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 REGINALD P. DICKERSON, M.D.
WEDNESDAY, JANUARY 16, 2002
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Deposition of REGINALD P. DICKERSON, 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 Ulmer & Berne, 900 Penton Media Building, Cleveland, Ohio, commencing at 5:30 p.m. on the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff
Becker & Mishkind
HOWARD D. MISHKIND, ESQ.
Skylight Office Tower Suite 660
Cleveland, Ohio 44113
216-241-2600

On behalf of the Defendant Meridia Health Systems
Reminger & Reminger
JOSEPH FARCHIONE, ESQ.
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On behalf of the Defendant D'Hue
Reminger & Reminger
ERIN HESS, ESQ.
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On behalf of the Defendant Dickerson
Ulmer & Berne
MURRAY LENSON, ESQ.
900 Penton Media Building
Cleveland, Ohio 44115
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REGINALD P. DICKERSON, 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:

EXAMINATION OF REGINALD P. DICKERSON, M.D.

BY MR. MISHKIND:

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

A. Reginald P. Dickerson, M.D.

Q. You are a cardiologist; is that true?

A. Correct.

Q. Dr. Dickerson, my name is Howard Mishkind. I'm going to be asking you some questions about your background and then I will talk to you about Mr. Edwards with regard to your treatment of him.

A. Okay.

MR. MISHKIND: Do you have a CV for the doctor?

MR. LENSON: He has it. He didn't bring it. We will get it to you.

Q. Where is your office located, doctor?

A. 5 Severance Circle, number 205, Cleveland Heights, Ohio.

Q. How long have you been there?
A. Approximately 18 years, with a hiatus of one or two years that I was at another address.
Q. What hospitals do you get privileges at?
A. Currently, Huron Hospital, South Pointe Hospital, Hillcrest Hospital.
Q. Have you ever had your privileges at any hospital suspended or revoked?
A. No.
Q. Or applied for privileges to a hospital and been denied?
A. No.
Q. Are you board certified?
A. Yes.
Q. Which boards?
A. American Board of Internal Medicine and American Board of Internal Medicine/ Cardiology.
Q. How long have you been board certified in both of those areas?
A. The internal medicine examination and certification commenced in '91 and the cardiology certification commenced in '93.

Q. When you say commenced, what do you mean by that?
A. Basically, that's when I completed the certification examination.
Q. Were you successful in becoming certified, board certified in both areas, on your first attempt?
A. No.
Q. Let's talk about internal medicine. How many attempts did you make?
A. I took the internal medicine boards three times.
Q. And the cardiology boards?
A. Once.
Q. Did you have to participate in any additional residency training --
A. No.
Q. -- before being able to take the internal medicine boards again?
A. No.
Q. I know sometimes there is a requirement that you go back for further training, but that wasn't the situation?
A. There was no stipulations, no.
Q. I reviewed the interrogatory answers

that you provided through Mr. Lenson and I know that you indicated that you have been named as a defendant in medical negligence cases before. I'm not sure that you gave me in the interrogatory answers the number of times. So I am going to ask you a few questions about that. I'm not going to repeat that which you already answered in the interrogatories, but tell me how many times you have been named as a defendant.

MR. LENSON: Object. You can answer, doctor.

MR. MISHKIND: You can have a continuing objection.

Q. Go ahead and answer.

A. To my recollection, twice.

Q. This is the third situation that you have been named as a defendant?

A. Correct.

Q. The one case that you referenced. I don't know if I have the interrogatories with me.

MR. LENSON: Let me show the doctor. There it is.

THE WITNESS: Okay, yes.

MR. MISHKIND: If I could see that

for a second, just borrow Mr. Lenson's copy.

Q. Let me give you the opportunity, is there any clarification you need to make on the record given this interrogatory answer to your previous answer?

A. Yes. There is a discrepancy. That says one and I have two. There is a recollection of one other case that was settled, and those are the only two cases.

Q. All right. The one that is referenced here, Diana Seliga, S-E-L-I-G-A, was settled in 1991?

A. Correct.

Q. And that's an accurate statement?

A. Yes.

Q. The other lawsuit against you was dismissed?

MR. LENSON: Howard, to clarify, I believe there was one other that he just now told me about that was settled. All others have been dismissed, without compensation.

MR. MISHKIND: So there were three lawsuits before --

MR. LENSON: There may be more, but all of them were dismissed, other than Seliga

and the one he is about to tell you about.

Q. Doctor, what I want to ask you about is how many times have you been named as a defendant where you have been served with papers for court, whether they were dismissed or payments made or trials occurred, just how many times in total, including or excluding this case?

A. I don't have an exact number, but I would approximate four to five.

Q. And the four to five would include the Edwards' matter or would that now make it an additional five to six?

A. Five to six.

Q. Just so I don't mischaracterize your testimony, I think you told me that there have been two cases that were settled with payments made?

A. Correct.

Q. One is the Seliga matter?

A. Correct.

Q. Do you remember the name of the other case?

A. I think the name is Brandice.

Q. Do you remember the subject matter of

the Brandice case?

A. Yes.

Q. What was it, please?

A. Brandice, this was an individual that had coronary bypass surgery that expired in the postoperative period.

Q. Are you an invasive cardiologist?

A. Yes.

Q. Do you do bypass?

A. No.

Q. Do you do heart catherizations?

A. Correct.

Q. Were you managing the patient -- was it Mr. Brandice?

A. No, it was a woman.

Q. Mrs. Brandice?

A. Yes.

Q. Were you managing her care in the postoperative period after the CABG was done?

A. The postoperative care delivered to virtually all post coronary bypass surgery patients is given by the surgeons, by the cardiac surgeon.

Q. The Brandice case, as it relates to you, was settled with some monetary payment

being made on your behalf; true?
A. Correct.
Q. How long ago was the Brandice case?
A. Prior to the Seliga case. I don't know the exact date, but prior to.
Q. The Seliga case you had was settled in '91, so sometime before '91, the Brandice case?
A. Yes.
Q. And those are the only two that you were involved in where payments were made on your behalf?
A. Correct.
Q. Are you currently named as a defendant in any other cases besides this case?
A. No.
Q. So the other cases, the three or four, whatever number that have been filed against you, have all eventually been dismissed without payments being made?
A. Correct.
Q. Did any of those cases go to trial?
A. That, I don't know.
Q. Were you ever in a courtroom defending yourself before a jury or a judge on

any malpractice case?
A. No.
Q. Did any of those cases involve issues concerning -- and I'll break it down -- preoperative clearance for a cardiac patient undergoing a noncardiac surgery?
A. No.
Q. Did any of those cases involve postoperative management of a patient, one of your patients that had undergone noncardiac surgery?
A. No.
Q. I'm going to get your CV, so I will very quickly skim over a couple things with you.
You went to medical school where, sir?
A. Hahnemann Medical School.
Q. Graduated what year?
A. 1977.
Q. Your practice at Severance Circle, is it a solo practice?
A. Correct.
Q. And pretty much has that been your practice over the years?
A. Yes.

