IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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NADIRAH D. MALIK, etc.,
Plaintiff,
vs Case No. 443949
Judge Russo
MERIDIA HEALTH SYSTEMS,
et al.,
Defendants.

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DEPOSITION OF JOEL O. D'HUE, M.D.
WEDNESDAY, FEBRUARY 27, 2002

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Deposition of JOEL O. D'HUE, M.D., a Defendant herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Reminger & Reminger, The 113 St. Clair Building, Cleveland, Ohio, commencing at 4:30 o'clock p.m. on the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff
Becker & Mishkind
HOWARD D. MISHKIND, ESQ.
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216-241-2600

On behalf of the Defendant Meridia Health Systems
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CHRISTINE S. REID, ESQ.
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On behalf of the Defendant D'Hue
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SUSAN M. SEACRIST, ESQ.
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On behalf of the Defendant Dickerson
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MURRAY LENSON, ESQ.
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JOEL O. D'HUE, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

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EXAMINATION OF JOEL O. D'HUE, M.D.

BY MR. MISHKIND:

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

A. Joel D'Hue.

Q. Dr. D'Hue, my name is Howard Mishkind and we have never met before, but we were introduced before the deposition started.

As I think you probably know, I represent the family in this case that's brought the lawsuit against you. You understand that, don't you?

A. Yes, I do.

Q. I'm going to be asking you some questions concerning your involvement and treatment of this patient, both at the time of your surgery and then during the postoperative period. Okay?

A. Yes.

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(Thereupon, D'HUE Deposition Exhibit 1 was marked for purposes of identification.)

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Q. Doctor, is that document marked as Plaintiff's Exhibit 1 a current copy of your curriculum vitae?

A. It appears to be.

Q. You were born in Jamaica?

A. I was.

Q. Have you written anything or submitted anything that is not referenced in the CV?

A. No.

Q. You are an otolaryngologist?

A. I am.

Q. Do you specialize in head and neck surgeries?

A. No. I don't specialize. I treat it as part of being an otolaryngologist.

Q. What percentage of your practice is involved with head and neck surgeries?

A. I don't know that I can give you a specific number. I see patients with ear

problems, throat problems, nose problems. I don't have a number that I could define as just being head and neck surgery.

Q. In looking at your CV, I wasn't able to detect immediately whether or not you are board certified.

A. I am.

Q. You are board certified. When did you become board certified?

A. In 1984.

Q. Were you successful in becoming board certified first time through?

A. No.

Q. How many attempts?

MS. SEACRIST: Note an objection. Go ahead, doctor.

A. I had three attempts.

Q. What years did you sit for the boards?

A. '82, '83, and '84. '81, '82, '83, sorry.

Q. And I'm sorry, you said you were successful in '84 or successful in '83?

A. I was actually successful in '83. The test was done in '83, and as I recall, a

part of the test was done in '84. It's a two-part test. There is a written part of the test and an oral part of the test. And as I recall, the oral part is actually done in '84.

Q. You have had your deposition taken before; is that true?

A. Yes.

Q. How many times have you been deposed?

A. I don't remember. Two or three times.

Q. You have also been named as a defendant in medical negligence cases in the past; correct?

A. Yes.

Q. How many times have you been named as a defendant?

MS. SEACRIST: Note an objection, please.

A. I don't remember specifically. I do not remember specifically. Four or five times, maybe six times.

Q. Have all the cases been here in Cuyahoga County in Cleveland?

A. No.

Q. How many of the cases against you

have been here in Cleveland?
A. All but one.
Q. All but one?
A. Yes.
Q. Where was the one that was not in Cleveland?
MS. SEACRIST: Continuing objection.
MR. MISHKIND: That's fine.
A. In Erie County, where Sandusky is.
MS. SEACRIST: That's Erie County.
Q. Are any of those cases still open, to your knowledge?
A. No.
Q. The two to three times that you have been deposed, were they in connection with the cases that were brought against you?
A. Yes.
Q. Have you ever had your deposition taken, sir, as an expert witness?
A. No.
Q. Have you ever served as an expert witness?
A. No, not that I can recall.
Q. Did any of the cases that you were named as the defendant involve from your

perspective any similar issues to the issues which you understand exist in this case?

A. I'm not sure what you mean by similar issues.

Q. You performed oral cancer surgery in this case; correct?

A. Yes.

Q. You were caring for this patient during the postoperative period prior to his demise?

A. Yes.

Q. And then the patient died of complications following your surgery; correct? The patient that we are talking about is Molvin Edwards.

A. The patient died. I'm not sure he died of complications following my surgery.

Q. He died of complications which developed after your surgery; correct?

A. The patient died two days after surgery.

Q. Did any of the other cases involve patients that you had performed any type of a head and neck surgery on that died following surgery?

A. No. Well, I should take that back. There was one case, the patient died several months later and I was sued as part of a global lawsuit. But not in the immediate postoperative period, the patient didn't die in the immediate postoperative period.

Q. Of the cases that you have been named as a defendant, the ones here in Cleveland, did any of them go to trial?

A. Yes.

Q. How many?

A. One.

Q. And what was the result of that?

A. I obtained a defense verdict.

Q. How long ago was that, sir?

A. This was about a year or so ago.

Q. The other cases were either dismissed or resolved in some way?

A. Yes.

Q. What about the case in Sandusky?

A. It was settled.

Q. Have you ever had your privileges revoked or suspended or drawn into question in any type of a disciplinary action?

A. I have had my privileges suspended

temporarily for charts, but that's the only reason.

Q. Have you ever applied for privileges at a hospital and been denied privileges?

A. No.

Q. Do you remember Mr. Edwards?

A. I do.

Q. Do you remember performing surgery on the patient?

A. Yes.

Q. Do you remember meeting his daughter?

A. Yes.

Q. Did you have any contact with Mr. Edwards outside of either the office or the hospital setting?

A. No.

Q. The same question with regard to his daughter. Did you have any contact with her outside of the office or the hospital setting?

A. I think I may have had lunch with her once after his death. I don't remember that I went to the funeral. I think I might have gone to the funeral. I don't remember.

Q. But you have a recollection of having lunch with her after her dad died?

A. Yes.
Q. Tell me about that, what you remember.
A. We just talked. I wanted to express my condolences to her. It was just lunch. I don't remember specifically what we talked about.
Q. She, obviously, wanted to know why her dad died, I would presume; is that a fair assumption?
A. She was just expressing grief over the fact that he had died. That's what I remember it being.
Q. Where did you have lunch at, do you recall?
A. It was at Baker's Square in Cleveland Heights, in the Circle, Severance.
Q. Did she contact you to set up a meeting or did you contact her?
A. That, I do not recall.
Q. Was it shortly after the death that the lunch happened?
A. Yes.
Q. And was this a one time get together?
A. Yes.

Q. During the course of your meeting with her, did you express to her any opinions as to why her dad died?

MS. SEACRIST: Note an objection.

