Doc. 103

State of Ohio,)
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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DEWEY GLEN JONES, et al., Plaintiffs,	)	
V.	)	Case No. 306012 Judge Lillian Greene
MERIDIA HURON HOSPITAL, et al., Defendants.	)	

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THE DEPOSITION OF HELMUT F. CASCORBI, M.D., Ph.D.

WEDNESDAY, AUGUST 6, 1997

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The deposition of HELMUT F. CASCORBI, M.D., Ph.D., a witness herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Lauren I. Zigmont-Miller, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at University Hospitals, Department of Anesthesiology, 11100 Euclid Avenue, Cleveland, Ohio, commencing at 12:20 p.m., the day and date above set forth.

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ALSO PRESENT:

Kelli McGregor - Videographics

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PLAINTIFFS' EXHIBITS MARKED

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OBJECTIONS BY

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(Thereupon, Plaintiffs' Exhibit 1 and 2 to the deposition of Helmut F. Cascorbi, M.D., Ph.D., were marked for purposes of identification.)

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HELMUT F. CASCORBI, M.D., Ph.D., a Witness herein, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. ALLEN:

Q. Doctor, I'm Charles Allen, one of the attorneys for the plaintiff. If I ask you a question you don't understand, just ask me to repeat it. If you need to take a break, we'll do so. I expect this whole process to take about an hour and a half, two hours at the max.

MR. CASEY: Just so you're aware, Charles, he's got to be somewhere after 2:00, so push it.

MR. ALLEN we'll push it. I'll try to talk fast for a southern boy.

Q. Doctor, if you'll state your name and your address for the record for me.

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A. Helmut F. Cascorbi, 2844 Fairmount Boulevard, Cleveland Heights.
Q. Doctor, what medical records have you reviewed for today's deposition?
A. I reviewed the perianesthetic records of Meridia.
Q. Any other records?
A. I reviewed or read some depositions, one by Dr. -- a statement by Dr. Downs, deposition by Dr. Kaplan, statement by Dr. Kaplan. I think -- did I have anything on Senchyshak or not, I don't know.
Q. You don't know whether you reviewed the deposition of Dr. Senchyshak?
A. Is there a deposition, yes, then I did.
Q. All right. And you said you reviewed the anesthesia records. Did you review any of the other records of Meridia?
A. Only as they pertain to the perianesthetic event.
Q. And define that for me.
A. The time before anesthesia, the pre-anesthetic assessment management, the anesthetic management and the post-anesthetic management, to the unit, and from then on, no.
Q. And so before anesthesia, we're talking

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the night before in which there was clearance given?
A. Correct.
Q. You reviewed those records, okay.
Then everything up until -- did you review the Dr. Heart records and the subsequent --
A. Dr. who?
Q. The Dr. Heart record in which the patient was resuscitated.
A. The resuscitation record, yes.
Q. All right. Did you generate any reports other than the one marked as Exhibit 2?
A. No.
Q. That's your original report, Doctor?
A. That's a copy of the original.
Q. Is that the only draft of the original? Did you make another draft?
A. No, this was the only document.
Q. You wrote that yourself?
A. Yes, I did.
Q. Did you have any conversation with any of the parties in the case, any of the defendant doctors?
A. No.
Q. When did you first discuss your opinions with the lawyers that hired you?
A. Whenever I was contacted.

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Q. That would have been around May of this year, or was it earlier than that?
A. Without checking my calendar, I don't know.
Q. But it was sometime this year, correct?
A. Oh, yes.
Q. How much time have you spent reviewing this case?
A. Two to three hours.
Q. And that includes all of the depositions and reviewing the records?
A. I'm a fast reader.
Q. Sorry?
A. I'm a fast reader.
Q. You're a fast reader. All right.
Now, if I understand it -- kind of maybe shortcut things -- you're here to give opinions as to anesthesia care as it relates to the resident in this case, correct?
A. I was asked whether the resident was acting properly for a resident.
Q. So you were not asked to look at how Dr. Adamek's care was given to Dewey Jones?
A. I was not asked about the care by Dr. Adamek.

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Q. And you're not asked about the care of Dr. Ho or Dr. Badri, correct?
A. I was not.
Q. You're not going to give opinions as to causation, meaning what occurred and how it occurred to put Dewey Jones into the state that he s in today?
A. I don't know how to answer that, because if it pertains to how the resident was supervised, I can, of course, not fail to have an opinion about this case, I am an anesthesiologist.
Q. Sure.
A. But my specific -- if I understand it correctly -- reason for being here is that I am an educator in anesthesia, a chairman of the anesthesia department, and I'm asked whether the resident did something that he shouldn't have done or did something that he should have done and whether he acted outside his competence.
Q. And that is the extent of what you expect to testify if you go to court, correct?
A. Yes.
Q. Do you have any opinion as to how long Dewey Jones would have lived if this operation had not occurred or how long he would live today?
A. No.

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Q. As far as your report, Exhibit 2, if you can just go to that real quick. This is it, correct?
A. Yes.
Q. Okay. It says -- before you wrote this report it says you reviewed depositions. Which depositions did you review, Dr. Senchyshak and Dr. Adamek before?
A. Yes.
MR. CASEY. He may not have reviewed Senchyshak before.
It was right at that time that he was taken, so I can't tell you if I had yet sent that to you at the time you wrote this report, Doctor. His deposition was taken right around that same time, May 29th, just so you know.
BY MR. ALLEN:
Q. You state here that you came to the conclusion that the resident was properly supervised and acted under the direction of his attending faculty anesthesiologist, correct?
A. That's correct.
Q. And that means that he was properly supervised, meaning that Dr. Adamek properly oversaw what Dr. Senchyshak was doing; is that correct?

