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THE STATE of OHIO,
: SS:
COUNTY of CUYAHOGA.

IN THE COURT OF COMMON PLEAS

MICHELLE MACK, administratrix
of the ESTATE of JENNIFER MACK, :
plaintiff, :

vs. : Case No. 322444

UNIVERSITY HOSPITAL HEALTH
SYSTEM, INC., et al.
defendants.

Deposition of WILLIAM DOUGLAS, M.D., a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at the offices of Jacobson, Maynard, Tuschman & Kalur, 1001 Lakeside Avenue, Cleveland, Ohio, on MONDAY, MAY 19TH, 1997, commencing at 4:08 p.m. pursuant to agreement of counsel.

APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

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I N D E X

WITNESS: WILLIAM DOUGLAS, M.D.

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

WILLIAM DOUGLAS, M.D.

of lawful age, a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

MISS KOLIS: Good afternoon, Dr. Douglas. As you know my name is Donna Kolis, we've just been introduced. I've been retained to represent the Estate of Jennifer Mack. As you are aware, based upon some paperwork I guess that you received, you have been named a defendant in this matter. Have you ever given a deposition before?

THE WITNESS: No.

MISS KOLIS: I'm pretty certain based upon my knowledge of your attorney he probably went over some of the ground rules for you. For the record I'll statement them.

My purpose today is to clarify what information is contained in the records that I do have, to the best of your ability.

Additionally I hope to obtain some other information that may not be written about your recollections of this matter. We're not in a

rush for time unless you have some restriction that causes you to leave in two hours or so.

With that in mind, if I ask you a question you don't understand, say you don't understand what I'm asking. The reason I want to specify that for you, is since as you know this proceeding is under oath, if you answer a question it's going to be presumed you understood the question, your answer was responsive to it. Any time you don't feel comfortable with how I asked a question, you can confer with Steve or indicate for the record the same.

THE WITNESS: Understood.

MISS KOLIS: Likewise, that was a great response, "understood," the court reporter does not take down or attempt to interpret our body language. All your answers should be oral.

If at any time you need to take a break let us know, all right?

THE WITNESS: Okay.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. With those things having been said, prior to

coming here today I took two packets of records which have previously been submitted, I hope with no error on my part to other counsel in this case, I marked them Exhibit A and B. I'm going to ask you questions from those documents.

(Plaintiff's Exhibits A and B marked for identification.)

MR. CRANDALL: Look through there real quick.

MISS KOLIS: Generally speaking we just want to ascertain you've at least seen these documents before.

MR. CRANDALL: Breeze through here.

MISS KOLIS: So to be clear about it, I'm going to ask you probably about a question about each and every piece of paper. If we come to a document you haven't seen you'll let me know.

MR. CRANDALL: Off the record.

(Discussion had off the record.)

MISS KOLIS: Additionally, Doctor, we're going to mark what has been handed to me today, your curriculum vitae, as Exhibit C.

(Plaintiff's Exhibit C marked for identification.)

Q With all the preliminaries under way, out of the way, hopefully now I can ask you some questions.

Doctor, what is your current business address?

A. 11311 Shaker Boulevard, Cleveland 44104.

Q. Whom do you work for?

A. Saint Luke's.

Q. What is your position at Saint Luke's Hospital?

A. I am a staff emergency physician and a staff surgeon in thoracic and vascular surgery.

Q. When did you begin that position?

A. February 1, 1997.

Q. It's probably clear from your CV, I just got it so I didn't get a chance to memorize it yet.

A. I didn't --

Q. It's not on there?

A. You would have to look.
Q. Let's go through briefly, although you've handed it to me in CV form, I want to make sure it's accurate at this point in time.
You had your medical training where?
A. I went to medical school at UCLA.
Q. You completed that education in 1988?
A. That's correct.
Q. Then pursuant to your CV from 1988 through 1998 which we're not in yet, you've continued with post graduate training, correct?
A. Yes.
Q. Are you Boarded in emergency room medicine?
A. No.
Q. Have you taken the ACLS certification?
A. Yes.
Q. When did you take it?
A. July, 1996.
Q. Did you take that at -- first of all let's go backwards.
I see what all your post graduate training is. Your faculty positions 1996 to 1997 it says you were Clinical Instructor of Medicine at Case?

A. That's correct.
Q. During that time were you also employed as a physician?
A. Yes.
Q. Who was your employer?
A. Emergency Medical Services.
Q. When did you first start working for them?
A. July, 1996.
Q. About two months before Jennifer Mack's admission to Bedford Hospital?
A. Roughly.
Q. In that neighborhood?
A. Yes.
Q. Did you take your ACLS certification at the request of your employer?
A. Yes.
Q. Were you aware that that was part of the requirement to serve as an emergency room doctor at Bedford Community Hospital?
A. No.
Q. You had a contract with Emergency Professional Services, is that who you said you were working for, Emergency Medical Services?
A. No -- you are right, Emergency Professional Services.

Q. I can never remember your employer. We'll state for the record you had a contract with them for employment?
A. That's correct.
Q. I would ask that you deliver a copy of that contract, the contract that was in effect at the time of Jennifer's admission to Mr. Crandall, all right; do you still have one?
A. I believe so.
Q. Good enough.

Prior to July of 1996, were you employed by any other entity as an emergency room physician?
A. Yes.
Q. Whom did you work for?
A. The Rural Wisconsin Hospital Cooperative.
Q. A group I have to tell you candidly I'm not familiar with.

From what year to what year did you work for them?
A. Roughly 1989 through 1991.
Q. When you worked for them from '89 to '91, did you at that time undergo any ACLS or LCS -- I'm tired already -- certifications?
A. No.

Q. The one that you received in the Summer of 1996, was that your first certification?
A. Yes.
Q. Subsequent to 1991, but before 1996, were you employed as a physician by any emergency services group for emergency room medicine?
A. Yes, one other at Berlin Memorial Hospital Berlin, Wisconsin.
Q. At the time when you saw Jennifer Mack, you were doing a residency or had your residency been completed in thoracic surgery?
A. It had been completed.
Q. Had you already at that time applied for continuing education in thoracic surgery?
A. I don't understand what you mean.
Q. I didn't ask the question a good way.

Did you have a lapse in your post graduate training between June of 1996 and June of 1997?

A. Yes.
Q. We're just about going to hit 1997. Took a year off from training I guess is the way I'm phrasing it?
A. That's correct.
Q. Had you, although you took the year off,

applied for Fellowship programs before your residency ended in June?

A. Yes, I did.

Q. You were not accepted in any Fellowship program at that time?

A, Yes, I was.

Q. Can you tell me what programs you were accepted in?

A. I was accepted as a Fellow in pediatric cardiac surgery at the University of Michigan, I was accepted for that position in May of 1996.

Q. To begin in 1997?

A. That's correct.

Q. Is that how it is with that program, there is a year's lapse, or they didn't have a space for you in July?

A, Meaning why there was a year when I was accepted?

Q. Right.

A. They ordinarily pick their Fellows a year in advance.

Q. I didn't know that, that is why I had to ask.

Q. In July, August and September of 1996, how many hours a week were you working as an emergency

room doctor?
A. Roughly 50.
Q. Were you working exclusively at Bedford Community Hospital, that's what I'm going to call it?
A. No.
Q. What other hospitals were you working at?
A. I worked at Trumbull Memorial Hospital in Warren, Shelby Memorial, Shelby, and University Hospitals in Cleveland.
Q. Where you would work on a given day, was that determined by what the needs were for staffing?
A. That's correct.
Q. When this event occurred, I'm going to call it September 13th/September 14, 1996, how many times had you worked at Bedford Hospital in the emergency room?
A. I don't recall specifically. Less than five.
Q. Are you fairly certain it was less than five?
A. Fairly certain.
Q. Let me state this for the record so that you aren't insecure about this. I'm not going to come back at some later time say you worked there six times. You said approximately five and I can

accept that answer.

A. Okay. Approximately five.

Q. Given that you had worked there approximately five times, let me ask the question a little bit more expansively.

Each and every time you had a shift at Bedford Hospital, what was the duration of time you spent there, was that preset?

A. Yes.

Q. Can you tell me what number of hours were in a shift you would work at Bedford?

A. Roughly eight. It would vary to a maximum of 12, I don't recall specifically that shift.

Q. To what extent, given that when you arrived on September 14, 1996, were you able to familiarize yourself with the equipment available at Bedford Community Hospital to deal with emergency room procedures is what we will call it?

A. I don't understand what yardstick you are driving at.

Q. I didn't have a yardstick. It was a pretty general question. Probably I should make it a little more specific.

The first time you went to Bedford Community Hospital to serve as an emergency room

physician did you have an orientation of the hospital's facility and equipment?

A. Yes.

Q. Who provided that orientation for you?

A, I don't recall. One of the physicians did, I don't recall which one.

Q. When you say one of the physicians, are you indicating a house officer from Bedford or a physician from your emergency medical group?

A. Physician from the emergency medical group.

Q. Who would be within the realm of possibility, not trying to get you to guess, I take it you interacted with a number of doctors in that group?

