Journal Of Medicine. And then what I need from the
10:03:17 library. Those are the ones that I would have in the
10:03:21 office, and then what I have access to on the internet
10:03:24 and our library.
10:03:32 Q. In the Notice To Take Deposition I'd asked
10:03:34 that you bring with you any literature that you deem
10:03:38 authoritative or reliable that may be referenced by you
10:03:43 as authoritative or reliable at the trial of this
10:03:45 matter. Is there any literature that you, as you're
10:03:49 sitting here right now, that you deem to be
10:03:52 authoritative or reliable as it relates to the subject
10:03:55 matter of this case?
10:03:56 MR. WILT: Objection.
10:03:59 THE WITNESS: I don't think I can pull
10:04:01 one piece of literature that I would consider
10:04:04 authoritative in this situation or in most medical
10:04:09 conditions.
10:04:09 BY MR. MISHKIND:
10:04:09 Q. Well, I'm not necessarily saying one because
10:04:12 obviously there can be more than one authoritative or

10:04:14 reliable one. But are there articles in your work
10:04:19 connection with this case that you have come across
10:04:23 that you have brought to Mr. Wilt's attention, or you
10:04:27 have in mind that you believe to be reasonably reliable
10:04:30 or authoritative as it relates to the opinions that you
10:04:35 have in Anthony Arachikavitz's case?
10:04:37 MR. WILT: Objection.
10:04:39 THE WITNESS: No. You know, I did bring
10:04:42 one literature piece here but I don't view it as
10:04:46 authoritative in the sense. It was just an
10:04:48 interesting literature piece that I brought.
10:04:50 BY MR. MISHKIND:
10:04:50 Q. Having to do with the synergistic effect of
10:04:53 opiates?
10:04:54 A. Yes.
10:04:55 Q. And we'll talk about that. Other than that,
10:04:57 that's the only literature that you brought with you
10:05:00 today?
10:05:00 A. Correct.
10:05:00 Q. Okay. I take it you -- strike that.
10:05:05 Have you done any research in the medical
10:05:09 literature, other than coming up with this opiate
10:05:13 article as you have been going through the material
10:05:20 that has been provided to you in this case?
10:05:22 A. No. Let me correct that.

10:05:28 Q. Sure.
10:05:28 A. I did look up Aldretti Scale -- Aldretti
10:05:30 Score, because I wasn't familiar with that.
10:05:35 Q. Okay. Do you know any of the other experts in
10:05:38 this case?
10:05:38 A. No.
10:05:39 Q. You've received a number of depositions but
10:05:44 you haven't, in all likelihood, seen the deposition of
10:05:48 Dr. Nichols who is an expert for the hospital, his
10:05:53 deposition having just been started on Monday. Do you
10:06:00 know Ron Nichols?
10:06:01 A. No.
10:06:01 Q. Do you know Gary Williams, a surgeon up at
10:06:07 Akron General Medical Center?
10:06:09 A. No.
10:06:10 Q. Do you know any of the nursing experts in this
10:06:12 case?
10:06:13 A. No.
10:06:14 Q. And in terms of Mr. Wilt's experts, Dr.
10:06:23 Nakata, do you know Dr. Nakata?
10:06:25 A. No.
10:06:26 Q. There is also an expert that was identified,
10:06:28 Howard Nearman. Do you know Dr. Howard Nearman?
10:06:31 A. No.
MR. MISHKIND: Who else do you have, Ron?

I'm trying to remember.

10:06:32 MR. WILTS: Keith Armitage.

10:06:32 BY MR. MISHKIND:

10:06:39 Q. Yeah. Keith Armitage, an infectious disease doctor, do you know him?

10:06:42 A. No.

10:06:42 Q. Have you been provided with his deposition?

10:06:44 A. No.

10:06:45 Q. Okay. So that's one deposition that we know of that you have not seen?

10:06:49 A. Correct.

10:06:49 Q. Okay. What about Dr. Nakata, have you seen that deposition? He's an anesthesiologist out of Indianapolis, Indiana.

10:07:01 A. Can I look at my notes?

10:07:03 Q. Sure can.

10:07:03 A. Thanks.

10:07:30 MR. WILT: Here it is.

10:07:31 THE WITNESS: Yes.

10:07:33 BY MR. MISHKIND:

10:07:33 Q. Mr. Wilt has brought it to your attention. Do you see any notes at all?

10:07:38 A. No.

10:07:39 Q. Okay. Doctor, tell me what you charge to review medical records in a medical negligence case?

10:07:50 A. $400 an hour.
10:07:54 Q. How long have you charged $400 an hour?
10:07:59 A. Couple years.
10:08:01 Q. For purposes of deposition, what do you
10:08:04 charge?
10:08:04 A. $500 an hour.
10:08:07 Q. And to come to Akron, Ohio, for the trial,
10:08:11 which is a little bit less than three weeks away, what
10:08:15 will you be charging for purposes of leaving here and
10:08:18 coming to us?
10:08:19 A. $1500 a day and then $500 an hour during the
10:08:24 trial.
10:08:26 Q. $1500 for the day, plus an additional $500?
10:08:33 A. During trial time.
10:08:35 Q. So when you're -- if you're in the courtroom
10:08:38 for, let's say 4 hours on a particular day, it will be
10:08:44 $1500 plus $2000?
10:08:47 A. I think I would just do while I'm -- not
10:08:51 sitting in the trial, but if I'm on the stand, that
10:08:54 time.
10:08:54 Q. So if you're here for two days traveling up
10:09:00 it's going to be $1500 and then whatever -- if it goes
10:09:03 into a second day, you're going to be charging $500 for
10:09:08 your courtroom time and the balance, what, would be
10:09:11 prorated on that $1500 for that day?

10:09:17 MR. WILT: Objection. I lost you there.
10:09:17 THE WITNESS: Yeah.
10:09:23 BY MR. MISHKIND:
10:09:23 Q. If you're gone for two days?
10:09:23 A. $3,000 for the two days, and then whatever time I'm at the trial I would charge an hourly basis for that.
10:09:30 Q. How much time have you spent so far on this case?
10:09:34 A. I don't know. Several hours.
10:09:36 Q. Several?
10:09:37 A. Several -- probably 12. Maybe more than that; 12 to 14. There's a lot of depositions.
10:09:47 Q. Have you billed on this case so far?
10:09:49 A. No.
10:09:50 Q. When were you first retained by Mr. Wilt on this case?
10:09:53 A. When you say retained, do you mean when did he ask me to see it?
10:09:57 Q. Yes.
10:09:58 A. Probably a year ago. But I don't recall exactly when.
10:10:03 Q. Do you have any record of when you first were contacted by Mr. Wilt?
10:10:10 A. No.

10:10:10 Q. And you say that you put in in the teens by
10:10:17 way of hours?
10:10:18 A. I would say teens, yes.
10:10:20 Q. Is there a reason you haven't billed at this
10:10:23 particular point?
10:10:24 A. I'm not a very good businessman. No great
10:10:30 reason. I just haven't submitted a bill.
10:10:32 Q. Have you kept track of the time?
10:10:34 A. Uh-huh.
10:10:35 Q. That's a yes?
10:10:36 A. That's a yes.
10:10:36 Q. And where is that time kept?
10:10:38 A. In my desk. I have a little tabulation and I
10:10:42 would say it's in the teens.
10:10:43 Q. All right. What I'd ask you to do -- and does
10:10:47 it show the hours that you -- for example April 9th,
10:10:50 you put in two hours?
10:10:51 A. Some of them do. Oftentimes I'll just put
10:10:54 like one hour -- you know, the case, Arachikavitz, one
10:10:57 hour, you know.
10:10:59 Q. Okay. That's an item that I'd requested that
10:11:03 you bring with you, and perhaps during a break we can
10:11:06 get a copy of that because we're going to mark your
10:11:08 notes as Exhibit No. 2 and then we can mark the note
10:11:11 that you have concerning your -- the time that you have

10:11:15 put in as Exhibit No. 3. Does that sound reasonable?
10:11:18 A. Sounds fine. It's not a really formal piece
10:11:22 of paper.
10:11:22 Q. I won't -- I'm not looking for anything
10:11:25 formal.
10:11:25 A. Okay.
10:11:26 Q. Doctor, I want to sort of get a sense of what
10:11:31 we're going to be talking about, since this case is
10:11:34 going to trial in three weeks, and it's the first time
10:11:38 I have met you and I don't have a report from you. So
10:11:40 I want to sort of get an idea of the scope of the
10:11:44 opinions that you're going to be providing, okay?
10:11:46 A. Sure.
10:11:47 Q. Do you intend to provide any standard of care
10:11:52 opinions in this case in support of Dr. Loboda and his
10:11:57 care as an anesthesiologist?
10:12:00 MR. WILT: Objection.
10:12:01 THE WITNESS: No.
10:12:02 BY MR. MISHKIND:
10:12:02 Q. Do you intend to provide any opinions
10:12:06 concerning the medical care that was provided by the
10:12:12 medical team that managed the code?
10:12:16 A. No.
10:12:16 Q. You certainly, as a pulmonary and critical
10:12:22 care doctor, have experience in handling codes,

10:12:26 correct?
10:12:26 A. Correct.
10:12:27 Q. And I presume you have handled codes and know
10:12:33 about the ABC's of getting the airway going and the
10:12:39 steps that need to be taken with regard to a code?
10:12:48 A. Correct.
10:12:49 Q. Do you intend to provide any standard of care
10:12:53 opinions as it relates to the care in the PACU?
10:13:03 A. No.
10:13:04 Q. Have you arrived at any standard of care
10:13:11 opinions in this case?
10:13:12 MR. WILT: Objection. If you want to
10:13:14 take him there -- I mean, it's not my intention --
10:13:18 MR. MISHKIND: Right.
10:13:19 MR. WILT: -- to present Dr. Canonico on
10:13:21 standard of care opinions.
10:13:23 MR. MISHKIND: I understand.
10:13:23 MR. WILTS: But if you want to ask him
10:13:25 about standard of care, you go there at your own peril
10:13:29 there, Howard. I'm just letting you know.
10:13:31 MR. MISHKIND: Okay.
10:13:32 BY MR. MISHKIND:
10:13:32 Q. Have you?
10:13:33 A. Yes.
10:13:33 Q. You have not been asked to provide standard of

10:13:35 care opinions?
10:13:36 A. That is correct.
10:13:37 Q. Okay. Who is it that you have arrived with
10:13:41 regard to standard of care opinions concerning?
10:13:45 A. What are my opinions regarding standard of
10:13:48 care, of what he received? I guess I have an opinion
10:13:53 of the care he received in the PACU and I have an
10:13:56 opinion of the care he received on the floor.
10:13:58 Q. Okay. Are you qualified to provide those
10:14:02 opinions from the standpoint of PACU care?
10:14:06 MR. WILT: Objection.
10:14:09 MS. SMALL: Objection.
10:14:10 THE WITNESS: Well, I'm not an
10:14:11 anesthesiologist so, you know, I had no intention of
10:14:14 making a standard of care statement here. I mean, you
10:14:18 asked if I have an opinion.
10:14:19 MR. MISHKIND: Sure.
10:14:20 THE WITNESS: I do. But I'm not an
10:14:22 anesthesiologist. I don't run a PACU.
10:14:25 BY MR. MISHKIND:
10:14:25 Q. Okay. And I take it you have discussed those
10:14:27 opinions with Mr. Wilt?
10:14:29 A. My standard of care opinions?
10:14:31 Q. Yes.
10:14:31 A. I have shared opinions regarding how I thought

10:14:34 the care went.
10:14:34 Q. Okay. And nonetheless, you have indicated to
10:14:40 me on the record that it's not your intention
10:14:42 to provide standard of care opinions at the time of the
10:14:45 trial of this case, correct?
10:14:47 A. That is not --
10:14:48 MR. WILTS: And, yeah, just let me make
10:14:49 sure you're not going to get up and imply to this jury
10:14:52 that he doesn't have opinions, because he does. Now
10:14:55 I'm not going to take him there, but let's be clear
10:14:58 about this, Howard. You're not going to get up and
10:15:00 tell this jury that I didn't ask him to give opinions
10:15:05 because maybe his opinions are negative, okay? So just
10:15:07 -- you know, I'm letting you know, and you can hold me
10:15:10 to it, I'm only going to present this doctor on
10:15:13 causation. But I want it to be clear, he's not giving
10:15:18 opinions because that's my decision, not because he
10:15:21 doesn't have them.
10:15:23 MR. MISHKIND: I understand it loud and
10:15:25 clear.
10:15:25 MR. WILT: Okay.
10:15:25 MR. MISHKIND: And I'm entitled to ask
10:15:27 him what I did, and I did.
10:15:28 MR. WILT: Okay. That's just fine. Just
10:15:30 read it back. I don't know want to have anything

misconstrued later.

MR. MISHKIND: We don't need to read anything back. We're fine.

MR. WILT: Okay.

BY MR. MISHKIND:

Q. Doctor, do you intend to provide any opinions as it relates to the cause of Anthony's arrest?

A. Yes.

Q. Okay. Do you intend to provide any opinions as to the cause of Anthony's brain damage?

A. I have a -- yes.

Q. Do you intend to provide any opinions as it relates to Anthony's life expectancy?

A. No.

Q. Do you intend to or have you arrived at any opinions with regard to the neurological sequallae of Anthony's injuries? In other words, what the quality of his life is currently?

A. No.

Q. Tell me just sort of in a general sense what you believe to be the cause of the arrest, and then we're going to go into great detail because depending upon what you tell me to be the cause of the arrest will determine which areas of my questioning I will be asking you about. But tell me in general what you

10:16:56 1 believe to be the cause of the arrest the early morning
10:16:59 2 of December 17, 2001 at Akron General Medical Center?
10:17:04 3 A. I think Anthony was septic and had -- in that
10:17:10 4 setting he had an event that precipitated his cardiac
10:17:16 5 arrest. The most likely explanation to me would be an
10:17:19 6 aspiration event. There are, I guess, other
10:17:25 7 possibilities but that would be my most likely
10:17:28 8 explanation as to what happened at the time of the
10:17:30 9 event.
10:17:31 10 Q. Okay. May I take it that when you say that he
10:17:34 11 was septic, you're not suggesting that he was in septic
10:17:38 12 shock, are you?
10:17:40 13 A. At what point?
10:17:41 14 Q. At the time of his arrest?
10:17:44 15 A. That's a little harder to answer. Following
10:17:49 16 his arrest, he was in shock. Now, I can't say that it
10:17:57 17 wasn't a progression of his sepsis or just the fact of
10:18:01 18 coming out of his cardiac arrest, but he was in shock
10:18:05 19 at the following -- once they stabilized him from his
10:18:08 20 arrest.
10:18:09 21 Q. And we're going to talk about the reasons that
10:18:12 22 you believe he was in shock afterwards, but I want to
10:18:15 23 understand whether or not based upon what you saw
10:18:17 24 afterwards, and you have done some research on sepsis
10:18:21 25 and you have done -- I presume you know the difference

between SIRS and sepsis and severe sepsis and septic shock, correct?

A. Correct.

Q. And what I want to know is from a pathophysiological standpoint, are you able to state to a reasonable degree of medical probability that the cause of Anthony's arrest was due to him being in a state of septic shock?

A. Can you rephrase that question for me?

Q. Sure. Was he in septic shock, from a physiological standpoint, that caused him to arrest?

MR. WILT: Objection. Asked and answered. Go ahead.

THE WITNESS: I think that that can explain the situation.

BY MR. MISHKIND:

Q. Is it your opinion, to a reasonable degree of medical probability, that he was in septic shock and that that caused his arrest?

MR. WILTS: Objection. Go ahead.

THE WITNESS: Yeah. Again, I think -- I mean, the problem -- one of the problems is it's obviously a confusing situation. I think sepsis and septic shock possibly with aspiration at that time is, to me, the most likely explanation.

10:19:44 BY MR. MISHKIND:
10:19:44 Q. Now, I'm going to tell you that the one
10:19:47 deposition that you have not read, which is Dr.
10:19:49 Armitage's deposition, who is an infectious disease
10:19:55 doctor for Dr. Loboda, the same doctor that you've been
10:19:58 retained by, his opinion is that Anthony was not in
10:20:02 septic shock. That that did not cause his arrest.
10:20:06 Now then, that's why I asked you from a
10:20:10 pathophysiology standpoint, do you believe Anthony met
10:20:15 the criteria at the time that he went into
10:20:21 cardiopulmonary arrest to say that his cardiopulmonary
10:20:25 arrest was caused by septic shock?
10:20:30 A. Again, he was septic. He had evidence of
10:20:35 shock. And it does -- an episode like aspiration could
10:20:42 have triggered the whole thing. I can't separate all
10:20:44 that out. It's too -- it's too blurred and confusing
10:20:48 at that point.
10:20:48 Q. One thing you did say was a septic event,
10:20:52 correct?
A. A --
10:20:54 Q. You used the term that he suffered a septic
10:20:57 event, which is sort of a generic term which doesn't
10:21:03 mean a lot from a medical standpoint until you define
10:21:06 what you mean by a septic event.
10:21:07 A. Well, he was septic.