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A. Dr. Adamek was there and was in charge of the case and discussed, as far as I know, the case with his resident and the resident never acted independently.
Q. Okay. Well, let's -- if I can kind of get your understanding as to the roles between a resident and an attending anesthesiologist. What is -- is a resident a student in the field of anesthesiologist? If you can, explain to me your opinion.
A. He is a student in the wider sense of the word. He is a graduate medical doctor who is at that point after an internship undergoing or doing specialty training. He/she will be instructed for three years in the clinical management of patients who require anesthesia, pain management, et cetera. There are class courses and there's, of course, the clinical work.
Residents are not independent practitioners, and until the day they graduate from a legal point of view they don't have the direct responsibility for the patient, certainly not in my program, in no program. It is the attending who is responsible for the care of the patient.
Having said that, since we are trying to teach people how to fly, they must be able to take

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the plane off one of these days by themselves.
Q. So there are periods in which they're not directly under the supervising eye of an attending; is that what you mean?
A. Well, it comes -- it is a gradual process. If you are totally new, everything that you do is tightly supervised. As a matter of fact, you show this is how you do it. At the end of the training, if the training was successful you have a young doctor who in consultation with you will make a plan for the anesthetic management and will execute it. You will be there at all times available, and in the final analysis you still will say I approve of this plan, it is my plan.
Q. Okay. Is it your opinion that Dr. Senchyshak was totally new to the field of anesthesiology?
A. No, it is not, because he had been for at least a year, I believe, at Cincinnati, so he had some experience, and he had been about three months in this program. So he knew many of the things, I hope, how to do them and certainly knew his way around the anesthesia machine and the monitors, et cetera.
Q. Okay. So you would give him a level of training of over a year, is that what you would

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categorize it?
A. That's what the record says.
Q. Due to his 11 months before and three or four months in this program?
A. Yes.
Q. Now, what about, how does a resident and an attending communicate when they're overseeing the care of a patient? I want to just in a general sense ask you that, but kind of focus you on a high risk patient and a resident that's in his first year of residency in anesthesiology. How would you expect the two to communicate?
A. They'll talk to each other.
Q. Would that be -- at what stages would you expect in this case, in the Dewey Jones case, for the attending, Dr. Adamek, to have -- at what stages would you expect him to be there and communicate to his resident?
A. I don't understand that question.
Q. Would you expect Dr. Adamek to be at the bedside of Dewey Jones while the resident was doing a pre-op evaluation?
A. No, I would not.
Q. Okay. What would you expect to happen?
A. I would expect the resident or a member of

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the department to see the patient and prepare a pre-anesthetic report. I would expect the resident, a resident, if he or she didn't do the preoperative visit him or herself, to be familiar with the preoperative visit. I would expect the resident and the faculty before the case, either on the day of the case or the evening before the case, to have a conversation and develop a treatment plan.

Q. And did that occur in this case?

A. I understand that there was a discussion in the morning between Dr. Adamek and the resident.

Q. And in your opinion, it's appropriate for the pre-op evaluation to be done by an outside, another resident, one that did not do the anesthesia?

A. That's appropriate.

Q. Would you expect that resident to have then communicated his pre-op evaluation verbally to Dr. Adamek?

A. Not necessarily.

Q. How would you expect him to communicate?

A. That's why we have pre-anesthetic records.

Q. All right. So in your opinion, all the communication in this case that occurred between the pre-op resident that evaluated Dewey the night before and Dr. Adamek was done through the record, medical

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record?

A. I have no knowledge and I don't even know who did the preoperative visit, whether there was a conversation, as well.

Q. So you don't know whether or not there was a conversation between the pre-op resident and Dr. Adamek?

A. I do not know that.

Q. Would y expect hat to have occurred?

A. No. I've already answered that. No, not necessarily.

Q. Not arily. B you ld :p t th pre-op resid(to - enough information in the :al record to then communicate - Dr. \damek; is that a fair s :1 t?

A. That's correct.

Q So now we go t the pre-op evaluation the day of surgery in this :, th Dewey Jones case. Do you expect Dr. Adamek to be at the bedside when Dr. Senchyshak was doing his pre-op evaluation?

A. No, I don't.

Q. Whe do you expect Dr. / damek to be there?

A. After the resident has finished a separate evaluation the resident presents his finding to the attending and the attending checks certain things if

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that is necessary, and then a discussion of the treatment plan should take place.

Q. Do you know whether or not Dr. Adamek reviewed the pre-op notes of the resident that did the evaluation the night before before surgery started?

A. I don't know that.

Q. Would you have expected him to do that?

A. Yes.

Q. That would have been good medical care, correct?

A. That's correct.

Q. Okay. Now, as you're at the bedside -- as Dr. Senchyshak and Dr. Adamek are communicating about Dewey Jones' plan for anesthesia, you'd expect Dr. Adamek to take the lead as to what shouldn't be done during the operation; is that true?

A. Partially true. It depends on the age of the resident. At his status I would not be surprised if the resident would say, should we do the case in such and such way, make a proposal, and then the attending would say, that sounds all right or we will do this for the following reason.

Q. Now, you know that in this case Dr. Senchyshak suggested a Swan-Ganz be in place during the operation, true?

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MS. REINKER: Objection.

A. I don't know whether I know that. Did he state so in his deposition? If so, then I know that.

Q. \ right So d you remember -- you don't remember seeing that in the deposition, but --

A. I reviewed the deposition sometime ago and I didn't review it recently.

Q. Okay. So anyway, if Dr. Senchyshak had stated we should insert a Swan-Ganz and Dr. Adamek said, no, it's not necessary, all the responsibility of whether or not that was appropriate thus lies with Dr. Adamek in your opin :

A. Well, that's precisely the point about this teaching, the resident will make a proposal and the attending will approve or not approve. The responsibility is the attending's, not the resident's.

Q. I understand I just want to ask you specific definitions of that as it relates t th is case. I'm not trying t be t th

Now, if y can tell me, do you have an opinion as to whether a sh d have been in place for this patient during this operation?

A. Yes, I have an opinion.

Q. What is that?

A. More likely than not there should have

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been a Swan-Ganz.
Q. And why is that?
A. Because the patient represents a high risk patient and the anesthetic management for this patient required, in my opinion, pretty aggressive monitoring.
Q. And a Swan-Ganz would have given them what sort of information during the operation?
A. It gives you information about the status of cardiac output and of fluid load.
Q. And that's important with Dewey Jones because?
A. A patient of Jones' history represents a likelihood of having hypertension, cardiac damage, problems with ventilation. They are risky patients. Their risk of morbidity and mortality is considerably higher than a normal patient and there are anesthetic techniques that decrease the risk.
Q. And that Swan-Ganz is one of those techniques that decreases the risk, true?
A. A Swan-Ganz catheter, insertion of, has its own morbidity and mortality. The risk-benefit ratio of that risk versus the information has to be weighed and can be, in the judgment of reasonable people the result can be different.
Q. But in your opinion, the risk

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had -- I mean, the risk -- the
risk in the case and a Swan-G should have been placed, correct?
A. Partially correct. I might have -- I personally might have started with a central line, see whether that, which is a lesser monitor, but also a lesser risk, was sufficient.
MS. REINKER: Move to strike.
BY MR. ALLEN:
Q. Was that done in this case?
A. I think there was a central line, but it wasn't used for monitoring, it was used for infusion.
Q. Would that have been -- in your opinion, was the standard of care violated by Dr. Adamek by not inserting a Swan-Ganz?
MS. REINKER: Objection.
A. It's the same answer that I just gave. Reasonable people can come to different conclusions here.
Q. Would it have been the standard throughout the country for a patient like Dewey Jones more likely than not that they'd use a Swan-Ganz?
MR. CASEY objection.
MS. REINKER: objection.
MR. CASEY He just

