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State of Ohio,)
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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DEWEY GLEN JONES, et al.,)
Plaintiffs,)
vs.) Case No.: **306012**
) Judge Lillian Greene
MERIDIA HURON HOSPITAL, et al.,)
Defendants.)

DEPOSITION OF: **JOHN** B. DOWNS, **M.D.**

TAKEN: Pursuant to Notice

TIME: Beginning at 2:00 p.m.
Concluded at 3:50 p.m.

DATE: Thursday, August 7, **1997**

PLACE: Raytheon Aircraft Services
2450 N. Westshore Boulevard
Tampa, Florida 33607

BEFORE: LYNDA J. **MILLS**
Registered Merit Reporter
Notary Public
State of Florida at Large

ORIGINAL

APPEARANCES:

On behalf of Plaintiffs:

DON C. KEENAN, ESQ.
STACY HERREN, ESQ.
The Keenan **Law** Firm
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On behalf of Defendant Winston Ho, M.D. (Via Telephone):

STEPHEN WALTERS, ESQ.,
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On behalf of Defendant Peter Adamek, M.D.:

SUSAN REINKER, ESQ.
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C O N T E N T S

EXHIBITS

EXHIBIT NO.: PAGE

For the Plaintiff:

S T I P U L A T I O N

It was stipulated and agreed by counsel for the parties that:

1. Same stipulations apply as contained in previous depositions taken.

Whereupon,

JOHN B. DOWNS, M.D.,

was called as a witness, and being duly sworn by the Notary, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. KEENAN:

Q Okay. Let me go ahead and direct the Doctor's attention to Exhibit 1 which, Doctor, is your curriculum vitae, and also Exhibit 2, being the letter that was furnished to us, and I just ask you to confirm the correctness of those.

A The CV appears to be dated 11/5/96, so it's several months old at this time, but it does appear to be otherwise a complete copy of my curriculum vitae and my bibliography.

Q all right. And the opinion letter, Exhibit 2?

A All four pages of that letter appear to be present.

Q All right. Doctor, with regard to your CV, can you identify any specific book chapter or journal article or abstract or even letter to the editor which deals with the issues in this case?

A Let me first give you a broad answer that my areas of expertise and interest deal with pulmonary

physiology, cardiovascular, cardiopulmonary monitoring, and critical care medicine so that there's a likelihood that probably half of the articles here, at least tangentially, deal with issues that might be discussed in this case.

As far as direct application, we have some work in progress dealing with cardiopulmonary resuscitation which has not yet been published. There are some issues in some of the articles that I have authored dealing with monitoring cardiac and pulmonary functions. But if I were to go through these on an item by item basis I suspect that there would be a very large number that would have tangential importance to the case, but nothing directly that I can recall without going through each of them.

Q Well, in fairness let me ask you some specific questions. Have you ever written on the circumstances or conditions that mandate a pulmonary artery catheter or Swan-Ganz?

A I have, I have written some things where that is mentioned, particularly in dealing with the topic of dual oximetry and when a pulmonary artery catheter would be indicated for investigating the pulmonary condition of the patient.

I have written a few articles dealing

with the accuracy of a pulmonary artery catheter for evaluating left ventricular function in an experimental setting.

Q All right. Let me refine that question. Have you ever written specifically on what preoperative and intraoperative circumstances mandate the use of a pulmonary artery catheter?

A I hesitate to say no because it's possible that I have mentioned, but I don't recall any particular article that speaks to the precise issues that would mandate a pulmonary artery catheter placement prior to an operative procedure.

The one possible exception to that might be for major vascular surgical procedures, and it is likely that I have mentioned in some articles that pulmonary artery catheter is indicated for such operations.

Q That would not apply to Dewey's case, would it?

A It would not.

Q Now, at one point you did a study or wrote an article which elicited a response from Dr. Swan and Dr. Ganz, do you recall that?

A I believe it was Dr. Swan. I don't think Dr. Ganz actually participated in that, but it's been

over twenty years ago so I could be wrong.

Q And what was it that Dr. Swan was taking issue with that you made a response?

A Again, it's been twenty years since I have reviewed that, but I believe that Dr. Swan was somewhat insulted that we published an article that insinuated that in critically ill patients and unstable post-operative patients that thermodilution cardiac output might not be as accurate as other means of measuring cardiac output.

Q All right. You didn't have to review any literature in this case, did you? Or did you?

A I did not review any literature.

Q Did not.

A And I don't believe I was expected to.

Q Okay. And what materials did you review prior to forming your opinions that are set forth on Exhibit 2?

A I reviewed the hospital records of Mr. Jones for his admission to Meridia Huron Hospital on 10/17/94; the deposition transcripts of Drs. Adamek and Sanchyshak; and I also reviewed reports from Drs. Greendyke, Kaplan, Greenhouse, Semigran, Khan, Tompson, Orloff, Nearman, and Rapkin.

