IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

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DOC 465

FRANCES SMITH, Administratrix, etc.,

Plaintiff,

vs. : Case No. 100877

ST. LUKE'S HOSPITAL, ET AL.,

Defendants.

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Deposition of JOHN B. DOWNS, M.D., a witness herein, called by the Defendant Lee for cross-examination under the statute, tsken before me, Nicholas A. Marrone, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without notice or other legal formality, at 410 W. Tenth Street, Columbus, Ohio, on Monday, February 23, 1987, at 10:15 o'clock a. m.

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APPEARANCES:

Charles Kampinski Co., L.P.A.
1530 Standard Building
Cleveland, Ohio 44113,
By Messrs. Charles I. Kampinski and
Christopher M. Mellino,

On behalf of the Plaintiff.

Reminger & Reminger
The 113 Building
Cleveland, Ohio 44114-1273
By Mr. Marc W. Groedel,

On behalf of Defendants
Stephens and Smith.

Jacobson, Maynard, Tuschman & Kalur
100 Erieview Plaza, 14th Floor
Cleveland, Ohio 44114
By Mr. Stephen Charms,

On behalf of the Defendant Lee.

Kitchen, Messner & Deery
1100 Illuminating Building
55 Public Square
Cleveland, Ohio 44113
By Mr. Steven W. Albert,

On behalf of Defendant Sims.

Arter & Hadden
1100 Huntington Building
Cleveland, Ohio 44115
By Mr. Michael C. Zellers,

On behalf of Defendant
St. Luke's Hospital.

Monday Morning Session

February 23, 1987

10:15 o'clock a. m.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that the deposition of John B. Downs, M.D., a witness herein, called by tho Defendant Lee for cross-examination under the statute, may be tsken at this time by the Notary by agreement of counsel without notice or other legal formality; that said deposition may he reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualification of the Notary is waived.

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JOHN B. DOWNS, M.D.

first duly sworn by the Notary, as hereinafter certified, deposes and says as follows:

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CROSS-EXAMINATIa~

BY MR. CHARMS:

Q. Doctor, my name is Steven Charms and I'm an attorney representing Dr. Lee, an anesthesiologist who is one of the party defendants in this case. And yon have been identified by Mr. Kampinski as an expert against Dr. Lee. Mr. Kampinski has provided me with the report which will been marked as Deposition Exhibit A.

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Thereupon, Downs Deposition Exhibit A was marked for purposes of identification.

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BY MR. DOWNS:

a. Would you take a minute and look at that,

A. Yes.

Q. That's a copy of the report that you prepared and submitted to Mr. Kampinski?

A. It appears to be, yes.

Q. I'm going to he asking you a number of questions today about the opinions that you have rendered in this case. If for any reason you don't understand a question, you can't hear it because of the fan, it's confusing or whatever -- would you prefer it --

A. I would think so because it's right over me, if you wouldn't mind? Thank you.

Q. Now hopefully you should be able to hear me. So if the question is confusing or it didn't make sense to you for any reason, please stop and tell me what your problem is with the question and I'll try to rephrase it or ask you to rephrase it for me, and that way at the end of the deposition we'11 have an understanding that you understood the questions I asked and answered them to the best of your ability. Is that correct?

A. Yes.

Q. Would you state your full name for the record, please?

A. John Burton, B-u-r-t-o-n,Downs.

Q. And your occupation?

A. I'm a physician,

Q. Oksy. And you specialize in?

A. Anesthesiology and critic31 care medicine.

Q. I want you to assume that Mr. Smith didn't go to surgery on November 17th, 1984, okay, the second surgery in his last admission to St. Luke's Hospital. How long would he hsve lived?

MR. KAMPINSKI: You are asking him if he has an opinion as to that?

MR. CHARMS: Do you have an opinion?

A. I would not be able to judge how long he would live with any degree of certainty.

Q. Okay. Well, I see from your CV that you are a fellow of the American College of Chest Physicians; correct?

A. Correct.

Q. And you have expertise in pulmonary medicine?

A. I have expertise in anesthesiology and critical care medicine which involves to a large extent the respiratory system, respiratory physiology, pathophysiology and so on. But I have not ever had formal training in the designated subspecia1ty of interna1 medicine ca11ed pulmonary medicine.

Q. All right. Rut you have training in pulmonary medicine as it relates to anesthesia, right, and critical care medicine?

A. Well, again, pulmonary medicine is a specific subspecialty of internal medicine. Again, I have had training in critical care medicine which involves to a large extent the pulmonary system.

Q. Okay. I didn't mean to interrupt you.

A. So you could indirectly say I've had some training in a generic pulmonary medicine.

Q. Okay. In critical care medicine, you also have had some training in cardiology?

A. Again, that's a subspecialty of intern31 medicine as well. I have had training and experience in dealing with people with cardiac problems.

Q. Okay. In your position here at University Hospitals, I assume you anesthetize patients?

A. I supervise the anesthetization of patients on a much mare frequent basis than I actually induce anesthesia.

Q. Are you involved in supervising anesthetizing patients for cardiac surgery?

A. Only on a very infrequent basis now. Up until about six month5 ago, I did that relatively frequently.

Q. So you are trained in cardiac anesthesia?

A. I have -- I was trained in cardiac anesthesia and I have extensive experience in cardiac anesthesia.

Q. Okay. The only reason I ask is in your report you make numerous references to Mr. Smith's preoperative cardiorespiratory status, his intraoperative status and his postoperative status. So I just assumed from your report that you had some degree of expertise in those areas; is that a fair assumotion on my part?

A. I have expertise in the preoperative assessment of those areas and also in the intraoperative and postoperative management of cardiopulmonary problems, yes.

Q. In your report you indicated I think it's on page one, halfway down that big paragraph talking about EKG interpretations?

A. Yes.

Q. Do you have it tnere, Doctor?

A. Uh-huh.

Q. Okay. My first question io you is I assume you have reviewed the actual EKG?

A. As a matter of fact, I Aid not. I reviewed only the interpretation of the EKG.

Q. 'Jhy don't you take a minute and look at that actual EKG.

MR. KAMPINSKI: Did you bring the original record?

MR. ZELLERS: No.

MR. CHARMS: This is off the record.

(Discussion held off the record,)

MR. CHARMS: On the record. On my copy the page is 136.

MR. KAMPINSKI: There could be different numbering systems used.

MR. ZELLERS: What's the date?

MR. CHARMS: This is the EKG of November 14th, 1984.

A. I think I have the one.

Q. Are we all on the sane page, so to speak?

A. Uh-huh.

Q. Have you had an opportunity to review it now, Doctor?

A. I have reviewed the interpretation again

and I have looked at the tracing which I have which is rather poor Xerox quality,

3. Understanding that limitation, do you agree, now having looked at the tracings that are available with Dr. Krall's interpretation of that EKG?

A. I can only assume thst Dr. Krall is qualified to interpret this record and that he has interpreted it correctly, and I would not put myself forward as an expert in this area and would not attempt to interpret this EKG personally.

Q. Doctor, when you have patients in the opersting room under anesthesia, you follow them on the monitor, don't you?

A. Yes, but that's not the same thing as a twelve-lead EKG. That's just a monitor.

Q. Assuming tnat Dr. Krall's interpretation is correct, would it be significant to you as to how long Mr. Smith may have been exhibiting those kinds of changes on an electrocardiogram?

A. Could you be more specific abouc which changes you are referring to?

MR. KAMPINSKI: And I'm going to object. Significant to him in what context? His opinions

with respect to what?

MR. CHARMS: We will get into it.

BY MR. CHARMS:

Q. Okay, You have no reason to disagree with Dr. Krall's interpretation that Mr. Smith had probable left atrial hypertrophy?

A. I have no reason to disagree with that.

Q. Now, that would be enlargement of the left atrium; right?

A. Yes.

Q. Okay. Dr. Krall also notes in enlargement of the left ventricle, left ventricular hypertrophy. You don't disagree with that?

A. I don't disagree with left ventricular hypertrophy. I would disagree that necessarily implies enlargement of the left ventricle, It just means that the muscle is increased in mass.

Q. Okay, We can look at a chest x-ray for some corroboration of whether the heart was enlarged; correct?

A. You could look at a chest x-ray and perhaps determine enlargement of the left ventricle. But you could not diagnosis left ventricular hypertrophy. You could just have dilatation of the

left ventricle without necessarily having hypertrophy of the muscle of the left ventricle.

Q. But tha chest x-ray would show whether the heart was enlarged in toto, cardiomegaly?

A. it might, night not.

Q. Did you notice in Mr. Smith's chest x-rays that they found generalized -- strike chit.

Did you notice in your review of the records that at least the radiologist found cardiomegaly on Mr. Smith's chest x-rays prior to surgery on November 17th, 1984?

MR. KAMPINSKI: Which x-ray are you talking about?

A. The only interpretation that I recall is the one from 11-14-84 at 11:10 p.m., which is postoperatively that noted moderate cardiomegaly, unchanged from a previous examination.

Q. Okay. I assume that Mr. Kampinski provided you with the prior admission of Mr. Smith to St. Luke's Hospital on October 22nd, 1984?

A. Yes. And I had just forgotten that I reviewed that and I see that interpretation ROW as well.

Q. Would I be correct in stating that with

left atrial hypertrophy and left ventricular hypertrophy as interpreted by the cardiologist -- I'll represent to you that Dr. Krall is a cardiologist -- and the generalized cardiomegaly as seen on the chest x-rays prior to surgery on November 17th, 1984, do you have an opinion as to whether or not those findings nave any significance with regard to Mr. Smith's heart condition or life expectancy?

MR. KAMPINSKI: All right. Let me just interject an objection at this point and let me state the reasons for it. The Ohio Revised Code sets forth life expectancy tables which presumably include people with cardiomegaly and left ventricular hypertrophy as well as people who don't have that, and therefore they reach an average for purposes of determining average life expectancy of individuals of varying ages.

And I don't understand your question as to whether or not you are asking the Doctor to give somo type of interpretation on that type of proceeding or to cast himself in the role of God to give you some type of opinion as to whether Mr. Smith would have lived ten years, twenty years,

sixty years. I don't understand your question. To that extent, I object to it.

BY MR. CHARMS:

Q. With all due respect to Mr. Kampinski, I'm not casting you in the role of God, I think we all know that, Did ycu understand my question?

A. I believe I understood your question. It was actually in two parts.

Q. Okay. You are correct, it was. I apologize. Can you answer them both?

A. In view of these, I would say there is evidence that this gentleman did have some cardiac change which quite likely was resultant of his hypertension; that is, his left ventricular hypertrophy and cardiac enlargement.

As tc what effect that might have on his life expectancy, I actually don't have an opinion regarding that.

Q. Would it be significant for you to know how long Mr. Smith had been hypertensive?

A. In terms of what?

Q. In consideration or trying to evaluate the extent of his cardiac problems?

A. It is likely that the longer standing his

hypertension, the greater the significance the effect on the heart would be. But that's again a very generalized opinion in terms of specific effects on the heart, I could not give you an accurate evaluation of the extent of heart disease.

Q. If -- assuming Mr. Smith had EKG changes as fsr back as three or four years preceding his desth of the type that are described on the EKG interpretation of November 14th, 1984, do you think that that information would impact on the extent of Mr. Smith's cardiac condition?

MR. KAMPINSKI: Condition, what, before these operations?

MR. CHARMS: Yes. I haven't even --

A. It would mean to me if his EKG had remained stable for four years, that in fact probably the duration didn't have a tremendous impact on at least the electrical activity of the heart, and it would mean to me that his left ventricular hypertrophy and left atrial enlargement and so on had remained relatively stable during that four-year period of time. That's how I would interpret that.

Q. You made inention of the electrical

situation, for lack of a better term. Would it be fair to say that Mr. Smith had electrical dysfunction of his heart prior to November of 1984?

A. Well, when I referred to the electrical activity, I was referring to the fact *that* the EKG was in fact purely an electrical diagnostic tool resulting from the periodic discharge and repolarization of the cardiac conducting system in the heart muscle.

Q. Are we talking -- I don't mean to interrupt you and if I have I am sorry. When we are talking about an electrical problem, are we talking about in this EKG of November 14th the atrial ectopic beats, the wandering atrial pacemaker and the left anterior hemi block and right bundle branch block, Those are electrical problems?

A. I don't know that I used the term electrical problems. I think I used the term electrical activity. If I didn't, then I would have to stand corrected.

Q. Okay.

A. The entire electrocardiogram, as stated in the title is an electrical diagnostic test of

the heart. And I was referring particularly to the left ventricular hypertrophy and left atrial hypertrophy which you had referred to earlier. In fact, the fact that there is a wandering atrial pacemaker and there is some degree of heart block, that does indicate that there is some electrical abnormality of the conducting system of the heart as well,

Q. Okay. Aren't findings of left ventricular hypertrophy and ST and T wave changes also indicative of muscle damage?

A. No, not necessarily muscle damage at all. They are indicative of changes that usually result from an excessive workload placed on the left ventricle, at least left ventricular hypertrophy is. And what was the other one you referred to besides hypertrophy?

Q. The ST changes.

A. The ST changes are very nonspecific in my experience,

Q. I don't -- I'm not talking about necessarily, but one of the possible explanations of those findings is muscle damage to the heart.

A. You would have to be more specific before

I could agree witn that. You mean like ischemic damaga or heart attack?

Q. Uh-huh, ischemic or infarct?

A. Usually infarcts do not result in left ventricular hypertrophy to my knowledge.

Q. Before I forget, Doctor, we were handed a copy of your curriculum vitae just before the deposition started and it's rather voluminous. The abstracts and the articles that are contained in your bibliography, we can find those in the journals. I want to ask you, there are a number of pages -- I didn't count them, it looks like fifteen pages or so of pap? that you put under a heading of papers in preparation, submitted or in press.

A. I don't believe there are fifteen pages that fall in that category, It's not even close.

Q. I'm sorry, you are right. There are papers and lectures presented probably covers more of it.

A. Right.

Q. If I wanted to get those materials, could I just ask Mr. Kampinski and he can provide them to us, get them from you?

A. Which, the papers that are in

presentation?

Q. Papers and lectures that you presented.

A. No.

Q. Those aren't written anywhere?

A. Some have summaries that were handed out to the audience and they may be available or they may not. But basically those are lectures as stated and some of them are on tape that would be available.

Q. Well, if I go back to my office and go through the papers and lectures that you presented and wanted to see if there was anything written on it, do you have any problem with my contacting Mr. Kampinski to see if you have anything written and provide it for me?

A. No.

Q. Good. In your publications, there are a number of articles, but have you contributed to any textbooks?

A, Yes.

3. Okay. Which textbooks hnve you contributed to?

A. I don't remember. They are listed there. If they are there, and I don't believe they

are broken out separately under chapter headings, but they will be listed appropriately as, you know, in a textbook or edited by so on.

Just by memory, I can remember I did one for International Anesthesia Clinics, I did one for a textbook on critical care medicine. Just recently submitted one, it hasn't been published yet, for a Chinese textbook on critical care medicine. And there are several others, I just don't remember.

Q. But they are all contained in your curriculum vitae?

A. Right. Or in my bibliography.

Q. All right. I assume part of your function here at Ohio State is teaching residents?

A. That's correct.

Q. Okay, Are there any textbooks that you recommend for them to review or read in their trainin

A. I recommend that they read at the beginning of their training the textbook An Introduction to Anesthesia by Dripps, Ecknnhoff and Van Dam.

Q. Dripps is the first author?

A. Right.

Q. Are there any other texts that you

recommend for your residents?

A. Not that I specifically recommend. They frequently ask my opinion on texts and I give them my opinion on specific texts.

Q. Now I'm asking; okay? Assume I'm one of your residents asking for textbooks on cardiopulmonary considerations in anesthesia preoperatively, intraoperatively and postoperatively, what texts would you recommend that I review?

A. For that, I would probably recommend Kaplan's textbook on thoracic anesthesia.

Q. Is that K?

A. K-a-p-l-a-n-s, which I also wrote a chapter for,

Q. Okay. What journals do you subscribe to, sir?

A. Oh, there are probably close to fifteen of them. Medical journals you are referring to?

Q. All the journals, anesthesia journals, critical care journals?

A. But medical, not like Time --

Q. No. I'm not interested in Time.

A. Anesthesia and Analgesia, Canadian

Anaesthetists Journal, Anesthesiology, Critical Care Medicine, Did I say the Canadian Anaesthetists Society Journal?

Q. I think so.

A. And through the department, I also read monthly Chest, New England Journal of Medicine, Anesthesiology Review, occasionally British Journal of Anesthesia, and probably six or seven others that I can't recall off of the top of my head that come through, the A.M.A. newsletter and A.S.A. newsletter.

Q. Do you review any of the cardiology journals from time to time?

A. Occasionally.

Q. The Journal of the American College of Cardiology?

A. I'm not familiar with a journal by that title. There is the American Journal of Cardiology which I think is their journal.

Q. Okay.

A. And that I do review occasionally, not very often.

Q. Do you review Circulation?

A. Rarely.

Q. Are there any other journals that you can think of that we haven't --

A. I'm sure there are but they don't coins to mind immediate1y.

Q. Okay. Is this Defendant's Exhibit A tne only report that you have prepared for Mr. Kampinski?

A. I believe so.

Q. Were there any drafts of that report prepared?

A. Just from my notes.

Q. Okay. Do you have your notes?

A. Yes, ▮ do.

Q. May I see them?

MR. KAMPINSKI: I made copies for all you guys.

A. I don't know which ones I used and which ones I didn't, but unfortunately at that time -- that nay have been more recent, The second set she gave I think when I reviewed Sims' deposition, Lee's deposition, Smith, and that would be this one.

MR. KAMPINSKI: These are all your notes, though?

THE WITNESS: Yes. I may have also had a

written outline for the lettar. I frequently do, but I discard that as soon as I have the original.

Q. You mean the original of your report?

A. No. The original of the report Mr. Kampinski has. And I think if I had constructed an outline, and I don't recall if I did or not, that would have been destroyed since I made sure all my points were in this report.

Q. In the letter you provided to Mr. Rampinski is what you are referring to?

A. Yes.

Q. Okay. In your report, you indicate that you reviewed Drs. Lee, Stevens and smith's depositions as well as the deposition of one of the nurses in this case, Miss Sims?

A. Correct.

Q. What other materials have you reviewed?

'A. Subsequently?

Q. At any point.

A. Subsequently I reviewed an x-ray which was a flat plate, a KU3 of the abdomen of the patient. I believe that I reviewed that after I wrote this letter, but it may have been before. In addition, I reviewed depositions of Randall Peters,

Michael Gill, Scott Miller. And I believe that's all. I also received an amended answer that I reviewed.

Q. An amended answer from whom?

A. This here.

MR. KAMPINSKI: Dr. Lee.

A. Dr. Lee.

MR. KAMPINSKI: Your client.