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answered that question. He said that reasonable le can r to different
BY MR
Q. All right, Doctor. Now as we talk about the Swan-Ganz, it measures fluid overload and cardiac output, correct?
A. Correct.
Q. When you have that type of t can you predict or anticipate pulmonary edema?
A. You can anticipate it and predict it better than without the monitor.
Q. Why is that?
A. Because you have information that you don't have when you don't have the monitor.
Q. That information being?
A. What the pulmonary wedge pressure is, what the cardiac output is, what the fluid status of the patient is.
Q. All right. What would you expect to see in the Swan-Ganz readings that would indicate that pulmonary edema would occur or might occur?
A. I would like to make a comment here.
Q. Yes, sir.
A. I consider myself as an expert on the

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casc. are asking me as an expert on the management of this case.
Q. That question was just, I wanted to understand the relationship of the Swan-Ganz. It's general medical knowledge in which the resident in this case suggested it occur, so I think it's kind of along the same line.
A. I don't understand your answer.
MS. REINKER: I would like the record to note a continuing objection to this entire line of questioning in this case.
BY MR. ALLEN:
Q. Can you answer the question? I'm not going to spend too much more time with it.
A. What is your last question?
Q. Last question was, what would you expect the Swan-Ganz to read to anticipate possible pulmonary edema?
A. Decreased cardiac output, increased wedge pressure, increased -- period.
Q. Now, when there's a difference of opinion between a resident, in this case Dr. Senchyshak and Dr. Adamek, does the resident have any responsibility to second-guess the order of the attending doctor?

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A. Only in absurd situations. If the attending tells the patient to throw the patient out of the window, he shouldn't do that. But as far as the use of a Swan-Ganz catheter in this case -- we went over this ground before -- there can be a difference of opinion, and a first-year resident is generally not in the position, doesn't have enough knowledge to really make a convincing case.

As a matter of fact, again, in the educational situation, I expect a good resident to argue his case and I expect a good attending to argue his side of the case, and it has happened certainly to me that the residents have convinced me of a change in management. That's what this whole process is about.

Q. Do you know if the two argued about whether or not the Swan-Ganz shouldn't have been placed?

A. I do not know that.

Q. Do you know what was communicated for the reason why the Swan-Ganz should be in place when he talked to Dr. Senchyshak?

A. I do not know that.

Q. Now, at 12:30 -- you can look at the anesthesia record if you'd like, Doctor, at any time -- is it your opinion that at that time they were

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reversing the neuromuscular block and bringing this patient out?

A. Since you state that, it's probably true.

Q. Thank you.

A. Yes.

Q. So is it your understanding of the facts that at that time Dr. Adamek was in the room?

A. No. I don't know whether Adamek was at the beginning of the reversal in the room; I do not know that.

Q. Would it be good medical practice for the attending in this high risk patient to be at the bedside when the reversal began?

A. More likely yes than not.

Q. Now, after the reversal began do you understand in your opinion whether this patient was completely extubated at that time or not?

A. My reading of the record is that the patient was not extubated.

Q. And what occurred at the time, 12:30, when the neuromuscular block was reversed to cause the pulmonary edema?

MR. CASEY: objection.

That question makes an assumption that the pulmonary edema started at 12:30.

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A. If the patient was reversed at that time, spontaneous respirations would have started. That changes airway pressures. The record, as far as I can see, doesn't say whether the patient bucked, that is, coughed on the tube or not, but it's possible that he did. And these are some of the things that in a precariously balanced system like Dr. Jones might be the final trigger for pulmonary edema. There are many reasons for pulmonary edema, that could be one.

Q. Now, is it your understanding that the resident proceeded the reversal on his own accord?

A. No, it's not my understanding. I don't know.

Q. You don't know whether or not he took it on himself to start reversal at that time?

A. That's correct.

Q. And you don't know whether or not Dr. Adamek gave that order, correct?

A. I do not know.

Q. So would you be critical of the resident if he started that procedure by his own accord without talking to the attending?

A. Yes.

Q. Would you be critical of the resident for starting the reversal process if Dr. Adamek in his

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preoperative plan did not tell him what to do at that point in the procedure?

A. What is your question, sir?

Q. During the pre-op evaluation if Dr. Adamek had not given the resident a complete plan of management for this care of Dewey Jones to include at what time to reverse the anesthesia, would you still be critical of the resident to have taken that on himself?

MR. CASEY: I'm confused by the question, Charles. Are you asking him should he had reversed the patient -- should Adamek have said whether to reverse the patient intraoperatively or wait until they go to the ICU, is that what you're asking?

MR. ALLEN: Right.

BY MR. ALLEN:

Q. If you had this preoperative meeting and Dr. Adamek didn't walk down the road to say at what stage you should reverse and at what stage you should go to room air and at what stage et cetera, if the resident took it on himself to do those steps, would you be critical of the resident?

MR. CASEY: objection.

That's two questions now.

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Q. Pull the room air out of it.
MR. CASEY It's two questions. You're asking should Adamek have done it and then would you be critical of the resident. Break them up and we can go forward with the question.
BY MR. ALLEN:
Q. Would you be critical of the resident? I'm just asking about the resident at this point.
A. About what?
MR. ALLEN Let me try this on my own, Jim, if you don't mind.
Q. Would you be critical of the resident if he started this reversal process without a preoperative plan by the attending, Dr. Adamek, that stated that, you know, you should or shouldn't -- didn't state whether or not he should or should not reverse at that time?
A. If I understand your question correctly, if *the* resident had no information of whether to reverse or not, then a prudent resident would ask should we go ahead with reversal.
Q. Would a prudent resident also go ahead and ask whether or not the patient should go to room air?
A. No. I expect a resident with that amount

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of training to know that these patients stay on oxygen.
Q. For how long?
A. It depends on the vital signs.
Q. So at 12:30 according to the vital signs, between 12:00 and 12:30 what would you -- how long would you expect the patient to stay ventilated?
MR. CASEY: you're asking about 12:00 and 12:30?
MR. ALLEN 12:30.
BY MR. ALLEN:
Q. Just the progression here, Doctor.
A. The vital signs are not changing there. There was a little increase in pressure which, of course, I would expect. The pulse ox starts to fall later.
Q. So t before 12:30 would it, in your opinion, be appropriate to bring th t t t room air?
A. Again, you are asking me the management of this case. I'm the expert for the education of the resident.
Q. I understand that. But the resident is the one that s in the room at this time, correct?
A. Correct.
Q. My understanding from deposition

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testimony, he's the only one in the room at this time and he's doing things on his own accord, so I'm asking you, what, in your opinion, is the appropriate thing to do at 12:30, to leave the patient ventilated or on room air?
A. The patient is not to be on room air at that point.
Q. Does that same opinion hold true for the next 30 45 minutes?
A. Zero resuscitate, yes.
Q. Now, as proper management of this patient would it be reasonable to expect this patient to stay ventilated for a matter of hours or even days after this procedure?
A. That's one way of handling a patient of this kind.
Q. You were able to look at the fluid management of this patient intraoperatively, correct?
A. Yes.
Q. Do you feel that too much fluid was given to this patient intraoperatively?
A. That's borderline. The answer is no, not really.
Q. But it's a jump ball, is that basically --
MR. JONES: Objection.