Q All right. The depositions then you have

reviewed are of the resident and the defendant anesthesiologist?

(Brief interruption.)

BY MR. KEENAN (resuming):

Q I'm sorry, Doctor,

A That's correct. In addition, I have also reviewed the deposition transcript of Dr. Beverly O'Neill.

Q Were you provided the deposition taken in New York of plaintiff's expert Dr. Kaplan?

A No.

Q Were you made aware of any of the sworn testimony that he's given?

A I was provided with several faxed pages of his deposition transcript this afternoon. I did not have a chance to read that.

Q Were you aware that two anesthesiologist experts were deposed yesterday, Dr. Kascorvy (sic) and Dr. Rapkin?

A Yes, I was told that.

Q Were you told the substance of their opinions?

A I was told some of the substance of their testimony. I can't recall anything in particular. It was more the feeling rather than the substance that was

discussed.

Q Well, were you told specifically what their opinion was regarding the placement of the Swan-Ganz catheter?

A If I was I don't remember.

Q About whether the attending should have been there at the time of induction?

A I think I was told that Dr. Rapkin felt that he should be there essentially throughout the whole case. Whether that's what he said *or* not I don't know, this was just verbal communication with Ms. Reinker.

Q Okay. So you weren't specifically told they had this opinion or that opinion that differed from yours?

A I don't believe so.

Q All right. And I assume that conversation occurred today?

A That's correct.

Q All right. Doctor, when did you first begin testifying in medicolegal matters?

A I believe the year was approximately 1981.

Q And how many times do you believe you have either been in front of a jury live or your

videotape has being shown to them?

A I don't know that a videotape has ever been shown to a jury of my testimony, but it's a possibility because I have given some videotaped testimony.

It would be an estimate of how many times I have appeared live in court. Up until a few years ago it hadn't been very many at all, maybe three or four times, but in recent years it's been more frequent, and in fact I think I've testified two or three times already this year in court, which is a very large number of times for me.

So I would estimate somewhere in the range of ten times in court. But I can't say that that's accurate, it could have been more than that.

Q And depositions given?

A That's very difficult to estimate because most of the depositions I have given do not result in -- the cases do not go to trial. I suppose I give a deposition on the average of five, six times a year in recent years.

Q Do you recall testifying three years ago that you actually kept a list of all the cases that you reviewed, all the cases that you have given a deposition in, and that your assistant keeps a list and

you occasionally review it; do you recall that testimony?

A I think that probably was testimony that said I kept it for the year. But, no, I don't recall testifying that I have a permanent list because I do not, nor do I -- I don't think I ever did. If I did it would have been in years when the list wasn't very long. But for a number of years I have not kept a complete list of all the cases.

Q Have you ever testified in a federal court that requires you to list every case that you have, in fact, testified in or reviewed?

A I have testified in federal court. The one time I remember was in South Carolina last year, and I do not recall that that required that I provide every case. I don't think it did. If it did I wouldn't have been able to do it.

Q Okay.

A To my knowledge the only list I have are of active cases.

Q You have previously testified that your split between defense and plaintiff was at one point 70/30 and at another it was 65 percent for the defense. What is it now?

A It's about 50/50. And the only time that

it was -- you said 70 for the plaintiff or --

Q For the defense.

A I don't recall that being the case. If it was it was sometime back. It would have been when I lived in Ohio. If anything, I would say that the preponderance has been more towards plaintiff since I moved to Florida, and in the last two or three years it's leveled out to approximately 50 percent.

Q Okay. Doctor, if we drove from Tampa to Cleveland, you would have testified in every state that we would drive through, true?

A You mean at trial?

Q Either by trial *or* deposition testimony. And if my geography is correct, that would be Florida, Georgia, Tennessee, Kentucky, and Ohio.

A Kentucky certainly.' Ohio certainly. I don't recall testifying in Tennessee. I don't recall testifying in Georgia. Now, I have reviewed cases from Georgia. I don't remember Tennessee, but it certainly is possible. **And** I have given depositions in cases that the suit was brought in Georgia. But I don't remember Tennessee.

Q South Carolina certainly?

A Oh, sure, South Carolina. A very memorable case in South Carolina.

Q Several in Indiana or Illinois?

A Many in the Chicago area, yes.

Q And also in the Detroit area, Michigan?

A Yes, correct.

Q And also as far away as Arizona, too?

A Yes, I gave a deposition here in Tampa with an attorney from Arizona once. I don't remember any other than that one case.

Q Okay. Do you keep copies of your depositions, Doctor?

A No.

Q And why not?

A When the case is settled or completed the only -- I'm trying to think if I even keep the correspondence. But when the case is settled or completed at trial, then my associate calls and asks what do you want done with the records.

