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

DO 128

- - -

IN THE COURT OF COMMON PLEAS

- - -

Naginbhai Patel, et al.,)
)
Plaintiffs,)
) Case No. 151341
vs.)
) Judge James J. McMonagle
Alejo Sryvalin, M.D., Inc., et al.,)
)
Defendants.)

- - -

DEPOSITION OF PAUL J. DAUCHOT, M.D.

FRIDAY, SEPTEMBER 28, 1990

- - -

The deposition of Paul J. Dauchot, M.D., a witness herein, called by the Plaintiffs for examination under the Ohio Rules of Civil Procedure, taken before me, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at University Hospitals of Cleveland, 2074 Abington Road, Cleveland, Ohio, commencing at 10:05 a.m., on the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiffs:

Jerome M. Ellerin, Esq.
Leslie Chavers, Esq.
Jerome M. Ellerin Company
1717 Bond Court Building
Cleveland, Ohio 44114

On behalf of Defendants W. L. Gregory Siefert, M.D.:

Marc W. Groedel, Esq.
Reminger & Reminger
113 St. Clair Building
Cleveland, Ohio 44114

On behalf of Defendant Than J. Jain, M.D.:

Marc W. Grodel, Esq.
Reminger & Reminger
113 St. Clair Building
Cleveland, Ohio 44114

On behalf of Defendant Joseph Ringel, M.D.:

John M. Baker, Esq.
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
Cleveland, Ohio 44113

On behalf of Defendant Medina Community Hospital:

Richard G. Reichel, Esq.
Amerman, Burt & Jones
1972 Wales Road, N.E.
Massillon, Ohio 44646

PAUL J. DAUCHOT, M.D.

a witness herein, called by the plaintiffs for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

MR. ELLERIN: Let the record show that the deposition of Dr. Dauchot is being taken today pursuant to agreement by and between counsel, with all formalities of service and notice waived; is that correct, gentlemen?

MR. GROEDEL: Yes.

MR. REICHEL: Yes.

MR. BAKER: Yes.

MR. ELLERIN: And let the record further show that this is a discovery deposition of Dr. Dauchot.

CROSS EXAMINATION

BY MR. ELLERIN:

Q. For the record, Doctor, will you state your full name, please?

A. First name is Paul, middle initial is J, last name Dauchot, D as in David, a-u-c-h-o-t.

Q. Do you have a curriculum vitae?

A. I do have -- well, not with me, but I sent one to Mr. Groedel.

MR. ELLERIN: Do you have it with you, Mr. Groedel?

MR. GRQEDEL: I thought I gave it to everybody, but maybe not.

Here, I have a copy.

A. (Continuing) If I may make a statement, this one, I am working on sending actually a chapter on the outcome of surgical anesthesia in the elderly to Dr. David Brown from the Mayo Clinic as my contribution to a book, second edition of a book, outcome in the elderly surgical patient, that will be published later next year, and I do not think that was mentioned in my CV, but I just want to mention this.

Q. Have you written any articles or chapters in any books dealing with the subject of the use of anesthesia in patients who are hypovolemic?

A. No, I haven't, as far as I can recall, no.

Q. Have you written any articles or chapters in books dealing with the subject of hypotension that has been induced through the use of anesthetic agents?

A. No, I haven't.

Q. Have you written any articles or chapters in any book that in any way relate to the subject

matter of the Patel case?
A. Well, that is more difficult for me to answer. When I started in the United States, I was involved with monitoring techniques and monitoring of the heart function, and we used a technique that is not used any longer now, it is called systolic time intervals, as a way to monitor the cardiac function of patients during various types of surgery.
Q. And what years was that procedure used, Doctor?
A. That was used in the late '70s, and then it was an NIH grant that we had to receive so the technique could be used on line in the operating room, and since then, with the advent of echocardiography and electrocardiography, it provided more information of systolic intervals, and was not used any longer.
Q. When did the use of GVP lines and Swan-Ganz catheters become prevalent in the use of monitoring patients during anesthesia?
A. Well, I suppose that central venous pressure, as a way to monitor the patient, certainly was available, I would say, in the '60s. I think Swan started to publish about the Swan-Ganz catheter,

which was called then, I suppose, the pulmonary artery fluid catheter, he started to publish about this in the mid '60s, I suppose.

The pulmonary artery catheterization became part of intraoperative monitoring, I would say from the mid '70s on.

Now, I want to point out the following, that in certain centers, the use of pulmonary catheters, pulmonary artery catheters is -- or pulmonary catheters are used very frequently; in other places, it is not.

Q. All right,

Let me ask you this, Doctor:

As far as the information obtained from a CVP line versus the information obtained from a Swan-Ganz catheter, will you tell us what the difference is, and whether there is any more significant or reliable information that can be obtained from a Swan-Ganz catheter monitoring than from a CVP line monitoring?

A. Well, the bottom line is the following:

If a patient has cardiac dysfunction, an abnormal functioning heart, without specifying the degree, the CVP readings may not reflect the degree of the volume load of the patient, what we call in

our professional jargon the pre-load of the patient, as compared to the after-load, which is the resistance against which the left ventricle has to eject.

Q. In a patient who is hypovolemic, can more accurate information be obtained concerning cardiac status and his hemodynamic condition from a Swan-Ganz catheter as opposed to a CVP line?

A. Well, again, it depends. If the patient has no cardiac disease, one can obtain from a central venous pressure reading information about the volume status of the patient. If, however, the patient has to some degree cardiac dysfunction, which may include pulmonary dysfunction, then the CVP reading may be false high, meaning that the CVP may reflect the fact that the blood cannot go through the -- or is impeded to be ejected by the right ventricle because the right ventricle itself is in dysfunction, or maybe the tricuspid valve, the connection between the right atrium and the right ventricle is misfunctioning. Also, there may be some severe pulmonary dysfunction, which then is called in the extreme case cor pulmonale.

Q. What3

A. C-o-r, p-u-l-m-o-n-a-l-e.

Cor means heart, and pulmonary -- it means a lung-heart, actually.

Q. So basically, Doctor, what you have done is given us a number of examples or illustrations in which the use of a Swan-Ganz catheter would provide more accurate information than a CVP line; is that correct?

A. Yes.

Another advantage potentially from the Swan-Ganz catheter would be, besides giving information on the pre-load condition, it also provides information on cardiac output.

Q. More so and better than a CVP line?

A. Well, yes.

Q. If the patient -- pardon me.

A. Well, it depends on the equipment one is using. One can use a CVP line to inject what we called in the past the green dye, for instance, and in some of my clinical research papers we have used dye dilution techniques, but then one has to have on the arterial side of the circulation -- well, an arterial line actually to sample arterial blood, to compare, to measure the concentration of the dye we injected on the arterial side of the circulation.

Now, with thermodilution, this becomes much

more simplified, because one can inject a bolus of either room temperature D5 water or ice cold D5 water, whatever one chooses to use, to get an estimate of the cardiac output at a given time. It is not a continuous method at the present time, it is just a snapshot.

Q. So what you are telling us is that there are a number of procedures and techniques available with the use of a Swan-Ganz catheter that would aid you in assessing the hemodynamics of the patient?

A. Correct.

Q. Now, in the matter of Mr. Patel, Dr. Dauchot, you were asked to review this case presumably from the standpoint of the anesthesia management, I take it; is that correct?

A. That is correct.

Q. All right.

Can you tell us approximately when you were asked to take a look at this case, and by whom you were asked?

A. I was -- as far as I can remember, I think Mr. Groedel, either by letter or called, I cannot remember anymore.

Q. Do you have that letter with you?

A. It must be in the file somewhere, I am sure.

MR. GROEDEL: I can provide you with a copy of the letter. I am not sure he has it.

A. (Continuing) I do not have it in here, but as far as my recollection goes, it must be somewhere in May or June of last year.

Q. Of --

A. Of 1989.

It may have been a little bit earlier, it may have been April or so.

Q. And at that point were you asked to review the matter strictly from the standpoint of the anesthesiologist, or were you asked to give your comments as it relates to the care and treatment of any other physician involved in the case?

A. No, Mr. Groedel asked me just to review the case in the function of anesthesia management provided to Mr. Patel during his surgical procedures that he had at Medina Hospital,

I was not involved to review the -- well, the anesthetic management at Lutheran, he didn't ask me to do that, so I strictly kept myself to the management, the management as far as it involved Dr. Siefert for the two procedures that occurred.

Q. By the way, do you know or have you met Dr. Siefert at any time?

A. No, never.
Q. Did he train under you at any time?
A. No, not that I know of.
Q. What materials did you have at the time of your initial review?
A. I think Mr. Groedel gave me the medical records from Medina Hospital, and also the medical records from Lutheran, they were together, and also he provided me, I think, with the report of Dr. Stirt, I believe, and the deposition of Dr. Siefert -- I was not quite sure whether it was the same time -- and Dr. Siefert's deposition.
Q. And did you obtain any verbal information from Mr. Groedel concerning any of the facts or circumstances of this case, other than that contained in the hospital record of Medina, the hospital record of Lutheran, and the deposition of Dr. Siefert, and the report of Dr. Stirt?
A. Not then. I did receive, however, I think it is the deposition -- no, the report of Dr. Szilagyi, but that was post hac. I think I received this at one of the moments that I was going to have the deposition, and then it was canceled.
Q. Do you know Dr. Szilagyi, or know of him?
A. Well, I know him by name, I know that he is

the editor in chief of the General Vascular Surgery, that he has an impressive academic and clinical record. Besides that, no, I never met him, I do not know him.

I may -- he is mentioned also in one of our books on vascular surgery published -- or edited by Dr. Michael Roizen.

Q. Rosen?

A. Roizen, R-o-i-z-e-n.

And I think in there, in one of the tables that Dr. Roizen puts in his book, I think the experience of Dr. Szilagyi in the '60s is mentioned as one of the reports.

Q. Is Dr. Roizen a physician in anesthesiology here at University Hospital?

A. No, no. Dr. Roizen is the chairman of the department of anesthesia at Chicago University, I suppose. Chicago University.

And he -- well, he has published quite a bit on vascular surgery, anesthesia €or vascular surgery, and he edited a book maybe six months ago, maybe more, maybe a year ago, about that.

Q. Dr. Roizen did?

A. Roizen, yes.

Q. And in that book he quotes or cites from

Dr. Szilagyi?

A. There is a table about the mortality of vascular surgery over the years, and I remember -- well, on top of the table, Dr. Szilagyi is mentioned as in the '60s, where Dr. Roizen is quoting -- not quoting -- but just taking the information that Br. Szilagyi gave supposedly in the '60s on mortality and vascular surgery. That is why the name --

Q. Rings a bell with you?

A. Well, it is the same Szilagyi that wrote the report.

Q. Okay.

A. And also in the Journal of Vascular Surgery that we also read for articles, he is the editor-in-chief, Szilagyi,

So I suppose it is the same one, unless two people are the same name, that is something I don't know. But I suppose the Szilagyi from vascular surgery and the Szilagyi that Michael Roizen is quoting is the same one that wrote the report.

Q. You say you, at a later time, received the report of Dr. Szilagyi?

A. Yes.

Q. And did you read it?

A. Yes, I did,
Q. Did you find his presentation analytical?
A. It was, yes,
Q. Did you find anything in there that you took any disagreement with --
A, Yes.
Q. -- in any major extent?
A. Yes.
Q. What?
A. I recall hat when he discussed or reviewed the hypotension and its consequences, and then the thrombosis that followed, I do remember that he had three -- that he mentioned three possibilities, three hypotheses; one was that the hypotension that occurred intraoperatively the first time had as a consequence the development of a thrombosis that caused all the problems for Mr. Patel. There are also two other hypotheses that he is mentioning there, I do not recall exactly which they were, he chose one of the three. I think personally that one of the others is more appropriate as true.

So this is a disagreement that I would have with him. He is a vascular surgeon, I am an anesthesiologist.

Q. In reading your report that you submitted to

Mr. Groedel, Doctor, I was able to interpret or learn from your report that you apparently feel, based on the timing as to when the ischemia was observed at perhaps 3:00 to 4:00 or 4:30 p.m. on the date of July 17th, that working backwards from that, you felt that this hypotensive event that he had on the morning of the 17th as documented once the Swan-Ganz was put in was the most probable cause of the thrombus; is that correct?

MR. GROEDEL: Objection.

Go ahead.

A. I would not put it that way, What I was trying to put across was the following:

Any hypotensive episode that may have occurred in the peri, or perioperative period, may have triggered the occurrence of a coagulation cascade resulting in thrombosis. If one assumes that hypotension can do this, then one should consider all the hypotensive episodes that occurred.

When I was reviewing the material, first I found that when Mr. Patel arrived in the ER, his blood pressure was not all that great, and according to the nurses in the ER, his pedal pulses were not all that great, either.

So to me, already at that moment, a

coagulation process may have started, unnoticed by anyone, but that resulted later on in a thrombosis.

Now, we have --

Q. Well, if I may interrupt for a moment, you commented in your report that around midnight of the 16th into the 17th, a number of nurses felt quite strong pulses in the feet after he had had some rehydration --

A. Right.

Q. -- do you recall that, and I thought you used that as your basis of your thought that the later episode at perhaps in the early morning hours, between 6:00 a.m., 8:00, 9:00 a.m., until they put in the Swan-Ganz and got the reading from that, would have been a precipitating factor, or a culprit, and that that was consistent with the timing as to when the ischemia first became apparent; we then have a passage of perhaps eight hours from the time of that insertion of the Swan-Ganz and that low reading until we begin to see ischemic effect on the legs?