Q. So when Mr. Edwards was a patient of yours, going back a number of years, and he would see you in the office, would he be seen exclusively by you? When I say that, if there were any physician interactions, was it always by you?

A. Yes, always me.

Q. Have you done any publishing of anything in the medical literature?

A. Yes.

Q. How many articles or book chapters have you published?

A. Approximately three articles which were case reports.

Q. And are they delineated on your CV?

A. At least one is.

Q. Tell me about the articles.

A. One article was Conduction Abnormalities in a Patient with Cancer. Another article I was a co-author, the Significance of Elevated Troponin Level in Patients with Congestive Heart Failure and Systemic Hypertension.

Q. The Conduction Abnormalities in a Patient with Cancer, what type of cancer was

that?
A. Lung cancer, as I recall.
Q. Where was that article published?
A. Journal of Cancer. I would have to get that reference for you.
Q. Would that be difficult for you to provide Mr. Lenson with when you provide him with a CV?
A. It would take some time.
Q. Do you know what year it was published?
A. Approximately 1986 to '88.
MR. LENSON: Is it on your CV, doctor?
THE WITNESS: That one is not. I don't think so, no.
Q. Were you the lead author on that?
A. No.
Q. Who was the lead author?
A. Dr. Hassan Tahsildar.
MR. LENSON: He is an oncologist.
MR. MISHKIND: Where does the doctor practice?
MR. LENSON: Lake County.
MR. MISHKIND: Can you spell his last

name for me?

MR. LENSON: T-A-H-S-I-L-D-A-R.

MR. MISHKIND: Hassan?

MR. LENSON: Yes.

MR. MISHKIND: Thank you.

Q. The second article that you referenced, what was that published in?

A. That article is currently being submitted to various journals. The lead author is currently a research fellow at Cleveland Clinic.

Q. What is his name?

A. His name is George -- I'm blocking his name. I'm sorry, I'm blocking his name. It will come to me.

Q. If you think of it during the --

A. Angeliu A-N-G-E-L-I-U or something like that.

Q. The third article is the one that's referenced in your CV?

A. This is the article that's referenced in the CV.

The third article, again, this is my recollection. I'm not a prolific writer, as you can see.

Q. What is the third article on?
A. I could not elucidate that at this point in time.
Q. Have you done any research at all in preparation for today's deposition?
A. No.
Q. Are you relying on any articles with regard to your preoperative clearance of Mr. Edwards in terms of what you did in this case?
A. Not specific articles, but general, you know, cardiology principles and the referenced textbooks.
Q. Which referenced textbooks would you be relying on?
A. Hurst, and also the various guidelines that are produced by American College of Cardiology and American Heart Association.
Q. Which specific guidelines do you believe to be relevant to this case?
A. The guidelines that reference perioperative management of cardiac patients for noncardiac surgery.
Q. Any other guidelines that you believe to be relevant to this case?

A. No.
Q. Do you believe the guidelines on perioperative management of cardiac patients for noncardiac surgeries to be a reasonably reliable source of information as it relates to what is expected of a cardiologist?
A. Yes.
Q. Dr. D'Hue was the surgeon?
A. Correct.
Q. You provided clearance, medical clearance for Mr. Edwards; true?
A. Cardiology clearance, yes.
Q. You had been Mr. Edwards' cardiologist for a number of years?
A. Correct.
Q. I see that he had had coronary artery bypass surgery years back?
A. Correct.
Q. I now know that you were not the surgeon to do that.
A. I was not.
Q. Do you recall who the surgeon was?
A. Dr. Thomas Santoscoy.
MR. LENSON: 0-Y.
Q. Where did he do the surgery?

A. Huron Hospital.
Q. Have you talked to Dr. D'Hue at all about the Molvin Edwards case?
A. No.
Q. Since the time the lawsuit was filed, the answer is no?
A. No.
Q. What about since the time that Mr. Edwards passed away, have you talked to Dr. D'Hue at all about --
A. Only that he expired.
Q. When did you learn that Mr. Edwards had passed away?
A. To my recollection, I was called that he had arrested.
MR. LENSON: I think he is asking when, too, doctor, if you remember.
THE WITNESS: I do not remember the date.
Q. There is a reference on the code sheet to notification of physicians and your name is on there.
A. Okay.
Q. Do you have a recollection of being notified at or around the time that the code had

been completed and he had expired?

A. I can't attest to when I received the call relative to what the events in the hospital were, but I do recall getting a call.

Q. Any recollection as to who the call came from?

A. Not really.

Q. Was it a nurse or a physician?

A. I can't really say.

Q. Did you make any type of notation in your chart or your records concerning that telephone call?

A. No.

Q. Mr. Lenson permitted me to look through your office records and you have them in front of you; correct?

A. Correct.

Q. Or to your side. Feel free to reference them during the course of the deposition.

Is that a complete set of records on Mr. Edwards?

A. A complete set of office records. I cannot attest to anything that happened in the hospital. It may not be contained here.

Q. Has there been anything removed from that file that relates to medical treatment of Mr. Edwards?
A. No.
Q. Had you had an opportunity to treat any of Mr. Edwards' family over the years?
A. No.
Q. Did you ever meet his daughter, his granddaughter?
MR. LENSON: Granddaughter?
MR. MISHKIND: His daughter, I'm sorry.
A. I met a daughter. I'm not sure what her name is, but there was a daughter that consistently accompanied Mr. Edwards.
Q. And did you meet any grandchildren?
A. No. Not that I recall.
Q. After Mr. Edwards' death, did you have an opportunity to talk to any family members, daughter, granddaughter, or anyone identifying themselves as an Edwards family member?
A. No.
Q. Have you had any conversation at any time with any nurses or house physicians after

Mr. Edwards' death related in any way to the circumstances surrounding his death?

A. No.

Q. In your file, do you have copies of any of the hospital records for the admission for the cancer surgery leading up to the time of his death?

A. I'll have to refer.

Q. Okay.

A. I have the face sheet of the admission with the demographic data. I have a consultation.

MR. LENSON: From whom, doctor?

THE WITNESS: That was performed by my resident; that I saw and I reviewed both the documentation on the patient, and I also have a discharge summary from that admission.

Q. Let's talk about the consultation. I think you've indicated a resident; is that correct?

A. Correct.

Q. Did you see Mr. Edwards when he was in the hospital?

A. Yes, I did.

Q. If I could just see your copy just to

make sure I'm looking at the same thing.
MR. LENSON: That's not his consult.
MR. MISHKIND: Well, the consult sheet that he is referring to.
MR. LENSON: But that's not his. You asked if he had seen the patient in the hospital. And he said yes, and that would be a consult, but that's not the one.
Q. The report of consultation, I have a copy of it as well, so I wanted to make sure that we were referring to the same document.
A. But this is not my document that I provided when I saw the person personally.
Q. I understand that. The report of consultation that is written, where it says signature of consultant, whose name is that?
A. That's Dr. Sylvia Labes, L-A-B-E-S.
Q. And Dr. Labes was a resident?
A. Yes, she was.
Q. Was Dr. Labes working under your direction and control?
A. Yes.
Q. What year was she in her residency?
A. Obviously in 2000.
Q. What year of her program?