A. I had some interaction with the doctors in that group.

Q. Could you reduce it for me to a few choices who would have given you an orientation?

A. Probably Lou Horowitz.

Q. In preparation for today's deposition, did you review medical records?

A. Briefly.

Q. First of all define briefly for me.

A. Less than 10 minutes.

Q. Is 10 minutes the sum total of time you've spent since I initiated this lawsuit reviewing the

medical records?
A. That or close to it.
Q. What medical records did you review?
A. I have seen my handwritten note, I have seen my dictated note. I have seen the x-ray report. I have seen the nurses' notes.
Q. Have you at any time reviewed the Rainbow Babies and Children record for Jennifer Mack?
A. No.
Q. Have you at any time subsequent to me filing the lawsuit talked with Dr. Irefin?
A. No.
Q. When did you learn that Jennifer Mack had died?
A. Within a week after she died.
Q. Can you tell me how you came to know she had passed away?
A. One of the residents in the hospital, and I don't recall which one, just bumped into me while I was walking through University who knew I sent the patient over, told me she died.
Q. You saw Jennifer Mack at University Hospitals, didn't you?
A. Yes.
Q. Do you remember how many times you saw her at

UH?

A. Saw her once.

Q. At that time, when you learned she died, did you have any conversations with Dr. Irefin advising him Jennifer passed away?

A. No.

MR. CRANDALL: So it's clear, he saw her at UH not in the capacity as a physician, her attending.

Q. Your attorney makes a point. You did not render any medical care or treatment to Jennifer at UH, you did stop and see her however; isn't that correct?

A. That's correct.

Q. Doctor, I want to go through the records because I have a lot of questions about them, okay?

A. Okay.

Q. Let's start with the packet marked A, for you guy's benefit the packet says on the front page Bedford Hospital records.

Exhibit A has six pages to it, including the cover pages, that is how I did this.

Let me ask you first, page 4 of Exhibit A, this is denominated in terms of printed form to be the emergency department record; do you

agree with that?
A. Yes.
Q. Can I gather that the narrative portion of this written document in the center was written by yourself?
A. That's correct.
Q. Jennifer Mack, according to this document, was admitted to Bedford Hospital at 15 minutes after 12:00 midnight; do you agree with that?
A. Yes.
Q. At approximately 12:40 she was intubated, do you agree with that from your review of the record?
MR. CRANDALL: Wait a second.
MR. NORCHI: Which record are you on?
MISS KOLIS: Short set.
MR. NORCHI: Can you read that.
MR. CRANDALL: The first intubation.
MISS KOLPS: We will call it the initial intubation.
MR. CRANDALL: You're asking based on those records?
Q. Based on the record would you agree she was

initially intubated at 12:40?
A. That is what the record says. I could not recall that from my memory as far as the specific time course or times.
MR. CRANDALL: She wants to know from the record.
A. From the record.
Q. To be perfectly clear in terms of following up on the response you've just given me, do you have an independent recollection of this case aside from the medical notes?
A. Yes.
Q. Does your independent recollection of the circumstances surrounding the treatment of Jennifer vary from the information that the initial intubation would have been at 12:40?
A. It seems like that it happened faster than that. I couldn't be 100 percent clear on that.
Q. Why does it seem like it happened faster than that, however inartful that question is, you are telling me it seems to you from your recollection of what occurred she would have been intubated quicker than 25 minutes into that admission?
A. Or at least the decision to intubate her was before then and the process thereof.

Q. Who made the decision then to intubate?
A. I did.
Q. Because you were the emergency room physician who saw this child, correct?
A. That's correct,
Q. Can I gather from the state of the record that decision to intubate was made by yourself and yourself alone?
A. That's correct.
Q. Tell me what factors you took into account, the clinical factors in making the decision to intubate this child?
A. The acuity of onset of her symptoms.
Q. Okay.
A. Her severe distress, her severe respiratory distress, her stridor. The fact the child would certainly need to be transferred to another hospital, that transfer with an unstable airway is poor standard of care, the airway needs to be secured prior to transport.
Q. You describe Jennifer as being in severe respiratory distress?
A. Correct.
Q. Can you tell me what clinical constellation of symptoms she had that warranted your description

of severe respiratory distress?
A. The fact that stridor was present. Her use of accessory muscles and restrictions when she is breathing.
Q. When you say stridor, what are you defining?
A. I'm defining noisy breath that I believe is from the upper airway.
Q. Then you said inspiratory effect using the accessory muscles to breathe?
A. That's correct,
Q. At that point in time you made a determination she did in fact have an unstable airway, correct?
A. That's correct.
Q. Prior to September **14, 1996** had you ever intubated a child in an emergency room?
A. No.
Q. Doctor, from your review of the record, your recollection of the events that are independent of what is in the record, did you at any time between Jennifer's admission to Bedford and her discharge to Life Flight to RBC intubate this child exclusive of the trach?
A. No.
Q. Prior to September **14, 1996** had you ever done

an emergency we will call it a tracheostomy, that is what it is called on the discharge, we will clarify later, had you ever performed that procedure prior September 14, 1996?

A. Yes.

Q. About how many times?

A. Once I can remember.

Q. What kind of training did you receive regarding that particular procedure prior to Jennifer, exclusive of the fact you did it once, tell me where you got your training from?

A. I had been -- I had done probably a good couple dozen tracheostomies electively as a surgical resident, in addition to thyroid surgery, parathyroid surgery and other forms of neck surgery.

Q. Which would have required you to use that particular set of skills, correct?

A. That's correct.

Q. When you say you had done elective tracheostomies, what kind of things did you do elective ones?

A. Patients who required long-term ventilation.

Q. To the best of your recollection, other than Jennifer, you have a recollection of one other

emergency procedure, correct?

A, That's correct.

Q. Although I'm skipping around, sometimes when I'm in an area I like to ask the question.

There is a note, not in this set of documents but in our Exhibit B that indicates that the Life Flight team was trying to perform the tracheostomy; do you recall seeing that note?

A. No, I don't recall seeing that.

MR. CRANDALL: Why don't you look at it.

MISS KOLIS: Go ahead.

A. I see it.

Q. Can you explain to me what that note means?

MR. CRANDALL: I don't know what you mean by that, Donna.

MR. NORCHI: Can you read off the exhibit?

MISS KOLIS: Exhibit B, Bates stamped page 00009. Even though it's out of order I want to ask it now.

MR. CRANDALL: What is your question now?

Q. This is the Community Hospital of Bedford record, correct, the advanced life support record?

A. That's correct.
Q. On it I found a notation that says, "Trach being attempted by Life Flight," you see that?
A. I see it.
Q. Do you know if Life Flight was attempting a trach?
A. I do. They didn't.
Q. We will talk later. That's not your handwriting, is it?
A. No.
Q. So how quickly did you make the decision that Jennifer should be intubated?
A. Within 10 minutes of arrival, give or take, more or less, maybe less.
Q. Do you recall as you sit here how many other patients were in the emergency room that night?
A. No. I know that they were there. The

Q.

A. Yes.
Q.

A.

Q. Do you remember what nurse was working on Jennifer with you?
A. No, I do not.
Q. Male nurse, you don't remember who it is?
A. No.
Q. Okay.
MR. CRANDALL: You said no?
THE WITNESS: I said no.
Q. What did you do to facilitate the intubation occurring?
A. When I realized that she need to be intubated, I asked the nurse who was the house physician that night. I knew Bedford had a house physician, I know they are frequently an anesthesiologist. The nurse said the house physician is an anesthesiologist, I asked her to page him to come to the emergency room.

The patient was moved from one room to another room, where there is more room to do a difficult procedure.
Q. When you say she was moved from one room to another room, somewhere in the notes, perhaps your discharge, I believe there was a reference she was moved to a cardiac room?
A. Um-hum,

Q. Does that sound right to you?
A. That sounds right.
Q. What is a cardiac room?
A. Room one, it is where typically chest pain patients are brought in where they were seen in the emergency room.
Q. What kind of equipment is available in that room that would aid and assist in the placement of an endotracheal tube, intubation tube?
A. Primarily space. Most of the other equipment is portable, you need room.
Q. So the decision to move her was made on the need for larger physical area?
A. Space.
Q. Were you in attendance when Dr. Irefin first intubated Jennifer?
A. Yes.
Q. Did you stay with that child continuously through her arrest, or did you leave the room?
A. If I left the room, it was for a very brief time period. Essentially I stayed throughout.
Q. So that I'm clear about this, if we're going to agree that the intubation itself according to the documents, the initial intubated, occurred at 12:40, it's your testimony that you did

continuously stay in that room with the exception of perhaps a brief moment through the code; is that right?

A. That's correct.

Q. In your discharge summary which we're going to go over, I sometimes ask questions because it comes up, there is a paragraph, if you want to look it's in Exhibit A, on the second page, discusses an apparent administrative issue problem regarding the belief Jennifer should have been transferred to CCF; do you see which paragraph I'm referring to?

A. Yes.

Q. The way it was written it may or may not be important, were you the person who was trying to make these phone calls to CCF to see if they would accept this child?