Q. I think I know what that says. Anything else, sir?

A. Possibly, but I don't remember. I'm not being evasive, I just don't remember.

Q. Okay. Have you at any time seen any medical records from physicians who may have been creating Mr. Smith prior to his admission to St. Luke's Hospital -- well, before I ask that, have you reviewed -- what medical records from St. Luke's Hospital have you reviewed?

A. I reviewed the medical records of two admissions, one on the 22nd of October, 1984, and then the other on the 12th of November, 1984.

Q. Have you had an opportunity to review any hospital records or doctors office charts preceding that October 22nd, 1984, admission to St. Luke's?

A. There was one sheet from the Associates in Orthopedics, Incorporated, that was included, and the date is not legible, and I reviewed that. The only thing I can read on it is a 12.

Q. I'm sorry, can I see that?

A. Uh-huh.

Q. Okay. That's the extent of Dr. Smith's office chart, isn't it?

A. But the handwriting is sufficiently illegible that I can't say that I can read it anyway.

Q. So you haven't seen any records from any other physicians predating the admission to the hospital?

A. Unless they wore included in these records that I'm now holding, no.

Q. Can I see that for a minute?

A. It's possible they might have stuck something in from their office and I didn't *see* it, but to my knowledge there was nothing substantial there except for those two hospital admissions.

Q. Did you bind these records or did they come provided to you that way?

A. I didn't bind them. They were provided

that way.

Q. I guess to save time, the only question I'm trying to ask is whether you've had an Opportunity to review a Dr. Jackson's records?

A. Dr. Jackson wrote several notes here, but they were not --

Q. Not -- I'm sorry.

A. They were not to my knowledge records that he took in his office or during any other hospitalization.

Q. Okay. Other than the medical records and the depositions that were submitted to you by Mr. Kampinski, have you received any other correspondence from Mr. Kampinski?

A. I suspect I havs received some letters that accompanied those.

Q. Can I see those?

MR. KAMPINSKI: No, you can't.

Q. Is there -- were there any correspondence from Mr. Kampinski which summarized testimony of any of the witnesses in the case?

A. Not that I recall.

Q. Okay. Was there any communication from

chronology of events in Mr. Smith's case?

A. If there was, I don't believe I now have it. I don't remember seeing such a chronology and I don't think that I have seen anything like that.

Q. Okay. That takes care of the next question. So then obviously you didn't rely on anything in written form from Mr. Karnpinski in formulating your opinions?

A. No.

Q. Okay. Throughout the course of this case, have you had occasion to speak with Mr. Kampinski on the phone about the case?

A. Yes.

a. I'm not interested in scheduling your deposition or anything like that. In any of those telephone conversations, did you and Mr. Kampinski discuss the events in this case or your thoughts about the events in this case?

A. I'm sure we did.

Q. Do you have any recollection of any of thoss conversations?

MR. KAMPINSKI: You are not asking him about the conversations. You are just asking him if he recalls.

MR. CHARMS: Not yet.

MR. KAMPINSKI: Go ahead.

A. I know they occurred. I believe we had a discussion and I don't remember the date. I might be able to reconstruct it roughly within a few weeks following my review of the depositions of the residents, Peters, Gill and Miller, and we had a discussion I believe following my revieu of the hospital record that would have been a separate discussion in the depositions of Lee, Stevens, Smith and Sims,

Q. You seem to recall at least two conversations with Mr. Rampinski, one involving your review of the medical records; right?

A. And the depositions of Sims, Smith, Stevens and Lee.

Q. Okay.

A. Which I reviewed at the same time, I believe.

Q. Okay. What did you tell Mr. Kampinski during that conversation?

MR. KAMPINSKI: Objection. He doesn't have to answer that. Why don't you just move on.

MR. CHARMS: Instruct the witness to

answer the question.

THE NOTARY: You are so instructed.

MR. KAMPINSKI: You don't have to answer the question.

Q. Mr. Kampinski isn't your lawyer, is he?

MR. RAMPINSKI: Mr. Charms, get a court order, get a ruling, and then we will come back. If you get it in your favor, then we can deal with that. Why don't you just move on.

MR. CHARMS: Fair enough.

MR. KAMPINSKI: If you want to know his opinions or what opinions he holds, why don't you ask him that as opposed to what it is he talked to me about.

MR. CHARMS: I will *get* to his opinion, Mr. Kampinski.

MR. KAMPINSKI: Good.

BY MR. CHARMS:

Q. Did vou receive any written summaries froin Mr. Kampinski with regard --

MR. KAMPINSKI: You asked him and he answered already. Why don't you move on.

Q. What about statements, any written statements from family members?

A. NO.

Q. Okay. Did you receive any statements from other physicians other than the depositions?

A. No.

Q. Okay. Is this the first case of medical malpractice you reviewed for Mr. Kampinski?

A. I believe so.

Q. Could you tell me how many cases of claims of medical malpractice you have reviewed?

A. How many claims?

Q. Or lawsuits? How many times have you been asked to review a medical record --

A. I don't know precisely but it suspnct it would be in the range of thirty, perhaps forty, in that range.

Q. Could you give me a breakdown of who you were reviewing for, plaintiffs, people suing doctors as opposed to defending tho physician?

A. From the time that I began reviewing cases, which was 1930, I believe, till present, I cannot. But last year I did keep a record of that, and it's 55 percent for defense and 45 for plaintiffs.

Q. How many times have you given your -- had

your deposition taken in one of these cases?

A. Again, I don't know precisely but I suspect it's in the range of 15 to 20.

Q. Okay. Have you had occasion to testify in any cases that were similar to this case?

A. Well, depending upon how you define similar, yes.

Q. Okay. Cardiopulmonary problems in a patient having an elective orthopedic procedure?

MR. KAMPINSXI: Objection.

A. I don't recall specifically. Yes, I do recall specifically. I have reviewed a case involving cardiopulmonary problems in a case that was involving elective orthopedic procedure.

Q. Did you give a deposition in that case:

A. Yes, I did.

Q. Can you remember the name cf that case?

A. I should because it was just a couple of weeks ago but I don't remember the name. It was here in Franklin County.

Q. Was that for the plaintiff or for the doctor?

A. 'That was for the defense, that was for the hospita1.

Q. Okay. It was a couple of weeks ago?

A. I think it was maybe three weeks ago.

Q. Okay. Could you check with your secretary for the name of that case and give it to Mr. Kampinski and I will get it from him?

A. Certainly, I know the defendant was St. Anthony's Hospital.

Q. I notice that on the copies of the notes that you made in this case that you made notation of the amount of hours that you spent doing something?

A. Correct.

Q. What is your hourly rate?

A. Two hundred fifty dollars.

Q. Okay. That's for review of the records and the depositions; correct?

A. Correct.

Q. Okay. I assume then that the charge for this deposition is also two hundred fifty dollars?

A. Correct.

MR. KAMPINSKI: Well make sure you get the Sill.

MR. CHARMS: I'm sure you will, Chuck. I'm sure you will. And we will be happy to pay it.

MR. KAMPINSKI: I just wanted to assuage any concern you had.

MR. CHARMS: I didn't have any concern, thank you.

BY MR. CHARMS:

Q. As you sit here today, do you have any criticisms of Dr. Lee's care, the anesthesiologist in this case, that aren't contained in your report? I mean, is there anything new?

A. Well, very possibly I might have specific criticisms of specific actions. I intentionally was somewhat limited because I didn't want to prepare a 30-page report. So that the exhibit that you are referring to outlines my major criticisms, although certainly as we go through each detail of the treatment of the patient in question, his preoperative assessment, his intraoperative management and his postoperative care, I'm sure I would have many more criticisms that were not specifically outlined in this report.

Q. I'm' sorry, are you through?

A. Uh-huh.

Q. I'm sure Mr. Kampinski told you that the primary purpose of this deposition is for me to

find out all of your opinions in the case, so now is the time.

A. Correct.

MR. KAMPINSKI: Wait a minute. His primary purpose is to answer your questions. If you have specific questions abour treatment and care, why don't you ask him, And I think he's responded to your last question, Steve, as best he can.

BY MR. CHARMS:

Q. I don't mean to be facetious, Doctor. But did Dr. Lee do anything right in this case in your opinion?

A. I'm sure he did some things right.

Q. All right, Let's talk about -- well, from your previous answer, just in your onn mind, you are dividing these criticisins up in three phases; right? Preoperative involvement with Mr. Smith, the intraoperative involvement and postoperative involvement. And that's the way you have it compartmentalized in your mind, Is that fair?

A. To some extent. That's generally how i compartmentalize any patient receiving anesthesia

care.

Q. Okay. Let's talk first about the preoperative evaluation: okay? In what ways do you believe Dr. Lee's preoperative treatment of Mr. Smith fell below accepted standards of care? And if you would do me a favor and take it kind of slow so I can make notes,

A. I believe that Dr. Lee when notified that Mr. Smith required an operation was obligated to see the patient and do a very careful review of his medical records.

He did see tho patient, I believe. He did not do a careful review of the medical records as indicated by the fact that he did not record up-to-date laboratory values, I didn't see any evidence he did a careful assessment of the patient's physical condition.

THE WITNESS: Can we go off the record for just a second?

(Discussion held off the record.)

A. We made no notation of the fact that the patient had extensive dysrhthmias following his first operative procedure. He made no notation that the patient had evidence of myocardial damage

as indicated by the elevated creatine phosphokinase, specifically --

Q. The CPK?

A. -- the MB fraction. Did not not:? that the patient had had recent anemia noted, did not note that the patient had recently been vomiting, complaining of abdominal pain.

Q. I don't mean to interrupt you, but what is the significance of the recent anemia in your opinion?

A. Well, anytime a patient develops an unexplained anemia, there is a possibility of internal bleeding. knd of course in a patient with myocardial disease, it's of significance because there is a decrease in the oxygen carrying capacity of the blood making the patient more prone to exacerbation of his myocardial ischemia,

Q. What in your opinion is an anesthesioloyist required to do in a scenario like this when he notes this recent anemia?

A. Well, depending upon the emergency of the operative procedure, he is raquired to note that these abnormalities are present, formulate in his mind an evaluation of the anesthetic risk to the

patient, and then discuss that with the surgeon in charge who is scheduling the case and make sure that he is aware of the added risks to the patient. And then following such a discussion, the two of them would have to decide whether or not to proceed with the operative procedure.

Q. So in this case, one of your criticisms of Dr. Lee then is not having that type of a discussion with Dr. Smith, the attending surgeon?

A. Well, my first criticism is that he was unaware of the patient's condition, and thersfore ne likely didn't see the necessity to discuss the case with him. 3ut certainly that would also be a criticism,

Q. What is the basis of your opinion that he was unaware of these problems?

A. That ha recorded false information on nis preanesthetic chart and did not record the appropriate positive facts on the chart.

Q. Okay.

A. I would like to correct that. He didn't record false information. Did he not record accurate information.

Q. Okay. I had interrupted you when you

were starting to talk about no notation of an episode of vomiting and you ware telling me about that. What is the significance of thst?

A. I don't think i said that he didn't note there was an episode of vomiting. I think the patient actually had a couple of episodes of emesis.

Q. That's vomiting; right?

A. Yes. And that was not noted on the chart and in view of the patient's complaints of abdominal pain, dropping hematocrit, one would be concerned about gastrointestinal bleeding, and in addition to that one would have to be concerned about the possibility of bowel obstruction, especially in a patient who I believe had had previous abdominal surgery. I'm not sure of that, but certainly any prudent anesthesiologist would look into that.

Q. Why? What would the purpose of looking into that be?

A. The patient has bowel obstruction, he's at marked increased risk for vomiting and aspiration during induction of anesthesia, both spinal and general anesthesia.

Q. Is that just somebody who is obstructed

or has a history of prior bowel obstructions?

A. I don't understand your question.

Q. Okay. I'm sorry, maybe it wasn't clear. What if a patient has a history of bowel obstructions in the remote past that the physicians treating him at that time were unaware of? Would that fact be significant in your evaluation of the GI -- the abdominal complaints this fellow had?

A. You know, you threw in the proviso the physicians were unaware of it. If a patient has a history of past bowel obstruction, then that clearly is significant because he's at marked increased risk for repeat episode of bowel obstruction. I'm not sure I understand why you said that the physicians were unaware of it.

Q. I was just asking --

A. The significance of that is not clear to me.

Q. I just asked you to assume that, Doctor.

Yell, obviously the place where you get the history is from the patient, right, you as an anesthesiologist?

a. No. I get the history not only from the patient, certainly I try to do that, but also from

family, also from the medical record and also from the patient's physician.

Q. Okay.

A. And anybody else that might be able to help, the nurses on the floor and so on.

Q. All right. We were talking about vomiting, abdominal pain and SI bleeding in the context of your preoperative criticisms of Dr. Lee. Have you told me all you wanted to tell me about the GI bleeding? Is there anything else that you are critical of Dr. Lee with regard to the bleeding, the emesis?

A. Well, I'm not sura I understand the question again. I think that's a very significant fact that he was unaware that he was anemic, ne was unaware of the fact that he was having GI problems which would have significant impact on his anesthetic management,

Q. Those are inferences that you draw from, what, from the record itself OF from a review of the record and Dr. Lee's deposition?

A. Certainly I can draw those inferences just from the record alone, but then also from his deposition that corroborates that opinion.

Q. Okay. What else with regard to the preoperative evaluation of Mr. Smith? What other criticisms of Dr. Lee do you have?

A. Well, it was an inaccurate preoperative assessment and it was an incomplete one. And I think that those are both of significance, he did not record the chest x-ray findings, he did not record when the patient last ate. He gave the patient an A.S.A. physical status of three which I think was inappropriate and inaccurate.

Q. What do you think his A.S.A. risk or physical status should nave been?

A. I think it should have been four, and since Dr. Lee has claimed later it was his understanding that this was an emergency, he should have ranked it as an emergency. In my opinion, I don't believe he thought it was an emergency and that's why he didn't circle E. The fact that he circled three but didn't circle E would indicate to me that he did not believe it was an emergency,

Q. Okay.

A. And I doubt seriously, although this is an assumption on my part, that his statement discussed about spinal, patient accepted the idea

and risks explained, I doubt seriously that the risks were explained accurately to the patient because I don't tnink Dr. Lee knew what the risks were, so he therefore could not have discussed them in detail with the patient.

Q. What in your opinion is the significance of not recording the chest x-ray findings?

A. The significance is that it just is one of many points indicating that this is an inaccurate and inconplete preoperative assessment.

Q. Is there anything in the chest x-ray itself that you consider significant in Mr. Smith's case?

A. Only the fact as we have already discussed that he did appear to have some enlargement of his heart which would mean to me that he had a tenuous cardiovascular system and that he should have attempts made to prevent both hypo an3 hypertension intraoperatively.

Q. Okay. You also are critical of Dr. Lee's failure to document when Mr. Smith last ate, Again, other than the overall criticism of his record keepin what is the significance of when Mr. Smith last ate in this case?

A. The fact that he left that blank, didn't make any recording at all, would lead me to believe that he was not considering the increased risks of vomiting and regurgitation in this patient likely because of the misbelief that spinal anesthesia is not associated with an increased risk for vomiting and regurgitation.

Q. Is it your opinion that postoperatively, Mr. Smith regurgitated his gastric contents? Is that what you are saying?

A. That's correct,

Q. Okay. And then he aspirated then?

A. It appears that he did.

Q. Okay. Unfortunately we don't have an autopsy to confirm any of this and I'll get to that opinion in a few minutes,

A. No. But gastric contents were suctioned from his endotracheal tube which is more conclusive than an autopsy would have been in any case.

Q. I'm sorry, what were *you* looking for, Doctor?

A. I was looking for the anesthesia record, anticipating that that would he the next area you would want to discuss.

Q. Not quite. I have got a few questions, specific questions to ask you about your preoperative criticism, then we will move on to the intraoperative stuff.

One of your preoperative criticisns is the failure of Dr. Lee to appreciate the possibility of a myocardial infarction after the first surgery that Mr. Smith had on November 14th; right?

A. I don't know that it was after. It was in the perioperative period of that operation.

Q. I'm sorry, the question wasn't clear. I'm not talking about when Mr. Smith actually had the heart attack. Dr. Lee's -- your criticism of Dr. Lee not realizing it after the fact is all I was trying to yet at.

A. Correct.

Q. Okay. The elevation in the CPK and the MB fraction, is that the primary piece of evidence? you use to conclude that Mr. Smith experienced a heart attack either in the first surgery on November 14th or shortly thereafter?

A. That's one of several bits of information that I have used and it's a significant bit of

information. It's certainly not the only one.

Q. All right. Because I have some specific questions about the enzymes. But before I get to that, what are *the* other pieces of information? You make reference in your report to periods of hypotension during the first surgery.

A. Right. He had periods of hypotension that would be somewhat unexpected and necessitated vasopressor therapy. He had significant hypoxemia quite likely secondary to heart failure during the intraoperative period.

Q. Wait a second. You are moving a little too fast for me. I'm sorry. He had hypoxemia secondary to heart failure?

A. (The witness nods head up and down.)

Q. Okay, I'm sorry. Go ahead, sir.

A. He had an unstable cardiovsscular course in the intensive care unit. It was felt by the treating physicians that he required a Dopamine infusion for sometime in the postoperative period. He had continued arterial hypoxemia in the surgical intensive care unit postoperatively.

Q. Did he have continued heart failure'?

A. Quite likely,

Q. Okay.

A. And did I mention he had the dysrhthmias?

Q. You mentioned it earlier.

A. This was a --

Q. What different dysrhthmias than he had preceding the surgery?

A. I have to review the nurse's notes to be completely accurate, hut I believe that he had bouts of bigeminy and trigeminy.

B- Those weren't noted anywhere before going to surgery, at least based on your review o€ the records?

A. Not thit I'm aware of.

Q. Okay.

A. I believe that's accurate.

Q. Okay. Now have we covered all of the things in the chart that leads you to conclude that Mr. Smith experienced an infarct either during the November 14th surgery or shortly thereafter?

A. Yes, plus we have to add to that, of course, the fact he had an elevated CPK/MB fraction.

Q. You already told me about that, okay.

Heart attacks evolve over time, don't they, myocardial infarctions?

A. Well, that's certainly a true statement. The period of time can vary considerably, however.

Q. Prom what to what?

A. I think if you have complete occlusion of a coronary vessel, you could have ischemic changes and then evolving heart muscle damage within a matter of minutes, or you might have just a progressive ischemic insult over a period of hours if you nave partial occlusion or you have increased load on the heart with insdequate oxygen supply. So I would imagine it would range from minutes to hours.

3. Could infarcts evolve over days?

A. I don't know. I'm not a cardiologist, but I suspect that they could.

Q. Okay. On the enzymes, other than the CPK, what other enzymes are there that a physician would look to for assistance in whether a patient has experienced a myocardial infarct or some heart injury?

A. To my knowledge today, there aren't other enzymes you would look for. In the past LDH was measured and some others, out I think the MB fraction is so specific that thst is the one that's

utilized now.

Q. Okay. Now, I want to talk about November of 1984; okay? Are you telling me that in your opinion the only enzyme to Look to in 1984, in November of 1984, was the MB fraction of the CPK?