A. I would have to get that documentation and reference that for you.
Q. Is she still a resident that works under your --
A. No, she is not. She finished her training and is in private practice now.
Q. Private practice here in town?
A. I don't think she is in town. I could find out where, but she is not in town.
Q. Did she do all of her residency training under your tutelage, if you will?
A. Well, she did all of her residency training at Huron Hospital.
Q. And were you the principal attending under --
A. I was an attending at that point in time, yes.
Q. And certainly, when she did this consult, it was pursuant to your direction; correct?
A. Correct.
MR. LENSON: What's the date of that consult?
MR. MISHKIND: Requested January 25 and it is signed January 25.

(Discussion off the record.)

Q. You also wrote a progress note in the records; correct?

A. Correct.

Q. Is your progress note written January 25?

A. Yes.

Q. If you want to get your progress note in front of you.

If I could just see it. Is this a copy of your progress note dated January 25?

A. To the best of my knowledge, yes.

Q. And your signature is in the lower right-hand corner?

A. Yes.

Q. Is that the only progress note that you have in the chart?

A. No.

Q. What other dates do you have progress notes?

A. I think it's January 27th.

Q. Before we talk about the hospitalization itself, I want to talk about Mr. Edwards' medical condition before he was cleared medically for the surgery.

A. Yes.
Q. I take it that you are not an expert in the area of this cancer?
A. Not at all.
Q. Do you have any knowledge as to Mr. Edwards' prognosis had he not died as it relates to the cancer?
A. As it relates to the cancer?
Q. Yes.
A. No, I do not.
MR. LENSON: Independently of talking to Dr. D'Hue or anybody?
MR. MISHKIND: Right.
MR. LENSON: In other words, do you have your own opinion or opinion based upon information provided by --
MR. MISHKIND: No.
Q. Do you have any expertise to comment on what Mr. Edwards' prognosis was relative to the cancer that he had?
A. No.
Q. Or what his prognosis was following the surgery in terms of any morbidity or mortality associated with this type of cancer?
A. No.

Q. Now, because curiosity frequently killed the cat, I will ask you, have you had any conversations with Dr. D'Hue at any time prior to the lawsuit, since the lawsuit, where he has given you any indication as to Mr. Edwards' prognosis with this type of cancer?

A. The only discussion that I had with Dr. D'Hue was that he needed clearance. He had oropharyngeal cancer -- the type, I do not know -- and that it appeared from the preliminary evaluation that it was localized to the site and that the surgery was being done for cure.

Q. So that certainly sounds like good news going into surgery.

A. If it was not for a curative procedure, I would not have cleared it.

Q. Is that the only time that you had any conversation with Dr. D'Hue about Mr. Edwards and his prognosis prior to surgery or the kind of morbidity or mortality that he likely was going to be subjected to after undergoing this type of surgery?

A. Yes.

Q. Now, I have some questions for you

relative to -- I don't mean to jump around, but I'm going to go back before the hospitalization now and hopefully I will clear that out and then we will talk about the events that occurred at the hospital. Okay?

A. Okay.

Q. You had back in 1994 -- I'm looking specifically to August 19, 1994 if you want to take a look at your records. You had noted that if Mr. Edwards' symptoms were to recur, you would recommend a diagnostic cardiac cath. Do you see that?

A. Yes.

Q. After 1994, did you ever perform any diagnostic catheterizations?

A. If you just let me thumb through the records.

Q. Take your time.

(Pause.)

A. No, I did not.

Q. A, echo was performed in December of '95; true? December 18th?

A. Yes, December 18th, yes.

Q. And at that time, there were a number of findings, left ventricular dilatation, as

well as left ventricular dysfunction?
A. Yes.
Q. Also apparently some thickening of aortic stenosis and aortic insufficiency?
A. Yes.
Q. From 1995 up through 1999, Mr. Edwards would see you on a fairly regular basis for cardiac monitoring; is that correct?
A. Correct.
Q. Was he a compliant patient?
A. Yes, he was.
Q. Because he had been your patient as long as he had, I presume you remember Mr. Edwards?
A. Very well.
Q. I will ask this, because I don't want to assume anything. Did you have any interaction with Mr. Edwards on a social basis?
A. None.
Q. Did he ever invite you anywhere or you him?
A. I never invited him anywhere. Whether he invited me, I have no recollection, but that's very common.
Q. Was he a personable kind of

gentleman?
A. In terms of -- was he a nice guy?
Q. Was his affect flat, was he jovial, was he personable?
A. He was a normal person.
Q. Sometimes patients come in, especially cardiac patients, and they are always down and depressed and worried about their cardiac condition to the point where they hardly say anything.
Did he seem to be active and interacting with you?
A. Yes.
Q. Is there anything that stands out in your mind about Mr. Edwards in terms of anything that you would describe as negative in terms of how he complied with your medical treatment?
A. No.
Q. Or what he was doing relative to any noncardiac related matters that you were aware of?
A. I don't understand that.
Q. Was there anything that you saw from the standpoint of his overall health status that you were concerned about with regard to

Mr. Edwards, things that he was doing that he shouldn't have been doing?

A. My recollection is that he was a compliant individual. I was not his internist.

Q. Do you recall who his internist was?

A. The record shows.

MR. LENSON: It may have changed, but to your best knowledge.

A. To my best knowledge, the record shows Dr. Andrew Jimerson at the time of at least the original cardiac catherization and procedure.

Q. So if I can make a broad statement, from 1995 up until 1999, Mr. Edwards would see you on a fairly regular basis, he was compliant as far as you knew with his medical management, and he was a gentleman who basically lived independently. He wasn't in any type of an assisted living facility; he was able to function, as far as you knew?

A. Correct.

Q. He wasn't a cardiac cripple, if you will?

A. No.

Q. He had a lot of coronary artery

disease; correct?
A. Yes.
Q. He had hypertension, which he was medicated for; correct?
A. Let me just reference that.
(Pause.)
A. Yes, he had hypertension.
Q. And that was being managed with what medication?
A. He was on Accupril, 20 milligrams per day. Yes, he was on Accupril, 20 milligrams per day.
Q. Now, I touched on a moment ago the comment that you had made that if symptoms recur, we will do a cardiac cath. And from 1994, we went a number of years where he was seen and I think you told me there was no cardiac catherization done; true?
A. Correct.
Q. In October of 1999 -- you saw him on October 8, 1999, if my records are accurate.
A. Yes.
Q. Do you have that note in front of you?
A. Yes.