A. I made one -- I made one attempt at calling them at least. I'm not certain, I think a nurse tried making the other attempt.

Q. Were you trying to make this call from the cardiac room?

A. Yeah.

Q. All this information that is contained in that paragraph about insurance and maybe she should have gone to CCF, et cetera, did all the

transactions that led up to you writing that paragraph occur before the end of the code?

A. No.

Q. When did they happen to the best of your knowledge?

A. There was certainly a period of time after the tracheostomy the child stabilized, a lot of these issues were addressed, certainly talking to the parents, that happened after the tracheostomy. There was not a lot of extra time to be making phone calls during the code.

It takes the Life Flight team a considerable few minutes to package somebody up and get them ready to actually roll out the door. That is probably when a lot of these things were addressed, but I don't recall specifically.

Q. According to the documents in these particular records can you tell what time Life Flight left Bedford with Jennifer to go to RBC?

A. According to the nurses' notes at 1:30 in the morning.

Q. You had tried to call the Clinic before Life Flight left with her, correct, you or someone in the group?

A. Yes.

Q. Let's go back to where we started, which was page 4 of Exhibit A, your handwritten note, your handwriting is pretty legible.

A. Thank you.

Q. I would like to go through at least what I think it says, to make sure I made no errors reading what you recorded. I'll read it as far as I can read it, you tell me,

"Patient is five year old who apparently had attack," you put that in quotes, "'of croup.'" I don't know what the very next line says.

A. "At midnight."

Q. "Patient arrived by EMS at 12:15 with severe stridor, respiratory distress," correct?

A. That's correct.

Q. "Patient was intubated approximately 10 minutes," is that after "arrival"?

A. That's correct.

Q. Therein lies my first question.

When did you fill out this emergency room sheet, this emergency department record?

A. After -- I believe I filled it out after she left.

Q. The same night?
A. Yes.
Q. This isn't dictation, this is your handwriting to complete a chart page, correct?
A. That's correct.
Q. Was she immediately attended to upon presentation to the emergency room because she had come by ambulance? That may not make sense, do you know what I'm asking?
A. I know what you are asking.
MR. CRANDALL: Let me object, compound. Go ahead.
A. She was attended to because she arrived by ambulance and because of her clinical scenario.
Q. When you wrote this that night, that she was intubated, I think you said quickly, does that mean within 10 minutes after arrival?
A. Approximately.
Q. Approximately 10 minutes after arrival, that would make the initial intubation time 12:25. Based upon all the documents you looked at and thinking about this, is 12:40 actually the time of the initial intubation or is it earlier; do you know?
MR. CRANDALL: I'm going to

object, asked and answered. Go ahead.
A. It may have well have been 12:40. The decision to make the intubation was made a few minutes after arrival. I didn't put a stopwatch on how long it took to get the anesthesiologist, get her moved, put the tube in her throat,
Q. Prior to the time you performed the trach, how many intubations did this child undergo?
A. Two.
Q. Was the tube changed at any time before you performed the trach for size?
A. The anesthesiologist initially tried putting in a tube that was larger than the 3.0 tube, he couldn't pass a tube that was larger, a 3.0 was the size eventually used at the first intubation.
Q. After that first intubation, at any time was that 3.0 tube removed and a different tube placed, or was that tube the one that essentially continued to be repositioned until the time you did the trach?
A. It was either that tube or a similarly sized tube.
Q. After the initial intubation how many repositions of the tube were there before the trach?

A. I recall one.
Q. Did Dr. Irefin remain in the room with you from the time of the initial intubation through the code?
A. I do not recall specifically whether -- how much time he spent out OF the room or if he was out of room for a significant time.
Q. Is Dr. Irefin the physician who repositioned the tube?
A. Yes.
Q. Did you ask Dr. Irefin to perform the trach?
A. No.
Q. Let's go back to where I stopped in your note dealing with when the patient was initially intubated. I think it says 3.0 something was largest. I don't know what that word is, tube?
A. "3.0 tube largest that could be inserted. Patient did poorly over the next 10 minutes."
Q. Looking at that note in conjunction with what else you've seen in the chart, please define for me what you meant when you said the patient did poorly?
A. Her oxygenation was poor.
Q. Did you record any notes about what her oxygenation levels were in the time period of

10 minutes when you thought she was doing poorly?
A. I would have to look.
Q. You can look.
A. It looks like the transcriptionist didn't type it out.
MR. CRANDALL: Read the sentence with respect to what you are talking about.
A. "The patient did rather poorly over the next 10 minutes. Initially pulse ox was 10 minutes, but began to deteriorate. Endotracheal tube became dilodged," da, da.
Q. It was missing what it was initially by your dictation, you didn't dictate what the saturations were within that period?
A. In that period, correct.
Q. I wanted to be clear about that.
So back to where we were, "Patient did poorly over the next 10 minutes, eventually arrested approximately 10 minutes after intubation," correct?
A. Correct.
Q. What time, based on any document in front of you, did the arrest itself occur?
A. Based on these documents at roughly 54, 55

minutes after midnight.
Q. Are you reading the nursing note?
A. Yes.
Q. We will get to that.
A. According to the nurses' note.
Q. Would you have any reason to dispute what is is in that nursing note?
A. I don't have any reason to dispute that particular point of it.
Q. We're going to go through some points you might dispute I suppose.
Immediately following that, "Patient had been reintubated," you see that?
MR. CRANDALL: Back on his note?
Q. Back on your note, sorry, right after.
A. Um-hum.
Q. Eventually arrested approximately 10 minutes after intubation, patient had been reintubated; is that correct?
A. Correct.
Q. Can you tell me at what point in time the patient was reintubated after the initial intubation?
A. The patient's saturations were deteriorating,

it was just on clinical grounds it became a concern that the tube was not in good position as she was deteriorating, she was reintubated. You want to know --

MR. CRANDALL: Her question is at what point in time was the patient reintubated.

A. In terms of time on the clock?

Q. Sure.

MR. CRANDALL: The chart.

A. It's not clear from the nurses' notes exactly when the tube was -- when the patient was reintubated.

Q. Between 12:40 and 12:52, I'm calling it 12:52, you didn't say that, between 12:40 and 12:52 did the repositioning of the tube occur?

A. To the best of my recollection.

Q. We don't know what precise moment?

A. No.

Q. Have you seen the EKG strips in this file?

A. I noticed they were there. I didn't look at them in detail.

Q. Were you at that time capable of interpreting EKG strips for their clinical significance?

A. Yes.

Q. Is there anything in your opinion, based upon

what you knew medically in September of 1996, that the EKG strips can tell you about whether the tube was positioned properly or not positioned properly?

MR. CRANDALL: The strips in the chart?

Q. Yes, just what is in the chart.

A. Yes.

Q. Tell me what they tell you.

A. They tell me a lot of things. There is a point at which the patient became bradycardic.

Q. About 12:52, 12:54?

A. It looks to be.

Q. Between 12:40 and 12:54, we will call it that, somewhere in there this patient as you pretty clearly indicated at least in your handwritten note had been reintubated, I gather she was reintubated at that point by Dr. Irefin?

A. (Indicating affirmatively.)

MR. CRANDALL: You need to say --

A. Yes.

Q. Did Jennifer self-extubate her tube during that time?

A. I don't recall her self-extubating.

Q. Did she cough her tube out?
A. I don't recall her coughing the tube out.
Q. Between 12:40 and 12:52 were you aware that the tube was in the esophagus?
A. I knew that she was doing poorly, at some point in that time period that Irefin felt the tube was probably dislodged, that is when he reintubated her.
Q. You are telling me it's your recollection because you didn't write a note about that in the chart, right, that you and Dr. Irefin had a conversation, your note is this note, the one we're looking at, that is your handwritten note?
A. That's correct.
MR. CRANDALL: He's got a dictated note.
MISS KOLIS: I'm talking about what he has in handwriting.
MR. CRANDALL: Right here.
Q. What CO_2 monitoring equipment was in the cardiac room on September 14th?
A. I couldn't tell you exactly.
Q. Was there CO_2 monitoring equipment in the cardiac room?
A. I couldn't tell you specifically. I couldn't

tell you.
Q. You don't remember it?
A. All the equipment that they had in the room, no. Not in terms of CO_2 detectors.
Q. Were CO_2 detectors used on this child during the first two intubations?
A, I do not recall one being used,
Q. What experience had you personally had with CO_2 detectors before attending to Jennifer Mack on September 14th?
A, Which CO_2 detectors are you referring to?
Q. As we both know there are a couple of kinds. Tell me the kinds you had worked with color metric, had you worked with that previously?
A, There are end tidal CO_2 monitors as a typical part of the anesthesia equipment. I have seen those, Worked with them during anesthesia rotation, et cetera. There are handheld disposable CO_2 detectors.
Q. From your training, which would you have received a couple of months prior to this, do you recall how quickly the CO_2 detector can alert you to the fact you have a tube in the wrong place?
A. It can alert you quickly.
Q. Do you recall how quickly?