And if she's told to destroy them she does, and if she's told to send them back she does that. And I would say that the answer to your question then is because the attorneys have directed me to do whatever they want done with the records and I have. complied with their wishes.

Q Doctor, have you ever testified in a case similar to Dewey Jones? And we understand that no two

medical cases are the same, but I'm talking about a chronic disease process, obesity, cardio problems, a relatively elective surgery that either caused brain injury *or* ultimate death?

A Probably.

Q **Do** any of them come to mind?

A No.

Q And I assume that you approached the Dewey Jones case in the same analytical manner that you would those other cases?

A well, I don't know if your assumption is correct *or* not. I would hope that I would, and I feel that I usually am pretty consistent over the years in my opinions. But that's not to say that my opinions don't occasionally change.

Q Well, let me ask you specifically about a statement that you wrote a number of years and see whether or not you still agree with it.

"In the anesthetic management of any surgical patient the knowledge of the pathophysiology of the disease process, the effect of the pharmacologic and surgical intervention and anticipation of pre-intra and post-operative complications will usually result in minimal morbidity and mortality." Do you still agree with that statement?

A Pretty safe statement.

Q Okay. Now, what can you tell me about your knowledge of Dr. Adamek?

MR. MALONE: I'm having trouble hearing you guys.

MR. KEENAN: I'm sorry, Jim.

MR. MALONE: I'm having a little trouble hearing you. The voice kind of cuts out. When your voice goes down, that speaker doesn't pick it up.

MR. KEENAN: Okay. Are we okay?

MR. MALONE: Great. We hear you when you're kind of maybe closer to the microphone, but you get into periods of quiet. I don't mean to interrupt but we're trying to follow you here and it's getting difficult.

MR. KEENAN: Jim, if that occurs, please speak up and we will do better on this end, okay?

MR. MALONE: We will try not to interrupt too much, but I appreciate anything you can do. Thanks.

BY MR. KEENAN (resuming):

Q Okay. Tell me about the qualifications of Dr. Adamek.

A In terms of his training and so on?

Q Yes. I mean, where did he go to school? Where did he do his residency? Is he board certified? Does he have any specialties?

A I would have to refer back to his deposition transcript to answer that question if that's okay.

Q Okay.

A I don't have an independent recall of all of those things.

Q Do you recall specifically how many times he was unsuccessful taking his boards?

MS. REINKER: Objection.

A I do not recall the specific number. I do recall him being asked, and I believe he had failed his oral boards. I don't remember if it was the written or oral for sure. But I know that he was not board certified.

Q Did you make any determination of why he was unsuccessful?

A Not that I recall.

Q And at Tampa General how many attendings do you supervise?

A I have on my faculty approximately twenty-three clinical anesthesiologists. They are not

all at Tampa General at any one time. There are a number of anesthesiologists at Tampa General Hospital that are not on my faculty for which I have no responsibility.

Q You are board certified, aren't you?

A Yes, I am.

Q Successful the first time?

A The first time that I took the written and orals I passed, yes.

Q All right. And you have participated over the years in the examination process, haven't you?

A I have.

Q Do you know whether or not Dr. Adamek had, prior to Dewey Jones, a similar patient with similar complications and risk factors?

A I do not know that.

Q Was it any significance to you that Dewey was given oxygen on the morning of the surgery prior to going into the operating room?

A That is done sometimes as a routine in some institutions, and it did not, it did not have any significance to me.

Q So, your understanding of the facts was that the oxygen was given just as a pre-operative routine?

A I, frankly, did not give thought to it, and at this time I do not recall having an impression of why it was given or if it was given.

Q All right. You are aware that the evening before the surgery an n.p.o. order was written by the resident?

A Yes.

Q And that's standard practice, isn't it?

A It's standard practice for an n.p.o. order to be written.

Q All right. And you were aware that Dewey had been for quite sometime on some blood pressure medication?

A Yes.

Q Do you understand that that n.p.o. order the evening before his surgery also included a discontinuation of that medication?

A It would unless it was specified that he would be given that medication orally on the morning of the operation.

Q And did the conduct of the resident in so not designating that he should be continued on with his blood pressure medication meet the standard of care in your opinion?

A It would not be a deviation to omit the

anti-hypertensive medication on the morning of the operation.

Q All right. What was the medical reason for discontinuing his medication?

A You would have to ask the resident who wrote the order what his reason was. I don't believe it was given in the chart.

Q Well, when you instruct residents and when you, yourself, practice, do you automatically discontinue blood pressure medication on the evening before gall bladder surgery?

A Usually not.

Q Why not?

A Usually the medication is continued on the morning of the operation in order to ensure that the medication has a continued effect on the patient throughout the pre-intra and post-operative period.

Q All right. And is it your opinion that the discontinuation of the blood pressure medication by the n.p.o. order the night before had no effect on the consequences of the outcome of Dewey Jones' case?