10:21:08 Q. Okay.
10:21:09 A. We know that. And then he had, sometime
10:21:13 around 8 o'clock, an event. So I'm tying the fact that
10:21:20 we know he was septic and he had some type of event
10:21:23 that triggered this cardiac arrest. And given that,
10:21:30 how would you tie it together? Well, he was septic,
10:21:33 plus aspiration, septic, plus some other event.
10:21:38 Q. Okay.
A. And --
10:21:40 Q. We'll talk about -- go right ahead.
10:21:42 A. I was going to say it could be potentially a
10:21:46 progression of the sepsis, too, that just tipped him
10:21:49 over.
10:21:49 Q. And we'll talk about all of the bases for
10:21:51 that. I just want to sort of get a laundry list of
10:21:55 what it is that you believe.
10:21:58 MR. WILT: Howard, before you go on
10:22:00 forward, just so we don't -- I don't want you to think
10:22:03 we've held anything back on you. I showed him the
10:22:06 records of Dr. Balagani today before the deposition.
10:22:09 So he has reviewed those.
10:22:11 MR. MISHKIND: Okay.
10:22:13 BY MR. MISHKIND:
10:22:13 Q. Is there anything else, Doctor, because I just
10:22:16 want to have your testimony -- is there anything else

10:22:18 that you have reviewed today that you didn't have
10:22:26 before today other than the family practice doctor's
10:22:38 records?
10:22:38 A. No.
10:22:40 Q. Are there any other causes that you consider
10:22:45 in terms of being either probable or possible
10:22:51 explanations for why Anthony suffered the
10:22:55 cardiopulmonary arrest?
10:22:56 MR. WILT: Objection.
10:23:00 THE WITNESS: If I were there at the time
10:23:02 of the arrest and you're saying what happened, I would
10:23:06 start with septic -- sepsis, possible aspiration, could
10:23:11 have had a PE, could have had an arrhythmia. Those are
10:23:17 the most likely explanations I can come up with.
10:23:21 BY MR. MISHKIND:
10:23:22 Q. Now, after going through the medical records
10:23:23 and reading the depositions, I presume that there are
10:23:26 certain explanations that you do not believe elevate to
10:23:33 a probability, correct?
10:23:36 A. I don't understand the question.
10:23:37 Q. You understand legally, in terms of causation,
10:23:41 the question is do you hold an opinion as to what
10:23:44 caused Anthony's arrest, to a reasonable degree of
10:23:48 medical probability? You understand that, don't you?
10:23:50 A. Yeah. Again, I guess I would say from my --

10:23:53 from a perspective of medical probability, I think the
10:23:56 most likely explanation is he was septic and aspirated.
10:24:00 Q. Okay. Other explanations in terms of
10:24:06 causation, would they be possibilities? In other
10:24:12 words, less than likely?
10:24:15 MR. WILT: Objection. Vague. Other
10:24:17 explanations, what are you talking about?
10:24:20 BY MR. MISHKIND:
10:24:20 Q. You considered other potential causes? We
10:24:23 talked about PE, we talked about --
10:24:24 MR. WILT: Okay.
10:24:25 BY MR. MISHKIND:
10:24:25 Q. We talked about --
10:24:26 MR. WILT: Arrhythmia.
10:24:28 BY MR. MISHKIND:
10:24:28 Q. MI, arrhythmias, things of that nature?
10:24:31 A. Well --
10:24:31 Q. Let me finish the question first. What I want
10:24:34 to understand is you have told me that your opinion is
10:24:36 that he was septic and that he probably aspirated
10:24:40 leading to his cardiopulmonary arrest, true?
10:24:45 A. I think that he was -- I think the likely
10:24:48 explanation is he was septic and had an aspiration that
10:24:53 led to it.
10:24:54 Q. And that is the pathophysiology that led to

his cardiopulmonary arrest, correct?

A. That's is the most likely scenario, in my opinion.

Q. And you hold that opinion to a reasonable degree of medical probability? Greater than 50 percent?

A. I think if you look at all that transpired there -- I would say, yeah, I think that's probably greater than 50 percent likely.

Q. Are there other explanations that you have considered, such as PE?

A. I think PE was a possibility, or is a possibility.

Q. But can we agree that it is less than -- it is a possibility, but it's not a probability?

A. I think it is less likely than this scenario as I have described.

Q. Less than 50 percent likely?

A. I would think it would be less than 50 percent but, you know, the problem with situations like this is each possibility -- I mean, even if it was a 20 percent probability, if it occurred, it was the event.

Q. Sure. I understand that. But legally, are you going to take the stand and say that Anthony suffered, in your professional opinion, to a reasonable

10:26:02 degree of medical probability, a pulmonary embolism
10:26:06 that caused his arrest?
10:26:07 A. I would say it would be less likely.
10:26:09 Q. So your opinion would be, "I can't say to a
10:26:11 probability that he suffered a pulmonary embolism?"
10:26:14 A. That is correct.
10:26:15 Q. Okay.
10:26:21 A. I also can't say he didn't.
10:26:24 Q. Right. But you understand there were a number
10:26:26 of tests done, correct?
10:26:30 A. A number of tests?
10:26:34 Q. Right. There was a spiral CT scan done --
A. Right.
10:26:34 Q. -- correct?
10:26:34 A. Correct.
10:26:34 Q. And in 2001 spiral CT scans are fairly
10:26:38 reliable in terms of determining whether or not a
10:26:43 patient has a PE, correct?
10:26:47 A. There's a false negative rate.
10:26:49 Q. Sure.
10:26:49 A. I mean, again, so you go back and say that I
10:26:52 can't say he didn't have a PE based solely on a
10:26:55 negative spiral CT.
10:26:57 Q. I understand that, but based upon the negative
10:27:01 spiral CT that -- from a clinical standpoint, that

10:27:02 gives you a high degree of confidence that it's
10:27:05 unlikely that he suffered a PE, correct?
10:27:08 A. I think it makes it less likely.
10:27:10 Q. And certainly there are other tests that could
10:27:14 have been done if there was a high index of suspicion
10:27:17 that he had a PE once the CT scan, the spiral CT came
10:27:22 back, correct?
10:27:23 A. There are other tests they could do, yes.
10:27:25 Q. Including doppler ultrasounds, VQ scans,
10:27:30 things of that nature, correct?
10:27:31 A. There are other modalities that you can look
10:27:32 for DVT/PE.
10:27:36 Q. Okay. And some of what I've just mentioned
10:27:38 are some of the modalities that you can use, correct?
10:27:40 A. Are you asking, are those modalities to
10:27:43 evaluate for DVT/PE or are they appropriate in this
10:27:48 situation?
10:27:48 Q. Well, if one wasn't satisfied with the CT scan
10:27:50 that came back and showed no evidence of pulmonary
10:27:53 embolism, if one wasn't satisfied that that was
10:27:56 accurate, what other tests would have been reasonable
10:27:59 to do to further confirm or rule out the existence of a
10:28:04 PE?
10:28:05 A. I would do lower extremity venous dopplers.
10:28:09 Q. And certainly, Doctor, if in fact he had a

10:28:11 pulmonary embolism, number one, we know that he was not
10:28:15 given any anti-coagulation therapy, correct?
10:28:20 A. Well, he actually -- when you say
10:28:23 anti-coagulation, again, you mean fully anti-coagulated
10:28:26 or do you mean DVT prophalaxis?
10:28:31 Q. Was he treated in a manner that one would need
10:28:33 to treat a patient that had a pulmonary embolism?
10:28:36 A. He was treated in a manner to prevent
pulmonary embolis. If he had pulmonary embolis, he
10:28:41 wasn't on treatment for that.
10:28:45 Q. I'm sorry. If he had a pulmonary embolism, he
10:28:48 wasn't given the therapeutic treatment that one would
10:28:51 give for pulmonary embolism, correct?
10:28:52 A. That's correct. But he was on treatment to
10:28:55 prevent pulmonary embolis.
10:28:57 Q. Sure. And what was that treatment?
10:28:58 A. His SCDs.
10:28:59 Q. Which is what?
10:29:01 A. Sequential compression device on his legs.
10:29:03 Q. All right. But certainly if he had a blood
10:29:06 clot that went to the lungs, then, and the spiral CT
10:29:15 scan came back and said no evidence of pulmonary
10:29:18 embolism, the doctors treating him at that time didn't
10:29:21 give him the type of drug therapy that you would give a
10:29:25 patient that you suspected to have a pulmonary

10:29:31 embolism, true?
10:29:32 A. Well, given the CT findings, it wouldn't be
10:29:36 appropriate to anti-coagulate him at that point.
10:29:39 Q. And why is that?
10:29:40 A. Because there's no evidence of a PE.
10:29:42 Q. Okay. And certainly if, in fact, that CT was
10:29:45 a false negative -- by the way, what's the incidence of
10:29:50 false negatives on CT scans, spiral CTs?
10:29:54 A. Well, first of all, it's very operator
10:29:55 dependant, both by technique of doing it and your
10:29:59 radiologist interpretation. So it's really going to
10:30:03 vary from an institution to an institution.
10:30:05 Q. Generally speaking?
10:30:07 A. You know, probably, this is going to be a ball
10:30:11 park number. I'd say probably 10 percent. Maybe 15.
10:30:14 Q. So 85 to 90 percent reliability when the CT
10:30:18 scan, the spiral CT scan is done, if it says no PE,
10:30:22 there's an 85 to 90 percent likelihood that the patient
10:30:25 has not suffered a pulmonary embolism?
10:30:26 A. Has not suffered a large pulmonary embolism.
10:30:29 Q. And certainly if the patient isn't
10:30:31 anti-coagulated or treated for a pulmonary embolism
10:30:35 with medication and has had a pulmonary embolism -- you
10:30:40 follow me?
10:30:41 A. I think so.

10:30:42 Q. In other words, the CT was -- fell into that
10:30:45 false category --
10:30:45 A. False negative CT scan.
10:30:48 Q. Right. Exactly. And he's not given
10:30:50 medication for the pulmonary embolism, would you agree
10:30:53 that there is a high likelihood that the patient would
10:30:58 succumb to the pulmonary embolism without medication,
10:31:01 without treatment?
10:31:02 A. Not necessarily, no.
10:31:04 Q. Well, I'm not saying -- in the literature if a
10:31:07 patient is not treated for a pulmonary embolism --
10:31:11 what's the consequences of not treating a patient who
10:31:14 just had a pulmonary embolism?
10:31:15 A. Well, there's a lot -- it can run the gamut.
10:31:19 I mean, in fact, a lot of people will think --
following surgery, people will throw a small pulmonary
10:31:31 emboli and are never treated for it. I mean, if he had
10:31:31 a negative CT scan for PE and say his lower extremity
10:31:31 dopplers were negative, he might have thrown a clot.
10:31:33 He doesn't need therapy for it.
10:31:35 So, in general, if somebody has an pulmonary
10:31:36 embolis you want to anti-coagulate them. But if you're
10:31:41 saying if he had a pulmonary embolis, that he was going
10:31:43 to die from that without therapy, I would disagree with
10:31:46 that.

10:31:47 Q. Well, if he had a pulmonary embolism that was
10:31:48 significant enough to have caused him to go into
10:31:52 cardiopulmonary arrest and to sustain the kind of brain
10:31:55 damage that he did, would this have been a small clot?
10:31:58 A. Well, you know, you could throw a small
10:32:01 pulmonary embolis that would cause a cardiac arrythmia
10:32:06 that did not necessarily have a massive PE and
10:32:09 cardiogenic shock from that, but develop a cardiac
10:32:11 arrythmia and go into cardiac arrest from that. So it
is possible -- I mean, for example, people will throw a
10:32:19 PE, and they pass out and they get syncopy from that.
10:32:21 They don't have to be big clots to do that.
10:32:23 Q. When you have a patient that you suspect has
10:32:26 had a PE and you get a CT scan, spiral CT and it's
10:32:30 negative, what do you do?
10:32:31 A. If my suspicion were high?
10:32:33 Q. Yes.
10:32:34 A. I would do lower extremity dopplers.
10:32:38 Q. Do you criticize the doctors at Akron General
10:32:43 Hospital -- Akron General Medical Center for not doing
10:32:44 a doppler in this case?
10:32:45 A. No.
10:32:46 Q. And if your suspicion is high, do you also
10:32:50 provide treatment?
10:32:54 A. If my suspicion is high and he has a negative

10:32:59 --

10:32:59 Q. Spiral?

10:33:00 A. -- spiral CT scan?

10:33:02 Q. Yes.

10:33:02 A. If I had a high suspicion, would I go ahead and anti-coagulate? Are you talking in general or in this case?

10:33:09 Q. In general.

10:33:10 A. In general, if I had a very high suspicion for a PE, I would anti-coagulate them and then get the studies. In this case I would not have a high suspicion for a PE.

10:33:19 Q. Okay. So we can agree, just so that we don't have to spend a lot of time talking about a subject which is not going to be your opinion to a probability, while you recognize there is an 85 to 90 percent reliability on the CT scan, spiral CT, that he didn't have a PE, what you're telling me and what you may tell the jury, if permitted to do so, on this topic is that, "It's possible that he had a PE but I can't state as an expert in this case to a reasonable degree of medical probability that that's what caused his arrest?"

10:33:49 A. Correct.

10:33:49 Q. Okay. Thank you.

10:33:50 I want to back up for a moment and then we'll

10:33:55 get back into what we immediately jumped into. I want
10:33:58 to talk to you a little bit about your medical
10:34:01 experience as an expert. How many times have you been
10:34:03 consulted in medical negligence cases?
10:34:10 A. Probably less than 20.
10:34:16 Q. How many in the last year?
10:34:22 A. Maybe three to four.
10:34:28 Q. Can you tell me how many cases you have that
10:34:31 are open currently that, at least to your knowledge,
10:34:33 are open that you're serving in some capacity as an
10:34:38 expert?
10:34:39 A. And when you say open, you mean a case I
10:34:42 reviewed?
10:34:43 Q. A case that you have reviewed and someone
10:34:46 hasn't called you up and told you, "Doctor, the case is
10:34:49 over?"
10:34:49 A. Shred everything?
10:34:50 Q. Shred everything?
10:34:53 A. One.
10:34:54 Q. You have one opened. Is it this case or
10:34:56 another case?
10:34:57 A. It's another case. And then I was just
10:34:59 requested to review another one that I have not seen.
10:35:04 So from my perspective, I have one.
10:35:07 Q. Do you know how Mr. Wilt happened to contact

10:35:11 you to serve as an expert in this case?
10:35:15 A. I met Mr. Wilt when I was at Vanderbilt,
10:35:21 before.
10:35:21 Q. Okay. And in what capacity did you meet
10:35:28 Mr. Wilt?
10:35:28 A. He knew one of my colleagues over there, whom
10:35:33 I'd met over there, sort of in passing, at that point.
10:35:36 Q. And did you serve as an expert on behalf of
10:35:40 one of Mr. Wilt's clients?
10:35:42 A. I have.
10:35:43 Q. And was that a PE case?
10:35:46 A. It was a PE case, yes.
10:35:48 Q. Was that the Jeffries versus River Valley
10:35:54 case?
10:35:54 A. I don't remember the name.
10:35:55 Q. Do you remember -- did you testify at trial in
10:36:02 that case?
10:36:03 A. Yes.
10:36:03 Q. And what was the outcome of that case?
10:36:05 A. The jury found in favor of the patient. Felt
10:36:12 that the physician should have diagnosed the PE.
10:36:16 Q. And as I recall, that was Attorney Scott
10:36:22 Bowling that took your deposition; do you remember
10:36:26 that? From Arlington, Ohio?
10:36:29 A. Sounds good, but I don't remember the name.

Q. B-o-w-l-i-n-g?

10:36:34 You testified in that case that the doctor was not negligent. In other words, you felt and your opinion was that he complied with the standard of care, true?

A. Correct.

Q. Yet the jury obviously disagreed with you?

A. Obviously.

Q. At that time Mr. Wilt, I believe, was with Arnold & Associates. Do you remember that firm down in Cincinnati that he was associated with?

A. Correct.

Q. Did you review any other cases for Mr. Wilt when he was with Arnold & Associates?

A. You know, I don't think so. I may have reviewed one other. There was one case he asked me to review and we discussed it and I said no, that's not one to review. And then I can't remember if I have reviewed any others for him.

Q. What about since he's moved up north? Have you reviewed any other cases for him since he's been with Buckingham Doolittle, or if he's been with any other firms up in the northern part of Ohio?

A. There was one more -- there is one I have reviewed with him since he's been up there.

10:37:48 Q. Is that one of the cases that's open currently?
10:37:51 A. No. That's closed.
10:37:52 Q. What was the subject matter of that case?
10:37:55 A. There was a CAT scan that was performed that was -- a dissecting aneurysm was missed, and I believe it was a pulmonologist that was sued because he did not see it on the CAT scan.
10:38:16 Q. How many times have you testified in a courtroom?
10:38:21 A. Twice.
10:38:24 Q. We know the one time for Mr. Wilt?
10:38:26 A. Uh-huh.
10:38:27 MR. WILT: Objection. Just so we're clear, I wasn't the attorney involved at that trial. I was not with the firm at that time. So, go ahead.
BY MR. MISHKIND:
10:38:35 Q. I'm not trying to disparage you. It was a case that Mr. Wilt was present for your deposition when Mr. Bowling took your deposition and that was the Jeffries versus River Valley Case, correct?
10:38:49 A. I don't know the name of the case. Apparently it is. I mean, I guess you have it there.
10:38:52 Q. Mr. Wilt was representing the doctor and that ultimately the case went to trial and the doctor was

found -- the jury found against the doctor that you were defending, correct?

A. If that is the case, yes.

Q. The other case, was it a plaintiff's case or a defendant's case?

A. I'm sure it was a federal case. And I was an expert for the U.S. Attorney's Office.

Q. How long ago was that, Doctor?

A. That has been within the year.

Q. What was the subject matter of that?

A. There is something called Dinitrophenol, D-i-n-i-t-r-o-p-h-e-n-o-l, that body builders will take to try to lose fat, and the problem is it increases your metabolic activity and it's pretty dangerous to take. And we had a patient, a young guy who took it here who became toxic from it and almost died. He had a temperature of 107, 108, multi-system organ failure. It was pretty horrendous. He recovered. The same day that he took this, which he got off the internet, another young man took this up in Long Island and died from it. And the FDA Office Of Criminal Investigation then arrested the distributor of this. And they have my name from that and requested me to speak on Dinitrophenol toxicity.