A. Within 15, **30** seconds.
Q. Fair enough.
Doctor, you've reviewed the records, you were there, can you tell me why Jennifer Mack had a cardiac arrest on September 14th?
A. She was being underventilated.
Q. Do you have a reasonable assessment based upon the documents in the record, your observation of this patient, for what period of time this child went without airway protection?
A. In the neighborhood of 15 to 20 minutes she didn't have -- she was underventilated at least part of that time.
Q. Let's try to finish up this at least written part of your note. I think we last concluded, although my memory fades with age and time of day, that she had been reintubated, that was the last thing we covered.
"Patient was resuscitated." Were you in charge of the resuscitation team?
A. Yes.
Q. We will talk a little bit about those notes later.
A. Yes.

Q. "Chest compressions, Epi," right? Is that HCO_3?
A. Correct.
Q. "Atropine, Code lasted approximately 16 minutes," right?
A. That's correct. That is what it says.
Q. Then I think your handwriting says "airway was lost again"?
A. That's correct.
Q. Tell me how the airway was lost again.
A. I don't recall in great detail. I know Dr. Irefin felt the tube was not in good position, this was during the arrest, that he wanted to reposition the tube.
Q. In other words, Dr. Irefin brought it to your attention, you were unaware that she lost her airway again?
A, It was always a concern.
Q. At the time her airway would have been lost again would you have been busy directing resuscitative measures in other areas, medication, compressions, things of that nature; do you know what I'm asking you?
A. No.
Q. Let see if I can reask that.

I thought that you had just told me Dr. Irefin indicated to you he thought her airway was lost again.

A. To the best of my recollection, yeah, he did.

Q. So that implied to me you were busy doing other necessary things, pursuant to protocol, to resuscitate the patient, so that you weren't the one that actually noticed that the airway was lost again?

A. That's not quite the way I would put it.

Q. Tell me how you would put it simply.

A. That I was directing the resuscitation, I was aware what was going on, that being actually -- he was at the head of the table, he at any point for whatever reason may have felt that the airway was lost because he's physically holding it in his hand. He told me he thought the airway was lost, he wanted to reposition it.

Q. Did he then reposition the tube one more time?

A. No.

Q. Because what happened at that point in time?

A. I did a tracheostomy.

Q. How quickly did you perform the trach after

it came to your attention the airway was lost again for the third time?

A. 30 seconds.

Q. In terms of clinical numbers, immediately following the trach -- it was actually -- I can never pronounce the word, you know what I'm --

A. Tracheostomy?

Q. Not tracheostomy, didn't you do a crico --

A. No, I did a tracheostomy.

Q. I'm confused by something that appears in the University Hospitals record. You wouldn't know because you haven't read them, correct?

A. Correct.

Q. If they say that is what you did, you did a tracheostomy?

A, I did what I said, a tracheostomy.

Q. You did what you said, you didn't use it shorthand for something else?

A. No.

Q. Fair enough.

At the time that Jennifer was in the emergency room, Doctor, based upon the training that you had for your ACLS, were you acquainted with the standard methods of confirming tube placement in the trachea?

A. Yes.
Q. Can you list for me what you believe they are?
A. Standard methods?
Q. Uh-hum.
A. Presence of breath sounds.
Q. What else?
A. Adequate oxygenation,
Q. How do you determine there is adequate oxygenation?
A. By the color of the patient and pulse oximetry,
Q. What else?
A. When they are available you can use a CO_2 detector. I'm not sure if that is the ACLS protocol or not.
Q. You haven't reviewed the ACLS protocol recently?
A. Not recently, no.
Q. Anything else?
A. Seeing the tubes go through the cords.
Q. By laryngoscope?
A. Yes.
Q. When Jennifer was initially intubated, I'm going by your assessment that you were in the room

most of the time, except you might have stepped out, were you involved in ascertaining whether or not there had been proper placement of the tube?

A. I was involved.

Q. Tell me how you were involved.

A. I was watching the pulse oximetry to see how she responded to her ventilation.

Q. Did you see her chest rise up and down after the tube was in?

A. I would ordinarily do that, I don't recall specifically what the sequence was with her.

Q. Was Jennifer also bagged at that time between 12:40 and 12:52?

A. She was bagged the entire time.

Q. I was going to ask that as follow up, it's not clear to me so I'm asking.

What kind of bag, self inflating or nonrebreathing is what I'm asking; do you know what kind of bag?

A. What kind of ambu bag?

Q. Yes.

A. No.

Q. How many kinds, not talking manufacturers, how many kinds of bags are there that you are aware of that perform that function a little different

from one another; do you know what I'm asking?
A. I know what you are asking.
Actually, no, I don't, go ahead, explain it.
Q. If I asked you if the child was being provided ventilation by a self-inflating bag, do you know what I mean?
A. By self-inflating bag, I believe I do,
Q. Did you know what it was last September, September of 1996?
A. I couldn't recall what kind of ambu bag it was.
Q. If I asked if she was being ventilated by a nonrebreathing bag, would you know what I meant?
A, I have an idea, although I'm not used to using that terminology,
Q. Is there some other terminology that you suspect I'm trying to get at?
A. No. I've used a number of different ambu bags. They all work adequately for most situations so we usually didn't break them apart in those terms.
Q. I probably have asked this and you've answered it, Steve will correct me, after the initial intubation, when did her saturation numbers

start to fall? I don't see them, that is why I'm asking you.

A. Relatively shortly. They picked up for a couple of minutes, then they deteriorated.

Q. At that point in time, as best you recall it, how long did it take Dr. Irefin to reposition the tube?

MR. CRANDALL: Again talking between the first and second intubation?

MISS KOLIS: Yes.

A. Exactly how long in terms of minutes?

Q. Um-hum.

A. How long it was between the first and second intubation, is that what you are asking?

Q. Um-hum.

A. I don't recall exactly. I would imagine --

MR. CRANDALL: Don't guess if you don't know.

A. I don't know.

Q. How soon after the second intubation -- do you want me to call it the second intubation or reintubation or repositioning?

MR. CRANDALL: Why don't we call it reintubation, that is what we've been doing.

Q. How long after the reintubation did Jennifer go bradycardic?

A. I don't recall exactly.

Q. What was done by yourself on the reintubation, what was done by yourself or Dr. Irefin, if you observed it, on the reintubation, to ascertain that the tube was in proper position?

MR. CRANDALL: Objection. Go ahead.

A. I asked him.

Q. I'm sorry, I didn't understand your answer.

A. We did all the same things that were previously mentioned, we looked at pulse oximetry, I don't recall who was listening to breath sounds at what point, breath sounds were listened to.

Q. Did he relaryngoscope on the reintubation?

A. Did he?

Q. Um-hum.

A. Yes.

Q. Chest x-ray was ordered at some point while the child was in Bedford, can you tell from your records, your recollection, nurses' notes, whatever, when in fact that chest x-ray was ordered?

A. After the first intubation.
Q. Doctor, how are you certain it was ordered after the first intubation? I'm just asking you.
A. To the best of my recollection.
Q. Am I incorrect when I state there is nothing in the record recorded by the nurse or a physician to indicate what time, at what point in time that x-ray was ordered?
A. That may well be correct. I didn't look through the records specifically to answer that. I'm sure you have,
Q. If in fact it was ordered after the first intubation, why isn't there a second chest x-ray after the second intubation?
A. There was no opportunity.
Q. Why was there no opportunity?
A. Because she had arrested.
Q. I'm very confused. Let's try to unconfuse me.

You're indicating at least as I'm following the sequence of events, there is intubation, initial intubation by Dr. Irefin by your request based upon the clinical factors.

At some point, what is documented to be 12:52, 12:54 it becomes apparent that the

child is "not doing well," I'm going put that in quotes, that is the best way I can do,

A. Okay.

Q. The tube is probably malpositioned, have I stated this correctly so far?

A. Yes.

Q. A decision is then made -- did Dr. Irefin make the decision to reposition, reintubate, did you make the decision, tell him to do it, if you know?

A. We probably both participated in the decision.

Q. Fine. She is reintubated at the point before she goes bradycardic.

Did she immediately arrest right after she was intubated for the second time?

A. She arrested in a relatively short period of time.

Q. Doctor, you have a portable chest x-ray in the cardiac room, don't you?

A. Yeah.

Q. Who performed the portable?

A. Who actually does the x-ray?

Q. Yes.

A. X-ray technician.

conclusion was from the x-ray; do you agree with that?

MR. CRANDALL: You're drawing a distinction between dictated and written?

Q. In other words, you didn't make a separate contemporaneous note, viewed film, saw A, B, C?

A. That's correct, I didn't.

Q. When you viewed the film, other than the note, the fact that the lungs bilaterally appeared to be whited out, did you note that the tube was apparently in the esophagus based on looking at the x-ray?

A. I knew the tube was in the esophagus looking at the chest x-ray, yes.

Q. At the time you looked at the chest x-ray?

A. At the time I first looked at it?

Q. Yes.

A. I couldn't recall that.

Q. Suffice it to say there isn't a note that discusses that?

A. Correct.

MR. CRANDALL: Not a handwritten note.