A It is my opinion that the discontinuation of his medication had minimal if any effect on the outcome.

Q Describe for me how from a minimal

standpoint it would have had an effect on his outcome?

A Anti-hypertensive medication, when administered for a long period of time, may have the effect of preventing precipitous increases and decreases in blood pressure during the operative procedure.

Anesthetic agents tend to exacerbate the etiologic factors, if you will, *of* hypertension so that during periods of light anesthesia, in particular stimulation, may cause large increases in blood pressure. And during the anesthetic phase the blood pressure may actually be decreased significantly when the anti-hypertensive medication is not maintained.

That was a convoluted answer. I hope it's clear in written form. It wasn't very clear verbally, I realize.

Q I understand it, Doctor. Do you know whether or not the resident who did not include a continuation of the meds in the n.p.o. order did so after consulting with an attending?

A I don't know that.

Q Do you know whether or not it was simply an oversight?

A I don't know that.

Q Well, from a surgical anesthetic

standpoint was there any advantage in discontinuing his blood pressure medication?

A Certainly none that I know of.

Q All right. Doctor, from an anesthetic standpoint how was Dewey Jones' surgery classified?

A Your question isn't clear to me,

Q All right. Does your institution use any kind of grading system or percentage system indicating how high a risk a patient presents?

A They use the American Society of Anesthesiologists' risk categorization, yes.

Q And who assigned the categorization of Dewey Jones?

A It would appear that Dr. Sanchyshak most likely, since he filled out the anesthetic record, was the one that did that.

Q And what grade did he assign?

A Three.

Q Do you agree with that?

A I don't disagree with it.

Q Your letter indicates, Doctor, that there was a long-standing history of congestive heart failure in Dewey Jones. Do you recall writing that?

A Yes.

Q Your letter also says that Dr. Adamek was

unaware of that. I believe that's page 2 at the bottom under number 1, Doctor.

A Could you direct me to the line?

Q Number 1 it says, "Records exist which were not made available to me, and which were not available to the anesthesiologist conducting the pre-operative evaluation, which document Mr. Jones' long-standing history of congestive heart failure."

Did I read that right?

A Yes. I thought your question had to do with hypertension, I'm sorry.

Q No. But do you understand the question?

A Perhaps you should repeat it.

Q Let me repeat it.

A Because I didn't understand it. I thought it was hypertension you had asked about.

Q Let me rephrase it. Dr. Adamek did not know of that long-standing history of congestive heart failure on the morning of surgery, did he?

A I believe that Dr. Adamek knew that he had a history of congestive heart failure, but I don't think that he knew of the length and significance of it.

Q Should he have? And by that I mean should someone have told him?

A I don't believe that the standard of care dictated that in this particular instance, but that kind of information is always desirable to an anesthesiologist.

Q All right. Now, the doctor who did the pre-operative anesthetic evaluation the evening before certainly didn't have that information, did he?

A We don't know, I don't believe. We don't know what information was made available to him I don't believe. I don't know that.

Q And is it your testimony that the absence of that information had no impact on the grading of the risk factors for surgery?

A No, that would not be my testimony. You didn't ask me that I don't believe.

Q Okay.

A I believe that that kind of information does have, in fact, relevance to the ASA physical status assignment.

Q All right. So, had the doctor who did the pre-operative anesthetic evaluation had the information, either the records or had been verbally told of this long-standing history of congestive heart failure, what would the grade have been?

A It still very likely would have been

three because Dr. Ho's assessment was that the patient was not currently in congestive heart failure, and so therefore it would have been of historical significance but not, certainly would not have placed the patient in the four category in and of itself.

Q Is it your understanding that this congestive heart failure was end-stage on the morning of surgery?

A No.

Q Where would you put it?

A Based on the information that was available to me in the chart and so on I would say that he had compensated left ventricular failure secondary to long-standing hypertension which was moderately in control. And certainly I would not classify it as end-stage congestive heart failure.

In fact, I don't think he demonstrated signs of congestive heart failure either prior to, during, or following his induction of anesthesia for some period of time.

Q You understand this was a 34-year-old man who was completely disabled, unable to work and was receiving a Social Security disability because of that condition?

A I don't think I was aware of all of that.

Q Not aware of that. Okay. What other risk factors were known prior to the surgery?

A The fact that the patient had hypertension was known, and the fact that the patient was obese, and the fact that he had evidence and a history of obstructive sleep apnea with mild oxygen desaturation during sleep. I believe those were -- that's a complete list.

Q well, does cardiomegaly go hand in hand with hypertension?

A It certainly is a secondary effect of long-standing hypertension, yes. And his chest x-ray did reveal cardiomegaly.

Q To what extent, profound?

A I don't remember what the adjective was that preceded it, I just remember the cardiomegaly. I will be happy to refer back to it if you want me to.