A. I don't remember saying anything to her as to why he died.

Q. Do you remember any of the questions that she had for you, if any, about what had transpired during the postoperative period?

A. I don't remember any questions she asked me, no.

Q. Did you maintain any type of a diary or notes relative to your get together with the daughter?

A. No.

Q. And was that recorded at all in any of your office notes; the fact that you had gotten together with her?

A. No.

Q. Did you have any communication with the daughter on any other occasion, by phone, or in any other manner, other than what you have just told me about?

A. No.

MS. SEACRIST: You know, you received

a thank you note from the family, which I can give you a copy of.

A. Yes, there was a thank you note sent to me by them.

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(Thereupon, D'HUE Deposition Exhibit 2 was marked for purposes of identification.)

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Q. Doctor, is Plaintiff's Exhibit 2 a copy of the thank you note that you received from the family?

A. It appears to be, yes.

Q. Do you recall the daughter questioning you at all about what went on while her dad was on the telemetry unit after being transferred out of intensive care?

A. No, I don't recall.

Q. How was Mr. Edwards referred to you?

A. He was referred to me by a dentist, an oral surgeon or someone like that. A dentist, I think.

Q. Other than the daughter, did you have any contact with any other family members?

A. I don't recall.

Q. You have a copy of your office records there?

A. Yes.

MR. LENSON: I don't have a copy. Can you make sure I get a copy?

MS. SEACRIST: Sure.

Q. If I could just see your copy for one second.

Doctor, your attorney provided me with a copy of your records, and what I'm going to do just to be complete, I'm going to mark them as Exhibit 3 to the deposition.

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(Thereupon, D'HUE Deposition Exhibit 3 was marked for purposes of identification.)

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Q. I believe it's exactly what you have in front of you.

I'm going to show you Plaintiff's Exhibit 3, and I don't necessarily expect that you are going to go through every page of it, but does this appear -- and I'll represent to you that it's a xerox and it was provided to me by your attorney -- but does this appear to be a

copy of your entire chart --

A. Yes.

Q. -- on Mr. Edwards?

A. Yes.

Q. And it would contain not only your office notes, but, as well, copies of labs and portions of the hospital record that would be sent to you; correct?

A. Yes.

Q. Do you recall receiving any correspondence from Dr. Dickerson relative to this patient?

And the reason I ask this, in looking at this record, which is Exhibit 3, I don't see any letters that either you wrote to him or that he wrote to you. And I'm not necessarily suggesting that there are any, but because Dr. Dickerson was his cardiologist, I was curious as to whether you received any such correspondence.

A. I don't recall getting any from him.

Q. If you had received correspondence from Dr. Dickerson, would that be part of your file?

A. Yes, it would.

Q. And it would then be contained within Plaintiff's Exhibit 3; correct?
A. Yes.
Q. Have you had a chance to read Dr. Dickerson's deposition?
A. No.
Q. Have you been provided with a copy of Dr. Dickerson's deposition?
A. I think so, yes.
Q. But you have not read it?
A. I don't remember.
MR. MISHKIND: Your attorney has a curious look on her face.
MS. SEACRIST: I don't think I did provide it to him.
Q. If you did read it, and it wasn't provided to you by your attorney, then I have a curious look on my face.
As you sit here right now, you have no recollection of having read it?
A. No.
Q. Do you and Dr. Dickerson see each other from time to time?
A. Yes.
Q. I take it you were aware that

Dr. Dickerson's deposition was taken a month or so ago?

A. I was aware that it was taken.

MS. SEACRIST: Objection as to what we discussed.

Q. Did Dr. Dickerson tell you that his deposition was taken?

A. No.

Q. Have you and Dr. Dickerson at any time talked about the circumstances surrounding Mr. Edwards' death?

A. We spoke immediately following his death.

Q. At the hospital?

A. We spoke by phone. I don't remember whether it was at the hospital or from my office, but we did speak about it.

Q. What do you recall about that conversation with Dr. Dickerson?

A. Well, I remember telling him that Mr. Edwards had died and his immediate reaction to me was he had a heart attack.

Q. Do you know how Dr. Dickerson arrived at that conclusion?

A. No, I don't.

Q. I'm going to represent to you that Dr. Dickerson in his deposition indicated that he cleared Mr. Edwards for surgery and that you had asked for medical clearance from him. Does that sound to be consistent with what probably happened?

A. That is what happened.

Q. And Dr. Dickerson, I'm going to tell you, indicated that he was advised by you that the surgery was intended to be done for a cure of Mr. Edwards' cancer.

A. Yes.

Q. And if Dr. Dickerson testified to that effect, was that an accurate statement on his part?

A. Yes.

Q. When you performed the surgery on Mr. Edwards, were you optimistic that surgery would provide him with a cure?

A. Yes.

Q. I want to go through a couple entries before the surgery and then I want to talk to you about the events that occurred in the hospital, okay?

A. Okay.

Q. There is an office note on December 16th, 1999. If you could refer to that.

A. Yes.

Q. In that note, it says discussed with patient and his daughter the various treatment options. Do you see that?

A. Yes.

Q. Would you explain to me in all likelihood what you would have explained to Mr. Edwards and his daughter at that time?

A. I would have told him that he had a malignancy in his mouth, throat, and that it was potentially curable by surgery, by radiation, or by a combination of both.

I would have told him the risks associated with both of those options; the advantages that he could expect from them, and the disadvantages that he might experience from either course of action.

And I would have told him, because I knew he had a bad heart, that his chance of, as I usually put it, getting off the table would be less, because he had other medical problems.

I would have told him that the surgery would be likely to change some of his

function later. We were planning to remove a portion of the base of his tongue and that would change his speech, at least temporarily.

I would have told him that it may affect his ability to swallow. I would have told him, because of the location of where this tumor was, that there was a good chance I would have to split his mandible; his mandible, the lower jaw, in order to get back there to remove it, and that I would need to remove tissue from his chest or someplace else to fill the defect after removing the cancer.

I would have told him that he would be in the hospital until I was convinced that he was able to eat and drink and that the surgery had relatively healed well enough for us to radiate him afterwards. Those are the things I would have said to him.

Q. Was Mr. Edwards a bright man?

MS. SEACRIST: Objection.

A. I'm not sure what you mean by a bright man, but he seemed to understand what I was talking to him about.

Q. Probably not the best wording, but what I meant by that was exactly what you just

said.

Did he appear to understand the nature and the significance of his condition and the options that you were explaining to him?

A. Yes, he did.

Q. His daughter was there to hear all of what you explained as well; true?

A. Yes.

Q. And it may be a poorly worded question again, but did his daughter appear to be a relatively intelligent woman that seemed to understand what you were explaining concerning her dad's condition, from your perspective?

MS. SEACRIST: Objection. You can answer.