A. I will say that if one looks at the timing, if there is any time relationship between the time of an event and the occurrence of the result, that then, yes, I would say that the hypotensive episode,

to me, could well be a cause of the subsequent thrombosis, because pulses, as far as perceived by nursing personnel, had been good at 6:00 o'clock after the first surgery, had still been good at midnight, and were felt to be weak around the time that Dr. Jain, I suppose, the cardiologist, was called by the nursing staff because the patient was hypotensive.

Now, I also noticed that the magnitude of the hypotension was not recorded here, and if one goes back to the flow chart, one does not see any hypotension marked in the nursing record. Yet --

Q. For what period of time, Doctor?

A. I am sorry?

Q. You say there is nothing marked in the nurses records or in the flow charts showing --

A. I didn't say nothing marked, I am saying that the values indicated around the period of time, 8:00 o'clock in the morning, 7:30, 9:00 o'clock, that the values of blood pressure are in the range of 110, 100, but not abnormally low.

Q. But low for a person who is hypertensive, and not on any drug in the hospital to counteract the hypertension?

A. I do not -- well, let me take a deep breath

before answering that question.

Q. Okay.

A. First of all, I have no knowledge of what Mr. Patel's normal values of pressure were. He was treated for hypertension with the drug Vasotec most probably because he was at the given point in time found hypertensive. What the values of the blood pressure were with which he was living, I do not know.

I would suppose, though, that a well treated hypertension in Mr. Patel's case would bring his pressure below the threshold values of hypertension which are set by the American Heart Association, 140/90, this is the threshold values. Below this, one cannot talk about hypertension.

So I suppose that Mr. Patel was living otherwise around these values.

Q. Around 140/90?

A. I suppose, treated, yes.

Q. If treated with Vasotec?

A. Yes, if successfully treated with Vasotec, that is what I would like to see his blood pressure values to be, in the normotensive range.

Right now, I do not think that a systolic pressure of 110 or 120 can be considered in

hypotension for Mr. Patel, I frankly cannot, I think it is still in the normotensive range.

Q. All right, now --

A. But if I may add something to this, considering the condition of Mr. Patel, the severe arteriosclerosis that he has, maybe he needs a higher value, I do not know.

Q. To keep the blood pumping and flowing; is that what you are saying?

A. Well, to keep perfusion of his body.

I do not know what -- and this also is very much dependent, I suppose, on regional characteristics of the vessels. But it is a fact that he was treated with Vasotec because his pressure was considered effective at a given point in time.

Also I would say when his pressure was 96 in the (emergency room, he was not -- he had no systemic, I mean cerebral signs that he was dizzy or lightheaded, I do not see this in the record, so I assume his pressure of 96 systolic that he had at that time was sufficient for him to keep an adequate circulation to the brain; otherwise, he would have been fainting, or dizzy, or semiconscious.

Q. All right, let us talk about the diastolic

pressures that this man registered.

Was there ever a time, in your review of the record, that a diastolic pressure was not obtainable on Mr. Patel?

A. I think the only -- if I have good recollection -- it was intraoperatively when the systolic pressure was very low, I think by Doppler, and again, I would like to refresh my memory.

Q. You are certainly welcome to look at the chart, Doctor.

A. I think when they started, the pressure was 60, that they also mentioned the diastolic was not obtainable, but let me see.

This was supposed to be well organized here.

Well, this is the first one here, Doppler. I suppose I see here 60 (indicating), but I don't think these was a diastolic here.

Q. And when you say "here", you are talking at about what time, Doctor?

A. Let's see here.

Q. And for the record, you also said intraoperatively, you are talking about the July 16th attempted operation that never went ahead?

A. Yes, right.

That would have been -- this is 4:30, this is

5:00 o'clock, that would be at 4:33, 4:34 -- between 4:30 and 4:35.

Q. All right,

A. That is the best I can tell you.

Q. Okay, there is a documentation that with Doppler, a systolic reading of 60 was obtained, but no diastolic reading was obtainable, or at least not recorded?

A. Yes, I think that is what I was about to say, I do not see any recording of a diastolic, so there is no check mark for diastolic.

Whether that was permitted, whether it was not possible to obtain -- I do believe, though, that in Doctor -- let me see now -- Dr. Jain's report, entry, they may have said this, but as far as this recording, no, there is no check mark for diastolic.

Q. Now, the blood pressures were not taken in the legs, were they, they were taken in the arms: is that correct?

A. It is not mentioned where they were taken. Normally, we do take blood pressures on one of the arms, except if there is a major reason not to do so, surgery on the upper extremities, extreme obesity, may preclude one from putting blood pressure cuffs around the arms,

Q. In other words, you may get higher readings or lower readings --

A. Yes.

Q. -- depending on which arm, and the condition of the vascular system in that particular arm?

A. Exactly.

Q. And you don't recall anything in the depositions that pinpoint which arm was used for the blood pressure readings?

A. No.

Q. Or whether they switched arms in taking the readings?

A. No.

Q. I want you to assume for a moment that at the time you mentioned, between 4:30 and 4:35, no diastolic reading could be obtained, even with the use of the Doppler.

Do you have an opinion that such an episode and the entries surrounding that particular time frame would be sufficient to --

A. May I interrupt? May I ask you a question now that has puzzled me through this?

Q. All right.

A. What is the Doppler, I would like to know for my own satisfaction, what type of Doppler instrument they used?

Q. I am not sure that that came out in the depositions.

A. Let me tell you why I asked you the question, because you seem to -- well, maybe rightly so -- attach much importance to diastolic pressure,

There may be some Doppler devices that although they record systolic flow, that there is flow to the extremity, do not record the diastolic.

So I know there are instruments based on the Doppler principle, blood pressure instruments, that do record systolic and diastolic. Yet they have to be specially, I suppose, designed for this.

Surgeons sometimes use a Doppler flow to examine flow to the arteries of the -- like the pedal arteries, for instance, they only give a sound of flow, the shh-shh that the blood is passing, yet I suppose they cannot give an accurate estimate of the diastolic.

Q. But can we at least assume that from the systolic standpoint, the use of the Doppler was needed to accurately hear that shh-shh sound that you just described?

A. Right. I would think so, otherwise --

Q. Why use it?

A. -- why use it?

Q. Is that correct?

A. Yes.

Q. Okay.

A. It may also have been that they wanted to have a confirmation that what the pressure they were reading was correct, that may also be -- I would not assume right away that because there was no pressure, they said, let us check the Doppler.

It may well have been that they found by the oscillometric method, I suppose, that the Dynamap did not record any more, and mind you, Dynamaps are sometimes very tricky instruments, and on a daily basis, sometimes Dynamaps give no readings anymore, God knows for what, and it may well have been to assure what the pressure was, they went to Doppler to be sure there was still a systolic blood pressure.

Q. But apparently the other readings were obtained without the use of a Doppler?

A. I would assume so, yes.

Q. Would you agree if the assumption is made that a diastolic pressure could not be heard or determined, and the systolic was heard with a Doppler at 60 for a period of time, as reflected on the anesthesia record, that this could be a time when a thrombus -- where you had stasis of the blood, and a thrombus formation being started?

MR. GROEDEL: Objection.

Go ahead.

A. Yes.

Q. Now, Doctor, let us --

MR. GROEDEL: It is all right, just answer his question.

Q. (Continuing) I want to talk with you for a moment about the drugs used in the anesthesia on the 16th.

A. Sure.

Can I have some more coffee?

MR. ELLERIN: Absolutely,

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

BY MR, ELLERIN:

Q. I was going to start to talk with you, Doctor, about the use of the anesthetic agents that were chosen on this particular occasion, that is the July 16th date.

Am I correct that there are, in the reservoir of drugs used by anesthesiologists, a great number of various agents that can be used for various purposes in the induction and the maintenance of the patient in an anesthetized condition?

A. That is correct.

Q. Can you quantitate that for us, Doctor? Wow many drugs are in your arsenal, so to speak, as an anesthesiologist, that are available for use, or your choice of use?

A. Are you referring to the induction agents to induce sleep and consciousness?

Q. I am talking about the whole regimen that falls within the purview of the anesthesiologist.

A. So you are including muscle relaxants, too?

Q. Yes.

A. I would say, excluding regional anesthesia, twenty, twenty-five.

Q. In total?

A. In total, including muscle relaxants, intravenous induction agents, narcotics.

Let us go maybe to thirty, thirty-five, actually, Actually, it is a good question.

Q. Let us break that down, Doctor, in the various categories that you are referring to, and one of the areas, of course, that you mentioned are muscle relaxants.

Would that be the first area of the administration of a drug in an anesthesia procedure, to give a muscle relaxant, if you are doing an intubation?

A. It depends. If Succinylcholine will be used for intubation, Succinylcholine being a depolarizing short acting muscle relaxant, then it is recommended to use, in the pretreatment of this, a non-depolarizing muscle relaxant to prevent what is called the fasciculations, the muscle movements and the small muscle contractions that are a side effect, actually, or the initial effect of 'the Succinylcholine.

Q. Now, what are some of these muscle relaxants, then, that are available for use to avoid the activity or the movement in the muscles?

A. Well, one is curare, tubocurarine, is one that is often used: others may, as well, be used, a small dose, one milligram of Norcuron, one milligram of Pancuronium, a few milligrams of Tracrium. It depends what the anesthesiologist will use subsequently, as a longer acting muscle relaxant.

That is the way I see it, and the way we try to teach our people here, not to mix too much all these drugs.

Besides, we are under financial constraints, also, and pharmacies ask us to limit our use of drugs, if possible, to a given category, and not use a vial of curare for only one cc, and then have to

dump it, and not use it later on.

(Short recess had.)

BY MR. ELLERIN:

Q. Do some of these muscle relaxants that are given bring on or could bring on hypotension?

A. Yes.

Q. From the literature and your experience, which ones tend to be more productive of hypotension than others?

A. Curare is by all means the one that has been most -- well, most reported to produce hypotension secondary to histamine release, because to my knowledge, those muscle relaxants do not interfere directly, I will say, with the relaxation process of smooth vascular muscles. They do it indirectly to the extent that they have histamine releasing properties.

If one asks a pharmacologist what or which drug does not release histamine, he will say, he will answer you, all drugs can release histamine, period.

Now, it is known in our profession that curare, for instance, can release more -- or more frequently releases histamine than, for instance, Pancuronium, although there are a few reports in the

literature that Pancuronium also may release histamine in a case, it has been reported,

The second one, then, that has been reported to release histamine would be Tracrium, or Atracurium, which is the generic name of the drug.

Now, the Atracurium has been reported only to do that when it is used in an "intubation dose". An intubation dose of Tracrium is in the range of .5 to .6 milligrams per kilo, which would have been, if you take Mr. Patel, given his body weight, 70 kilos, between 35 and 42 milligrams, IV.

Q. So it is your belief that the dose given at the time of the initial intubation --

A. The three milligrams, the pre Succinylcholine?

Q. Yes.

A. Most likely, not, because the drug itself is a histamine releaser, but a weak histamine releaser, and the dose used, three milligrams, to my knowledge, has never been reported to be involved with any significant histamine release.

Q. Now, could it have, to some degree, a synergistic effect with the Sodium Pentathol?

A. It may, but again, I suppose then they all could have synergistic effects. It is hard to tell.

To my knowledge, if one asked me, can it, I

would say no.

Q. But Sodium Pentathol in and of itself is known to be a cardiac -- a myocardial depressant; is that correct?

A. Yes, it is a dose dependent, dose related cardiac depressant, meaning that if one gives small doses, nothing may happen, and with high, very high doses, a cardiac depression may occur.

Now --

Q. If I can interrupt for a second, if a person is hypovolemic, can you bring on a hypotensive event with a lesser amount of Sodium Pentathol than in a patient who is fully hydrated?

A. The answer to that question is not simple, and I will try to explain to you why.

The function of the heart -- the determinants of the function of the heart are fourfold, One is the pre-load, which is volume coming back to the heart; the second determinant is the contractility, which is the contractile force of the heart muscle completely independent of the pre-load; three, then, is heart rate; and four is what is called the after-load, which is the load -- and I use that word, because some people may say the pressure -- it is the load that the left ventricle has to overcome

during ejection of the blood volume or the stroke volume into the aorta.

Q. Those are the four elements?

A. Those are the four elements.

They added recently a fifth element, which is the synchrony between the atrium and the ventricle. The atrial contraction must occur before the ventricle contraction, because the contraction of the atrium will push some blood from the atrium of the heart into the ventricle, either the right or Left, regardless. So if there is a dyssynchrony between the atrium and the ventricle, there may also be a cardiac dysfunction, and one is starting to call this the fifth determinant.

Q. Let us talk about these for a moment, Doctor.

The first one you mentioned was volume. I take it you are talking about --

A. Right.

Q. __ volume within the intravascular system of the patient; is that correct?

A. Right.

Q. So if a person, if a patient is hypovolemic, he obviously has a lesser volume of fluids within that intravascular system; is that a fair statement?

A. Yes.

Q. So that is one of the four conditions that you are speaking of?

A. Yes.

Q. Okay.

Now, the next one you mentioned is the contractibility of the heart wall or heart muscle itself; is that correct?

A. Yes.

Q. And that, I presume, is a function of the status or condition of the particular patient's heart muscle or heart wall; is that correct?

A. Yes.

Q. And that can vary with the age of the patient; the older the patient is, perhaps, the less contractible the heart walls are?