Q. At that time he had complaints of chest fullness?
A. Uh-huh.
MR. LENSON: You have to answer yes, doctor.
A. Yes. Sorry.
Q. And if you don't, Mr. Lenson will remind you.
MR. LENSON: I will.
Q. And if I read your notes correctly, on that visit, I think you made a similar statement that you had made back in August of '94, if symptoms persist, may need repeat cardiac cath; correct?
A. Correct.
Q. Now, it had been five years since you had made that statement about repeating the cardiac cath.
A. Yes.
Q. He returns October '99, has complaints of chest fullness. Why didn't you at that time recommend a cardiac catherization?
A. Because as stated in my note of October 8th of '99, his symptoms were inconsistent, so my suspicion of this being

truly a cardiac problem was not very acute.
Q. He returned to your office on December 1, 1999; correct?
A. Yes.
Q. Did you see him at all between October 8 and December 1?
A. Not in the office. And I have no recollection of other instanc s that I may have seen him between those times.
Q. Over the course of the years that you saw Mr. Edwards, did he ever experience either chronic or acute episodes of anemia?
A. I would have to refer back to my notes. However, that is something that would be monitored by his primary care physician.
(Pause.)
A. Relative to my laboratory documentation, I have no evidence of anemia.
Q. Mr. Edwards carried a diagnosis throughout the years under your care of both chronic stable angina as well as compensated CHF; correct?
A. Correct.
Q. What do you mean by compensated CHF?
A. No symptoms.

Q. What significance would an acute episode of anemia potentially have on a patient that has compensated congestive heart failure and chronic stable angina?

A. Could you repeat the question?

Q. Sure. If one of your cardiac patients that has the ongoing diagnosis that Mr. Edwards had experiences an acute episode of anemia, of what significance, if any, is that to you as a cardiologist?

A. That is an issue that needs to be evaluated in terms of if that anemia is contributing to the patient decompensating; tachycardia, for example. If those clinical indicators are suggestive that the anemia is affecting the person hemodynamically, you would want to, of course, transfuse those individuals.

Q. Can anemia in a cardiac patient lead to a fatal arrhythmia?

MR. LENSON: Hypothetically now?

MR. MISHKIND: Yes.

A. Hypothetically, yes.

Q. What is the compensatory mechanism of the heart when a patient is acutely anemic?

A. Tachycardia.

Q. Are there any other compensatory mechanisms?

A. No.

Q. Are there any concerns that you have as a cardiologist treating a patient that has acute anemia in terms of -- strike that. That was poorly worded. I was never going to get to where I wanted to be.

How do you treat acute anemia in a cardiac patient?

MR. LENSON: Objection. You are assuming he treats them.

Q. If you have a cardiac patient that you test and the patient is acutely anemic.

MR. FARCHIONE: Objection.

A. I just would like to clarify. What do you mean acutely anemic?

Q. If there is a drop in the patient's hematocrit and hemoglobin from their normal baseline and you have a patient that has compensated congestive heart failure and stable and nonsymptomatic angina.

MR. LENSON: This is a nonsurgical patient, a patient in the office without having undergone any surgical intervention?

MR. MISHKIND: Right. We will get to the hospitalization.

MR. LENSON: I want to make sure that this is a patient that presents in the office for a regular checkup, cardiological checkup and demonstrates now acute anemia.

MR. MISHKIND: You are correct.

A. The treatment?

Q. Yes.

A. Evaluation. Surveillance for cardiac manifestations, and decompensation from that anemia. And if those things are not present, and the level of anemia is acceptable, diagnostic treatments for the cause of anemia.

Q. And what are the diagnostic treatments of the cause of anemia?

A. Gastrointestinal procedures. Blood count for iron, various vitamins and the like.

Q. Are there any particular concerns that you had as a cardiologist in terms of transfusing a patient that has compensated congestive heart failure?

A. Again, rephrase that, please.

Q. Sure. One of the treatment modalities when you have a patient that is

anemic is to provide them with blood transfusions; right?

A. Correct.

Q. Are there any issues that have to be balanced from a cardiac standpoint in terms of giving a person that has compensated congestive heart failure blood transfusions?

A. Yes.

Q. What are the issues that you have to take into account?

A. Decompensation of the heart.

Q. Exacerbating the congestive heart failure?

A. Yes.

Q. Is that an issue of the timing of the transfusions or the amount of transfusion or both?

A. Usually the amount.

Q. After Mr. Edwards saw Dr. D'Hue, he was apparently referred to you for medical clearance for purposes of undergoing the surgery; is that correct?

A. Yes.

Q. Did you talk to Dr. D'Hue at that point in time about Mr. Edwards? Is that when

you had the conversation with him?
A. Yes.
Q. You did an echo at the time you did the medical clearance; is that correct?
A. Let me check. Yes.
MR. LENSON: Is that 12-19, doctor?
THE WITNESS: Yes. I'm looking for -- no, that was 1-19.
Q. Do you have that?
A. Here is the echo report.
MR. LENSON: It's summarized in your chart?
THE WITNESS: Yes, it is.
Q. That showed 30 percent injection fraction?
A. Yes.
MR. FARCHIONE: Did you say 30 percent?
MR. MISHKIND: Yes.
Q. Can you tell me, reflecting back on the echo that had been done back in '95, whether there was any significant change in his cardiac function between December of '95 and January of 2000?
A. Relative to the reports, none.

Q. So his diagnosis that he carried in 2000 was pretty much the diagnosis that he had had back in '95 from a cardiac standpoint; true?

A. Yes.

MR. FARCHIONE: You said 30 percent. I am looking at something that said 20 to 30 percent for ejection fraction. Did you have another page?

MR. MISHKIND: I'm looking at my note which I marked down 30 percent.

MR. FARCHIONE: The note I have says 20 to 30 percent.

A. That's what is listed here, 20 to 30 percent.

Q. I don't have the copy in front of me. I'm looking at my scribble here. These are qualitative estimates from an echo.

What I want to get an idea of, we have an echo in '95 and an echo in 2000, and there is no significant change from a decompensation standpoint cardiac-wise in Mr. Edwards from '95 to 2000; true?

A. Correct.

Q. Whether it's 20 or 30 percent, he was basically the same?

A. The same.
Q. Function, the ticker was working about the same?
A. The same, that's right.
Q. Did you have any concerns in clearing Mr. Edwards for the surgery?
MR. LENSON: Objection. When you say concerns, other than what he objectively evaluated?
Q. Did you have any concerns from a cardiac standpoint in terms of permitting Mr. Edwards to undergo the proposed surgery?
A. I had no concerns that Mr. Edwards would not be able to tolerate the surgery.
Q. There was on December 20th of '99 an EKG that had been performed. I'm not sure whether that was in your office or in Dr. D'Hue's. Do you have a December 20, 1999 EKG?
A. No, I did not see him on December 20th. And I have no -- no, I don't.
Q. In terms of your clearance for the surgery, did you make any recommendations in terms of any pre or perioperative medication that you wanted used?

A. No, I did not.
Q. Did you recommend any beta blockers?
A. No, I did not.
Q. Why?
A. Because this individual had compensated congestive heart failure. To initiate a medication that may potentially cause decompensation at a time when he would be in the hospital would not be in the best judgment of the patient.
Q. Under what circumstances would you use beta blockers on a cardiac patient that's undergoing noncardiac surgery?
A. I would use it when I had enough time to evaluate the effect of that beta blocker before the individual went to surgery, especially in someone that has left ventricular dysfunction as their baseline.
Q. You did see Mr. Edwards before he went for the surgery?
A. Yes, I did.
Q. If you can get your January 25 consult. Just so I make sure that I'm not missing anything, can you read into the record what your note says?