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BY MR. ALLEN:
Q. Now, as far as this intraoperative care of Dewey Jones, to your knowledge, at what points was the tending, Dr. Adamek, actually in the room?
A. The record doesn't state that. I don't know.
Q. Do you expect a resident on his own accord to understand that the attending should have been with him the entire case?
A. No; that's not up to the resident.
Q. Would you expect a resident of h training and education and backgrou to questi tl tending as t when th attending shoul be in the operating room?
A. No.
Q. t , in your opinion, a resident of this education and this t should not be making independent medical judgments, correct?
A. Correct.
Q. And all of those independent medical judgments should be done by the attending?
A. Correct.
Q. Have you ever testified for the law firm of Jacobson, Maynard before, reviewed cases for them?
A. Yes, I have.

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Q. Tell me how many times. Just take it the review of , how many times have you reviewed a case?

MS. REINKER: when you stated before this case, he has not reviewed on behalf of that firm.

MR. ALLEN: I understand.

A. I'd better make a general statement. I do not review more than four cases a year and last year I reviewed none. My guess is that for Jacobson six, seven times.

Q. Over a period of?

A. Many years.

Q. Ten years, five years?

A. Ten years maybe.

Q. And of those reviews, how many times have you given a deposition?

A. Too many times. Again, five, six. I don't know.

Q. How many times have you gone to trial?

A. Once.

Q. For that firm, once?

A. Once.

Q. Now, the law firm of Reminger & Reminger, the same question, how many cases have you reviewed for them in the past?

A. I think one.

Q. That's other than this case?

A. Correct.

Q. When was that?

A. I tried to ask Mr. Malone. I don't know. Several years ago.

Q. Was it for Mr. Malone?

A. Yes.

Q. Do you know what that case involved?

A. No, I forgot.

Q. Okay. Did you give a trial --

A. No, we didn't go to trial.

Q. Did you give a deposition?

A. Yes.

Q. Total, Doctor, how many times have you given trial testimony?

A. Given what?

Q. Trial testimony.

A. Being in court?

Q. es, sir.

A. I think once.

Q. That was one i for the Jacobson firm?

A. Wait a second. The one was out of town. Twice.

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Q. Twice?

A. Twice.

Q. Does that include maybe any videotaped depositions that you know were going to be used for trial?

A. I don't remember.

Q. So there may have been another time that you got in front of a video camera and you knew it was going to go to a courtroom?

A. Could be.

Q. You just don't recall?

A. I don't recall.

MR. CASEY: He doesn't know if this one is going to be used in the courtroom, Charles.

BY MR. ALLEN

Q. You know, sometimes you sit down in front of the camera and you know beforehand because of your schedule, you couldn't come to court.

A. I'm not camera shy. I'm being videotaped all the time when I give lectures.

Q. Now, tell me, have you ever been sued for malpractice?

A. Of course.

Q. How many times, Doctor?

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A. I can't tell you. But since I am the chairman of this department, I usually get named because I'm a chairman, so it is many times.

Q. How many times have you given a deposition because you were a defendant in the case?

A. Once.

Q. When was that?

A. I think -- I think '84.

Q. What was the nature of that case, did it involve anything similar to this?

A. It was a resuscitation of a baby.

Q. Did you have to go to trial?

A. No.

Q. The case was concluded before trial?

A. It was settled.

Q. Now, were you represented or been represented by any of the two law firms?

A. Yes, I was represented by Jacobson.

Q. Would that encompass every time you've been sued for medical malpractice you've been p s ed by J cobson?

my group -- as a matter of fact, all of the physicians at University Hospitals are with PIE, and PIE is with Jacobson, Maynard & Tuschman.

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Q. And they've always had your insurance, so it's always been this group of lawyers that have represented you?
A. Really not before PIE existed.
Q. And when was that? When did you -- do you remember when you went to PIE?
A. In the late '70s, early '80s, something like that.
Q. Do you know Dr. David Rapkin?
A. Yes. If he is the David Rapkin who was a resident here, then I know him.
Q. Did you teach him during his residency?
A. I tried.
Q. Did you succeed?
A. He passed his boards.
Q. When was the last time you had any contact with him?
A. years.
Q. What about Dr. J[illegible]onomy do you know him?
A. Who?
Q. Conomy.
A. No.
Q. Dr. Howard Nearman?
A. Yes. He works in my department.

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Q. He works where?
A. In my department.
Q. And you work with him on a daily basis?
A. Yes, I do.
Q. Tell me how long you've worked with Dr. Nearman.
A. I have known him since 1976, I believe.
Q. Do you know him on a personal basis?
A. Yes, I do.
Q. Do you go out to dinner or go to do other things outside the --
A. Occasionally.
Q. What about Dr. Richard Schlanger?
A. I don't know the name.
Q. Surgeon out of Columbus, Ohio.
A. Sorry.
Q. What about Dr. John Downs, an anesthesiologist out of Tampa?
A. I know John Downs.
Q. How do you know Dr. Downs?
A. He is a chairman and chairmen meet at national meetings. I don't know him well, but I know him. As a matter of fact, I was a visiting professor there once a long time ago.
Q. I'm going to run through some other doctors' names. If any of them rings a bell, say yea, okay. Joseph Bussey?
A. Nay.
Q. Joel Kaplan?
A. Yes.
Q. How do you know Joel Kaplan?
A. Same.
Q. Same, national?
A. Yes.
Q. Do you know he's written textbooks on anesthesiology?
A. Yes, I do.
Q. Is that a good textbook that he put out?
A. It's a textbook, yes.
Q. Do you have any opinion as to whether it's --
A. I don't do much cardiac anesthesia, so I don't know whether it's the best, but it's certainly a reputable book.
Q. And he is a reputable doctor, I *take* it?
MS. REINKER: Objection.
A. Yes, he's from New York.
Q. Meaning the two coincide?
A. M-hm.
Q. Okay. Dr. Marc Semigran, the cardiologist, do you know him?
A. No.
Q. Dr. Alvin Kahn?
A. No.
Q. Another New York doctor.
A. No.
Q. Dr. Francis Barnes, surgeon?
A. No.
Q. Dr. Robert Greendyke, pathologist out of New York?
A. No.
Q. Dr. Charles Greenhouse?
A. No.
Q. Dr. Marshall Orloff, the surgeon?
A. No.
Q. Dr. Paul Thompson, cardiologist?
A. No.
Q. Now, you're Board certified according to your curriculum vitae. Do you anticipate or expect all your attending physicians on staff to be Board certified?
A. Yes.
Q. Is there a hospital policy that they be Board certified?
A. Board certified or equivalent with

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exceptions being granted by special action of the clinical council.