A. No. I don't think I said that.

Q. Okay.

A. And I don't think I -- what I'm saying is the MB fraction is sufficiently specific that at least in my practice and to my knowledge there is no need to look for other enzymes. There may be others that are available, there may have been others available in 1984 that I am unaware of.

Q. Okay. But you mentioned the LDH and you said there were others. What other enzymes could you look to?

A. I don't recall now. When I was a medical student it seemed there were several laboratory tests that were ordered, out they were sufficiently nonspecific that they weren't of very great help.

Q. Okay. If all of the enzymes were elevated, what significance would that have in your opinion?

A. All of what enzymes?

Q. All of the enzymes that you would look to for cardiac damage including the LDH?

A. Well, I wouldn't look to the LDH. That's what I said. The only one I would look for is the MB fraction of the CPK.

Q. Well, there are other physicians who would look to other enzymes as well as the CPK?

A. I'm sure they would.

Q. I guess my question to you then is what would the significance be to physicians as a whole to having elevation of all of the enzymes?

A. Which enzymes are you referring to?

Q. The LDH, for example. Let's assume the LDH was also elevated.

A. I can't speak to what impression other physicians would derive from that.

Q. To you it's irrelevant?

A. What, an elevated LDH? It might mean there is liver damage, it might mean there is pulmonary damage.

Q. All right. Do the enzymes go up or are they known to go up when somebody goes through the trauma of surgery?

A. Well, certainly the CPK goes up because

that goes up anytime there is muscle damage.
Q. Okay.
A. But it's my impression that the MB fraction only goes up when there is myocardial damage. That's specific for the heart.
Q. Okay. Is there a ratio that doctors look to with regard to the enzymes?
A. I don't believe it's a ratio, It's usually recorded as a percentage of the total.
Q. Okay, That's not the MB fraction?
A. Yes, the MB fraction is usually reported as a percentage of the total rise in CPK -- or the total value of CPK, not the total Tis-?,
Q. Sir, on page two of your report, the first full paragraph, okay, you say: In summary, Mr. Smith likely suffered a significant degree of myocsrdial injury during the first surgery. Can you quantify the extent of the injury he experienced?
A. No.
Q. Can you quantify further then your statement it was significant, a significant degree of injury; right?
A. No, I can't.

Q. You have to bear with me, Doctor, I have a lot of questions for you.

You told me a few minutes ago that you felt that Mr. Smith experienced some hypoxemia, arterial hypoxemia and continued heart failure after the first surgery. Is it your opinion that that -- those conditions continued up to and including the time that Dr. Lee gave him anesthesia?

A. In my opinion to some extent, he had continued heart failure,

Q. To what extent?

A. I don't know to what extent. I can't answer you with that specifically, but it would be quite unlikely in view of his past history for him to have significant myocardial damage with his dysrhythmias and then return to completely normal state by the second or third postoperative day, So that's why I am inferring that he still had some continued dysfunction,

Q. Well, you are not suggesting, though, that after having axperienced the heart attack on November 14th, that Mr. Smith was going to return to the status quo physically from before that surgery, are you? Maybe my question isn't clear.

A. That he ever would, you mean?
Q. Yeah.
A. He certainly might return to close to the state that he was before depending upon how severe his infarct was.
Q. We don't know if that was a transmural infarct or a nontransmural infarct?
A- No. Because of lack of follow-up, we don't have any way of assessing. We can say that since he had an elevation of the MB fraction of the CPK within hours of surgery that it was quite likely a very significant insult because those enzymes don't generally rise far a period of hours after the insult. And he had an elevation relatively soon after that procedure.
Q. Do you recall from your review of the records how soon after surgery the enzymes were elevated or reported as elevated?
A. It was reported, I believe, at 2:00 in the sftarnoon on the 14th and I believe his operative procedure ended on -- at 1:00. And that's just really unusual to have an elevation that soon after injury. Usually we wait six hours to do the first test.

Q. So in your opinion, the fact that the CP -- the MB fraction of the CPK was elevated within an hour of surgery leads you to conclude that it was a myocardial infarct that caused that rise?

A. Well, it was severe myocardial cell injury which probably was an infarct, and it's possible thit he had that injury at 9:00 in the morning so it may have been really four hours before it rose. We have no way of knowing.

Q. I want to get to the anesthesia record because -- are we on the same page here?

A. It appears so/ yes.

Q. Will you show me -- it's the anesthesia record for the 14th, are you talking about the drop in blood pressure at 9:00, ths the hypotension at 9:00?

A. He had some drop in blood pressure before 9:00, but the most significant fall is recorded as being about 9:05.

Q. And that was what again?

A. When it goes down to 73 and stays there for approximately fifteen minutes.

Q. That's systolic; right?

A. That's correct.

Q. And diastolic was down to 45 or so?
A. Correct.
Q. And that stayed there for fifteen minutes?
A. But then he had three other episodes where his blood pressure fell to or slightly below a hundred as well.
Q. Are periods of hypotension acknowledged as a consequenca of giving a patient general anesthesia?
a. Anesthesia certainly can lower blood pressure and there is no question that in a hypertensive patient, especially one wno is poorly controlled as was Mr. Smith, those episodes are more frequent.
Q. Well, you believe then that when Mr. Smith went to surgery on November 14th, 1984, that his hypertension was poorly controlled?
A. I do believe that, yes.
Q. Was it inadequately controlled?
A. It was borderline.
Q. Well, do you have any criticism of any of the physicians for taking Mr. Smith to surgery on November 14th?
A. You mean do I find that doing so fell

below the standard of care?

A. Yes.

Q. NO.

A. That's, what, a judgment to take him?

Q. Oh, I think so, yes. I think that the anesthesiologists there were told that he was controlled in spite of the fact that ha wasn't, and that they had an internist who claimed that he was. And I don't believe that they would have been appropriate in snying -- in rsfusing to give anesthesia.

Q. Okay. I guess I'm asking a broader question. So that I understand it, as relates to the surgery on the 14th, you don't have a criticism of the anesthesiologist because he had a medical man giving clearance; right?

A. Where, on the 14th?

Q. Right.

A. Not because of that, no. He had an internist who told him his blood pressure was controlled.

Q. Right.

A. In my opinion, internists don't truly clear patients for anesthesia. That's a judgment

the anesthesiologist must make once he's given the information by the other experts caring for the patient.

Q. well, that raises another question that I wanted to ask you. What do you see as the roles of the various physicians in the preoperative evaluation and taking -- and then subsequently taking a patient to surgery? Ana by that I mean the internist, the surgeon and the anesthesiologist.

A. Which operation are vou referring to?

Q. Any elective surgery. All I'm trying to get at is the interplay between the three doctors.

A. That can vary extensively from situation to situation. I think it would be impossible for me to give you an answer that would cover all eventua1ities.

Q. Fair enough. Then it's your opinion that the anesthesiologist clears for anesthesia?

A. I don't think he clears it, He's the one that's going to be giving the anesthesia and he certainly has to do an evaluation and decide how he's going to manage the anesthesia, and he clearly is the one who is going to have to decide whether he's going to give anesthesia or not for an

operative procedure.

Q. Okay.

A. So if you want to call that clearing, I guess so.

Q. Okay. For lack of a better term, I'm thinking about three different subsets of players. One, a medical man giving medical clearance to yo forward with surgery; two, the surgeon giving his part in the process surgical evaluation, and the anesthesiologist clearing for anesthesia, if you will; all right? Do you understand what I'm trying to get at?

A. I understand what you are saying, and I dissgree. I don't think an internist can give clearance. I know that happens in some places and some anesthesiologists are willing to take an internist's word this patient is clear for anesthesia and surgery. I think that's inappropriate.

Q. On whose part, the anesthesiologist?

A. Both of them. I don't think an internist in general has the qualifications or the experience to assess the risks, hazards and techniques that are employed with anesthesia, so I don't think they

can clear them. All they can do is pass on information to the anesthesiologist regarding the patient's medical condition, and they certainly also have responsibility for optimizing a patient's medical condition oefore an elective operative procedure.

Q. Are you making any distinction between an internist and a cardiologist or any medical man?

A. Any other physician,

Q. Okay.

A. The anesthesiologist has a responsibility for evaluating the patient's condition, and anybody that can give information that would be helpful in that process I think would be appropriate.

Q. Okay. Have we exhausted all of the preoperative criticisms that you have of Dr. Lee?

A. Well, roughly, yes. We talked about the fact he didn't consult with a surgeon. He claims he was told it was an emergency, although I don't really think he believed it was an emergency, If he did, however, in any case, whether he thought it was emergent or not, I think he really should have contacted the attanding surgeon and discussed in detail the severe anesthetic risks.

?. What were the severe anesthetic risks?

A. Death,

Q. Okay. From spinal?

A. Not from the spinal. From exacerbation of myocardial ischemia, which also could be dysrhthmias or --

MR. KAMPINSKI: I want you to understand something at this point, Mr. Charms. When you ask him questions such as is that all of the problems, I don't understand your question to attempt to limit any questions I may have of Dr. Downs at the time of trial.

Certainly he'll respond to any questions I put to him at that time, and you know if I ask him about something tnat you haven't or that he hasn't thought of, I don't understand you to say that can't be done. Ie's trying to respond as accurately as he can to you.

MR. CHARMS: I certainly appreciate that, Mr. Kampinski, but you know this is a discovery deposition of an expert and this is *just* my opportunity to try to get all the opinion5 that you hold in this case. You know, I'm not trying to play games with you or Mr. Rampinski at all.

MR. KAMPINSKI: Okay.

MR. CHARMS: I just want to get your opinions.

BY MR. CHARMS:

Q. So you said death from exacerbation of the myocardial damage; right?

A. Yes. And also from dysrhythmias and heart failure.

Q. You told me earlier that in your opinion Mr. Smith regurgitated and aspirated his -- the food that was in his stomach?

A. Well, it probably wasn't food. It was probably just gastric secretions.

Q. Hell, do yoil have an opinion as to which of those problems caused Mr. Smith's death?

A. Oh, I think there are many things that caused his death, and those just were contributiny factors.

Q. So you think all of the myocardial. damage, the -- the physical damage to the heart! the electrical problems and the aspiration of gastric content all contributed to cause Mr. Smith's death?

A. Plus some other thing5 too. It's sort of like standing a man in front of a firing squad and

asking which bullet killed him.

MR. CHARMS: I would like to take a quick break if it's ill right with you?

(Thereupon, a brief recess was taken.)

- - - -

BY MR. CHARMS:

Q. I want to talk about your opinions postsurgery on November 17th in the recovery room. And before I do, just a couple of questions. Do you believe that Mr. Smith went into pulmonary edema after surgery on the night of November 17th?

A. He probably did.

Q. Okay.

A. There is no question he did as a terminal event.

Q. Do you believe that he also had a myocardial infarction after surgery on the 17th?

A. Whether or not he had an infarct would be difficult for me to say. There is no question he had severe heart failure.

Q. Okay. Which in your opinion came first, the pulmonary edema or the heart attack or heart failure?

A. Well, I think he had heart failure. He

had pulmonary edema and then he had hypoxemia and then he had exacerbation of his heart failure, and I think it was just a vicious cycle.

Q. Aspiration of gastric contents can cause acute pulmonary edema, can't it?

A. That's correct.

Q. And acute pulmonary edema can also cause an infarct?

A. Not directly.

Q. Okay. As a consequence of the edema, you can experience an infarct, a patient can experience an infarct?

A. A patient with aspiration pneumonitis may in fact have sufficient hypoxemia that myocardial failure and myocardial infarction can occur.

Q. Okay. In your report, you make reference to one criticism of Dr. Lee's failure to appropriately monitor his cardiopulmonary status before, during and after the surgery on November 17th. Am I correct that we have discussed already your criticisms about the preoperative failure to appreciate his cardiorespiratory status?

A. Yes, but we didn't discuss his preoperative monitoring of the patient at all.

Q. Okay. So you are also critical of his preoperative monitoring of the patient?

A. Yes.

Q. Okay. In what way are you critical of his preoperative monitoring?

A. Well, I believe that in view of the patient's recent myocardial injury, it was absolutely essential that continuous blood pressure monitoring be instituted before any anesthetic is induced, be it general or spinal.

Q. Just a cuff or ara you talking about --

A. No. Continuous bloc3 prassure. That can only be done -- in 1984 could only be done with an invasive.

Q. Swan-Ganz?

A. No. With an arterial catheter placed in an artery.

I also believe that he should nave had a pulmonary artery catheter in place to monitor his pulmonary artery occluded pressura.

Q. What do you believe those would have shown?

A. Hell, we don't know now. His blood pressure would have shown whatever the blood

pressure cuff was recording probably, and the pulmonary artery catheter probably would have shown a pretty significant degree of left ventricular dysfunction, possibly inappropriately decreased cardiac output, Considering his anemia, his cardiac output should have been very high with his anemic state but probably wasn't, but possibly a low or elevated pulmonary occluded pressure. There is just no way of guessing. That's why you need to put the catheter in so you can appropriately take care of the patient.

Q. Okay. Now I want to ask you about the postoperative monitoring, which is your criticism of Dr. Lee?

A. It should have been the same as pre. He should have had an arterial line in place. He should have had a pulmonary artery catheter in place. He should have been assessing his blood gases, both arterial and mixed venous optimally, although I will not fault him for doing the mixed venous.

Q. But you do fault him --

A. The arterial line and the Swan-Ganz catheter, definitely.

Q. Now, there were a couple --

A. He should have gone to the intensive care unit directly froin the operating room and not to the recovery room.

Q. There were a couple of arterial blood gases done in the recovery room?

A. I was only aware of one.

Q. It may only be one. Can you taka a minute and look at that?

A. Yes, sir.

The recovery room records is what it is.

MR. ZELLERS: We are talking about the 17th now; is that right?

MR. KAMPINSKI: Yes.

A. Yes.

Q. The only lab I see is page 122 of my record.

MR. KAMPINSKI: Okay. His numbering is different than yours though. 122?

MR. CHARMS: Yeah.

A. Well, it's also in the recovery room nurse's note, it's charted there as well. In fact, I may -- no, that's definitely not the one I was talking about. This is after he was intubated I

think. So he did have two then because there was one before he was intubated and that's the one I was -- at 10:57 his P32 vas 33.6, PCO2, 37.7, and pH 7.326.

Q. And what is that?

A. That's in the recovery room notes. That's it, that's the one.

Q. What do those blood gases tell you?

A. The patient has severe arterial hypoxemia, marked anemia with a hemoglobin of 6.7, inadequate ventilation, and a moderate degree of metabolic acidosis which may or may not be a reflection of inadequate perfusion.

Q. Inadequate perfusion where?

A. Of the body. Inadequate cardiac output, in other words.

Q. Well, do you have an opinion as to whether, if appropriate postoperative monitoring was in place, Mr. Smith would have survived all of this?

A. You mean after he already went to the operating room?

Q. Right, hits the recovery room.

A. He hits the recovery room with his

neosynephrine drip running and then had perfect care thereafter, would he have survived?

Q. Yes.

A. I don't know.

Q. You don't have an opinion?

A. I have an opinion that the likelihood of him surviving would have been infinitely better than it was given the care that he got. But at that point in time, whether or not he had passed the point of whether or not he could be salvaged is impossible for one to predict.

But I would say that the odds of him surviving were probably -- thzy were still favorable in that, I mean, it wasn't 90 percent certain he wasn't going to die after that second operation.

And again I'm going by just the statistics that have been reported in the literature. Somebody who nas had a recent myocardial infarction and gets an anesthetic, his chance of reinfarcting and dying from that are in the range of probably 30 to 50 percent roughly, and I would give him the same odds when he rolled into the recovery room and given perfect care.

Q. 53/52?

MR. KAMPINSKI: He said 30 to 50.

A. Somewhere between -- I think his chances of surviving would be somewhere in the range of 50 to 70 percent if he got perfect care. Of course it's impossible for me to predict.

Q. Is there some distinction in your mind between standard of care and perfect care?

A. Yes.

Q. Okay. Now, assuming that he got standard of care once he hit the recovery room?

A. I would have to decrease those odds considerably.

Q. To what?

A. I can't give you an accurate number. I mean, if you ask me today and tomorrow, I'll give you two different numbers. Maybe if I said 50 to 70 before, maybe his odds would fall down to 25 to

Q. Okay. In your report, you indicate that when he hit the recovery room or shortly thereafter, Mr. Smith's cardiopulmonary status was severely compromised. I think that's the term you used in your report. My question to you is how was it

compromised from before tha surgery?

A. Well, he had been given a spinal anesthetic and had been rendered severely hypotensive in my opinion probably to a much greater degree than the anesthesia record reflects, which severely compromised his cardiac function.

Q. I don't mean to interrupt you, sir. Are you suggesting that Dr. Lee's anesthesia record is wrong, has baen altered?

A. No. I'm not suggestsing it's been altered at all. I'm suggesting it's not accurate.

a. What leads you to conclude that his anesthesia record on November 17th is not accurate?

A. The fact that Dr. tee had administered ephederine, epinephrine and neosynephrine, which is extremely unusual therapy for a single Dout of hypotension.

I wish I had these in -- I haven't memorized them sufficiently, 'Thank you.

For a single isolated bout of hypotension that lasted for less than five minutes, as an example, in the previous anasthetic, there were at least four episodes of hypotension much worse than that, and they treated it with ephederine alone.

But yet he used ephederine, epinepherine and neosynephrine first thing and he reported pulse levels that don't alter at all and blood pressure dipped down and responded back just perfectly.

Q. So you infer from the medications that were given in the record that the record has got to be inaccurate?

A. I think that he has not recorded all of the blood pressures that probably occurred.

Q. All right. You were telling me -- I was asking you about why his cardiopulmonary status was severely compromised from before, and you were telling me -- now we are talking about the recovery room.

A. That's right.

Q. He was given a spinal and he was severely hypotensive?

A. Because of his sympathetic innervation, the lower half of hi5 body had been interrupted.

Q. What kind of block did Mr. Smith get?

A. Spinal.

Q. Was it sympathetic or motor?

A. It would have bean both. Do you want me to continue with my answer?

Q. Yes, please,

A. Following the sympathetic block, he then had an infusion of neosynephrine, which will markedly increase left ventricular afterload.

Q. How does it do that?

A. Constricts the blood vessels and will increase the workload on the left ventricle significantly.

In addition, it appears that his anemia was worse after the operation than it was before since his hemoglobin level had fallen to six point seven grams percent. His arrhythmias were apparently worse than they were before operation.

Q. What's the basis for that statement?

A. I believe that the nurse repeatedly referred to dysrhythmias.

Q. 'The bigeminy and trigeminy?

a. PC, PVCs, trigeminy.

Q. Do you know if Mr. Smith had experienced any of those arrhythmias prior to going to surgery on November 17th?

A. Whether he had on that particular day I don't recall, but he certainly had in the SICU. Dr. Lee didn't note that in his anesthesia record,

I don't believe, She admitting nurse in the recovery room said when the patient came in, he was short of breath, that he had atrial fibrillation with uncontrolled vantricular response and frequent multi-focal PVCs.