A. I would -- well, I know the subject rather well on aging, because I am writing a chapter on this, and at the present time in the gerontologic literature, there is more tendency to separate the healthy elderly from the sick one. And there is absolutely no hard proof that the contractile state of a healthy elderly, say 70 or 75, whatever you call old -- I do not know any more, it varies from day to day now.

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

A. (Continuing) I will put it that the healthy elderly have more contracted function. The rest is diseased.

Q. Is there some relationship to the degree of arteriosclerosis that the patient has, with the contractibility of the heart walls?

A. If the arteriosclerosis extends to the coronary arteries, yes.

Q. Now, you were talking about the third element, which was heart rate. Are you talking about the heart rate of the person going into surgery, or the heart rate of the person as affected by the anesthetic agent?

A. No, I am talking now strictly in terms of physiology.

Q. All right, if I can interrupt, Doctor, what you are saying is that if the heart rate stays up, there is a greater tendency for the pressure to stay up because the heart is pumping more?

A. No, that is not correct. There is a given threshold again where a fast heart rate will be dangerous for the heart, and let me explain you this.

Q. Can you quantify the number?

A. In our literature, they consider that -- and this is now for cardiac surgery, but it also applies, probably, to other patients with cardiac disease, whether it is documented or whether there may be evidence, I do not know -- but give and take, if the heart rate increases twenty percent above a "base line" heart rate, that should be treated.

Now --

Q. Are you talking about during anesthesia?

A. Yes.

Q. So there are some drugs that you can give a patient that will cause the heart rate to go up, as opposed to causing the heart rate to go down?

A. Right. And I would like to tell you why.

The perfusion of the heart and of the left ventricle occurs during relaxation of the heart. If the heart rate is too fast, or is fast or very fast -- I will put it differently.

The faster the heart, the smaller the relaxation of the left ventricle, the smaller the perfusion. That is why tachycardia is one of -- tachycardia meaning an increased heart rate, an excessive increased heart rate -- is one of our major enemies, and we treat that -- I treat this

aggressively, and I prevent heart rate to go above a given level.

Q. During the anesthesia?

A. Well, even before, even before. If I see that a patient comes to surgery with what we call a PAT, paroxysmal atrial tachycardia, of even 120, which is not a bona fide PAT, I will try --

Q. With what, Doctor?

A. Well, the drug which most readily brings the heart rate within normal limits -- I will do it differently.

It depends what condition the patient is in,

For instance, the patient has pain, pain may be the factor to increase the heart rate. So I may give him a pain medication, a narcotic, to see if narcotics may affect the pain.

But by the same token, narcotics also will, by themselves -- they are cholinergic drugs, they will decrease heart rate, so they will treat the pain that may, by reflex, cause increased heart rate, but their pharmacological effect is also one of decreasing heart rate.

If that doesn't work, and if I have evidence that a patient may be in heart failure, or borderline heart failure, that may be a problem for

him, I will treat him with a short acting beta blocker, which is Esmolol, for instance, and see if it brings his heart rate down to acceptable limits.

Now, these drugs are like a two edged sword. The beta blockers, the fast acting, as Labetalol, Inderal, Propranolol, also depress the heart, but that is then the give and take, try to find the dose that will decrease heart rate and increase ,perfusion of the heart without being detrimental to the contractility, the contractile state, the second determinant that we talked about, of the heart.

Q. Now, am I correct that you are doing these things prior to the administration of the anesthesia in order to try to put the patient in the best possible condition to undergo the anesthesia and the proposed surgery?

A. Like you said, or like I said, if that occurs before induction, I will try to treat this before induction so that heart rate is within acceptable limits before I start my anesthetic.

If now this occurs during surgery, well, then again, I will take various steps and actions, like deepening anesthesia, like giving narcotics to see if that may be -- if awareness of the patient during surgery, or during the procedure, may be a cause of

the increased heart rate.

If deepening the anesthetic or giving more narcotics does not return the heart rate within normal limits -- and by the way, I may as well mention fluids, too, if I can -- if I have evidence, clinical or documentation, that the patient is not hypovolemic, dry, as we call it, then I will eventually resort to giving beta blockers,

Q. You say if you have evidence he is hypovolemic, you would give him fluids?

A. I would give him a fluid push, yes, that is part of the standard approach. We do a few checks to be sure that the most obvious causes of increased heart rate intraoperatively are covered, which is pain, awareness, volume load, and that if all this has been covered to the best of our capability, we may start and rely on the use of beta blockers, because it may be a problem of the heart itself.

Q. But is it a fair -- is my original statement a fair statement, and that is that you, as an anesthesiologist, or one, as an anesthesiologist, attempts to put his patient in the best possible condition preanesthesia in the hope that you won't get into these problems during anesthesia?

A. If there is time to do so, yes, right,

And may I give you an example?

Q. Well, I understand. I mean, that is clear, it is a time factor that is --

A. A ruptured aneurism comes in without pressure, there is no time to prepare, so we have to go ahead.

Q. The person will bleed to death in five minutes, or two minutes, or whatever?

A. It is all a question of balance, and if there is time, if there is time, yes, we will.

Q. Okay.

And 1 appreciate your breaking this down into the four and perhaps five categories that you did in the explanation of the use of Sodium Pentathol in a hypovolemic patient, but as a general statement, and as is written in the anesthesiology texts, Sodium Pentathol, used in a case where a person is hypovolemic, is known to bring on hypotension; I mean, that is reported in the texts, is it not, as a general statement, without getting into the details of the whys and the wherefores?

A. No, I cannot, you know, agree with that statement, because it depends upon the degree of volume depletion, and the dose, and perhaps also the rate at which Sodium Pentathol has been

administered.

Q. I understand that, and I accept everything you are saying. And I didn't mean to say that someone who is one liter hypovolemic will react in the same fashion as someone who is five liters hypovolemic, and I didn't mean to infer that if you give Sodium Pentathol at the rate -- at a high rate versus a low rate, or a moderate rate, you 'will always get the same result.

A. Right.

Q. But the more hypovolemic the patient is, the greater the chance of the hypotension --

A. Yes.

Q. -- and the greater the dose, because it is dose related, the greater the chance is, I would presume; is that a fair statement?

A. That is a fair statement, but it is not limited to thiopental alone.

Q. So really what you have is the anesthesiologist, as the captain of the ship, looking after the patient, that must attempt to see what the condition of the patient is, to whom he is administering the drugs, and then choose the drugs that would be most appropriate to avoid a severe hypotensive event?

MR. GROEDEL: Objection.

Go ahead.

A. I do not agree with the anesthesiologist being the captain of the ship.

Q. He is the captain of the choice of the drugs €or the anesthesia, is he not?

A, That is true, however, as a general statement, we use the term captain of the ship for the surgeon, he is the one who has the final say, actually, because that is the way it has been. And maybe this will change, or should be changed, but as far as drugs go, I will say that yes, the anesthesiologist is very often completely free and uses the drugs he deems or he thinks are appropriate.

MR. GROEDEL: Why don't you call him the captain of the anesthesia ship? That, we can live with.

MR. ELLERIN: Okay, we have two boats on the ocean.

BY MR. ELLERIN:

Q. Now, with respect to the use of anesthesia, if an anesthesiologist feels that his assessment of the patient is such that the man will not be able to withstand the anesthesiology, and the surgery will

be canceled, the anesthesiologist can confer with the surgeon and try to determine how emergent is this operation, should we do some things prior to inducement of anesthesia and surgery, how long will it take to prime the patient, and have that kind of discussion with the surgeon; you do that all the time, do you not?

A. Well, we try to be sure that the condition of the patient is as well as possible.

Q. All right.

And that is within the role of an anesthesiologist to do?

A. Yes.

Q. I am not saying --

A, Yes.

Q. -- that it is his sole responsibility, but it is within the role of an anesthesiologist to do that?

A. Right.

Q. And if you were to differ with the surgeon, you would express your concern to the surgeon, would you not?

A. I would.

Q. And that is done everyday, if the occasion arose?

A. Yes, it can happen everyday, yes,
Q. And then based on the issue, as you mentioned before, for example, if it were an aneurism that has ruptured, and the person is hemorrhaging to death, then really everybody's hands are tied, the anesthesiologist, and the surgeon's; you must go forward with the anesthesia, and you must go forward with the surgery, at that moment?
A. Right.
Q. But if the surgery has some elective lement to it, as far as the timing of the surgery, both the anesthesiologist and the surgeon can take advantage of that window of time in order to try to put the patient in the best possible condition for going ahead with the anesthesia and going ahead with the surgery; is that not true?
A. That is true to the extent that the surgeon and anesthesiologist have the same knowledge about what delay one can give the patient before going to surgery.
Q. And that would require a discussion between the two of them, would it not?
A. Well, not necessarily.
I would say this: If the surgeon, who is usually one of the first physicians to see the

patient, sets a given time frame, he says, well, we are now noon, or it is now 8:00 o'clock at night, for instance, this condition, I think we have to go ahead, and we will let -- we will give four hours, five hours, give and take, but we have to go ahead and do surgery then because I think -- I am speaking as a surgeon -- we may have the possibility by delaying too much of infection in a case of an abdomen, peritonitis, sepsis, and so on, then pretty much the time frame is set,

And it becomes for us, anesthesiologists, very difficult to argue, unless we say to the surgeon, if I do not -- if you do not give me another hour to do something, this patient's life may be severely compromised.

Q. But you could say that to the doctor, to the surgeon, give me an hour, because I want to do A, B and C. What do you think, Doctor, will another hour that dramatically hurt the patient?

A. I could perfectly well say this, and say, I think one hour waiting may benefit in this or that respect.

Re may tell me, yes, but on the other hand, you forget to think about infection, and sepsis, and this and that, and I do not think, looking at the

balance, that it is right to do so.

And if you push the case, I can say, well, I am sorry, I really feel strongly that I cannot go ahead, and you better call someone else to do anesthesia.

Q. Theoretically, as an anesthesiologist, you could make that statement?

A. Yes, with all the consequences.

Q. That is right, but I mean, you could stick to your guns and make the statement?

A. Right.

Q. Now, in your report, Doctor, with respect to the Sodium Pentathol, you described this dose as -- I forgot exactly -- like the low end of a moderate range?

A. That may be it. Let me refresh my memory.

MR. GROEDEL: I think that s how you described it.

MR. ELLERIN: I don't remember exactly where it was.

A. (Continuing) I have my report with me,

Q. Well --

A. It must have been in the discussion, I suppose.

Q. Let me just state --

A. I think you are correct.

MR. GROEDEL: Yes, here it is.

THE WITNESS: In the discussion?

MRS. CHAVERS: What page, Marc?

MR. GROEDEL: Page twelve.

Q. Twelve?

A. It is in the discussion,

MR. GROEDEL: Down at the bottom.

Q. He was administered three milligrams of thiopental, which is at the low end of the range of a moderate dose of thiopental?

A. Yes.

Q. So you classify three milligrams as being in the low end, I guess, of the range of moderate dose; is that correct?

A. Yes.

Q. What numbers would be a high range, in your mind?

A. High range would be above a five, for sure, more than five is high range.

Q. Does the normal range for one patient vary from what may be a normal range for another patient, depending on age and condition of the patient?

A. Yes, definitely.

Q. When you say that a normal range is like five

milligrams, what kind of patient are you talking about?

A. Well, I would think here a healthy 40, 45 year old person, 50 year old person, or younger, coming to surgery -- coming for elective surgery.

Q. Not under a stressed type of situation; is that what you mean, when you say elective?

A. I do not think -- well, it depends what you call stress, I think every patient coming to surgery --

Q. Is stressed?

A. -- is nervous, because of what he is facing.

If you call stress the severity of the disease, then that may obviously greatly affect the range or the dose that will be used.

Q. So that in a patient such as Mr. Patel, who I believe was 67 --

A. That is correct.

Q. -- and obviously with a known and diagnosed perforated ulcer, with some third spacing of fluids, we can presume, for some period of time, as long as the perforation was there --

A. Yes.

Q. -- you would not put him in that category of the 40 to 50 year old healthy person who comes in

for elective surgery?

A. Not at all.

Q. In that kind of person, what would be a range of Sodium Pentathol that you feel could be used without encountering the adverse effects or complications from the use of that drug?

MR. GROEDEL: Which kind of person are we talking about now?

MR. ELLERIN: Such as Mr. Patel, under this circumstance,

MR. GROEDEL: Okay, go ahead.

A. I cannot give a straight answer to this for the following reason:

Mr. Patel had been vomiting for a couple of days. So he had breakfast, or he had something as intake the morning of surgery, 9:00 o'clock. I found one statement about wheat and milk, so he cannot be considered an empty stomach.

It follows that if such a patient goes to surgery, he must be treated for induction of anesthesia by what is called a rapid sequence procedure, which is what Dr. Siefert did, and the rapid sequence procedure does not give anyone very much time to look how well a drug can be tolerated.

Q. Is it important, Doctor, to try to place some

determination as to how much breakfast this man in fact did have, if people are available that can communicate that either to the surgeon or to the anesthesiologist?

A. Well, the amount -- it is more the fact that there is an abdominal syndrome going on here, and one can assume that the emptying of the stomach has been delayed or is not at all working anymore, so even without any intake in the morning, one cannot assume an empty stomach.

Q. Because of the underlying condition?

A. Because of the underlying condition; even more so, that Mr. Patel was suffering from a gastric ulcer, and one could assume that the gastric acidity or the pH of the gastric content was going to be very low.

