

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

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4 IN THE COURT OF COMMON PLEAS

5 -----

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

9 UNIVERSITY HOSPITALS OF  
10 CLEVELAND, et al.,  
11 defendants.

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

1 APPEARANCES:

2 ON BEHALF OF THE PLAINTIFF:

3 Donna Taylor-Kolis, Esq.

4 Donna Taylor-Kolis Co., LPA

5 330 Standard Building

6 Cleveland, Ohio 44113

7 (216) 861-4300.

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9  
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11  
12  
13 ON BEHALF OF THE DEFENDANT ERIN FUREY, M.D.:

14 Marilena DiSilvio, Esq.

15 Reminger & Reminger

16 The 113 Saint clair Building

17 Cleveland, Ohio 44114

18 (216) 687-1311.

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I N D E XWITNESS:JOHN DOWNS, M.D.PAGE

Cross - examination by Miss Kolis

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(NO EXHIBITS MARKED)

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(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

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

5                               MISS DISILVIO:               Absolutely.

6                               JOHN DOWNS, M.D.

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

12                               -----

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

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

23                              THE WITNESS:               Yes.

24                              -----

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

1     you highlighted; would that be correct?

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

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

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

10    A.     \$300.

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

14    A.     Thank you.

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

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

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

23    A.     Correct.

24    Q.     what teaching responsibilities do you have?

25    A.     I have a responsibility for teaching residents in

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

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

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

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

14 A. I have never broken it out into a division between  
15 training and teaching per se. I would say that nearly  
16 100 percent of my clinical activity would be involved  
17 with supervising or teaching the practice of medicine.

18 Q. That leads --

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

21 Q. That was going to be my next question.

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

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

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

5 A. only in a supervisory fashion.

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

8 A. That's correct.

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

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

12 Q. what are your clinical privileges for?

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

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

21 A. Yes.

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

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



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

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

7 Q. ■■■ understand your CV correctly, you have Boards  
8 from the American College of Anesthesia, correct?

9 A. No, they don't issue Boards.

10 Q. They don't?

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

17 Q. You obtained that Board, am ■ misunderstanding  
18 this?

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

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

25 A. By examination.

1 Q. Is that likewise a certificate, not a Board?

2 A. No, that actually is a certificate issued by the  
3 American Board of Anesthesiology. ■ believe it is  
4 entitled a subspecialty Board certification now they  
5 changed it.

6 Q. Doctor, let me ask you this question: You've  
7 given a few depositions over the years, correct?

8 A. Yes.

9 Q. would you happen to know how many depositions  
10 you've given over your lifetime doing medical/legal  
11 work?

12 A. No, I wouldn't be able to guess that accurately.

13 Q. You began giving medical/legal testimony in what  
14 year?

15 A. 1981.

16 Q. So that is approximately 18 years worth of  
17 testimony?

18 A. Yes.

19 Q. You think that it probably exceeds 100  
20 depositions?

21 A. Depositions?

22 Q. Yeah.

23 A. It probably is in that range. It might exceed it.

24 Q. If ■ understand from reviewing some of the  
25 depositions you've given over time, your percentage of

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

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

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

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

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

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

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

1 of this case I produce deposition testimony from the mid  
2 '80s to the mid '90s you testified your case load was  
3 70 percent for the physician, 30 percent plaintiff, you  
4 would have to acknowledge that testimony?

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

7 Q. Fair enough.

8 Doctor, do you recall when you met  
9 Marc Groedel?

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

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

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

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

21 A. I don't remember.

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

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

1 the case.

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

5 A. ■ do recall Dewey Jones, ■ cannot recall the  
6 specifics of the case.

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

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

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

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

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

17 A. ■ have a correspondence file.

18 MISS KOLIS: ■ will ask Miss  
19 Disilvio to take the correspondence file, provide it to  
20 me upon her return to Cleveland. Can ■ secure that  
21 agreement?

22 MISS DISILVIO: YOU can, Donna.

23 THE WITNESS: That's agreeable  
24 with me.

25 Q. Doctor, ■ see some of the material in front of

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

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

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

15 Q. That's all right.

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

19 A. No, I have not.

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

22 A. No.

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

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

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

3 A. NO.

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

6 A. No.

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

10 A. Yes.

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

15 A. Yes.

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

18 A. Yes.

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

21 A. Yes.

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

24 A. Yes.

25 Q. Can you and I agree that the death certificate

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

3 A. Yes.

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

7 A. Yes.

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

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

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

14 A. All right.

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

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

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

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



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

4 A. No.

5 Q. Fair enough.

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

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

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

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

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

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

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

11 A. That's correct.

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

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

22 A. which ones?

23 Q. The cause of death specifically?

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

1 Q. which portion of the autopsy are you referring to?

2 A. I believe I was referring to the death  
3 certificate. You know this was authored some time ago  
4 so I can't say for sure that is what I referred to. It  
5 does not say the autopsy concluded it. what it says is  
6 it was concluded the cause of death was pulmonary  
7 emboli, that is what was stated on the death  
8 certificate.

