Doc. 141

IN THE CIRC'JIT COURT OF THE
11th JUDICIAL CIRCUIT IN
AND FOR DADE COUNTY FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO. 89-14928 CA 15

ROBERTO PINO, as survivor and personal representative of the Estate of Albertina Berta Pino,

Plaintiff,

vs.

AMI/KENDALL REGIONAL MEDICAL CENTER, et al.,

Defendants.

9100 South Dadeland Blvd.
Miami, Florida
Tuesday, March 12, 1991
6:20 p.m.

TELEPHONE DEPOSITION OF JOHN DOWNS, M.D.

Taken before TERI NAAR, Registered Professional Reporter and Notary Public for the State of Florida at Large, pursuant to Notice of Taking Deposition filed in the above cause.

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APPEARANCES:

KEITH CHASIN, ESQUIRE
on behalf of the Plaintiff.

STEPHENS, LYNN, KLEIN & McNICHOLAS
By: SONDRA L. FARBER, ESQUIRE
on behalf of Defendant Rodriguez.

PARENT1 & FALK
By: MICHAEL J. PARENTI, ESQUIRE
on behalf of Defendant AMI.

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Thereupon:

JOHN DOWNS, M.D.

was called as a witness on behalf of the Plaintiff and, after having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. CHASIN:

Q. State your name, please.

A. John Downs.

Q. Dr. Downs, since your last deposition do you know what other materials you have reviewed to date?

A. Since my last deposition the only thing I reviewed that I can recall is the deposition transcript of my deposition which I reviewed for correction.

MR. PARENTI: I don't think I sent him anything.

BY MR. CHASIN:

Q. The morning of July 24th, 1987, it's your understanding that Nurse McKay contacted Dr. Rodriguez and informed him of the extubation with Berta Pino.

Is tha't correct?

A. Let me state, because I wasn't sure what material we'd cover and I assumed it wouldn't be the entire thing, that I really didn't review for this

deposition any of the material in any significance, so I don't remember the nurse's name, but I agree that a nurse did contact Rodriguez to inform him of the extubation.

Q. Okay. .Well, we know the case pretty intimately so that nurse has been identified as Nurse McKay for the purpose of this deposition. Okay?

A. All right.

Q. And-she said that she contacted Dr. Rodriguez about 1:10 in the morning of July 24th, '87 and informed him that the tube extubated.

MR. PARENTI: She called him and then he called back. The call to him was about, I think, quarter to one and he called back around 1:10, or 1:15.

BY MR. CHASIN:

Q. Whatever. At 1:15 Dr. Rodriguez is informed of the extubation event.

Can you assume that as true, Dr. Downs?

A. Yes. That's what the nurses' notes stated.

Q. Okay. Was it appropriate at that time for Dr. Rodriguez to order that this patient be reintubated?

A. By appropriate do you mean is that what he

should have done?

Q. Yes.

A. I believe so.

Q. Why do you believe that it was appropriate for Dr. Rodriguez to order that the patient be reintubated at about 1:15 a.m.?

A. Because at that time I believe that it was Dr. Rodriguez's impression that the patient still required mechanical ventilation and/or a PEEP and an inspired oxygen concentration to maintain optimum pulmonary status.

Q. Before Dr. Rodriguez is informed of the extubation the nurse put Mrs. Pino on a non-rebreather mask with 100 percent oxygen after the extubation event occurred at approximately 12:40.

Can you assume that as true, Dr. Downs?

A. Again, I believe that's what was stated.

I do not assume that the patient was really getting 100 percent oxygen, but that was the attempt, yes.

Q. Okay. Would it have been appropriate at 1:10 or 1:15 that morning when Dr. Rodriguez communicates with the nurse and is informed of the extubation and that the patient is on a non-rebreather mask to allow the patient to remain on a non-rebreather

mask?

A. You mean rather than to remove the mask?

Q. Rather than to order reintubation.

A. With the knowledge that he had at the time I don't believe that would have been appropriate.

Q. Would that be below the prevailing standard of care for a pulmonary physician in Dr. Rodriguez's position at that time?

MS. FARBER: Object to the form.

THE WITNESS: Not necessarily. He could have asked for further information regarding the patient's status which might have led him to the conclusion that she did not require immediate reintubation.