Q. What does that mean to you, sir?

A. Well, just what it says. That he had a rather irregular chaotic atrial rhythm with variable ventricular response and frequent premature boats which would not result in perfusion.

Q. Okay.

A. That's what it means to me. So those are the reasons that I believe he was in an altered cardiopulmonary status from preop.

Q. Okay.

A. Also I should mention that the nurse noted on admission that he was cool and diaphoretic and yet the nurses noted when Re left the recovery room that he was warm and dry.

Q. What do those notes of cool and diaphoretic and shortness of breath, what do those mean to you?

A. Those mean to me he had a marked decrease in cardiac output, he was not perfusing his

periphery well.

Q. What in your opinion was causing thit decrease in cardiac output'?

A. Probably the neosynephrine infusion.

Q. What other causes --

A. And heart failure added to that.

Q. All right. And you go on to talk about -- is that it in terms of your opinion as to why his cardiopulmonary status was severely compromised?

A. I think those are the major portions of it.

Q. Yell, is there anything else?

A. If there is, I can't think of it now, but if I do I sure will let you know.

Q. Okay. Thank you.

Then you talk about again failing to adequately monitor his status. Is that just a reference back to the notion that he wasn't being monitored with an arterial catheter and a pulmonary artery catheter or are there other criticisms of monitoring?

A. Yes. I found no evidence that he monitored his breath sounds or his heart rhythm.

Q. Dr. Lee --

A. Dr. Lee. He did have an EKG on. Whether he was looking at it or not --

Q. I'm talking postoperatively now, not in the operating room.

A. I'm sorry, I thought you were still in the transition phase.

Q. No.

A. In the recovery room, blood pressure, again, was monitored inappropriately.

Q. How so?

A. The dynamap rather than invasively and continuously. There was no assessment of cardiac function other than blood pressure and EKG to monitor rhythm. They did not order twelve-lead ERG, I don't believe, at that point in time.

Q. You believe all of that is raquired practice?

A. In this patient?

Q. Yes.

A. Absolutely.

Q. Okay.

A. And I think a chest x-ray should have been ordered. I think blood gases should have been ordered.

Q. Okay.

A. And appropriate support should hsve been instituted.

Q. What is the appropriate support that should have been instituted?

A. It depended on the values that came back from all of those monitors.

Q. Now in looking at the case in hindsight and again without benefit of an autopsy, what kind of support do you think should have been instituted?

A. Well, I suspect that positivs pressure breathing of some sort would have been required. There is no question that the neosynephrine infusion should have been discontinued before it was, I believe it ran for forty-five minutes before it was discontinued, although I'm not sure of that.

MR. KAMPINSKI: 5:40?

A. 5:40. So it was only fifteen minutes, I'm sorry. So clearly he didn't need it when he went into the recovery room. His blood prassure was up, 143 over 77, so it should have been discontinued. He might have required at that time digita1ization.

Q. For what?

A. For heart failure.

Q. Heart failure, What drugs would those be:' Lasix?

A. He was already receiving Lasix.

Q. Digitoxin?

A. I don't recall now if he would have required Lasix. Probably Digoxin. He may havn required Nitroglycerin infusion. But you can't give that kind of therapy without the appropriate monitors and he didn't hive them.

3. Okay. While we are in the recovery room, do you have any criticism of anybody else who was in the recovery room with Mr. Smith, nursing staff, hospital employees?

A. Basically I do not have any criticism of the nurses that cared for Smith in the recovery room. Again, there might be isolated actions or omissions that I'm not thinking of right now that I might come up with,

Q. What about any other hospital employees in the residents or anybody like that?

A. What about it?

Q. In the recovery room, any criticisms?

a. Well, they weren't there, that's a

criticism basically.

Q. You believe they should have been there?

A. No question about it. So should his doctor.

Q. His attending physician?

A. Yes.

Q. That would be Dr. Smith.

Okay. You talked in your report about. failure to initiate appropriate ventilatory support. By that, were you referring to the positive pressure breathing for him?

A, Well, that or continuous positive airway pressure to, you know, let him breathe but still with an elevated airway pressure that would have been appropriate too.

Q. How would you do that or how is that accomplished?

A. If you really want to know, it will take me a while to explain it. Basically you put a device on that will elevate the airway pressure and then let the patient breathe with the elevated airway pressure. His breathing is exactly the same as it would be without it.

It can be done with a face mask or it may

require insertion of a tube in the trachea to accomplish it, to do it with a Ventura device which generates a high flow of gas past a resistive device at the exit of the circuit.

Q. In your report, you talked about tha injection of sodiua pentothal and you sre obviously critical of that. Would you tell me what the basis of that criticism is?

A. Pentothal is a rather significant myocardial depressant and even in small doses. A hundred milligrams is not by any means a small dose. The standard induction dose for general anesthesia would be in the range of throe or four hundred milligrams, so a hundred milligrams given intravenously is significant.

In this man who already had a very low cardiac output then, this pentothal would hit in a fairly high concentration his coronary arteries. His heart is already rendered hypoxemic and -- hypoxic, rather, for two reasons. One, he's anemic so he doesn't have much oxygen in the blood; and two, his PO2 is only 32.6.

So I think it was entirely predictable that following the injection of pentothal this man

would have a cardiac arrest. It was just like giving a toxin to his heart,

Q. Just before that he gave Verapimal and Dig together, which right on the insert says that shouldn't be done.

Q. That's my next question. Do you have any criticisms of the medications that Dr. Lee --

A. The Verapimal and Digoxin, he said in one of his notes, he gave the Digoxin IV and then P which means push and he put an X through the P, but I suspect it was given push, especially since tha nurse said it was given push by Dr. Lee. And than I believe shortly after that he gave the Verapirnal.

a. What time was that?

A. The Digoxin was given according to the nurse at 10:05 and then within fifteen minutes he gave the Verapimal,

Q. By the way, do you believe that Mr. Smith had already aspirated the gastric contents by 10:00?

A. Oh, it's difficult to say, but I doubt it. I doubt that he did that. The most likely time wcuild be when he was going to intubate him, butt you know, you can't be sure,

Q. Well, do you have an opinion as to when

ne aspirated or are you just guessing?

A. I just gave you my opinion. It could havn been anytime, but the most likely time would have been at the time of intubation.

Q. And you were telling me that the Verapimal and Digoxin together is contraindicated in a patient like this?

A, I think it says has to be given with extreme caution because it can cause complete heart block.

Q. What would be the reason for giving Verapimal and Digoxin together?

A. To control his heart rate, to lower it.

Q- Was he -- did he have a high heart rate at that time?

A. Well, he did at that time. He didn't for much longer, though.

Q. Do you have an opinion as to why he had a high heart rate at that time?

A. I think it was because of the disturbance in his conduction system, He had an uncontrolled atrial fibrillation and had a rapid ventricular response. That is not too uncommon with heart failure.

Q. Do you have any criticisms or do you intend to offer any opinions with regard to the care and treatment rendered to Mr. Smith, by his orthopedic surgeon, Dr. Smith?

MR. GROEDEL: Objection.

A. Well, if asked I'll give my opinion. I don't think Dr. Smith actually did anything. I mean, he wasn't there. If he was in the operating room -- and we have from the depositions a claim that he in fact was present for the operation -- he must nave left either before the patient left the operating room or shortly thereafter, and to my knowledge he did not see the patient again.

Q. Is that the extent of your criticisms of Dr. Smith or do you have any criticisms preoperatively of Dr. Smith?

A. Well, that's pretty significant, because basically I don't know what the legal term for it would be, but it would be close to abandonment I would think. He has a critically ill patient in the hospital dying, and he's both unaware of it and not present.

Q. I'm sure someone else will be asking you questions about that.

A. So that's the extent of my criticism, yeah.

Q. Do you have any criticisins of Dr. Smith or Dr. Stevens, the other orthopedic surgeon, Dr. Smith's partner, preoperatively?

A. Well, I think that as the patient's attending physician, they should have been aware of his physical condition prior to the operation and should have considered the risks of having this operation in this particular state, so that I would quite likely have some criticism in a preoperative assessment in preparation for this patient for this operation.

Q. What specific criticisms, though, do you have of him in a preoperative evaluation? Can you tell me specifically?

A. I think I just did.

Q. Okay. You may have.

In your report, talking about the anesthesia that was used in the case, you criticized Dr. Lee for not, according to my notes, sufficiently limiting the level of the anesthetic. What do you mean by that?

A. Could you point exactly to what you are

referring to in my letter?

Q. Yeah. Page three where you are discussing what you perceive as Dr. Lee's departures from standards. No. 2, you say he administered spinal anesthesia in such a manner that -- to limit its effect, there, you are critical of him?

A. Right.

Q. My question to you is whst do you mean by that?

A. Well, I mean just that. He didn't -- the patient was given a presumably hyperbaric spinal so that gravity would determine its direction of flow once it's injected into the cerebrospinal fluid containing space. And if ne had had the patient positioned so it would flow downward, it would be unlikely that the level of the anesthetic would go much higher than where the anesthetic was injected.

In a man of this age, you would have to leave the patient in a lateral position with the dislocated hip down for at Least twenty to thirty minutes to insure that the spinal anesthetic level would not rise once the patient was mobilized.

And I suspect that that was not done,

that the spinal anesthetic was injected and the patient was placed immediately supine, whereupon the level of the anesthetic rose. It was not appreciated in time by Dr. Lee, and therefore was inadequately treated initially. That's why it was necessary for him to use all those vasopressors.

Q. Can you show me in either the anesthesia record or in the intraoperative notes what you base that opinion on?

A. Well, that's what I'm basing it upon, the fact that there isn't anything in the notes or the record that would indicate that he tried to do any of these things to limit the spread of the anesthetic. The fact that there is no information indicating that he tried to limit the spread of the anesthetic and the fact that there was extensive spread of the anesthetic would mean to me that he did not not just record it, he didn't do it.

Q. Okay, Well, what level was the injection in?

A. I don't believe that they recorded that on their record.

Q. So you don't know what level?

A. No, I don't.

Q. Do you know how much anesthetic agents were used?
A. It looks like milligrams.
Q. Of Tetracaine?
A. Tetracaine.
Q. Okay. Can you show me in there what level of anesthesia was reached?
A. Not on this because Dr. Lee didn't record it, but the nurse in the recovery rooin did and she said it was at the 6th rib.
Q. Okay. That would be where along the spine, correlate that?
A. That would be equivalent then to a sixth thoracic level, but that was about an hour after the spinal anesthetic had been injected when it would have been receding, So it would have been higher than that in the operating room most likely.
Q. That's an inference that you are drawing from the level of numbness complained of or identified when he hit the recovery room, that the level of anesthesia during surgery was higher?
A. Yes. I'm -- that's correct. It wouldn't make any difference whether I inferred it or not, though, because the sympathetic block Level would

have been approximately two to four segments higher than the sansory block, so it would have been at a level of T4 to T2, which is clearly sufficient to markedly decrease cardiac output and decrease blood pressure. And it's much higher of course than they needed for this procedure. He only needed to have it at the top of the lumbar spine, in fact. He didn't have to have it above the 12th thoracic level.

Q. So that in your opinion is substandard anesthetic care?

A. Which?

Q. The level of anesthesia.

A. No, because that could happen to anyone. But it is substandard to not make attempts to try and limit the anesthetic spread.

Q. Okay. So the criticism there is positionin early on when ha was inducing or starting his anesthesia; right? You were telling me earlier he should have the --

A. That's correct, or the positioning would be one. He also could have inserted the catheter and done a continuous spinal and just injected small amounts of anesthetic until he got precisely

to the level he wanted. There are any number of things that he could have done differently to limit the spread, none of which Dr. Lee did.

Can I make a correction then to previously what I said?

Q. Sure.

A. The last line was not visable on my recovery room *note*. The nurse notes, quote, has sensation approximate level sixth rib, parentheses, just below nipple line, close parentheses. The nipple line is at the fourth thoracic dermatome, so in fact it was a very high spinal when he reached the recovery room. And he would have had basically a total sympathetic block.

Q. I think we are nearing tho end, Doctor. Let me take a minute and just Look these over.

Doctor, I think that's all I have for you. Thank you very much.

A. Good. Thank you.

MR. KAMPINSKI: This is Mr. Groedel, he represents Dr. Stevens and Dr. Smith.

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CROSS-EXAMINATION

BY MR. GROEDEL:

Q. Doctor, as you know, I represent Drs. Stevens and Smith. With regard to the first surgery that was performed on November 14, would you agree that that procedure itself was an appropriate procedure for tha symptoms that the patient was presenting with?

A. Well, i certainly don't present myself as an expert in octhopedic surgery, but to my knowledge, and which is a very superficial level, it would seem very appropriate and seems -- and certainly in accordance with what I have observed in my private practice of anesthesia before I came here and subsequently.

Q. Are you going to render any opinions in this case with regard to the surgical technique involving either surgeries in this case?

MR. KAMPINSKI: As to the orthopedic: technique?

MR. GROEDEL: Correct, the orthopedic surgeons.

A. I can't imagine that I would.

Q. Okay. Are you going to render any

opinions in this case regarding whether or not the proper cement or other prosthetic materials were used in this case?

A. No, I would not be prepared to do that.

Q. Okay. Up through the completion of the first surgery, the one that was performed on November 14, do you believe that either Dr. Stevens or Dr. Smith were guilty of substandard medical care?

A. No, I don't.

Q. Okay. Are you going to render any opinions in this case regarding the hip dislocation itself?

A. Could you be more specific?

Q. Sure. Are you going to testify as to whether or not the nip dislocation was the result of any negligence or substandard care?

A. I don't think I would be qualified to comment upon that, the dislocation of the hip.

Q. Okay.

A. In terms of its etiology and prevention and so on,

Q. Okay. Do you have any knowledge with regard to the consequences of leaving a hip

dislocation untreated for a period of time?

A. I hsve some knowledge of that. I'm sure that it can't be tolerated,

Q. Did you say --

A. It cannot be tolerated, it would have to bo relocated.

Q. Okay. And that would be because by leaving it untreated, this could lead to severe sciatic nerve damage?

A. Oh, I think it could lead to nerve damage and also probably significant morbidity in terns of the patient remaining bedridden, unambulatory for a prolonged psriod of time

Q. Vascular damage, could it lead to that as well?

A. ▮ think it could. I'm not sufficiently knowledgeable about anatomy to say that, but I believe thare could be compromise of lower extremity circulation, especially the venous circulation.

Q. Okay. Do you believe that the second procedure that was performed was an emergency procedure as anesthesiologists use that term emergency?

A. No.

Q. Would you consider it an urgent procedure?

A. I consider it an urgent procedure under most circumstances and I would consider it nonelectiv in this patient in that it would have to proceed within a reasonable amount of time, say, twenty-four hours or so, But I do not consider it sufficiently urgent that it would have to proceed within two or three hours.

Q. When you say twenty-four hours, that would be twenty-four hours from when the hip became dislocated?

A. I would say twenty-four hours from that morning of detection. It would have to be replaced within a certain amount of time. And again I'm not sufficiently expert in that area that I could comment, but I know it can't go on for a long period of tine,

An3 if there was compromise of circulation or evidence of impending nerve damage, then it would have to proceed even sooner.

Q. Okay, But when we talk about the possible problems that would be incurred with a delay in not treating a hip dislocation, you

believe that those questions would be better left to orthopedic surgeons as opposed to other doctors?

A. Could you repeat your question?

MR. GROEDEL: Would you just read it back.

(Thereupon, the record was read by the Reporter.)

A. I believe that the sssessmnnt of the complications that could arise from leaving a dislocated hip untreated, that assessment would best be done by orthopedic surgeons.

dut in terms of determining when the operative procedure to replace the hip would take place, I do not believe that would be left alone to the orthopedic surgeons. That would have to be done in consultation with the other consultants caring for the patient and the anesthesiologists.

Q. So the second part of your answer then is dealing with medical clearance, so to speak, for that necessary surgery?

A. No. Again, I won't use the term medical clearance. I don't believe that internists should clear patients for anesthesia or surgery. I think they should perform an assessment of the patient's medical condition and pass that information on to

the surgeons and the anesthesiologists and they have to then decide which action to take.

Q. Okay. Would you agree that a hip surgery such as the type of surgery that Mr. Smith underwent is generally associated with a certain amount of blood loss'?

A. You mean tha total hip replacement that he unwent?

Q. Yes.

A. Absolutely.

Q. And the blood loss that's caused by the operation generally continues not only during the surgery but after the surgery as well?

A. Correct, into the operative site, yes.

Q. And for about how long does that blood loss continue?

A. I believe it stabilizes within twenty-four hours.

Q. Okay. Doctor, generally speaking, what are the clinical signs of a patient who is hypobulimic?

A. Generally speaking, the patient nay on a very simple physical assessment initially complain of dizziness upon sitting up. Generally the

patient will have moderate tachycardia. There may or may not be any alteration in blood pressure, but generally there would be a slight diminution in the pulse pressure; that is, a slight fall in systolic pressure, slight rise in diastolic pressure, but without hypotension necessarily if it's just moderate hypobulimia.

There is usually a decrease in urinary output with concentration in the urine, and then with invasive monitoring one would detect a decrease in vascular pressures.

There may be some degree of hemoconcentration with an increase in hemoglobin or hematocrit. If it's simple hypobulimia secondary to blood loss the patient will usually have dry mouth. I think that covers substantially the physical signs.

Q. Is increased venous tone another sign?

A. Increased venous tone? Could you be more specific, because that's not something that's measured?

Q. Something that would be seen clinically on the patient, the veins?

A. No. You would not see venous tone that

I'm aware of. That's not a physical sign that I'm familiar with.

Q. Okay. In this case, we know that Dr. Lee performed a preoperative evaluation on November 17th prior to the second surgery. I would assume you would agree that this preoperative evaluation, at least the form that he had filled out, is to be filled out by the anesthesiologist and not the surgeon?

A. That would be my understanding.

Q. Okay. And would it be fair to state that the surgeon, a surgeon such as Dr. Smith, more often than not depends upon the anesthesiologist for important information which may dictate whether or not the surgery is going to be performed?

MR. CHARMS: Objection.

A. I can't agree with that in total. I think that it's important for the surgeon to have a dialogue with the anesthesiologist if there is any question about a compromised physical status of the patient.

If you are referring to whether or not the anesthesiologist will in fact agree to do the anesthesia, then clearly if there is a question of

that, then the surgeon should have a dialogue with the anesthesiologist so that they both understand with each other the risks involved with either proceeding with the case or with not proceeding with the case.

Q. Okay. When the anesthesiologist is performing the preoperative evaluation, I would imagine that there are several factors that he's got to evaluate. Can you tell me what those factors are? For instance, would past medical history be important?