Q. So it wasn't really a medical malpractice

10:40:32 case, it was really more of a drug liability product?
10:40:35 A. Well, it was a criminal case.
10:40:37 Q. Criminal case. So that would be the second
10:40:41 time that you have testified in a courtroom?
10:40:43 A. Yes.
10:40:43 Q. The 20 cases that you have reviewed, in total,
10:40:51 how many times have you had your deposition taken?
10:40:55 A. A handful.
10:40:58 Q. Give me an idea what that means to you?
10:41:00 A. Five to eight. Five to seven. Twenty might
10:41:06 be high, too, by the way. I'm just trying to -- it may
10:41:09 be a high number.
10:41:10 Q. In terms of your total review?
10:41:11 A. Yeah, probably. But I think deposition-wise,
10:41:14 sitting down and taking a deposition, it's not going to
10:41:17 be over 10. It's probably less than eight.
10:41:23 Q. Give me an idea, Doctor, in terms of how
10:41:27 that's divided down? You know that you're appearing at
10:41:30 the request of an attorney representing a defendant in
10:41:33 this case, of the seven to 10 or whatever, less than
10:41:38 eight --
10:41:38 A. Right. Including in that are the -- I mean,
10:41:43 including the criminal case, so, as part of those
10:41:48 numbers.
10:41:48 Q. Okay.

10:41:49 A. And I'm including another criminal case that I
10:41:53 was requested from the U.S. Attorney to review. And
10:41:55 then included in that was a deposition about disability
10:42:01 from pulmonary fibrosis. So if you take those out,
10:42:08 probably 60/40, 70/30, defense to plaintiff.
10:42:14 Q. So it sounds like there's only been maybe four
10:42:17 or five depositions that you have given, maybe five or
10:42:22 six that relates solely to the topic of medical
10:42:25 malpractice, standard of care and causation issues?
10:42:28 A. That would -- yeah, that sounds reasonable.
10:42:33 Q. And 60 percent --
10:42:36 A. 60 to 70 percent would be as requested by the
10:42:41 defense. Probably 30, maybe 40 percent for plaintiff.
10:42:46 Q. Have you -- the case that is open currently,
10:42:53 the other case and the one that's come across your
10:42:57 desk, are those plaintiff or defense cases?
10:42:58 A. Defense.
10:42:59 Q. Do you recall the name of any of the attorneys
10:43:04 that you have worked with from the plaintiff side?
10:43:07 A. Debbie Thompson in Knoxville. And she
10:43:19 actually is now a defense lawyer, but at the time she
10:43:23 was a plaintiff lawyer. Hard to believe, isn't it?
10:43:30 Q. Any attorneys that are -- are and were
10:43:36 plaintiff attorneys, that you can recall?
10:43:39 A. That would be the only one that I can recall.

10:43:43 Q. When are you scheduled to give a deposition or
10:43:45 testify in trial next, aside from the Arachikavitz
10:43:50 case?
10:43:50 A. When am I next? I have a -- there is a
10:43:56 deposition coming up where I'm to give a deposition not
10:44:00 as retained by defense or plaintiff, but there was a
10:44:03 suit on a physician and I have been asked -- I was part
10:44:08 of the care of that patient. And so I have to give a
10:44:11 deposition in that.
10:44:12 Q. Have you ever been named as a party in a
10:44:16 medical negligence case?
10:44:17 A. No.
10:44:18 MR. WILT: Objection.
10:44:18 THE WITNESS: Excuse me. No.
10:44:21 BY MR. MISHKIND:
10:44:22 Q. Ever worked with the Reminger & Reminger firm,
10:44:25 which is one of the firms that's defending one of the
10:44:28 doctors in this case?
10:44:29 A. No.
10:44:30 Q. What about Roetzel & Andress, one of the other
10:44:32 firms?
10:44:33 A. No, not that I know. I don't keep track of
10:44:39 that, so --
10:44:58 Q. Has your name ever been listed with any search
10:45:06 firms that provide expert witnesses?

10:45:08 A. Not to my knowledge.
10:45:10 Q. So the cases that you have received, you have
10:45:14 been contacted by attorneys that may have gotten your
10:45:16 name from other lawyers?
10:45:18 A. Correct.
10:45:19 MR. WILT: Objection.
10:45:22 BY MR. MISHKIND:
10:45:22 Q. Just a couple more questions on pulmonary
10:45:24 embolism and then I'll --
10:45:25 A. Can I back up?
10:45:26 Q. Sure. Go right ahead.
10:45:27 A. I should -- actually should qualify I don't
10:45:30 know how they got my name. Maybe from the lawyers,
10:45:32 maybe from other doctors. I've never solicited or put
10:45:35 my name out there. So I don't know how they got my
10:45:38 name.
10:45:38 Q. You have never advertised?
10:45:40 A. That's correct.
10:45:40 Q. Have you ever had your privileges suspended or
10:45:43 revoked?
10:45:43 A. No.
10:45:44 MR. WILT: Objection.
10:45:44 BY MR. MISHKIND:
10:45:44 Q. Have you ever applied for privileges and been
10:45:47 denied?

10:45:47 MR. WILT: Objection.

10:45:48 THE WITNESS: No.

10:45:48 BY MR. MISHKIND:

10:45:50 Q. A couple pulmonary embolism questions to just put that under the rug and we'll move on.

10:45:53

10:45:55 A. Sure.

10:45:55 Q. Can we agree that there is no scientific evidence in the records to support an opinion greater than 50 percent that Anthony suffered a pulmonary embolism causing his cardiopulmonary arrest?

10:45:59

10:46:02

10:46:06

10:46:11 A. Yes.

10:46:11 Q. I think we talked briefly, if there had been a suspicion even with the negative CT scan, the spiral CT, there were other tests available, including doppler ultrasound that would have been appropriate to do if the index of suspicion existed, that notwithstanding the negative test he might still have a PE, correct?

10:46:14

10:46:18

10:46:22

10:46:26

10:46:31

10:46:36 MR. WILT: Objection.

BY MR. MISHKIND:

10:46:38 Q. Did you not follow my question?

10:46:39 A. No, not really.

10:46:40 Q. We talked about this before, but there were other tests that were available that the doctors caring for Anthony, if they had a high index of suspicion, that, "Yeah, the CT says it's negative but we don't

10:46:44

10:46:47

10:46:53

10:46:57 1 think clinically the CT correlates with what we're
10:47:01 2 seeing," there are other tests that they could have
10:47:04 3 done, correct?
10:47:05 4 A. If they had a clinical suspicion, there was
10:47:08 5 probably one other test that would be reasonable to do.
10:47:10 6 That was the lower extremity doppler.
10:47:13 7 Q. And you don't see any indication in the
10:47:14 8 records or from the deposition testimony that anyone
10:47:17 9 felt that there was reason to do that, correct?
10:47:20 10 A. Going through the records, I don't see any
10:47:23 11 reason that they would have needed to do that.
10:47:25 12 Q. Is it fair to say that from a clinical
10:47:28 13 standpoint the doctors caring for him also felt
10:47:31 14 reasonably comfortable that it was unlikely that
10:47:33 15 Anthony had suffered a pulmonary embolism?
10:47:36 16 A. I think that when they obtained his spiral CT
10:47:40 17 scan, it was a very good thought because clearly the
10:47:42 18 presentation is consistent with a pulmonary embolis.
10:47:45 19 And I think that when they did the study, which was a
10:47:48 20 great study to do to evaluate that, and it was negative
10:47:51 21 and they felt comfortable feeling he didn't have a
10:47:54 22 pulmonary embolism, and I would agree with their
10:47:57 23 comfort level.
10:47:58 24 Q. Okay. And it would be speculation on your
10:48:01 25 part to say that he had a pulmonary embolism

notwithstanding their comfort level and notwithstanding the results of the CT scan, correct?

A. It would be speculation.

Q. Can we agree from what you have seen in the records and read about that before Anthony suffered his arrest and his brain damage, for whatever reason, that he had what you would consider as an internist, a pulmonary specialist and a critical care specialist, as essentially a health history that other than his thyroid condition, would not have suggested that he had anything other than a normal life expectancy?

MR. WILT: Objection.

THE WITNESS: You know, I really wasn't -- I have no comment on what his normal life expectancy is. I didn't know the gentleman. I didn't know what kind of lifestyle he had. Medically speaking, he presented -- his only medical problem was hypothyroidism.

BY MR. MISHKIND:

Q. And with that, just from the standpoint of your assessment, had he not suffered this arrest, had he made it through the appendectomy without any complications thereafter, do you see any reason, other than perhaps getting hit by a bus or developing cancer down the road, that he would have had a reduced life

10:49:34 expectancy?
10:49:36 MR. WILT: Objection.
10:49:37 THE WITNESS: From the information I
10:49:39 have, he looked like a pretty healthy 42-year-old
10:49:42 person.
10:49:42 BY MR. MISHKIND:
10:49:43 Q. Thank you. You did not mention in your list
10:49:59 of causation, adult respiratory distress syndrome. Do
10:50:06 you hold an opinion, to a reasonable degree of medical
10:50:09 probability, that Anthony suffered an arrest as a
10:50:17 consequence of ARDS?
10:50:19 A. I include ARDS as part of the sepsis. It's a
10:50:24 component of the sepsis syndrome.
10:50:27 Q. Yes. Okay.
10:50:28 A. So, yes, he had ARDS.
10:50:36 Q. All right. Can we agree that ARDS is a
10:50:40 diagnosis from clinical history compatible with the
10:50:43 syndrome and supported by radiographic and lab data?
10:50:47 A. Repeat that again, please?
10:50:48 Q. Can we agree that ARDS is a diagnosis made
10:50:52 from clinical history compatible with the syndrome and
10:50:56 supported by radiographic and lab data?
10:50:58 A. Yes.
10:50:59 Q. Sounds like something you've written, doesn't
10:51:01 it?

10:51:02 We can agree, Doctor, can we not, that
10:51:12 hypoxemia that is relatively refractory to supplemental
10:51:12 oxygen therapy is, by definition, a feature of ARDS?
10:51:15 A. Yes.
10:51:16 Q. Agree that Anthony did not have refractory
10:51:19 hypoxemia?
10:51:21 A. No.
10:51:21 Q. His O_2 stats improved once he was given
10:51:25 supplemental oxygen, correct?
10:51:27 MR. WILT: Objection. Go ahead.
10:51:29 THE WITNESS: That's not part of the
10:51:30 definition of ARDS.
BY MR. MISHKIND:
10:51:33 Q. What is your definition for refractory
hypoxemia?
A. A P to F ratio of less than 200. P to F ratio
10:51:42 of less than 300 is acute lung injury. A P to F ratio
10:51:47 of less than 200 is one of the criteria for ARDS.
10:51:53 Q. And is it your testimony that's he had a ratio
10:51:57 less than 200?
10:51:58 A. Yes.
10:52:00 Q. Can we agree that by definition radiographic
10:52:25 evidence of pulmonary edema must also be present to
10:52:28 earn the diagnosis of ARDS?
10:52:29 A. No.

10:52:30 Q. So you wouldn't -- would you be surprised to
10:52:33 see medical literature that suggests that?
10:52:36 MR. WILT: Objection.
10:52:37 THE WITNESS: When you say pulmonary
10:52:38 edema, my interpretation is that that would be fluid
10:52:42 overload. And, in fact, with ARDS part of it is that
10:52:47 they don't have pulmonary -- that they don't have
10:52:51 evidence of elevated left atrial pressure.
10:52:54 If I may qualify that?
10:53:07 BY MR. MISHKIND:
10:53:07 Q. Sure. Go right ahead.
10:53:08 A. No evidence of hydrostatic pulmonary edema.
10:53:12 They may have interstitial edema, or pulmonary edema
10:53:14 secondary to non-hydrostatic reasons.
10:53:17 Q. Doctor, you've not seen all of the depositions
10:53:21 including the deposition of Dr. Nichols for the
10:53:26 hospital, but if Dr. Nichols testifies that the patient
10:53:29 did not have ARDS, I take it you would disagree with
10:53:33 him?
10:53:34 A. Yes. That's correct.
10:53:35 Q. Okay.
10:53:37 A. You mean, by definition he has ARDS.
10:53:44 Q. Was Anthony's pulmonary blood flow normal?
10:53:50 A. I don't know.
10:53:54 Q. Did you check the records?

10:53:56 A. Uh-huh. I don't know what you mean by
10:53:58 pulmonary blood flow.
10:54:00 Q. In ARDS isn't the pulmonary blood flow normal
10:54:03 or balanced in 90 percent of the patients?
10:54:06 A. I don't know what you mean by pulmonary blood
10:54:09 flow, again.
10:54:11 Q. You don't recall writing that in ARDS
10:54:17 pulmonary blood flow is normal or balanced in 90
10:54:20 percent of the patients?
10:54:20 MR. WILT: Objection.
10:54:21 THE WITNESS: I may have.
10:54:21 BY MR. MISHKIND:
10:54:22 Q. But you don't know what you meant?
10:54:23 A. Probably not.
10:54:25 Q. Okay.
10:54:25 A. That's why it's part of my literature. Again,
10:54:28 I think you need to go back to what the definition of
10:54:31 ARDS is. The definition of ARDS is a clinical syndrome
10:54:35 that would explain lung injury, bilateral infiltrates
10:54:43 on radiographic imaging and a P to F ratio of less than
10:54:46 200.
10:55:16 Q. The CT scan that you looked at showed diffuse
10:55:19 consolidation of both lungs, correct?
10:55:24 MR. WILT: Take a look.
10:55:24 THE WITNESS: Can I take a look?

MR. MISHKIND: Oh, absolutely.

10:55:28 THE WITNESS: I'm not quite sure that was
10:55:31 the wording they used.

10:55:31 MR. MISHKIND: Please.

10:55:31 MR. WILT: Radiology.

10:55:39 THE WITNESS: Radiology.

10:55:44 THE WITNESS: The bilateral upper and lower lobe consolidations and multifocal infiltrates.

BY MR. MISHKIND:

10:55:49 Q. And, by the way, that CT that you're looking
10:55:51 at also says no evidence of pulmonary embolism,
10:55:53 correct?

10:55:54 A. Correct.

10:55:54 Q. Diffuse consolidation of both lungs can be
10:55:58 caused by cardiopulmonary resuscitation during a code,
10:56:02 correct?

10:56:03 A. You could probably have some evidence of
10:56:06 pulmonary edema from that. I mean, he received a lot
10:56:11 of fluids around that time, so that's possible.

10:56:13 Q. And certainly during a code diffuse
10:56:15 infiltrates can be caused by fluid resuscitation,
10:56:19 correct?

10:56:19 A. In general or in this case?

10:56:21 Q. Well, in general.

10:56:23 A. In general, if you put a lot of fluid into a

person, you can put him into pulmonary edema. That's not the case here, though. We have that data, too.

Q. Why? On what basis?

A. Well, when they put the Swan Ganz catheter in, we have his wedge pressure, and his wedge pressure was 18.

Q. Diffuse consolidation in both lungs, would you consider that to be during resuscitation over -- the only way it could happen is if there was too much fluid?

A. No.

Q. Can you have diffuse consolidation caused by the cardiopulmonary resuscitation and still have normal wedge pressures?

A. You -- it would be very unusual. You would have to have a situation where somebody went into -- basically you're describing a situation where they have flash pulmonary edema, you resuscitate them, they then diurese all the fluid out before you put your Swan in. That doesn't appear to be what happened -- I mean, if we're talking specifically in this case, that's not the situation.

Q. Quantify for me the amount of the diffuse infiltrates that were seen on the x-rays that you believe were related to pre-arrest events versus fluid

10:57:44 resuscitation or CPR following the arrest?
10:57:47 A. Well, I look at that CT report and I -- to me,
10:57:51 that's a great CT description for ARDS. He's got
10:57:56 diffuse infiltrates and consolidations.
10:57:59 Q. But can you tell me what percentage of the
10:58:01 diffuse infiltrates and the consolidations were related
10:58:05 to ARDS, which would be a pre-arrest event, and what
10:58:09 was related to fluid resuscitation or CPR following the
10:58:14 arrest?
10:58:15 A. Well, ARDS -- or ARDS, here, is not an
10:58:18 isolated pre-arrest event. It's a continuum. So it's
10:58:23 not like he had an arrest. He had ARDS, arrested, and
10:58:28 then it went away. He still had ARDS. So ARDS was not
10:58:32 a pre-event that disappeared. It's still there.
10:58:35 Q. And you believe that the subsequent findings
10:58:37 which we'll talk about are consistent with him having
10:58:41 ARDS?
10:58:42 A. Yes.
10:58:43 Q. When do you believe he first had evidence of
10:58:46 ARDS?
10:58:48 A. Well, the first documentation where he
10:58:51 satisfies the criteria of ARDS is the 18th, or whatever
10:58:55 -- is that the 18th?
10:58:56 Q. 17th.
10:58:58 A. 17th.

10:58:58 Q. What about in the PACU, did he have evidence
10:59:03 in retrospect that would be consistent with ARDS?
10:59:07 A. I think in the PACU he had some problems with
10:59:13 oxygenation. Now he could have had some lung injury at
10:59:16 that point.
10:59:16 Q. Would that be more consistent with
atelectasis?
10:59:20 MR. WILT: Objection.
10:59:23 THE WITNESS: In retrospect or
10:59:24 prospectively?
10:59:24 MR. MISHKIND: Take it either way you
10:59:28 feel comfortable.
10:59:30 THE WITNESS: I think in -- I think, in
10:59:35 retrospect, with his CAT scan he probably had some lung
10:59:40 injury there and I think coming out of surgery probably
10:59:42 had some atelectasis.
10:59:44 Q. Do you have an opinion as to what caused
11:00:00 Anthony to develop hypoxemia in the post-op period?
11:00:07 A. I think that in the post-op period he probably
11:00:12 was coming out of anesthesia, he could have had some
11:00:15 hypoxemia from that and he probably had some lung
11:00:20 injury going on at that point that caused him to have
11:00:23 some hypoxemia.
11:00:24 Q. Is it fair to say that there didn't appear to
11:00:27 be any appreciation during the PACU stay that he had

any lung injury?