BY MR. CHASIN:

Q. What other information would be important for Dr. Rodriguez to know at that time if I asked you to assume that he did not order immediate reintubation?

A. If following the extubation the patient was noted to be breathing comfortably and regularly and if arterial blood analysis revealed adequate oxygenation and adequate carbon dioxide elimination, then it might be appropriate to continue with mask oxygen therapy at least for a period of time.

Q. Doctor, can you give me a range or

parameters of ABG's which would be acceptable at that time to enable the patient to remain on a non-rebreathing mask?

A. Well, it's very difficult to give you the absolute parameters.

It would be a lot easier to give examples when it would not be acceptable for the patient to remain on a non-rebreathing mask.

Q. Let me ask it this way. That's fair.

What if on the non-rebreathing mask her PO2 was less than 60?

Would that alone mandate that the patient be reintubated?

A. If the patient what, I'm sorry?

Q. Would that alone mandate that the patient be reintubated?

A. Most likely, but not necessarily. I would prefer to pick something in the range of 50 if we're splitting hairs.

Q. What about a PC02 greater than 45? Would that finding alone mandate that the patient be reintubated?

A. No, definitely not.

I think that more important than the PCO2 would be the combination of the PC02 and the pH.

In other words, if the patient were to demonstrate a significant respiratory acidosis along with a physical examination that dictated that the patient was probably not going to be able to continue breathing adequately much longer, I'd have to have that information together.

So PC02 alone wouldn't be adequate. If her pH was 7.40 with a PC02 of 45, I would say that's perfectly acceptable.

Q. What about about a PC02 of 77, doctor, and a pH level of 7.3?

A. A PC02 of 77?

Q. Yes, and a pH level of 7.3.

A. That would be-- again, we're not discussing this patient in particular now obviously, but generally speaking a pH of that level with a PC02 in that level would indicate to me that the patient was probably going to be in serious respiratory distress within the next-- well, at least in the immediate time frame, and intubation should proceed along with mechanical ventilation probably in the very near future.

Q. Why do you say that it would indicate to you that the patient would be in serious respiratory distress based on the two parameters I've given you, a

PC02 of 77 and a pH of 7.3?

A. Well, normally the patient would try and maintain a pH around 7.40, and obviously with those two numbers that you've given me the patient is not maintaining an adequate pH, and the PC02 is sufficiently high that I would be worried about C02 narcosis occurring should it climb much higher.

Q. Can you give me--

A. Very rapidly the patient would begin to hypoventilate even more seriously and probably go into respiratory arrest.

Q. You used the phrase C02 narcosis.

Can you give me a brief description of what that is in this scenario, Dr. Downs?

MR. PARENTI: In what scenario?

THE WITNESS: Well, I don't know about in this scenario.

C02 narcosis, generally speaking, would be-- don't hold me to the definition, but would be a physiologic state where the carbon dioxi.de tension is so high that it's actually taking on a sedative-like effect rather than a respiratory stimulant effect that it normally would have.

BY MR. CHASIN:

Q. Can a patient who is undergoing C02

narcosis have a clouded mental process?

MR. PARENTI: Let me--

THE WITNESS: Yes.

MR. PARENTI: --just note an objection.

THE WITNESS: They do have a clouded mental process. Almost always.

MR. PARENTI: Okay.

Dr. Downs, let me just note an objection. This deposition was to ask you about Dr. Rodriguez, not to give Mr. Chasin another opportunity to redepose you.

So unless we get back on track with Dr. Rodriguez, I may have to instruct you again not to answer any more questions.

THE WITNESS: All right.

MR. PARENTI: Mr. Chasin is on the other phone now so we're sort of taking a break.

Keith, I don't know where you're going, but the Court gave you the right to resume the deposition to continue your line of questioning about Dr. Rodriguez.

I have not talked to this doctor about carbon dioxide narcosis.

This has nothing to do with what the Court has permitted you to question him about and I

wish we'd get back on track'or I'm going to be forced to instruct him again now not to answer the questions.

BY MR. CHASIN:

Q. Would the patient's pH levels be important for Dr. Rodriguez to know when he is informed of the extubation event?

A. Well, ordinarily it would be probably less so in this patient.

Our previous discussion on C02 narcosis and so on is essentially irrelevant to this case as far as I'm concerned.

