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

IN THE COURT OF COMMON PLEAS

ESTATE OF LAWRENCE BROWN, :
plaintiff, :
:
vs. : Case No. 346342

UNIVERSITY HOSPITALS OF CLEVELAND, et al.,
defendants.

Deposition of JOHN DOWNS, M.D., a witness herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken via videoteleconference before Constance Campbell, a Notary Public within and for the State of Ohio, at 1375 East Ninth street, Cleveland, Ohio, on THURSDAY, APRIL 1ST, 1998, commencing at 10:30 a.m. pursuant to agreement of counsel.

APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

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ON BEHALF OF THE DEFENDANT ERIN FUREY, M.D.:

Marilena DiSilvio, Esq.
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The 113 Saint clair Building
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I N D E X

WITNESS: JOHN DOWNS, M.D.

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

MISS KOLIS: For purposes of the record can I secure an agreement with you that because the court reporter is located here in Cleveland, that it is acceptable for her to swear in the witness?

MISS DISILVIO: Absolutely.

JOHN DOWNS, M.D.

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

MISS KOLIS: Doctor, by way of introduction my name is Donna Kolis, I'm the attorney who has been retained to represent the Estate of Lawrence Brown.

I'm quite certain given your background you're familiar with the deposition formalities and techniques. I won't go over all those issues except to say if for any reason you can't clearly hear me, let us know. I think the connection is pretty good; have you understood what I said?

THE WITNESS: Yes.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. Doctor, my purpose in deposing you today is to discover the basis of some of the opinions which I believe that you have issued in the letter to Mr. Groedel.

Do you have a copy of the report which you prepared in this matter?

A. Yes, I do.

Q. Doctor, can I ask you is this the only record that you prepared in this matter?

A. Yes.

Q. Is it your custom to make notes as you review medical material in anticipation of writing a report?

A. My custom is to make minimal if any notes in reviewing these matters; however, I do use a highlighter extensively. So both in the medical records and in the deposition transcript of Dr. Furey I have multiple highlighted areas, and as far as I know any notations I have are contained on little yellow flags within the chart. I don't believe I have any notation in the deposition transcript.

Q. So if I understand you correctly, as laborious as it may be, if I ask you today to go through the medical record, you can read into the record the portion that

you highlighted; would that be correct?

A. I could do that. It would be laborious.

Q. I might want to find out what you thought was important. I guess we'll deal with that issue in a minute.

Doctor, undoubtedly I'll be compensating you for your time spent today. usually I know that ahead of time, I failed to obtain that information, what will you be charging me per hour today?

A. $300.

Q. Fair enough. I ask at the conclusion of today's deposition you prepare a bill, submit it directly to myself. It will be promptly paid, okay?

A. Thank you.

Q. Let's go through your background a little bit.

Prior to today's deposition Mr. Groedel submitted what I believe is your current CV. You won't know that because we're not together. Let me ask you a couple of questions.

My understanding is that you are currently the Chairman for the Department of Anesthesia at the University of South Florida; is that correct?

A. Correct.

Q. what teaching responsibilities do you have?

A. I have a responsibility for teaching residents in

anesthesia, Fellows who are considered now the advanced residents in anesthesia in the areas of cardiovascular anesthesia, critical care medicine and on rare occasion pain medicine, pain management.

I also have responsibilities for teaching medical students in certain areas, currently physiology, and critical care medicine.

I'm responsible for overseeing people who teach them as well in operating room anesthesia but I rarely have exposure to medical students in the operating room environment.

Q. what percentage of your time is devoted to the academic training of young doctors?

A. I have never broken it out into a division between training and teaching per se. I would say that nearly 100 percent of my clinical activity would be involved with supervising or teaching the practice of medicine.

Q. That leads --

A. I almost never administer care to patients on a one-on-one basis.

Q. That was going to be my next question.

Do you have -- I won't like to call it a clinical practice in anesthesia, you don't have an office where people come to see you. Are you involved in the clinical practice of anesthesiology?

A. I am in terms of teaching and supervision of residents.

Q. Do you currently perform anesthesia in the operating room?

A. only in a supervisory fashion.

Q. You yourself do not do actual anesthesia at this point other than to supervise?

A. That's correct.

Q. Are you an attending of any sort in a hospital?

A. Yes, I have clinical privileges at several hospitals.

Q. what are your clinical privileges for?

A. The practice of anesthesiology and for critical care management at Tampa General Hospital and for anesthesia at the James Haley VA Hospital in Tampa. The H.L. Moffitt Research and Cancer Center in Tampa and I have anesthesia privileges at the Shriners crippled children's Hospital in Tampa.