MR. WILT: Objection.

THE WITNESS: No, I don't think that's fair to say.

BY MR. MISHKIND:

Q. Why?

A. They were treating him with supplemental oxygen. They appreciated that he was having problems with his oxygen.

Q. Okay. But did they appreciate what the cause of that was, from what you can tell?

A. I don't think they knew -- they, at that point in the PACU, necessarily knew that he had ARDS or was developing ARDS at that point. Of course, there was no reason to think that at that point.

Q. Do you, in your practice, treat patients with sleep apnea?

A. I'm not a sleep specialist, but I see a lot of sleep ap -- I don't read the tests, but I treat patients for sleep apnea.

Q. In a patient that's demonstrating episodes of hypoxia, or hypoxemia in the post-op period where there's evidence of tachycardia and seesawing O_2 saturations and documented evidence of sleep apnea in the PACU records where the patient also has a

11:01:49 1 respiratory rate down to 12 and a systolic blood
11:01:52 2 pressure that was ranging between 80 and 100 over the
11:01:56 3 course of three hours in the PACU, would that suggest
11:01:59 4 that the patient was at increased risk for
11:02:03 5 post-operative complications?
11:02:06 6 MR. WILT: Objection.
11:02:07 7 MS. SMALL: Objection.
11:02:07 8 THE WITNESS: You know, I don't do PACU.
11:02:10 9 I'm not -- my therapy, what I do is not in the PACU.
11:02:12 10 I'd have to defer to an anesthesiologist as I look at
11 that.
11:02:16 12 But I do have a question, though, because you
11:02:18 13 said hypoxia and hypoxemia, which one did you mean?
11:02:22 14 BY MR. MISHKIND:
11:02:22 15 Q. Take hypoxia.
11:02:23 16 A. Well, he had no evidence of any hypoxia, no.
11:02:26 17 Q. In the PACU?
11:02:27 18 A. Correct.
11:02:27 19 Q. Did he have evidence of hypoxemia?
11:02:30 20 A. He had evidence of having low sats that
11:02:33 21 responded to oxygen.
11:02:35 22 Q. Okay. And they were seesawing, as well,
11:02:39 23 correct?
11:02:39 24 A. Well, that was their term.
11:02:40 25 Q. Okay. And, in fact, if we looked at the

11:02:43 record, he came in, he couldn't be extubated in the
11:02:47 operating room. He wasn't extubated until he got into
11:02:51 the PACU, correct?
11:02:52 A. Well, I'm not sure that's correct.
Q. Well --
11:02:55 A. You mean -- no. I mean, you said he couldn't
11:02:57 be extubated. I'm not sure he -- I wasn't there. I'm
11:02:59 not sure if he couldn't be or if they chose not to.
11:03:03 Q. Do you know what his O_2 sats were when he was
11:03:05 initially extubated?
11:03:07 A. They fell down into the 80s.
Q. And then --
11:03:08 A. Or when he was on -- he had a T-piece in there
11:03:09 and they had to bag him a little bit because his sats
11:03:14 fell.
11:03:14 Q. And then about 2:00, or 2:20, he's two and a
11:03:18 half hours into his PACU course, his oxygen saturation
11:03:23 also was falling back down into the 80s, correct?
11:03:27 MR. WILT: Objection.
11:03:27 THE WITNESS: Can I look?
MR. MISHKIND: Sure. Absolutely.
11:03:31 THE WITNESS: I'd have to look at the --
MR. MISHKIND: Go right ahead. If you'll
look at 2 a.m.
11:03:43 THE WITNESS: Yeah, 85 to 96.

BY MR. MISHKIND:

11:03:46 Q. Okay. So during the two hours of the PACU
11:03:53 stay, at that point, even at 2:35, two and a half
11:03:57 hours, the O_2 sat was 89 to 90. That would certainly
11:04:04 certainly suggest that there was some evidence of some
11:04:07 hypoxemia, correct?
11:04:09 A. Correct.
11:04:09 Q. And when they would give him oxygen, it would
11:04:18 -- his oxygen saturation would increase, correct?
11:04:21 A. Correct.
11:04:21 Q. A patient who has refractory hypoxemia does
11:04:27 not respond to supplemental oxygen, correct?
11:04:30 A. Incorrect.
11:04:31 Q. They don't -- they do respond?
11:04:33 A. Sure.
11:04:34 Q. Refractory hypoxemia?
11:04:36 A. Yeah.
11:04:36 Q. Explain to me how that is.
11:04:38 A. Well, refractory hypoxemia is somebody who has
11:04:41 just refractory hypoxemia. It doesn't mean that they
11:04:44 don't respond to supplemental oxygen.
11:04:46 Q. Do they respond to the point where they get to
11:04:48 normal levels?
11:04:50 A. They can, if you give them enough oxygen. I
11:04:54 mean, essentially anybody, if you gave -- if you're

11:04:58 looking at hypoxemia, there's certain causes of
11:05:01 hypoxemia. There is really very few causes that if you
11:05:03 don't -- that if you gave 100 percent oxygen they
11:05:06 wouldn't normalize. So refractory hypoxemia just means
11:05:10 they need additional oxygen. That they're hypoxemic.
11:05:13 Q. So your definition of refract -- give me your
11:05:16 precise definition so that I'm not confused.
11:05:19 Refractory hypoxemia, to you, means what?
11:05:23 A. Well, again, if you look at a P to F ratio, in
11:05:27 a sense where you oftentimes will cause -- the P to F
11:05:30 ratio of less than 300 is somebody who has evidence of
11:05:33 lung injury and it's refractory hypoxemia in that they
11:05:37 need additional oxygen to correct their hypoxemia.
11:05:42 Q. And how long does it take in refractory
11:05:44 hypoxemia to correct?
11:05:49 A. You mean, after you put oxygen on?
11:05:51 Q. Yes.
11:05:52 A. I can't answer that. It varies so much. I
11:05:56 mean, it depends on the cause of the refractory
11:05:57 hypoxemia.
11:06:00 Q. What do you believe to be the cause of the
11:06:04 refractory hypoxemia in Anthony?
11:06:06 A. In Anthony's situation? Well, at what point?
11:06:11 Q. Did he have refractory hypoxemia in the PACU?
11:06:15 A. He had hypoxemia that responded to

11:06:17 supplemental oxygen.
11:06:19 Q. Okay. So there was no evidence of refractory
11:06:22 hypoxemia in the PACU?
11:06:23 A. Again, he was hypoxemic and needed additional
11:06:24 oxygen, and with that he would normalize but not
11:06:31 completely, not back to what would be considered
11:06:31 normal.
11:06:31 Q. So do you classify that as refractory
11:06:37 hypoxemia?
11:06:37 A. I would classify that as having oxygenation
11:06:40 problems.
11:06:40 Q. Not refractory hypoxemia? I know we may be
11:06:40 splitting hairs, but it's important.
11:06:44 A. Yeah, I think we may be splitting hairs, but
11:06:46 yeah, well, it depends. I think if you would look at
this situation and say well, he needed supplemental
11:06:48 oxygen. So it's really hard to say. If somebody had
11:06:56 an O_2 sat of 100 percent, you wouldn't give him
11:06:58 supplemental oxygen. So if we're looking at it that
way, saying if he needed supplemental oxygen, then you
could argue that he had refractory hypoxemia corrective
11:07:00 with supplemental oxygen.
11:07:09 Q. Okay. Do patients that have had abdominal
11:07:19 surgery have more pulmonary complications because of
11:07:22 the difficulty of expanding the lungs during the post-

operative period?
A. More pulmonary complications compared to?
Q. Patients who do not have abdominal surgery? In other words, the fact that a patient is having abdominal surgery, does that have some impact on the respiratory muscles and the respiratory mechanism?
MR. WILT: Objection. Overbroad.
BY MR. MISHKIND:
Q. Go ahead, Doctor.
A. I know you hate to have the question back, but I'm just trying to understand it.
Are you asking, does abdominal surgery -- can abdominal surgery cause pulmonary complications?
Q. Does it increase the -- in the post-operative period does it increase the potential for the patient to have difficulty with respirations because of the impact on the pulmonary musculature?
A. Pulmonary complications can occur after abdominal surgery. I mean, I'm not sure -- I'm having a hard time. I'm not sure -- you're comparing it to something and I'm not sure -- if you're comparing it to somebody who didn't have surgery, yes, you have more pulmonary complications after surgery than if you didn't have surgery during the same time period. So surgery, abdominal surgery, you can have pulmonary

11:08:38 complications after abdominal surgery.
11:08:40 Q. In terms of Anthony's stay in the PACU, his
11:08:44 vital signs, clinical course, there has been some
11:08:48 testimony as to whether this was a normal or an
11:08:52 abnormal course. I take it you're not going to be
11:08:58 commenting on whether or not Anthony's PACU course was
11:09:03 an uneventful PACU course?
11:09:06 A. I'm not in a position to comment on a PACU
11:09:09 course.
11:09:09 Q. If Anthony had been transferred from the PACU
11:09:13 into an intensive care unit and your theory that he
11:09:16 developed -- that he was septic, that he developed over
11:09:23 time ARDS and the precipitating event that caused his
11:09:27 arrest was an aspiration, would you agree that from the
11:09:32 standpoint of recognizing Anthony's progression from
11:09:37 sepsis, the developing ARDS and then the aspiration,
11:09:41 that it would have been preferable to have him in a
11:09:44 monitored setting rather than on a medical/surgical
11:09:48 floor?
11:09:48 MR. WILT: Objection.
11:09:49 MS. SMALL: Objection.
11:09:52 THE WITNESS: And you're talking about
11:09:54 Anthony, in particular --
11:09:54 BY MR. MISHKIND:
11:09:54 Q. Sure.

11:09:55 A. -- in this situation. You know, he was
11:09:57 watched on the floor, was doing well, and then when
11:10:01 they found him at 8, in a sense at that point he was
11:10:06 then witnessed and potentially monitored. So I don't
11:10:12 -- you know, all things being equal, I guess if you
11:10:15 know that somebody is going to have an arrest, you'd
11:10:17 want them to be in ICU where you have paddles and
11:10:19 monitors and everything right there at your bedside
11:10:22 waiting for them to arrest.
11:10:22 So, you know, but I think that's sort of a
11:10:26 silly way of looking at it. I mean, the thing is, is
11:10:29 he was stable throughout. He had an event, they were
11:10:34 there, had the code cart, they got everything there in
11:10:40 some timeframe. Would it have been better if they had
11:10:42 everything there in ICU? I don't know. I mean, if you
11:10:46 look at it they would have had to witness the arrest,
11:10:49 if they had to witness the arrest in ICU, could have
11:10:52 been the same outcome.
11:10:54 Q. And are you going to comment on the quality of
11:10:57 the handling of the code?
11:11:00 A. You know, I run -- I've done codes. I'm not
11:11:04 part of the code team here. I have no intention of
11:11:06 commenting on the quality of the code.
11:11:08 Q. Doctor, Anthony was given Morphine at 4:15,
11:11:20 correct?

11:11:20 A. Yeah, I believe so.
11:11:21 Q. Do you know what Anthony's respiratory rate
11:11:25 was at the time that he was given -- or after he was
11:11:31 given the Morphine?
11:11:33 A. I'm not sure it was documented.
11:11:36 Q. Well, do you see any evidence that anyone
11:11:38 checked his vital signs after giving him Morphine?
11:11:42 A. At what time?
11:11:43 Q. 4:15.
11:11:47 A. I don't think there was documentation there.
11:11:49 Q. And we know he was on oxygen, three liters of
11:11:52 oxygen at the time, correct?
11:11:53 A. Correct.
11:11:53 Q. And certainly as a pulmonary expert you
11:11:58 recognize that Morphine can suppress the respiratory
11:12:05 drive, correct?
11:12:05 A. Correct.
11:12:05 Q. And we know that in the PACU Anthony had had,
11:12:10 was given essentially 10 milligrams of Morphine while
11:12:15 they were tytrating his oxygen, correct?
11:12:17 A. Correct.
11:12:17 Q. And these levels were going up and down at
11:12:20 that point, correct?
11:12:22 MR. WILT: Objection.
11:12:23 THE WITNESS: I'm not sure the levels

were going up and down the whole time they gave him the Morphine.

MR. WILT: Take a look. I think Morphine starts here, on this page. Yeah.

BY MR. MISHKIND:

Q. If you look at the 2:35, his oxygen saturation was 89 to 90?

A. Right.

Q. And they increased his oxygen to six liters and then they gave him two additional milligrams of Morphine, and then they decreased his -- they gave him more medication, his oxygen saturation went up. They decreased the Morphine -- they decreased the oxygen. Then after 2:50 we actually don't have any further recording of what his oxygen saturation was, correct?

MR. WILT: Objection.

THE WITNESS: There is no other documentation here.

BY MR. MISHKIND:

Q. Right.

A. Although I believe in one of the nurse's notes, don't they document by exception there?

Q. Well, that's what the testimony was, but based upon the record you don't see any indication of what his oxygen saturation was?

11:13:32 This is testimony after the lawsuit has been filed. What I'm saying is based upon the record, itself, do you see any indication as to what his oxygen saturation was after 2:50?

MS. SMALL: Objection.

11:13:45 MR. WILT: Objection.

11:13:47 THE WITNESS: You know, actually, to me, if you look at this, you figure the guy is doing better. He had sats of 95 percent on four liters, that they turned him down to three and he was stable.

BY MR. MISHKIND:

11:13:57 Q. But it doesn't say what his oxygen saturation was?

11:14:00 A. There is no O_2 sat number recorded.

11:14:03 Q. And we can agree, can we not, that after 2:45 they don't record what his respiration -- in the PACU what his respiratory rate was, what his blood pressure was or what his heart rate was prior to his transfer, correct?

11:14:20 A. Well, that is correct. It's not recorded there. I'm not sure what that means. I mean, if you look at the floor, we have vital signs right away on the floor.

11:14:29 Q. Doctor, I'm talking about prior to the patient being transferred.

11:14:31

11:14:32 A. Was there anything documented?
11:14:34 Q. Right.
11:14:34 A. No.
11:14:34 Q. And we know that prior to him being
11:14:36 transferred, his respiratory rate was 12, correct?
11:14:58 A. Right. Is there -- yeah. No. I mean, you
11:15:00 know, that's the last documented respiratory rate.
11:15:03 Q. Sure.
11:15:03 A. So, but, I mean, if you're saying you don't
11:15:04 know what the vital signs are when he was transferred,
11:15:06 you also don't know what his respiratory rate was when
11:15:06 he was transferred.
11:15:08 Q. Right. The last recorded respiratory rate was
11:15:11 12, correct?
11:15:12 A. With an O_2 sat of 95 percent.
11:15:15 Q. Right. And we don't know what impact the
11:15:17 additional Morphine had on his respiratory rate prior
11:15:20 to discharge, correct?
11:15:22 A. Well, you do.
11:15:26 Q. On what basis?
11:15:27 A. Because when he goes to the floor, you have
11:15:29 all that data. So to say that you don't know what
11:15:33 impact the Morphine has, it just isn't true. You know
11:15:36 what impact it has because you have all the
11:15:40 documentation from the floor. Are you saying if --

Q. Well --
A. If you're asking me --
MR. WILT: Let him ask his questions, but go ahead. I mean, you know, if you don't understand his question, let him reask it, but I think you have answered.
THE WITNESS: Okay. There's no documentation of his vital signs prior to discharge from the PACU.
BY MR. MISHKIND:
Q. And as to whether or not that is a standard of care violation, you can't comment on that, correct?
THE WITNESS: That is correct.
MS. SMALL: Objection.
BY MR. MISHKIND:
Q. Can a patient demonstrate signs of aspiration pneumonitis as a consequence of cardiopulmonary resuscitation?
A. As -- well, I'm not -- I think I don't understand that question. Can a patient -- well, excuse me. I don't understand the question.
Q. Can a patient demonstrate on x-ray, evidence of aspiration pneumonitis as a consequence or consistent with aspiration pneumonitis as a consequence of cardiopulmonary resuscitation?

11:16:54 A. It -- I'd have to say no to the way that
11:16:58 question was asked.
11:17:01 Q. Tell me, Doctor, then on the x-ray and the CT
11:17:04 scans in terms of the bilateral consolidations what you
11:17:08 find to be more consistent with an aspiration as
11:17:11 opposed to responses to resuscitation?
11:17:17 A. Well, he has multifocal infiltrates, they're
11:17:23 upper lobe and lower lobe, and we know he wasn't fluid
11:17:29 overloaded.
11:17:33 Q. And in order to have a diagnosis of ARDS, the
11:17:38 pO_2 to fiO_2 ratio, does it have to be less than 200?
11:17:45 A. That's for ARDS.
11:17:47 Q. Right.
11:17:47 A. Less than 300 for acute lung injury, which is
11:17:50 a continuum.
11:17:52 Q. But for ARDS the pO_2 to fiO_2 ratio has to be
11:18:05 less then 200, correct?
11:18:05 A. Correct. One of the criteria.
11:18:05 Q. And in acute lung injury it has to be less
11:18:09 than 300, did you say?
11:18:10 A. That's correct.
11:18:11 Q. In this case wasn't his pO_2 to fiO_2 ratio 345?
11:18:18 A. Well, I don't think so.
11:18:23 MR. WILT: I think it's in Labs.
11:18:24 THE WITNESS: Labs?