Q. My question is would the pH level be important for Dr. Rodriguez to know when deciding whether she may be able to remain on the non-rebreather mask?

A. The pH and PC02 together would be important.

Q. And that's to determine whether she's reaching a stage where she can enter C02 narcosis?

A. No. I don't think that was ever consideration in this patient.

Unless my memory is totally deficient, I don't recall that this patient was ever in a range of hypoventilation that they'd worry about C02 narcosis.

That's generally only considered in patients with severe chronic obstructive pulmonary disease.

This patient didn't have that problem, to my knowledge.

Q. So it seems to me, doctor, that when the extubation event was told to Dr. Rodriguez, that most likely you feel that he should have ordered reintubation at that point knowing this patient's history and status as he did?

A. Yeah. I think you asked me that before and that's what I said.

Q. Okay.

A. If I understood your question correctly.

If it's a different question, perhaps you should restate it. I didn't understand, perhaps.

MR. PARENTI: It was the same question. You gave the same answer.

THE WITNESS: Pardon?

MR. PARENTI: I said that was the same question and you did give the same answer.

BY MR. CHASIN:

Q. The reintubation when Dr. Rodriguez was informed of the extubation event, should it have taken place within a reasonable amount of time after he gives

the order?

MS. FARBER: Object to the form. Are all of your questions regarding reintubation assuming that Mrs.--

THE WITNESS: Reasonable period of time.

MS. FARBER: Dr. Downs. You can tell him I'm talking because he can probably hear you better.

MR. CHASIN: Can you Sondra, doctor?

THE WITNESS: No.

MR. CHASIN: Speak up, Sondra.

MR. PARENTI: If he's talking, that won't come through. It's like a walkie-talkie. You say 10-4 at the end.

If he's talking, he can't hear an objection.

THE WITNESS: I can't hear much of anybody.

MR. PARENTI: Okay.

MS. FARBER: My objection is all your questions about whether or not she should have been reintubated or when and how fast and so forth, is that all assuming that Mrs. Pino refused or didn't refuse?

You're not laying a proper predicate.

BY MR. CHASIN:

Q. Assuming that Dr. Rodriguez ordered reintubation.

Should Dr. Rodriguez have ordered reintubation within a certain period of time, such as STAT or ASAP, Dr. Downs?

MS. FARBER: Same objection.

THE WITNESS: I believe that Dr. Rodriguez should have ordered the patient to be reintubated as soon as possible, you know, and that entails that reasonable care in reintubating her should take place.

In other words, I don't think STAT would be appropriate because they might kill her in trying to get a tube in and cramming it in too quickly, so I don't think that would be reasonable.

I think it should be done expeditiously.

BY MR. CHASIN:

Q. Okay. Can you give me the maximum length of time that you feel an expeditious reintubation should take place and to comport with the standard of care if you assume the order for reintubation is received at 1:10 a.m.?

MR. PARENTI: Are you assuming also the

consent of the patient?

MS. FARBER: Same objection.

MR. CHASIN: Obviously.

THE WITNESS: I didn't hear Mr. Parenti.

MR. PARENTI: My objection was whether in the hypothetical presented to you Mr. Chasin was also including that the patient consented to reintubation and he answered yes, that would be part of the hypothetical.

MS. FARBER: Join.

THE WITNESS: Could you repeat it for me because I couldn't hear Mr. Parenti again.

BY MR. CHASIN:

Q. Assuming that the patient consents to the reintubation at 1:10, Dr. Downs, what would be the maximum length of time that an intubation should take place?

A. That can't be answered because you have to take many other things into consideration.

Whoever is going to be there to intubate would have to evaluate the patient's physical status and then determine whether or not the patient would need to be sedated, paralyzed, whether it would be an oral tracheal intubation, a nasotracheal intubation and so on.

So the answer to your question is it could be as little as fifteen minutes perhaps or even ten or perhaps it could even be an hour, and then in that time in evaluating the patient if the patient seemed to be relatively stable, breathing comfortably with stable arterial blood gases, then the clinician who's there to intubate might call Rodriguez and say, "I don't think you ought to reintubate her right now. She seems to be doing all right. Maybe we ought to watch her a while."