Q. Are you done with that answer? I didn't want to interrupt you again.

A. Yes.

Q. Doctor, are you currently serving as an attending in the critical care unit of any hospital?

A. I have attending privileges only at Tampa General Hospital in the intensive care unit.

Q. I'm probably not asking the question correctly. Although you have privileges, have you in the last six months served as the attending on duty in the critical care unit of Tampa Hospital?

A. I have taken call on two occasions in the last six months.

Q. If I understand your CV correctly, you have Boards from the American College of Anesthesia, correct?

A. No, they don't issue Boards.

Q. They don't?

A. We have listed here -- it's listed under the subheading of Boards but it's just a credential given by examination in 1972. They stopped doing that in the late 1970's, it's not a Board. There is only one Board of Anesthesiology, that's the American Board of Anesthesiology.

Q. You obtained that Board, am I misunderstanding this?

A. No. The American College of Anesthesiologists just issued a certificate that was administered following successful completion of an oral examination. I did achieve that. It is not a Board certification.

Q. what about your certificate in critical care, tell me how you obtained that.

A. By examination.

Q. Is that likewise a certificate, not a Board?
A. No, that actually is a certificate issued by the American Board of Anesthesiology. I believe it is entitled a subspecialty Board certification now they changed it.
Q. Doctor, let me ask you this question: You've given a few depositions over the years, correct?
A. Yes.
Q. would you happen to know how many depositions you've given over your lifetime doing medical/legal work?
A. No, I wouldn't be able to guess that accurately.
Q. You began giving medical/legal testimony in what year?
A. 1981.
Q. So that is approximately 18 years worth of testimony?
A. Yes.
Q. You think that it probably exceeds 100 depositions?
A. Depositions?
Q. Yeah.
A. It probably is in that range. It might exceed it.
Q. If I understand from reviewing some of the depositions you've given over time, your percentage of

whom you testify for has changed; is that an accurate statement?

MISS DISILVIO: Can you please repeat the question, I didn't catch it.

Q. Initially when you began doing medical/legal work you were more heavily weighted on the side of defense; that's a fair statement?

A. That is not my recollection. The first case I ever did was certainly plaintiff, a very famous case in Chicago. I would say initially in the early 1980's was probably more heavily weighted for the plaintiff for a while. Didn't become more defense until I moved to Columbus, Ohio in 1985.

Q. I was just looking at the continuum of testimony that you gave, it appeared to me in the mid '80s to about 1990 you were testifying 70 percent for the physician, 30 percent for the plaintiff, recently you testified it's about 50/50; is that accurate?

A. I think it's been 50/50 all along. I don't believe it was 70/30. You are now asking me to recall what I might have testified to 12 years ago. If I said that at some time, then it was most likely accurate. My recollection is that I've been very close to 50/50 for as long as I can remember.

Q. I guess what I hear you saying is if at the trial

of this case I produce deposition testimony from the mid '80s to the mid '90s you testified your case load was 70 percent for the physician, 30 percent plaintiff, you would have to acknowledge that testimony?

A. I would say that is not my recollection. I believe it was accurate.

Q. Fair enough.

Doctor, do you recall when you met Marc Groedel?

A. I don't know that I've ever met him.

Q. If I refresh your memory, indicate in 1987 you testified for Charles Kampinski in a case called Frank Sealey versus Saint Luke's, Mr. Groedel was one of the defense lawyers, would that refresh your recollection?

A. No. I do remember Kampinski, I don't remember any of the other names you mentioned. I certainly don't remember meeting Mr. Groedel. That was then a plaintiff case I assume; is that correct?

Q. That was a plaintiff case. In fact, have you ever done any work for Mr. Groedel prior to this case?

A. I don't remember.

Q. Have you ever done any work for the law firm of Reminger & Reminger prior to this case?

A. I think so. I think I'm familiar with that firm's name. Again, I don't have any specific recollection of

the case.

Q. Doctor, in 1996 you were retained as an expert in the case of Dewey Jones versus University Hospitals; do you recall that?

A. I do recall Dewey Jones, I cannot recall the specifics of the case.

Q. Your recollection of Mr. Groedel is limited at this time to this case?

A. I haven't met him in this case so certainly that would be the case.

Q. Doctor, how were you contacted by Mr. Groedel?

A. I don't remember that either. I would have to review my correspondence file, which I don't have right now.

Q. YOU didn't bring the correspondence file to the deposition but you do keep one?

A. I have a correspondence file.

MISS KOLIS: I will ask Miss DiSilvio to take the correspondence file, provide it to me upon her return to Cleveland. Can I secure that agreement?

MISS DISILVIO: YOU can, Donna.

THE WITNESS: That's agreeable with me.