A. 1-25-00 cardiology. Patient known to me with history CABG, coronary artery bypass graft. CHF, congestive heart failure, HTN, hypertension. Found to have oropharyngeal CA, cancer. Currently no symptoms of angina/CHF, no palpitations or syncope. ECG, electrocardiogram, sinus rhythm, LVH, left ventricular hypertrophy, nonspecific ST, T changes. PE, physical exam, VSS, vital sign stable. Blood pressure 140/70. Pulse, 70s. No JVD, jugular venous distention. Heart regular rhythm. No S3. 2/6 SEM systolic ejection murmur. Lungs, hyphen, clear. EXT, extremities, no edema. CXR, chest x-ray, no CHF, minimal blunting of costophrenic angles. Labs, hyphen, K plus potassium 4.3, BUN/creatinine, 13/1.2.
H and H, hemoglobin/hematocrit, 13/40.
Impression, stable, no signs of angina/CHF.
Chest x-ray, probably chronic pleural changes.
Plan, cleared for surgery, R. Dickerson.

Q. What was the significance, if any, of the minimal blunting?

A. None.

Q. Was that part of the chronic pleural

changes?

A. Probably, yes. That is a common finding.

Q. Did you see Mr. Edwards between the time that he had the dilatation of the esophagus and when he had the radical neck dissection?

A. If you could tell me when he had the dilatation of the esophagus.

Q. The 25th, and then the radical neck on the 26th.

A. No, I did not.

Q. Did you order any post-op EKG's?

A. I would have to refer to the record, to the hospital record.

(Pause.)

A. I do not see any orders from me for an EKG, no.

Q. Did you order cardiac enzymes at any time on a postoperative basis?

A. I did not see an order from me for that, no.

MR. LENSON: Were there any orders from you at all, post-op?

THE WITNESS: No.

Q. Now, did you see Mr. Edwards when he

was in the ICU after surgery?
A. Yes.
Q. On what day did you see him?
A. I would assume that was the 27th.
Q. Is that the last note that you wrote in the chart?
A. Yes, it is.
Q. And again, just to make sure that I'm not missing anything that you have written, it's a shorter note, so it will take less time.
A. 1-27-00. Hemodynamically stable, awake, alert, communicating with sign language. Vital signs stable. Blood pressure 130 over 80. Regular rhythm murmur unchanged. Lungs clear, extremities, no edema, labs stable. Impression, tolerated procedure well. Plan, same, restart outpatient medications, watch for fluid overload and CHF.
Q. Now, were you seeing him on consultation or were you seeing him just to follow up because he was your cardiac patient?
A. Consultation.
Q. At the request of Dr. D'Hue?
A. Correct.
Q. And the 27th is the last time that

you saw Mr. Edwards alive?

A. The last documented note that I have.

Q. Do you have any recollection of seeing Mr. Edwards at any time prior to his demise after the 27th?

A. I can't document that.

MR. LENSON: Do you have any recollection?

A. I think I did. I usually see all my patients every day. Me writing notes every day, I have residents sometimes document that we saw the patient.

Q. On the 28th, the following day, Mr. Edwards was transferred to telemetry, and then it's on the telemetry floor that he expired early morning on the 29th. I tell you that just to give you a framework. Do you recall seeing him on the telemetry floor on the 28th?

A. I recall making rounds with the resident, but again --

MR. LENSON: The question is specific. Do you recall seeing this patient?

THE WITNESS: No.

MR. LENSON: Not what your standard is.

A. No, I do not.
Q. If you could look at the doctor's orders on the 28th.
A. Okay.
Q. There is a long list of orders starting at 9:00 a.m. Transferred to 6 main telemetry and at the very bottom there is a note, transfuse, towards the bottom. Do you see that?
A. Yes.
Q. Whose order was that to transfuse?
A. That appears to be one of the surgical residents.
Q. And would that be a resident under Dr. D'Hue?
A. Correct.
MR. LENSON: All he can say, it's a surgical resident.
Q. As best as you know, would it be a surgical resident that would be working in conjunction with Dr. D'Hue?
MS. HESS: Objection.
MR. LENSON: All you can say is it's a surgical resident?
A. A surgical resident.

Q. Do you know which surgical resident it was?
A. I think this signature is Namury, I think.
Q. How does doctor --
A. I'm not sure.
Q. Do you know Dr. Namury?
A. He is currently a resident. Well, if he is currently a resident, he couldn't have been on this case. But I'm pretty sure this is a surgical resident. And the reason being is because the patients are admitted to services and those services have residents rather than surgical or medical. This was a surgical admission of a patient and so these types of tasks are designated to the surgeons and the residents.
Q. Why didn't you order a postoperative EKG on Mr. Edwards?
A. He was hemodynamically stable, without any complaints.
Q. Given his history, you didn't feel it was necessary to do a postoperative EKG?
A. The information that you would receive in an asymptomatic individual is

limited.

Q. The transfusion order, even though it's not your order, are you able to decipher what that order says?

MR. LENSON: Doctor, I don't want you guessing. He can always depose the person that wrote the order. I don't want you guessing.

MR. MISHKIND: I'm not asking him to guess.

MR. LENSON: That's what he would have to do, because I'm not sure he could read someone's order.

MR. MISHKIND: Murray, if that's an objection, object.

MR. LENSON: I don't want him to feel obligated to read someone's.

Q. Doctor, I don't want you to feel obligated to answer any of my questions unless you can do that.

Can you interpret what that says? Transfuse, and then there is a note -- does that say two units?

A. It appears that that's the notation, two units PRBC's, looks like packed red blood cells.

Q. And then it says each unit over -- is that four hours?
A. Yes.
Q. Mr. Edwards on January 28th had a hemoglobin that had dropped to 8.8. Was that brought to your attention?
A. It was noted.
MR. LENSON: Was it brought to your attention?
THE WITNESS: No, it was not.
Q. As his cardiologist, in a postoperative noncardiac surgery, should a drop of the hemoglobin in your patient who had previously not been chronically or acutely anemic be brought to your attention?
A. Could you repeat the question?
Q. Sure. There is no question that on January 28th his hemoglobin had dropped to 8.8. The records indicate that. And I think you probably have seen that, as well; correct?
A. Yes.
Q. I asked you before whether or not he had ever been chronically or acutely anemic, and you said no; correct?
A. To my knowledge, yes.

Q. An 8.8 hemoglobin is a concerning hemoglobin, is it not, in a patient who has not previously had a low or --

A. It is concerning if you do not know the cause and if there is hemodynamic instability.

Q. And over the course of time in the hospitalization postoperatively, if there is a continued drop in the hemoglobin from the postoperative from 10 to 9 to 8.8, is there reason to be concerned about what is causing the drop in the hemoglobin?

A. Yes, there should be some concern.

Q. Is transfusion of your patient --

A. Of Dr. D'Hue's patient.

Q. Of Mr. Edwards.

A. Okay.

Q. Was that, in your opinion, a reasonable order to have been made?

MS. HESS: Objection.