Q. And monitor her ABG's?

A. And her physical status.

Q. Monitor her ABG's and her physical status?

A. Yes.

Q. And if the ABG's, particularly the arterial, PO2 gets too low, then perhaps reintubation may be necessary.

Is that correct?

A. That would be a possibility or, as I think I mentioned in my other deposition, I don't remember for sure, perhaps even CPAP by face mask.

Q. Once Dr. Rodriguez was informed that the patient refused reintubation, assuming by 2 a.m. he is told that this patient categorically is refusing reintubation, Dr. Downs, should Dr. Rodriguez have ordered anything else on this patient?

A. No.

I think he should have just told the nurses to keep trying to convince the patient that she should be reintubated.

Q. Should he have informed the nurses to communicate anything specific to Mrs. Pino?

A. To try to emphasize that it would be important that she receive appropriate respiratory care.

Q. Do you think Dr. Rodriguez should have had the nurse say to Mrs. Pino, "Besides that, it's important to have good respiratory care."

A. Well, I would assume that the nurses understood that her condition might be life-threatening and that they should communicate that to Mrs. Pino, but obviously Mrs. Pino was aware of that, and I might also suggest that her husband come in and see if he can be convinced to try and convince her of the need for reintubation.

Q. If you can assume this as being true, Dr. Downs, if Dr. Rodriguez is physically in the hospital when the extubation event occurs and he's aware that the patient is refusing reintubation, do you believe to comport with the standard of care that he should have gone to the patient's room and spoken to the patient

himself?

MS. FARBER: Object to the form.

THE WITNESS: Well, not necessarily. Let's assume that if he was there and he was tied up in a procedure with another patient, then I do not believe that standard of care would dictate that he leave that patient, for example, to go see this one.

Rather, that he could just ask that another physician take responsibility for getting her reintubated and put back on a ventilator.

BY MR. CHASIN:

Q. Well, that was a good point.

Let's assume he's doing rounds and he's not involved in an operation, but he's physically in the hospital at the time the extubation event occurs and he's informed that his patient is refusing reintubation.

Do you believe he should come to the patient's room and communicate directly with the patient?

MS. FARBER: Object to the form.

THE WITNESS: That certainly would be advisable. If he's been informed by the nurses

that she's refusing treatment, then he might talk with the patient and see if he in fact would have any effect on it.

Whether or not the standard of care would dictate that I actually haven't given consideration to.

I think the standard of care dictates that he be available to take care of her as soon as she's agreeable or have someone else do it, and clearly if he's able I would think it would be advisable for him to go there, but I can't honestly say that the standard of care would dictate that he do that because there wouldn't be anything he could do.

BY MR. CHASIN:

Q. Well, one thing he could do would be to communicate directly with the patient.

Is that correct?

A. Yes, he could.

Q. Another thing he could do would be to independently assess the patient.

Is that correct?

MS. FARBER: Object to the form.

THE WITNESS: That's correct.

MS. FARBER: Hold it.

MR. CHASIN: We're still on my hypothetical.

MS. FARBER: That he's in the hospital and not busy?

BY MR. CHASIN:

Q. That he's in the hospital and he's available to see the patient.

MR. PARENTI: Can I ask you is there any proof of this?

MS. FARBER: Object to the form.

MR. PARENTI: If there's some proof of it, then fine.

MS. FARBER: Assumes facts not in evidence.

THE WITNESS: Your hypothetical assumes he's in the hospital, which theh obviously makes it easier for him to get there than if he was in his car or in his house or in a different town, and I guess the problem I'm having is I don't know that the distance he is from her makes any difference.

If the patient has refused therapy, as I said, I think it would be advisable for him to do it, but I can't honestly say that the standard of care would dictate that he show up

in an attempt to change her mind when nobody else has been able to change her mind.

BY MR. **CHASIN:**

Q. You said that the distance that the doctor is from the patient really in your mind doesn't make any difference.

Is that correct?

A. Well, within reason. Obviously if he couldn't physically get there within a couple of hours, that would make a difference, but then he clearly would have to have transferred his responsibilities for patient care to someone else.

So assuming that he could get there in five minutes or twenty-five minutes, I don't think that makes a lot of difference.