Q Well, I just want to know whether or not it was significant to you in forming your opinions. There was no statement in your report on it, and if it has no significance to a degree then we will move on.

A The chest x-ray just said the impression was cardiac enlargement unchanged.

Q Doctor, would you agree that it's inappropriate for an anesthesiologist to accept the

internist's clearance for anesthesia in surgery?

A No, I wouldn't agree with that.

Q You would not?

A No.

Q So, if an internist clears a patient for surgery the anesthesiologist then has no independent responsibility to go beyond that and to make an independent assessment?

A I don't agree with that either.

Q All right. Tell me your opinion then on the role between the anesthesiologist and the internist if, in fact, the internist has been asked to clear the patient for surgery?

A Well, the term clearing for surgery is not a very helpful or meaningful term, per se. I expect the internist to elucidate an accurate history and to perform a relevant and accurate physical examination and determine whether or not the patient is in optimal condition for the planned operative procedure and anesthetic, and, if not, to relay that information to me as the anesthesiologist.

And then I will take that information into account in determining whether or not I feel the patient is an appropriate anesthetic risk and plan the anesthetic appropriately.

Q Well, you would agree that it's important for the anesthesiologist and the surgeon to have a dialogue between each other about the relative risk factors?

A The anesthesiologist and the surgeon?

Q Yes.

A In some cases, yes. Not in all cases.

Q Well, clearly in Dewey's case?

A I think in Dewey's cake that it would have been appropriate for the surgeon and the anesthesiologist to discuss the patient's medical condition.

Q Did they?

A I know of no evidence that that took place.

Q Do you assume they did?

a I don't assume they did.

Q Well, did the standard of care require them to do so?

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

Q Was the surgery itself elective?

A I believe it was -- if it wasn't elective it was close to elective.

Q And did the surgery itself carry any

accepted classification or grade to it?

A I'm not sure what you mean by the question, I don't understand the question.

Q Well, do surgeons have a similar classification about degree of elective surgery, necessary surgery that anesthesiologists grade risk factors?

MS. REINKER: Objection.

A I don't think it's a 'similar categorization. I think that they certainly classify the operative procedures according to emergent urgent, elective and so on, but that has nothing to do with the ASA physical status assignment.

Q And what was it, what was it in this case?

A I don't remember.

Q You certainly have formed no opinions about the necessity for surgery, true?

A That's correct.

Q And will give no opinions on that?

A I haven't been asked to and I don't think I would. I think I could go back and review it with that in mind whether or not, but it was certainly not my impression that this was an emergent procedure that had to be performed that morning.

Q All right. In this case did Dr. Adamek make an independent decision to clear this patient for surgery from both an anesthetic and a surgery standpoint?

A According to his deposition transcript testimony, I don't believe that he did.

Q And it's your opinion he should not have?

A I don't believe he had the opportunity to. According to his testimony, I believe that he basically came on the scene about the time that the patient was to be induced, or shortly thereafter, and that another anesthesiologist perhaps was there for the first part of the procedure.

Q Well, that's nowhere in the records, is it?

A Oh, it's certainly not in the records.

Q All right. And it's only in Dr. Adamek's testimony, true?

A I believe that's correct.

Q All right. That should be something that was charted, wouldn't it? Wouldn't you chart an attending's present at the beginning of a procedure?

A I would say that it would not always get charted.

Q Do you tell your attendings don't bother

with it?

A No, I would not tell them that.

Q You tell them to chart it, don't you?

A I would certainly tell them if asked that if an anesthesiologist was present for induction of anesthesia that that individual's name should appear on the record, and probably would appear in the operating room record,

Q Did you review the operating room record?

A Yes.

Q And was this other doctor, who Dr. Adamek says was there at the beginning, is he reflected in that record?

A I don't believe so.

Q Doctor, is it your opinion that it was the resident Sanchyshak that did the pre-operative evaluation, or what doctor was that?

A We are talking about the pre-anesthetic sheet?

Q Correct. Correct.

A That's not entirely clear to me, but I believe that Dr. Adamek signed it, that another resident filled out at least a good part of it on the 19th, but yet it was dated the 20th at eight o'clock in the morning.

And there is some writing that appears to be made with a similar type pen that Dr. Sanchyshak used on the anesthesia record, so it is not completely clear to me who was responsible for either all, or a majority, or some *of* this record.

Q Well, specifically the pre-operative evaluation, we don't know who did it, is that your testimony? And by "we" I don't mean myself, I mean you don't know who did it?

MS. REINKER: Objection, it was in Dr. Sanchyshak's deposition.

MR. KEENAN: I'm sorry.

A It was referred to in Dr. Sanchyshak's deposition, so whether or not he was right or not he said it was -- he gave a name, but when I looked at the initials it didn't look like the initials fit the name that he gave. But he said that he recognized it. I believe it started with an "F" the first name. I don't remember precisely.