A. Yes.

Q. An actual physical examination, that would be important for the anesthesiologist to do?

A. Yes.

Q. Okay. A review of the prior laboratory data?

A. A review of all laboratory data would be important.

Q. Okay. Why are those factors important for the anesthesiologist to consider?

A. Well, the patient's past medical history may have relevance in terms of previous anesthetic problems for the patient.

Q. In Mr. Smith's case, did his past medical history have any relevance in the preoperative evaluation?

A. Absolutely. His previous anesthetic was certainly not a smooth and uneventful one and it resulted in probably a myocardial infarct and that would be included in the past history that Dr. Lee would take. That would be of extreme significance.

In that it was not noted in the chart except for a laboratory value of an elevated CPK and a note by Dr. Peters? I believe, that indicated there was an elevation of the CPK, it may be difficult for the anesthesiologist to glean that from the written chart. For that reason, I believe a verbal dialogue with the surgeons tc let him know what kind of problems they had had in the previous two days would be important.

Q. What in fact do you believe the anesthesiologist should be giving to the surgeon when that dialogue is taking place?

A. Well, I think once the surgeon informs the anesthesiologist that we have an urgent or emergent case, it must proceed as soon as possible, the anesthesiologist then has the obligation to

tell the surgeon, all right, if we do, though, these are the increased risks that will be attendant to that particular operation and anesthetic.

Q. And in Mr. Smith's case, what were those increased risks that he should have advised the doctor of?

MR. KAMPINSKI: Wait a minute,

MR. CHARYS: Objection.

MR. KAMPINSKI: We have taken a jump, and I'm sorry to interrupt you, Doctor, but was your response to his last question premised on the fact that accurate medical history was being given by the surgeon for the anesthesiologist then to give that dialogue back?

THE WITNESS: Yes, absolutely.

MR. KAMPINSKI: And your question now is what information he should -- the anesthesiologist should have given him about the risks, assuming he would have gotten the correct medical information from the doctor?

MR. GROEDEL: From the chart.

MR. KAMPINSKI: From the chart,

MR. GROEDEL: Right.

MR. KAMPINSKI: His question though referred to tho anesthesiologist possibly not gleanin it all from the chart but having to get that as the reason for him having to speak with the surgeon?

MR. GROEDEL: Well, I wasn't Sure --

1R. KAMPINSKI: I mean, am I right?

MR. GROEDEL: I wasn't sure what the time sequence was as far as who spoke to whom when. Perhaps that's the problem. I'm not sure when he's talking to --

MR. KAMPINSKI: Your question called for a leap in logic and it forgot about the important

as a prior myocardial infarct.

the surgeon is explaining why it is important to proceed with the operation, what the risks are, and the anesthesiologist then with full knowledge of the patient's medical condition then must explain

to the surgeon what the risks of proceeding with an anesthntic are.

Q. *Okay.* In this case, what risks do you believe that Dr. Smith should have advised Dr. Lee of when he first apprised him of the need for surgery?

A. I think he should have informed him of why he felt this was an emergent procedure that inust proceed before invasive monitoring was placed, arterial lines, Swan-Ganz catheter and stabilization of the patient's medical condition, placement of the nasogastric tube for emptying the stomach and so on,

All of those things would have markedly decreased the patient's risks for anesthesia and it is *my* impression that Dr. Lea proceeded assuming that in fact he had to go right away with the anesthetic without any of that taking place ahead of time.

Q. Was there any indication from your review of the materials that Dr. Lee did not have an adequate time at which to review ths past medical history of Mr. Smith with regard to this same hospital stay?

A. Well, that wouldn't be possible for me to glean from the chart, but I don't know what Dr. Lee's other commitments were. I don't know what time he was informed that this procedure was to take place. I do know that he had time to come up and fill out this sheet very quickly, but this could have been done in five or ten minutes.

Q. Why don't we take a look at that sheet for a second. I'm referring to page 152, the preoperative evaluation,

A. Right.

Q. On that sheet, Dr, Lee notes that the patient is suffering froin hypertension; correct?

A. Yes.

Q. And that he had been on high blood pressure medication; correct?

A. Yes.

Q. Dr. Lea also apparently knew that the patient was in SICC after the first surgery according to that sheet; true?

A. Right.

Q. Apparently Dr. Lee was also aware of the fact that the patient had a history of chronic obstructive puimonary disease?

A. He wrote down COPD.

Q. We also know that Dr. Lee was aware of prior history of smoking, I take it?

A. Well, he put an X by it.

Q. Apparently Dr. Lee was also aware of the prior EKG results?

A. He did copy down the interpretation.

Q. Okay. And apparently Dr. Lee was also aware of prior blood gas results; is that true?

A. From two days before he did, yes.

Q. Okay. And apparently Dr. Lee had the opportunity to review some of the lab data as some values were put in in the section involving hemoglobin and hematocrit, although I realize those are incorrect?

A. Yeah. Mine aren't that legible. I think what he did was just copy down the values probably.

Q. Okay. Were these factors, the ones we have just gone through, were they significant to Dr. Lee or should they have been significant in his preoperative evaluation?

a. Which factors?

Q. The ones that I have noted, the hypertension, the fact that he was in SICU after

surgery, his history of COPD, his history of smoking., the prior EKG results?

A. Those would all be relevant in a preanesthetic evaluation.

Q. Okay- Would those findings alone have indicated whether or not any additional monitoring would have been necessary during the second surgery?

A. No, those findings alone would not have done that.

2. Okay. What additional findings do you need before you mako the assessment that you need to have addition31 monitoring during that second surgery?

A. Well, the major and significant thing was the fact that he had evidence of myocardial damage following the first procedure.

Q. Okay, And that was evidenced by the MB fraction?

A. Yes, of the CPK. It would also be evidenced by the other factors that I mentioned earlier in a review of his course in the SICU with the arrhythmias, the requirement for Dopamine infusion and so on.

Q. Okay. Do you believe that it was the

responsibility of Dr. Smith to be aware of that MB fraction?

A. Yes.

Q. Do you believe it was the responsibility of Dr. Lee to be aware of that MB fraction?

A. Yes.

Q. Do you believe that that MB fraction should have bean a precursor to further care?

A. Yes.

Q. What care?

A. He should have had repeated analysis of CPK performed once it was determined that it was elevated and he in fact had suffered significant myocardial damage, and I'm sure that would that have been corroborated, it's quite likely they would not have transferred him from the surgical intensive care unit or if thay would, they would have transferred him to a monitored bed rather than to a ward.

Q. Okay. The MB result came back on the 14th I take it after the first surgery?

A. I doubt it. Usually they don't come back right away. Probably it didn't come back for some time. And I don't know if we can tell on this when

it was reported.

On the sheet where I'm reading where it's reported, it's printed out on a sheet that says discharged 11-19-34, so it was a summary sheet. Usually what happens and probably happened in this case is each time new lab snnets come up, they destroy the previous ones and insert these, so it's not possible for me to tell. But Peters, the orthopedic resident, did write that information in his progress note.

Q. Is that the one on the 16th?

A. That's what I'm thinking, yes. At 12:45 on the 16th, CPK 349 with MB two percent.

Q. That's referring to the initial and only apparent test that was done?

A. Right.

Q. Do you believe that it was substandard medical practice on the part of Dr. Smith not to be - well, let me strike that.

Do you think it was substandard on the part of anybody in this case not to have taken further action in response to the elevated MB fraction?

A. I think that that elevated MB fraction

indicated myocardial damage? and I don't think the man was treated from that point on once it became known that he had that as if he had had myocardial damage. And I think that was substandard care, and I think that Dr. Smith was his attending physician and therefore was ultimately responsible for that activity. Although there were other people, Dr. Oliver, I believe, who must be a critical care physicisn who was taking care of the patient as well as residents with him as well as the orthopedic residents, I think it would be the attending physician's ultimate responsibility to insure appropriate care for his patient.

Q. Okay.

A. Unless he authorizes and hands over that responsibility to another physician, and I'm not aware that that happened in this case.

Q. In this case, had a repeat CPK/MB fraction been obtained, what do you believe it would have shown?

A. I think if another one had been obtained on the evening of the operation? it would have been markedly elevatcd.

Q. More so than what was initially seen?

A. Yes.

Q. And how would that have impacted upon whether or not surgery was feasible on the 17th?

A. Well, they would have treated him as if he had a recent myocardial infarction, stayed in the SICU in a monitored bed, and assuming his hip still stayed dislocated, they would at least have known they were going to the operating room with an individual that had a myocardial infarction within three days, they would have given more appropriate monitoring presumably, and also more appropriate anesthetic care and management.

Q. So I take it then even had a myocardial infarction been diagnosed prior to the hip dislocation, he still could have gone into surgery on the 17th appropriately for surgery?

MR. KAMPINSKI: Objection. It was diagnosed; it just wasn't treated. It was recognized in terms of the lab tests.

Q. Okay. Let me rephrase the question.

A. Please do.

Q. Even with the inyocardial infarction which you believe was evident and which you believe was not treated, I take it then you believe that with

the hip dislocation that we saw on the 17th, surgery still could have been an appropriate option with the appropriate monitoring?

A. Yes.

Q. And what additional monitoring would have been necessary in this case that you did not see?

A. Well, as I stated before, I believe he should have had an arterial catheter in place. He would have had to have a Foley catheter in place, a pulmonary artery catheter placed. He before going to operation should have had an assessment of his cardiovascular function and also of his pulmonary function, and those organ systems should have been optimized prior to going to the operating room.

Q. Let's deal with the optimizing of the cardiac and pulmonary systems first. Who would have been the doctor that would have Seen in charge of that area of his care?

A. It would depend upon the hospital setting, and I'm not that familiar with St. Luke's but I believe from the notes I read there is a medical director of the intensive care unit who is there presumably. That was Dr. Oliver. Am I incorrect in that assumption? Doe5 anybody know? And

probably it would have been him.

He's the one that seems to have bean following the patient and writing notes. it says SIC resident note, and it's co-signed by A. Oliver. I believe that's who that is.

Q. And the purpose of this optimization would be to stabilize the patient at least as much as possible prior to surgery?

A. To stabilize him and also to minimize any intraoperative complications that might occur in terms of changes in blood pressure.

Q. Okay.

A. Pulse and so on,

Q. And the various devices that you mentioned with regard to monitoring during surgery, the decision to use those pieces of equipment would fall to the anesthesiologist, I would imagine?

A. Which -- you are talking about the Swan-Ganz -- the pulmonary artery catheter and the pulmonary catheter and so on?

Q. Right.

A. Well, it certainly would in most institutions, although it's feasible that an intensive care practitioner, critical care

physician might initiate that therapy or those monitoring modes before going to the operating room, in which case the anesthesiologist would simply continue with that monitoring.

Q. But you wouldn't expect an orthopedic surgeon to handle that aspect of the patient's care, would you?

A. Well, not necessarily. Although it's interesting to note when the patient came back from the first operation, apparently it was the orthopedic resident who inserted the arterial catheter.

Q. Okay.

A. So in this hospital, it's possible that the orthopedic resident did assume care for patients in the intensive care unit. It would appear they assumed a major role in this particular setting,

Q. As far as making the decision with regard to whether or not the monitoring during surgery should be utilized, in other words, the pulmonary catheter and the arterial catheter, those are decisions that are mads by the anesthesiologist and not the surgeon generally?

A. Generally speaking, that's correct.
Q. Okay. In this case had Mr. Smith's cardiac and pulmonary status been stabilized and optimized as you put it and had there been appropriate monitoring during the surgery, do you believe in all likelihood he would not have died after the second surgery?
A. Well, and then presuming that that monitoring and treatment continued into the postoperative course and surgery intensive care setting, than the likelihood of him surviving would have bnen significant. According to figures that have been published in the past, they would have been high.
Q. Can you give me a ballpark figure?
A. Well, there is a particular article by Rao, Jacobs and El-Etr tnat I would go by.
Q. Can you give me the title of that article you are referring to?
A. It's titled Reinfarction Following Anesthesia in Patients with Myocardial Infarction,
Q. What journal is that in?
A. Anesthesiology, Volume 59, pages 499 through 505, published in 1383.

Q. Can you -- you had already given me a ballpark figure.

A. 5.7 percent of patients who had an infarct within zero to three months had a reinfarction. And if they had a reinfarction, then their mortality rate I believe was in the range of about 50 percent. So his chance of surviving would have been in the range of 95 plus percent.

Q. Doctor, I take it you are critical of the fact that the patient wasn't transferred to SICU in this case after the second surgery?

A. I don't think it was a breach of standard of care to not transport him to ICU as long as the postoperative anesthesia recovery area is capable of providing the same care that would be obtained in the surgical intensive care unit, which is the case in many instituticns,

Q. Do you believe that to be the case in this case here?

A. It's not possible for me to judge. I don't know whether they could put in a pulmonary artery catheter or care for it or monitor it an3 arterial line, but I kind of suspect they could in this setting. So I'm not prepared to say that I

think it was negligent to take him to the anesthetic recovery area as long as the appropriate personnel are there to care for the patient afterwards,

Q. Why don't you tell me than exactly what monitoring you would have wanted to have seen while the patient was in the anesthesia recovery room in this case so that you would be so assuaged it was no big deal he didn't go to an intensive care unit?

A. The same monitoring that I would have felt appropriate preoperatively and intraoperatively, indwelling arterial catheter, pulmonary artery catheter, continuous readout, electrocardiographic monitor, constant nursing care and immediate availability of a physician trained in appropriate critical care practice.

Q. Is there anything that you have seen here that would lead you to believe that there wasn't such a physician available to Mr. Smith?

A. Yes. I don't think Dr. Lee was capable of performing that task,

Q. Is there anything in the record that would lead you to believe or anything in the materials that you reviewed that would lead you to

believe that Dr. Lee or anybody did not have enough information or enough time to decide whether or not Mr. Smith should have been transferred to the surgical intensive care unit?

A. Could you rephrase the question? I heard it and I understood it but I can't answer it the way it's phrased. I'm not sure what the major point is of this enough tine is.

Q. Well, was there any indication from what you have reviewed in this case to lead you to believe that either Dr. Smith or Dr. Lee did not have enough information or enough knowledge about the case for them to make a decision as to whether or not the patient should have gone to SICU?

A. I may or may not answer your question; tell me if not. I don't believe that either Dr. Lee or Dr. Smith were sufficiently informed about this patient's condition that they appreciated his severe risk. And I think that both Dr. Lee and Dr. Smith treated him as sort of a routine patient, as evidenced by the fact that Dr, Smith apparently left the area ana was unreachable it's my understanding following the operative procedure and that Dr. Lee transported the patient to the

recovery area as he would any other routine patient for a short procedure.

So I'm surmising based on that activity that they did not appreciate his serious cardiac condition, I don't know if that answers your question, And presumably they didn't appreciate it because they didn't have tne information that would have led them to feel differently.

Q. Oksy,

A. The information was clearly available to them, though,

Q. Okay. Generally speaking, the decision to send someone to SICU after surgery if their intraoperative problems are not related to the surgical procedure itself is usually made by the anesthesiologist?

A. I think it's a joint decision, the anesthesiologist would most often say I think you better go to the ICU, and I can't imagine the surgeon arguing with that, But once the patient is transportad to that area, than the responsibility for care goes over to the surgeon.

Q. To what area?

A. To the surgical intensive care unit, and

he will become the responsibility of the surgeon or in an institution where it's designated it would be to the critical care physician in charge.

Q. Okay. Before I forget, you mentioned that it was your understanding that Dr. Smith vas no longer involved or abandoned the patient after the surgery. Did the recovery room note indicate uhether or not Dr. Smith did in fact come in to see the patient after the second procedure?

A. I --

Q. Why don't you take a look at it.

A. Yeah.

A. Oh, I apologize, I missed that. Yeah, Dr. Smith visited, so he did come to the recovery room at 5:25. I just forgot that. I'm sure I knew it once upon a time.

Q. So you would agree then it does not appear as though Dr. Smith abandoned his patient; correct?

A. Not immediately after the operation. It was my understanding that he was not reachable after that point in time.

Q. Okay. And you believe that he should have been?

A. Yes, I do, or to have designated another physician at his level, an attending staff physician, who could be reached in case of an emergency.

Q. Was there anything in your review which led you to believe that either Dr. Smith or an appropriate replacement was not available?

A. No, I can't say that that's the case.

Q. Generally speaking, what would you say the surgeon's role is after a surgical procedure has been completed and the patient has been transferred to the recovery room?

MR. KAMPINSKI: Generally or in this case?

MR. GROEDEL: Generally.

A. Subsequently it's his responsibility, I think he still maintains responsibility for the overall medic31 care of the patient.

Q. Generally speaking, who is in charge of the recovery room?

A. It varies from institution to institution, but it's the anesthesiologist in almost all institutions medically. You mean medically, the medical director or whatever it would be.

Q. Okay. Would it be fair to state if there

are complications in the recovery room and that these complications deal primarily with the heart or the respiratory system, these types of problems are best left to the anesthesiologist as opposed to the surgeon. particularly an orthopedic surgeon?

A. I would say not best left as if, you know, the orthopedic surgeon wouldn't have any involvement, but clearly the primary responsibility for management should fall on the shoulders of the anesthesiologist in that situation.

Q. Okay. Can you tell me as far as the preoperative evaluation is concerned, where do you think Dr. Smith fell below the standard of care?

A. For the second operation?

Q. Right.

A. Yes.

Q. Preoperative evaluation for the second operation?

A. First of all, did I say that he did fall below the standard of care in the preoperative evaluation?

Q. Well, why don't you answer that one too then,

A. Did I state that?

before. He may have been, he may not have been, I don't know.

So for him not to communicate that to the anesthesiologist would be obviously -- I mean, it would be difficult for him to communicate something he doesn't have any knowledge of. I don't believe thst Smith really knew what was going on much with this patient.

I think he assumed the residents were taking care of things, and I'm not prepared to say that's a breach of the standard of care because I think in many teaching institutions that's a fairly common occurrence.

I do, however, tnink that when tne patient hit the recovery room, it should have been apparent to any physician as it was to the nurse that the patient was in critical condition, and at that point in time I do have criticism of Dr. Smith leaving and assuming that another physician would take care of the patient in an appropriate fashion, which obviously did not occur.

Q. Just so we can put some parameters then on our discussion that will take place from now on, up until the surgery is completed and we get to the recovery room on November 17, you don't believe Dr. Smith was guilty of substandard conduct'?

A. I'm not prepared to say that. I'm not an expert in orthopedic management and care, I don't tnink his care was optimum by any means. Hopefully it wasn't even average, but I'm not prepared to say that it was substandard in terms of negligence.

Q. Okay. If you change your opinion for any reason, please I would ask you let Mr. Kampinski know an3 I'm sure ha will apprise all of us as well.

MR. KAMPINSKI: Are you sure of that?

MR. GROEDEL: I'll ask him again.

MR. KAMPINSKI: Just keep asking, Mr. Groedel. We still have discovery ongoing.

A. I don't change my mind very often. It's too confusing if I do that,

Q. dell, the CPK/MB enzyme thar we have discussed, is an elevation in that enzyme also consistent with muscle damage usually seen in major surgical procedures and not necessarily cardiac muscle damage?