Q. Now, Dr. Downs, if a patient such as Mrs. Pino is refusing reintubation and Dr. Rodriguez has been informed that the nurses are unable to convince her to allow for his ordered therapy, that is, reintubation, do you believe that he should have ordered that a doctor go to her bedside?

A. **No.**

Q. **Do** you believe that he should have made sure that someone get to her bedside besides the nurses who are unable to convince her for reintubation if he

was physically unable to do that?

A. I don't think the standard of care dictates that.

As I said, I think it would be advisable to have her husband come in and try and talk her into it.

You know, to get somebody there who might have some influence on her, and in my opinion the nurses who had been caring for her hour after hour would have a much greater likelihood of talking her into the form of therapy than some strange doctor she had never seen before.

Q. What about the attending physician who had cared for her for years?

Do you think it would'have been advisable for Dr. Rodriguez to contact him when he's aware of the fact that the patient is refusing reintubation?

MR. PARENTI: Let me just object.

THE WITNESS: Only if Dr. Rodriguez felt that the attending or the primary care physician would have a likelihood of being more convincing than the nurses, and again I don't think that's the standard of care.

That would just be common sense and advisable.

MS. FARBER: I just want to object to the form of that question.

THE WITNESS: Whoever might be able to talk her into it, to come in. In his opinion nobody could talk her into it.

I don't think the standard of care would dictate that he call anyone else.

MS. FARBER: I'm just going to object to the form of the last question.

I think again it's not a proper hypothetical given the past history of Mrs. Pino's extubation and the fact that her family doctor for years was called and wasn't able to convince her.

THE WITNESS: Are we still connected?

MR. CHASIN: Still connected. The attorneys are voicing an objection.

MS. FARBER: Doctor, were you able to hear me?

MR. PARENTI: No.

MR. CHASIN: Why don't you speak up.

MS. FARBER: Can you hear me?

THE WITNESS: Just barely.

MS. FARBER I objected to the question because I felt that it was not a proper

hypothetical because Mr. Chasin failed to include that the patient's family physician had been called on the prior extubation and he was not successful in convincing her at that time.

Can you hear me?

THE WITNESS: Yes, I heard you.

BY MR. CWASIN:

Q. Doctor, you understood that a code was called that morning.

Correct?

A. Yes, that's right.

Q. And the nurse says that she contacted Dr. Rodriguez for the code.

Do you know why a doctor such as Dr. Rodriguez would be contacted when a code is called on his patient?

A. I suspect that's standard hospital procedure to call a patient's physician when the patient arrests.

Q. And do you believe that Dr. Rodriguez should have responded to the code by coming into the hospital?

MS. FARBER: Object.

THE WITNESS: I'd say more often than not when a physician is called at home to be told

that their patient is coded'that more often than not at most community hospitals they don't come in.

MS. FARBER: I'm objecting to the form of the last question.

THE WITNESS: The emergency physician usually responds to the code in most community hospitals that I'm familiar with.

BY MR. CHASIN:

Q. Do you believe that Dr. Rodriguez should have responded at all to the code in any manner?

MS. FARBER: Object to the form.

BY MR. CHASIN:

Q. He answers the telephone and he's informed of a code.

Should he do anything more?

MS. FARBER: There's not been that testimony, so I'm objecting to the form.

THE WITNESS: I would think that he would ask that he be kept informed of the patient's status.

BY MR. CHASIN:

Q. Anything else?

MS. FARBER: Same objection.

THE WITNESS: Perhaps ask the nurses-- if

it appears that she might be successfully resuscitated, then he should come in and assume care of the patient.

MR. PARENTI: Why don't we just give you a standing objection to make it easier.

Is that okay, Keith?

MR. CHASIN: Sure.

THE WITNESS: Are you still on?

MR. CHASIN: Yes. It's not going to be that much longer.

BY MR. CHASIN:

Q. With regard to ordering reintubation or not on Mrs. Pino, Dr. Downs, does it matter how the extubation event occurred?

In other words, whether the patient herself extubated or whether the tube inadvertently came out of her trachea?