11:18:26 MR. WILT: Yeah. Here it is.

11:18:26 THE WITNESS: The blood gases -- if you go to 12-17 there is a blood gas that's 717, pCO_2 of 36, and then the pO_2 is 344.

11:19:09 If you go to the one at 10 o'clock on an fiO_2 of 1 his pO_2 was 111. So that's a P to F ratio of 111.

11:19:26 If you go to 11:20 his P to F ratio is 120. On the 18th his fiO_2 is point 6 and his pO_2 is 106. So that's a P to F ratio of 170.

If you go to the 19th, his fiO_2 is point four, his pO_2 is 115, so now you're, what, 270, something like that? 280.

11:19:55 Then as you work your way up, here's -- if you look at like the 24th at 5:20, he has a fiO_2 of point 11:20:00 five, his pO_2 was 82, that's a P to F ratio of 160.

11:20:18 If you look at the 31st, an fO_2 of point four, his pO_2 is 83, that's a P to F ratio of 200.

11:20:19 So he has persistent evidence of refractory 11:20:33 hypoxemia by P to F ratio. In fact, all the way out to 11:20:43 the 1st he still was having oxygenation problems on his 11:20:49 blood gases.

11:20:50 BY MR. MISHKIND:

11:20:50 Q. Now why are his chest x-rays after essentially 11:21:05 the 21st grossly clear? In ARDS would you expect for 11:21:15 the lung fields to clear that quickly?

11:21:19 A. Well, yes, you can. So --
11:21:22 Q. Is that an unusual response?
11:21:25 A. Not necessarily, but the problem with the
11:21:27 chest x-rays here is really as far as looking at the
11:21:30 lung injury pattern they're sort of irrelevant because
11:21:33 on the 17th he had a chest x-ray that was interpreted
as clear and the same day we have a CAT scan that shows
11:21:41 these multifocal infiltrates.
11:21:43 So it just sort of reflects the lack of
11:21:45 sensitivity of the chest x-ray compared to a CT scan.
Q. Well, but -- are you faulting the doctors,
11:21:45 then, at the hospital for not repeating the spiral CT
11:21:53 as soon as --
11:21:54 A. No, not at all.
11:21:55 Q. And aren't x-rays used, radiological films
11:21:59 used as opposed to the CT scans to watch the serial
11:22:04 resolution?
11:22:05 A. Absolutely.
11:22:06 Q. And, in fact, the x-rays that we have as we go
11:22:10 along show lung fields clear, grossly clear. Lung
11:22:13 fields remain clear as of the 24th, correct?
11:22:17 A. Right. But the one on the 17th shows the same
11:22:20 thing.
11:22:20 Q. Right. But in ARDS if, in fact, this was
11:22:24 adult respiratory distress syndrome, secondary to the

sepsis, are you telling me that you would expect the lung fields to clear that quickly?

A. The chest x-ray was never a good imaging modality in Anthony's case. You have --

Q. I mean --

MR. WILT: Wait. Let him finish.

THE WITNESS: Yeah. I mean, you look at the CAT scan. The CAT scan shows you he has diffuse infiltrates. They're present the same day as the chest x-ray that was interpreted as clear. The chest x-ray is not as sensitive as a CT scan in looking at parynchemal abnormalities of the lung.

So they're -- it's sort of moot. Now, they're great. I mean, the serial chest x-rays are great to make sure there's no interval change, make sure the lines are good, the ET tube is good. So it's appropriate to follow on chest x-ray. And again, you need to go back, it's not really a question of whether he has ARDS. We know he has it. Really, the question is why did he get it? I mean, he fulfills all the criteria of ARDS. So it's a clinical syndrome. I mean, it's really sort of a moot point to say whether he does or doesn't because he satisfies all the criteria; acute onset, diffuse infiltrates, refractory hypoxemia and a wedge less than 18, and no evidence of

11:23:35 left atrial -- elevation in the left atrial pressure.

11:23:40 So he has ARDS. Now the question is why did

11:23:42 he get it, and the most likely explanation in a guy

11:23:44 who's septic is sepsis.

11:23:47 BY MR. MISHKIND:

11:23:47 Q. Well, where does the aspiration fall into this

11:23:50 equation?

11:23:51 A. You're asking -- one question you asked is why

11:23:55 at 8 o'clock did he have this event? It could have

11:23:59 been the progression -- I mean, he was obviously sicker

11:24:02 than I -- than he let people know. It could have been

11:24:07 the progression just of ARDS and he developed

11:24:10 respiratory failure from that, or is there another

11:24:11 event? And to me it makes sense that he could have

11:24:15 aspirated right then.

11:24:16 Q. Do you see any evidence in the case -- in the

11:24:22 records that Anthony aspirated gastric contents?

11:24:27 A. No. But there is record -- there is evidence

11:24:30 in the case that he had a lot of nausea and vomiting

11:24:35 and emisis. We also know he drank a 12-pack of beer to

11:24:39 try to get rid of the pain. So even at home when he

11:24:45 was nauseated and vomiting, he was also drinking a

11:24:46 12-pack of beer. So he could have aspirated at home.

11:24:47 There is no documentation of aspiration in

11:24:50 here. It doesn't mean he didn't aspirate. And again,

11:24:53 you're asking for why at that point. It's just -- it's
11:24:56 a theory. Doesn't mean it was necessarily exactly what
11:24:59 happened, but it makes the most sense.
11:25:00 Q. Well, I'm asking you, Doctor -- theory or no
11:25:02 theory, I'm asking you for opinions to a probability.
11:25:06 I'm asking you if, in fact, you believed to a
11:25:08 probability he aspirated at that time? I want to know
11:25:14 what evidence in the records, what evidence in the
11:25:17 depositions, what evidence is there for you to say that
11:25:22 Anthony had secretions or gastric contents that led to
11:25:28 this aspiration event?
11:25:31 MR. WILT: Objection. Asked and answered.
11:25:33 Go ahead, Doctor.
11:25:34 THE WITNESS: Well, we know he has acute
11:25:36 lung injury, we know he's septic, we know he has
11:25:40 diffuse infiltrates on his CT scan in a pattern that
11:25:43 could be due from aspiration. We know he was okay at
11:25:46 seven. Something happened at eight, or around eight.
11:25:49 So to me it's either a progression of his sepsis
11:25:54 syndrome or he also had an event like aspiration.
11:25:59 So I guess if you ask me probability, I put
11:26:04 those two together. Progression of sepsis plus an
11:26:07 aspiration event, minus an aspiration event. I can't
11:26:11 say for sure he aspirated. You're asking me what's my
11:26:14 likely explanation, that's what I would say.

11:26:16 BY MR. MISHKIND:
11:26:17 Q. Well, Doctor, if he aspirated wouldn't you
11:26:19 expect that some doctor, some nurse in the records, in
11:26:24 the depositions, would comment about seeing the
11:26:28 obstruction caused by the aspiration during the code or
11:26:33 thereafter if this was truly an aspiration that
11:26:36 occurred?
11:26:37 A. Not necessarily.
11:26:39 Q. Doctor, you're going to suggest that the oral
11:26:42 pharanyx from an aspiration that would be clear that
11:26:45 someone wouldn't describe something either frothy or
11:26:48 gastric contents if, in fact, this was an aspiration
11:26:54 event?
11:26:54 A. Yeah. I mean, you're talking massive
11:26:56 aspiration. I'm not necessarily talking just massive
11:27:00 gastric aspiration, but if he aspirated a small amount
11:27:03 into his lungs, it could have triggered everything
11:27:06 over. Again, I'm trying to see what makes sense for
11:27:11 what happened at that point. It makes sense, we know
11:27:14 he's septic. Is it a progression of his sepsis and he
11:27:18 tipped over around eight or did he have another
11:27:21 precipitating event that just tipped him over
11:27:23 completely?
11:27:24 Q. Blood cultures were negative, correct?
11:27:27 A. Correct.

11:27:27 Q. And there were no serial blood cultures
11:27:31 showing any evidence of sepsis, correct?
11:27:34 MR. WILTS: Objection.
11:27:36 THE WITNESS: That's irrelevant. We know
11:27:38 he's septic.
11:27:38 BY MR. MISHKIND:
11:27:38 Q. And how do we know he was septic?
11:27:41 A. Again, by definition. He had a white count,
11:27:45 he was febrile, he was tachycardic and he had a
11:27:48 perforated viscus. That satisfies the criteria for
11:27:52 sepsis.
11:27:53 Q. He was febrile; was he febrile at the time of
11:27:56 his arrest?
11:27:57 A. Well in the emergency room he was febrile.
11:27:59 Q. Right. But was he febrile at 7 a.m.?
11:28:01 A. He's still septic. You don't -- it's not like
11:28:04 just because you don't have a fever at that point
11:28:06 doesn't mean you don't have sepsis. But he still
11:28:09 satisfies the other criteria. I mean, even if you want
11:28:10 to take, if you say okay, well, there's no more fever,
11:28:10 he's tachycardic, he has an elevated white count, he
has a perforated viscus, I mean, he's septic by
11:28:13 definition.
11:28:20 Q. And he was treated with the appropriate
11:28:21 antibiotics for the ecoli, correct?

11:28:24 A. I guess my opinion regarding infectious
11:28:27 disease and the therapy with antibiotics?
11:28:30 Q. Sure.
11:28:33 A. Yeah. And can I check something here?
11:28:36 Q. Yeah, go right ahead.
11:28:41 A. And, in fact, the cultures that were taken
11:28:43 from the surgery showed that it was a good choice
11:28:45 because he was sensitive to Ampicillin.
11:28:49 Q. Right. So he had appropriate antibiotics on
11:28:53 board at the time of the surgery that you would expect
11:28:55 would treat a patient that has an intra-abdominal
11:28:59 sepsis, correct?
11:29:00 A. That has an intra-abdominal infection?
11:29:03 Q. Right.
11:29:03 A. Yes.
11:29:03 Q. Okay. And from the standpoint of him being
11:29:09 normal at 7 a.m., you're basing it upon the testimony
11:29:12 of the nurses' aids in terms of them coming in and
11:29:14 seeing him, correct?
11:29:16 A. Well, I'm basing it on the testimony of
11:29:18 everybody who came in and saw him from the transfer to
11:29:22 the floor, from 3:15 or 3:45 up until 8. Everybody who
11:29:27 came in and saw him, I'm basing it all on that.
11:29:29 Q. Do we know why his oxygen saturation dropped
11:29:33 from 95 at 2:50 down to 92, 93 when he was on the

11:29:39 floor?
11:29:54 A. Well, we know the last time they checked his
11:29:57 sats in the PACU he was on four liters at 95 percent,
11:30:00 and then on the floor he was on three liters. So it
11:30:05 could be that on three liters his sats were 92 to 93
11:30:08 percent, and on four liters it's 95 percent.
11:30:11 Q. So he had desaturated slightly from 2:50 to
11:30:15 3:45, correct?
11:30:17 A. You know, those changes are really irrelevant.
11:30:21 Q. But from 95 to 92, 93, there was -- on sheer
11:30:29 number his oxygen saturation had dropped, correct?
11:30:32 A. His measure -- yeah. You know, I can tell
11:30:35 from my perspective as a pulmonologist 93, 95 percent,
11:30:40 it's no different. I don't view that as a different
11:30:43 number. If he came in at 93 percent, that's great.
11:30:46 Q. Do you know what his oxygen saturation was
11:30:49 after he was given the Morphine at 4:15?
11:30:52 A. I don't know that.
11:30:52 Q. Would you like to have known that?
11:30:54 A. Not necessarily.
11:30:56 Q. Would that have been a reasonable thing, to
11:30:58 know whether or not his -- the Morphine was affecting
11:31:01 his respiratory drive?
11:31:05 A. There is no reason to think it was affecting
11:31:08 his respiratory drive, though.

11:31:09 Q. Why?
11:31:09 A. Well everytime someone came in to see him, he was sleeping, he was very comfortable. I mean, the nurse had these checks, which she went in in several hours, he's resting comfortably. The medical student went in at 5, he was resting comfortably. So, I mean, you know, from -- I mean, is it nice to have the numbers? I mean, it's nice. I don't think it really has any bearing.
11:31:29 Q. Did you read Dr. Trupiano's deposition?
11:31:32 A. I did. But that's going back awhile, so --
11:31:36 Q. Do you recall his testimony that he didn't believe that Anthony was in septic shock?
11:31:42 A. I don't really recall that, but --
11:31:53 MR. WILT: Is this a good point for a break?
11:31:55 MR. MISHKIND: Yeah, we can take a couple minute's break. I want to try to keep moving.
11:31:59 MR. WILT: No. Absolutely.
11:32:00 VIDEOGRAPHER: Off the record.
(Recess.)
(Documents marked Exhibit Nos. 2 and 3.)
11:45:02 VIDEOGRAPHER: Back on the record.
11:45:08 BY MR. MISHKIND:
11:45:11 Q. You have an article on opiates that you found

11:45:17 to be of interest to you. What I'm going to do at the
11:45:21 end of the deposition is have that marked as Exhibit
11:45:24 No. 4. Tell me the significance of that article as it
11:45:28 relates to this case?
11:45:30 A. I'm not sure it is. I got the article, I just
11:45:34 thought it was interesting. I read in a deposition
11:45:37 where somebody says there is a synergistic effect
11:45:41 between Morphine and Fentanyl.
11:45:41 Q. Okay.
11:45:44 A. I had never heard of it and I just went and
11:45:47 looked this up. It's an animal study and it's just --
11:45:50 on page 559 in it they looked at the effects of
11:45:56 Morphine alone and then Morphine and Fentanyl. And in
11:45:59 this study there was no synergistic effect of adding
11:46:04 Morphine and Fentanyl together.
11:46:06 Q. So if I show you at the time of trial
11:46:09 literature that indicates that there is a synergistic
11:46:13 effect with regard to Fentanyl and Morphine, that's
11:46:16 going to surprise you, right?
11:46:18 MR. WILT: Objection.
11:46:20 THE WITNESS: No. I'm just -- this was
11:46:22 interesting and I just brought it because I thought it
11:46:25 was interesting.
11:46:26 BY MR. MISHKIND:
11:46:26 Q. Right.

11:46:26 A. I'm not a pharmacist, I'm not a
11:46:27 pharmacologist. I just read it. I had never heard it,
11:46:32 so I looked this up. If you have other articles that
11:46:34 tell me there's a synergistic effect, I have no real
11:46:38 opinion one way or the other.
11:46:39 Q. And simply because you have that article
sitting in front of you, isn't meant to be that
therefore your opinion is that there's no way that
11:46:40 there's a synergistic effect, it's just that you have
11:46:48 this one article that you believe doesn't support that
11:46:52 proposition. Is that a fair statement?
11:46:53 A. That's a fair statement.
11:46:54 Q. Okay. Fentanyl has a fast onset of action and
11:46:57 a short duration, correct?
11:46:59 A. Correct.
11:46:59 Q. It's about 100 times more potent than
11:47:04 Morphine, isn't it?
11:47:05 A. Sounds correct.
11:47:06 Q. Do you know whether its pharmokinetics, if I'm
11:47:08 pronouncing it correctly, are changed with renal
11:47:17 dysfunction?
11:47:17 A. I don't know. I don't -- I don't know.
11:47:21 Q. Do you know whether it shows a cumulative
11:47:24 effect after prolonged infusion in an obese patient?
11:47:28 A. It does -- well, I mean, I know Fentanyl is

11:47:32 very lypophillic, so there is the risk. I don't know
11:47:35 if it actually exists in reality. That's a theoretical
11:47:37 risk.
11:47:38 Q. And it often results in prolonged ventilation,
11:47:42 correct?
11:47:42 A. What results in prolonged ventilation?
11:47:47 Q. It shows that the use of Fentanyl and Morphine
11:47:52 can show a cumulative effect after prolonged infusion
11:47:58 in an obese patient.
11:47:59 A. You know, I don't know. I have not seen
11:48:01 anything that says that Morphine has a prolonged effect
11:48:06 in obese patients.
11:48:07 Q. So you have not seen anything in literature
11:48:09 that says that studies show that it has a cumulative
11:48:16 effect after prolonged infusion in obese patients?
11:48:18 A. Which drug?
11:48:19 Q. What? Fentanyl and Morphine.
11:48:21 MR. WILT: Objection. Go ahead.
11:48:22 THE WITNESS: Fentanyl, to me, makes
11:48:24 sense that it would.
11:48:25 BY MR. MISHKIND:
11:48:25 Q. Okay. Can Fentanyl cause chest wall rigidity?
11:48:37 A. I don't know.
11:48:39 Q. If it can cause chest wall rigidity, would
11:48:43 that prevent a patient from being extubated?