Q Okay. And do you know anything about the background or qualifications of the resident that did the pre-operative evaluation?

A No.

Q Did you make any assumptions?

A No.

Q Did you assume that whoever did the pre-operative evaluation was not the same resident who did the induction?

A Yes.

Q Doctor, at Tampa General, do you spend most of your time at Tampa General?

A I spend a major portion of my time at Tampa General. I spend a little bit of time at Moffitt Cancer Hospital but not very much.

Q Are you chair at Tampa General?

A I'm no longer chief of anesthesia at Tampa General.

Q All right. You were a chief for a while, weren't you?

A I was. That's an elected position.

Q And as such, did you have a role in developing policies and procedures for the anesthesia department?

A Probably at least a few of them, more than -- the major role would have been in revising and reapproving them though.

Q Let me go back for a minute on the pre-anesthesia evaluation. Dr. Adamek signed off on it?

A Yes, I assume he did.

Q And what do you assume that meant?

A What it usually means and what I would assume it meant was that he reviewed it and he agreed with it.

Q Now, the next morning you assumed that Dr, Adamek was not present for the induction?

A Well, he said he wasn't. Sanchyshak said he was. I'm not sure that I assumed he was or he wasn't. There's a conflict in the record there.

Q Well, if he wasn't present and if there was a resident himself, that would be a breach of the standard, wouldn't it?

A That would not comport with the standard of care if the resident did it in an unsupervised fashion in an elective case, yes.

Q And unsupervised you mean an attending not being there?

A Not being physically present. But neither Sanchyshak or Adamek claimed that that was the case. Adamek claimed that another anesthesiologist was there.

Q We can assume that the pulmonary artery catheter was not used during the operative procedure, true?

A Yes, that's correct.

Q What resident was it that suggested that the Swan-Ganz should be used?

A Sanchyshak claimed that he did.

Q All right.

A Or asked. He may not have -- I don't know if he said he suggested it be used, but he brought up whether or not it should be used with Adamek.

Q And at what point did he bring it up, preoperatively?

A He said that he brought it up prior to taking the patient into the operating room, I believe. But it was definitely preoperatively.

Q And was that commendable for a resident to make that suggestion?

A Well, I'm not sure that he made the suggestion or if he just raised the issue of whether or not it should be done. And I don't believe it's either commendable or uncornmendable.

Q It wasn't stupid, though?

A Wasn't stupid? No.

Q And what was Dr. Adamek's response?

A According to Sanchyshak his response was that that wasn't necessary.

Q Now, you are aware that Drs. Kaplan, Kascorvy and Dr. Rapkin are all of the opinion it was

necessary; you are aware of that?

A I knew that Kaplan thought it was necessary. I don't recall what Rapkin and I don't believe I saw a report on Kascorvy.

Q All right. Well, assume that their sworn testimony yesterday indicated that?

MS. REINKER: Objection.

A I will assume that. What, indicated what, that it should have been used?

Q Should have been used.

A Does that mean the standard of care dictated that it should be used?

Q Correct.

MS. REINKER: Objection. That was not the testimony.

BY MR. KEENAN (resuming):

Q What's your opinion?

A My opinion is that the standard of care did not dictate that a pulmonary artery catheter be used. And my opinion is that, although it certainly would have been acceptable to put a pulmonary artery catheter in preoperatively, that it would have had no effect on the ultimate outcome in this case.

Q Why would it have been acceptable?

A Well, I believe that the risk of a

pulmonary artery catheter in accomplished hands is fairly small, and that the information that one can gain from the pulmonary artery catheter is sometimes very helpful. And that's particularly true in patients with unstable cardiopulmonary physiology.

So that oftentimes the catheters are used and are of no value, which would have been likely the case here, at least in terms of outcome -- I wouldn't want to say would have been worthless but it would not have altered the outcome -- but there are times when things happen unexpectedly and the information that's gained from the catheter is helpful in guiding therapy.

Q Did you see where **Dr.** Adamek in his sworn testimony said that if a Swan-Ganz would have been in that it would have, according to him, foretold the bradycardia?

A **I** don't recall him saying that.

Q Is that true?

A No.

Q It would not have?

A I don't believe that at all.

Q All right. Now, what kind of useful information can a Swan-Ganz generate, Doctor?

A We could be here for a long time discussing that.

Q Well, just give me a thumbnail.

A Well, as long as there's a stipulation it's not a complete issue.

Q Sure.

A I think that in a case similar to this a pulmonary artery catheter would give useful information regarding the after-load to the right ventricle from the pulmonary artery pressure and the filling status of the left ventricle.

I personally do not believe that cardiac output measurement would be very useful in an individual such as this. And mixed venous saturation values would confirm adequacy of cardiac output.

So that's a very rough thumbnail sketch of how it might be used in a case such as this.