A. The MB fraction?

Q. Right.

A. It's my understanding that that's specific €or tha myocardium.

Q. Okay.

A. Perhaps trace amounts can be found elsewhere, other smooth muscle, but my understanding is that elevation of two percent is quite likely significant, especially in light of the proximity to the surgical procedure, within one hour.

Q. Do you believe that Mr. Smith actually had an MI?

A. I believe that he had severe myocardial muscle damage. I'm not prepared to differentiate between severe ischemic damage to the heart and an actual myocardial infarct which I suppose would be a pathologic diagnosis. But I do believe he had severe myocardial injury, and I would call that a myocardial infarct. But it is possible there is some subtle differentiation which I'm not familiar that might prove that wrung.

Q. This myocardial injury that you are talking about, do you believe in Mr. Smith's case it was acute?

A. Yes.

Q. Not chronic?

A. No.

Q. And what do you base that on?

A. The intraoperative difficulties that he

had that did not respond to appropriate therapy as a transient hypotension that frequently occurs with anesthesia in surgery will. The fact he had fairly significant dysrhythmias in the postoperative period and his past history and electrocardiogram indicating a preexisting heart disease all would lead me to believe that it was myocardial injury rather than just a transient ischemic episode that occurred intraoperatively.

Q. Knowing what we do know about Mr. Smith's hypertension and the other findings that we saw in his EKGs, do you have an opinion as to whether or not Mr. Smith was suffering from coronary artery disease when he was hospitalized?

A. I suspect that he was, but that's all it would be is just a suspicion.

Q. Would you be able to give us any indication as to the degree of coronary artery disease you believe that he had?

A. No.

Q. So, Doctor, I take it your first criticism of Dr. Smith is that he was not in the recovery room?

A. It's not so much he wasn't in the

recovnry room and that he didn't -- since he was the patient's physician, even if he's not capable of taking care of the complications and problems, I think it's his responsibility to see to it that somebody does take care of them.

In other words, that he serve as the general protector of the patient's well being to the best of his ability in any case. And it may be that there is nothing that can be done in some circumstances, but he should at least attempt to oversee the care and management of his patient and see to it that proper consultants are available in taking care of his patient.

Q. How long do you believe Dr. Smith should have been in the recovery room in this case to insure thar proper consultations, if necessary, could be taken care of?

A. I don't think that the time is a critical element. I think he should have recognized that his patient was not in good condition.

Q. Whan should he have recognized that?

A. I think immediately upon entrance into the recovery room. Whan I read the nurse's admitting notes, they describe a patient who I

think is critically ill.

Q. What are the signa -- what are the indications in that record that lead you to believe that the patient was critically ill?

A, He was cool and diaphoretic, dusky nail beds, respirations were rapid, he was dyspneic, he was complaining of shortness of breath.

Q. Anything else?

A, His atrial fibrillation with -- I think what it says is uncontrolled ventricular rata and frequent multi-focal PVCs. And I think those signs and symptoms would be sufficient to tell any physician that the patient is not doing well.

Q. Okay. And under those circumstances, what type of physician do we need to see involved in the patient's care3

A. Well, in fact, I think an anesthesiologist would be perfectly appropriate to cafe for the patient as long as he is sufficiently qualified to do so. And it would be appropriate for Dr. Smith to assume that Dr. Lee was appropriately qualified to do so, but I think he then still has the responsibility to follow up on the patient's care on a fairly frequent basis, at

least every half hour, every hour, I won't be specific about that, sut just to insure that the patient is in fact receiving appropriate therapy and is responding appropriately to that therapy. If he's not, then I think immediate transfer to the surgical intensive care unit would be an obvious move.

Q. So you chink that Dr. Smith should have after his initial visit gotten back in touch with the recovery room about thirty minutes later and basically said how are things going?

A. I don't think he should have left.

Q. Okay. Do you think it was substandard for him to leave?

A. I'm not prepared to say it was substandard for him to leave the room as long as he checked back on a frequent basis *to* monitor the patient's progress.

Q. Okay. And *if* Dr. Smith didn't check back within thirty minutes or so, you believe that would be substandard?

A. I believe the fact he didn't check back at all was substandard.

Q. Okay. How often do you believe he should

have checked back?

MA. KAMPINSKI: I think he just answered that,

A. As often as would be required to insure that the patient was making satisfactory progress and as often as would be necessary to allow him to make an appropriate judgment about when transfer to a more capable facility and/or physician would be appropriate.

Q. Okay. Had Dr. Smith checked back in this case as you say that he should have, what do you think would have occurred?

A. I think he would have transferred him to the surgical intensive care unit.

Q. Okay.

A. And hopefully there would have been a physician there who would have inmediately taken care of his care and made appropriate attempts to treat the patient.

Q. Had the patient been transferred to surgical intensive care, say, within thirty minutes or so of the time when he was first brought to the recovery room, do you think that in this case that would have prevented Mr, Smith from dying, assuming

he received appropriate care?

A. This is the question we were discussing earlier, and it's difficult if not impossible for me to answer that with any degree of accuracy.

I think that prior to the operation the patient had probably a 95 percent chance of getting out of the hospital alive. knd with each subsequent act that was committed and then later in the recovery room omitted as well, his chances of survival became smaller and smaller and smaller until finally he received his sodium pentothal intravenously which was basically the final insult to his heart in my opinion,

So that I think, you know, the earlier the transfer, if he had gone directly from the OR to the ICU, his chances would have been better than if he went to the recovery room and then to the ICU. But I really can't put a percentage on it.

Q. At what point in time do you believe he would have had less than a 50 percent chance of living?

A. Boy, that's extremely difficult for me to answer that. Maybe I can by going through the recovery notes.

Q. Let me modify that to 50 percent or less,

MR. KAMPINSKI: Your question was just more. Say your question again so we all understand it.

MR. GROEDEL: Okay,

MR. KAMPINSKI: And just so the Doctor understands why you are asking in terms of those percentages, I think it's only fair for you to explain to him the legal significance of the percentages that is in terms of probability.

MR. GROEDEL: I tnought you would have.

MR. KAMPINSKI: You are asking the question, just so we have it all in context.

MR. GROEDEL: All right. Let me rephrase the question.

BY MR. GROEDEL:

Q. Doctor, at wnat stage in the recovery room or at any stage in this case do you believe that Mr. Smith had a 50 percent or less chance of living following the surgery?

A. I can say for sure that after about 9-00 when he began really having his problems and Nurse Sims I believe it is was writing notes every five or ten minutes or so on, I think his chances of

survival were less than 50 percent at that point in time.

It's no: possible for me to even say at the time that he came into the recovery room did he have a 50 percent chance of survival. I think ne did. I think it was greater than 50 percent when he came into the recovery room, but it's just this type of thing doesn't happen enough that I can call upon my past experience and say the percentages are thus and so. I just can't do that, I mean, it would be a guess, and that's all it would be would be a guess.

Q. Assuming that the patient has been transferred to SICU in this case from the recovery room, what would have beer! going on there that was different than what was happening in the recovery room from a monitoring standpoint?

A. Well, I don't know what the intensive care setting is in this particular hospital, but if it were the intensive care unit and I was the physician, he immediately would have an arterial catheter placed €or monitoring heart pressure and he would have immediately had a pulmonary artery catheter placed to assess his cardiac pressure.

Then he would hsve had immediate therapy aimed at decreasing hi5 workload in terms of the heart and optimizing cardiac function.

Q. Would he have received any different medications?

A. Very likely.

Q. Such as?

A. He possibly would have received Dopamine, maybe Dobutamine.

Q. What are those drugs for?

A. To increase contractility of the heart, increase perfusion to the kidneys in the case of Dopamine as well,

And he probably would have received Nitroglycerin infusion to decrease systemic vascular resistance as well as to decrease preload on the heart. He certainly would have gotten blood transfusions to increase his hemoglobin concentrations. He would have had blood gases performed, He may have received CPAP by mouth, Perhaps he would have had his trachea intubated and mechanica1 ventilation institu**ted.**

Q. In your revieu of the record, was there anything that would lead you to believe that the

patient couldn't have been transferred from the recovery room to the SICU unit earlier than what actually occurred here?

A. Not in my review of the records.

Q. Do you have any other criticism of Dr. Smith in the postoperative period?

A. Not that occurs to me offhand.

Q. Do you have any other criticism of him whatsoever then?

A. Mot thit we haven't discussed that occurs to me at this time,

Q. Okay. In the review of the records and depositions, do you have an opinion whether or not Dr. Timothy Stevens is guilty of substandard conduct in this case?

A. None occur to me at the time. Dr. Stevens did not really participate in this patient's care, did he?

Q. It was --

A. After the first operation.

MR. KAMPINSKI: His name I guess was on the operation but ha didn't perform.

Q. He didn't perform any surgical procedures.

A, He was identified as the attending

surgeon on one of the operating room records but he was not physically present,

A. Correct,

Q. Then he was the one that said send him to the ICU at 10:45.

A. Correct, So tne answer is, no, there is no substandard conduct as far as Dr, Stevens is concerned?

Q. The reason I'm hesitating is that Dr. Stevens was notified at 10:45 of the patient's condition. He wouldn't have had time I don't think to respond to come in before the patient's demise in any case.

A. So I believe that's true. He was not aware up to that point in time the patient was having difficulty, to my knowledge. If he knew that the patient was having trouble, then I would certainly be critical that ha didn't come? in and see the patient. But to my knowledge, he was unaware that the patient was having trouble at 10:45.

Q. In othar words, you are critical of him if he knew that he was having trouble before 10:45?

A. Correct.

Q. Okay.

A. Any indication in what you reviewed thit Dr. Stevens did know prior to 10:45 that the patient was having problems?

A. I'm not aware of that.

MR. GROEDEL: I have no further questions. Thank you, Doctor.

THE WITNESS: Thank you.

MR. KAMPINSKI: This is Mike Zellers, he represents St. Luke's Hospital.

CROSS-EXAMINATION

BY MR. ZELLERS:

Q. Dr. Downs, I believe it's been your testimony that you do not have criticisms of the nurses in this case; is Chat correct?

A. That's correct.

Q. What criticisms do you have, if any, of the hospital or its residents in this case?

A. Well, let me start with the hospital just in general terms.

I believe it's the responsibility of the hospital when a patient comes in €or an operative procedure to guarantee the best in the hospital's ability they will receive at least adequate medical

care while they are there.

And in order to do that, they have to have certain representatives. They have to have medical directors of various departments to insure that there is appropriate care, for example, in the recovery room. 30 I believe it's the hospital's responsibility to insure that there will always be a capable individual present in the recovery rooin to care for any postoperative complications that might arise.

And I do not believe that Dr. Lee was capable of handling the complications that arose in this case in an appropriate manner. And so there is certainly the possibility that the hospital was negligent in allowing Dr. Lee to serve as a medical person in charge of the recovery room at that time.

Now, it may be that the hospital somenow handed that responsibility to another anesthesiologist, in which case they truly were in good faith and felt they had fulfilled their responsibility. But clearly at the time that this patient was in the recovery room, he did not have adequate medical management.

Q. Any other criticisms of the hospital in

this case?

A. If the residents are -- they are hospital employees, there is no question about that. I do not believe that the residents in this case acted in an appropriate fashion to insure the patient's health and welfare. They did not adequately care for the patient following the first operative procedure and they certainly didn't adequately care for the patient in the recovery room.

However -- well, let me continue on that line. Then upon reading the depositions of some of them, I would say that their lack of medical knowledge I would have to term is unbelievable.

It's hard to believe that a physician could get this far in training and know as little about the things that thzy wert questioned about as they apparently do. This was especially true of Michael Gill and Scott Miller, Scott Miller in particular. Miller I believe is the one that kept -- was called from the emergency room and came up to see the patient,

However, it still falls back on the attending surgeon who is ultimately responsible. So the fact that these people were not practicing

medicine at a standard that I find acceptable in my mind, it's the attendin.3 surgeon's responsibility to see to it that these people carry out their wishes appropriately, and if they don't, then they shouldn't have them serving in their stead.

So whether or not the hospital is negligent in having these resident;; is not clear in my mind and I'm not prepared at this time to say that the hospital was negligent because the residents were negligent, although I would like to reserve that right, There is no question that these people were nat taking good medical care of this patient and their actions were substandard.

Q. If it at some point becomes your opinion that the hospital was negligent in this case through the acts or inactions of tne residents, will you advise Mr. Kampinski of that?

MR. KAMPINSKI: Excuse me. I do have to interject because that's not a fair question and the determination as to whether the hospital is responsible for the actions of the residents is a legal determination and the Doctor's testimony to you when you just made that request is appropriate. He's not in a position to tall you whether the

hospital is legally responsible for the residents. That's something that a judge will instruct a jury on and they will nave to decide appropriately,

I think he's trying to tell you what he finds wrong with the residents' actions, but you can't impose upon him or me the burden of coming back to you and saying, Yeah, it's the hospital, I a personally do, but that's a legal question.

BY MR. ZELLERS:

Q. Doctor, in your medical practice, between yourself as an attending physician and the hospital as an employer, who bears medical responsibility for the acts or inactions of a resident?

MR. KAMPINSKI: Objection, just for the record,

A. In my opinion, any action or lack of action on the part of a resident who is under my medical supervision becomes my medical responsibility.

Q. In this case, would the acts or failure to act on the behalf of the orthopedic residents be the ultimate responsibility as you know it as a medical doctor of the attending orthopedic physician as opposed to the hospital?

MR. GROEDEL: Objection.

MR. KAMPINSKI: Objection.

A. Again, not answering from a legal sense, I believe tnat Dr. Smith was responsible for the actions and lack of action of the residents in this case.

Q. Do you have any other criticisins in this case of either the hospital or its residents?

A. Not that occur to me right at this time.

Q. If at some point you review additional materials which cause you to have opinions in addition to what you have said today insofar as the negligence of the hospital or the residents may be concerned, would you advise Mr. Kampinski?

A. I'm sure I would.

Q. Insofar as your first criticism goes that Dr. Lee was managing the recovery room on November 17th, 1984, what's that criticism based on?

A. My criticism was that he was given responsibility for this patient's care and recovery in the recovery room based upon the fact that he was assigned as the anesthesiologist to care for the patient.

Q. Let me stop you right there. In general,

is it appropriate for a hospital to delegate to an anesthesiologist responsibility for care in the recovery room?

A. In general that occurs, yea.

Q. Is it your criticism in this case that Dr. Lee did a bad job in the recovery room? I mean, is that the distinction you make in this case?

A. He did a bad job in the recovery room in this case. If you remember, I don't think he was capable of doing a good job in the recovery room, and my criticism as far as the hospital is concerned is that other physicians have testified that the reason that they didn't follow the patient more closely is because it is the policy of the hospital that anesthesia cares for the patient while they are in the recovery room,

Q. You don't criticize the hospital policy, do you, that it's the anesthesiologist that's in charge of the patient in the recovery room?

A. I don't question that policy at all.

Q. And you don't find that policy to be negligent?

A. No. If there is negligence, I found the negligence to be that the hospital didn't insure

that there would be adequate and appropriate care for the patient in the recovery room.

Q. How should the hospital in this case have insured that there was appropriate and adequate care in the recovery room?

MR. KAMPINSKI: Well, let me object because I want you to understand the implication of your question. I have requested the personnel file of Dr. Lea as well as soma of the other residents and nurses involved, It's my understanding you are going to object to providing that personnel file and the otner things that would go to possibly assist the Doctor in answering the precise question you are asking him. So with that understanding? you know, I have no objection to your question, but I want to make sure you understand the implications of your question.

MR. ZELLERS: Let me back up then.

BY MR. ZELLERS:

Q. Doctor, per Mr. Kampinski's comments, am I correct that you don't have an opinion one way or the other as you sit here today as to whether oc not the hospital was negligent in allowing Dr. Lee to serve in the recovery room following this

operation?

A. First of all, let me state I was not being critical of Dr. Lee following his patients in the recovery room. I was being critical of the fact that it is anesthesia's responsibility, the anesthesiologist's responsibility to be in charge of patients in general in the recovery room, and therefore I believe it's the hospital's responsibility to insure a capable medical practitioner taking care of the patient in the recovsry room.

And because that is the policy of the hospital, other physicians did not check on the patient as carefully as they would have had they felt they were responsible for the patient's care in the rscovery room. Now, that may not be the policy of the hospital, but that's my understanding at this time. I've not seen the hospital policies.

So therefore? I think it is the hospital's responsibility to insure with careful credential checks, follow up on care and capability and so on, to insure that any anesthesiologist to whom that responsibility is delegated is capable of caring for critically ill patients such as Mr. Smith.

Q. In a case such as this, how should St. Luke's Hospital have determined that Dr. Lee was a capable, qualified anesthesiologist, not based on perfect standards, but based upon the standard of care as you understand it?

A. Well, they should have obviously had a very careful credential check of him beforehand with letters of recommendation of capabilities and so on. They should have insured that he was capable of performing a variety of different procedures such as pulmonary artery catheterization, radial artery catheterization, and if he was not, they should have told him when you have a patient that requires those procedures, you must obtain a consultation and put appropriate restrictions on him as they would any other physician.

And they also should have then made a determination of whether or not he should be allowed to serve as the person in charge of the recovery roon at any point in time. Because it's possible he should not have had privileges to care for patients in the recovery room. It's highly unlikely, but possible.

Q. Anything else that the hospital should

have done in terms of determining Dr, Lee's qualifications?

A. Should have received a letter or some statement from the head of the department that would have assured the hospital and its credentialing board that Dr. Lee was, in fact, capable of

A. I think I covered it all.

Q. Could you distinguish for me the various responsibilities between a hospital and its credentialing committee and its medical staff in terms of policing or monitoring the physicians on the staff?

A. I'm not prepared to do that at this time. That would require a great deal more thought than I can give you in sitting here in five minutes and answering the question,

Q. Who is the physicisn that would be in the best position to know whether or not Dr. Lee was a capable, qualified anesthesiologists?

A. It would be another anesthesiologist, and if there was such a person at this hospital, it

would be the head of the anesthesiology department.

Q. Would it be appropriate for the hospital to delegate its duty of passing upon the qualifications of Dr. Lee to the head of the anesthesia department?

A. It would, as long as that individual then responded back to the hospital with assurance that he had, in fact, fulfilled his responsibility in checking the individual's credentials, capabilities and so on.

MR. KAMPINSKI: I'm going to object to the question to the extent that it assumes that the duty is delegable. There is case law that suggests it is not a nondelegable duty.

MR. ZELLERS: I'm asking Dr. Downs what his opinion is and what his understanding is based upon his experience.

MR. KAMPINSKI: I understand, so I am just interjecting my objection so we don't have any misunderstandings of what exactly you are trying to do at some point in the future.

A. In my opinion that would be appropriate, but it's still the hospital's responsibility, even if they delegate it, in my opinion,

Q. Assume in your opinion that it is acceptable for the hospital to delegate to the head of the anasthesia department the right to pass on Dr. Lee's qualifications and credentials -- read back what I got.

(Thereupon, the record was read by the Reporter.)