A. Yes.

Q. You indicated that you were going to do a biopsy first; correct?

A. Yes.

Q. And a biopsy was done, I believe, on December 19th?

A. That was done before. Because December 16th says that he has cancer.

Q. I'm sorry, the biopsy was actually done December 7.

A. All right.
Q. And on December 16th, you reviewed --
A. The results of that biopsy.
Q. Got it. Based upon the biopsy results, you were optimistic, were you not, that the surgery would provide him with a cure for the cancer?
A. Yes.
Q. After seeing Mr. Edwards and his daughter on the 16th of December -- I'm sorry for going out of order there. We have the biopsy on the 7th, you see him on the 16th. How many times did you see Mr. Edwards then before he was admitted to the hospital for the actual surgery?
MS. SEACRIST: In total or following the 16th?
MR. MISHKIND: Following the 16th.
A. I saw him twice following the 16th.
Q. Was one of those visits December 20th?
A. Yes.
MS. SEACRIST: Just as to some of the dates, it's a little difficult to see in the copies, so as best as we can tell.

Q. On December 20th, doctor, it looks like, at least in your chart, there is an EKG that was performed.
A. In my chart?
Q. In your chart.
A. I don't do EKG's at my office.
Q. Actually, it looks like the EKG may have been received by you on December 20th.
A. Right.
Q. But it was performed on December 6th.
Was this part of the pre-op assessment before his biopsy was done, the EKG was done?
A. It would have been.
Q. And then that EKG was sent to, a copy of it was sent to you; correct?
A. Yes.
Q. Just to save time, you see where it says referred by Dr. D'Hue, and then there is a stamp, December 20th, that would be the date that you received it?
A. Right. And I initialed it.
Q. And those are your initials?
A. Yes.
Q. So there is, in fact, a copy of the

EKG that was done on a pre-op basis before the biopsy, a copy of which was eventually sent to you for your chart; true?

A. Yes.

Q. When did you obtain surgical clearance from Dr. Dickerson?

A. I don't remember the exact date, but I remember speaking to Dr. Dickerson about him. I made a note in my chart that I would discuss it with Dr. Dickerson. That was the date, the 16th of December, and I discussed it with him by phone, and then when the patient came back to discuss the treatment, I actually sent him to Dr. Dickerson for surgical clearance, cardiac clearance for surgery.

Q. And normally you receive correspondence from Dr. Dickerson relative to the clearance for surgery?

MS. SEACRIST: Objection.

A. It depends. If the patient is going to be going into the hospital to have surgery, sometimes Dr. Dickerson will clear him there and he won't necessarily send me a correspondence before the patient gets admitted. Sometimes if the surgery is scheduled far down the road, he

will send me a letter, the doctor that admits.

Q. Your testimony in this case is that Dr. Dickerson did not send you a letter?

A. I don't recall him sending me a letter before the patient actually got admitted to the hospital.

Q. Do you have any type of a letter from Dr. Dickerson at all relative to this patient in your chart?

A. I have to review this. There is one here. I know there is a note from him in the hospital chart.

Q. I'm talking about an actual letter on his letterhead that he sent to you.

A. I don't recall there being one.

Q. In any event, doctor, you were satisfied based upon the clearance that you received from Dr. Dickerson that Mr. Edwards was an appropriate surgical candidate; true?

A. Yes.

Q. I noted in your records that you have lab work from Huron Road Hospital. I think it was December 6th, lab work.

A. When you say December 6th, do you mean December 6th was the day when I initialed

it or the date --
Q. The date that the lab work was done.
A. Okay, yes.
Q. And at that time, his lab work, at least relative to the hematology, the hemoglobin and the hematocrit were within normal limits; correct?
A. Yes.
Q. And he was not anemic at that time; correct?
A. No.
Q. Were you aware of any history, either on an acute or chronic basis, of Mr. Edwards being anemic?
A. No.
Q. Let's talk about the surgery itself. First, you actually did two surgeries when he was in the hospital at Huron Road; correct?
A. First I biopsied him and then I operated on his neck, yes.
Q. Were you involved in inserting the peg tube?
A. No.
Q. So that was done by general surgery?
A. That was done by a gastroenterologist.

Q. And that was for purposes of post-nutritional care after you performed your oral surgery; right?
A. Right.
Q. Obviously, with the nature of the surgery that you were going to be doing, he was going to need to have some type of hyperalimentation or feeding, and it wasn't going to be oral?
A. Right.
Q. That went fine in terms of the peg tube placement; no complications that you are aware of?
A. As far as I'm aware.
Q. How many days after the peg tube was your surgery done?
A. I don't recall exactly. It would have been one or two days. Dr. Okafor's progress note, I think. That would have been on the 25th. Right, it would have been a day before.
Q. You were assisted by a resident at the time of your surgery?
A. Yes.
Q. Who was the resident?

A. Dr. Ahmed.
Q. Is Dr. Ahmed still with you?
A. He was never with me.
Q. Let me rephrase that. Is Dr. Ahmed still in his residency through Huron Road?
A. No, he is not.
Q. Where is he now?
A. He is an attending at Huron at this time.
Q. What year was he in his residency at the time?
A. He was in his last year.
Q. Would that have been --
A. That's his chief residency. That would have been his fifth year.
Q. There is reference to a Dr. Nimeri, also.
A. Yes.
Q. Who is Dr. Nimeri?
A. A junior resident.
MR. LENSON: In surgery?
THE WITNESS: Yes.
Q. So Dr. Ahmed would have been the senior resident in your department?
A. Yes.

Q. And then Dr. Nimeri would have been the junior resident?

A. Yes.

Q. There is also reference to -- and I'm just trying to get the players, if you will, the names of the people. There is another resident that's referenced, and I'll just show you a page from the record. Perhaps you can tell me who that resident is. You can see by the highlighted language, the lower left-hand corner, there is a name identified with a 7149. Do you know who that is?

A. I do not recognize the signature. But I suspect this is Dr. Ahmed's handwriting.

(Recess had.)

Q. Doctor, before I continue to move on through the chart, I failed to ask you whether or not you reviewed any medical literature at all prior to coming here today.

A. No.

Q. Have you reviewed any medical literature at all since this lawsuit has been filed?

A. No.

Q. Is there any medical literature that

you deem to be reasonably reliable as it relates to the issues that are involved in this type of surgery and the postsurgical management of this type of a patient?

MS. SEACRIST: Objection. You can answer, doctor.

A. There are a number of medical publications that deal with the subject. The Archives of Otolaryngology, JAMA, Journal of the American Medical Association, the Archives, the Journal of Otolaryngology, Head and Neck Surgery Society. There are a number of them. Clinics of North America. A number of them.

Q. Any that you looked at specifically with regard to matters that would be relevant to this case?

A. I have not reviewed any.

Q. So as you sit here right now, there is nothing that you can cite me to that you would deem to be authoritative in the area of head and neck surgery that you reasonably rely on on a day-to-day basis; is that correct?

MS. SEACRIST: Objection. Go ahead and answer.