Now, if that pH is below two, I would think that in such a condition, I would assume if some fluid is regurgitated or comes back into the mouth during induction of anesthesia, and aspirated in the lungs, that is by itself a disaster.

Q. So if I understand you correctly, because of the full stomach, there is a requirement that the anesthetic agent has to be rather rapidly delivered to prevent regurgitation or vomiting during the

inducement process?

A. Right.

Q. The anesthesiologist would be denied the opportunity to feed this slowly enough to be able to catch a catastrophic drop in blood pressure in a timely fashion before the patient bottomed out, so to speak?

A. Yes, that would be a fair statement, yes.

Q. And we know that that is the way the anesthetic agent must be delivered, because of this issue of regurgitation or vomiting during the inducement; is that a fair statement?

A. Yes, both induction agents here, the thiopental, or the Sodium Pentothal -- it is the same thing -- and the Succinylcholine, are often given simultaneously to have a joint effect, so at the moment the patient becomes unconscious, he is also relaxed, that intubation can proceed immediately.

Q. Now, would you agree with me that because of the necessity for rapid induction through the use of Sodium Pentathol or any other drug which may bring on a rapid drop in the blood pressure, it would be important to eliminate as much as possible any outside factors that are interplaying with this

rapid induction of anesthesia that can bring on this sudden drop in blood pressure?

A. I agree.

Q. So it would be necessary to make some kind of assessment as to the degree and extent of hypovolemia in the patient, would it not?

A. Yes.

Q. And in your reading of Dr. Siefert's deposition, did you come to the conclusion that he did try to make some kind of assessment as to the degree of dehydration or the degree of hypovolemia that this man was suffering from at the time he saw him, and at the time that he was going to be inducing the anesthesia?

A. From what I recall from Dr. Siefert's deposition -- it should be in there -- he spoke about the turgor, which is the -- how should I say it -- the elasticity of the skin.

But I assume, although it is not quite clear that they try to -- and I say "they", now, the nursing, the surgical team tried to insert a Foley catheter prior to surgery, I presume, and they couldn't get a Foley catheter in, so that could have been a source of evaluating if there was urine output, which then could have told whether or not

the kidneys were functioning and eliminating extra fluid.

Q. Are you under the impression that someone did try to put in a Foley catheter prior to the induction of the anesthesia?

A. Well, I think I may, because there is in the records somewhere a phrase, a sentence written by Dr. Chen, and that sentence was written before the final preoperative evaluation. So if one assumes the sequence of notes reported in the progress report, I could have the impression that yes, someone tried.

Q. Would you agree with me that it is important, as an aid in attempting to determine the fluid status of the patient, to try to obtain some I & O information on the patient to aid the physicians, both the surgeon and the anesthesiologist, in determining the fluid status of the patient?

A. Again, I would put it this way: If one had the impression that -- I will put it differently.

The introduction of a Foley catheter itself may be fraught with complications and dangers, complications being bleeding, infection. So it is not a fact of saying, I am going to just put a Foley catheter in. Some people with Foley catheters have

been -- have, secondary to that, a chronic bladder infection, and they have to live with this for the rest of their life.

So again, it must be a balance made between Foley catheter versus none.

A. All right.

MR. GROEDEL: Just let him finish, he is almost done.

Go ahead, Doctor.

Q. (Continuing) I understand what you are saying, and let me just follow up with this:

In a situation where the hydration level or the question of hypovolemia or dehydration due to A, not eating and drinking; B, vomiting; C, third spacing of fluids through a perforated viscus over a period of days, is at issue, in weighing the pros and the cons of having a means of monitoring and checking fluid status, in such a case, one would conclude, in the absence of any other means available for measuring the fluid status, that the insertion of a Foley catheter would presumably outweigh these risks for the insertion of a Foley catheter, would they not?

A. Yes, if there were no other ways to be sure that the treatment was improving the condition of

the patient, yes, I agree, an attempt should be made to do that.

Q. And there are other ways, also, that are available to physicians to determine the fluid status of the patient, other than I & O records obtained through a Foley catheter, are there not?

A. Yes.

Q. And by that I mean the CVP lines and the Swan-Ganz catheter?

A. Right.

Q. And either one of those two methods were available to the surgeon and any other treating physician in this case to attempt to aid them in making an assessment of the fluid level: is that not true?

A. Yes.

Q. And again, I suppose, as you mentioned with the Foley catheter, everything has some risk at the time of insertion, or caused by the insertion, but again, in weighing the pros and cons, you could conclude that it is important in this particular patient, or a particular patient, to have that information available, and you would go ahead and do those procedures, one or the other, that is the CVP line or the Swan-Ganz?

MR. GROEDEL: Objection.

I mean, are you asking him specifically in this case whether or not --

MR. ELLERIN: No, I said a patient.

MR. GROEDEL: Objection, but go ahead, you can answer.

Q. (Continuing) As a means of obtaining that information.

A. That means is certainly available. Whether I should use it or not, that is open to my clinical interpretation of the condition of the patient.

Q. That is right.

In other words, if you had some concern that this patient was hypovolemic, in that kind of a situation, you might -- not might -- but you would want to either do a CVP or Swan-Ganz, would you not, if you are going to be -- if you are asked to go ahead with the anesthesia now?

A. If I were absolutely certain the patient was hypovolemic, that there were clinical signs that pointed towards that, and not only history, then yes, I would seriously consider using those means.

Q. Okay.

A. And we do it very often.

Q. Now, before we were talking about the -- when

we were talking about the anesthesia, and the use of Sodium Pentathol, we were talking about the degree of hypovolemia as it relates to the degree or extent that the blood pressure could drop through the use of the Sodium Pentathol; do you remember our discussion on that?

A. Yes, I do.

Q. What, in your mind is -- we are here talking about a hypovolemic condition.

What, in your mind, would you consider a hypovolemic condition in Mr. Patel? By that I mean, are you talking one liter deficient, two liters, three liters, four liters? How would you classify hypovolemia in a case such as Mr. Patel, with a perforated viscus?

MR. GROEDEL: Objection.

Are you asking him in retrospect how hypovolemic he believes Mr. Patel was prior to surgery; is that what you are asking?

MR. ELLERIN: Yes.

MR. GRQEDEL: Okay.

A. Let me answer the best I can.

Mr. Patel had been sick, some people in the record say two days, others three days., pain., vomiting, no diarrhea. Intake is not known, except

that from a nursing note in the morning, it said that he had had some intake. Whether he had intake the day prior to, I do not know.

So I would say this, that for the days before, prior to his admission in the ER, I cannot assume that Mr. Patel had been completely without any fluids. The fluid intake of a patient is -- requirements are about two to two and a half liters a day, I suppose. Urine output of Mr. Patel the day prior to admission is not known, he does not know, he doesn't remember.

Q. Was he asked?

A. I do not know. I suppose one asked him, but it is not stated, as far as I know, that Mr. Patel denied having gone to the bathroom.

Q. The record is totally silent on that subject; is that correct?

A. It is silent.

Q. It is silent from the standpoint of anybody asking him or he volunteering any information on that subject; is that correct?

A. Well, we do not know.

Q. There is nothing on the subject recorded in the chart, as you see it?

A. Yes.

Q. Okay.

A. So now Mr. Patel was admitted in the ER, he was given promptly fluids, and when I read the deposition, what I could assume from the records was that Mr. Patel received between two to three liters of fluids in the interim period between admission in the ER to the moment surgery started,

Dr. Siefert, in his deposition, says that that also was his impression, two, three liters, he says.

He says that prior to starting anesthesia, he started a new "bag", and that since anesthesia starts, he knows about hypovolemia, and thiopental, and the rate at which the -- I am sorry -- the fluids that had gone in were fast, which is quite appropriate.

Dr. Siefert, to some extent, bases his assumption of fluid replacement, one, I suppose, on the records of the emergency room; two, probably on talking to the surgical team, asking how much fluids the patient received.

In his preoperative assessment, which is important, he notes that there was a drop in hemoglobin and hematocrit over the time between admission and the moment he saw the patient in the

preoperative visit, which must have been, as I can recall from the timing, between 3:30 -- well, probably 3:30 and 3:45, something like that.

From calculations I made, and I suppose that if those values are correct, that the circulating volume of Mr. Patel had increased by about 700, 800 ccs, which is the circulating volume.

From there, I deduct that if that is the case, and since electrolyte solutions do not remain very long in circulation, they go to the tissues, that Mr. Patel must have received, give and take, between two and three liters at the moment that hemoglobin value came back.

Q. What you were trying to do is determine by what degree or extent his hemodynamic fluid balance improved from the moment of his arrival in the emergency room until the time that the anesthesia was induced?

A. Yes.

Q. Forget about that for a moment.

Just from your knowledge of the condition that the patient had, perforated viscus, the vomiting, things that you know as far as the ability or appetite of a person to eat and drink with this kind of condition, when he came into the emergency

room, if you had to put a number on his volume depletion at that time, and forget about the correction that took place afterwards through the use of IVs, et cetera, how much fluid depletion do you think he had? That is what I meant about how hypovolemic he was.

A. As I mentioned to you, I do not know what Mr. Patel's intake was over the last two days.

Q. I want you to assume that if asked, he would have been -- the physician would have been told, he nadn't been eating.

A. Well, I would say he probably was behind at least two or three liters, at least, the low end. Maybe three, four, would be a better assumption, I presume.

Q. Okay.

A. Again, here, we have no -- this is just a guess that you are asking me now.

Q. There have been, as you may or may not know, a number of doctors who have reviewed this case, and basically given their impression as to the degree or extent of hypovolemia at the moment he came into the emergency room, and I believe it ranges from four to seven liters.

Would their estimates be as valid as your

estimate?

MR. **GROEDEL:** Objection.

Go ahead.

A. Well, I would like to answer it in this way:

From the reports I have read, I am the only one who is mentioning that Mr. Patel had anything to eat or drink in the morning prior to his admission, so all the people that have made the reports either did not see, did not peruse through this stack of papers very well and just didn't see the report of the nurse in that regard, or they thought it was irrelevant.

Q. Or so minimal as to not change the overall picture; is that a fair statement?

A. Yes.

Q. Now --

A. Now, I have noticed this, I marked it in my report, and from this I do deduct that perhaps Mr. Patel had had some intake, besides vomiting, I agree.

Q. Did you attempt to quantitate how much intake he would have had in the morning?

A. No.

Q. When we say someone is, for example, five liters depleted, and hypovolemic to that extent,

assume I am five liters depleted right now, and I take a glass of water and drink that, am I still five liters depleted, or an I five liters depleted minus eight ounces of water?

A. Well, that depends if you resorb the glass of water, if the glass of water stays in the stomach. And if you vomited, no. If the glass of water you drink goes right away to the smaller cavity of the stomach and bowel, and passes, and dissolved in the intestine, then sooner or later you will have the benefit of having the glass of water.

Q. And is it a one to one reduction?

In other words, when we talk of a liter, we are talking a thousand ccs; is that correct?

A. Yes.

Q. In an eight ounce glass of water, how many ccs are there, roughly?

A. Frankly, you have to tell me how many ccs in an ounce.

MRS. CHAVERS: Thirty.

A. (Continuing) 250 ccs.

Q. 250 ccs.

If I get the full benefit of drinking 250 ccs of a glass of water, and I had previously been 5,000 ccs depleted, will I then be 4,750 ccs depleted?

A. No, I do not think so, I do not think that -- it depends again on the timing, how much you do resorb, the condition of the intestine, if the mucosa can resorb the water, yes or no, if there is any inflammation.

And besides that, I am not a gastroenterologist, so I have a hard time answering the question.

Q. What you are saying, though, is that I won't necessarily pick up or reduce my fluid deficiency by 250 ccs simply because I drank a 250 cc cup of water?

A. Not necessarily, but you may.

Q. Okay.

A. What I was trying to say in this, I am not trying to minimize the fact that Mr. Patel was hypovolemic and was dehydrated, there is no question in my mind about that. The only question is, that I wanted to make and put in my report, was the degree. Dr. Stirt calls it severe, I suppose I use the word moderate, and between that, there are ranges that one -- and just possibilities that one can say, well --

Q. I understand.

But am I correct that to the extent that you

attempted to reconstruct the volume of fluid that he received IV once he got into the hospital, you attempted to reduce the quantity or degree -- the quantity of fluid deficiency that this man had by the amount of fluids he got IV in the hospital?

A. Yes.

Q. So that is an important consideration in your making the determination as to the degree and extent of hypovolemia of this patient at the moment that the anesthesia was administered?

A. Yes.

Q. And for that, you looked at Dr. Siefert's deposition, and I presume you also looked at the hospital chart, to try to, in your own mind, determine to what extent has this patient been rehydrated before the anesthesia was administered?

A. That is correct.

Q. You came upon a number of things in the chart that you used in coming up with your understanding as to the degree and extent of rehydration; is that correct?

A. Yes.

Q. One of the things that you used were the hematocrit and hemoglobin readings that are recorded on the preanesthesia record; is that correct?

A. That is correct, yes.

MR. ELLERIN: And I think we have that sheet here.

(Thereupon, Plaintiffs' Exhibit 1 (Dauchot) was marked for identification.)

(Short recess had.)

BY MR. ELLERIN:

Q. Doctor, 1 an going to hand you what has been marked as Plaintiffs' Deposition Exhibit 1, Dauchot deposition, and I believe in your report you made use of the hematocrit and hemoglobin values that are written on that report, did you not?