Q And it's your opinion then that in Dewey's case, although the Swan-Ganz can give useful information about decreases in cardiac output, it wouldn't in Dewey's case?

A No, that was not my testimony.

Q Okay. Well, let's take it this way then, Doctor. With regard to the cardiac output in Dewey's case, what benefit would a Swan-Ganz have in telling a doctor what the cardiac output was?

A Well, it could tell what the cardiac

output was. But in my opinion, based on his blood pressure and pulse throughout the operative procedure and his oxygen saturation while receiving 50 percent oxygen, I believe that the cardiac output measurement itself would not have been particularly helpful.

I think that the pulmonary artery occlusion pressure would have aided in guiding fluid therapy, and my estimation would have been it would have led to an increase in fluid thkrapy, not to a decrease.

And the cardiac output measurement itself would not be as useful as the mixed venous saturation in determining whether or not the output was actually adequate to meet the body's demand.

Q All right. What information would the Swan-Ganz give regarding the degree of left ventricular dysfunction?

A If the pulmonary artery occlusion pressure were elevated, and I don't think it would have been because it wasn't in the post-resuscitative phase, it would have given an indication that there, in fact, was left ventricular dysfunction and left ventricular failure.

In the absence of decreased cardiac output and increased pulmonary artery occlusion

pressure, the pulmonary artery catheter would not give an accurate reflection of left ventricular dysfunction.

Q All right. Doctor, do you recall testifying in a case that without the Swan-Ganz or the pulmonary artery catheter you can't tell the degree of left ventricular dysfunction, you can't tell any decreases in cardiac output, you can't tell low or elevated pulmonary occluded pressure, and according to you, and I quote, "There's just no way to tell. You would simply be guessing, and that's exactly the reason you need the catheter"; do you recall testifying to that?

A I don't recall testifying to that, but I don't disagree with the statements in some clinical situations. But that's certainly -- clearly those statements would not be true of a perfectly normal, healthy human being, for example, so that it would depend upon the clinical situation. And I don't know what the context of that statement was.

Q And you are not telling me that Dewey Jones was in the category of a perfectly good human being, true?

A Well, no, and he was under general anesthesia. And I certainly wouldn't say that I could say what his pulmonary artery occlusion pressure was at

eleven o'clock, or that anybody else would either, but that doesn't mean that it's 25. The fact that I don't know exactly what it is doesn't mean that it's distinctly abnormal high or low.

Q Well, isn't that the point of why we use the catheter is to tell so no one's guessing?

A Well, I think that's the reason one would use it if it's important to know that information. And there are times when it is important to know that information. There is a big debate going on right now whether it's ever useful or important.

Q For the -- I'm sorry.

A And a moratorium was called for by Dr. Roger Bone in the last few years saying that we shouldn't use them anymore at all because there is no evidence that they are ever of any value. So that's certainly not an opinion held by everyone that there's even ever a use for the Swan-Ganz catheter.

Q Well, when is the last time that you circulated in a case with a Swan-Ganz?

A That I circulated? You mean --

Q Yes, that you were either at the beginning, end, or middle of a procedure?

A Friday.

Q Did you think that --

A Thursday or Friday.

Q Did you think it was useless to the patient?

A In this particular case it probably was not very helpful. But you can't predict ahead of time sometimes when it will be helpful or not

Q Well, isn't that the point? You don't have to know for certain before you use it to use it; you use it in the anticipation that'it may be helpful?

A I agree with that statement.

Q All right. Now, prior to Friday when is the last time that you used a Swan-Ganz?

A Probably the day before in the intensive Care Unit.

Q Okay. So you use Swan-Ganz frequently in your practice?

A Very.

Q Very frequently?

A Very frequently.

Q What percentage of surgical procedures do you think a Swan-Ganz is in?

A I have no idea. it used to be put in every open heart, and we're doing that less and less now. Certainly any time the aorta is cross-clamped I believe it's indicated.

It's not an insignificant number. It's certainly not a high percentage of all patients undergoing anesthesia for operative procedures, but it's a high percentage in some operative procedures. And in most high risk patients for cardiovascular surgery I would say a pulmonary artery catheter will be placed.

Q When was the arterial catheter placed in this case?

A During the -- it's listed on the code sheet, I believe.

Q By code we are talking about after the arrest?

A It was 1:27 p.m., so approximately thirteen minutes after the CPR was initiated.

Q Certainly not during the surgery then?

A I agree.

Q Okay. Doctor, do you recall writing the following: "That arterial catheterization is necessary for anesthetic management of patients with significant pulmonary dysfunction or cardiovascular insufficiency, severe metabolic disorders, or morbid obesity to facilitate monitoring of the arterial blood pressure and to allow frequent sampling of the arterial blood for assessment of blood gasses"; do you recall writing

that?

A No, but I would guess if I did that it was before 1988.