Q. I'm sorry, not a handwritten, Steve is correct in making the distinction.

MR. CRANDALL: You said contemporaneous when he dictated, the same time, you are saying written versus typed?

MISS KOLIS: I'm asking --

MR. CRANDALL: Handwriting?

MISS KOLIS: -- handwritten by the doctor as things were progressing,

Q. The answer is no, correct?

A. No, I did not.

Q. In your discharge note, the one that your counsel already is referring to -- I'm starting to lose pieces of paper which happens to me all the time -- in your typed discharge note, first of all let's get a frame of reference, how soon after Jennifer left the hospital did you dictate this note?

A. Shortly thereafter. Probably within half an hour.

Q. When would you have come to work that night?

MR. CRANDALL: Do you know?

A, Either 8:00 or midnight, probably eight o'clock. 8:00 p.m.

Q. The evening before?

A. That's correct,

Q. Your shift would have been, if I follow what

you told me, an eight hour shift, 8:00 p.m. to 4:00 p.m.?

A. No, probably a 12 hour shift, probably 8:00 to 8:00.

Q. Fine. Any place in this discharge summary I'm looking at does it indicate that you looked at the film and drew the conclusion that the tube was in the esophagus?

A. No, it's not noted there.

Q. That is in this typed discharge summary, which was pretty contemporaneous with her discharge from the hospital, correct?

A. That's right.

Q. Doctor, how much training had you had in interpreting and looking for tube placement in the trachea prior to treating Jennifer Mack?

A. How much training?

Q. Yes, once again going back to the yardstick analysis, I never know given people's subspecialty training how much experience, exposure they had dealing with any particular issue.

The question is how much experience did you actually have in interpreting an x-ray film on your own regarding tube placement in the trachea, or tube position is what you like to call

it?

A. Plenty.

Q. We're going to move to a different area I think. I'm going to go to packet B, Exhibit B.

You've indicated you briefly reviewed these notes, I want to go through them to see what it is you do and don't dispute in terms of your recollection.

A. Okay.

Q. In packet B, Exhibit B, the first page that is Bates stamped 0, which is about the third page in on these documents, let's look at what the nurses' documents -- this is a nursing chart, isn't it, for the emergency room?

A, That's correct.

MR. CRANDALL: Isn't that stamped 01?

MISS KOLIS: Yes, third page in from the top.

MR. GROEDEL: You said 0.

MISS KOLIS: 001. There is no 0.

Q. At 0052 there is an indication that Jennifer is bradycardic, her pulse ox is at 50, do you see that?

A. Yes, I do.
Q. Does that note refresh your recollection or help you to determine how much before 0052 her sats went from the 90's down to the 50's?
A. Not more specifically than I could have told you before. She was at 90 for a couple of minutes, then she deteriorated thereafter.
Q. If the initial placement -- I try to do these the best I can. I thought I heard you say you thought that the tube was improperly placed on the first intubation; did I hear that correctly?
MR. GROEDEL: Objection. Go ahead.
A. At some point the first intubation went awry. Whether it was with initial intubation or whether it became dislodged a couple of minutes later is speculation.
Q. Just so we can speak the same language, so I can ask these questions intelligently, you don't know whether it was improperly placed initially, or whether it was dislodged, that's what you are telling me?
A. Not with 100 percent certainty.
Q. If her sats went up to the 90's, 90 and 91 as indicated on the 0040 note -- do you agree that is

what it says, where it begins "Versed given, patient intubated," blah, blah, blah?

A. Yes.

Q. What does that tell you, if anything, regarding whether the initial placement was appropriate?

A. It means that the endotracheal tube was -- it implies it was appropriately placed.

Q. Because if it was in the esophagus from its initial placement, do you have an opinion whether or not those sats could have gone up to 90 and 91 or that might be 94, I'm not positive?

A. It's a 9 something. 9, could be 99.

Q. I can't tell, we don't have that person here, but that is the question.

MR. GROEDEL: We'll call it 99.

MISS KOLIS: For you we will call it 99.

Q. Would the sats have gone up to into the 90's if on initial intubation if the tube was in the esophagus?

A. It's conceivable that it could have come up if she was mask ventilated right before, taken a couple minutes to drop. Probably not. It probably

was in the trachea at the beginning.
Q. How soon after that tube was placed would the chest x-ray have been taken?
MR. CRANDALL: Wait a second, we've been through this.
Q. Initial intubation?
MR. CRANDALL: We went through that. He said he can't be more specific than that.
Q. We see the nurses' notes that the endotracheal tube became dislodged, that is what the nurse said, correct, in writing, see that right after the 90 up to maybe 99?
A. Um-hum.
MR. CRANDALL: You need to say yes.
A. Yes.
Q. Then says reintubated, correct?
A. Um-hum.
Q. At that point the patient is given Pavulon, correct?
A. That's correct.
Q. What does Pavulon do?
A. A muscle relaxant, a chemical paralysis.
Q. Does it paralyze the lungs in any way?

A. Paralyzes the muscles that move the lungs.
Q. Why was she given Pavulon at that point?
MR. CRANDALL: Objection.
Q. Did you order the Pavulon?
A. I do not believe I did.
Q. Why do you think you didn't order the Pavulon? I'm asking why you don't think you ordered it?
A. Because I don't recall ordering the intubation drugs. I would have considered that an intubation drug.
Q. This is written how it's written, of course we all know the record speaks for itself.
Was Pavulon given before the second -- before the reintubation?
MR. CRANDALL: If you know.
A. I couldn't tell you specifically.
Q. Would it make sense to you it would be given after the second intubation, the reintubation?
A. Not necessarily.
Q. In that same I'm going to call it paragraph, the 0040 time, it indicates that the patient was intubated with a 3.5 tube?
A. Yes.
Q. Do you agree or disagree she was intubated

with a 3.5 tube initially?
A. My notes recollect a 3.0. In the hour that passed between the time of initial intubation and the time I dictated my notes I could have mistaken a 3.5 for a 3.0 tube.
Q. Based on the sum total of the record and your recollection, you don't know if a 3.5 was initially placed when she was intubated or a smaller tube, a 3?
A. No. I know the initial tube was not the usual tube given to a five year old. I know it was a small smaller tube, 3.5, 3.0 tube.
Q. On a chart I saw it specifies a 3.5 is standard or general, if you look at the chart, that is used on six month olds, somewhere in that range?
MR. CRANDALL: Do you know?
A. Yes.
Q. You agree with me, right?
A. Yes.
Q. Going down a little further, we're going to have the testimony of this nurse, there are some things I want to ask you.
At the 0104 note, "Patient has strong pulse," can you see that note?
A. Yes.

Q. You follow that BP 98/76, pulse 98, bagged 100 percent 02. Do you see any other notes in the nursing chart about the child being bagged?

MR. CRANDALL: Other than that note?

Q. Other than that note?

A. No, I don't.

Q. Then says emergency trach by Dr. Douglas?

A. Yes.

Q. We're asking the silly questions about the way notes get written.

Your decision to trach the patient was based upon what?

A. It was based on my concerns that an adequate airway was not being achieved via oral endotracheal intubation.

Q. You determined -- your concern at that point was based on what; pulse oximetry, vitals, CO_2, what was it that made you decide to do a trach at that point? I know what you are telling me is the end product, your medical conclusive result was a concern over the airway, what clinical factors that --

A. The fact she --

MR. CRANDALL: Objection to

form. Go ahead.

A. That she had undergone an arrest.

Q. She did not get better from the arrest until after you trached her; that's an accurate statement?

A. Yes, that is an accurate statement.

Q. I could have gotten a quicker answer if I asked it that way to begin with.

When the nurses' note indicates the patient has a strong pulse, does it seem to you the patient has a strong pulse after the trach, not before the trach?

A. The patient got a strong pulse after the tracheostomy.

Q. It's just the way the person wrote the note, just putting information in there?

A. Correct.

Q. How soon after you trached the patient did she lose her cyanosis, if you know?

A. She got better quickly.

Q. One, two minutes?

A. Something like that.

Q. You had read prior to coming here the nurses' notes, right?

A. Not exhaustively, yes.

Q. You had implied in your answer you had some dispute with something in the notes, did I misinterpret or is that accurate?

MR. CRANDALL: No, that's not accurate.

Q. We will put the direct question so we have an answer for the record.

Based on your review at that point in time, do you dispute anything as it's recorded in the nurses' chart?

A. Although I don't clearly disagree in specific with these parts of the notes, neither do I recollect the details such that I could take every statement in there and specifically say whether it was the time sequence, or exact form was unquestionably true or false.

MR. CRANDALL: She asked do you disagree with anything in here?

A. No.

Q. Fair enough.

A. Not in this section, these two pages.

Q. Is there a section of notes where you have a dispute with something that is recorded?

A. The only dispute was what was brought up earlier, Life Flight.

Q. Life Flight was not there doing a trach?
A, That's correct.
Q. That's the only dispute you have based on the information recorded in the chart?
A. So far.
Q. There is a note by Dr. Irefin, page 005. Had you reviewed that note?
A. Yes.
Q. You agree with me that this note which is written by Dr, Irefin, by the house officer, only indicates one placement of one tube; is that right?
A. That --
Q. As far as the note goes?
A. That is what the note indicates.
Q. Do you see any indication in Dr. Irefin's note of a CO_2 monitor being used?
A. No.
Q. You do see he notes bilateral breath sounds, correct?
A. Yes.
Q. Did you -- I don't like calling you the attending.