MR. LENSON: Objection. Remember, the reason I'm going to object, he is not a surgical -- he can't utilize his surgical skills because he can't testify as to what a surgeon would do, but go ahead.

Q. Doctor, so there is no question, because I want your answers --

MR. MISHKIND: And Murray, with all due respect, if you want to object to something, that's fine, but under the local rules I would ask that you not make speeches or statements.

Q. I'm asking you from a medical standpoint, from a hemodynamic standpoint in your patient that's postoperatively day two post-op that has a drop in his hemoglobin down to 8.8, that has a history that you're aware of, is it reasonable to order transfusions of two units packed red blood cells each unit over a four hour period for Mr. Edwards?

MS. HESS: Objection.

MR. LENSON: Objection.

A. Transfusion, whether in the postoperative period or not, in the cardiac individual, the guidelines must also include the stability of the individual, and if that level of hemoglobin is responsible for any observed hemodynamic alterations.

Q. As best as you can tell from looking at the record, what were the hemodynamic alterations that led to an order being initiated

for transfusing packed red blood cells?
A. Up until the time that I saw Mr. Edwards on the 27th, he remained hemodynamically stable.
Q. On the 28th, what were the hemodynamic parameters as you understand them that prompted an order for transfusion of packed red blood cells on the morning of the 28th?
MS. HESS: Objection.
Q. You can go ahead. The objection is just for the record.
A. Not having evaluated him that day, I have no response to that. I did not evaluate him or there is no documentation for that.
Q. Did the nurses notify you that Mr. Edwards' hemoglobin levels had been dropping?
A. Not to my knowledge.
Q. Should they have notified you?
A. That is not a nursing function, no.
Q. Should you have been notified?
A. Well, that is a function of and all of the data that is obtained is under the responsibility of the attending physician, so the nurses themselves do not have responsibility

to report any laboratory data except what we call panic values, and I'm not sure that this was a panic value.

Q. Did you participate at all in or did the cardiology team residents participate at all in the decision to initiate an order for transfusion?

MS. HESS: What was that question?

(Record read.)

A. No.

Q. When a patient is transferred to telemetry, how frequently are heart rhythm strips to be recorded in the chart?

A. I cannot attest to the hospital's protocols for that. We would have to get the protocols.

Q. There is a telemetry strip on the 28th, and I'll give you the time, just to reference it, but it looks to be about 11:24 a.m.

MR. LENSON: On the 28th, Howard?

MR. MISHKIND: On the 28th, correct.

Q. Would you tell me whether you see in lead two any deepening ST depression?

A. Deepening?

Q. Yes.
A. Compared to what?
Q. The previous strip.
MR. LENSON: The previous or previous strips, plural?
MR. MISHKIND: The previous strip.
MR. LENSON: Do you have the previous strip?
A. Well, in both of these tracings, the patient does have nonspecific ST and T wave changes. The telemetry monitoring system is not designed to measure ST segment changes. The design of the telemetry or the purpose of telemetry is to monitor cardiac rhythms.
Q. Because of changes in body position, the telemetry --
A. Lead positions, various things.
Q. -- may not be as reliable?
A. They are not standard -- well, they should be standard, but they are not always standard.
Q. How does one then determine whether or not those ST segment depressions are consistent with any myocardiac ischemia?
A. Electrocardiogram, symptomatology.

Q. Did you see those rhythm strips at or around the time?
A. On the 28th?
Q. Yes.
A. I cannot attest to that. I did not interpret any of these.
MR. LENSON: The answer is you don't recall.
A. I don't recall.
Q. Can you tell me, looking at those strips, had you seen those at the time, whether or not you would have ordered an EKG?
MR. LENSON: Objection as being speculative, but go ahead, doctor.
A. No.
Q. No, you can't tell me, or no, you wouldn't have?
A. This strip would not have made me order an EKG on the basis of the strip itself.
Q. In the context of a patient who has also had a drop in the hemoglobin, that there has been an order for blood transfusion, would that enter into whether you, having this information brought to your attention, would have ordered an EKG or any other diagnostic

cardiac studies?

MS. HESS: Objection.

A. Again, rephrasing.

Q. Go ahead.

A. If I would have known about transfusion, and if all of these things were brought to my attention --

Q. Yes.

A. -- was there an indication for a cardiogram?

Q. Yes.

A. There was still no indication.

Q. Would you have ordered an EKG?

A. Not necessarily.

Q. Would you have ordered cardiac isoenzymes?

A. No.

Q. Why not, as to both?

A. I would have spoken to the patient and evaluated the hemodynamic stability of the patient and the symptomatology.

Q. The strip that we just talked about at 11:34 -- I'm sorry, 11:24 a.m. on the 28th --

A. Is that still this?

Q. Yes, sir. Do you see any other

strips in the chart over the next 12 plus hours prior to Mr. Edwards being found unresponsive in his room?

MR. LENSON: After?

A. After this strip, we would have to go through and document the times and the dates.

Q. As you are looking at this, what I'll represent on the record is I don't see any rhythm strip after 11:24 a.m. through the balance of the day up to and including before and at the time of the code. I just want, number one, to see whether or not there is anything that you have that might be different than what I have.

A. No, not on that point, but I do see the same nonspecific ST and T wave changes.

MR. LENSON: That was not the question, doctor.

Q. When do you see the same nonspecific ST and T wave changes?

A. Even on the 26th.

Q. Can you explain to me why there are no rhythm strips for this patient at any time after 11:24 a.m. on January 28th and for the balance of that day into the 29th?

MS. HESS: Objection.
MR. LENSON: Can you explain it?
A. I can't explain it, no.
Q. If the patient is on telemetry and experiences an arrhythmia, or a fatal arrhythmia, some type of arrhythmia, isn't the telemetry unit set up such that rhythm strips would automatically be on the patient?
A. I think the mechanics of the machine is supposed to do that, yes.
Q. Do you see any rhythm strip at or around the time that Mr. Edwards was found unresponsive shortly after midnight on the 29th?
A. Looking through the documentation, I don't see any strips from the 29th.
Q. Do you have any explanation -- again, I recognize you did not see him -- but do you have any explanation for why there isn't a strip?
A. No, I do not.
Q. Under normal procedure, when a patient codes and is on telemetry, is a rhythm strip, number one, generated?
MR. LENSON: Objection. If you know, doctor.

A. Is the question, during the resuscitation procedure?
Q. Actually, if a patient sustains --
A. The code means resuscitation.
Q. If a patient sustains an arrhythmia that leads to a state of unresponsiveness, is a rhythm strip, when a patient is on telemetry, if the equipment is on, is a rhythm strip generated?
A. It should be.
Q. If one was not generated in this case and the patient sustained an arrhythmia, do you have any explanation for why there wouldn't be such a strip in the chart?
A. No.
Q. Has anyone ever explained to you at any time why there is no strip on Mr. Edwards leading up to him becoming unresponsive and being found shortly after midnight?
A. No.
Q. Do you have any explanation?
A. No.
Q. Do you see any evidence that Mr. Edwards was ever transfused?
A. I would have to look through the

records.

MR. LENSON: Do you want to represent that there is none?