Q. W is it important for tl to be Boar certified?

MR. AI S: Objection.

MS. REINKER:)j : o ..

A. It is a way to assess the knowledge and possibly the skills of a specialist. It is not perfect. As a matter of fact, it's the only thing we have. It could be better.

Q But it's a fair indication of the knowledge d skill of a practic anesthesiologist?

A. Yes.

MS. REINKER: objection.

BY MR ALLEN:

Q. In general, :t you have -- have you ver l asked to li l a patient, i epa dently c ed in for a consult in the past?

A. clear a patient?

Q. Whether or not they were stable or in a condition to go through the surgery.

A. Are you asking me whether I have been acting as a consultant in anesthesiology? The answer is yes.

Q. Okay. Whenever you medically clear a

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patient, it's as an anesthesiologist?

A. Yes, of course.

Q. Explain to me, an anesthesiologist when he does a pre-op evaluation of a patient, he is looking as to whether or not that patient is a candidate for the surgery, correct?

A. That's correct.

Q. Okay. So his entire focus is the overall health of that patient as to whether they can undergo the knife?

A. No, it's not undergo the knife, whether he can undergo the stress of anesthesia and surgery.

Q. So it's the stress of the anesthesia and --

A. And surgery.

Q. -- and surgery. Meaning, what part of the surgery, just the opening and the length of the time?

A. I don't understand what you're asking me.

Q. Okay. Let me just back up and rephrase another question.

It's more of the medical determination of whether they can -- it's not so much, say, the risk of gallbladder surgery or colon surgery, but it's the risk of the anesthesia and the surgery together?

A. That's correct.

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Q. Okay. Have you ever had t when you're looking at a patient dec whether or r a :ardiol consult was needed?

A. Of course.

Q. How often have you called in a di consult?

A. I can't answer that, because certainly recently the pre-anesthetic evaluation that I do is for a very special population, and cardiology consults, or not necessary. So personally I have not asked for a some

The system here works somewhat different from what you seem to assume. The patient, our now go a research clinic and are evaluated by members of the department of anesthesia and hopefully proper tests and hopefully only the proper tests will be asked and the proper consultations and only the proper consultations requested.

Q. Have you e stopped -- let me :k up. c you expect a resident of Dr. Senchyshak s du ti and training t recognize the ne for a diology t in Dewey Jones on the morning of th 20th?

MR. WALTERS: I'm going to

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object. It assumes he needs a cardiology consult.

Go ahead.

A. No, I wouldn't expect him. I would hope that he could, but that's what the attending is for, to tell the resident you didn't request, we should request.

Q. Now, have you ever -- you've had the occasion as an anesthesiologist to stop a surgery from occurring, correct?

A. I have occasions to advise my surgical colleague about the risk and advise my surgical colleague about the things that should be done before we proceed with surgery. In the final analysis it is a risk-benefit assessment, and I, of course, listen to the surgical side of the equation, and if the surgeon can convince me that the delaying of the surgery outweighs the risk of whatever consultation or whatever is requested then we will go ahead.

The question here is always that the total picture of the patient's treatment is seen. I'm not an expert in surgery, but if I work with surgeons I will find out that they can tell me about certain things for this case that make the risk of delaying higher than the risk of getting the test.

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Q. W(ll you expect Dr. S t itl his education, knowledge and background to recognize whether this procedure should have been delayed?

A. Same answer as before. He certainly -- I would be pleased if he questioned me on that, but I wouldn't necessarily expect it.

Q. But you would expect an attending anesthesiologist to be able to recognize that, true?

MS. REINKER: Objection.

A. The attending anesthesiologist has to be able to evaluate the risk for this patient regarding the surgery -- regarding the anesthesia and in consultation with the surgeon making a plan whether to proceed or not.

Q. Do you have an opinion as to whether this case should have been delayed?

MS. REINKER: Objection.

A. This is really Monday quarterbacking. I just cannot tell you whether this case should have been delayed or not. I would have been there.

Q. Do you have an opinion as to whether a cardiology consult should have been called in by anesthesia before surgery progressed?

MS. REINKER: Objection.

A. It probably wouldn't have -- with his

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history, assessment of his cardiac status was necessary, and as far as I can *make* out, some of the steps were taken by Dr. Ho.

Q. My question is a little more specific than that, but do you have an opinion as to whether anesthesia should have called in a cardiology consult?

A. They had the information from Dr. Ho who bad treated this patient before, *so* it's a toss-up whether they should have or should have not. It depends on their working relationship with Dr. Ho.

Q. Do you know if Dr. Ho has any specialty in cardiology?

A. I do not.

Q. Do you know if he's Board certified?

A. I do not.

Q. Would those be important conclusions as to whether or not they should have relied on Dr. Ho?

A. Not necessarily.

Q. Doctor, have you -- as an anesthesiologist, they don't diagnose the existence of ll t or the it of any ll t diseas , true, that's not your job?

A. That's not my job.

Q. It's not the job of pretty much any anesthesiologist, correct?

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A. No, but I can do it.

Q. You can do it, you have the ability to do it, but in this case it wasn't the duty of either Dr. Adamek or Dr. Senchyshak to determine how severe the gallbladder was?

A. That would be absurd. That's what the surgical -- the input with the surgeon is in the situation.

Q. That's what I'm trying to understand. That would be the surgeon's duty in this case, correct?

A. Correct.

Q. And in your understanding of the facts, it was Dr. Ho who was called in just to see if the patient could medically withstand anesthesia and surgery; is that true?

A. Well, I don't know whether that's what they did because internists and non-anesthesiologists really cannot assess whether somebody can withstand anesthesia. But I expect the non-anesthesiologist, internist, whoever, the information that I expect from them is the status of the patient is as follows, the status is as good as it can be or the following things could be done to improve it, and that information goes into my assessment together then with the risk-benefit of having the surgery now or delaying surgery.

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Q. So the risl -benef ied by e three of the physicians?