A. I don't rely on anything on a

day-to-day basis. I read medical journals as I need to.

Q. Have you read anything that would be specific or even relevant to any of the issues that you believe relate to this case?

A. Have I ever read anything or have I read anything since this case happened?

Q. Since this case happened.

A. No.

Q. Tell me, what is the overall prognosis for the squamous cell carcinoma that Mr. Edwards had?

A. What do you mean by overall prognosis? Are you talking about the chance of cure?

Q. Right.

A. Are you talking about survival?

Q. Morbidity and mortality.

MR. LENSON: I'm going to object because the pathology is moderately to poorly differentiated squamous cell carcinoma, and I don't think you gave the doctor that. If you are going to ask him for a diagnosis, give him what the actual pathology was.

Q. What did you believe to be the

overall prognosis for this patient based upon the results of your surgery and the pathology that you received following the surgery?

A. That is a difficult question to answer, because the patient had severe -- well, he had significant cardiac disease. And I am not able to make a judgment of his prognosis taking that into consideration.

Q. Okay.

A. Absent his cardiac condition, the chance of curing a cancer such as this patient had would be better than 50 percent, especially if you combine radiation with it afterwards.

Q. His cancer did not involve any distal metastases?

A. Not that we know of.

Q. And that's a good sign from a prognostic standpoint; true?

A. Yes.

Q. He had apparently only one node involved out of 18?

A. That's what the pathologist reported, yes.

Q. And that's another good prognostic factor; true?

A. Yes.
Q. Is there anything that you saw from your expertise reflected in the autopsy that would cause you to believe that his life expectancy would have been substantially reduced based upon the oral cavity cancer that he had?
A. I need to hear that question again.
Q. A moment ago you told me about prognostic factors and what you believe to be the likelihood of cure and the likelihood of him surviving this cancer. My question was sort of a corollary. Based upon the results of the autopsy, and limited to your expertise as an otolaryngologist, was there anything that you saw in the autopsy that would alter your opinion on his likelihood of survival other than what you have already told me?
MS. SEACRIST: Note an objection. It may have been some time since he looked at this. May he look at this for the purpose of your question?
MR. MISHKIND: Certainly. I assumed he had reviewed it.
Q. You have seen it at some time?
A. I did see it some time, yes.

You need to ask me the question again.

Q. Not a problem, doctor. You told me before, based upon this cancer and the pathology, you told me that you felt that the patient, aside from any cardiac issues, had better than 50 percent likelihood of survival; true?

A. That's what I believe, yes.

Q. And I guess my question to you is, based upon the autopsy results, do you have an opinion as to whether the patient's life expectancy would have been reduced based upon the oral cancer?

MS. SEACRIST: Objection. Is this again taking the cardiac issue out of the question?

MR. MISHKIND: Yes.

A. No. I do not think that the cancer alone would have reduced his life expectancy any more than his 50 percent chance, as I mentioned earlier.

Q. I think you told me that he had greater than a 50 percent likelihood of survival?

A. I think he had a better than 50 percent. Whether 80 or 60, I'm not able to say at this point, but I think he had better than a 50 percent chance of surviving at least five years, if I could have continued the treatment. Surgery was just the first part of the treatment. We had planned radiation afterwards.

Q. And that leads me to my next question. Quality of life.

How debilitating and -- I'll just leave it at that. How debilitating would the radiation treatment that he likely would have required to maximize his life expectancy have been?

A. It's varies a lot from patient to patient. One is not able to make a determination just by saying radiation is going to do this. Some patients do fairly well with radiation and some patients don't.

But in any event, any debility that he might have had would likely have been temporary during the course of the radiation and for some time thereafter.

There are some patients who have chronic pain as a result of radiation therapy

and the pain goes on for a long time, and some patients that go through the entire radiation course and they don't stop eating.

Q. Statistically, do most patients fair well with the radiation therapy following this type of cancer surgery?

MS. SEACRIST: Objection. You can answer, doctor.

A. More patients do well than don't do well.

Q. There is a reference to a doctor -- I will spell the name because I'm going to butcher it -- K-U-I-V-I-N-E-N.

A. Dr. Kuivinen.

Q. Who is Dr. Kuivinen?

A. He was one of the surgical residents. He was a junior resident at the time.

Q. So he was the same level as -- I forgot the other doctor's name.

A. Dr. Nimeri.

Q. Right.

A. I don't think so. I think Dr. Kuivinen was more advanced that Dr. Nimeri.

Q. Do you know where Dr. Kuivinen is located now?

A. I do not know.
Q. At Huron Road?
A. He is not at Huron. He has graduated and I don't know what he is doing.
Q. Mr. Edwards was admitted to the ICU -- and please feel free to look at the records -- on January 26th, I believe?
A. Yes.
Q. And then he was transferred from the ICU to telemetry on the 28th; correct?
A. Yes.
Q. To try to save some time, I'm going to ask you a couple questions, just in sort of a global manner.
Who was the attending to the patient while he was in the intensive care unit from the 26th to the 28th?
A. I was.
Q. And you had one or more of these residents assisting you during the day and perhaps during the evening?
A. Yes.
Q. How did the patient progress? How did Mr. Edwards progress from the 26th up to the time that a decision was made to transfer him on

the 28th?

A. Remarkably well.

Q. You were satisfied with his progress?

A. Very satisfied.

Q. Whose decision was it to transfer the patient from the ICU to telemetry?

A. It was my decision.

Q. And when was that decision made?

A. I think it was on the 28th.

Q. Doctor, there are a number of orders written. I'm going to show you, just to save some time, a sheet of orders dated January 28th, 2000, at 9:00 a.m. Do you see those orders?

A. Yes.

Q. Whose orders were they?

A. They were my orders. They weren't written by me, but they were my orders.

Q. And one of your orders included transfusing the patient, two units of packed red blood cells, each unit over a four hour period?

A. Yes.

Q. I take it that order was based upon the patient's hemoglobin and hematocrit that had gotten worse following the surgery?

A. Yes.

MS. SEACRIST: Objection to gotten worse.

Q. I'm going to hand you, doctor, just to save some time, a copy of the hematology results. And I think that reflects both the pre-op -- or let me just leave it -- from January 24th through January 28th.

A. Yes.

Q. And on January 28th, his hemoglobin was 8.8 and hematocrit was 25.9; correct?

A. Yes.

Q. And it had drifted lower each day; correct?

MS. SEACRIST: I'm going to note an objection to this exhibit, this cumulative chart, because I don't believe that those are created contemporaneously, while the patient is admitted. That's the basis of my objection, but you can answer.

Q. You knew on January 28th that his hemoglobin was 8.8 and his hematocrit was 25.9?

A. Yes.

Q. And you knew on the 27th that the hemoglobin was 9.1 and the hematocrit was 27.7?

A. Yes.

Q. And again, on January 26th, you knew the hemoglobin was 9.6 and the hematocrit was 28.4?

A. Yes.

Q. And just to be overly complete, you knew on January 26th that his hemoglobin was 10.4 and hematocrit was 31.1?

MR. LENSON: You said the 26th. Do you mean the 25th?