A. Yes.

Q. And I take it from your interpretation of Plaintiffs' Exhibit 1, you concluded that this man had originally a hernoglobin value of 17 and a hematocrit value of 51, and that later, but sometime prior to the induction of the anesthesia, those values dropped to 13.6 for the hemoglobin and 42.7 for the hematocrit; is that correct?

A. That is correct, yes.

Q. Were you able to find, either before you made your report, or up to this point, any documentation in the chart for the lab values 13.6 hemoglobin and 142.7 hematocrit? And by that I mean, any recordings

of these lab values in the lab reports themselves?

A. No. However -- and I want to show this to you, because from the copies I got, I got something close to it, although the timing is off, and it may have been 16 or 18, I got this here, and to the extent that in my copy this is 18, then it is 18. Initially, it could have been 16, although the timing, 4:42 in the morning, was completely off.

Now, I just want to tell you that these values, although not exactly the same, come close to what was mentioned here.

Q. Let us mark this sheet from our record, and make that an exhibit, Doctor.

Just a moment, please.

A. I put down, probably 7-18, but I cannot tell for sure from the copy I have got here, if this is 7-16.

Q. Could you open your notebook for a moment?

A. Oh, yes.

Q. Actually, let us mark this one as an exhibit.

A. You can have it, if you want to.

(Thereupon, Plaintiffs' Exhibit 2 (Dauchot) was marked for identification.)

BY MR. ELLERIM:

Q. Doctor, you have just been referring -- in

answer to my last question, you have been referring to flow sheet page 30 in the Medina Hospital chart, which we have taken out of your notebook, and marked as Plaintiffs' Exhibit 2.

A. Right.

Q. And you are referring to the column of date and time and numbers for hemoglobin and hematocrit that appear at the left side of the page; is that correct?

A. That is correct.

Q. And you have written above the date of 7-16 or 18, probably 7-18; is that correct?

A. That is correct.

Q. And when did you write the language, probably 7-18, on that sheet?

A. Exact recollection, I do not have.

Q. Well, let me ask you this:

Would it have been before you wrote your report?

A. I think that at that moment, I may have noticed it, yes.

Q. And wrote, probably 7-18, over the date, 7-18?

A. Right.

Q. And you have not seen the original chart?

A. No.
Q. And therefore you don't know how well the date, seven one six or one eight appears on that original chart: is that correct?
A. Right.
Q. I want you to assume for a moment on the original chart it is 7-18, and not 7-16.
Did you find any other areas or any other pages in the hospital chart that document the 13.6 and the 42.7 as shown on Plaintiffs' Exhibit 1?
A. No, I didn't.
Q. But it was based on these values for hematocrit and hemoglobin as reflected on Exhibit 1 that you made your calculations from and came up to the conclusion that this man's circulating volume had increased by 800 ccs?
MR. GROEDEL: Objection.
A. Yes.
MR. GROEDEL: I am not sure he understood that, but go ahead, ask it again.
Q. Well, did you understand my question?
A. Well, the question was that it was based on these values that I saw here (indicating).
MR. GROEDEL: Okay. I thought you were referring to Exhibit 2.

MR. ELLERIN: No, on Exhibit 1.

MR. GROEDEL: Okay, I've got you.

A. (Continuing) I did make some calculations, some estimates.

Q. You made calculations or estimates as to his increase in circulating volume, which you said in your report you estimated at 800, and you base that on what are the recorded numbers for hematocrit and hemoglobin on Plaintiffs' Exhibit 1?

A. That is correct.

Q. And based on those numbers for hemoglobin and hematocrit, you attempted to calculate how much fluid intake he had gotten in the hospital from the time that the first blood was drawn, and the hematocrit and hemoglobin values were obtained from that, until whatever time this second drawing was; is that correct?

A. That is correct.

Q. And by second drawing, I mean the drawing that would have resulted in the numbers of 13.6 hemoglobin and 42.7 hematocrit.

A. Right.

Q. And by the drop in those numbers, that would be called hemodilution?

A. Yes, one could use that term, yes.

Q. Okay.

You came up with, that you believed he might have gotten between 2,000 and **3,000** ccs of fluids between the times that those two blood samples were drawn?

A. That is correct.

Q. Did you make any other calculations with respect to how much fluid intake the man had following the hypotensive event in the surgery, and the next time that hematocrit and hemoglobin are documented?

A. Could you rephrase the question?

Q. All right, well, let me withdraw it. It got pretty burdensome there.

We know that he got a substantial amount of fluid after he became hypotensive in the operating room, do we not?

A. Yes, that is correct.

MR. ELLERIM: Mark this as Plaintiffs' Exhibit *3*.

(Thereupon, Plaintiffs' Exhibit *3* (Dauchot) was marked for identification.)

BY MR. ELLERIN:

Q. If we mark as Plaintiffs' Exhibit 3 the anesthesia sheet for the July 16th operative room

record of anesthesia, we see in the lower right-hand corner the fluids that this man received in the operating room; is that correct?

A. That is correct.

If I may say something, this first value here, to me, is not quite clear, because the other ones I can readily decipher.

Q. By first value, you are talking about the one that is numbered 1, D5LR?

A. Yes.

Q. And a bag is a thousand ccs, is it not? I mean, that is the size it comes in?

A. Well, they also come in sizes of quarter liters and half liters, some. I assume that they all used here the standard thousand ccs. That is my assumption, That is what is used normally.

Q. What interpretation, if any, do you make of the number that is opposite the number 1 D5LR?

A. I see here, 100. This here, this little open parentheses, I am at a loss, I cannot -- whether this belongs to the rest here. So that is why I am only questioning what this could be.

Q. All right.

A. I make it 100, but it may also be more, I do not know.

Q. It could be 1,000, could it not?
A. I suppose, yes.
Q. And the second line with the 2 D5LR would represent, would it not -- with the number 900 after it?
A. 950 -- 900, yes, for sure 900, yes,
&- __ would represent what fluid was absorbed from the second bag, would it not?
A. Yes.
Q. And what does the third line state, where the number 3 is circled (indicating)?
A. Well, this is D5, and the rest -- it may also be --
Q. Lactated Ringer's?
A. It may also be, I suppose, and 100 ccs.
Q. The handwriting leaves something to be desired; am I correct?
A. Definitely.
Q. And the fourth line, can you read that, where the 4 is circled?
A. Yes, I think it is .9 normal saline, I suppose that is what I would construe from it,
Q. And that would have been fed through the CVP, would it not?
A. Well, they prepared this to keep the CVP line

open, and I would assume that is what it is.

Q. So if we assume that in the operating room, line number 1, D5LR, is a full bag of a thousand, and the second one is 900, and the third one is a hundred, and the fourth of .9 normal saline is 50, we have **2,050** total volume intake?

A. That is correct. However, if this is only 100, then it drops to 1,100.

Q. **1,100?**

A. Yes.

MR. **REICHEL:** I think, to be fair to the doctor, you should indicate one witness indicated the first line, they thought, was 1,800, and the second line was 980.

A. (Continuing) I do not know. I have no knowledge of this. I only can look at the documents that I received, and make the best out of it.

Q. Doctor, let me say this:

Do you not agree, though, that if you are going to group your D5LR, you would just have one line with the total of **D5LR,** you would not have **two** lines, one with 1,800, and another one with 900, and 910; is it not more likely that we are listing quantities consumed or absorbed per bag on these four items?

MR. GROEDEL: Objection.

Go ahead.

A. Well, if that were true, then that would also apply to the emergency room fluids, wouldn't it, where they list 2,500, or 2,200, or even 3,000 ccs, where the bags have been changed all the time.

Q. But in the emergency room, we have recordings as to how much was absorbed, and we have a nurse's testimony as to the amount absorbed from each bag before the bag was discontinued?

A. Well, I am not aware of the nurse's --

Q. I understand you are not aware of it, because you haven't seen the nurse's deposition.

A. I can only, if I may say, give you my opinion on the documents that I did receive.

And if I may say something more, I can only say that what I thought from the record that Mr. Patel received came pretty close to my assessment, based on hemoglobin, of what he actually should have received.

So those two numbers, the emergency room recordings and what I thought from the hemoglobin, well, it makes sense to me.

Q. I understand, I understand that you had nothing in front of you, other than the chart, as

written, and admittedly some of the handwritings in there are poor, and it is difficult to decipher some of the numbers.

A. They surely are, it is a fact.

Q. I mean, everybody is in agreement on that, correct?

A. Yes.

Q. Or you and I are in agreement?

A. Yes.

Q. Using whatever number you wish -- Mr. Reichel suggested that one witness testified that the number 1 in a circle, D5LR, was 1,800, and he is correct, one witness thought that that might be 1,800, and that the second line might be 950, or 980 -- he got a fairly good volume after the hypotensive event in the operating room, did he not?

A. Yes, but I want to point out that in Dr. Siefert's deposition, he mentioned that he gave also a fairly good fluid push before induction, but from what I can reconstruct from his deposition, he said the patient got about -- that he changed the bag before, outside the operating room, he changed a bag, whatever bag we are talking about.

Q. What happened to the fluid that was in the bag that he came down with?

A. Was it out? Was it almost out?
Q. Well, the record shows that the third bag of fluid was under orders of Dr. Chen to run for one hour at 300 ccs, and then be reduced to 120, and that it ran for approximately two hours, and then he was brought to surgery, and the nurses indicate that they reduced the rate.

So that would it be fair to say that more than one half of that bag was still unconsumed at the time he went to surgery, I mean, assuming that the nurses' recordings as to the flow and when they cut back on the rate are accurate?
A. Well, I would like to -- well, to ask, because all this fluid management situation is -- well, was very complicated to me, it was to Dr. Stirt, it is in his deposition, until Miss Cook testified, and things became more clear also to Dr. Stirt, and he even reduced his estimate of fluids given by --
Q. Doctor, I want you to understand, I am not faulting you for your original assessment in your report, you did that based on numbers that you had in front of you on the chart, or your interpretation of numbers you had in front of you.
A. Right.

Q. And everyone has had this problem of trying to determine what these amounts were, by trying to read back into a chart now. You weren't there at the time of the treatment of the patient, we all understand that, and neither were any of the other doctors that have come forward as experts in this case.

But all I am trying to establish at this point is that from the time of what would have been the second reading for hemoglobin and hematocrit, and that was before these fluids were administered --

A. Absolutely.

Q. __ a substantial amount of fluids came in, or were absorbed by this patient?

A. Yes.

Q. And then we have a third reading of hematocrit and hemoglobin, do we not, at a later time, as exhibited on a lab value? And I want to mark this as Exhibit Number 4.

(Thereupon, Plaintiffs' Exhibit 4 (Dauchot) was marked for identification.)

Q. (Continuing) I am going to hand you, Doctor, a lab sheet marked page number six, Result Summary, which we have marked as Exhibit 4, and it shows at

the top of the page that in the ICC, after Mr. Patel had been returned there from the operating room, on the 16th, they drew blood at **1923,** which would be **7:23** p.m.; is that correct?

A. Yes.

Q. And from that blood sample we have hematocrit and hemoglobin readings recorded, do we not?

A. That is correct.

Q. And am I correct that the hemoglobin reading is 15.6, and the hematocrit is 45.6?

A. That is correct.

Q. Mow, for the moment, Doctor, if we look at the original values of hemoglobin and hematocrit that are reflected in the preanesthesia record of hemoglobin **17** and hematocrit **51** --

A. Right.

Q. -- and we know that quite a bit of fluid was ultimately given in the operating room, after the recording of the second set of hemoglobin and hematocrit values by Dr. Siefert --

A. Right.

Q. -- we wind up with hematocrit and hemoglobin values on blood drawn at **7:23** p.m. of even being of higher concentration than Dr. Siefert's second set of recorded values on his preanesthesia record?

A. That is true. Those are the numbers.
Q. Now, for the moment, if we were to eliminate or forget about the second set of hemoglobin and hematocrit values as recorded on Exhibit 1, and just go with the original values of hemoglobin, 17, hematocrit, 51, and then pick up with the values on Exhibit 4 of 15.6 for hemoglobin, 45.6 for hematocrit --
A. Yes.
Q. -- just using those two sets of values, do you find that the drop in hemo concentration of the hemoglobin and hematocrit is consistent with the added volume of fluids that Mr. Patel had in the operating room, and from the time he first came into the hospital until the time the second blood samples were drawn at 7:23?
A. It could certainly represent or reflect the volumes or the volume he received from his admission in the emergency room to this point in time.
Q. Okay.
A. Although if I may comment on this, it would represent the balance between the administration of the fluids and the third spacing, because --
Q. He continued to third space?
A. Right.

Q. Yes.

A. But I would say this, and just in a hypothetical situation, if one started to third space much more, then -- or third spacing at the rate higher than the rate of administration of fluids, a patient's hemoglobin could certainly not drop that much, as one would anticipate from the fluids given.

But this is a hypothetical situation that I have never tried to solve, but from a purely theoretical standpoint, they are two processes going on: One is the administration of fluids; the other one is, where do the fluids go once they are in the body?

And we assume, or you may assume that the situation of resorption of fluids out of the extravascular space -- out of the vascular space to the extravascular space may have changed. It may have worsened as time goes by. And I am not qualified to answer that question.

Q. But the numbers that are reflected in Plaintiffs' Exhibit 4 for hematocrit and hemoglobin, when it is considered with the amount of fluids that Dr. Siefert records on his anesthesia record, Exhibit Number 3, would indicate that the drop in

hemo concentration is based in a large part on the fluids obtained in the operating room?