A. That's correct.

Q. But it is -- in your understanding of the case, it wasn't the role of Dr. Ho to determine how bad the gallbladder was?

A. No.

Q. That was Badri's?

A. That's correct.

Q. If we go to trial and you're asked t come to trial, if you're asked to give testimony, you don't expect to give any testimony as to how severe the gallbladder was and whether or not gallbladder surgery was indicated?

A. No.

Q. Correct?

A. No.

Q. So you're not going to give any opinions as to whether alternatives to surgery were appropriate, true?

A. That's true.

Q. You don't have any opinions as to rendering any -- scratch that. You don't feel -- I'm sorry.

You don't feel that you will come to

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trial and testify as to whether or not the pathology report in this case indicated the gallbladder was in any way diseased, et cetera, correct?
A. Yes, that's absurd.
Q. In your opinion, is hypertension under control if there is medication being given?
A. It can be under control.
Q. So a patient that has medicated hypertension and stayed under control, that's controlled hmertension?
A. If the hypertension is controlled, it is controlled hypertension, that's correct.
Q. Whether or not it's medically controlled by medicine or not?
A. That's correct.
Q. So a patient that strictly takes medicine to control his hypertension would not be, in your opinion, a patient that has uncontrolled hypertension, correct?
A. Yes.
Q. Is it your opinion that hypertension will decrease if on bedrest?
A. I'm sorry?
Q. Will hypertension decrease if on bedrest?
A. It can.

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Q. More than likely it will, true?
A. Depends on the type of hypertension.
Q. In this case did you review the status of Dewey s hypertension?
A. No. I reviewed the perianesthetic facts and, yes, he was a hypertensive.
Q. Is it your opinion that before surgery Mr. Jones' hypertension was under control?
A. I have no opinion.
Q. Do you have an opinion as to whether a resident of Dr. Senchyshak's training should have recognized whether or not this hypertension was under control?
A. Probably not.
Q. Did Dewey Jones have what's called cor pulmonale?
A. I don't know that.
Q. If Dewey Jones had cor pulmonale, would that affect any readings of a Swan Ganz catheter?
A. Probably.
Q. How would that affect it?
A. It would make the readings unreliable.
Q. Is there any determination as to the extent of the cor pulmonale, that it would be, you know, if it's minor or major, if that would have any

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effect on the Swan-Ganz?
A. What has that to do with resident education?
Q. The need or not the need for the Swan-Ganz.
A. I think we discussed that already.
Q. Okay. Does cor pulmonale -- is there any range of cor pulmonale in which a Swan-Ganz is appropriate to insert?
A. I'm not testifying about the treatment of this patient, I'm testifying about the education of Dr. Senchyshak.
MR. CASEY: Jim, I *think* that's a fair question. I mean, I'm not asking --
MR. CASEY: If you understand the question, Doctor. I mean, I guess you have already told him that the existence of cor pulmonale would not make the readings unreliable in a Swan-Ganz catheter, and I *think* as it pertains --
MS. REINKER: He said the opposite.
MR. CASEY: I thought you said would not.

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THE WITNESS: Might make it unreliable.
MR. CASEY Might make it unreliable.
BY MR. ALLEN:
Q. My question is, is there an extent, is there a disease process that it would be reliable and still have cor pulmonale?
A. I really don't know how to answer that because there is a huge gamut of cor pulmonale and that now gets us into specifics of cardiology and cardiac anesthesia, and I don't think I'm going to testify on that.
Q. And so as an anesthesiologist, to determine the extent of cor pulmonale you would expect a cardiologist to be called in to determine that?
A. Yes, I would.
Q. Do you have an opinion as to whether anesthesia should have called in a cardiologist to evaluate the extent of Dewey Jones' cor pulmonale if he had it?
MS. REINKER: Objection.
A. In this particular case the patient was evaluated by Dr. Ho, and I think it is proper, unless there is something glaring that the anesthesia team,

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rely upon the medical team that was taking care of Mr. Jones.
Q. So in other words, it's okay not to call in a cardiology consult to determine the cor pulmonale?
MR. CASEY: objection. That's not what he just said.
MR. ALLEN: Is that what he just said?
MR. CASEY: He said that it was proper to rely on the medical team and their decision whether to call in a cardiology consult, Charles. Don't rephrase what he says.
A. I agree, it's proper for them to work with the team.
MR. ALLEN: I rephrase it to understand, Jim, you know that.
MR. MALONE: He's trying to answer your question.
MR. ALLEN I know he is. I'm just trying to understand. I'm not trying to be difficult.
MR. MALONE: I know you're not, you're not being difficult. He's trying to answer, he just did.

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BY MR. ALLEN:
Q. Doctor, I appreciate it. We're almost finished here.
A. I appreciate it.
Q. Before I leave the subject of cor pulmonale, there is a wide gamut of cor pulmonale and the best way to determine the extent of cor pulmonale is to get a cardiology consult, true?
MR. WALTERS: Objection.
A. That's correct.
Q. Doctor, can you look at the record at 12:30 and tell me what a Swan-Ganz would have read if in place at 12:30?
A. No.
Q. Can anybody do that?
A. No.
Q. It would be pure speculation, true?
A. Yes.
Q. And why is that?
A. Because people are not machines. There are too many factors. It's just simply not possible to say with any reasonable certainty what the Swan would read at this point. It's not doable.
Q. Do you -- in your opinion, Dewey Jones is a high risk surgical patient, true?

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A. That's correct.
Q. What are the risk factors that Dewey Jones had that led him to be a high risk surgical patient?
A. He was morbidly obese, he had a history of heart disease, he had a history of sleep apnea.
Q. Hypertension?
A. And hypertension.
Q. Did you say -- I'm sorry, did you say congestive heart failure?
MR. MALONE: He said heart disease.
A. No, I said heart disease.
Q. Okay. Is it your opinion that Dr. Adamek was available during the induction of Dewey Jones?
A. Yes.
Q. Is it your opinion that the induction phase of Dewey Jones was properly done?
A. It was one way of inducing that patient, yes.
Q. What time do you understand that Dr. Adamek was physically in the room during the induction?
A. You asked me that before and I don't know.
Q. During induction I don't know if I asked you.