Q. Based upon my review of the records -- and certainly I'm here to learn. I learn every day. Sometimes I learn things I want to learn and sometimes I learn things I don't want to learn.

A. I tell my residents the same thing.

MR. LENSON: I'm not sure he has to go through the record. If you are going to represent that there is no indication, we will go along with that.

MR. MISHKIND: And certainly counsel for the hospital is here and counsel for Dr. D'Hue, if either of them have any evidence that would suggest that the transfusion order was carried out and the patient was given the transfusion, I'm happy to hear from anyone. I don't see any evidence.

MR. LENSON: You have no knowledge of that?

THE WITNESS: I have none, no knowledge.

Q. Do you see any orders or progress

notes that indicates that that order was cancelled or countermanded in any way?

A. Again, I will look through the orders.

MR. LENSON: You will represent that you found none, Howard? He is not making these entries and I think you will have to ask the hospital people rather than the doctor.

A. No evidence.

Q. Do you have an opinion, doctor, in this case, whether it was below the standard of care for Mr. Edwards to have been transferred from the ICU to telemetry with an order for transfusion, yet over the next essentially 24 hour period never receive a transfusion?

MR. LENSON: Objection.

MS. HESS: Objection.

MR. FARCHIONE: Objection. This is a fact witness, not an independent expert.

Q. Do you have an opinion?

A. No.

MR. LENSON: If the doctor is going to render any opinions on standard of care other than his own, we shall advise you, but as of today, he is not. We will provide you with a

report.

MR. MISHKIND: We can go around on the Voik case. And we have had this discussion before.

MR. FARCHIONE: I'm not raising the Voik case. You and I have talked about that before.

MR. LENSON: I'm raising it because the doctor is not here to testify as to the standard of care, the hospital, or any other position, just his own care.

MR. MISHKIND: I know that, but certainly under normal circumstances I'm entitled to cross-examine him on whether or not he has any criticisms or opinions, and based upon Voik versus Cleveland Clinic Foundation, one has to at least be back on their haunches.

MR. LENSON: I represent to you if the doctor is going to assert standard of care for or against, we shall advise you and you will have an opportunity to examine him again, but he is not.

Q. If one sees ST segment depression on a telemetry strip in a post-op patient that has a cardiac condition, should a 12 lead EKG and/or

cardiac enzymes be drawn?

MS. HESS: Objection.

A. My standard is to examine the patient and try to discern from his signs and symptoms if this is truly a cardiac issue or basically a mechanical problem with the monitor.

Q. How can you assess a patient that has ST segment depressions on a telemetry strip to make that decision without being contacted by either the attending or the nurses on the floor?

MS. HESS: Objection.

A. I cannot.

Q. Have you reviewed the autopsy at all?

A. No.

Q. Do you have an opinion as to what caused Mr. Edwards to become unresponsive?

MR. LENSON: Do you have an opinion, doctor? That's all he asked you. Yes or no?

A. No.

Q. You started answering, you have no opinion as to what the cause of death was in this case?

A. The cause of death in this case, I don't have an opinion, but my opinion about death in people with cardiomyopathies and severe

coronary disease is that the mortality rate is extremely high and these people do have episodes of sudden death.

Q. If a patient has a bleed, a postoperative bleed, and is not given appropriate medication to treat that anemia, can the anemia lead to a fatal arrhythmia in a patient?

MS. HESS: Objection.

MR. LENSON: He is asking you hypothetically, doctor.

MR. FARCHIONE: Objection.

A. Hypothetically, yes, depending on the level of the anemia.

Q. In this particular patient, being at 8.8 in the hemoglobin, is that sufficient enough of a drop in the hemoglobin to cause the patient to experience an abnormal arrhythmia?

MR. LENSON: Objection.

MS. HESS: Objection.

MR. FARCHIONE: Objection.

A. I can only answer that relative in context to the stability in the hemodynamic status of the patient as I saw him last, and the last I saw him, he was very stable.

Q. Well, can you tell me whether you assessed him from a hemodynamic standpoint on the 28th while he was on the telemetry floor during the context of there being this order for him to be transfused, or more likely, did you see him at some point in time before that order had been given?

A. I saw him before, but I can't attest to anything after the date that I saw him, which was on the 27th.

Q. Fair enough. So that on the 28th, if there was an order given for blood transfusion, what you are telling me is that you were not aware of that at any time on the 28th?

A. Correct.

Q. You did not see him on the 28th to assess what his hemodynamic status was?

A. Correct.

Q. I take it, had you seen him on the 28th, you would have been aware -- one of the things doctors look at is to see what doctor's orders are; correct?

A. Yes.

Q. So you would have looked and seen there is an order for blood transfusion and you

would wanted to have known whether or not the patient had been transfused, and if not, why not; correct?

A. No. Potentially why would he get transfused if he was hemodynamically stable.

Q. Do you conclude that if someone has ordered a blood transfusion that there must be some evidence of hemodynamic instability?

A. No.

Q. Why would someone order a blood transfusion in a postoperative patient that has a cardiac history unless there is hemodynamic instability?

MS. HESS: Objection.

A. Unfortunately, most practitioners are not aware of the finer points of managing the cardiac patient and what is necessary relative to symptomatology versus numbers, so you have some people that, because the hemoglobin is down, feel let's get the number looking well. There are numerous occasions and instances of individuals in postoperative coronary bypass surgery that do not get transfused for these types of numbers.

Q. So as to the decision for

transfusion, you don't have an opinion whether or not the decision was based upon appropriate clinical parameters or not?

A. Correct.

Q. From what you can see from the record, for whatever reason that the order was given, you don't see any evidence that it was actually implemented or followed through on; true?

A. No, I don't.

Q. And if there were clinical indications sufficient enough to justify the order in a cardiac patient, sufficient clinical symptoms of anemia can, in fact, cause a fatal arrhythmia; correct?

A. Hypothetically.

Q. And if that anemia is not balanced out or if the patient is not restored to their hemodynamic status in a patient like Mr. Edwards with his cardiac history, he would be at increased risk for fatal arrhythmia over a patient who has a drop in hemoglobin that doesn't have a cardiac history; true?

A. Mr. Edwards --

MR. LENSON: Is that a true

statement, doctor?
A. You have to tell me again.
Q. Too much?
A. Yes.
Q. A drop in the hemoglobin to 8.8 in the context of Mr. Edwards' cardiac history --
A. History.
Q. Right. With his compensated congestive heart failure, et cetera, his left ventricular function and everything else that he had from a cardiac standpoint, was he at greater risk with a hemoglobin of 8.8 of experiencing a fatal arrhythmia than any other postoperative patient that has a hemoglobin of 8.8 but not the same cardiac history?
A. Not the same cardiac history or normal?
Q. Normal.
A. Of course Mr. Edwards would be at more risk.
Q. The telemetry unit is on the 6th floor at Huron Road Hospital?
A. At this point in time, we have a different number, but, yes, he was on the 6th floor telemetry.

Q. If a patient is on telemetry, are they literally hooked up with leads, so that there is a readout at the nurses' station?