9 Q. can you tell me in your opinion what the cause of  
10 death was in this person, if it's different than the  
11 death certificate?

12 A. I believe that the man had an acute myocardial  
13 infarction on the morning of the 4th, in particular  
14 involving the right ventricle.

15 Q. Doctor, let me ask you this question: Do you  
16 recall in prior depositions when asked cardiac questions  
17 your response was that you were not a cardiologist,  
18 couldn't interpret those results?

19 A. what results? You have to give me specifics of  
20 the results. I can assure you I'm capable of  
21 interpreting the results of various monitoring  
22 modalities involving the heart. I've authored many,  
23 many papers in that area. I certainly would feel that  
24 I'm capable of expert opinion in some areas of  
25 cardiovascular monitoring and function. There are some

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

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

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

11 Q. what caused the profound right heart failure?

12 A. I believe that his chronically elevated pulmonary  
13 artery pressure led to certainly days, if not weeks, of  
14 progressive right heart failure. I believe that he then  
15 subsequently suffered ischemia, more likely than not his  
16 right ventricle caused his death on the morning of the  
17 4th.

18 Q. what caused the elevated pulmonary artery  
19 pressure?

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

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

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

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

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

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

14 Q. what would cause the flow limitation?

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

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

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

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

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

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

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

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

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

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

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

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

6     Q.     In this case --

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

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

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

15    Q.     Fair enough.

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

22    A.     ■ believe ■ said we know he was not stable from  
23    the cardiovascular standpoint.

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

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

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

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

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

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

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



1       ventricle and probably killed him.

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

6       Q.       Thank you, Doctor.

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

9       A.       Yes.

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

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

16       A.       Yes.

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

19       A.       Yes.

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

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

1 originated.

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

7 A. Yes.

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

11 A. Yes.

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

14 A. Yes.

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

18 A. Yes.

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

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

25 ■ do also as an anesthesiologist have

1 subspecialty training and expertise in critical care  
2 medicine.

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

5 A. That's absolutely untrue.

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

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

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

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

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

1 arteries greater than 80 percent occluded.

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

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

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

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

12 Q. Absolutely.

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

18 Q. Let's move to a different issue.

19 A. You want me to explain that?

20 Q. No, it's acceptable.

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

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

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

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

9 MISS KOLIS: Sure, third  
10 paragraph, first sentence.

11 MISS DISILVIO: Thank you.

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

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

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

1 his presurgical condition or not.

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

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

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

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

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

21 A. Certainly more than a week or two.

22 Q. what do you base that on?

23 A. I base that on knowledge I've had for some time.

24 ■ cannot refer you to any particular document. webs are  
25 the result of thrombus that has been organized, then

1 somewhat dissolved and the webs remain behind.

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

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

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

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

10 Q. Fair enough answer.

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

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

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

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

20 MISS DISILVIO: Generally or for  
21 this patient?

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

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

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

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

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

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

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

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



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

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

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

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

25 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 A. It was the vein.

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

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

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

20 A. I wouldn't disagree with that.

21 Q. Fair enough.

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

25 A. Yes.

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

3 A. Sure.

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

6 A. I would have given him an ASA 5 rating, possibly  
7 4.

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

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

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

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

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

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

23 A. He was definitely a 4, he had some characteristics  
24 of an individual that would be given a classification of  
25 5.

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

4 A. ■ don't understand your question.

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

8 A. Correct.

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

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

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

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

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

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

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

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

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

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

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

1 aspiration of gastric content.

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

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

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

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

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

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

3 Q. such as?

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

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

10 ■ gather that you believe Mr. Brown  
11 would not have been a candidate for rapid sequence  
12 induction?

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

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

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

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



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

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

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

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

15 A. It would mean it reached an equilibrium, there is  
16 600 remaining, 90 leaving every hour with 90 remaining  
17 behind.

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

20 A. Let me add to that.

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

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

6 Q.       Are you finished?

7 A.       Yes.

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

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

11 A.       I'm sorry, I'm not what?

12 Q.       A pathologist?

13 A.       No, I'm not.

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

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

1 change my opinion that the lack of arterial hypoxemia  
2 was evidenced in the chart. It would however surprise  
3 me greatly he could have a fresh pulmonary embolus, no  
4 change whatsoever in arterial oxygenation. (PO<sub>2</sub>)

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

9 MISS DISILVIO: we will read it.

10 THE WITNESS: can we talk?

11 -----

12 (Recess had.)

13 -----

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

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

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

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

7 MISS KOLIS: Is that all?

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

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13 (Deposition concluded; signature not waived.)

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[illegible]

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

JOHN DOWNS, M.D.

1 The State of Ohio, :

2 County of Cuyahoga. : CERTIFICATE:

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

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

17 ■N WITNESS WHEREOF, ■ have hereunto set my hand and  
18 affixed my seal of office at Cleveland, Ohio,  
19 this 5th day of April, 1999.

20

21

22 Constance Campbell, stenographic Reporter,  
23 Notary Public/State of Ohio.

24 Commission expiration: January 14, 2003.

25

**JOHN DOWNS, M.D.**

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