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A. It appears that he was there during induction, but I don't think that the record states specifically when and when he -- when he was in the room and when he wasn't.
Q. Do you have an opinion that Dewey Jones had or did not have chronic obstructive lung disease?
A. I don't know whether he had chronic obstructive lung disease, but his -- I don't know.
Q. If he did, would that change the course of management of anesthesia?
MS. REINKER: Objection.
A. No, not essentially.
Q. Are there any anesthesia risk factors associated with chronic obstructive lung disease?
A. Yes, of course.
Q. What are they?
A. The question of work of breathing, the question of whether or not shunting develops, the question of general oxygenation. The patient just is not as able to react to particularly anesthetic that changes the response of pulmonary vasculature to hypoxia.
Q. Would you expect a resident of Dr. Senchyshak's training to be able to recognize the extent of Dewey's chronic obstructive lung disease if

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he had any?
A. I doubt it.
Q. But you would expect an attending to be able to do that, correct?
A. Yes.
Q. Now, Dewey Jones had sleep apnea, correct?
A. Yes.
Q. And sleep apnea increases the risk during surgery and anesthesia of what?
A. As a matter of fact, it does not increase the risk during surgery and anesthesia, it increases the risk postsurgery because people don't breathe.
Q. So during the reversal phase?
A. That's where it would start, yes.
Q. If the patient was extubated then it would carry over and have an effect on extubation, true?
A. No, it wouldn't have an effect on extubation, extubation would have an effect on it.
Q. Okay. I said it backwards.
What effect would that be?
A. Again, this is -- for Mr. Jones particularly, his work of breathing, because of his obesity, is tremendously increased. After surgery, after drugs, et cetera, he is weaker. If you combine that with abnormal pulmonary functions you have a setup

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for people who become apneic and hypoxic. That's why such people have to be in an ICU regardless of how you manage them postoperatively.
Q. Would you expect a resident of Senchyshak's training to recognize that?
A. He may or may not. The understanding of how dangerous morbid obesity is postoperatively, it takes a while to learn that.
Q. But you do expect an attending to appreciate that, true?
A. Yes.
Q. Do you have an opinion as to if taking Dewey Jones off his anti-hypertensive medications the night before had any effect one way or another as to his operative anesthesia?
A. It probably didn't.
Q. How is that?
A. It probably did not because he probably still has a bit of a hangover from the medication the next day.
Q. So it's just too short of a time frame?
A. Probably.
Q. Eight hours or so?
A. Probably.
Q. Was Mr. Jones at high risk for cardiac

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dysrhythmia postoperatively?
A. Higher than normal, yes.
Q. He was at a higher risk for developing pulmonary edema, true?
A. Yes.
Q. He was at a higher risk for developing either cardiac or pulmonary arrest, true?
A. I don't know what pulmonary arrest is.
Q. Cardiac -- cardiac arrest.
A. Yes.
Q. Pulmonary complications that could lead to the cessation of breathing, he was at a higher risk for that?
A. Yes.
Q. Were you aware that oxygen was given to Mr. Jones preoperatively?
A. Yes.
Q. What was your understanding of why that was given?
A. He was morbidly obese, has sleep apnea, he is probably chronically somewhat hypoxic.
Q. And how would that affect his management of anesthesia?
A. During the anesthesia he is better off because we can feed him a hundred percent oxygen which

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he cannot get while he's awake.
Q. So it would have no difference as to whether or not he was preoperative oxygenation?
A. Not for oxygenation during the anesthetic.
Q. Would it make any difference as to the postoperative care?
A. Of course.
Q. How?
A. His oxygenation has to be carefully watched.
Q. And in your opinion, was it up to Dr. Senchyshak to recognize that need?
A. Same answer as before, maybe, maybe not.
Q. Do you know if Dr. Senchyshak was aware of whether Dewey was on preoperative oxygen?
A. I do not know that.
Q. But you do expect him to know that, true?
A. Yes.
Q. I know you probably answered this, but you have no idea as to the sequence of events that led to Mr. Jones' arrest, true?
MR. MALONE: You mean the physiologic sequence of events?
MR. ALLEN: Physiological.
A. I can speculate on it, but, no, I don't

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have an opinion.
Q. And within a reasonable degree of medical certainty, you can't tell me exactly what happened --
A. No.
Q. -- inside Dewey's body to create the arrest, true?
A. No.
Q. Do you have an -- you're not expected to come to trial and form an opinion, correct, as to that?
A. I don't expect to have an opinion at trial.
Q. Do you have any knowledge as to Mr. Jones' present state?
A. No.
Q. If Mr. Jones had a history of a previous TIA, would that have any effect as to his operative management of anesthesia?
A. Not more or less than all his other disease.
Q. Just another risk factor?
A. Yes.
Q. And it's a risk factor because why?
A. It shows that his cardiovascular system is in poor shape.
Q. Poor shape to -- poor shape in what way?

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A. Well, at one time it clearly didn't perfuse his brain because he fainted.
Q. And would it be more of a problem during the operation or postoperatively?
A. Same answer, not during the operation.
Q. But during his postoperative management, true?
A. That's true, with the proviso that the blood pressure during the operation did not go too low for a long period of time.
Q. Do you have an opinion as to if that happened?
A. It didn't happen here according to this record.
Q. Do you have an opinion as to whether Mr. Jones was in active congestive heart failure before the operation?
A. The record certainly doesn't show that.
Q. So your opinion is he wasn't in active --
A. Probably not.
Q. What is your fee in a review, Doctor?
A. I charge a little less than lawyers, but I charge $250 an hour.
Q. And then does it change to give deposition testimony?

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A. No, it does not.
Q. What about trial testimony?
A. Same.
Q. Same all the way across the board, okay.
Have those numbers been the same since you started doing this?
A. No. I started with a little less. Incidentally, I really am not going to do this for the money at all. I have a very good income. I'm doing this because maybe I can help make medical care, delivery of medical care a little better.
Q. I understand that and appreciate that, Doctor.
MR. CASEY: Just so you know, Charles, we've got 25 minutes until 2:00 and I think some of the other people

BY MR. ALLEN:
Q. This is Exhibit 1. Is this up-to-date, sir?
A. When did you get it?
Q. I don't know, a couple months ago.
A. Well, obviously I'm a couple of months

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older. Yes, I guess so.
Q. Is there anything that needs to be added to it?
A. No, not now.
Q. Is there any articles, publications, et cetera, listed that would shed light on your opinions as it relates to this case?
A. Yes, there are some articles on resident education.
Q. Which ones are those Doctor?
A. I think you are chasing -- I don't know when those were. Somewhere in the '70s.
MR. CASEY: Are the titles self-explanatory, Doctor?
THE WITNESS: Yes.
BY MR. ALLEN:
Q. They are self explanatory?
A. Something about the function of the resident conference, and I believe there's the other one of the frequency of teaching cases somewhere.
Q. Doctor, you have some publications that were written in German?
A. Yes.
Q. That's not self-explanatoryto me. Is there anything that was written in German that you

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could draw my attention to?
A. No, and the French one wouldn't either and the Spanish one wouldn't either.
Q. Other than the State of Ohio, have you testified in any other states?
A. No, I have not.
Q. How many times have you testified for a plaintiff or a patient?
A. I have been consulted on the plaintiff, but not testified.
Q. How many times have you been consulted?
A. I think it was two times. One time I refused to get involved.
Q. Why was that? You felt the care was appropriate?
A. I was too busy.
Q. But at that time you did feel the care was inappropriate?
A. I was too busy to evaluate it.
Q. Too busy to evaluate. And the other time?
A. Not that I recall.
Q. I'm sorry?
A. Not that I recall.
Q. Do you have any upcoming trial dates scheduled or depositions scheduled?