You were the physician in charge of this particular patient, correct?
A. Yes.

Q. Do you want me to call you the attending?
A. You can call me whatever you like.
Q. In reviewing the chart, did you ask at any time for Dr. Irefin to write a more detailed note regarding the subsequent event?
A. I only saw this note months later.
Q. Going back to page **006**, which was the x-ray page, are you there with me?
A. Yes.
Q. This was dictated on the 14th, I know you are not the radiologist, I'm going to ask you this question: At the bottom says, "Film was obtained in emergency, development note by Dr. Douglas indicates he was aware of the endotracheal tube malposition"; you see that?
A. Yes.
Q. Did they call you at some point, the radiologists, did they call you to tell you what their reading was; do you recall that?
A. No.
Q. When the note says that you have a note that says malposition -- I'm going to withdraw that, I'll ask you what -- you don't know what he meant -- do you know what in the note he's referring to when he discusses malposition?

A. I suppose I don't.

Q. We will skip that question.

What I'm going to do, Doctor, at this point Ann may give me some notes, questions she wants me to ask you, I'm going to ask some straight probably medical questions.

In the scenario of Jennifer Mack, who had the responsibility to continuously monitor Jennifer or monitor -- if you don't like the use of the word continuous -- to make sure she had a protected airway?

A. The responsibility of the patient is mine. When an anesthesiologist participates in intubation, they would ordinarily have some input into the situation.

Q. In looking at the notes that you record, you probably have some memory, you told me you had, of Jennifer's condition on arrival, how did you characterize it, fair, critical, what was your assessment initially on her arrival?

A. At least serious.

Q. Did you talk with this child, do you remember one way or another?

A. Do I remember specifically talking?

Q. If she verbally is talking?

A. No, I don't remember that.
Q. She was conscious, correct?
A. She was conscious, yes.
Q. Extremely agitated, do you remember that, I'm characterizing?
A. She was in distress.
Q. When you say she is in distress, eliminating for a moment the respiratory distress we discussed, are you describing her psychological state or her emotional state?
A. No, I'm describing her respiratory state.
Q. What about her psychological state in terms of agitation?
A. I don't remember specifically how agitated she was.
Q. Doctor, do you have an opinion based upon your experience at the time, your medical experience, as to why the tube became dislodged at the first and second intubations?
A. It's speculation. I would presume it's just a very thin tube, very thin floppy tube for which you are trying to do physical manipulation with to ventilate a patient, there is not a lot of rigidity or support to it.
Q. How important is it to maintain a patient's

airway?
A. Very important.
Q. Based upon your recollection or the notes, do you know if the tube was secured by tape at any time?
A, I do not recall how they secured it.
Q. Did you see any notes either in the nursing section or we know you didn't write any notes other than the handwritten initial note, your discharge summary, did you find any notation that the tube was secured by tape at any place in this chart?
A. I didn't look for it, I don't recall any,
Q. Is that something you had learned prior to Jennifer Mack, that you should tape or secure the tube with tape?
A. At some point you are certainly supposed to.
Q. Why do you do that?
A. So it doesn't become dislodged.
Q. I'm going to ask you a few medical questions that regard the issues that present themselves. I honestly will try to be brief, it will take me longer to read them and eliminate than to actually probably ask what is in there.
Doctor, unrelated to the actual event, although you spent just a little bit of time

with the record, did you do an independent literature search, medical literature search regarding the issues you felt might present themselves in this case?

A. No.

Q. Are you familiar with t e standards for basic anesthetic monitoring that are set forth by the American Society of Anesthesiology?

A, In specific, no.

Q. I should ask that question better.

Prior to attending to the medical condition of Jennifer Mack, had you familiarized yourself with the standards that are promulgated by the American Society of Anesthesiologists?

A, Not per se.

Q. You didn't receive any subspecialty training in anesthesiology, did you? I didn't see it, I'm asking.

A. No.

Q. Were you relying upon Dr. Irefin to provide the anesthesiology services?

A. Yes.

Q. We've gone through this, at the time were you familiar with the American Heart Association's Advanced Cardiac Life Support guidelines for

intubation? Was that too many words in a sentence?
A. Yes.
Q. I think we went over, you have already stated for the record what you believed the standards were as you had learned them in your certification program, correct?
A. Yes.
Q. You had just received that certification about two and a half months before Jennifer came to the hospital, correct?
A. That's correct.
Q. By the way, how did you receive your certification?
A. How did I?
Q. Yes.
A. In the mail.
Q. I'm sorry, you got me, asked a bad question. What program did you undergo to allow you to obtain a certification?
A. It was a course given by Saint Luke's.
Q. Saint Luke's Hospital?
A. Yes.
Q. When did you take the course?
A. July, '97. '96.
Q. It would be hard to do it in '97, right.

Can you describe for me the length of the program and course material provided to you?
A. It was over two days, neither day was a full day.
Q. Neither day was a full day, two days at Saint Luke's?
A. Standard ACLS booklet handed out,
Q. I don't have mine with me, who taught the course?
A. Jeff Wilson.
Q. Was it didactic only or didactic and clinical? In other words, you had a lecture series, correct, on those two days?
A, That's correct.
Q. You went over the basic textbook information?
A. That's correct.
Q. In conjunction with that, were any of the -- were you required as part of the certification program to perform any procedures?
A. Yes.
Q. What procedures did you perform in that two day period in July?
A, Intubation, central line placement. Actually, they were performed in front of the instructor.

Q. I'm sorry?
A. There wasn't rigorous testing. They were performed in front of an instructor that felt we had adequate skills.
Q. You said intubation, what kind of intubation did you do?
A, Oral.
Q. I'm sorry, on a patient who was in the hospital who needed oral intubation?
A. No, on the dummy.
Q. I'm sorry, I'm not asking great questions because it's six o'clock.

You were not performing these procedures to demonstrate your skill level on human beings as part of the certification, doing it on models?
A. Correct.
Q. So you did intubation and central line placement, correct?
A. Yes.
Q. You just took that course, you told me you got a certification, would you consider that the published guidelines of the American Heart Association Advanced Cardiac Life Support program would be the standard of care for the proper

placement of endotracheal tubes, as well as for confirmation of the placement?

A. What do you mean by set the standards?

Q. I mean, what you learned in that course, if they have printed what you should do to confirm the placement of an endotracheal tube, would you accept that in fact would be the standard of care, what at a minimum should be done to confirm placement if that is in fact what the guidelines say?

A. That depends on I don't recall exactly what they printed. Every situation has to be adopted to what is going on at the time. I couldn't say that absolutely everything that is in their guidelines necessarily needs to be applied to every clinical situation.

That book is also meant for people who are not usual providers of that kind of care. Paramedics, nurses, respiratory therapists, to give them a basic guideline to undergo. It's not meant to imply that physicians can't use their individual judgment in a given situation.

Q. I think we understand your answer.

Would you at least then consider them authoritative as a baseline minimal requirement for endotracheal intubation and

confirmation of placement?
A. Except as limited by what I said above.
Q. Were you aware that Bedford Medical Center had a protocol using the ACLS guidelines for both -- I'm testifying I guess, I don't have my question in front of me -- for both how to place the tube and confirmation of tube placement?
A. No.
Q. Had you availed yourself of the opportunity to review what the protocols of Bedford Medical Center were before you undertook work there?
A. No.
Q. What are some risks of improper placement of an endotracheal tube?
A. Hypoxia, respiratory acidosis.
Q. Is one of the -- let me ask it this way: Would you agree with me that it is possible to inadvertently intubate the esophagus when you are trying to do an endotracheal intubation?
A. Yes.
Q. Would you agree with me that is not a rare and unheard of occurrence?
A, Yes, I would agree with that.
Q. Would you agree with me that intubating the esophagus will lead, can lead -- first of all, what

do you think intubating the esophagus can lead to, we will ask that question?

A. It leads to not being ventilated or oxygenated.

Q. Which then can lead to cardiac arrest?

A. Yes.

Q. Which then can lead to hypoxia?

A. Yes.

Q. Anoxia, correct?

A. Correct.

Q. Do you have any idea or did you know at the time that you took care of Jennifer Mack, what approximate percentage of time that the endotracheal tube accidentally intubating the esophagus was? I'm just asking if you know based upon your studies.

A. If I know that?

Q. What percentage? I'm asking if you have an idea based upon studying medicine what percentage of time the esophagus is inadvertently intubated?