MR. MISHKIND: There were two readings on the 26th.

A. Yes, I was aware.

Q. And the 24th shows a hemoglobin of 13.5 and a hematocrit of 40.9; correct?

A. Yes.

Q. What caused this patient's hemoglobin and hematocrit to drop?

A. Whenever you operate on someone, you lose some blood. But also, there is a dilutional effect from the fluid that's given to the patient during surgery. And I believe that was reflected in the lower numbers for the hemoglobin and hematocrit.

Q. Why on the 28th did you give an order to transfuse the patient?

A. He had been out of surgery for a couple days. He had been diuresed, which means we had tried to get some of the fluid off him, and the hemoglobin was still low, so we thought it would be wise to increase the oxygen carrying capacity of the blood, which is what hemoglobin does.

Q. What concerns did you have with regard to the hemoglobin by way of any potential problems that might happen if he was not transfused?

MS. SEACRIST: Objection.

A. Healing is affected when your body is not carrying around enough oxygen like it used to. That is one concern. It is not good to have someone with a low hemoglobin like that if you can help it. Patients are accustomed to having a higher hemoglobin, so you want to make sure that it is returned to at least closer to normal.

Q. Doctor, this would be Dr. Ahmed that wrote the order, but it would have been pursuant to your instructions; correct?

A. Yes.

Q. And certainly, you agreed with the

plan to transfuse the patient; correct?
A. Yes.
Q. Doctor, I don't mean to jump around in the chart, but in the discharge summary, that was prepared by Dr. Nimeri and also has your name on it --
A. Yes.
Q. -- it indicates that the patient was transfused with two units of blood, as his H and H was 8.8 and 25.9, which was a drop from 9.2 and 27.7. Do you see that?
A. Yes.
Q. That's not correct, is it?
MR. LENSON: What's not correct?
MR. MISHKIND: That he was transfused.
A. I don't think the record reflects that he was actually given the transfusion.
Q. The intent was for him to be transfused?
A. Yes.
Q. But where it says he was transfused, that is not accurate?
A. I don't think it is.
Q. And the only reason I ask you, I'm

trying to figure out whether there is something that I have missed that would suggest that he was transfused, and this discharge summary caused me to at least question that in my own mind.

A. I don't think he was transfused.

Q. The order was taken off by a nurse from the physician's orders; correct?

A. It appears so, yes.

Q. And you then, I take it, rely on the nurses to implement your orders.

MS. REID: Objection.

A. Yes.

Q. Is there any indication that your order or Dr. Ahmed's order was countermanded or was withdrawn or changed?

A. No.

Q. Do you have any explanation in this case why the patient was not transfused?

A. I do not have an explanation.

Q. Did you expect that the patient should have been transfused on January 28th, 2000?

A. Yes. You expect it to happen that day.

Q. And the responsibility for doing the type and crossmatch on the blood, was that nursing?

A. Yes.

Q. And then making sure that the blood comes up from the blood bank and then is hung, that's a nursing responsibility, as well; true?

A. Yes.

Q. And you don't see any evidence in the record that the patient was typed and crossmatched or the blood was administered; correct?

A. I don't see any evidence that that was done.

Q. You rely on nurses to take care of all of those aspects; correct?

MS. REID: Objection.

A. Yes. I rely on the nurses to carry out the orders that I write.

Q. Did you see the patient at all later on on the 28th?

A. Yes.

Q. Did you make any note at all on the 28th acknowledging that an order that had been taken off that morning had not been implemented?

A. I did not write that, no, but I made a note of condition.
Q. What was your note to his clinical condition?
A. That he was doing quite well.
Q. That doesn't mean that you didn't want the patient transfused; correct?
A. No.
Q. You expected that when that order was given and taken off at 9:00 a.m. that it was going to be followed through; correct?
A. I expected that the order would be carried out, yes.
Q. Can you tell by looking at this note which nurse it was that took the order off?
A. It appears that the person who signed off on it was named C. Welden, and the time was 11:55.
Q. And do you know who that nurse is?
A. I don't know. I cannot put a face to that name.
Q. Do you have a recollection of ever discussing with this nurse or with any of the nursing staff why it is that an order that had been given and taken off was not implemented?

A. You mean this specific order?
Q. Yes, sir.
A. No.
Q. Do you know of any reason from what was going on on the 28th that would have prohibited the nursing staff from having administered two units of blood to Mr. Edwards at some time during the day?
A. No.
Q. So is it fair to say that had the nurses done what you had asked them to do, Mr. Edwards should have received two units of blood?
A. At sometime during the next several hours, 24 hours or so, I would expect it to be carried out, yes.
Q. Absent that, would you agree that the failure to comply with your order would not be reasonable and acceptable nursing care?
MS. REID: Objection.
MS. SEACRIST: Objection.
A. I wouldn't go that far. I do not know what mechanisms have to take place before blood can be transfused. I don't know whether the blood is in the hospital or it has to be

obtained. So if it were not given by the following day, I would say to someone, explain to me what is happening.

Q. Do you know how long it takes to type and crossmatch a patient?

A. That I don't know.

Q. Do you know what his blood type was?

A. No.

Q. Assuming his blood type wasn't something so bizarre that we had to go places outside of the hospital, do you know how long the normal time period is, absent some other emergency, to be able to type and crossmatch and to get packed red blood cells hung and started?

A. I don't know that there is any specific time that it requires to do all that.

Q. In your order you said that you wanted each unit hung or each unit over four hours; correct?

A. Yes.

Q. You didn't indicate that you wanted the two units of packed red blood cells each unit to be given over the next 24 hours; correct?

MS. SEACRIST: Objection.

A. Right.
Q. Correct me if I am wrong, what you expected and what you were saying to the nurses is that you wanted two units of packed red blood cells, each unit to be administered over a four hour period; correct?
A. Yes.
Q. Thus, over eight hours, the two units --
A. Would be given.
Q. -- would be given?
A. Yes.
Q. And clearly in this case, they were not given; correct?
MS. REID: Objection.
A. I don't see any record -- I don't see any indication in the record anywhere.
Q. Again, you have no explanation that would explain why the nurses didn't do what you asked them to do; true?
A. I don't.
Q. Dr. Dickerson had a resident by the name of Dr. Labes. I think Sylvia is her first name. Do you recall?
A. I don't know who Dr. Dickerson's

resident was at the time.

Q. There is a note on the 28th, cardiology resident indicating that -- I'll show it to you to save some time. It refers to, under number two, the patient's anemia.

A. Yes.

Q. And it indicates, where it references transfusion, that the cardiologist wanted to make sure that the patient was not given any type of an overload; correct?

A. Yes.

Q. And that would be standard practice when a transfusion is given, just to make sure that the patient is appropriately diuresed; correct?