A. Right.

But if I may say one more thing here, if we assume now that Dr. Siefert's values were correct --

Q. You are speaking about the values on the preanesthesia record?

A. Exactly,

Q. Plaintiffs' Exhibit 1.

A. These two, one would have some sort of a paradoxical situation where large amounts of fluids had been given intraoperatively, yet the hemo concentration had worsened, as compared to the second values that Dr. Siefert reports there.

Q. Despite being given all the fluids?

A. Despite.

And as a hypothetical answer to this, I mentioned to you the balance between giving the fluids and what happens in the body, the disposal of those fluids once they are in.

Q. But you have no evidence that he perforated more, is that correct, or greater?

A. No, I do not think personally -- it is my opinion as an anesthesiologist -- that this has anything to do with the size of the hole in the

duodenum here. If the peritoneum, the inflammation of the peritoneum is increasing over time, as it may well be, because that is the reason of the urgency . to prevent this, then large quantities of fluid will be resorbed and go inside to the intraperitoneal.

Q. And then if we carry it further, and apply it to later hemoglobin and hematocrit values, the same thing should hold up, should it not?

A. Yes ,

Q. And I don't want to take the time to do it here on these values, and you haven't had the opportunity to do that, either, to verify this hypothesis that you have just suggested?

A, Not at all, no,

Q. And am I correct that when you wrote your report, you went simply on the two sets of values recorded by Dr. Siefert on Plaintiffs' Exhibit 1?

A. Exactly.

Q. You have had the opportunity to read Dr. Stirt's deposition, have you not?

A, Yes.

Q. And Dr. Stirt raises in his deposition the issue that he did not find in his copy of the chart any documentation in the laboratory reports for the values recorded by Dr. Siefert as the second set of

hemoglobin - hematocrit values; is that correct?

A. That is correct.

Q. And you could not find that in your chart, either, once you set about looking for it?

A. For the exact numbers, as written down there (indicating), no.

Q. As written on Exhibit 1, you could not find it anywhere in the chart?

A. No, I could not.

Q. You saw some concern raised by Dr. Stirt in his deposition that this man who he says was hypovolemic, because of all of the conditions that you have mentioned, and what he feels was the limited amount of fluid that the man received once admitted to the hospital, he felt that it would be below the standard of care for an anesthesiologist to take this man to the operating room and administer anesthesia when he had only one 20 gauge IV needle on the top side of the left hand.

Do you have an opinion as to whether, if the man were hypovolemic by four, perhaps five liters of fluid when he came to the hospital, that his administration of fluids for rehydration purposes, as opposed to simply feeding medicines through, could have and should have been managed through one 20

gauge IV needle in the top of his hand, when you are getting him prepared for surgery?

MR. GROEDZL: Objection,

You are assuming that the doctors knew at that time he was four to five liters dehydrated?

MR. ELLERIN: That they knew the condition that he had, and had available to them, if they chose to ask, the amount of food that he had.

MR. GROEDEL: Okay. Go ahead.

A. I will give you a theoretical answer and a practical one.

The theoretical comes from a discussion we had in the past about liver transplantations and how much fluid can go through a 20 gauge angiocath. As it turns out, if one raises a bag, one liter bag of saline about fifteen -- a meter and a half, so let us say it is three yards, four yards, above the patient's level, one can infuse optimally 60 ccs of crystalloids, fluid, a minute.

Q. So what you are saying is that a significant amount of fluid can be fed through a 20 gauge needle?

A. Can be given through a 20 gauge.

Q. Would you take a man into an operating room with only that IV line, and administer anesthesia to him under the facts and circumstances of this case, where he has a known perforated viscus with limited food intake, limited liquid intake, and a history of vomiting?

MR. GROEDEL: Objection.

You mean this doctor, personally?

MR. ELLERIN: Yes.

MR. GROEDEL: Objection.

Go ahead, you can answer that.

A. Well, that was going to be the practical answer to it. If, clinically, I was under the impression that someone was severely dehydrated, no, I would not.

However, if I was under the impression that a patient had already received through that same 20 gauge angiocath two or three liters of fluid, and if the venous access was difficult for a given patient, what we certainly could consider is to start a cautious induction of anesthesia through the 20 gauge, and immediately, when the patient is asleep, change it to a larger size.

Because these situations arise occasionally, and it becomes again a question of clinical

judgment, and of -- well, how much this and how much that?

Q. Of course, if you had a CVP line or a Swan-Ganz in the patient before he was taken to surgery, you would have that route available not only for monitoring the hemodynamics of the patient, but also to feed fluid to the patient, would you not?

A. Well, it depends on the size of the central venous catheter. Some central venous catheters are 20 gauge, exactly as an angiocath.

Q. But it would be a second route?

A. Yes, no question about that. The Swan-Ganz catheters are usually inserted with a large gauge or large bore introductor, and yes, large quantities of fluid can be given through the Swan-Ganz catheter, through the cordis, as we say.

Q. And given quickly, as far as the size goes?

A. Yes, no question about that.

Q. Now, I want to talk to you about the fluid balances that you mention on page eight of your report.

(Thereupon, Plaintiffs' Exhibit 5 (Dauchot) was marked for identification.)

MR. REICHEL: What are you marking

now?

MR. ELLERIN: I am marking as Exhibit 5 the graphic chart and nurses notes.

BY MR. ELLERIM:

Q. Doctor, on page eight of your report, and I suppose I should read that short paragraph into the record, "Of note is that the first fluid balance of Mr. Patel's hospitalization was positive (532 cc intake versus 452 cc output, see graphic chart and nurses notes of 7-16). This is in contradistinction with the statement of Dr. Stirt on page four, paragraph one of his report which documents a negative fluid balance."

Have I read your report correctly, Doctor?

A. Yes.

Q. Would you turn to that chart, the graphic chart and nurses notes that you cite in your report, Doctor?

A. Yes.

Q. First of all, you record an output of 452 ccs; is that correct?

A. Yes, and I refer to the output mentioned here, 452.

Q. Yes.

And that is for an eight hour shift of

apparently 4:00 p.m. to 12:00 p.m. -- or wait -- perhaps 11:00, 3:00 p.m. to 11:00 p.m. shift; is that correct?

A. I would think so, yes.

Q. Yes.

And it shows urine, 302 ccs, in Levine tube, 150 ccs?

A. Yes, that is correct.

Q. For a total fluid output of 452; is that correct?

A. That is correct,

Q. And that is what you are commenting upon when you are talking about output; is that correct?

A. Yes.

Q. And in commenting on intake, you use the number, 532 cc intake. And where did you get that?

A. I got it from IV, 532. It says intake, eight hour, oral, and apparently this means nothing, I would presume, and then IV 532.

Q. Well, I think it is npo above the 532, meaning nothing by mouth, obviously, Doctor?

A. Yes,

Q. And then by IV, 532, for a total of 532?

A. Yes, that is where the numbers come that I mention here.

Q. All right.

And here we are talking about IV fluid that the man received back in the intensive care unit, are we not, after he is taken there from the operating room where he had this hypotensive event and was given the fluids in the operating room?

A. Right.

Q. So if we balance just those two items from the time he came -- or the intake from the time he came back to the ICU unit to the end of the 11:00 p.m. shift, we see an intake by IV of 532; is that correct?

A. Yes.

Q. And we see that by 11:00 o'clock that evening, through measurements done in ICU, both through the Foley catheter and through the Levine tube, that we have the output of 452?

A. Right.

Q. You are aware, are you not, that the catheter was put in in the operating room by a Dr. Slaby --

A. Yes.

Q. -- after the hypotensive event?

A. Yes.

Q. And that whatever fluids came through that Foley catheter and went into a bag was taken up to

ICU?

A. No, I am not aware of that.

Q. All right,

Did you see any records where any fluid was emptied or measured in the operating room?

MR. GROEDEL: From the record?

MR. ELLERIN: From the record.

A. No, I have no evidence of that.

Q. If we assume for a moment that all of the fluids that were absorbed -- well, for that matter, all of the fluids that were absorbed IV-wise from the moment he came into the hospital through 11:00 p.m. on the 16th represents the total fluid intake of the patient?

A. Yes.

Q. And if we assume that the total output of the patient is 452, to 11:00 p.m. --

A. Yes.

Q. -- then under those circumstances, and under the assumptions that I have just stated, the man would have a negative fluid balance, would he not?

A. I cannot follow you.

If we increase the input and leave the output as such, his balance would even be more positive.

You see, if you go to the next line --

Q. Well, what I am getting at, there would have been a whole lot more fluids going into the man than is represented by the 452 ccs of fluids coming out of the man?

A. Oh, yes, because that would have been probably depending -- two liters in the OR, assuming, and I assume two liters in the interim, would give him an input of 4,500, versus an output of 450, a positive balance of 4,000.

Q. All right.

A. My point was here to say that Dr. Stirt says that there is a negative fluid balance, which I do not recognize, looking at the numbers.

Q. By negative -- let us assume for a moment that when he says there is a negative fluid balance, he is meaning that there is substantially more fluid going in by IV than is coming out by Foley.

MR. GROEDEL: Just assume that that is what he meant, okay?

Q. (Continuing) Would you agree that that is a correct statement?

A. Could you rephrase your question?

Q. All right.

I mean, the man is getting -- has gotten, since he came into the hospital, until 11:00 p.m.,

he has taken in much more fluid --

A. Yes.

Q. __ than is represented by the output of 452?

A. Right.

Q. How do you explain the difference in the quantity of fluid that the man absorbed through IV from the time he came into the hospital until 11:00 p.m., in light of only an output of 452?

A. Well, the fluids leave the vascular space and they go to the intracellular space, or intravascular space, so this may be a third spacing, or just a movement of fluids across membranes.

So fluids leave the vascular compartments, go to the extravascular, and at the kidney level, they come back, and they are eliminated.

Q. Would they also represent the fact that the person was hypovolemic when the fluid started, the IV fluid started?

A. Well, to some extent, yes, because if the output was nothing, then one has to assume that the patient is absorbing all the fluids, and is not eliminating anything, so he needs the fluids that he received. Assuming that his kidneys are otherwise functioning normally, and there is no anatomical or disease process that prevents his kidneys to

eliminate any surplus.

Q. Do you have any knowledge or information that this man, even as of today, has any kidney malfunction?

A. I have no absolute indication of it. All I can say is from looking at the patient itself, I mean, on the record, on the values, his BUR was elevated on admission.

Q. Could that be due to hypovolemia?

A. Oh, yes, it is called the prerenal condition. His creatinine was elevated, that also could reflect hypovolemia, and even -- well, clinically speaking, it is the ratio of the BUM divided by the plasma creatinine that may give an indication if the patient had so-called a prerenal azotemia.

Q. Well, I want you to assume for the purpose of my question that this man has no kidney problems today, and has had no surgery, or is not under any treatment for a kidney condition.

Based on these numbers that you have just given for the BUN and the creatinine, and knowing what we know about the original hemoglobin and hematocrit, aren't those all consistent with a patient who comes to the hospital in a hypovolemic state?

A. They reflect to some degree a hypovolemic state, yes.

Q. And the degree and extent of hypovolemia is something that both the surgeon and the anesthesiologist should attempt to quantitate in their care and management of the patient?

A. Yes.

Q. If Dr. Siefert was at all in doubt when he was looking at the original chart which he had, that existed at the time he prepared the preanesthesia report, if he were at all in doubt about the recordings, or any of the readings, or was unsure as to what a nurse wrote, or a doctor thought in the emergency room, is it incumbent upon him to pick up the phone and try to determine these actual volumes of absorption that took place prior to his getting involved in the case?

A. Well, he should certainly inquire and double check, I assume. The question is, to what extent?

I mentioned to you earlier that there is a chain of treatment going from the ER, over to the nursing division, to the operating room.

Dr. Siefert came in rather late, he did a brief evaluation of the patient. As he mentioned in his deposition, he says the patient received two to

three liters of fluid, that was what he assumed from the records, maybe he gave a call to find out what was given, maybe someone told him that it was something like that.

When I looked to the records, I had the impression that he had received two to three liters.

Q. All right.

MR, GRQEDEL: Let him finish.

A, The hematocrit, whatever -- I do not know from where the values come, but they are from Dr. Siefert's preoperative anesthesia record, reinforced to him the idea that yes, the patient had received a decent amount of fluids, maybe not precisely what one should wish the patient had received, or should receive if there had been sufficient time to do so. Plus the heart rate that was 120 on admission was in the range of 80 to 88, so a clinical sign of hypovolemia had disappeared.

There was, I suppose, a slight hypothermia that occurred, which may be consistent with the administration of fluids, When we give cold fluids, patients cool off.

When the patient was -- or just before entering the operating room, the pressure was 130, I don't know the diastolic. So there are a lot of

signs, and I cannot weigh here the importance of these signs that would reinforce Dr. Siefert's idea that the patient had received between two to three liters of fluid, and it was his clinical judgment that yes, he could go ahead.

Q. And that is basically because, in your opinion, there was no accurate recording of the amount of fluids that the man in fact received?

MR. GROEDEL: Objection.

A. Well, whether Dr. Siefert went through these records with a fine tooth comb to find out exactly how much fluids the patient actually received, I do not think he had the time to do so, he just probably, and maybe wrongly so, relied on, how much fluids did you give; I gave two, three liters.

The bottom line was that he had the impression that that was the amount of fluids the patient had received, and there were some clinical signs pointing towards that.