A. Yes.

Q. Can you account for how a patient that's on telemetry, hooked up to leads with a readout at the nurses' station, would be found unresponsive?

MR. LENSON: Doctor, do you know?

A. No, I don't know. I don't know if you know what the whole telemetry concept is.

MR. LENSON: He will learn that. You answer the question.

Q. I'm going to ask you another question. What I want you --

MR. MISHKIND: Murray, please.

MR. LENSON: Howard, I want to make sure that he understands that he doesn't have to go beyond what you ask him, and he doesn't, that's it.

MR. MISHKIND: I don't want to play games.

MR. LENSON: I don't want to either. He is answering a question that's beyond what you asked. I'm telling him as my client not to

do that, just answer the question.

Q. Doctor, stay with me. Explain to me how a patient on telemetry would be found unresponsive by a nurse coming into the room as opposed to information being up on the screen available for the nurses at the nurses' station ahead of time?

A. I can't explain.

Q. Would you agree that the concept and the way that the telemetry is set up is that nurses should be aware of any change in the heart rhythm on the monitors before a patient advances to a state of being unresponsive?

MR. FARCHIONE: Objection.

A. The monitors should register.

Q. And indicate that there is something abnormal going on with the patient?

A. Yes.

Q. And then what are the nurses supposed to do, from your understanding, once the monitor shows an abnormal heart rhythm?

A. Assess the patient.

Q. And are they then supposed to contact an attending if there is a serious change in a patient's hemodynamic status?

A. Relative to the assessment, there is notification of attendings, residents. I'm not sure what the ascension in the surgical realm is, but someone should get a call.

Q. Late on the 28th, early on the 29th of January, who would the nurses have to report to to notify about Mr. Edwards in terms of a change in his condition? Would it be you or would it be Dr. D'Hue or someone else?

A. It would probably be Dr. D'Hue or one of his agents, possibly the residency staff, the resident staff.

Q. In terms of the quality of Mr. Edwards' life had he survived, do you have any opinion in terms of what his enjoyment of life would have been had he been discharged following his surgery without experiencing a fatal arrhythmia?

A. No.

MR. LENSON: Objection. Speculation.

Q. Do you have an opinion as to whether or not Mr. Edwards sustained a myocardial infarction the morning of the 29th or late on the day of the 28th?

A. No.

Q. You don't have an opinion one way or another?
A. I haven't seen the autopsy.
Q. There is some reference to organized and organizing acute myocardial infarction. Do you have any way to tell me from what you know at this point whether or not his clinical course leading up to the time that he was found unresponsive would be consistent with a pathologic finding at the time of autopsy of organizing myocardial infarction?
A. No, no evidence that would support that.
Q. We don't have any rhythm strips over a 12 hour period to show what his heart rhythm was, correct, leading up to the time of his death?
A. I think the last strip --
MR. LENSON: The 28th.
Q. Before noon.
MR. LENSON: 11:24 or something.
Q. Do you know whether the telemetry monitors were working properly on the floor on the 28th?
A. I do not know.

Q. Do you know whether the hospital experienced in January of 2000 any staffing shortages?

A. I do not know.

Q. Are you in a position at this point to say that Mr. Edwards was managed properly on January 28th up to the time of his death?

MS. HESS: Objection.

MR. LENSON: Objection.

A. I have no way of knowing that. I didn't evaluate him that day.

Q. So as to whether or not the care provided by the nurses, Dr. D'Hue, or any of the residents was or was not appropriate, any opinion?

MS. HESS: Objection.

A. No.

Q. I think in your interrogatories, you indicated that Mr. Edwards was, in your opinion, not at fault. In other words, there is nothing that you see that he did that caused or contributed to his death. And I take it you still stand by that?

A. Yes.

Q. After the 27th, is there anything

that you recall that occurred on the 28th or up to the 29th when he died that we have not talked about?

A. No.

Q. Did any nurses or anyone from the hospital ever explain to you in any way, generally or specifically, how it is that Mr. Edwards was found unresponsive without any telemetry strips or indication of some problem immediately prior to him coding?

A. No.

Q. You did not participate in the attempt to resuscitate him; correct?

A. No.

Q. Did you ever talk to anybody that was involved in the resuscitative efforts?

A. No.

Q. Sort of a global statement, but I just want to find out at this time, other than to the extent that there is any opinions that you arrive at beyond what we have talked about, have you told me in terms of the context of this man's hospitalization everything that you can recall, either from the record or independently?

A. Yes.

MR. MISHKIND: I have nothing further. Thanks.

EXAMINATION OF REGINALD P. DICKERSON, M.D.

BY MR. FARCHIONE:

Q. As you know, my name is Joe Farchione and I represent the hospital in this case. A couple questions.

You had indicated in answer to a question that you had no opinion with regard to the standard of care for the hospital staff or for the other surgeons involved, and that's because you were not there to clinically assess that particular patient?

A. Correct.

Q. The clinical assessment, I take it, is a very important part of evaluation of a patient such as this in the postoperative period?

A. Correct.

Q. Now, when you see patients like this with residents, sometimes do the residents write the note for you?

A. The resident writes a note relative to their assessment, and usually it is customary that the attending physician, when they evaluate

the patient, authenticates the documentation and usually co-signs in some notation.

Q. On the 28th, was there a note written by a cardiology resident? If you can take a look at the progress section, please.

A. Yes, there was.

Q. The orders toward the bottom, what does that read?

A. Consider transfusion to keep hematocrit greater than 30.

Q. The rest of it reads what?

A. Patient has CAD with increase -- okay, consider transfusion to keep hematocrit greater than 30. Patient has CAD, coronary artery disease, with increased diuresis if transfused.

Q. Was that something that you would have been consulted on or aware of at that time?

A. If, in fact, the patient was transfused, and if I was involved with this by my resident, that would have been my recommendation, to diurese the patient.

MR. LENSON: The question is, were you aware of this?

THE WITNESS: No, I wasn't.

Q. Any disagreement with what is written there by the cardiology resident?
A. No.
Q. Is that something that you would have ordered had you been aware of the information that we have been discussing for the past couple hours?
MR. LENSON: Objection. You can answer. It's speculative.
A. Again, this is not an order, this is a consideration.
Q. But you would have recommended or put out for consideration?
A. Consideration relative to hemodynamic stability.
Q. And then it would have been up to the attending service, Dr. D'Hue and his residents, as to whether or not to implement the record?
A. To make that decision, yes.
MR. FARCHIONE: Thank you. That's all.
MS. HESS: No questions

EXAMINATION OF REGINALD P. DICKERSON, M.D.

BY MR. MISHKIND:

Q. Do you know who the resident is that

signed that January 28th cardiology note?

A. Yes. That's the same individual we talked about here, Slyvia Labes.

MR. LENSON: We will read.

MR. MISHKIND: We will waive the seven days.

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(Deposition concluded at 7:15 p.m.)

(Signature not waived; seven days waived.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 77 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

REGINALD P. DICKERSON, M.D.

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

Notary Public

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 REGINALD P. DICKERSON, 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 23rd day of January, 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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EXAMINATION OF REGINALD P. DICKERSON, M.D.