A. Well, in this case, it was a consideration because the patient had a cardiac history and we did not want to overload him. He had had surgery two days before, and although we had diuresed him, there was still some more fluid in him. He had more in than had come out. And when you have a patient like that, you want to be careful about how much fluid you are giving them, and this was the consideration.

Q. And that would certainly be a

reasonable thing to do while the patient is receiving the transfusion, is to diurese the patient to avoid any congestive heart failure?

A. Yes.

Q. But in any event, the patient never received the blood, so there was no need to diurese the patient any further to avoid any congestive heart failure; true?

A. I don't know that there wasn't any reason to not diurese the patient further. But if we were going to give the patient blood, then we would want to diurese them.

Q. Did you see the patient in the afternoon on January 28th?

A. I did.

Q. And you then should have been aware that the order given in the morning had not been followed through on in terms of the blood; right?

A. Yes.

Q. Do you remember being aware of that order?

A. No, I don't remember. I don't recall not being aware of it.

Q. If you had been aware of it on the

28th, and that the order had been taken off but not implemented, what would you have done?

MS. SEACRIST: Objection.

A. I don't know that I would have done anything at that time. I would probably have waited a while longer to make sure that everything was okay.

The patient, when I saw him, he had been transferred from the ICU to the telemetry unit, and he had just gotten to the telemetry unit when I saw him. And I don't know what they had to do and how they were prioritizing the orders, so I don't think I would have done anything at that point in time when I saw him at 1:00 o'clock that afternoon.

Q. That answers my question. So you saw him shortly after his transfer?

A. Yes.

Q. And at that point, I think there probably was one rhythm strip that would have been available?

A. May I see it? This rhythm strip was done at 11:24.

MR. LENSON: a.m.?

THE WITNESS: a.m. on the 28th.

A. I'm not sure if this rhythm strip was done on the floor or in the ICU.

Q. Okay.

A. I do not know exactly what time the patient went to the telemetry unit, and I do not know exactly what time he left the ICU.

Q. If, in fact, this was a rhythm strip that was done on the telemetry floor, would this rhythm strip have been available to you if you saw the patient at or around 12:00 or 1:00 o'clock that afternoon?

A. Yes, it would have been available to me.

Q. On the telemetry floor, do you know how frequently or how often per shift a strip from the telemetry unit is to be placed in the patient's chart?

A. No, I don't know.

Q. When did you last see the patient before the patient coded?

A. It was that afternoon around 1:00 o'clock in the afternoon.

Q. Did you then go back to your office, perhaps?

A. Yes.

Q. And then did you get a call in the middle of the night that Mr. Edwards was found unresponsive?

A. Yes.

Q. And you came back to the hospital?

A. Yes.

Q. Had he already been pronounced?

A. Yes.

Q. Who was responsible for the medical management of the patient on the telemetry unit that afternoon between 1:00 o'clock or so on the 28th, up until the time of his death?

A. I consulted Dr. Dickerson, because he knew the patient; he was a cardiologist. And in fact, the day when I transferred him, I discussed that with him and he said make sure you put him in a telemetry unit.

So when you say the medical management of the patient, I understand that to mean medical things as opposed to surgical things. Cardiological things, I expect him to be aware of those things.

Q. Would it be fair to say that you and Dr. Dickerson were jointly responsible for the care of Mr. Edwards the afternoon and evening of

January 28th, 2000?

MR. LENSON: Objection.

A. He was responsible for some things, I would think, because I consulted him to do that.

Q. And you were responsible for some things, as well; correct?

A. Yes.

Q. If a problem arose during the night with Mr. Edwards' condition, who would the nursing staff contact; you or Dr. Dickerson?

A. Their first contact would have probably been the surgical resident, who would then contact me, or he may contact the cardiology resident and contact me, depending on what the problem was.

Q. Is it fair to say that because both you and Dr. Dickerson were jointly responsible for the care of the patient that the nursing staff could contact either one or both of you?

MR. LENSON: I'm going to object to jointly responsible. Go ahead.

A. I would expect them to call Dr. Dickerson if there was any arrhythmia or something that is cardiological.

Q. Do you know who Nurse L. Nance is?

A. No.
Q. I'm going to show you a note which I believe you wrote after Mr. Edwards died. First, that is a note dated January 29th at 2:45 a.m.; true?
A. Right.
Q. And is that your handwriting?
A. That is my handwriting.
Q. Just so I don't misinterpret your handwriting, although it's a lot better than my handwriting, and a lot better than some doctor's handwriting, would you read into the record what you have written there?
A. I wrote informed of patient's demise. Came in to discuss case with resident and with family. Dr. Dickerson was called and is aware. Family understandably upset. No nurse's note recorded on patient after 5:00 p.m., 12-28-00. No telemetry strip recorded during 3:00 to 11:00 shift. Apparently patient's EKG strip noted on monitor to be flat. Code was called. Resident responded but resuscitation was not successful. Will get post and then I signed it.
Q. First question is, why did you prepare that note?

A. I just wrote my impressions.
MS. SEACRIST: Objection.
Q. Should nurse's notes have been recorded on this patient after 5:00 p.m. on December 28th, 2000?
MS. REID: Objection.
Q. I'm sorry, actually it's not December, it's January. I think you have marked down December 28th, but I think you meant January 28th.
A. Oh, yes, I did say 12-28, but it's actually January 28th.
Q. We knew what you meant.
A. I think nurse's notes should have been recorded, yes. I would expect them to be.
Q. And no telemetry strips were recorded during the 3:00 to 11:00 shift. Would you have expected telemetry to be recorded during the 3:00 to 11:00 shift?
MS. REID: Objection.
A. Yes.
Q. Do you know of any reason in this case why they weren't recorded?
A. Actually, I asked the nurse in charge that night and the answer that I got was that

after the patient coded, and they took him off the monitor, that the memory of the telemetry was erased. So there were no strips. I really did not get a very good answer about why there were no strips on the patient.

Q. When someone codes or has some type of an abnormal arrhythmia, the telemetry unit is set up to, for lack of better terminology, spit out a strip at that particular time; correct?

A. That is my understanding, yes.

Q. And your understanding in this case is that no such strip was generated at the time that the patient became unresponsive; true?

A. True.

Q. And there should have been a strip if the monitor was working properly at the time that the patient became unresponsive; true?

MS. SEACRIST: Objection.

A. I would have expected there to be one.

Q. And no one has ever given you a memory chip problem as the explanation?

A. The explanation was that the memory was erased. That's what I recall. I didn't write that down there, but that's what I recall

hearing.

Q. That's not normal operating procedure at Huron Road Hospital, is it?

MS. REID: Objection.

Q. I don't mean it in a facetious manner, but that's not something that normally happens at this hospital?

MS. SEACRIST: Note my objection.

A. I don't know what normally happens. I just know when I ask for something, I usually get it.

Q. And did anyone explain to you why during the 3:00 to 11:00 shift there weren't any rhythm strips that had been placed in the patient's chart similar to the one that we have at 11:24 a.m. on January 24th?