Q. Doctor, I see some of the material in front of

you. can you tell me what material you review prior to writing your expert report?

A. I reviewed the medical record for the university Hospitals hospital admission 5-24 to 6-4-97 for Mr. Lawrence Brown which included the death certificate and autopsy report. Also I cannot tell you if I reviewed Dr. Gluck's report before then or not, that of course would not have entered into my opinions in authoring this report.

I also reviewed the deposition transcript of Dr. Furey but I can't tell you if that was before or after I authored the report. I apologize that I don't have that information with me. I normally would, I apologize.

Q. That's all right.

Have you had the opportunity to review the deposition testimony of the cardiothoracic surgeon, Dr. Lee?

A. No, I have not.

Q. Have you read any expert reports authored by persons other than my expert, Dr. Gluck?

A. NO.

Q. Do you know Dr. Mendelsohn or Dr. Hoyte?

A. I know Dr. Hoyte, I don't believe I know Dr. Mendelsohn.

Q. Were you provided with the deposition testimony of Mrs. Lawrence Brown?

A. NO.

Q. Did you review any medical records that predated the hospitalization at University Hospitals?

A. No.

Q. DO you feel that you have reviewed each and every medical record that was necessary for you to reach a conclusion in this matter?

A. Yes.

Q. Doctor, I would like to ask you initially you were referring to the medical records that you reviewed, it would appear at least from my point of view they are contained in a notebook; am I stating that accurately?

A. Yes.

Q. Were those provided to you by Mr. Groedel's office?

A. Yes.

Q. Initially let me ask you if you would turn to the section of the chart marked death certificate.

A. Yes.

Q. Had you seen that death certificate obviously before you authored this report?

A. Yes.

Q. Can you and I agree that the death certificate

says the cause of death is pulmonary embolus due to deep vein thrombosis?

A. Yes.

Q. It says, the notation to the right-hand side, I would suspect it indicates minutes, do you see that, MIN?

A. Yes.

Q. Do you dispute that is the cause of death in this case?

A. I dispute that a pulmonary embolus was the immediate cause of death.

Q. Please turn to the section of the chart provided to you that is marked autopsy.

A. All right.

Q. Can you indicate to me how many pages are contained in that document?

A. The first page which is labeled postmortem record is numbered one, there is then a second page. There is another one that says postmortem record, this is different. It has a final clinical anatomic examination and the other has provisional, this has seven pages.

Q. You've reviewed essentially the completed autopsy information, correct?

A. I reviewed those nine pages that I just listed. I believe that is the complete report.

Q. At any time between the time you were initially contacted and today, have you reviewed any pathology slides?

A. No.

Q. Fair enough.

Doctor, I want to get right to asking you some questions -- I suppose that was a lie, I'm not going to ask the questions right away.

In reviewing your publications, how would you characterize your interests in terms of the material that you've published, is there an area you feel you've most heavy published in?

A. I most heavily published in the area of cardiovascular physiology and ventilatory physiology and mechanical ventilatory support, the treatment, diagnosis and treatment of acute respiratory failure, cardiopulmonary monitoring, and in recent years I would say that my publication emphasis is spread out a little bit because of my obligation to assist young residents and faculty in areas -- research areas that are a little bit broader than I just mentioned. They still tend to border on ventilatory physiology and cardiovascular physiology.

For example, I recently have participated in several publications dealing with

cardiopulmonary resuscitation which previously was just a fringe area of interest.

Q. I would have characterized it as most of your publications dealth with mechanical venti1ation, I didn't do a count. Let's get to looking at your report.

The initial portion of your record was simply a summary of the findings in the hospital records, would you agree with that? In other words, you are reviewing the history, some of the laboratory values and things of that nature in your first long paragraph?

A. That's correct.

Q. Let's get to your second paragraph. It says the following: Autopsy revealed biventricular infarc, a patent foramen ovale -- which I can never pronounce -- organizing and organized thrombi of the large, medium and small pulmonary arteries, intemal proliferation and webs were present. It was concluded the cause of death was pulmonary emboli with superimposed cardiovascular disease.

Tell me how you drew the conclusions that are contained in that paragraph.

A. which ones?

Q. The cause of death specifically?

A. I didn't draw that conclusion, I said it was drawn.

Q. which portion of the autopsy are you referring to?
A. I believe I was referring to the death certificate. You know this was authored some time ago so I can't say for sure that is what I referred to. It does not say the autopsy concluded it. what it says *is* it was concluded the cause of death was pulmonary emboli, that is what was stated on the death certificate.
Q. can you tell me in your opinion what the cause of death was in this person, if it's different than the death certificate?
A. I believe that the man had an acute myocardial infarction on the morning of the 4th, in particular involving the right ventricle.
Q. Doctor, let me ask you this question: Do you recall in prior depositions when asked cardiac questions your response was that you were not a cardiologist, couldn't interpret those results?
A. what results? You have to give me specifics of the results. I can assure you I'm capable of interpreting the results of various monitoring modalities involving the heart. I've authored many, many papers in that area. I certainly would feel that I'm capable of expert opinion in some areas of cardiovascular monitoring and function. There are some

areas where I clearly would not have such expertise, I'm not a cardiologist.