A. No, that would vary drastically, depends on the situation.

Q. Knowing that can happen, knowing if it's in the esophagus, goes undetected, one of the critical concerns is to confirm placement, make sure you're

not in the esophagus; would you agree with that?
A. Yes.
Q. It's not an option or within a doctor's judgment, you have to do everything that you can do to confirm a placement, correct?
MR. GROEDEL: Objection to the word "everything."
Q. Let me ask it a different way.
If there is anything the least bit suspicious in terms of the placement, in terms of the person's saturation, return, how they are breathing, you continue to investigate, you continuously monitor to make sure a tube doesn't get dislodged, don't you?
A, It's always a concern, yes.
Q. Did you ever hear a gurgling sound in Jennifer's throat after the first or second intubation?
A, I don't recall hearing a gurgling sound.
Q. Do you recall ever having any secretions coming back from the tube?
A. No.
Q. No notation of suctioning in the chart anywhere, is there?
A. I'm sure you would know better than I would,

Q. I don't want that to be your answer.

MR. CRANDALL: You don't want him to look through the whole chart for suctioning?

Q. As you read it were you -- we'll pull the question back, say what you m an, mean what you say.

There was the suggestion I believe in your discharge summary about pulmonary obstructive edema; am I right?

A. Yes.

Q. If that was going to be something you were thinking about, you would be looking for a secretion of a pinkish color, wouldn't you?

A. Yes, but those don't necessarily develop right off the bat.

Q. Of course not, While she was on your watch, under your care, nothing like that existed or you would have documented it in some fashion, either in your discharge, typed discharge summary, or in that handwritten note, wouldn't you?

A. I don't know if I necessarily would have dictated it in my note. I don't recall seeing anything like that.

Q. What was suggestive to you that there could

possibly be obstructive pulmonary edema?
A. It was the patient had whited out hemothoraces bilaterally, I didn't have -- I did not have a good explanation for it. It was just one of the differentials that I was thinking about because she was inspiring with great force.
Q. Is that caused by laryngospasm?
A. Yes, can be a sequela of a laryngospasm.
Q. You told me you have not looked at the records from RBC?
A. That's correct.
Q. Have you asked to look at the records?
A. No.
Q. Do you believe that it's the standard of practice to document in a patient's chart the method of confirming the placement of the tube?
A. I think that if you reviewed charts from multiple, a long series of consecutive intubations, you probably would not find a lot of documentation confirming it, other than probably bilateral breath sounds. That's the reality.
Q. That is the reality, do you believe the standard requires that you document what you have done to confirm placement of the tube?
MR. CRANDALL: He just

answered that.
Q. Is that your answer, what you just told me?
A. Yes.
Q. You took the history from the mother; is that right, from Mrs. Mack; do you recall that?
A. I certainly would have gotten some from the paramedics.
Q. Do you remember talking to Mrs. Mack after the code but before Jennifer was transferred --
A. Yes.
Q. -- to RBC? What did you tell Mrs. Mack happened to Jennifer?
A. To the best of my recollection, she had arrested, that we had to do a tracheostomy, we had gotten her back, but we had a rough go of it. I mentioned briefly that her insurance leads her to the Clinic, to the Cleveland Clinic, I was going to send her to Rainbow anyway given all the things that had been going on.
Q. Do you recall if Mrs. Mack asked you why Jennifer arrested?
A. No, I don't,
Q. Do you recall having a conversation with Mrs. Mack when you saw Jennifer at RBC?
A. I do not recall having a conversation with

her.

Q. Do you agree that having an attack of croup can cause edema, which in turn does make endotracheal intubation more difficult?

A. Yes.

Q. At any time, of course I'm asking what you remember, I've read the chart pretty carefully, did you consider transporting Jennifer to the operating room for the evaluation of her upper airway and intubation, as opposed to the cardiac room?

A. I did consider it.

Q. Yes?

A. I don't recall it specifically. I have considered such things in the past.

Q. In this case you don't know?

A. Not specifically.

Q. You originally or a long time ago told me that one thing that was perhaps -- I think you said this in your differential was epiglottitis?

A. Yes.

Q. You agreed we had no confirmation that would have been in existence. Did you consider there was a foreign body in her throat that was causing her symptoms?

A. I didn't consider it at that time. It seems

like it would have been unlikely.

Q. Did you actually hear her barking cough at the time you saw her? I'm using the phrase that is in the history.

A. I don't specifically remember that. I remember her stridor. She may have coughed, I don't really remember the cough. The cough would have been less meaningful to me.

Q. Were you fairly certain by the time of discharge she had an attack of the croup?

A. I felt fairly certain of it.

Q. When bilateral breath sounds are listed in the chart, what does that mean to you? Observing the thoracic inflation, deflation, is that what it means?

A. Yes.

Q. Did you yourself at any time directly visualize the tube passing through the vocal cords?

A. No.

Q. Once again, I don't think I asked this question as specifically as I would have liked to, I don't think it's actually asked and answered.

Going back to when I asked you to look at the nursing note, it says endo tube became dislodged, do you agree or disagree with that

recorded event by the nurse?
A. Yes, endotracheal tube was not in place.
Q. Does that mean something to you different when you say it's not in place, is that different to you than dislodged?
A. No.
Q. Do you have a specific recollection -- let me ask it this way: You haven't been able to tell me time, no documentation of pulse ox, pulse ox crash, we have got that sentence where it goes to 90, up to maybe, Mr. Groedel, 99, then we have her being bradycardic, the pulse ox is in the 50's, do you know what alerted -- what number alerted yourself or Dr. Irefin to the fact the tube was dislodged?
A. I wouldn't think it was one thing in particular.
Q. When you say it -- let's ask this question: This child's pulse ox is being monitored by pulse ox, on the pinky was it? I'm asking do you remember if that is how it was being done?
A, I don't remember which digit it was on.
Q. The digit, but that was the kind of pulse ox you were doing, right?
A. Right.
Q. Who was watching those numbers?

A. I was.
Q. Did the pulse oximeter suddenly go from 90 something to 50?
A. No, it gradually goes down.
Q. As it was gradually going down, what did you think was the reason it was gradually going down?
A. It was either a problem in the lungs or problem with the airway.
Q. As it was gradually going down, is that occurring after or before the second intubation?
A. It gradually went down, she was reintubated.
Q. When she was reintubated please tell me what her pulse ox was?
A. I couldn't remember specifically, my best recollection is that it's in the 60's.
Q. Did her sat start going up?
A. No.
Q. Over what period of time -- what is your best recollection of reintubation to actual arrest?
A. That it was short. A couple of minutes.
Q. How long did it take you to perform an emergency tracheostomy on Jennifer when you did that?
MR. CRANDALL: You already asked that.

MR. GROEDEL: Yes.

MISS KOLIS: I'm sorry, are you sure I asked that?

MR. CRANDALL: Yes.

THE WITNESS: I am positive you asked.

MR. GROEDEL: You know the answer?

MISS KOLIS: 30 seconds. Sometimes I think I know the answer, I don't always know it, Marc.

MR. GROEDEL: Never seen that happen once, Donna.

Q. Doctor, I asked this, but I think I asked the general question, I didn't go back and ask the specific question: When you wrote your discharge summary note you were using a CO_2 monitor during the arrest, was that color metric readings? You know what color metric readings are?

A. Probably, yes.

Q. You just don't remember, you can't tell me what you were using?

A. I don't remember using color metric. I don't remember using anything other than that.

Q. If you don't remember using any that is

fine, You had experience with that type of monitor?

A. Yes.

Q. Was auscultation applied at any point from 1240 through the arrest at 1679?

A, Auscultation?

Q. I can spell it, I can't say it.

A, There was ongoing concern about her respiratory status, I'm sure that I did. I don't remember how many times or exactly when I put a stethoscope on her chest.

Q. That's not documented in the nurses' notes, I didn't see it, I'm asking if you see it?

A. No, I don't remember seeing that.

Q. We've covered you made no notes -- go ahead.

A, They did note breath sounds with intubation, doesn't note --

Q. Initial, right.

A, Yes, didn't note anything after that.

Q. Once again to make sure I covered it, by using the correct terminology you did not note any pulmonary edema, fluid coming from the endotracheal tube during this entire situation?

A. That's correct,

Q. Was any suctioning required that you recall

after the second intubation, reintubation?
A. Was any suctioning required?
Q. Yes.
A, Not that I recall,
Q. You were in the room at the time of the code, you didn't have to be called back in, correct?
A, I do not believe so.
Q. Was Dr. Irefin still there at that time?
A. I don't remember him leaving the emergency room. He may have stepped out of the room.
Q. That is what I mean, the cardiac room?
A. I don't remember exactly when he was in and out.
Q. During the arrest, when it became apparent that the airway was again lost, as you already testified you did not attempt to reintubate, you immediately did the trach?
A. That's correct.
Q. Was Dr. Irefin still in the room at that point?
A, Yes.
Q. Would you have considered Dr. Irefin qualified to perform an emergency trach?
A. No, not as qualified as me.
Q. Based upon all your surgical training?