A. No one explained to me, no.

Q. Family understandably upset. Do you remember any of what the daughter or any other family member said or was saying at the time that you arrived?

A. Well, they asked me what happened, and I told them what I knew. I cannot remember specific words that said this one said this or that. I don't remember specific words.

Q. Tell me if you recall learning either from the nurses or from the family that the hospital on the floor on that evening was short staffed?

MS. REID: Objection.

MS. SEACRIST: Objection.

A. I don't recall hearing that, no.

Q. Do you remember a nurse by the last name of Bagi being there at or around the time that you arrived?

A. I don't remember that name, no.

Q. Did anyone ever explain to you how long Mr. Edwards had been unresponsive prior to being discovered in his room?

A. No.

Q. Which resident was this that responded but was unsuccessful with the resuscitation?

A. That was Dr. Kuivinen.

Q. Did you ever talk with Dr. Kuivinen at all about his observations that evening?

A. Yes, I did talk with him about it.

Q. Tell me.

A. I recall him saying that when he got to the floor to see the patient, the patient was

cold.

MR. LENSON: C-O-L-D?

A. Cold. And that his pupils were fixed and dilated, and that he got no response with anything he tried in terms of resuscitation. That's what I recall him saying to me.

Q. Did he give you any indication based upon his body temperature or his pupils being fixed and dilated as to how long he felt he likely was unconscious when he discovered him?

MS. REID: Objection.

MS. SEACRIST: Objection.

A. No, he didn't.

Q. Did anyone ever indicate to you in any discussions that you had at the hospital how long Mr. Edwards likely had been unconscious without anyone discovering him?

MS. REID: Objection.

A. No.

Q. Again, it's my understanding that if a patient loses consciousness or has any type of an abnormal arrhythmia, that if they are hooked up to the telemetry unit on this floor, that there is a mechanism that the information is conveyed to the nursing station?

A. Usually there is a beep. The unit makes a noise.
Q. And what's the purpose of that?
A. It's an alarm, to alert the nurses that something is wrong.
Q. And then whose responsibility is it to respond to those alarms?
A. I would think it would be the nurse taking care of the patient. I don't know what policies the hospital has for that particular floor; whether they have someone especially just looking at a monitor or whether it was each nurse's responsibility, I don't know.
Q. No one has ever given you a good explanation for why -- strike that.
Did anyone ever indicate to you that an alarm sounded on Mr. Edwards?
A. No.
Q. Were you, in fact, advised that Mr. Edwards wasn't even hooked up to the telemetry unit at the time that he became unresponsive?
MS. REID: Objection.
A. No one told me that, no.
Q. Now, you told me before that

Dr. Dickerson told you that he felt that the patient suffered an MI?

A. Yes.

Q. Myocardial infarction?

A. Yes.

Q. Did he express that to you before or after you became aware of the information that we have just talked about in terms of there not being any notes during the evening; that the resident found Mr. Edwards with fixed and dilated pupils?

A. I did not know what he knew when he said that to me.

Q. Did he ever indicate to you whether Mr. Edwards likely would have survived, assuming this was an MI, had he been on a monitor at the time that he suffered any type of electrical disturbance?

MS. REID: Objection.

A. I don't remember Dr. Dickerson saying anything about that to me.

Q. And I take it that would be outside of your area of expertise?

A. Yes.

Q. I'm going to show you another note

and ask you if you can tell me who this is. The highlighted language, highlighted name.

A. I cannot put a face to that name, no.

MS. REID: Can I see what you are showing him, Howard?

MR. LENSON: Do you know the name, though?

MR. MISHKIND: It looks like the first name is Nadir.

MS. REID: I don't know who that is, no.

MR. LENSON: Zitoni.

A. May I see that again, please? Well, I know he is a medical resident because he said it up top. He said medical resident on call. So that's what he is. He is a medical resident.

Q. But as to who he is specifically, you have no personal knowledge of him?

A. No.

Q. Other than his identification?

A. Right.

Q. You don't have any recollection of having any discussion with him; is that correct?

A. No. Right. That is correct.

Q. Now, in his note, he says the

attending was called by the surgical resident who decided to call it off and was announced dead at 1:00 a.m.

The surgical resident that decided to call it off, meaning the CPR, that surgical resident would have been whom?

A. Dr. Kuivinen.

Q. After this death occurred, did you ever talk with any of the nurses following the death to determine why Mr. Edwards was found unresponsive when he was on a telemetry unit floor?

A. I remember asking a nurse manager, nursing supervisor to look into it, but I cannot recall who it was I spoke to. And I don't remember her getting back with me about what happened. But I do remember after the event making a contact with a nurse manager and letting her know that something happened here and I would like to know what happened.

Q. And I take it you never got a satisfactory answer from the nurse manager?

MS. REID: Objection.

MS. SEACRIST: Objection.

A. I don't remember someone getting back

to me about it.

Q. So whether the answer was satisfactory or not, you just never got an answer, period?

A. That's my recollection. I wish I could recall who it was that I spoke to, but I don't.

Q. What about any physicians, residents, Dr. Dickerson, did you talk with them to try to determine how this could have happened at Huron Road Hospital when a patient is supposed to be monitored on a telemetry floor?

MS. REID: Objection.

MS. SEACRIST: Objection.

A. I don't remember having any specific discussion about that with any residents, beyond that night when the resident spoke to me about it.

Q. The frequency of postsurgical nurses placing telemetry strips on a patient's chart, is that something that you are or are not familiar with?

MS. REID: Objection.

A. I don't know how often they are supposed to do it.

Q. Fair enough. And as to what Mr. Edwards' cardiac rhythm was shortly before his cardiac arrest, has anyone, Dr. Dickerson, or any other physician given you any indication as to what his likely rhythm was shortly before he arrested?

A. No.

Q. In terms of the ultimate cause of death -- actually a couple questions I have for you on that.

One, with regard to Dr. Dickerson's statement that he said to you he likely suffered a heart attack, I take it with regard to that issue you would defer to a cardiologist?

A. Yes.

Q. I will save you some time. In the Coroner's verdict, under other conditions leading to the patient's death, do you know what it means when the Coroner indicates therapeutic complication?

MS. SEACRIST: Objection.

MS. REID: Objection.

A. I don't know what he means, no.

Q. There is no question in your mind that the patient's death was not caused by the

cancer; correct?
A. That's correct.
Q. Do you have any criticism of Dr. Dickerson?
A. No.
Q. If this patient had been monitored with notes recorded by the nursing staff during the 3:00 to 11:00 shift, do you know what the outcome in this case would have been?
MR. LENSON: Objection.
MS. REID: Objection.
A. I can't know.
Q. Has anyone ever expressed to you, other than what Dr. Dickerson told you, any opinions as to why this patient who was seemingly doing well following your successful surgery, who was transferred to the telemetry unit, died roughly 24 hours after being transferred to the telemetry unit?
A. Please repeat the question.
Q. Other than what Dr. Dickerson has told you --
A. Other than what Dr. Dickerson said, no one has ever said anything to me.
Q. What I want to find out sort of in a

global manner before I finish -- the drum roll comes in at this point to let you know that I am nearing the end -- I want to find out from you, because you have been very helpful and I appreciate you being candid with what you remember, but I want to find out whether there is anything else that you recall or anything else that you learned at or around the time of this incident concerning Mr. Edwards' care or what took place leading up to him being found unresponsive that we have not talked about already?