Q. Let me ask you then, since I didn't write a note, you disagreed that the pulmonary embolus was the cause of death; am I getting that correctly?

A. I don't believe that is what I stated. I said I think that his pulmonary emboli certainly contributed to the debilitated state, ultimately contributed significantly to his death. I believe that his death was a result of a profound right heart failure.

Q. what caused the profound right heart failure?

A. I believe that his chronically elevated pulmonary artery pressure led to certainly days, if not weeks, of progressive right heart failure. I believe that he then subsequently suffered ischemia, more likely than not his right ventricle caused his death on the morning of the 4th.

Q. what caused the elevated pulmonary artery pressure?

A. I believe the cause of the PA pressure were pulmonary emboli.

Q. what evidence do you have in the chart that he had ischemia caused by profound right heart failure?

A. we know that individuals with right heart pressure as high as Mr. Brown sustained have specifically

subepicardial ischemia of the right ventricle. There is evidence of that on the electrocardiograms from the time of his admission, then on the rhythm strips just prior to his cardiac arrest, there is obvious evidence of ischemia with marked S,T segment changes.

Q. what caused those changes in your opinion on that strip just before he arrested?

A. I believe that the changes that were evident on that strip just before he arrested were caused by ischemia and since we know he did not have an arterial hypoxemia, his arterial saturation was in the 90's, ischemic changes that were present had to have come from flow limitation through the right ventricle.

Q. what would cause the flow limitation?

A. Decreased blood pressure and/or increased resistance to blood flow through the right arterial system, coronary arterial system.

Q. what is the most likely thing to have caused that?

MISS **DISILVIO:** I don't mean to interrupt, I'm sorry, to have caused --

MISS **KOLIS:** He just offered two opinions of what would have caused the changes on the strip. I'm asking him what underlying condition or what pathophysiological change occurred to make those changes occur.

A. when you have a right heart failure you have a decrease in perfusion, so it's a spiral effect. I believe that he had right heart failure, decreasing cardiac output, decreasing perfusion of the right ventricle, increasing ischemia, decreasing output, increasing ischemia until he arrested.

Q. Doctor, as you went through the chart did you make note of the fact the cardiothoracic surgeon and his team indicated that he was stable from a cardiac standpoint on or about May 31st?

A. There was a notation in their progress note to that effect. we know of course that was not an accurate statement because of his profoundly elevated pulmonary artery pressure, which by itself indicates lack of the ability of cardiovascular function.

Q. The pulmonary artery pressure, what causes that to be increased?

A. There are a large number of things that causes it to be increased, all of them eventually go back to marked increase in pulmonary vascular resistance.

Q. what causes the marked increase in pulmonary vascular resistance?

A. There are a number of causes, can be hypoxic pulmonary vasoconstriction secondary to hypoxemia. It can also be due to destruction of the pulmonary vascular

beds. It can be due to pulmonary edema occlusive disease. I've never known a patient to have pressure this high with that pathology. Of course it could be due to obstruction of the pulmonary vascular bed by mechanical causes, a variety of different emboli.

Q. In this case --

A. There are probably other causes as well, I'm not sure that I need to strain myself to go through other causes that have nothing to do with this case.

Q. In this case do you agree or have an opinion the most likely cause of the increase in pulmonary artery pressure was an obstruction of the pulmonary vascular bed due to embolus?

A. Yes, that would be the most significant cause.

Q. Fair enough.

Going backwards, when I asked you did you not note that the cardiothoracic team felt he was stable, you indicated that you acknowledge that note. In fact that is inaccurate, he wasn't stable from a cardiac standpoint; am I inferring what you are saying correct1y?

A. I believe I said we know he was not stable from the cardiovascular standpoint.

Q. Do you feel given that you've just testified that you've got some expertise in dealing with this issue,

that appropriate medical care was given to address his what you believe to be oncoming right heart failure?

A. what would I believe -- I didn't hear that word.

Q. You think he died, if I get this correctly, from a right-sided heart failure, ischemia. I'm asking if the treatment given to him in the last three days of his life was appropriate to address that issue?

A. Right ventricular dysfunction that occurred secondary to clincally elevated pulmonary artery pressure can be extremely difficult to treat. The only way of treating it over the long-term is decreased pulmonary vascular resistance.