11:48:48 MR. WILT: Objection.
11:48:50 MS. SMALL: Objection.
11:48:50 THE WITNESS: Not necessarily.
11:48:53 BY MR. MISHIKIND:
11:48:53 Q. But you don't know that for a fact?
11:48:56 A. No, I know that, for a fact, that not necessarily.
11:48:58
11:48:59 Q. But it can?
11:49:01 MR. WILT: Objection.
11:49:02 MS. SMALL: Objection.
11:49:02 BY MR. MISHKIND:
11:49:02 Q. When you say not necessarily, are you saying that the chest wall rigidity would never prevent
11:49:05
11:49:10 extubation, secondary to Fentanyl?
11:49:14 MR. WILT: Objection.
11:49:15 THE WITNESS: Is your question then that Fentanyl, if you had chest wall rigidity, there may be
11:49:17
11:49:20 a situation where you could not extubate a patient?
11:49:23 BY MR. MISHKIND:
11:49:23 Q. Secondary to the use of Fentanyl?
11:49:25 MR. WILT: Objection.
11:49:29 THE WITNESS: Again, I'm trying to understand. If you're saying Fentanyl gives you chest
11:49:31
11:49:34 wall rigidity, could you therefore not extubate the
11:49:37 patient? I would say no, that's not necessarily a true

11:49:39 statement. Could Fentanyl cause chest wall rigidity
11:49:42 that's so severe that it might happen? Well, again if
11:49:46 Fentanyl can cause chest wall rigidity, and in a
11:49:48 situation where chest wall rigidity is severe enough
11:49:51 that you couldn't extubate somebody for whatever reason
11:49:54 of the chest wall rigidity, then that would be, I
11:49:56 guess, a true statement.
11:49:58 BY MR. MISHKIND:
11:49:58 Q. Do morbidly obese patients have marginal
11:50:01 baseline respiratory status?
11:50:03 A. Not necessarily.
11:50:04 Q. Are they at increased risk of having
11:50:07 marginally baseline respiratory status?
11:50:10 A. Compared to?
11:50:11 Q. Non-morbidly obese patients?
11:50:17 A. Again, in what situation are we referring to?
11:50:20 Just walking around?
11:50:22 Q. Laying down, recovering after surgery?
11:50:26 A. You know, there's controversy in that a lot of
11:50:29 studies say no.
11:50:30 Q. What's your take on it?
11:50:31 A. Does morbid obesity in and of itself increase
11:50:37 the risk of post-op complications?
11:50:39 Q. Or having, marginal baseline respiratory
11:50:42 status?

11:50:42 A. Well, now again baseline is different than
11:50:44 post-op, so I'm trying to figure out -- I'm trying to
11:50:46 answer your question.
11:50:46 Are you saying that baseline, walking around
11:50:50 they have marginal respiratory status just because
11:50:53 they're obese? Not necessarily. And then does morbid
11:50:59 obesity, in and of itself, cause post-op problems,
11:51:03 independent of anything else, just as an independent
11:51:09 risk factor? You probably could suffice it to say
11:51:10 that, yes. You also find a lot of studies who say no
11:51:14 to that.
11:51:14 Q. Is there an increased risk in a morbidly obese
11:51:17 patient of having respiratory compromise in the
11:51:20 post-operative period as compared to a non-morbidly
11:51:22 obese patient?
11:51:23 A. Again, controversey exists. You'll have
11:51:27 studies that say no. You may have some studies that
11:51:29 say yes. So it's not a clear -- it's not a yes or no
11:51:32 answer to that.
11:51:35 Q. You said you have experience with sleep apnea,
11:51:38 correct?
11:51:39 A. Correct.
11:51:39 Q. What percentage of the patients in your
11:51:44 practice do you follow that have obstructive sleep
11:51:50 apnea?

11:51:52 A. Oh, I don't know percentage. I'm not boarded
11:51:57 in sleep. I see a lot of patients that I evaluate for
11:52:00 sleep apnea. When I do the evaluation, I evaluate them
11:52:05 and refer them for a sleep study. Somebody else reads
11:52:07 the sleep study. I do not interpret it. And they
11:52:11 arrange for the CPAP therapy, when appropriate. And
11:52:14 then I will follow them afterwards. If they become --
11:52:15 Q. How many patients in that category -- I didn't
11:52:17 mean to cut you off.
A. No.
11:52:18 Q. How many patients in that category after
11:52:21 having the studies do you follow?
11:52:22 A. Oh, geeze, I don't know. Number-wise or
11:52:26 percent-wise?
11:52:26 Q. Whatever is easier for you.
11:52:28 A. Low. Ten percent, maybe.
11:52:29 Q. You are certainly familiar enough that most
11:52:31 patients with obstructive sleep apnea are undiagnosed,
11:52:35 correct?
11:52:35 A. The feeling is that most are undiagnosed.
11:52:38 Q. And you recognize that obstructive sleep apnea
11:52:43 can be a very serious condition, correct?
11:52:48 A. Correct.
11:52:48 Q. Obstructive sleep apnea patients can develop
11:52:56 fatal or abnormal cardiac rhythms, correct?

11:52:56 A. A subset can.
11:52:58 Q. They can develop a ventricular tachycardia or
11:53:03 other arrythmias that can cause a patient to arrest?
11:53:08 A. What kind type of sleep apnea patients are you
11:53:11 referring to?
11:53:11 Q. Obstructive sleep apnea patients.
11:53:11 A. But, I mean, mild, moderate or severe?
11:53:17 Q. Do you differentiate those patients that have
11:53:20 --
11:53:20 A. Sure.
Q. Okay.
11:53:21 A. Sure. I would think somebody who has mild
11:53:23 obstructive sleep apnea, the chances of them having a
11:53:27 V-tach arrest is probably extremely low.
Q. Okay.
11:53:30 A. If somebody has a severe sleep apnea with
aveolar hyperventilation, hypocarbia, corpulmonal,
11:53:34 pulmonary hypertension, on that their risk is higher.
11:53:39 So sleep apnea, like many illnesses, cover a
11:53:39 whole spectrum. It would be analogus to hypertension,
you have mild hypertension, you have malignant
hypertension. To group them all together is not easy
11:53:43 to do.
11:53:51 Q. Can you say in this case that Anthony
11:53:54 Arachikavitz did not have a presumptive diagnosis of

11:53:57 obstructive sleep apnea?
11:54:01 A. Yeah, I think you could say he did not have a
11:54:04 presumptive diagnosis of sleep apnea. Nowhere in there
11:54:07 was he diagnosed with sleep apnea.
11:54:09 Q. No. And I use the term presumptive
11:54:10 intentionally. Obviously he had not been diagnosed,
11:54:14 but did he have risk factors that would increase the
11:54:17 likelihood that he had obstructive sleep apnea?
11:54:21 A. Okay. To me, that's different than saying he
11:54:23 has a presumptive diagnosis. There is no diagnosis,
11:54:26 presumed or otherwise, that he has sleep apnea. Does
11:54:29 he have risk factors for sleep apnea? Yes.
11:54:32 Q. Okay. Morbid obesity is one, correct?
11:54:37 A. To a point.
11:54:39 Q. Okay.
11:54:40 A. Okay? I mean, clearly people with -- most
11:54:43 people with sleep apnea are obese, are morbidly obese.
11:54:49 But now how many people are morbidly obese that have
11:54:53 sleep apenea is unknown. And probably more important
11:54:55 than just morbid obesity is neck size, airway size,
11:55:00 things like that.
11:55:01 Q. So with Anthony, if we just talk about him,
11:55:04 morbid obesity with him would be one factor, I'm not
11:55:08 necessarily putting a weight on it, if you'll pardon
11:55:11 the use of that term. The other factor that would

11:55:14 increase his risk would be his body habitus, his neck
11:55:20 size and chest?
11:55:21 A. With him, in particular, or in general are we
11:55:24 talking about sleep apnea?
11:55:24 Q. With him, in particular.
11:55:26 A. I don't know what his neck size was. I saw
11:55:30 nowhere there that they documented it a really large
11:55:33 neck. But with morbid obesity neck size is probably
11:55:38 more important than just obesity. So if he had a
11:55:40 really large, big neck, then that would be a risk
11:55:43 factor also.
11:55:44 Q. What about the chest wall?
11:55:46 A. I don't think so.
11:55:48 Q. You don't think that's a factor?
11:55:50 A. As far as a risk factor for sleep apnea?
11:55:53 Q. Yes.
11:55:54 A. Above and beyond what we just talked about?
11:55:59 Q. Yes.
11:56:00 A. I don't think so, but I'm not a sleep apnea
11:56:03 expert.
11:56:04 Q. All right. Fine. I'll accept that. Can
11:56:07 patients with obstructive sleep apnea develop
11:56:10 respiratory failure?
11:56:14 MR. WILT: Objection.
11:56:14 THE WITNESS: In what setting?

11:56:16 BY MR. MISHKIND:

11:56:18 Q. Is respiratory failure a complication that can be seen in patients that have obstructive sleep apnea that's not treated?

11:56:26 MR. WILT: Objection.

11:56:30 THE WITNESS: Well, that's a tough one to answer, actually. I mean, again you have to talk about the severity of sleep apnea. So if you had a person who came in who was morbidly obese, had aveolar hypoventilation, was polysythemic, corpulmonal, pulmonary hypertension, could they just -- they develop respiratory failure? Yes. Somebody who has mild sleep apnea just out of the blue develop respiratory failure? I would think that would be extremely unlikely.

11:56:56 Q. Is a patient that has morbid obesity, that has the risk factors for obstructive sleep apnea, and that in the post-operative period after having abdominal surgery is given Morphine, are they at increased risk of developing respiratory compromise as compared to a patient who is not obese, who does not have obstructive sleep apnea but is also given Morphine?

11:57:22 MR. WILT: Objection.

11:57:23 THE WITNESS: Is this a general question?

11:57:24 BY MR. MISHKIND:

11:57:25 Q. General statement, yes, sir.
11:57:25 A. General question?
Q. Right.
11:57:26 A. Diagnosed with sleep apnea?
11:57:28 Q. Well, diagnosed we know we have to have a
11:57:31 polysomniogram, but presumed based upon the fact that
11:57:35 the patient meets the clinical parameters for it,
11:57:39 absent a diagnostic testing. That's the term that I
11:57:44 used before, a presumptive diagnosis?
11:57:49 A. And this is general or with respect to this --
11:57:52 Q. General.
11:57:53 A. If you're suspicious that somebody has sleep
11:57:58 apnea which, to me, is very different than a
11:58:01 presumptive diagnosis. Again, when you say presumptive
11:58:01 diagnosis, to me it infers they have sleep apnea. What
11:58:04 I'm hearing in the general statement is you have an
11:58:06 overweight person who snores. Are they at an increased
11:58:10 risk post-operatively for sleep apnea or for apnic
11:58:16 episodes? You know, that's a large patient population.
11:58:21 I guess, you know, you would be more vigilant if you
11:58:27 had a morbidly obese patient who snores.
11:58:31 Q. Are you done?
11:58:32 A. Yeah.
11:58:33 Q. Would you agree that obstructive sleep apnea
patients desaturate more quickly than non-obstructive

sleep apnea patients during post-operative management?

A. When you say non-obstructive sleep apnea, do you mean essential sleep apnea, then?

Q. Well --

A. Or do you mean patients without sleep apnea?

Q. Yes, sir.

A. Can I answer it a little differently?

Q. Go ahead.

A. Here's the deal. Obstructive sleep apnea patients are -- there are patients out there who may more likely desaturate during a surgical period of time, either anesthesia inducing them. In that group of patients, such as pregnant women, sleep apnea patients may have more problems with desaturation.

Q. Would you agree that obstructive sleep apnea patients are typically more sensitive to narcotics than non-obstructive sleep apnea patients?

A. And when you say sensitive, what do you mean?

Q. From the standpoint of the effects on their respiratory drive?

A. No, not necessarily.

Q. Well --

A. I don't know. Let me answer it that way.

Q. Do you have an opinion as to what Anthony's PVCs were caused by in the PACU?

11:59:50 A. I have opinions as to what caused them, yes.
11:59:54 Q. What caused them?
11:59:55 A. Well, first of all, we don't know if he
11:59:58 doesn't just have PVCs. So that's number one. He may
12:00:01 just be an individual that has PVCs.
12:00:04 Q. Did you see any evidence from the records --
12:00:05 you said you saw the family doctor's records
12:00:08 beforehand, so did you see any evidence of PVCs before?
12:00:11 A. Well, I can tell you my review of the family
12:00:13 doctor's records were very cursory. So I don't even
12:00:17 know if they had EKGs in there.
12:00:17 Q. Okay.
12:00:19 A. But so you don't -- I mean, he may be a
12:00:20 gentleman who just has isolated PVCs. So that's a
12:00:23 possibility. He's in pain, he's vasodilated from his
12:00:30 anesthesia, he received Ephedrine during anesthesia and
12:00:35 it could be that his oxygen, when it was low, had some
12:00:39 contribution to it also.
12:00:41 Q. So I assume PVCs can be caused by hypoxia,
12:00:45 correct?
12:00:46 MR. WILT: Objection.
12:00:46 THE WITNESS: Hypoxia or hypoxemia?
12:00:49 BY MR. MISHKIND:
12:00:50 Q. Hypoxia.
12:00:51 A. Hypoxia. It's part of what could do it. Are

12:00:54 we referring specifically to Anthony, also, still?
12:00:56 Q. Sure.
12:00:57 A. Another thing, if you look at his initial
12:00:59 potassium, I believe it was 3.5, 3.6. Yeah, on the
12:01:17 16th, on that night it was 3.6. So, you know, it's
12:01:21 within normal but it's pretty low. I mean, it's low
12:01:23 normal there. Hypokylemia can cause PVCs.
12:01:28 So you have a gentleman who's in pain, who's
12:01:30 septic, who has anesthesia, receives some Ephedrine
12:01:35 during OR who has a low -- who has some oxygen
12:01:38 problems, you know, you can pick one as good as
12:01:42 anybody. There's so many possibilities there.
12:01:44 Q. Would you agree that opiates from what you've
12:01:48 read or what you know decrease hypoxic ventilatory
12:01:52 drive?
12:01:53 A. At high enough doses they can.
12:01:58 Q. Would you agree that opiates can effect the
12:02:01 control of respiratory rhythm and pattern, including
12:02:04 decreasing respiratory rate, increasing pauses and
12:02:08 decreasing normal tidal volumes?
12:02:11 A. At high enough doses.
12:02:13 Q. What dose do you have to have to cause that?
12:02:15 A. It's sort of a circular argument as to the
12:02:18 dose that causes it.
12:02:19 Q. Do you know what area of the brain opiates

12:02:22 interfere with?
12:02:23 A. It's mid -- mini receptors, but beyond that
12:02:28 -- I mean, they must affect respiratory drive, if they
12:02:29 can do that.
12:02:30 Q. But do you know what portion of the brain?
12:02:32 A. No.
12:02:32 Q. And Fentanyl depresses respiratory drive and
12:02:40 activation of respiratory muscles, correct?
12:02:43 A. I would think all the opioids would act in a
12:02:46 similar fashion.
12:02:47 Q. Would you agree that patients that are
12:02:49 sleeping are usually more sensitive to respiratory
12:02:53 depressant effects of narcotics?
12:02:55 A. If somebody is sleeping and you gave them a
12:03:01 dose? I don't know. I mean, you're asking -- I don't
12:03:03 know a situation where somebody is sleeping, you go and
12:03:05 give him Morphine would that suppress their
12:03:08 respiration? I mean, if you gave them a lot I guess it
12:03:11 could. If you gave them a milligram, I don't know.
12:03:13 Q. Would you agree that even small doses of
12:03:16 narcotics can markedly potentiate the normal right
12:03:21 shift of the $paCO_2$ to aveolar ventilation curve that
normally occurs during natural sleep?
MR. WILT: Objection.
MS. SMALL: Objection.

12:03:30 THE WITNESS: Can you rephrase that?
12:03:30 BY MR. MISHKIND:
12:03:30 Q. Sure. I'll read it back to you. Even small
12:03:33 doses of narcotics can markedly potentiate the normal right shift of the $paCO_2$ aveolar ventilation curve that
12:03:37 normally occurs during natural sleep.
12:03:44 MR. WILT: Objection.
12:03:45 MS. SMALL: Objection.
12:03:46 THE WITNESS: In normal patients?
12:03:47 BY MR. MISHKIND:
12:03:47 Q. Yes.
12:03:47 A. Just normal volunteers that you were to study
12:03:50 that from?
12:03:50 Q. Sure.
12:03:51 A. I don't know.
12:03:59 Q. Would you agree that the respiratory
12:04:02 depressant affect of opiates are increased and
12:04:05 prolonged when administered with other central nervous
12:04:08 system depressants, including inhaled anesthetics?
12:04:12 A. Well, if you're going into inhaled
12:04:14 anesthetics, I'd have to defer to anesthesia on that.
12:04:18 Q. Do all patients that experience -- that are
12:04:46 septic, that have a progressive case of ARDS, that may
12:04:52 or may not aspirate but that experience what's
12:04:59 described as a witnessed arrest, do all of those

12:05:02 patients suffer profound brain damage?
12:05:08 A. Actually, probably the ARDS point of that is
12:05:12 irrelevant. Really, it's more of a question about
12:05:16 witnessed cardiac arrest. And, you know, do witnessed
12:05:19 cardiac arrests all suffer brain damage? No. We know
12:05:21 there's a percentage.
12:05:24 Q. Would you agree it's a small percentage of
12:05:27 patients that have a witnessed arrest that are
12:05:29 otherwise healthy that experience profound brain
12:05:32 damage?
12:05:32 A. No.
12:05:33 Q. Do you know why in this case Anthony suffered
12:05:36 the profound brain damage?
12:05:38 A. Well, he was hypoxic.
12:05:42 Q. Yeah. But were there interventions -- do all
12:05:47 patients that are hypoxic suffer profound brain damage?
12:05:50 A. If you're hypoxic enough and long enough,
12:05:54 everybody would.
12:05:55 Q. And how do you treat a patient that's hypoxic?
12:05:58 A. Depends what the cause is, but in general you
12:06:02 would use either oxygen or positive airway pressure.
12:06:06 Q. And do you see any -- do you have an opinion
12:06:09 as to why in this case Anthony suffered the kind of
12:06:12 brain damage that he did?
12:06:15 A. Well, he was hypoxic.