Q. Doctor, do you know whether he, in fact, even asked anybody how much fluids this man had received?

A. I do not know.

Q. And we know that the fluids started in the emergency room; is that correct?

A. Yes.

MR. ELLERIW: Would you mark this as the next exhibit,

(Thereupon, Plaintiffs' Exhibit 6 (Dauchot) was marked for identification.)

BY MR. ELLERIN:

Q. We know, also, do we not, Doctor, that at the time Dr. Siefert became involved in the case, the first page of the record that he had or should have had available to him was the emergency room record, that would have gone with the patient, would it not?

A. Normally the sheet would be in the patient's chart.

Q. And we can tell from that record that the man had absorbed only 50 ccs from the first bottle, can we not?

A. I tell you frankly, when I looked over this, I did not make that conclusion.

Q. All right.

so --

A, To me, it was not crystal clear,

Q. All I am saying is that either the record should be written clearly enough by the hospital staff, or if the doctor is in doubt or has any doubt, he should check with the people in the emergency room who made the entries?

A. Right.
Q. Okay. I mean, either one or the other?
A. Yes.
Q. And then secondly, that first bottle was discontinued after 50 ccs absorbed, and a second solution of just lactated Ringer's was hung at 12:40 p.m.; is that correct?
A. Yes.
I say yes, but -- yes, right.
Q. And we also see that 200 ccs absorbed?
A. Right.
Q. And that is at the point in time when Dr. Chen got into the case, and he discontinued the lactated Ringer's and switched to the DRL -- D5RL, and that at the rate, based on his order, of 300 ccs for the first hour, then reduced to 120?
A. Well, I do not see that Dr. Chen was involved with this.
MR. GROEDEL: Do you want to look at the order?
MR. ELLERIN: Yes.
(Thereupon, Plaintiffs' Exhibit 7 (Dauchot) was marked for identification.)
BY MR. ELLERIN:
Q. Doctor, handing you what has been marked as

Exhibit 7, I will tell you that from previous depositions in this case, that Plaintiffs' Exhibit 7 is an order sheet prepared by Dr. Chen when he came to the emergency room and undertook the care of the patient, and changed the order of the fluids, and that this took place roughly about 2:30 p.m. on the 16th, okay?

And you can assume that the emergency room record and the order sheet record prepared these was part of the man's chart when he was taken to the floor and then taken to the operating room, all right?

And you see that on Plaintiffs' Exhibit 7, that Dr. Chen changed the order to five percent D/RL 1,000 ccs, and a nurse has written, started in ER at 2:30, or 2:36 p.m., I can't be sure of the exact time.

A. Well, I saw this, and let me comment on this order.

You say the order was changed. I do not see any change. I only see the order, five percent --

Q. Changed from Dr. Haynesworth's.

A. I do not see this, I am sorry.

Q. See, we are now on the third bottle?

A. Yes.

Q. After the absorption of 50 ccs and the absorption of the 200 ccs from the first two bottles, they then went to the third bottle, which is what Dr. Chen wanted, and that was started at 2:30 or 2:36?

A. But excuse me, all I am saying, looking objectively at this record --

Q. Yes.

A. -- I see only that someone wrote down on the third or the fifth line, 1,000 cc D/RL added, and then something, I cannot decipher.

Q. At 12:40 p.m.

MR. GROEDEL: You are looking at the wrong line, Jerry, he is not referring to that line.

A. Just following the thousand ccs, I do not know what it means.

Q. Well, I want you to assume that that one thousand D/RL added was the order of Dr. Chen started at 2:36.

A. But I have no evidence that that is so, and excuse me that I am a little bit argumentative about this thing.

What I am saying is this: Those are two separate records. The way I see it, if I may just

give you the way I see this, I see an order written by Dr. Chen, five percent DRL. It doesn't say on this order, what usually is the case, D/C LR, followed by then what should be given. It says a thousand ccs. And someone scribbled here, in a different writing, started in ER at 2:30 p.m.

Q. The nurse.

A. Well, that is what you say. I have no evidence that this is a nurse.

Q. All right.

A. I am only saying, this handwriting is different from that, and someone --

Q. By "this handwriting", you are talking about the handwriting for the order is different from the handwriting that says, started in ER, 2:36 p.m.?

A. That is correct.

Q. All right.

Well, are we clear that the order itself was written by Dr. Chen?

A. Yes, right.

Q. And that somebody who took off that order stated, started in ER at 2:36, to give you a timing on it?

A. I am in agreement with you, in your interpretation of this.

Q. All right,

So that there is certainly enough here in these two pages of the record which show by the nurses on the emergency room record the amount absorbed from the first bottle as being 500 -- 50 ccs, absorbed from the second bottle as ZOO ccs, and then we switch to the order of Dr. Chen, that the third bottle, which is now DRL -- that is dextrose Ringer's lactated solution, is it not?

A. Yes.

Q. __ to flow at the rate, based on Dr. Chen's order, of 300 ccs €or one hour, then 120 ccs per hour?

A. I agree with one exception, and I want this to be very clear, that as far as I am concerned, that there is doubt in my mind that this thousand ccs are the same as this (indicating). I can assume -- this was changed at 12:40.

MR. GROEDEL: Which line are you referring to now, Doctor?

THE WITNESS: I am referring to the third line here, at 12:40.

MR. GROEDEL: Okay.

Q. That was going from the first bottle to the second bottle?

A. Right.
Q. Okay.
A, Then 200 ccs --
Q. Was absorbed from the second bottle?
A, -- was absorbed.
And I would like just to make a hypothetical statement here. Assume that these 200 ccs were infused at the rate of 100 cc per fifteen minutes, then this bottle here, or this bag, the third one, would have been replaced at 1:00 o'clock.
Q. Doctor --
A. And then I am wondering what happened to this volume here of a thousand ccs when Dr. Chen, in his orders, just -- he states, give the five percent D5LR, and someone scribbles, it was started at 2:30.
Q. Doctor, you don't want to argue with me, I don't want to argue with you, but we have gone through many, many depositions in this case, and your scenario is not in fact what happened, okay?
And I am not saying that you are saying that that in fact is what happened. What you are saying is that to you, as an anesthesiologist, the documentation in this chart is not good enough for you, as an anesthesiologist, to pick up the chart and know what fluids this man got from the time he

came to the hospital until the time you came in to take care of him; is that a fair statement?

A. That is correct, yes, very fair.

Q. Whose responsibility is it to write these charts in such a fashion that an attending physician, in this case, an anesthesiologist coming on the case several hours later, can pick up the chart an6 figure out what this man has gotten?

I mean, he hasn't been there for weeks, he has only been there several hours, so it is not that long and complicated a history.

Whose job is it to keep these records in such a fashion that you, as an anesthesiologist, can pick it up and not have to guess, or make interpolations of what happened to the hematocrit and all of that, but can simply find out how much fluid has this man been given?

A. The one who signs the record has the responsibility for the way it is written.

Q. Now, are the nurses supposed to make their entries clear enough so that the entry can be read?

MR. GROEDEL: Objection.

Go ahead.

A. Yes.

My point is, if a doctor signed this record,

he is responsible for the way the nurses enter -- well, write the entries.

Q. Well, do you think --

A. If I sign an anesthesia record when it is, you know, entered by a resident, in the final analysis, I am responsible for the way that he produces, he constructs the record.

Q. Do you feel that an attending physician or a physician who has privileges in the hospital is the one who is required to teach the nurses operating in the emergency room on how to write a record?

MR. REICHEL: Objection.

MR. GROEDEL: Objection.

A. I do not want to enter into this situation here. I do not know what a given hospital has as a policy to see that the records are complete and clear. But the bottom line is, in my opinion, whatever way they use, the bottom line is, the records should be clear --

Q. And the bottom line taken one step further --

A. -- and complete,

Q. The bottom line taken one step further is that if they are not clear and complete, and an anesthesiologist picks them up, and they are not clear and complete, he should inquire?

A. I would say yes, I would say yes.

MR. ELLERIN: Let us just take a moment, and I think I am through.

(Pause)

MR. ELLERIH: Doctor, we have no other questions, and I want to thank you for spending the time with us today to go over this matter.

MR. GROEDEL: We will send you a bill for it, though, don't worry about it.

MR. GROEDEL: Any other questions, folks?

MR. REICHEL: I have just several questions.

CROSS EXAMINATION

BY MR. REICHEL:

Q. Doctor, my name is Richard Reichel, and I am the attorney for Medina Community Hospital in this particular litigation.

In the real world of practicing medicine in a surgery suite, are there communications, verbal communications between one physician and another physician, such as the anesthesiologist and the surgeon, and are there communications between physicians and the nursing staff, verbally, that do

not end up being documented in the written chart?

A. Well, the way I am practicing medicine here now, this cannot be considered the real world. This is an academic institution, and on@ of our tasks is to teach people to do it the best they can, and that there should be no question, to have everything complete.

So I am not actually the right person to answer this question, in the real world. However, what I can say, yes, there are moments where we can give orders, over the phone, change preoperative medications.

However, as far as I know, the nurse is supposed to enter this in the nursing notes, that a verbal order was taken from Dr. So-and-so to change order so-and-so to this and that, or to give this and that.

And usually, then, when we do this, the nurse is asking us if they can take the verbal order. That is the way that it happens here, as far as I know.

MR. REICHEL: Thank you, Doctor. That is all that I have.

MR. GROEDEL: John?

MR. BAKER: No questions.

MR. GROEDEL: Jerry?

MR. ELLERIH: No questions.

- - -

(DEPOSITION CONCLUDED)

- - -

_____

Paul J. Dauchot, M.D.

CERTIFICATE

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

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and €or the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named PAUL J. DAUCHQT, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 26th day of October, 1990.

Ivy J. Gantverg

Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.
My commission expires September 13, 1993.

MEDINA COMMUNITY HOSPITAL MEDINA, OHIO 44258

EMERGENCY OUTPATIENT REGISTRAT

ROOM	DATE OF SERVICE	TIME OF SERVICE	PATIENT'S LAST NAME	FIRST	INITIAL	AGE	SEX	
3	7/16/87	12:21	PATEL	NAGINBHAI		067Y	M	MR# - 000058 ACCT - 73195

CHIEF COMPLAINT
WEAKNESS / VOMITING

NURSING ASSESSMENT moist pounding cough — legs cold — (L) leg colder in (R) - popliteal pulse present — unable to feel pedal pulses - S.B.

TIME	T	P	R	BP	ALLERGIES	LAST TETANUS	CURRENT MEDICATIONS
	100	120	32	98/	NKA 104/100 225#	LMP G. P.	[illegible]
M/P		120		100/64		VISUAL ACUITY OD 20/ OS 20/	[illegible]

FAMILY DOCTOR Ringel ☐ CALL MY FMD NOTIFIED talked with 1:00 pm

CONSULTING DOCTOR Chin ☐ ER DOCTOR TREAT → call placed to Chin will call back.

Family states vomiting & constipation: seen by Dr Ringel yesterday who states mid epigastric pain BUT family ~~[illegible]~~ refused x-ray. very weak today.

Alert in NAD
neck supple
Chest clear
HSR [illegible]
ABD Benign ō masses, mild distension
B.S. ↓
ō LKS or MAES
ō JVD
ō CCE

Admit to Dr Chin per Dr Ringel

IMPRESSION: PERFORATED VISCOUS

COD Stable

E.R. PHYSICIAN Haynesworth

E.R. PHYSICIAN SIGNATURE Haynesworth M.D.

					LABORATORY		CARDIAC		MEDICATIONS		SITE	TIME
SKULL	CHEST ✓	ABD			CBC		EKG ✓		1) TETANUS 0-5 cc			
C-SPINE	DORSAL	LUMBAR			SMA-6		ABG ✓		2) Mefoxin 1 Gm		IV	12:55
HAND L R	WRIST L R	ELBOW L R			U/A		ACU. PKG ✓		3)			
FOOT L R	ANKLE L R	KNEE L R			AMYLASE		OTHER		4)			
OTHER: 3 Way abdm.					GLUCOSE				5)			
RESULTS: Free air in Abd indicating ruptured viscus - other wise no chest disease - D Rome					C&S				6)			
					OTHER				7)			

IV 1) 1000cc 5% 1/2 NS K/O
2) 500cc obs. D/C @ 12:25 [illegible] 12:55
1000cc L/R added @ 12:[illegible]

NURSE'S NOTES (SIGN)

NURSING TREATMENT Bedside [illegible]

1000cc D/RL added - doTV →

☐ DOA ☐ DAA	LAST ROOM	REFERRED	ADMITTED RM 302	ADMITTING DR Chin	PHYSICIAN NOTIFIED Ringel	DISCHARGE TIME 2:25	DATE 7-16	☒ AMB. ☐ W/C ☐ CART/CARRY

R N SIGNATURE S. Barber R.N.