A. That's correct,
Q. Do you recall he was qualified to do it but not as qualified as yourself?
MR. GROEDEL: Objection about what he knows about Dr. Irefin's qualifications.
MISS KOLIS: I'm asking what he's thinking.
MR. GROEDEL: I'm still objecting. Go ahead,
A, I thought I should be the one performing the tracheostomy.
Q. We've already covered that for whatever reason when I found that Life Flight was attempting trach, they did not attempt a trach?
A. They did not attempt it.
Q. On the advanced life support record, packet B, close to the end,
A. Which page is it?
Q. I'm sorry, page 00009 of the B packet.
A. Yes,
Q. See on the bottom says participants, can you tell me who these people are by name; if you can't that is all right?
A. I can tell you first one second line, I can tell you second one, second line.

Q. Douglas, we know who that is?
A. That is it. I don't know anybody's names.
Q. You don't know these people?
A. No.
Q. M.D. signature, that's you?
A. That's me.
Q. Did Dr. Irefin participate in this resuscitation?
A. In the sense he was at the head of the patient, he was -- he had intubated the patient, I'm sure part of the time he was ventilating the patient, so forth, yes. I ordered, I was the one ordering the medication for resuscitation.
Q. Let me ask this question: Is there any evidence in this chart as you reviewed it of paracardial restriction?
A, No.
Q. No paracardial tamponade in the x-ray, et cetera, correct?
A. No.
Q. No diuretics were administered?
A. That's correct.
Q. If there was a high index of suspicion on your part for any reason of obstructive pulmonary edema you probably would have given a diuretic,

wouldn't you?

A. If I had a high index of suspicion, yeah. If I had a high index of suspicion.

Q. Stupid question, I love to ask them so I can get my record, so nobody can say I didn't get it at trial: Are you going to offer any opinion critical of the care rendered at Rainbow Babies and Childrens?

A. No.

Q. Are you going to offer any opinion critical of the care rendered by nurses at Bedford Hospital?

A. No.

Q. How about Dr. Irefin?

A. No.

Q. Do you know this child's cause of death?

A. Presumably.

Q. You say presumably because?

A. I didn't review the record at Rainbow.

MISS KOLIS: I don't have any further questions.

MR. GROEDEL: Just a few. I am Marc Groedel, I represent Dr. Irefin, I have a few questions for you.

CROSS-EXAMINATION

BY MR. GROEDEL:

Q. Was this child restrained when she was being treated in the emergency room?

A. At any time?

Q. Prior to her going into arrest?

A. She may have needed some restraints as she was being initially intubated, I don't recall specifically.

Q. Was she in sufficient distress so as to potentially cause her endotracheal tube to come out after it was initially first successfully placed?

A. Was she moving around and agitated enough, it may have been. I do not recall how much wiggling she did after her first intubation. I don't recall it specifically one way or another.

Q. When did the patient go into cardiac arrest, what time was that?

A, As far as actually giving a time, I don't recall anything more specifically than you can see in the nurses' note.

Q. At 12:52 or a little bit after that?

A. A little bit after that.

Q. On the code sheet says CPR started at 12:52, would that be when the code --

A. Yes.
Q. Does CPR start when a patient goes into asystole, or starts when she became significantly bradycardic?
A. It would have started when she became significantly bradycardic. I don't think there was a very long period of bradycardia.
Q. At what time did you perform the tracheostomy?
A. Give or take 10 minutes after she arrested.
Q. I'm sorry?
A. Give or take 10 minutes after she arrested.
Q. At what stage were you with the child when you saw the x-ray results?
A. In relation to her being reintubated?
Q. In relation to anything.
A. The x-ray came back roughly at the time she got reintubated, more or less. It takes several minutes to get an x-ray back. There was not a significant amount of time, plus or minus, when the x-ray came back and when she got reintubated.
Q. Are you saying the x-ray came back, at around the same time she was reintubated for a second time, there was only one reintubation?
A. I only recall one reintubation. Somebody

might have adjusted the tube a little bit, called that repositioning.

Q. This occurred prior to the child's arrest?

A. Yes.

Q. Can the manipulation involved in taking a portable chest x-ray cause an endotracheal tube to become dislodged?

A. It's unlikely but it's conceivable.

Q. I know there has been a number of questions asked, I want to make sure the record is clear on this point: In terms of whether the end tidal CO_2 monitor was used prior to arrest you don't know one way or the other, correct?

A. I don't recall one being used. If *you* are asking me do I specifically remember asking for one, not having one available, no, I don't remember specifically that.

MR. GROEDEL: That is all I have. Thanks.

MR. NORCHI: Dr. Douglas, my name is Kevin Norchi, I represent Bedford Medical Center, I have a few questions to ask you.

CROSS-EXAMINATION

BY MR. NORCHI:

Q. In follow-up to Mr. Groedel's last question, was there any equipment that you requested that was not available for you during these events?

A. Again, not specifically.

Q. Is there anything as you review the records before you, now that we've gone over them for the last two and a half hours, based on your review of the records previously before the deposition, based upon your memory, is there anything that was not available to you that you specifically requested or required, or that prevented you from doing your job as an emergency room physician as relates to Jennifer Mack?

A. Again --

Q. Based upon what you know?

A. Upon what I know, no.

Q. Do you have any criticisms of -- I know this was already asked, let me ask it more specifically -- do you have any criticism of any Bedford Medical Center nurses during the time that Jennifer Mack was in the emergency room?

A. Certainly not.

Q. Why do you say "certainly not," is it your

opinion they acquited themselves well, did as you told them to?
A. It's always a difficult circumstance, every situation like this is always a little different. It's not as though you are having a well orchestrated performance that has been done exactly the same way, exactly the same sequence multiple times. They did a fine job.
Q. No criticisms of the respiratory therapist or radiology technician who were also present?
A. No.
Q. Do you remember when the Pavulon was given in relationship to when you interpreted the x-ray?
A. No, I saw it on the nurses' notes. I actually to be perfectly honest didn't recall the Pavulon at all. I know it's in the nurses' notes. The issue of Pavulon completely escapes me.
Q. You don't remember ordering it or administering it?
A. No.
Q. Doctor, in the emergency room setting such as we have here, it is the physician's duty to determine whether intubation is necessary, correct?
A. That's correct.
Q. Here you made the determination it was time

to intubate Jennifer Mack?
A. That's correct.
Q. Not a decision delegated to a nurse or hospital staff?
A. That's correct.
Q. In an emergent setting it is the physician's obligation to actually do the intubation, correct? Would you permit a nurse to intubate a patient?
A. No.
Q. You've intubated patient's before; is that correct?
A. Yes.
Q. Youv'e intubated adults?
A. Yes.
Q. In those situations, where you've made a determination that you will intubate this patient, then you followed up by actually intubating the patient, have you also secured the tube, the endotracheal tube?
A. Usually not.
Q. Who does that?
A. Usually the respiratory therapist does it, sometimes I'll do it.
Q. How do you do that, hand it off, say here you go, or how do you do that?

A. Yes. They put their hands on the tube, they can secure it.
Q. Your hand would be on the tube, then the respiratory therapist's would come to the tube?
A. That's correct.
Q. Like passing a baton in a relay in a track meet?
A, Except the baton is not moving,
Q. Hopefully. In this case do you know whether or not this child was moving at all during any of the intubations?
A. She was given Succinylcholine before the first one I performed, she wasn't -- I don't recall details like was she moving at point X, Y, Z so forth.
Q. You don't recall so other than isolated incidents you don't recall there being a continual problem or concern early on this child is moving or bucking against the tube or coughing against the tube or turning her head back and forth against the tube?
A. No, I don't recall that as being a problem.
MR. NORCHI: That's it. Thank you, Doctor.

RECROSS-EXAMINATION

BY MISS KOLIS:

Q. The purpose of giving Jennifer Succinylcholine is to calm her down so intubation could be done, isn't that right, to relax her muscles so intubation could be done?

A. Yes.

MISS KOLIS: I don't have any further questions.

MR. CRANDALL: Do you guys have anymore? We will read it. Send it to me.

MISS KOLIS: I'll waive the seven days. Not forever.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

I have read the foregoing transcript and the same is true and accurate.

_____

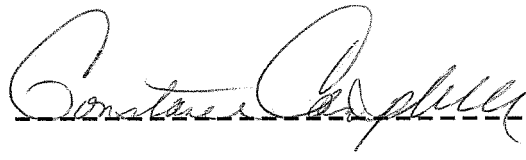
WILLIAM DOUGLAS, M.D.

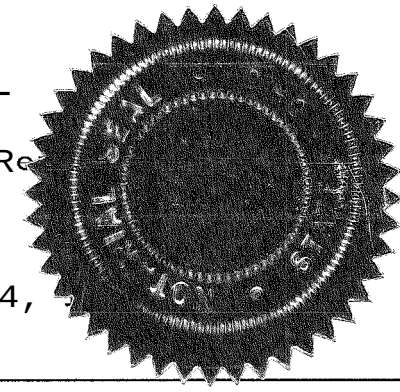
The State of Ohio,
County of Cuyahoga. CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, WILLIAM DOUGLAS, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 22nd day of May, 1997.





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UNIQUE WORDS: **1,472**
TOTAL OCCURRENCES: **5,296**
NOISE WORDS: **385**
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MAXIMUM TRACKED OCCURRENCE THRESHOLD: **50**

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NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: **6**

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