12:06:17 Q. Do you have an opinion as to whether or not
12:06:19 the management of his hypoxia at the time of his arrest
12:06:23 was managed appropriately or inappropriately?
12:06:27 MR. WILT: Objection.
12:06:28 MS. SMALL: Objection.
12:06:29 THE WITNESS: You know, I really wasn't
12:06:31 in -- I didn't feel like I was put in a position --
12:06:34 you're asking me to comment on the code and, I mean,
12:06:37 it's -- do you want a comment on the code? Is that --
12:06:41 because, really, that's sort of the question you're
12:06:43 asking.
12:06:44 BY MR. MISHKIND:
12:06:44 Q. I want to understand whether you have an
12:06:46 opinion as to why this patient, whom you believed was
hypoxic, secondary to the conditions that you've
12:06:46 described, why this particular patient suffered the
12:06:55 kind of brain damage that he did where other patients
12:06:58 who are hypoxic that suffer a witnessed arrest do not
12:07:02 experience the kind of profound --
12:07:05 A. Probably because he was hypoxic for a longer
12:07:08 period of time.
12:07:09 Q. And by that there was a deprivation of oxygen
12:07:13 to the brain for a longer period of time, correct?
12:07:16 A. There was a lack of profusion to the brain for
12:07:42 oxygen.

12:07:50 Q. You have not reviewed any policies or
12:07:52 procedures from the hospital, correct?
12:07:53 A. Correct.
12:07:54 Q. And you mentioned something about the Aldretti
12:07:56 Scale, but I presume that's not terribly relevant to
12:08:01 your opinions in this case, correct?
12:08:02 A. It was an educational opportunity for me.
12:08:04 Q. But as to whether or not the patient was an
12:08:08 appropriate candidate to be transferred out of the
12:08:11 PACU, given the PACU course, that's not something that
12:08:16 you're going to be commenting on, correct?
12:08:18 A. Unless asked, my intention is not to comment
12:08:20 on it.
12:08:21 Q. Okay.
12:08:30 Q. Do you believe that Anthony was septic during
12:08:33 the surgery?
12:08:34 A. Yes.
12:08:37 Q. So Dr. Papouras' testimony, the surgeon, that
12:08:40 he didn't feel that Anthony was septic during the
12:08:43 surgery, you would take issue with that, correct?
12:08:46 MR. WILT: Objection.
12:08:48 THE WITNESS: It's really sort of
12:08:49 irrelevant. I mean --
12:08:51 BY MR. MISHKIND:
12:08:51 Q. It's not a question of -- the fact that he

12:08:53 testified that Anthony was not septic, you disagree
12:08:57 with his statement?
12:08:58 A. By definition, he satisfied the criteria for
12:09:00 sepsis.
12:09:02 Q. So you would disagree with him?
12:09:04 A. Yeah, I would disagree that he --
12:09:13 Q. Okay. The treatment for sepsis is to remove
12:09:15 the septic focus, correct?
12:09:19 A. If possible.
Q. Okay.
12:09:22 A. Well, that's not the only treatment. That is
12:09:24 part of the treatment.
12:09:27 Q. Do you have any reason to believe that it was
12:09:28 not done in Anthony's case? Removal of the septic
12:09:33 focus?
12:09:34 A. You know, that's going into a surgical arena.
12:09:38 My impression is he had an acute appendicitis that was
12:09:42 taken care of appropriately, but I'm not a surgeon.
12:09:45 Q. Can we agree that in patients that are going
12:09:50 into septic shock, the initial manifestation is an
12:09:52 overwhelming inflammatory response to the infection?
12:09:57 A. I don't know what you mean by overwhelming.
12:10:00 Q. Did Anthony have SIRS?
12:10:03 A. Yes.
12:10:04 Q. Okay. And SIRS is a component of septic

12:10:09 shock, is it not?
12:10:10 A. Yes.
12:10:11 Q. And when one goes into septic shock, isn't one
12:10:15 of the components of that an overwhelming inflammatory
12:10:19 response to the infection, by definition?
12:10:23 A. No, you just changed it. Part of the
12:10:23 definition is SIRS. I mean, it's different than saying
12:10:27 an overwhelming inflammatory response. He has SIRS,
12:10:29 systemic inflammatory response syndrome.
12:10:33 Q. Show me what evidence of an overwhelming
12:10:36 response he had?
12:10:36 A. I didn't say he had an overwhelming response,
12:10:40 you did. I'm saying he had systemic inflammatory
response. I'm not saying -- I mean you're saying it's
overwhelming. I'm just saying he had SIRS. If you
12:10:40 choose to define it as overwhelming -- I mean, you may
12:10:52 choose that. I'm just saying he had SIRS. He has a
12:10:54 systemic inflammatory response syndrome. Part of maybe
12:10:56 why Dr. Papouras is looking at it this way is because
12:11:00 in the context of his SIRS he was hemodynamically
stable. You know, he was lucid, oriented, able to
12:11:02 answer questions. But by definition he still was
12:11:11 septic and had SIRS.
12:11:14 Q. His cardiac index was normal, correct?
12:11:17 A. Well, actually it was kind of high. I thought

12:11:19 the first one was like three and a half. Normal is
12:11:22 usually over two, two and a half, or so.
12:11:24 Q. Don't you take into account the body mass in
12:11:27 terms of how that impacts?
12:11:28 A. Well, that's cardiac index.
12:11:31 Q. Okay.
12:11:31 A. Cardiac output on him actually was high, at 9
12:11:33 to 10, and then you take into consideration his body
12:11:37 mass and that gives you the cardiac index. And his
12:11:40 index, I believe, was about three and a half. So it's
12:11:46 -- you know, it's high. You know, it's up there. He
12:11:49 also had a low SVR.
12:11:51 Q. A patient in septic shock has a decrease in
cardiac output, correct?
12:11:52 A. Depends when you measure it. There is a
12:12:00 myocardial depressant effect from sepsis that can
12:12:01 decrease your cardiac output and cardiac index. But in
12:12:04 somebody who has a lot of vasodilitation, they can have
a marked increase in their cardiac output. And, in
12:12:10 fact, I mean, classic sepsis is high output, low SVR.
12:12:12 So it really depends on when you measure it.
12:12:15 Q. Can we agree that a patient in septic shock
12:12:18 has an increase in systemic vascular resistance?
A. An increase in systemic --
12:12:23 Q. Yes.

12:12:23 A. No.
12:12:23 Q. You disagree with that?
12:12:24 A. Yeah.
12:12:25 Q. Would you agree in sepsis respiratory
12:12:39 achylosis is present to compensate for lactic acidemia?
12:12:45 MR. WILT: Objection.
12:12:49 THE WITNESS: If there is lactic
12:12:52 acidosis, a person will have a respiratory
12:12:57 compensation.
12:12:58 BY MR. MISHKIND:
12:12:58 Q. Can we agree that septic shock leads to a
12:13:01 progressive increase in BUN and creatinine due to renal
12:13:07 failure?
12:13:07 A. If renal failure is present.
12:13:09 Q. Was renal failure present in this case?
12:13:11 A. He had evidence of renal injury.
12:13:13 Q. What was the evidence?
12:13:14 A. His creatinine bumped up. Let's see. His
12:13:23 creatinine on admission was 11. On the 18th it was 21,
12:13:26 then it came back down. So, you know, his kidneys got
12:13:30 stunned, if you will.
12:13:31 Q. Is that the same as renal failure?
12:13:35 A. No.
12:13:35 Q. Okay. When you're talking about septic shock,
12:13:38 you're not talking about stunning, you're talking about

12:13:42 organ failure, are you not?
12:13:44 A. Well, now you're talking about septic shock
12:13:46 with multi-system organ failure. So it depends which
12:13:50 organ you want to refer to. He has one organ failure.
12:13:53 We know that.
12:13:54 Q. And which organ was that?
12:13:55 A. Lung.
12:13:56 Q. Okay.
12:13:56 A. So he has, you know, sepsis syndrome. Now, he
12:14:01 also had lactic acidosis. So he had evidence of lactic
12:14:08 acidosis. I mean, just because -- when you have
12:14:14 sepsis, it doesn't mean every organ every time is
12:14:16 damaged.
12:14:16 Q. Did you read Dr. Fry's deposition?
12:14:18 A. I did.
12:14:20 Q. Do you recall that when we discussed with him
12:14:23 Anthony's pH at the time of the arrest and then shortly
12:14:32 thereafter that his -- after his arrest the metabolic
12:14:36 acidosis was corrected and within two or three hours
12:14:39 his levels were relatively normal?
12:14:41 MR. WILT: Objection.
12:14:43 THE WITNESS: Can I look?
12:14:44 BY MR. MISHKIND:
12:14:45 Q. Sure, absolutely.
12:14:57 A. Well, yeah. Okay. So his metabolic acidosis

was corrected.

Q. And in a patient in septic shock can we agree that most patients do not have that kind of resolution secondary to septic shock to their metabolic acidosis?

A. No. I mean, they intervened. They gave him Bicarb, they put him on Levsin, they gave him -- they supported his hemodynamic. So they actually responded appropriately and were able to correct his metabolic acidosis.

Q. And you find that the correction they were able to do is consistent with a patient that has gone into septic shock?

A. Well, again, I mean, it doesn't really matter. By definition, he has it. I mean, we keep going back to that. But by definition, he has it. What you're seeing, I think, is very good care. I mean, they corrected all this stuff really nicely. I mean, they were on top of this guy right away, you know. So, in fact --

Q. So -- I'm sorry. You're talking about after the arrest?

A. Post-arrest.

Q. Okay.

A. Which is where we're talking about metabolic acidosis --

12:16:02 Q. I don't -- I just don't want the record to be misinterpreted.
12:16:05 A. Right. But in answer to your question, looks to me like you go, wow, they did a nice job getting on top of this and correcting everything.
12:16:11 Q. But what I'm saying is, and I want to understand your testimony so that when we meet again at trial, what you're saying is that the responses that they gave in terms of the Bicarb and his reaction, his pH and in terms of normalizing over the next two or three hours, you're saying that that kind of response is -- can happen in a patient who has arrested as a result of septic shock?
12:16:41 A. Yeah. I mean, you can see things turn around. Now the question is, is his acidosis from sepsis or is it from his cardiac arrest? And that's sort of an unanswerable question right now. You don't know.
12:16:55 Q. Early signs of sepsis are often hyperventilation?
12:17:02 A. Hyperventilation can be a sign, or -- you mean -- by hyperventilation do you mean tachypnea? Fast respiratory rate?
12:17:10 Q. Uh-huh.
12:17:10 A. Yeah, you can see that with sepsis.
12:17:13 Q. And a patient that is developing ARDS, would

12:17:20 you agree that one of the first signs that you would
12:17:23 see would be an increase in the respiratory frequency
12:17:27 followed by dyspnea?
12:17:28 A. It could be something you would see.
12:17:30 Q. Is that a common --
12:17:31 A. As somebody who is short of breath? If
12:17:35 they're developing ARDS would they be short of breath?
12:17:37 Yes.
12:17:38 Q. So they have initially an increase in
12:17:40 respiratory frequency, then followed by the shortness
12:17:44 of breath, correct?
12:17:44 A. Yeah, I guess. I can't -- I don't think
12:17:48 they're -- I wouldn't put one then the other. I think
12:17:51 they're short of breath and they're tachypnea from
12:17:53 ARDS.
12:17:54 Q. Is there any indication at 5 or 7 a.m.,
12:17:57 according to the notes, that Anthony was short of
12:17:59 breath?
12:17:59 A. Not according to the notes.
12:18:01 Q. Any notes at 5 or 7 that he was in respiratory
12:18:05 distress?
12:18:06 A. No.
12:18:13 Q. And is it your testimony that a patient can be
12:18:16 breathing unlabored and restful with a respiratory rate
12:18:20 of between 14 and 20 breaths per minute, and one hour

later develop ARDS secondary to the sepsis sufficient enough that they would arrest?

MR. WILT: Objection.

THE WITNESS: No, I never said that. I didn't say they developed ARDS one hour later.

BY MR. MISHKIND:

Q. No. The manifestations, within one hour they can go from breathing unlabored and restful with normal respiration rate and then one hour later they would go into cardiopulmonary arrest?

A. Well, see that's why I say what was the precipitating event? And that's why, to me, aspiration makes sense.

Q. Okay. So you're looking for something to explain the ARDS in terms of -- well, explain to me why you fit aspiration in there?

MR. WILT: Objection. Asked and answered, but go ahead.

THE WITNESS: Well, he has this evolution. I mean, see, it is very possible -- I mean, his ARDS evolved. Could it have been a critical point at 8 a.m. that he tipped over from that purely from the progression and evolution of his ARDS? I guess so. The thing is, is at 7 o'clock, you know, with the inspection there, he wasn't tachypnic. He was pretty

comfortable looking. And that's why I'm saying it does seem strange to me that the ARDS would evolve to where at 8 o'clock -- I mean, that's the point. So what else could it be? And then, you know, that's why I'm saying he could have aspirated and that could have been enough to tip him over.

BY MR. MISHKIND:

Q. But again, we don't see any physical evidence described in the record at the time of the code, or when he was found, or when he was resuscitated that describes an aspiration, correct?

A. That's correct.

Q. All right. You're looking for an explanation for what tipped him over at 8 o'clock, correct?

A. Correct.

Q. But you don't have any scientific evidence to support the aspiration theory, based upon the records, correct?

MR. WILT: Objection.

THE WITNESS: That is correct.

BY MR. MISHKIND:

Q. Based upon the records, it would be speculative to say that he had an aspiration, correct?

MR. WILT: Objection.

THE WITNESS: I think any explanation is

12:20:47 going to be speculative at that point because that was
12:20:50 unwitnessed.
12:20:51 BY MR. MISHKIND:
12:20:51 Q. Sure. But, again, we're dealing with the
12:20:53 records and the evidence. Can we agree that it's
12:20:55 speculative when we talk about aspiration to say that
12:20:59 that's what tipped him over?
12:21:01 MR. WILT: Objection.
12:21:01 THE WITNESS: I think we can say anything
12:21:03 that is going to tip him over is speculative.
12:21:07 BY MR. MISHKIND:
12:21:07 Q. Okay. I take it you don't feel that Anthony
12:21:14 experienced any type of an obstructive event causing
12:21:20 his arrest?
12:21:22 A. Correct.
12:21:23 Q. Certainly a patient that has obstructive sleep
12:21:29 apnea that is given Morphine can go into respiratory
12:21:33 arrest, correct?
12:21:36 MR. WILT: Objection.
12:21:39 THE WITNESS: You can give somebody with
obstructive sleep apnea Morphine to where they may have
a code-developed respiratory insufficiency and
12:21:41 potentially arrest.
12:21:48 BY MR. MISHKIND:
12:21:48 Q. And it's not necessarily the amount of

12:21:50 Morphine that's given, each person reacts differently
12:21:53 to a dosage of Morphine, especially a patient that has
12:21:57 obstructive sleep apnea, correct?
12:22:00 A. I'm not sure that would be a complete
12:22:02 statement. I would think that there would be some dose
12:22:04 response, too. I mean, I would say if you gave
12:22:08 somebody one milligram of Morphine versus 20 milligrams
12:22:11 of Morphine, it's not an inter-individual variability.
12:22:16 People would have problems with that.
12:22:19 Q. Can we agree that Anthony's wedge pressures
12:22:48 were below 18 only on the 18th?
12:22:48 A. I'd have to pull all the Swan Ganz data. I
12:22:52 don't -- do you know where they would be in here? Do
12:22:54 you want me to go through it all?
12:22:56 Q. Let me ask you this, just hypothetically.
12:22:59 A. Okay.
12:22:59 Q. If, in fact, the wedge pressures were below 18
12:23:04 only at the 18th, and that every other wedge pressure
12:23:07 after that was above 18, of what significance would
12:23:10 that be to you as it relates to the cause of his
12:23:16 arrest?
12:23:18 A. It wouldn't have any bearing as to the cause
12:23:21 of his arrest. It gives you a reflection of the
12:23:24 therapy received in the ICU.
12:23:26 Q. So that has nothing to do with whether or not

12:23:28 from a causation standpoint he did or did not go into
12:23:34 this septic shock as opposed to some other causation?
12:23:41 A. Well, we know that the day of his arrest his
12:23:45 wedge was 18. We also know they did various
12:23:48 interventions after that, and the follow-up wedge was
12:23:51 21 or 20, whatever. He was also on a fair amount of
12:23:58 PEEP, I believe. I think they had him on tandem PEEP,
12:24:00 or so, and, you know, that's going to falsely elevate
12:24:02 your wedge also.
12:24:04 Q. The fact the chest x-rays taken following the
12:24:06 cardiopulmonary resuscitation cleared over time, you
12:24:11 give no real significance to that as it relates to
12:24:15 whether or not he truly had ARDS, correct?
12:24:18 A. Well, they didn't clear over time. They were
12:24:21 clear at the beginning. So when you have a chest x-ray
12:24:24 that was normal on the same day that the CAT scan
12:24:28 showed diffuse infiltrates, they didn't clear, they
12:24:31 were normal. And you have a CAT scan that shows the
12:24:33 diffuse infiltrates.
12:24:35 Q. Okay. I understand your answer.
12:24:48 Is one of the first treatments for septic
12:24:53 shock fluid challenge?
12:24:55 A. Probably more Pro-VC fluid resuscitation.
12:25:01 Q. Did Anthony receive fluid resuscitation?
12:25:04 A. I'd have to -- are you talking about septic

shock or just -- I'm sorry. Can you rephrase the question so I can answer it more appropriately?

A. Sure. In terms of treating septic shock, did he receive a fluid --

A. Resuscitation?

Q. -- resuscitation?

A. All right. I know from admission to the PACU unit, you know, that at 5 a.m. in the morning he had a very nice fluid resuscitation with his sepsis and hypotension. How much fluid he received after the code, during that period of time, I didn't calculate. So I don't have that answer for you. I mean, I'd be happy to look, if you want, but I don't know.