Q. -- what is the hospital's responsibility for insuring that that's carried out? Do you understand my question?

MR. KAMPINSKI: I'll object to it.

A. Once they have delegated it, what should the hospital do to insure that it's appropriate? Is that what you are ssying?

Q. I guess what I'm looking at and I'm trying to break this down into each segment, assuming the hospital has delegated to the head of the anesthesia department the job or the obligation to pass on Dr. Lee's qualifications --

a. And by that do you mean to review them and make a recommendation to the hospital?

A. Yes, that's what I mean. What docs the hospital have to do in order to appropriately delegate that function to the head of the

anesthasia department?

MR. KAMPINSKI: Objection.

A. You mean what would the mechanism be by --

Q. The mechanism and -- what I'm trying to find out is if the hospital or what standards or criteria are there that the hospital would have to follow in order to properly delegate its responsibility for passing on Dr. Lee's qualifications to the head of the anesthesia department?

MR. KAMPINSKI: Objection.

A. I don't think I understand the question- I'm sorry.

Q. If the hospital has appropriately reviewed tho qualifications of the head of the anesthesia department, may it then delegate to that person the job of passing on the credentials of the staff anesthesiologist?

MR. KAMPINSKI: Objection. So I don't have to continue interrupting, let me just have a continuing objection to the entire line of questions dealing with the assumption that the hospital can delegate this particular duty.

A. They can do it and they do do it in many

instances, I believe. They have in the past.

Q. Do they do it in this institution?

A. They used to, They don't anymore, I don't tnink. They used to just take the recommendation of the chairman of the department and pass on it at the medical staff meeting. They don't anymore.

Q. Based upon your knowledge, is that stiil within the standard of care for a hospital to delegate to tne head of a department the right to pass on the credentials of persons on its staff?

MR. KAMPINSKI: Objection.

A. I don't think that's a question, a medical practice question. I think it becomes more of a legal question, and I'm not qualified to answer that. I could be incorrect, but it is so far away from the practice of medicine that I don't feel that I have the information to make a judgment.

Q. There is no question in your mind, though, that the input of the head of the department -- in this case, the head of the anesthesia department's recommendations are important in terms of the hospital passing upon the competency and qualifications of a given physician?

A. I'm sure they are very important.

Q. Does the hospital and its credentialing board have the right to rely on the opinion of the head of the anesthesia department in terms of passing on the qualifications of members of that department?

MR. KAMPINSKI: Objection.

A. In my opinion they do not have the right to just rely on his word that so and so is all right, I think that they should have specific criteria by which the head of the department makes his recommendation, and in my opinion the hospital board or whatever, the credentialing committee should specifically look at those areas and in addition they should specifically specify what procedures and activities an individual is to perform or not to perform within the institution.

Q. In this case, to determine whether or not the hospital was negligent in granting privileges or credentials to Dr. Lee, we have to look at its policies on credentialing and whether or not thosa policies were appropriately carried out in this case; is that correct?

A. Correct, And in addition to that, I would think if there had been other instances where

Dr. Lee had failed to act appropriately in the care of patients, either during anesthesia, before anesthesia or after anesthesia, those I think would be relevant as well.

Q. Assuming that the hospital followed its policies and its procedures and also had the input of other actions or inactions of Dr. Lee and that in doing those they followed the procedures they set up, would the hospital -- strike that. I want to shorten it and make it simpler.

You don't have an opinion as you sit here today whether or not the hospital was negligent in giving Dr. Lee privileges and in letting him act in the recovery room?

A. I think that I don't hive sufficient information to form that opinion, but I certainly tnink it's possible that if I knew all that I could know about his previous activity, what the hospital's policy and procedures state and how they went about granting him privileges to be in charge, medically in charge of the recovery room, I well might -- I might form the opinion that they were negligent in allowing him to do so.

Q. And in order to form an opinion one way

or the other, you need to see the hospital policies, and also how those were carried out in this particular case in terms of granting Dr. Lee privileges?

A. Correct. And also if there had been other instances where Dr. Lee had failed to perform in a satisfactory function, how that was dealt with by the hospital.

Q. You are not saying that the hospital becomes an insurer for all of the acts or inactions of the physicians on its staff, are you?

MR. KAMPINSKI: Objection. I think the Franklin County Court of Appeals has said that,

A. Well, I'm saying that if the hospital places a physician in charge of a certain area of the hospital, that they in fact are responsible for his activities.

Q. Are they responsible for his activities or are they responsible for using appropriate mechanisms to either pass on his credentials or not?

A. Well, I understand what you are saying, and I don't disagree as long as that's an ongoing process. I mean, they could have granted him staff privileges twenty-five years ago and he could have

been doing -- he could have been performing incompetent acts for many, many years. And if the hospital didn't intervene in that case, thzy would clearly be negligent in my eyes even though they passed on his credentials, as you say, twenty-five years ago very appropriately. So they need to have some continuing program to insure appropriate activity in those areas.

3. And as you see it on this point, that's the negligence of the hospital, if there is any, in the credentialing of Dr. Lee?

A. I don't know if credentialing is the appropriate word. In allowing him to be responsible for the care of patients in that particular area of the hospital.

Q. In giving him privileges that would permit him to act in that area?

A. No, that's not what I'm saying. It's noi only privileges to act; they grant that for all physicians in the hospital. But this is more than that. They have appointed him as being the individual in charge of an area of the hospital and for the medical care of all patients in that area. And that's much different, I think, than granting

him privileges to care for his patient.

Q. Do you have an opinion as to how often the hospital ought to review Dr. Lee's credentials?

A. There ought to be a process in my opinion for continuing review. There should be a mechanism by which if there is a questionable action or lack of action that that can be reviewed immediately, and in addition I would think there should be at least a yearly review of the physician's credentials to serve in capacity as director of thi recovery room.

Q. Other thin what we hava already discussed, is there anything else that you believe the hospital should do in order to pass on Dr. Lee's qualifications?

A, Anything else other than what I have mentioned already?

Q. Yes.

a. Not that I can think of.

Q. Your second criticism of the hospital in this case relates to the acts or inactions of the residents; is that correct?

A. Correct.

Q. What are you critical of in terms of the

residents' care and treatment prior to the second surgical procedure?

A. The residents who were charged with care of this patient did not recognize his severe cardiopulmonary compromise and ordered that he be transferred to the floor which I felt was inappropriate,

Q. It's your opinion that it was a resident that ordered this patient from the SICU to the floor?

A. I believe so, Can we go off the record for a minute while I look here?

I can't read this guy's -- is this Miller? Do you remember which one that is? We are off the record,

To answer your question, I believe it was a rssident slthough I can't identify his handwriting sufficiently to tell you which resident. I think it may be Miller.

Q. What other criticisms, if any, do you have of the conduct of the residents before the second operation?

A. Failure to adequately investigate the cause of his falling hematocrit, failure to

adequately investigate his compromised gastrointestinal track dysfunction; in particular, the possibility of bowel obstruction. Failure to adequately treat his apparent myocsrdial infarction. I believe that's all.

Q. Are the failures thit you have mentioned the responsibility of tho orthopedic residents acting in this case?

A. Well, in my opinion, as I have stated, I believe that any of their actions or lack of actions are ultimately the responsibility of the attending surgeon.

Q. Who makes the decision as to what investigation ought to be carried out, for example, to investigate the fall in hematocrit?

A. Who should or who does?

Q. Who does,

A. Nobody did. That's my criticism.

Q. In the exercise of ordinary care? is thit a decision to be made by the resident or by the attending physician?

A. It can be made by either appropriately, and I think the fault of the attending surgeon in this instance then is that he is the one that will

dictate ultimately how much freedom of action the residents have. I think it's up to the attending surgeon to determine if the residents in his mind are sufficiently qualified that he can give them -- or how much responsibility and freedom he can give them. Ultimately it is still his responsibility.

Q. Would that apply to each of the conditions that you hsvo identified?

A. Yes, it applies to a11 of their activity in my opinion. If in the opinion of the attending physician he has a basically incompetent resident working with him, then I think he should give him little or no responsibility and would have to supervise him constantly and consistently at all times.

Q. In this case, you have reached certain opinions insofar as Dr. Lee is concerned and insofar as Dr. Smith is concerned; correct?

A. Correct,

Q. The information which was available to you in terms of the St. Luke's Hospital record in formulating your opinions was also available to the attending physicians in this case; is that right?

A. At least some of it was, sone of the data

actually appeared in the chart after the patient's daath; for example, the final laboratory report, so I can't say for sure how much was available to them at the time the patient was baing cared for.

Q. What I'm asking is based on your review of all the records, was there anything that the residents knsw that they had not communicated to the attendings througn the chart prior to the second operation?

A. I don't know how much was actually communicated to the staff through the chart because that presumes that the attendings actually reviewed the chart carefully and I don't know that they did.

Q. Should the attendings in this case have reviewed the chart carefully prior to the second operation?

A. I believe tney should have or they should have obtained that information through other sources such as talking with the nurses, the residents, the whatever.

Q. Did the attending physicians in this case have the information available in the chart to make the decisions which you believe should have been made in this case?

A. I believe that the information was in the chart, it was available to them, and I believe it was their responsibility to be aware of that information.

Q. Did the failures to act on the part of the residents prior to the second operation cause or contribute to Mr. Smith's desth?

A. In that I believe the second operation and then prepared state contributed significantly to his demise in that his own prepared state resulted from failure of the residents to communicate the information or to have proper action taken. I believe that their inaction to some extent did contribute to the patient's ultimate demise.

3. Other than the criticisms you've had in response to the other questioning that's gone on here today, what else was it that the residents failed to do that caused or contributed to his death? And again we are looking here prior to the second operation.

A. Other than what I have already criticized, I don't know if there are any, but such things as allowing the patient to remain anemic and allowing the patient to be transferred to the ward and so on,

those were all significant --

Q. Are there any --

A. -- inactions.

Q. Are there any independent responsibilities the residents had in caring for Mr. Smith between the time of his first operation and the time of his second operation that caused or contributed to his death? By independent, I mean separate and apart from those things that are also the responsibility of the attending physician?

A. No.

Q. What criticisms do you have of the residents during the second operation?

A. Presuming that Dr. Smith was present and clearly then in charge of the patient's orthopedic management, up until the time the patient was transferred from the operating room, I don't have criticisms of the residents' action or lack thereof with the exception that the orthopedic resident who dictated his operative report clearly did not recognize the severity of the patient's problems. But that's not a deviation from the standard of care; that's just a comment on his lack of understanding of the patient's condition,

Q. So in terms of deviation5 from the standard of care, you don't find any insofar as the residents go during the second operation?

A. Correct.

Q. Insofar as the residents' acts or failures to act before the second operation, were those deviations from the standard of care?

A. Some of them were, I think the transfer of the patient from the intensive care unit to an unmonitored bed within a couple of days of myocardial infarction without further investigation would be considered a deviation from the standard of care.

Q. Were there any other deviations froin the standard of care on the part of the residents during that period of time between the first operation and the second operation?

A. I think I had several criticisms, but I can't say that they would be considered a deviation from the standard of care.

Q. What criticisms do you have of the residents in this case following the second operation?

A. My criticisms there relate primarily to

Dr. Gill who dictated the operative note and therefore was likely the operating surgeon under the supervision of Dr. Smith who, and I quote, said that the patient was transferred to the recovery room in good condition and tolerated the procedure well without intraoperative complications, unquote, thus indicating his lack of appreciation for the severely compromised stat; of the patient and thus leading him to leave the patient in the recovery room in a severely compromised state without insuring appropriate therapeutic maneuvers.

Anr? as I understand it, he was then gone and not available, leaving Dr, Miller who was also assigned to the emergency room to be the resident to care for any further complications that the patient might have on the evening of the operation.

I don't have specific comments about Dr. Miller's treatment of the patient thereafter except again a comment that I think that he was poorly responsive to Nurse Sims' calls in terms of taking appropriate action to reverse this patient's severely compromised cardiovascular status.

Q. Did Dr. Miller deviate from the standard of care following the second operative procedure?

A. In that he did not insure that the patient was appropriately cared for, I would say that is a possibility. And again the reason I'm hedging on that is that it's still my belief that it was Dr. Lee and Dr. Smith's responsibility. If Dr. Miller was Dr. Smith's representative, then capable or not, he should have insured that the patient was optimally treated even if Dr. Lee was theoretically in charge of that treatment. He should have been able to recognize that the patient was not getting better and made a decision to transfer the patient to a more appropriate facility. But again, that's not usually a resident's responsibility to do that.

Q. Whose responsibility usually is it to do that?

A. Dr. Smith and Dr. Lee.

Q. Did Dr. Gill's act or failures to act following the second operation fall below the standard of care?

A. Again, since Dr. Smith is ultimately responsible medically, that's a difficult question for me to answer. There is no question in my mind that Dr. Gill was negligent in his lack of

observation of the patient and in leaving the patient in the recovery room in a severely compromised state without insuring further appropriate action. But if it is the policy of the hospital that residents are not responsible for that activity, then it would he difficult for me to say that he was negligent.

Q. In terms of responsibility for the patient in the recovery room, what is your understanding of who is primarily responsible?

A. Dr. Lee was primarily responsible for the care of the patient in the recovery room.

Q. Who would have been secondarily responsible?

A. Well, let me go on and say that in addition, Dr. Smith is responsible for the overall medical management of his patient and he can delegate, you know, parts of that. And he does delegate by hospital policy, apparently, the recovery rooin care of the patient with respect to cardiopulmonary function, If the attending orthopedic surgeon, Dr. Smith, delegates to his resident care of the patient, then the resident becomes responsible as well. That would be Dr.

Gill, Dr. Miller.

Q. I'm not sure whether you ever answered my question as to whether or not it is your opinion as to whether Dr. Gill's acts or failures to act after the second operation fell below the standard of care?

A. Well, I think I answered it yes, I do feel they fell below a standard of care for a physician who has responsibility for the patient. The question then becomes whetner or not he was in fact responsible for the patient's care, and that's the thing I cannot answer. I don't knou if in fact the residents have no responsibility for medical care of the patient in this hospital and it's all the attanding physicians or not. If he hid that responsibility, clearly he fell below the standard of care in my opinion.

Q. As you sit here and judge the residents in this case, are you judging them as you would an attending physician or as you would a resident?

A. It depends upon what particular point we are discussing. In my opinion, many of their actions or lack thereof clearly should not have occurred regardless of their level of training,

assuming they are graduate physicians.

Regardless of Gill's status, he clearly should have recognized that the patient was not in good condition and he clearly should have recognized that there were intraoperative complications and he should have recognized *that* the patient didn't tolerate the procedure well and was not doing well in the recovery rocm.

Q. Isn't he dependent to some extent on input from the anesthesiologist in the case as to how the patient is doing?

A. Yes.

Q. 30 we know hero what input he was getting from Dr. Lee during the case?

4. We do not know that. However, we do know that the patient was cold, clammy, diaphoretic, dusky with unstable vital signs having multiple arrhythmias, and he would not have to depend on the anesthesioloyist to give him that information.

Q. **Assuming** Dr. Gill or Dr. Miller **were** in the recovery room following the second operation, what should **they** have done?

A. They should have insured that the patient **was receiving** appropriate medical management to

reverse the pathophysiologic processes, if you will, that were occurring following transfer to the recovery room. And in my opinion, they should have transferred him to the intensive care unit.

Q. As residents, did they have a right to rely on Dr. Lee carrying out those functions as the anesthesiologist in the recovery rooin?

A. They had a right to depend upon him carrying out some appropriate activity initially, but they ha3 a responsibility in my opinion to again follow up on the patient's care and insure that the patient was receiving appropriate care and was responding to the appropriate care in an appropriate fashion, and that they did not do.

Q. Is there one particular point in time when it became unreasonable for the residents to be relying on what Dr. Lee was doing in the recovery room?

A. Well, clearly within the first, hour that should have been apparent, It was apparent to the nurse that the patient was not responding appropriately, and even more clearly by 9:00 it would have been apparent. But it became progressively apparent as the evening progressed.

Q. You have made the comment that in reviewing the residents' depositions they demonstrated a lack of medical knowledge or understanding. Are there any specific references in their depositions that apply to the issues in this case?

A. Yes.

Q. Can you give me those, please?

A. At approximately pages 27 through 29, Randell Peters was questioned about evidence of myocardial damage occurring in Mr. Smith, and basically seemed to disregard the evidence that was there that would indicate that there was myocardial damage.

In general terms, Dr. Peters was very unknowledgeable regarding anesthesia evaluation5 for patients undergoing surgery.

Michael Gill on --

Q. Dr. Downs, before we move off of Dr. Peters, it's my recollection that he made a statement in his deposition that on occasion of at times he would review the preop anasthesia workup prepared by the anesthesiologist. Is that required by the standard of care €or a surgical resident or

an orthopedic resident to review the anesthesiologist's preoperative workup before the procedure?

A.

second operative procedure. That's clearly false. It's a strong relative contraindication.

Q. And your statement holds true looking at Dr. Gill as an orthopedic resident as opposed to a medical resident or some other specialist?

A. Absolutely.

a. Go ahead.

A. Page 16, line 17, he said the patient was transferred to the recovery room in good condition, and even at the time of his deposition he was unaware of the nursing assessment that disagreed with that condition.

He said thit on page 19, line 24, a fall in blood pressure to 50 percent of the preoperative value is not a complication, He's clearly

erroneous.

Page 30, line 9, he said the anesthesiologist is responsible for patient care in the recovery room and implied that the surgeon is not responsible for the patient once he enters the recovery room. I think that's inaccurate.

Page 46, line 5, he appears to be totally unaware of the effect of methyl methacrylate on cardiovascular function which clearly should be common knowledge for an orthopedic resident in my opinion.

Page 49, line 18, he said he was unaware of the significance of a two percent MB fraction.

Page 69, line 6, he says that one unit of blood has 250 milliliters in it. That's inaccurate.

Page 69, line 17, he said if you transfuse a patient with one unit of blood, the hemoglobin will go up two or three points. That's incorrect.

Page 98 and 99, as I read his deposition, I wasn't convinced that the attending surgeon was actually present for that second operation, and clearly the attending surgeon should have been present.

Page 115, line 16, even in retrospect he would not admit there were any intraoperative complications.

Page 121, line 24, he claimed he had no responsibility for the patient ifter the patient left the operating rooin.

On 123, he then said the patient was the responsibility of the anesthesiologist and the attending surgeon. Those are the only comments I have on Dr. Gill.

Q. Did eitner Dr. Gill or Dr. Miller have any independent responsibility to the patient following the second operation as opposed to the responsibility that they have through the attending surgeon?

A. 1 don't believe so.

Q. Were there any other depositions of residanta that you reviewed that you have not told me about and you have not gone through for me?

A. Yes. Dr. Miller.

Q. Are there things in Dr. Miller's deposition that you have picked up that impact on the issues in this case?

A. Yes.

Q. Can you tell me what those are?

A. On page 20, line 18, Dr. Miller states in my opinion incorrectly that he was responsible only for the orthopedic-related problems of the patient, referring to the recovery room.