FORM NO 03217698

PLAINTIFF'S DEPOSITION EXHIBIT 6 DAUCHOT

MEDICAL RECORDS

Graphic Business S... ns, Inc
A GBS company
North Canton, Ohio 44720

WRITE OR IMPRINT PATIENT INFORMATION BELOW

Nasinbhai Patel

MEDINA COMMUNITY HOSPITAL
MEDINA, OHIO

PHYSICIANS' ORDERS

DIAGNOSIS

ALLERGIES

Another Brand of Drug Identical in Form and Content May be Dispensed Unless Checked ☐

DATE	HOUR	ORDERS – DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS →
7-16		– 5% D/RL 1000 – started in ER 2:30pm
		Run 300cc/hr — one hr
		then 120cc/hr
		– Mefox 2.0 gm IV now done ER
		– CBC done ER
		– Chest X-ray done ER
		– EKG done ER
		– To OR around 4:30 pm
		K. [signature]

PLAINTIFF'S DEPOSITION EXHIBIT 7 DAUCHOT

FORM NO. FH32-0768-0480

USE BALL POINT PEN ONLY

PHYSICIANS ORDERS

MEDINA COMMUNITY HOSPITAL
** FINAL **

RESULT SUMMAR
** FINAL **

ACCT. NO.:7319509 PATIENT PATEL, NAGINBHAI PAGE: 6
DR.: CHEN, KE SHIAU MED. REC. NO.: 53564 DATE 7/21/87 ROOM: CC 7

DEPT: 402-LABORATORY

*******- 402-0666 CBC -******

84301 RES: 7-16-87 20:33 LAJH STAT ORD: 7-16-87 19:23 ICC
SPECIMEN: 7-16-87 19:46 AMB

WBC	13.7	X 1000/CMM	F 5.0 - 11.0	M 5.0 - 11.0
RBC	6.05	X MILLION/CMM	F 3.5 - 5.5	M 4.0 - 6.0
HGB	15.6	GM/DL	F 10.5 - 16.0	M 12.0 - 18.0
HCT	45.6	%	F 32 - 47	M 34 - 52
MCV	75	UUU	81 - 98	
MCH	25.8	UUG	27 - 33	
MCHC	34.2	%	32 - 36	
PLATELET	248	X 1000/CMM	150 - 450	
LYMPH	4.1	%	15 - 45	
MONO	4.5	%	3 - 12	
GRAN	91.4	%	42 - 80	
LYMPH	0.6	X 1000/CMM	0.6 - 4.5	
MONO	0.6	X 1000/CMM	0.2 - 1.0	
GRAN	12.5	X 1000/CMM	2.4 - 9.0	

JH

84901 RES: 7-18-87 7:57 LADB DOWNTM ORD: 7-18-87 4:42 ACM
SPECIMEN: 7-18-87 4:42 MA

WBC	11.9	X 1000/CMM	F 5.0 - 11.0	M 5.0 - 11.0
RBC	5.49	X MILLION/CMM	F 3.5 - 5.5	M 4.0 - 6.0
HGB	14.1	GM/DL	F 10.5 - 16.0	M 12.0 - 18.0
HCT	41.1	%	F 32 - 47	M 34 - 52
MCV	75	UUU	81 - 98	
MCH	25.7	UUG	27 - 33	
MCHC	34.3	%	32 - 36	
PLATELET	202	X 1000/CMM	150 - 450	
LYMPH	8.0	%	15 - 45	
MONO	3.7	%	3 - 12	
GRAN	92.3	%	42 - 80	
LYMPH	0.5	X 1000/CMM	0.6 - 4.5	
MONO	0.4	X 1000/CMM	0.2 - 1.0	
GRAN	11.0	X 1000/CMM	2.4 - 9.0	

MA

MEDINA COMMUNITY HOSPITAL

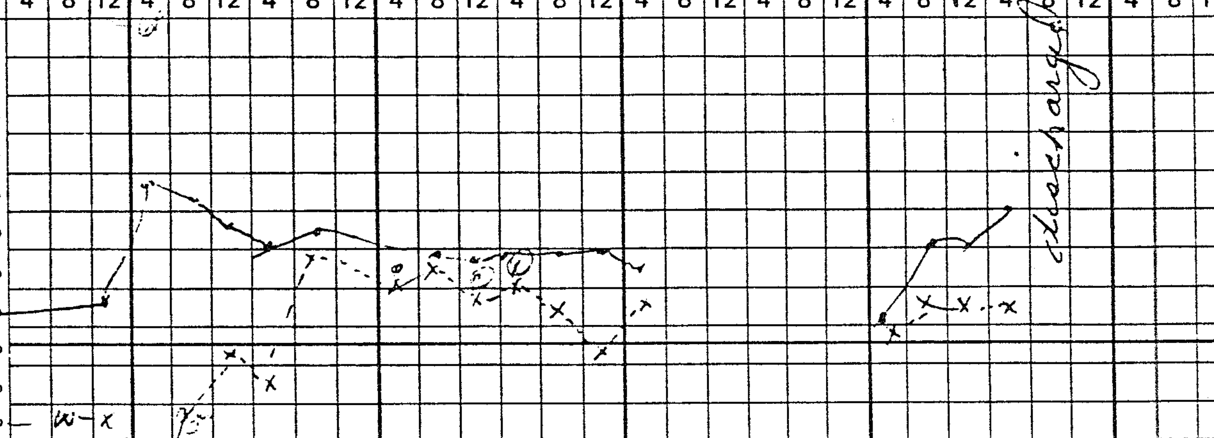
GRAPHIC CHART AND NURSES' NOTES

Date	7/16/87	7/17	7/18	7/19	7/20
Hospital Day	Adm	1	2	3	4
Postoperative Day	Surg	1	2	3	4

Pulse / TEMP (C., F.) — A.M. / P.M. — 4 8 12 4 8 12

● BLACK - PULSE X RED - TEMPERATURE

Pulse	C.	F.
150	41-1	106°
140	40-5	105°
130	40-0	104°
120	39-4	103°
110	38-8	102°
100	38-3	101°
90	37-7	100°
80	37-2	99°
70	36-6	98°
60	36-1	97°
	35-5	96°



RESPIRATION: 24 22 28 36 32 24 24 28 24 28 20 24 24 22 26 24 24

	7/16	7/17	7/18	7/19	7/20
BP 90/78 — 1		112/82	137/82	172/108	152/80
5	140/70	128/92, 127/79	156/?0, 167/91	162/98, 160/80	164/80
9-9	112/88	120/90, 140/92	171/95	138/70	
BATH			Complete	CB	CB
GENERAL CARE			Complete		
ACTIVITY			BR	BR	
DIET			NPO	NPO	
PATIENT FED	—	NPO	NPO, NPO	—	
WEIGHT 160#					
HEIGHT 5'8"					

INTAKE	7/16 7 AM	3 PM	11 PM	7/17 7 AM	3 PM	11 PM	7/18 7 AM	3 PM	11 PM	7/19 7 AM	3 PM	11 PM	7/20 7 AM	3 PM	11 PM
8 HR. ORAL			NPO	NPO	NPO	NPO	NPO	—	-0-	NPO	NPO	NPO	40		
IV			532	910	2710	1405	1200	2023	1060	2000	1457	615	709		
24 HR.			532		5025			4283			4082	100 Hep flush			
OUTPUT															
8 HR. URINE			302	211	330	416	320	450	1211	1285	1320	1525	1150+		
EMESIS															
LEVINE			150	450	75	170	200	100	30	100	70	400	850		
OTHER															
24 HR.			452		1652			2311			4700				
STOOL				ō		ō	ō	0	½		ō	ō	—		
VOIDING QS				F		F	foley	F			F	F	F		
24° Balance									0		-618				
					+4373			+1972							

MEDINA COMMUNITY HOSPITAL

FLOW SHEE

FINAL FLOWSHEETS

ACCT. NO.: 7319509 PATIENT PATEL, NAGINBHAI PAGE: 30
DR.: CHEN, KE SHIAU MED. REC. NO.: 58564 DATE 7/21/87 ROOM: CC 7

[redacted]

		H & H [illegible] 7/18			
DATE	[redacted]	07/18	37/17	[redacted]	NORMALS
TINE	[redacted]	00:00	00:00	[redacted]	
HGB	[redacted]	12.9	15.1	[redacted]	F 10.5-16.0 M 1
HCT	[redacted]	37.6	43.6	[redacted]	F 32-47 M 34-5

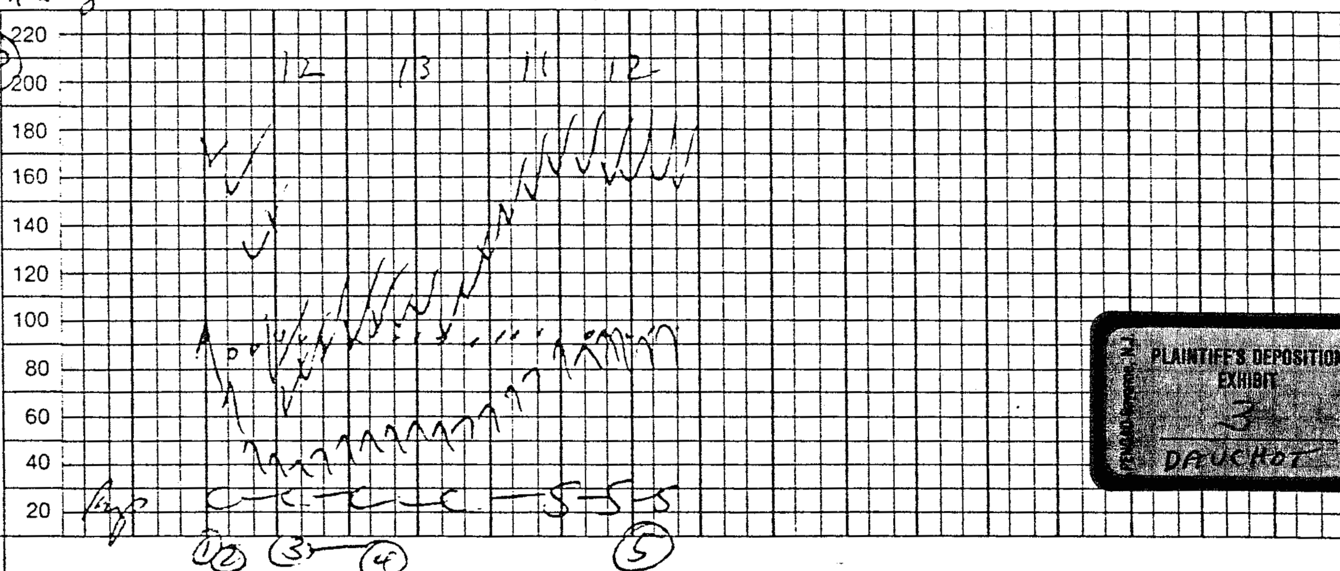
[redacted]

PLAINTIFF'S DEPOSITION EXHIBIT 2 DAUCHOT

SURGEON		DATE 7/16/87
OPERATION		
TIME START	AM PM	TIME END AM P
PRE OP MEDICATION		

TIME		4^30	5^00	5^30	6^00	6^15	ASA RISK 1 2 (3) 4 5
AGENTS	OXYGEN / L/m	2					
	N_2O	2 ↓			2 ↓		
	For-S	1 ↓					
	STP mg	250					
	SUX	100					
	Atra mg	3, 15					
	Ephedrine mg		10, 15				
	atropine mg				1.0		
	Tensilon mg				30		

(CVP)



INTUBATION

ORAL

NASAL

SIZE:

PLAINTIFF'S DEPOSITION EXHIBIT 3 DAUCHOT

ANESTHESIA PROCEDURE & REMARKS:

① ↓ HV Cunnift

② ITI RSI #7ET BBS atraumatic

③ Beg VBP — surgery cancelled

④ pt stabilized CVP inserted

⑤ Extubated → to ICU ABG's drawn — CXR done

140/90 117 28

MEDICATION:

MONITORS EKG Doppler pes to eyeme O2/CO2 monitor, DPM Pulse ox NG tube (R)

CONDITION AT CLOSE Good Doppler

TIME BEGAN: 430	AM (P)
TIME END: 610	AM (P)
POSITION: Supine	
FLUIDS: ① D5LR 1000cc ② D5LR 910cc ③ D5LR — 100cc ④ 5WB — 380cc	
EBL N/O	
URINE OUTPUT foley inserted at OR 400	
ANESTHESIOLOGIST SIGNATURE [signature] MD	

ANESTHESIA RECORD · MEDINA COMMUNITY HOSPITAL

MEDINA COMMUNITY HOSPITAL

PRE AND POST OPERATIVE ANESTHETIC EVALUATION

PREANESTHESIA EVALUATION DATE:

SURGICAL PROCEDURE ANTICIPATED: Exp Lap

ANESTHESIA HISTORY: ⊖

MEDICATION ALLERGIES: ⊖

PRESENT MEDICATIONS: ⊖ Vasotec

SYSTEM REVIEW

RESPIRATORY: COPD

CARDIOVASCULAR: HTN

GASTROINTESTINAL: ~~Peptic Ulcer Ruptured~~ — free Air

GENITOURINARY:

METABOLIC:

NEUROLOGICAL:

ENDOCRINE:

OTHER:

VITAL SIGNS: T. 96.7 P. 88 R 24 B/P 90/78 WT. 160 lb 5'8"

LABORATORY DATA:

EKG: Nonsp ST + T wave — wider qrs

Chest X-rays: COPD

CBC: Hb. 17/13.6 Hct. 51.0/42.7 WBC

Urinalysis:

Electrolytes: 136/4.0 Gluc 136 BUN 48

REMARKS

Choice of Anesthesia: (General) Regional Local

A.S.A. Physical Status: 2 (3) 4 5 (E)

Dentures: X Upper Lower Partial

Smoking and Drinking Habits: X

COMMENTS: 2 ciggs day

[signature] MD

(Signature)

PLAINTIFF'S DEPOSITION EXHIBIT DAUCHOT

DATE: 7/14/84

POSTANESTHESIA NOTE

Date of Anesthesia:

General Condition: ~~Pt experienced hypotension on induction~~ — case cancelled for more evaluation

Anesthesia Related Complications: Present Absent

IF PRESENT:

COMMENTS:

[signature] MD

(Anesthetist)

MCH #410