In this gentleman that would consist of Streptokinase or Urokinase type inotropic therapy with dislocation of the clot, which was not a possibility because he was a fairly fresh postoperative patient, or to operate on him and remove the clots physically, which I don't think he would have survived.

short-term therapy is just aimed at increasing the perfusion pressure of the right coronary artery. That was not a problem until the early morning hours of the 4th of June. other than that, I don't know of any way of addressing the right heart failure because inotropic therapy would be contra-indicated since it would merely increase oxygen consumption of the right

ventricle and probably killed him.

My answer to your question with that background, I believe they did all that they could to address his right ventricular failure. That completes my answer.

Q. Thank you, Doctor.

I would like to ask you to turn one more time to the autopsy; can you do that?

A. Yes.

Q. I'm not sure which page it is because we may not have them listed the same way. If you hang on, let me find mine. You might have it in a different spot.

On the provisional clinical and anatomic diagnoses, let's look at the pulmonary section first; would you like to do that, please.

A. Yes.

Q. The first notation is a massive organizing pulmonary embolism; do you see that?

A. Yes.

Q. Have you a medical opinion or conclusion from your thorough reading of the chart what or from where this massive organizing pulmonary embolus, singular, came from?

A. we know he had blood clots in the femoral system. It would be most likely that is where this emboli

originated.

Q. when you say emboli, so it's clear to both you and I, you would suspect based on the provisional clinical diagnosis *of* the pulmonary system there were multiple emboli contained in that lung; would you agree with that?

A. Yes.

Q. But the person who prepared this report chose to dissect out a massive organizing pulmonary embolus; you see that?

A. Yes.

Q. Later talks about organizing remote pulmonary embolus, correct?

A. Yes.

Q. Right under, the right and left main pulmonary artery greater than 80 percent occlusion; do you see that?

A. Yes.

Q. It's fair to say you're not a pulmonologist, correct?

A. I certainly do not have training in, training from a pulmonary medicine training program. Much *of* my career has been devoted to what one could call the practice of pulmonology.

I do also as an anesthesiologist have

subspecialty training and expertise in critical care medicine.

Q. suffice it to say, however, it's never been a part of your primary practice to treat diseases of the lung?

A. That's absolutely untrue.

Q. It is untrue? I'm sorry, go ahead.

A. That is not true. A significant part of my practice has been the treatment of a variety of diseases of the lung.

Q. In the critical care setting, that's what you are referring to?

A. Not always. when I was in private practice in Illinois I was the Director of Pulmonary Medicine at Mercy Hospital in urbana, Illinois. During that time I did examinations for Black Lung for the state of Illinois, I ran the pulmonary function laboratory, did all the interpretation of pulmonary function. I was the director of respiratory care for that hospital. I took care of all of the patients who were receiving different kinds of therapeutic modalities that are overseen and administered by respiratory therapy. I did not hold myself out to be an expert in the office practice of pulmonary medicine however.

Q. Anyways, back to the section of the autopsy that I was referring to, the right and left main pulmonary

arteries greater than 80 percent occluded.

Let me ask you if you have an opinion, Doctor, as to whether or not the right and left main pulmonary arteries were 80 percent occluded on June 3rd?

A. It is my opinion more likely than not they were.

Q. Do you believe that if the right and left pulmonary arteries were 80 percent occluded on June 3rd we would have seen the improvement in the status we had from the respiratory point of view in Mr. Brown?

A. By that you are referring to improvement in oxygen saturation I assume?

Q. Absolutely.

A. which did not necessarily denote an improvement in pulmonary function. So, if you would allow me to answer the question that I believe 80 percent occlusion of the pulmonary artery and an improvement in oxygen saturation on the 3rd on 4th, I would say yes, it is possible.

Q. Let's move to a different issue.

A. You want me to explain that?

Q. No, it's acceptable.

You stated that Mr. Brown had severe arterial hypoxemia, you've indicated in your report that you're acknowledging it was initiated by repeated episodes of pulmonary emboli; is that an accurate statement?

A. could you repeat the last part, it wasn't clear.

Q. You indicated, I'm going to relying upon this, that is why I'll give you some room to discuss it, Mr. Brown had arterial hypoxemia, you believe that arterial hypoxemia was initiated with repeated episodes of pulmonary emboli?

MISS DISILVIO: Donna, can you direct me to where you are reading from?

MISS KOLIS: Sure, third paragraph, first sentence.

MISS DISILVIO: Thank you.

A. I believe that is an accurate statement. I would say that it's possible that he had some degree of arterial hypoxemia from the obstructive lung disease, present perhaps months or years before he began to have emboli. severe arterial hypoxemia was clearly secondary to repeated episodes of pulmonary emboli.