Q. Does there have to be some source of infection in order to have an arrest from septic shock?

A. Well, again, you're kind of falling into a little bit of definition things. If you're septic, it's felt to be from an infectious process. Now, you can have systemic inflammatory response syndrome from other things, and you can develop hypotension and cardiogenic shock and other types of shock and not be from an infection process.

Q. Well, was his septic shock, in your opinion, from an infectious process?

MR. WILT: Objection.

12:26:20 THE WITNESS: By definition, he had an infectious process. He had a perforated viscus in his
12:26:27 abdomen.
12:26:27 BY MR. MISHKIND:
12:26:27 Q. Where are the serial blood cultures in this
12:26:30 case?
12:26:30 A. I don't know.
12:26:31 Q. We have one negative blood culture, correct?
12:26:35 A. But again, it's irrelevant for what we're
12:26:40 talking about because he has pus in his abdomen.
12:26:43 That's the source of the infection. He did -- his
12:26:46 sepsis was his bacteremia, it was an intra-abdominal
12:26:47 abscess. So we have a source of the infection. I
12:26:50 mean, you just need a source, and you have it.
12:26:53 Q. And going back to my question again, can we
12:26:55 agree, Doctor, that there was one blood culture taken
12:26:59 and that blood culture was negative?
12:27:01 A. He had one negative blood culture.
12:27:04 Q. And there were no serial blood cultures done
12:27:06 after that, correct?
12:27:07 A. No reason to.
12:27:08 Q. Doctor, my question wasn't really was there --
12:27:09 not whether it was necessary or a reason to, but can
12:27:13 we agree that there weren't subsequent blood cultures
12:27:17 taken?

12:27:17 A. None that I saw.
12:27:18 Q. Okay. In a case where a patient has arrested,
12:27:26 at that particular time according to the records, for
12:27:30 no known reason, everything else has been ruled out,
12:27:33 pulmonary embolism, in the doctor's mind, had been
12:27:36 ruled out, an MI in the doctor's mind at the time had
12:27:39 been ruled out; wouldn't it have been prudent and
12:27:42 reasonable for physicians to have ordered serial blood
12:27:46 cultures?
12:27:47 A. What do you mean by reasonable and prudent?
12:27:49 Q. To try to determine what was the cause of the
12:27:52 patient's arrest? If they didn't know what it was and
12:27:55 they had ruled out PE, they had ruled out MI and they
12:27:58 were looking for a cause, wouldn't it have been
12:28:01 reasonable to have done serial blood cultures?
12:28:03 A. Not necessarily. They already had a cause for
12:28:07 a sepsis. I mean, you already have an answer.
12:28:13 Q. Doctor, do you see any evidence that an
12:28:16 infectious disease consultant was ever called in on
12:28:20 this case?
12:28:21 A. I didn't look for an infectious disease -- I
12:28:24 didn't look to see if one was called in, so I don't
12:28:26 know.
12:28:26 Q. And assuming that the patient has septic shock
12:28:31 and you have got a source for the infection, would you

12:28:33 agree that one of the consultants that's typically
12:28:35 called in under those circumstances is an infectious
12:28:38 disease doctor?
12:28:38 A. I don't see any reason why they needed an
12:28:43 infectious disease consultant here.
12:28:43 Q. Doctor, that's not my question. Doctor,
12:28:45 typically in a hospital setting, and you spend some
12:28:46 time in the hospital, don't you?
12:28:48 A. Yes.
12:28:48 Q. Okay. When a patient develops septic shock
12:28:53 and there's a bacteremia, there is a source for the
12:28:55 infection, isn't one of the consultants that's
12:28:58 customarily called in, in cases of this nature, to
12:29:01 evaluate the patient an infectious disease expert?
12:29:06 MR. WILT: Objection.
12:29:07 MS. SMALL: Objection.
12:29:07 THE WITNESS: In this case?
12:29:08 BY MR. MISHKIND:
12:29:08 Q. In general. When a patient --
12:29:12 A. I would say, in fact, in this case they
12:29:14 probably didn't need an ID. They already had it
12:29:19 identified. The ID would help you more when you have
12:29:22 an infection and you don't know where it's coming from.
12:29:25 They knew and they had him on the appropriate
antibiotics because it was Pan sensitive. So they, in

fact, didn't need an ID.
Q. The appendix that was necrotic, Anthony only had a small to moderate gram negative bacteria, correct?
A. I'm sorry a small?
Q. Small to moderate, I believe.
A. Small to moderate what?
Q. Gram negative bacteria.
A. I don't know what that means.
Q. You don't?
A. You -- do you mean the bacteria was small, small size or a small spill?
Q. What was described in the pathology was small to moderate gram negative bacteria.
MR. WILT: What are you referring to? See if he can find it.
THE WITNESS: Yeah.
MR. MISHKIND: In the Labs.
MR. WILT: In the Labs? The BUN culture.
MR. MISHKIND: Uh-huh.
MR.WILT: Okay.
THE WITNESS: So the moderate gram negative bascilli, is that what you're referring to?
BY MR. MISHKIND:
Q. Right.

12:30:32 A. Oh, so they stained it, they saw a moderate
12:30:35 gram negative, that's the number of bascilli that they
12:30:39 saw.
12:30:39 Q. And do you know whether the antibiotics that
12:30:41 he was on at the time of the surgery were -- whether
12:30:45 that gram negative bacteria was susceptible to those
12:30:49 antibiotics or sensitive to them?
12:30:51 A. Well, it sure looks like it by this MIC
12:30:55 profile there.
12:30:55 Q. And his antibiotics were never changed or
12:30:58 increased thereafter, were they?
12:31:00 A. No reason to.
12:31:01 Q. Well, can we agree that a patient that's so
12:31:05 septic that he arrests from an infection, wouldn't you
12:31:07 find it awfully surprising that he can be stabilized
from his ARDS and his sepsis with nothing more than
12:31:16 Zosin over a six hour period?
12:31:17 A. Well, the Zosin didn't stabilize him. I mean,
12:31:18 he still had ARDS over the six hour period of time.
12:31:23 They hemodynamically stabilized him. So you're looking
12:31:27 at one component. Hemodynamically, they did a nice job
12:31:34 stabilizing him over that period of time.
12:31:34 Q. And in most patients that have ARDS that's
12:31:38 significant enough -- and the components that caused
12:31:39 the ARDS are significant enough to cause the patient to

arrest, normally do you see stabilization of the hemodynamic parameters as quickly as Anthony's parameters were stabilized?

A. Well, you know, they had him on vasopressors. So he was under hemodynamic support. So again, they did a nice job stabilizing him. They gave him fluids, it looks like, they gave him -- you know, they got his oxygenation up, they corrected his metabolic acidosis and they put him on vasopressors to keep -- get his pressure up. So, yeah, they did a nice job.

Q. And all those things, Doctor, your testimony -- because I'm almost done -- your testimony is that the responses after the fact don't defy or speak against this being septic shock causing his arrest?

MR. WILT: Objection.

BY MR. MISHKIND:

Q. Correct?

A. Everything follows --

Q. In a nutshell?

A. -- nicely. Yes.

Q. I didn't mean to cut you off, but what you're saying is that after he arrested, the Levsin being turned off after 14 hours, Anthony then no longer was hypotensive, all of the responses that he had are indicative of good response to the treatment as opposed

12:32:56 to suggesting that his arrest was not caused by a
12:33:00 septic shock, correct?
12:33:04 MR. WILT: Objection.
12:33:06 THE WITNESS: It's a long question. The
12:33:08 way I would answer it --
12:33:09 BY MR. MISHKIND:
12:33:09 Q. Go ahead.
12:33:09 A. -- is his course, following the arrest and the
12:33:12 resolution of his hemodynamics, and everything, is
12:33:16 consistent with sepsis, okay? Again, you know, we're
12:33:22 still having this unknown thing, exactly what happened
12:33:24 at 8, okay? But if you're asking me, is his course
12:33:28 from the 18th, or 17th on after he got intubated, put
12:33:33 in the ICU, is that a course that you can see with
12:33:36 therapy and resolution of sepsis? Yes.
12:33:38 Q. He never developed thrombocytopenea, did he?
12:33:43 A. Not that I know of.
12:33:44 Q. Never developed DIC?
12:33:45 A. I don't think so.
12:33:46 Q. Never developed azotemia?
12:33:49 A. I'd have to go look at his BUN again. I know
12:33:52 his creatinine bumped a little bit. No, it is --
12:34:03 actually, if you look at it, it's sort of interesting.
12:34:05 His platelets were 260 on admission. They fell to 145.
12:34:11 Now, oftentimes people define thrombocytopenea as less

than 100, or a 50 percent fall. He doesn't fulfill the criteria for it, but there is evidence there.

Q. Well, he doesn't meet the definition of thrombocytopenea?

A. Correct. Absolutely. But again, you look at -- you know, part of it is -- as you look at all this stuff it makes you curious. So, no, he -- he never had the azotemia.

Q. Doctor, just a couple more questions and then I'll be done because I do want to try to catch my flight.

In your experience have you -- strike that.

There's no question from what you see that Anthony suffered hypoxic ischemic encephalopathy?

A. To the best of my -- looking through this, that's what I say would be the -- yeah, what happened to him.

Q. And simply put, there was inadequate profusion that caused an injury to his brain, and a fairly substantial injury to his brain, correct?

A. Correct -- well, assuming given what I have read about him out in Las Vegas, I would say yes.

Q. You don't see anything that would suggest that there was some other factor that caused his profound ischemic encephalopathy, do you?

12:35:51 A. Or hypoxic ischemic encephalopothy?
12:35:54 Q. Right.
12:35:55 A. Well again, trying to figure out what was the
12:35:58 event that happened at 8, and I'm giving you my -- what
12:36:02 appears to be the most likely explanation, but that's
12:36:06 -- we're kind of stuck with that.
12:36:08 Q. And the event that you believe triggered it
12:36:11 was this aspiration?
12:36:15 A. I think that he clearly was septic and
12:36:18 something happened from 7 to 8. It could have been
12:36:21 just the progression of his sepsis and his overwhelming
12:36:28 sepsis, or another event on top of that. So given
12:36:29 that, and you think what else could the event be? The
12:36:32 one I come up with is aspiration. It fits. It makes
12:36:36 complete sense. PE seems unlikely, given what they've
12:36:40 looked at. You know, they monitored him, he had no
12:36:44 evidence of any fatal or lethal arrythmias, they ruled
12:36:48 him out for an MI. It's just what you kind of come to.
12:36:52 Q. So if someone testifies that he developed an
12:36:55 arrhythmia that caused his arrest, you would disagree
12:36:58 with that, correct?
12:36:59 A. No, I would not disagree. I just say we have
12:37:02 no evidence that he did.
12:37:03 Q. Okay.
12:37:04 A. So in the lack of any evidence to clearly

12:37:08 explain what that event was, we're then left to come up
12:37:12 with explanations in this case.
12:37:13 Q. Do you see any strips at all from the code to
12:37:18 show what his cardiac rhythym was?
12:37:21 A. I don't believe they had any strips in there.
12:37:24 Q. Would that have been of some help to us?
12:37:24 Q. Yes.
12:37:26 Q. Okay. And do you have any explanation for why
12:37:29 there aren't any strips that show what his cardiac
12:37:30 rhythym was at the time of his code?
12:37:33 A. No.
12:37:34 Q. I want to find out whether or not from the
12:37:45 standpoint of causation, whether or not we have
12:37:48 explored the opinions that you hold in terms of why
12:37:52 Anthony arrested during the course of this deposition?
12:37:56 MR. WILT: Objection.
12:37:58 THE WITNESS: I feel like I have answered
12:38:01 all your questions to the best of any knowledge.
12:38:03 BY MR. MISHKIND:
12:38:03 Q. Do you feel as if I have explored and gotten
12:38:06 from you what your opinions are as it relates to the
12:38:09 issue of causation, or do you have any other opinions
12:38:13 as it relates to the issue of causation that we have
12:38:16 not talked about?
12:38:17 MR. WILT: Objection.

12:38:19 THE WITNESS: I don't from -- right now, as we're sitting, I can't think of any other reason.
12:38:23 BY MR. MISHKIND:
12:38:23 Q. And you believe that -- we've talked about your opinions. You have told me that you don't believe that this was obstructive sleep apnea that caused his respiratory arrest, correct?
12:38:34 A. I'm not sure -- did you ask me specifically whether I thought it was obstructive sleep apnea that caused his arrest?
12:38:39 Q. Do you believe that it was obstructive sleep apnea that caused the arrest?
12:38:42 A. No.
12:38:42 Q. Okay. We did talk about it indirectly.
12:38:45 A. Okay.
12:38:46 Q. You have also indicated that you're not a sleep apnea expert?
12:38:49 A. That's correct.
12:38:51 Q. You have also talked about other factors that could have caused it and why those factors, including PE and MI, are not likely to have -- to be the cause, correct?
12:38:55 A. Less likely.
12:39:02 Q. Okay. Certainly less than 50 percent likely?
12:39:03 A. Yes.
12:39:06

12:39:07 Q. All right. Have we now explored during the
12:39:09 course of this deposition the opinions that you hold on
12:39:11 causation?
12:39:11 MR. WILT: Just let me make a note here
12:39:14 on one thing. You have never asked him a direct
12:39:16 question about Morphine. You have implied it several
12:39:19 times, but since you came back about sleep apnea I just
12:39:23 want to make sure we're all fair here.
12:39:24 MR. MISHKIND: Okay. Yeah.
12:39:26 BY MR. MISHKIND:
12:39:26 Q. Well, all right. Very quickly, Doctor,
12:39:27 obviously he had the last dose of Morphine at 4:15.
12:39:33 Do you know, during the sleep cycle, how -- with the
12:39:38 effects of the Morphine that he had had and the
12:39:41 Fentanyl that he had had before 4:15, do you know what
12:39:47 effects, from a hemodynamic standpoint, the combined
12:39:53 Morphine plus that additional dose of Morphine had on
12:39:56 him between 4:15 and when he was found at 8 o'clock
12:40:01 with the grunting noise in this case?
12:40:05 A. Well, you included Fentanyl in there at the
12:40:08 beginning.
12:40:08 Q. Well, Fentanyl --
12:40:09 A. Fentanyl--
12:40:10 Q. Fentanyl and the Morphine are from the
12:40:12 surgery. Then obviously he has Morphine in the PACU.

12:40:16 A. No. I understand. But you included Fentanyl
12:40:19 as part of that whole discussion there, and the effect
of Fentanyl should be gone. So really it's just a
12:40:22 question of Morphine, not the Fentanyl.
12:40:27 Q. Okay.
12:40:27 A. And, you know, I think again what you know is
12:40:29 the information that you have from the nurses and the
12:40:34 medical student that was there. You know he was not
12:40:36 grunting, he had no evidence of apnea when they were in
12:40:39 there. He was arousable, alert when they would talk to
12:40:43 him. So there's no reason at that point to think -- I
12:40:46 mean, he tolerated the Morphine well.
12:40:48 Q. So the reason for that opinion is based upon
12:40:52 what you perceive to be the quality or the adequacy of
12:40:57 the evaluations that were done after the Morphine was
12:41:01 given at 4:15 which would be by the medical student,
12:41:04 the nurse's aid and the nurse during the various
12:41:08 observations at 5 and 7 when his temperature was taken,
12:41:13 when the medical student came in at 5:15 --
12:41:17 A. Absolutely, because contrast it to the 8 p.m.
12:41:19 description. If you look at the 8 p.m. description,
12:41:21 they're standing outside and they hear a guy grunting
12:41:23 in there. I mean, they go in at 7, there's no
12:41:26 description of that. They go in at 5, there's no
12:41:30 description. So, in fact, the 8 a.m. event actually

12:41:33 helps you validate the earlier observations.
12:41:37 Q. And whether -- strike that.
12:41:40 All right. Have we now covered all the
12:41:42 opinions that you hold in this case?
12:41:44 A. I think so.
12:41:45 MR. MISHKIND: All right. I have nothing
12:41:46 further. Thank you.
12:41:48 MR. WILT: Janis?
MS. SMALL: I have no questions.
12:41:48 MR. JAMISON: No questions.
MR. MISHKIND: I presume you want him to
read, Ron?
MR. WILT: Yes, he'll read.
MR. MISHKIND: Okay. Let's -- 14 days?
MR. WILT: Yeah, 14 days is fine.
12:42:08 MR. MISHKIND: We'll show on the record
12:42:08 that the Doctor can have 14 days. I do want expedited
delivery on it. The trial is three weeks from
yesterday. So we need to give the doctor time so that
he has it read.
MR. WILT: Can you get information from
the doctor, just to speed this up, and send a copy of
the transcript directly to him so he can read and sign
it?
COURT REPORTER: Yes.

VIDEOGRAPHER: The time is 12:41. Off the record.

FURTHER WITNESS SAITH NOT.

C E R T I F I C A T E

I, Angelo E. Canonico, M.D., having read the foregoing examination under oath, Pages 1 through 132, do hereby certify said testimony is a true and accurate transcript, with the following changes (if any):

PAGE	LINE	SHOULD HAVE BEEN
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Angelo E. Canonico, M.D.

_____
Notary Public

My Commission Expires: _____

C E R T I F I C A T E

I, Florence Kulbaba, Court Reporter and Notary Public, State of Tennessee at Large, do hereby certify that I recorded to the best of my skill and ability by machine shorthand the deposition contained herein, that same was reduced to computer transcription by myself, and that the foregoing is a true, accurate, and complete transcript of the deposition testimony heard in this cause.

I further certify that the witness was first duly sworn by me and that I am not an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

This 22nd day of June, 2004.

Florence Kulbaba

FLORENCE A. KULBABA NOTARY PUBLIC AT LARGE WILLIAMSON COUNTY, TN

My Commission Expires:

December 9, 2007