On page 23, line 17, when asked what the significance of a return of gastric contents from the endotracheal tube were or how could they have come back, he said he had no idea.

Page 29, line 9, when asked is pentothal a barbiturate, he said he had no idea. Any medical student would know the answer to that.

For some reason on page 46, line 20, he says the patient was put to sleep, indicating that he wasn't even aware that the patient had received a spinal anesthetic. If that's the case, he clearly when he came up to see the patient, from the emergency room did not avail himself to all the information about the patient that he could. So he clearly couldn't have been treating him appropriately if he had no idea what the patient had received if the way of anesthesia.

On page 91, lines 21 and 24, when asked does a blood pressure of 180 over 120 indicate the

need for a neosynephrine infusion, hi5 answer was I wouldn't know. Again, that's something any medical student would know.

He was unaware, on page 95, that anemia causes an increase in left ventricular work.

Page 130 he stated that an operative note would inention only complications relating to the orthopedic operation and would not necessarily mention complications secondary to anesthesia.

So his deposition reveals to me, if in fact he was being truthful about this, very inadequate medical knowledge, certainly for an individual caring for critical ill patients.

'That completes my criticisms cf the residents.

Q. After going through the comments that you have made on each of the residents after reviewing their depositions, that doesn't bring any additional criticisms of the residents and their actions in this case to mind, doe5 It?

A. NO,

Q. We have covered them all in terms of my questioning you, asking you questions about the preoperative period, the second operation an3 the

postoperative period?

A. Yes. Any that I can recall at this time we have covered.

Q. And you have stated that at ail times the residents had no independent duty outside of the duty of the attending physicians involved in this case?

A. Because of my opinion that the attending physician is ultimately responsible for all activities of the residents or lack thereof, that's correct,

Q. In Mr. Smith's case, is it ultimately up to the attendings to make the medical decisions?

A. I believe so.

Q. Are you aware -- strike that.

You indicated that you have testified three weeks ago in a case similar to this; is that right?

4. I indicated I testified in a case of elective orthopedic operation involving recovery room care.

Q. And St. Anthony's Hospital was involved in that case?

A. Yes.

Q. Who was the attorney that retained you in that case?

A. The firm ot Bricker and Eckler.

Q. Do you recall the name of the attorney that you --

A. Michael Renner was the primary attorney I dealt with.

Q. Are there any other criticisms you have of the hospital or its residents that you have not told me about here this afternoon?

A. I don't believe so,

Q. Is there anything that the hospital residents or nurses did in this case which would have prevented Dr. Lee from carrying out his duties and responsibilities as the attending anesthesiologist?

A. Anything they did or did *not* do?

Q. Yes.

A. The only possibility would be -- and I'm not aware that this was the case, that they did not inform him preoperatively of the patient's medical status.

Q. That information was available by reviewing the chart; correct?

A. In my opinion it likely was.
Q. And was it the attending anesthesiologist's responsibility to review the chart before proceeding with anesthesia in the second case?
A. Rbsolutely.
Q. If Dr. Lee felt in this case he did not have sufficient time to do his preoperative workup, could he have taken additional time to do that?
A. He could have, and he made the statement that he felt it was an emergency and he didn't have that time. And I think that was inaccurate.
Q. Should he have taken the time?
A. In my opinion, yes.
Q. Based upon the records that you have reviewed and your background, training and experience, if tne attending physicians involved in this case had acted within the applicable standard of care, is it probable that Mr. Smith would have survived?
A. I believe so.
MR. ZELLERS: I have got nothing further. Thank you.
MR. ALBERT: No questions.

MR. CHARMS: Just a couple of questions, sir.

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RECROSS-EXAMINATION

BY MR. CHARMS:

Q. You made reference earlier I think in response to one of Mr. Groedel's questions to an article in your file. So you have any other literature that you have looked at or that you are relying on in rendering some of the opinions that you have today?

A. Well, there were some follow-ups. There was an editorial that accompanied this article and also a letter to the editor which I keep in my file together. And I glanced at these. So I did not read all of these specifically for this case.

MR. ZELLERS: Steve, could you just identify what's in there?

MR. CHARMS: The first one is the article by Rao, Reinfarction Following Anesthesia in Patients with MI.

Q. And maybe you can help me out with this, This is a letter to the editor in Anesthesia or Anesthesiology, Volume 61, page 213 and 214 in 1984.

That's just some physician's response to the Rao article; is that what that is?

A. That's correct,

Q. Okay. And then an editorial in Anesthesia -- the the Journal of Anesthesiology, Volume 59, page 493, 1983.

And that's all the literature you have in your file; right?

A. Correct.

Q. Okay. And you hive got all of the depositions that we have been discussing. Is there any other material in your files relating to this case other than the depositions and our amended answer?

A. Tne amended answer and then one letter from Mr. Kampinski.

Q. May I see the letter froin Mr. Kampinski?

MR. KAMPINSKI: No, you can't.

MR. CHARMS: Is there some reason I can't look at it?

MR. KAMPINSKI: Yeah, because it's a letter from me, that's why. If you want to exchange correspondence files, we csn discuss that, but it's my understanding that you are not entitled

to that.

MR. CHARMS: Well, we will take that up at a mors appropriate time,

That's it.

MR. GROEDEL: I just have a few more questions, Doctor.

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RECROSS-EXAMINATION

BY MR. GROEDEL:

Q. I note in the recovery room chart that there was an infiltration in the IV. Did you not? that in your review?

A. Yes.

Q. In your opinion, did that infiltration have any adverse impact upon Mr. Smith?

A. It quietly could have because I think for a period of approximately thirty minutes he had no IV and therefore didn't have the infusion of antiarrhythmic drug Lidocaine, and he was having severe dysrhythmias at that time. So it may have had some impact on his ultimate outcome.

Q. Okay. Also in the recovery room record there is the notation where Mr. Smith received the pentothal. Can you tell me immediately prior to

receiving that sodium pentothal, what was his chances of recovering or living through this episode?

A. By that time I think they were probably small.

Q. Approximately in percentage terms?

A. Maybe 10 percent, 5 percent.

Q. Okay.

A. After the pentothal, it was zero, though.

Q. Do you hold any opinions in this case regarding the appropriateness of the care and treatment rendered by Dr, Jackson?

A. I'm not sure what Dr. Jackson's role was. Dr. Jackson is I believe the patient's internist. He was managing his blood pressure.

I don't think he acted below a standard of care at any point. I don't think his care was very good. He didn't do anything for the patient's blood pressure after he was discharged the first time except for perhaps emphasising to the patient that he should take his medications. He did come in and visit the patient in the hospital, but he didn't really impact his care.

As an internist, I think he probably

should have noted that he had the myocardial damage during the first procedure and didn't seem to note that or comment on it. But again I'm not sure what his role really was except he was the doctor and he was there to see the patient and I don't think he really had any primary responsibility. In fact, I don't recall seeing an official consultation on the chart to Dr. Jackson.

Q. I think there was one, as a matter of fact.

A. Was there?

Q. The fzct that Dr. Jackson in his note of November 17 in the morning didn't make sny mention of myocardial injury, you don't consider thst to be substandard on his part?

A. Well --

MR. KAMPINSKI: Do you want to see the note before you respond to it?

A. No, that's okay, because the question is does he have to note everything in writing or be guilty of substandard care, and I don't think so. So the fact that his note doesn't inention it, the patient had already been transferred to the ward by that time, the patient was doing well, in my

opinion that does not represent substandard care.

Q. Do you believe he should have been aware of myocardial injury in this patient it that time?

A. Absolutely.

Q. And the fact that he wasn't, was that substandard?

A. I don't know chat he wasn't. He just didn't mention it.

MR. KAMPINSKI: Well, why don't you give the Doctor a chance to road the note.

A. Wait a minute. Were you talking about the 17th or the 18th?

Q. Correct, the 17th.

A. This is the 13th. This is after he was dead,

MR. KAMPINSKI: I'm sorry. There was a note from Jackson.

MR. GROEDEL: Progress note, morning of the 17th.

A. 1'11 look at it.

And your question?

Q. If Dr. Jackson was unaware of the fact that the patient had a myocardial injury when he saw the patient on the 17th, was that substandard

on his part?

A. Well, again, since he wasn't actively taking care of the patient, I don't believe he had that responsibility. He should have been aware of it, but I can't say that it was negligent for him not to be aware of it.

My guess is that he probably was aware of it. I can't imagine an internist not reviewing the patient's laboratory data. I mean, that's what they do. He may have just felt it wasn't significant since it was only two percent of basically a normal CPK value and not associated with the fact that it occurred within a few hours of the operation and probably represented the very earliest rise in CPK, MB/CPK.

Q. Is that a minimal finding! that two percent finding in the MB fraction?

A. No. I think it's a minimal value. Let me retract that, It's not a minimal value. It's a very small value because the CPK wasn't totally elevated that much if two percent is a small fraction of a level.

However, since it was recorded very early on, it probably represents the extreme very early

rise of MB/CPK which probably went on tremendously higher than that value ultimately.

And if he was in a hurry and he just glanced over it. and didn't realize when tho value was drawn, which he probably didn't, then he might have passed over it and felt in his mind that it wasn't a significant finding.

Q. And you wouidn't have faulted him for thinking that that lab data was from another day?

A. Well, or from a different hour. I think that hs should have seen it, should have recognized its significance, but I would not say it was substandard care for him *to* not recognize its significance.

MR. GROEDEL: Thank you, Doctor.

MR. ZELLERS: Doctor, one quick line.

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RECROSS-EXAMINATION

BY MR. ZELLERS:

Q. Do the criticisms you have of the residents in this case between the first operation and the second operation hold true for Dr. Jackson as well?

A. Let me look at the -- no. The reason

being is that Dr. Jackson was consulted on the 13th and the reason for his consult was please or something operative clearance for left total hip arthroplasty, and Dr. Jackson was just continuing to follow the patient in my opinion through the operative period because it was his patient before and he felt some responsibility. But I don't think that he had attending responsibility for that patient.

Q. So you don't believe he had responsibility for investigating the fall in Mr. Smith's hematocrit?

A. Not primary responsibility.

Q. Did he have responsibility for investigating Mr. Smith's gastrointestinal problems?

A. Not primary responsibility.

Q. What about for investigating Mr. Smith's apparent myocardial infarction?

A. Again, I think that was his attending physician's responsibility, and I am unaware that he passed that responsibility on to Dr. Jackson.

Q. Insofar as an orthopedic resident and Dr. Jackson as a practicing intern, who would be in a better position to investigate thosa conditions?

A. I assume you mean practicing internist?

Q. Yes, I'm sorry. Internist,

A. I don't know what Dr. Jackson's physical relationship to the hospital is. If he's an independent practitioner outside the hospital, then he probably rounds each day in the hospital for an hour or whatever and the orthopedic residents are full-time geographically-based physicians, so they would be in a better position to on a continuing and efficient basis investigate these problems.

Q. In terms of medical knowledge, who would have more?

A. Dr. Jackson.

MR. ZELLERS: I have got nothing further. Thank you.

MR. CHARMS: Just one quick question.

THE WITNESS: It just keeps going on.

MR. KAMPINSKI: Lawyers always say just one more question,

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FURTHEli RECROSS-EXAMINATIOn

BY MR. CHARMS:

Q. it sounds to me like you are saying that the critical -- let me preface it, as Mr. Kampinski

said earlier, we lawyers deal with 50 percent and those kinds of figures that I appreciate are difficult for you as a pnysician, but having sat here €or about four hours, it seems to me what you are saying is that the critical time for Mr. Smith was around 9:00. Is that --

MR. ALBERT: I object to that.

4. I don't believe I said that at all. That was in that area plus or minus an hour was one of many critical times for him.

Q. That's fair. There was a point in time when you felt it vas more probable than not that Mr. Smith was -- could, given standard recovery room care, was more probable than not that he would have survived; okay? Then you said there was a period of tine later in the evening where no matter what, he probably was not going to survive and it Just sounded to me like the watershed was at 9:00?

A. Well, certainly it was in that time range when things became very gloomy for him.

Q. Okay.

A. They were pretty bad around 5:00.

MR. CHARMS: Okay. Thank you.

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Thereupon, the deposition was concluded at 2:45 o'clock p.m.

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John B. Downs, M.D.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at _____ Ohio, on this _____ day of _____, 1987.

_____
Notary Public

My Commission expires: _____

CERTIFICATE

STATE OF OHIO

COUNTY OF FRANKLIN SS:

in and for the State of Ohio duly commissioned and qualified, do hereby certify that John B. Downs,

truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony than given was by ma reduced to stenotypy in the presence of said witness, afterwards transcribed by means of computer; that the foregoing is a true and correct transcript of the testimony so given as aforesaid; and that this deposition was taken at tne time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party herein, 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 Columbus, Ohio, on this 9th day of March, 1987.

Nicholas A. Marrone

NICHOLAS A. MARRONE, RPR, Notary Public
My Commission expires November 1, 1987.

John B. Downs, M.D., Ltd.
8530 Preston Mill Court
Dublin, Ohio 43017

October 15, 1986

Charles I. Kampinski
Attorney at Law
1530 Standard Bldg.
1370 Ontario Street
Cleveland, OK 44113

Dear Mr. Kampinski:

I have reviewed the medical records of Mr. Alvester Smith (#0707704-3-4296-4311) for St. Lukes Hospital in Cleveland, Ohio, and depositions of Drs. Lee, Stephens, and Smith, and Ms. Sims.

Mr. Smith was a 54 year old black male admitted to St. Lukes Hospital complaining of a painful left hip, Following examination and routine laboratory analysis, he had a total left hip arthroplasty perfomed on 11-14-84. His operative course was complicated by marked fluctuations in blood pressure with systolic pressures recorded as low as 70mmHg on three occasions, lasting for 10-15 minutes and necessitating several injections of ephedrine. He also had marked arterial hypoxemia in spite of increased inspired oxygen concentration. He was recovering in the Surgical Intensive Care Unit where atrial bigeminy was noted (as it was in the operating room) and he had an ECG interpreted as consistent with left ventricular strain or ischemia. He received mechanical ventilation and was extubated the next day, The orthopedic resident ordered "cardiac enzymes", which revealed elevations of the MB fraction of the CPK enzymes, indicating myocardial damage. On the second postoperative day, the patient was noted to complain of "stomach gas" and the postanesthesia note recorded "no" anesthesia complications. No was underlined multiple times, apparently for emphasis, However, there was no elaboration of this point. That evening Mr. Smith had emesis of coffee ground material, The next day, the patient was transferred from the SICU and was still noted to be distended with little flatus. The internal medicine consultant recommended that the hematocrit be measured twice a day. His hip was noted to be dislocated and he was scheduled for a closed reduction in the operating room, Dr. Lee, an anesthesiologist, saw the patient preoperatively and

described his American Society of Anesthesiologists' Physical Status as "3", and therefore, non-emergent. Laboratory analysis was recorded by Dr, Lee, but he did not include current values. There is no indication that Dr. Lee was aware of the patient's precarious cardiopulmonary status. According to the anesthesia record, the patient had a fair general condition and an ASA physical status of 3. Again, emergent status was not noted. The patient was given a spinal anesthetic with tetracaine and oxygen by nasal cannulae at 3 1/min. Apparently, the patient had a bout of hypotension immediately following induction of anestheia, as ephederine and epinepherine were administered, These drugs appear to have been given approximately 15 minutes prior to the most severe bout of hypotension recorded on the anesthesia record. A neosynephrine infusion was in place when the patient was admitted to the postanestheisa recovery area, but its use is not indicated on the anesthesia record. The record does not indicate how the spinal anesthetic was administered, the patient's position during administration of the anesthetic, nor monitors other than the electrocardiogram and blood pressure. The patient had severe problems in postanesthesia recovery necessitating constant nursing care, antiarrythmic medications, and vasoactive drug infusions, He developed severe respiratory distress with profound arterial hypoxemia several hours following admission and shortly after tracheal intubation the patient developed refractory cardiac arrest and died, Tracheal intubation followed the injection of 200 mg. of intravenous sodium pentothal,

In summary, Mr. Smith likely suffered a significant degree of myocardial injury during a total hip arthroplasty on 11-14-84. Three days later, it is likely that he suffered further and fatal myocardial damage during and following spinal anesthesia for reduction of a dislocated hip,

It is my opinion that Dr. Lee failed to meet acceptable standards of care in treatment of Mr. Smith, Having failed to adequately review records of Mr. Smith, he did not realize his precarious cardiopulmonary status and the grave risk that even spinal anesthesia posed. Furthermore, he failed to appreciate the possibility of a serious gastrointestinal bleeding problem and the possibility of gastric distention with its attendant risk of regurgitation and aspiration of gastric contents, In spite of his recognition that this was not an emergency procedure (as indicated by his failure to classify the patient as 3E), he

did not inform the operating surgeon of the grave risks attending any anesthetic and operative procedure for this patient. Having decided to proceed with spinal anesthesia, he failed to insure that the level of the spinal anesthetic was sufficiently limited to preclude severe hypotension and noted no attempts to do so on the anesthesia record, He failed to monitor the patient's cardiopuimonary status in an appropriate fashion, before, during, and after the operative procedure. Such monitoring should have included minimally an arterial catheter for continuous measurement of systemic blood pressure and a pulmonary artery catheter to monitor intravascular filling pressures and cardiac output. Following the operative procedure, Dr. Lee failed to recognize the severely compromised cardiopulmonary status of the patient, continued to inadequately monitor his status, and failed to initiate appropriate ventilatory therapy. When he finally decided to do so, he administered 200 mg. of sodium pentothal, which likely acted as the final insult to Mr. Smith's severely comprised and ischemic myocardium, causing his cardiac arrest and preventing successful resuscitation.

The standards of acceptable practice of anesthesiology require that an anesthesiologist of ordinary skill and diligence under these circumstances should have:

(1) performed a careful preoperative assessment and informed the surgeon that the patient was not in satisfactory medical condition to tolerate the proposed surgical procedure without further medical assessment and treatment.

(2) administered spinal anesthesia in such a manner as to limit its effect, so as not to severely compromise the patient's cardiovascular status and only following placement of appropriate monitoring devices, including an arterial catheter and pulmonary artery catheter.

(3) carefully monitored the patient's postanesthetic course, solicited appropriate consultation, and transported the patient directly from the operating room to the Surgical Intensive Care Unit where appropriate monitoring and treatment could have occured,

(4) Instituted appropriate ventilatory support as soon as pulmonary dysfunction was apparent,

TO THE REPORTER:

I have read the entire transcript of my deposition taken on the 23rd day of Feb, 1987, or the same has been rea to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the signature page and authorize you to attach the same to the origin transcript.

~~Page~~	Line	~~Correction or change and reason therefor~~
64	14	"..." not "."
86	3	"It looks like nine milligrams"
94	8	"Underwent" not inurent
143	2	I believe this sentence is inaccurately transcribed so as to alter my intent, which was "I am critical of the hospital's failure to insure competent medical Direction of the recover room."
179	16	"It quite likely could..." rather than "It quietly