Q Okay. Is that just flat out wrong today?

A It's not as accurate as it was at one time because we now have more accurate non-evasive blood pressure monitors and we have pulse-oximeters, which makes the necessity for frequent sampling of arterial blood much less and the necessity for blood pressure measurement much less than it used to be. But I certainly at one time believed that was true.

Q And would have been of no benefit in Dewey's case intraoperatively?

A Oh, I don't agree with that. I think it would have been of benefit as it turned out, especially during the period of time when he developed cardiovascular instability.

Q At approximately what time?

A Hard to say from the charting. But it would appear that at approximately 1300 it was a possibility and by 1315 it was a certainty.

Q And how would the arterial catheter have aided the surgical team in Dewey's case had it been in?

A It would have given them a beat to beat knowledge of his blood pressure. It would have allowed

them to sample arterial blood for analysis for oxygen tension, C02 and pH. It would have assisted them.

Q All right. Was it a breach not to have used it?

A No.

Q They could have used it?

A They could have.

Q And does the use of an arterial catheter pose less risk than a Swan-Ganz?

A They are different risks. I would hesitate to say it's less or more. They are different. I think that the general feeling would be that you can get away with less morbidity with an arterial line than with a pulmonary artery line.

Q Did you note the urine input or output, rather, during surgery?

A Yes.

Q And why was that significant to you?

A Well, there was a claim that the patient had fluid overload which caused his pulmonary edema, which I thought was highly unlikely. And the urinary output of only 25 milliliters an hour to an hour and a half into the case would certainly not substantiate fluid overload.

And the patient's response to Lasix later

with a 425 milliliter urinary output does not substantiate a substantial fluid overload, and it also confirms that the patient had profusion of his kidneys even after his period of cardiovascular instability. So I think there's useful information in the urinary output.

Q The fluids he received intraoperatively was how much?

A It was documented to be 2100 milliliters of crystalloid solution.

Q So, 2100 went out or went in, right?

A That's what was recorded.

Q And 25 went out?

A No, 425 went out.

Q And that's an adequate balance in your opinion?

A Well, in an obese individual who is undergoing a cholestectomy it's pretty much what you would expect. However, the 425 is with stimulation from Lasix, and that's not what you would expect, you would actually expect a little higher urinary output.

Q Now, who was in attendance when the muscle relaxant drugs were reversed?

MS. REINKER: At what point in time? Do you want to point out to us what you are talking

about?

BY MR. KEENAN (resuming):

Q No, I just wondered who was in attendance?

MS. REINKER: At what time?

BY MR. KEENAN (resuming):

Q When there was a reversal at the end of the surgical procedure?

A Well, that was at slightly after 12:30, assuming that the notation of time is accurate. And we know that Dr. Sanchyshak was present. It's likely that the surgeon had left the room by that time, and then there were nursing personnel and perhaps a surgical resident present.

Q Who made the decision to reverse?

A Well, we don't know that for sure. It's obvious that Sanchyshak did because he gave it. Now, whether Adamek felt that this particular muscle relaxant should be reversed or not I don't believe was addressed. If it was I didn't pick up on it and recall it. This was an intermediate acting muscle relaxant. It doesn't always have to be reversed.

Q Well, was the standard of care met by Dr. Adamek not being present during reversal in this patient?

A Oh, I think so, yes. I don't think that reversal of the medication in fact made that much difference anyway because he had documented before that there was a four over four train of four present, which meant that physiologically the relaxant had already been reversed.

Q In this case should there have been any anticipation of complications once the reversal occurred?

A Well, as I said, I think the reversal occurred over a period of time. The previous dose of Norcuron had been given at 11:15, so it was over an hour since there had been any administration, so that the reversal, in fact, had been occurring for over an hour at that time.

You are referring to the pharmacologic reversal in that, and I doubt that it had any significant effect one way or another.

Q Do you know whether or not Dr. Adamek gave specific instructions to the resident as to the timing or even the appropriateness *of* the reversal?

A I don't recall if there was such testimony.

Q If he didn't say a word would that have been in keeping with the standard of care, and that is,

Dr. Adamek not saying anything to the resident one way or the other?

A One way or another I don't think it would make any difference in this particular case. This individual had been doing anesthesia for a long time, this particular resident. And I think an attending could assume that after more than a year of anesthesia experience that he could judge when the appropriate time, if at all, would be for administration of pharmacologic reversal of the muscle relaxant would be. That is not synonymous with extubating the patient, obviously.

Q You utilize residents at Tampa General, don't you?

A We train residents at Tampa General.

Q Do you generally inform the patients in advance as to the role of the residents?

A Patients are informed upon admission to the hospital that it is a teaching hospital and that physicians in training will be playing a significant role potentially in their care and treatment.

Q Are they told that it could well be that residents alone will be attending the pre-operative evaluations?

A If a resident does the pre-operative