MS. SEACRIST: Objection. You can answer.

A. His daughter had been with him until around 6:00 or 7:00 in the evening, and when she left, she thought that he was looking fine. And Dr. Ahmed had gone by and looked at him that evening too. I don't know if he wrote a note, but he had looked in on him, and he was doing well. He had no complaints. And that would have been 6:00 or 7:00 o'clock or so.

Q. Okay.

A. That's all I can think of.

Q. Even as late as 6:00 or 7:00 o'clock,

Dr. Ahmed had not gotten the blood that had been ordered to be administered to the patient; correct?

A. There is no indication that the patient had the blood, so I'm sure he -- I don't know whether he was aware or not.

Q. Anything else that you recall from conversations with the daughter, with Dr. Ahmed, with the nurses, that we have not talked about already leading up to the time of his demise?

A. No, not that I can think of.

MR. MISHKIND: I thank you very much. I have no further questions.

EXAMINATION OF JOEL O. D'HUE, M.D.

BY MR. LENSON:

Q. Doctor, I appreciate your indulgence. I'll be very brief. My name is Murray Lenson and I represent Dr. Dickerson.

I want to make sure I understand your testimony. When the patient was transferred from the ICU to the telemetry unit, you have indicated that your impression would be a co-management of the patient between yourself and Dr. Dickerson; is that correct?

A. Yes.

Q. When he was transferred to the telemetry unit, there was nothing that you observed or in the chart which would suggest that there was, other than his history, a cardiac issue at that time; is that correct?

A. I'm not sure what you mean by a cardiac issue. I did not transfer him until I had discussed it with Dr. Dickerson.

Q. No, I understand that. But there was nothing in your observation of the patient which would suggest that there was any cardiac issue at that time?

MS. SEACRIST: Acutely on January 28th?

MR. LENSON: Yes.

A. I am trying to clarify cardiac issue. There wasn't anything new. Nothing acute on the patient.

Q. That's what my question is. Other than the history that he had had bypass surgery and the fact that he was a cardiac patient, there was nothing at that time of an acute nature which would suggest that he was at risk at that time; correct?

A. Correct.

Q. All right.
A. I wouldn't have transferred him if there were.
Q. And the reason he was transferred out of ICU is that, in your opinion, he no longer required intensive care attention; correct?
A. Right.
Q. Now, in the telemetry unit, he would still be monitored, but not to the extent that he would have been in the ICU; is that correct?
A. He would have been monitored as much as he was in the intensive care. He no longer needed the intensive nursing care. All of his tubes had been taken out, the Foley catheter was gone, he was taking tube feedings.
Q. And he had been extubated; correct?
A. He had a trache in. He wasn't in any pain. He was sitting up in a chair. So clinically he had progressed to the point where he did not need a nurse sitting there watching him eight hours a day.
Q. If he would not have been a cardiac patient, would he have been sent to a regular floor?
A. I make judgment based upon how the

patient is doing, and I cannot make that judgment now.

Q. Maybe it was inarticulately asked.

If this patient assumed the same status as far as the surgical intervention, but he was not a cardiac -- he didn't have a cardiac history, what would your choice have been once you determined that he no longer needed ICU care?

MS. SEACRIST: Objection. I think he already tried to answer that. He cannot answer it.

A. I would have referred him to a floor. I don't know that I would have insisted that he go to a monitored floor.

Q. So one of the options would have still been a telemetry floor; is that correct?

A. Yes.

Q. But you discussed the transfer of the patient to telemetry with Dr. Dickerson before you did transfer him; correct?

A. I did.

Q. It was your judgment that he was not an appropriate candidate to be transferred from ICU to another floor, and in discussing with

Dr. Dickerson, you determined it was most appropriate to be sent to the telemetry unit; is that a fair statement?

A. That is a fair statement.

Q. Doctor, I want to ask you a question. Mr. Mishkind asked you for a prognosis. The cancer which was eventually evaluated by the pathologist was referred to as moderately to poorly differentiated squamous cell carcinoma of the tongue with invasion of the skeletal muscle; correct?

A. Yes.

Q. And you have indicated in your opinion that he probably enjoyed about more than a 50 percent chance of cure. Is that correct?

A. Yes.

Q. And your definition of cure is five years survival?

A. Five years without cancer, yes.

Q. Now, are you suggesting, and I want to make sure, that cure means that he will not succumb to the illness?

MR. MISHKIND: Objection.

A. What illness are you talking about?

Q. He will not succumb to cancer. Is

that what you mean by cure?

MR. MISHKIND: Objection.

A. Cure means that he would not succumb. He would not have another one, another cancer of that type in the upper aerotitis tract.

Q. And what is the five year then? That he would survive five years?

A. That over the next five years, if we remove this cancer, and the margins, the surgical margins are clean, and we are able to radiate him, and we follow him, we expect that after five years we can say to him, you don't have this cancer anymore.

Q. Does that consider also whether or not there is distant microscopic metastatic disease?

MS. SEACRIST: Objection. You can answer.

A. Well, that is a part of the consideration, whether or not he would.

Q. And that's something that you just can't answer based upon the procedure that was performed by you in the hospital; correct?

MR. MISHKIND: Objection.

Q. Is that correct?

A. That is correct.

Q. My understanding, though, also, doctor, is that the decision for a transfusion was based upon your determination that the hemoglobin and hematocrit had gone down from the time of the surgical procedure until the time that you put in the order; is that correct?

A. Yes.

MR. LENSON: Thank you, doctor. I have no further questions.

MS. REID: I don't have any questions, doctor.

MR. MISHKIND: Nothing further.

MS. SEACRIST: We will read it.

MR. MISHKIND: You can have 28 days.

- - - - -

(Deposition concluded at 6:15 p.m.)

(Signature not waived.)

- - - - -

AFFIDAVIT

I have read the foregoing transcript from page 1 through 75 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

JOEL O. D'HUE, M.D.

Subscribed and sworn to before me this 11th day of April, 2002.

Notary Public Ericka R. DeLaney

ERICKA RENEÉ DeLANEY
Notary Public, State of Ohio, Cuy. Cty.
My Commission Expires Feb. 19, 2004

My commission expires .

CERTIFICATE

State of Ohio,
SS:
County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named JOEL O. D'HUE, 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 testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 7th day of March, 2002.

Vivian L. Gordon

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

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