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A. No, I have not.
Q. Have you ever testified in a similar case to this such as the standard of care required an anesthesiologist to stop the surgery preoperatively?
A. No.
Q. Have you ever testified in a similar case in which the standard of care required the placement of a Swan-Ganz catheter intraoperatively?
A. I have not.
Q. Have you ever testified to a similar case in which the standard of care required the patient to stay intubated postoperatively hours to days?
A. I have not.
Q. Have you ever testified in a similar case in which the standard of care required proper management of postoperative ventilation?
A. I have not.
Q. Have you ever testified in a similar case where the issues concerned the standard of care requiring proper resuscitation postoperatively to avoid brain damage?
A. I have not.
Q. You read Dr. Kaplan's report, true?
A. I read his report and his deposition.
Q. Do you agree with Dr. Kaplan when he stated that Dewey Jones was severely hypertensive on admission with a blood pressure of 189/127? Do you agree with that statement?

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A. If he had that blood pressure, that's severe hypertension, of course.
Q. Do you consider any literature authoritative as to the standard of care of causation in this case, authoritative?
A. Ask this question again.
Q. Do you consider any specific -- is there any specific authoritative literature upon which you base your opinion of the standard of care in this case?
MR. MALONE: That's actually a different question than you asked him.
BY MR. ALLEN
Q. That's a different question.
A. Is there an authoritative text that gives the recipe for treating this patient? No, that's not the way it works. There are many textbooks, and the synthesis of the opinions in those textbooks is probably the standard of care.
Q. When you formed your opinions you assumed the [illegible] were entirely correct, true?
A. Yes, we have to do that.

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MR. ALLEN: That's all I have right now. Pass.
MR. CASEY: Mark?
MR. JONES: No, I have no questions.
MR. CASEY: Steve?
MR. WALTERS: None.
MR. CASEY: Susan?
MS. REINKER: Yes.
- - -
EXAMINATION
BY MS. REINKER:
Q. Dr. Cascorbi, I represent Dr. Adamek. I just have a couple questions for you.
You said earlier that there are risks to using a Swan-Ganz catheter, correct?
A. [illegible]
Q. And that a physician in any given situation will do a risk-benefit analysis in deciding whether or not to use a Swan-Ganz?
A. Correct.
Q. What are some of the risks, can you list them for me?
A. Arrhythmias, perforation of major vessels in the heart, knotting of the catheter making it

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impossible to withdraw the catheter are some of the major risks.
Q. Are you familiar --
A. Infection.
Q. I'm sorry?
A. And infection.
Q. How about actually causing the patient or worsening their condition in some way, are you familiar with any --
A. Yes. If you have somebody that could cause a tachyarrhythmia through introduction of the Swan you may make the situation very serious.
Q. I think you said earlier that reasonable physicians may come to different conclusions as to whether or not to use a Swan-Ganz?
A. That's correct.
Q. And that's true in this case, too?
A. That's correct.
Q. That's a judgment call that the physician makes based on the best knowledge they have at the time?
A. That's correct.
Q. By the way, I think I missed the answer to this question earlier. You prepared a report directed to Mr. Casey dated May 29th of 1997?

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A. Is that my letter?
Q. Yes.
A. Yes.
Q. Is that the only report you prepared?
A. That's correct.
Q. You've prepared no supplemental reports of any kind?
A. I have not.
Q. The relationship between an attending and a resident is a two-way street, they each have some responsibilities to each other?
A. If I understand your question that the resident has to bring information to the attending, the attending has to bring information to the resident and that there is a sharing of information, then the answer is, yes, of course. It's a teaching relationship, it cannot be a one-way street.
Q. You rely on your residents to do certain things?
A. I try to.
Q. And you rely on them to report to you accurately?
A. I absolutely do.
Q. And to bring any problems to your attention?

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A. Yes.
Q. And to call you when necessary?
A. At home.
Q. Or during the case?
A. Yes.
Q. By the way, you were discussing Board certification before. Now, Board certification is obtained through taking a test, or taking two tests actually?
A. That's correct.
Q. One an oral and one a written?
A. That's correct.
Q. In your lifetime I would gather you've seen some people who just are not good at taking tests?
A. That's correct.
Q. And there could be some very fine practicing physicians who for some reason just are not good test takers?
A. That's correct.
MS. REINKER: I have nothing else.
MR. ALLEN Follow-up.
MR. CASEY: Go ahead.
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AM
BY MR. ALLEN
Q. Doctor, do you have an opinion as to if a Swan-Ganz was placed in Dewey Jones whether that would worsen his condition?
A. It could, but I don't -- I cannot have an opinion. Is there a risk that it worsens, we just discussed that, yes, that risk exists with him.
Q. But you can't tell me by your review of the records that it would be more likely or not that it would have worsened his condition, true?
A. The question is improper. You cannot by review of a record, even by a physical exam of a patient, predict whether one of the complications that are known to occur with a Swan-Ganz would occur in this patient, that's not possible.
MR. ALLEN: That's all I have. Let me just talk to Paul real quick.
Have you got some questions?
MR. CASEY No, I have no questions.
MR. ALLEN Let me just talk to him one second.
(Thereupon, there was a brief recess.)

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(DEPOSITION CONCLUDED.)

(SIGNATURE WAIVED.)

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STATEOFOHIO,)

COUNTY OF CUYAHOGA.) ss

CERTIFICATE

I, LAUREN I. ZIGMONT-MILLER, Registered Professional Reporter and Notary Public Within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named **Witness,** HELMUT F. CASCORBI, M.D., Ph.D., was by me first duly **sworn** to tell the truth, the whole truth and nothing but the truth in the **cause** aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, and afterwards transcribed by me through the **process** of computer-aided transcription, and that the foregoing is a *true* and correct transcript of the testimony so given by him as aforesaid.

I do **further** certify that this deposition **was taken** at the time and place in the **foregoing** caption specified.

I do further certify that **I** am not a relative, employee or attorney of either party, **or** otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affiied my **seal** of office at Cleveland, Ohio, **on** this 7th day of August 1997.

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Lauren I. Zigmont-Miller, RPR and Notary
Notary Public in and for the State of Ohio.