A. Well, are we talking hypothetically or in this case?

Q. In this case.

A. Well, I think the physiologic condition of the patient at the time the tube came out would be constant whether or not the tube came out or she pulled it out, so I don't think the mechanism by which the tube came out would have any effect on her physiologic

status and therefore would have no effect on the urgency or lack thereof of reinserting the tube.

In the hypothetical I think it might make a difference.

Just having it come out when having their bed sheets changed they might be in much more critical condition than if the patient doesn't want the tube in and reaches up and takes it out.

MR. PARENTI: Doctor, may I ask you not to offer hypotheticals?

He asked you about this case, and please don't go beyond the question asked of you because that's not required of you.

THE WITNESS: All right.

MR. PARENTI: Besides it may prolong the deposition and no one wants to do that.

MR. CHASIN: I'm enjoying it.

BY MR. CHASIN:

Q. The therapy of reintubation that Dr. Rodriguez I'm asking you to assume he ordered at 1:15 a.m., was that because Mrs. Pino had an accidental extubation in the preceding hour, Dr. Downs?

MR. PARENTI: Can I object, Keith?

Now we're going back to general questions about the case and what you asked the judge to

do was to resume the deposition for the purpose of asking about Dr. Rodriguez.

MR. CHASIN: I'm asking about the standard of care following an accidental extubation.

MR. PARENTI: What does that have to do with Dr. Rodriguez?

MR. CHASIN: It has everything to do with Dr. Rodriguez. It's his patient.

MR. PARENTI: It's five to 7. It's dark and we're--

BY MR. CHASIN:

Q. Would this be the standard of care for Dr. Rodriguez to follow after an accidental extubation, Dr. Downs?

MS. FARBER: Object to the form.

THE WITNESS: Now are we talking about a hypothetical or this case?

BY MR. CHASIN:

Q. We're talking about this case.

MS. FARBER: Object to the form.

THE WITNESS: In this patient when her tube comes out the question is would it be a standard of care to order reintubation?

BY MR. CHASIN:

Q. Yes.

A. In this particular case, I think so.

Q. Are are you familiar with the phrase accidental. extubation, Dr. Downs?

A. Sure.

Q. What does that mean, please?

A. Well, it's not a very specific term, but usually it means that the tube comes out of the trachea in an unintentional manner.

MR. CHASIN: That's 'a11 I have, Dr. Downs. The other attorneys may have questions for you, but I doubt it.

MR. PARENTI: Doctor, we have no questions.

We thank you for your time. Can you hear me, doctor?

THE WITNESS: Yeah, I heard that. Nothing else?

MR. PARENTI: Nothing else. We'll send you a copy of this transcript for your review as well.

Thank you again and good night.

THE WITNESS: Thank you very much.

Perhaps also you could send a copy of a deposition that I could keep.

MR. PARENTI: I will. I will send you the

old one too.

THE WITNESS: Okay.

MR. CHASIN: Good-bye, Dr. Downs.

(Thereupon, the deposition was concluded at 6:58 p.m.

Reading, signing and notice of filing were not waived.)

JOHN DOWNS, M.D.

Sworn and subscribed before me

this ___ day of ____ 1991.

CERTIFICATE PAGE

STATE OF FLORIDA)
) SS.
COUNTY OF DADE)

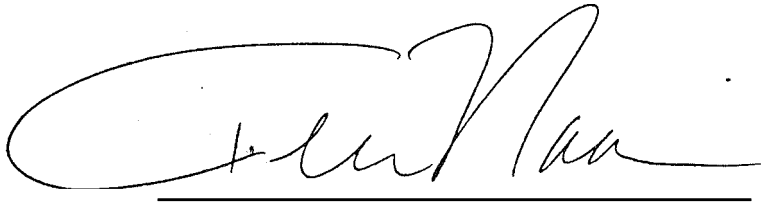
I, TERI NAAR, hereby certify that the foregoing transcript, pages 3 through 30, inclusive, is a true and correct transcript of the deposition of JOHN DOWNS, M.D. before me at the time and place stated in the caption thereof.

I further certify that said witness was duly sworn according to law.

I further certify that reading, signing and notice of filing were not waived.

I further certify that I am not of counsel to any of the parties to said cause or otherwise interested in the events thereof.

IN WITNESS WHEREOF, I hereunto set my hand and affix my official seal of office this 26th day of March 1991.



TERI NAAR

A