Q. At what point in his clinical course do you believe he began to demonstrate evidence of severe arterial hypoxemia?

A. unfortunately I was unable to glean from the medical records whether or not he was severely hypoxemic upon admission to the hospital on the 24th; however, in the discharged summary it was noted that he did have an increased gradient. I don't know if that referred to

his presurgical condition or not.

He also, immediately after coming to the hospital, received some therapy for his coronary occlusion, an oxygenation that was noted to be improved with that, as one might anticipate.

So I believe that he probably had hypoxemia before he was ever admitted to the hospital. The clear documentation of that doesn't become evidenced until around the time of his operation. That was the time when he of course required mechanical ventilation. We know that he had markedly elevated pulmonary artery pressure.

Q. You indicate in your next sentence these episodes of pulmonary embolization preceded significantly his hospitalization; tell me how you know that?

A. I'm basing that on the autopsy report that he had organized thrombus and webs in the pulmonary vascular bed. Those don't occur over a period of days.

Q. How long do you think it takes for the pathological finding to be determined at autopsy?

A. Certainly more than a week or two.

Q. what do you base that on?

A. I base that on knowledge I've had for some time. ■ cannot refer you to any particular document. webs are the result of thrombus that has been organized, then

somewhat dissolved and the webs remain behind.

Q. You believe that it takes more than two weeks for those webs to develop; is that what you are saying?

A. I would say that it would be more than a day, I'm going to say probably more than two weeks.

Q. can you refer me to any specific medical literature I could read to confirm the accuracy of your contentions?

A. No, ask your expert, I'm sure he would know.

Q. Fair enough answer.

Doctor, let's deal with what seems to be at least an issue from my point of view, insertion of the IVC filter in this case.

Do you know under what circumstances an IVC filter is indicated in a patient?

A. Yes, I think so. According to the accepted standard published guidelines I do.

Q. what don't you relate for me when you think it's indicated.

MISS DISILVIO: Generally or for this patient?

Q. Generally what is the standard of care say when a person should receive an IVC filter?

A. Insertion of an IVC filter should be considered in patients with known pulmonary embolic disease who are at

risk for recurrent emboli, who for a variety of reasons cannot be subject to anticoagulation therapy, such as a recent major operation, or hemorrhagic disease, gastrointestinal bleeding for example, someone in whom anticoagulation would present a significant risk.

It's also indicated in people who did not receive Heparin because of an adverse response to Heparin, Some people become hypercoagulable with it. It's also indicated in people who have pulmonary embolus who received treatment with Heparin who then have a recurrence of pulmonary embolus while on optimal Heparin therapy.

Q. would you agree with me Mr. Brown was a candidate for consideration of an IVC filter?

A. He certainly was a candidate for consideration of insertion of a filter.

Q. You indicated both in your report and in your testimony today that you have an opinion that he had been embolizing into his lungs for some time, I'm going to say some time, maybe two weeks or longer.

To what degree would the pulmonary vascular bed had to have been obstructed or occluded I guess is the right word, for him to show the pulmonary vascular or pulmonary artery pressure he did; do you know the answer to that?

A. We know that 50 percent occlusion of a pulmonary vascular bed can be easily tolerated and accommodated. For example, an individual can have a pneumonectomy and the pulmonary artery pressure not be elevated at all.

So in order for the pulmonary arterial pressure to be elevated to the degree that it was it's my opinion and I'm doing some rather crude calculation in coming to this conclusion, his pulmonary vascular bed would have to be more than 75 percent occluded to result in chronic elevation of his pulmonary artery pressure to this degree.

In other words, he would have to have over 50 percent removed and tolerated with no increase in pressure. 50 percent of the remaining vascular bed removed, that would result in no more than double normal pulmonary artery pressure. Since he had more than that, I'm going to conclude that in the days preceding his arrest he had more than 75 percent of his pulmonary vascular bed occluded. certainly compatable with an autopsy report of 80 percent.

Q. A person who has lost 75 percent of his capacity, ■ guess that is the way I'm going to state it, isn't that person at high risk of death if they throw another embolus, especially if it is a large one?

A. Yes.

Q. Let me ask you this question: I think that you've concluded, I'll try to find it, your last paragraph it says insertion of an IVC filter might have prevented embolization of thrombus to the lungs after 6-3-97. However, the risk of deep sedation was -- I think "was" is wrong, I'm not sure -- was subsequent risk of regurgitation and aspiration was significantly greater than the risk of pulmonary thromboembolism. That is the sentence I want to focus on.

A. That "was" should be "with."

Q. I didn't think that was a correct word, that is all right.

A. I did not -- this report was sent unread by me. As indicated by my assistant's initials on my signature.

Q. I don't have a signature on mine.

A. There was a cover letter sent to Mr. Groedel signed by Pat smith for me.

Q. The issue in this case seems to some extent to be whether the risk of sedation was greater than the risk of embolus in the lungs; do you agree with that?

A. well, that would be one of the issues in the case, if in fact he suffered further pulmonary emboli, which I don't think did he.

Q. Let me ask you this. Go ahead --

A. But, there is no question that the risk of

regurgitation in a heavily sedated patient who is not n.p.o. is significant.

If this individual regurgitated and aspirated, the likelihood of him surviving would have been essentially nonexistent.

Q. was the risk if he had another pulmonary embolus, his chances of surviving were also nonexistent, weren't they?

A. I believe if he had recurrent pulmonary embolus chances of his surviving would have been quite small.

Q. Doctor, you know there was fresh clot in the femoral artery -- vein?

A. It was the vein.

Q. You know there was the complication of acute clot in that area found on the morning of 6-3, correct?

A. I believe I have the ultrasound, I'll find it. I believe they referred to acute and subacute thrombus.

Q. Meaning a collection of old and new thrombus; do you agree with that?

A. I wouldn't disagree with that.

Q. Fair enough.

Doctor, in determining whether or not a patient initially can undergo an operative procedure, you use ASA ratings, don't you, you yourself?

A. Yes.

Q. Do you ASA rate someone who is not going to be undergoing general anesthesia?

A. Sure.

Q. Can you ASA rate Lawrence Brown for me on June 3rd?

A. I would have given him an ASA 5 rating, possibly 4.

Q. You would have given him an ASA rating 4 or 5 for deep sedation; is that right?

A. The ASA rating has absolutely nothing to do with anesthetic technique.

Q. So that I understand it, if I am gathering from the testimony when you do an ASA rating we don't take into account what kind of anesthesia we're going to use?

A. No, actually it is 5, you would consider that the patient is in such precarious condition that you would likely be doing a resuscitation rather than administering an anesthetic.

One could stretch it, say a 5 does take into account the anesthetic techniques, that is certainly not the case with 1 through 4.

Q. So he was a 4 or 5 in your opinion?

A. He was definitely a 4, he had some characteristics of an individual that would be given a classification of 5.

Q. In what way does an anesthesiologist then factor in the type of anesthesia used when trying to consider whether to go forward with a procedure?

A. I don't understand your question.

Q. Are you telling me the type of anesthesia doesn't come into play with the ASA rating if I understood what you said?

A. Correct.

Q. If a person is an ASA 4, how do we factor in deep sedation versus general anesthesia, which is more risky, which is more beneficial, if either?

A. Well, I would say that if conducted properly deep sedation and general anesthesia have some similar risks. They also have risks that are quite different. I don't know that the ASA classification would enter into that categorization. I'm afraid I'm confused by your question.

Q. There has been some discussion as you know from Dr. Furey's deposition as to risk factors in trying to establish how an anesthesiologist would determine that it would be too risky to proceed with deep sedation to place a filter?

A. That has little or nothing to do with ASA classification. That is what confused me. Deep sedation in normal healthy individuals carries a

significant risk of regurgitation or aspiration of gastric content. It also carries a risk of some complications in somebody with an ASA classification 4.

Q. To what extent does an anesthesiologist have to consider whether a particular procedure is elective, urgent or emergent, if at all, in determining whether or not to proceed with anesthesia?

A. well the anesthesiologist will have to weigh the risk/benefit ratio of proceeding with an operation immediately or proceeding in a period of time under urgent conditions, or in delaying it as though it's an elective operative procedure.

Q. Did you get the impression from reading Dr. Furey's testimony that he thought the insertion of a filter was an elective procedure?

A. I believe that he thought it was indicated but clearly was not indicated on an emergency basis.

Q. You've had the opportunity as you indicated to read Dr. Furey's deposition. Is it clear to you his basis in delaying the procedure for a day was because there was food in the stomach?

A. It was not only because there was food in the stomach. Because the patient that had food in the stomach, would require sufficient sedation that increased his risk of regurgitation, therefore

aspiration of gastric content.

Q. I think we're saying the same thing, you said it more articulately.

Let me ask you this question: In a situation where it's determined that the person is in need of a particular procedure, but has content in their stomach which should not be there, to avoid the risk of aspiration are you not aware of ways that you can empty the stomach content to a safer level?

A. I am aware that you cannot empty the stomach. Every anesthesiologist knows that. unfortunately some other specialists are not aware of that. We get pressure from the surgeons at times, the nasogastric tube has been placed in, the patient has an NG tube on suctioning, the stomach must be empty, we know that is not true.

Q. what does it require to empty the content of a stomach to a safe level for you?

A. There is no such thing as emptying it to a safe level. There is no such thing as an empty stomach. It is not physically possible to empty the stomach. I suppose if you operate, opened the stomach, sucked everything out, you can say it is empty. Putting a nasogastric tube in will not do it. we never proceed with induction of anesthesia under the assumption that

we have emptied the stomach. we do other things to protect the patient.

Q. such as?

A. we do rapid sequence induction, insert an artificial airway with a cuff to protect the airway in case they regurgitate when it is necessary to proceed in emergent fashion.

Q. Let me ask you a couple of questions about what you just said.

I gather that you believe Mr. Brown would not have been a candidate for rapid sequence induction?

A. well, he would have been a candidate. He would have been one heck of a high risk candidate. It probably would have had a significant risk of killing him.

Q. when you say that we can never empty the contents of the stomach, waiting 24 hours, does that make it likely that they are not going to aspirate; is that what you are tell me?

A. Makes it less likely. we know the stomach emptied itself. we can also give medication to speed emptying, that is of questionable value.

Q. Do you know what the content of his stomach were at the time this decision was made?

A. I know he was on tube feeding at the time. I believe getting 90 milliliters an hour. There is no way of knowing what the contents were.

Q. Let me ask you this, if you have a calculation which you can make had they discontinued the tube feed that moment, how long would it have taken to empty the stomach of 90 milliliters of fluid that went in the hour before?

A. It may take four, five hours for that 90, before that hour there is the same 90 before that, and the 90 the hour before that, we don't know whether there is 90 milliliters in there or 600 milliliters.

Q. If he had 600 millileters in his stomach that would mean it wasn't processing, wouldn't it?

A. It would mean it reached an equilibrium, there is 600 remaining, 90 leaving every hour with 90 remaining behind.

Q. Doctor, I only have a few more questions if you want to hold on.

A. Let me add to that.

If the tube feeding stopped completely, the guidelines recently issued by the American Association of Anesthesiologists say that it would take a minimum of six to eight hours to ensure that that had 1eft in an average circumstance.

We know that there is a delay, there is a delayed gastric emptying in critical illness, we can say with some certainly at six to eight hours later it would have been at a level where it to would have been safe to proceed with heavy sedation.

Q. Are you finished?

A. Yes.

Q. Thank you. If you hold on a minute.

Let me ask you a couple of final questions. You are not a pathologist, Doctor, correct?

A. I'm sorry, I'm not what?

Q. A pathologist?

A. No, I'm not.

Q. If there is testimony in this case that the end cause of the death was a massive pulmonary embolus, it had occurred sometime after the 3rd, in other words during the day of the 3rd or evening of the 3rd or morning *of* the 4th, does that change any of the opinions you have in this matter?

A. It would change one, wouldn't it? If he had a pulmonary embolus on the 3rd or 4th ■would then have to agree yes, that is what the pathophysiology says, there is evidence of fresh clot from the leg in the pulmonary artery. It would not change the opinion however that he died from profound right heart failure. It would not

change my opinion that the lack of arterial hypoxemia was evidenced in the chart. It would however surprise me greatly he could have a fresh pulmonary embolus, no change whatsoever in arterial oxygenation. (PO2)

MISS KOLIS: Doctor, I don't have any further questions for you. Today's deposition will be transcribed, it's up to you and your attorney whether or not you'll read it.

MISS DISILVIO: we will read it.

THE WITNESS: can we talk?

(Recess had.)

MISS DISILVIO: The reason that the Doctor wanted to take a break is because there is an aspect of his opinion you haven't asked him about, he wanted to raise it.

Q. Okay, Doctor, what would you like to tell me?

A. In the second paragraph of my report I refer to patent foremen ovale which you did mention. The patent formen ovale is significant because with the elevated right-sided pressure, a lot of his arterial hypoxemia was secondary to shunting of the blood from the left atrium to the right atrium, not secondary to obstructive lung disease and right to left intrapulmonary shunting

or the VQ would be mismatching. Because of that ventilation perfusion mismatching you get with a pulmonary embolus, that explains in my opinion why he got better on the morning of the 4th, he was actually getting sicker, his pulmonary artery pressure was going down because his cardiac output was going down.

MISS KOLIS: Is that all?

MISS DISILVIO: That's it. We will read. Thank you, have a good day.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/ LINE

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

JOHN DOWNS, M.D.

The State of Ohio, :

County of Cuyahoga. : CERTIFICATE:

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 5th day of April, 1999.

Constance Campbell, stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

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