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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.
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On behalf of Defendant Winston **Ho,** M.D. (Via Telephone):

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

SUSAN REINKER, ESQ.
Jacobson, Maynard, Tuschman & Kalur
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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 case 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 uncommendable.

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 also 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 p lmonary artery occlusion pressure would have aided in guiding fluid therapy, and my estimation would have been it ul have led to an increase in fluid therapy, not to a decrease

And the cardiac outpwt measurement itself would not be as useful as the mixed venows 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-resuscitation 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 importank 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, CO2 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 fudge 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

evaluation then the residents generally will tell the patient that they are a resident in training.

Q Is that also true if the resident does the induction, that that statement will be made prior to the use of the anesthetic agent?

A Usually not. Usually the patient will be told that there will be a resident and attending resident for induction of anesthesia, which is the case.

Q Is that also true with reversal, do you tell the patient that, such as in this case, reversal will occur totally with the presence of a resident?

A I don't think -- I can't remember ever discussing pharmacologic reversal of a muscle relaxant with a patient. That's not something that's discussed with a patient unless they specifically ask, and I don't remember a patient ever asking.

Q Tell me your understanding of the resuscitation efforts in this case, Doctor.

A Could you be more specific? I'm sorry.

Q When did it start? How long did it occur? What do the records or testimony that's significant to you tell us?

A That Dr. Heart, as they refer to it, was initiated at 1:14 p.m.

Q Right.

A And that's when advanced cardiac life support was initiated.

Q **Is** there a period in the records where there's nothing being recorded?

A Yes.

Q A fifteen --

A Well, not nothing. There's a fifteen-minute period where the vit'al signs and other relevant information is not recorded.

Q And having nothing in the records to tell you what's going on, what are you assuming is going on, if anything?

A Well, it's not nothing because it is recorded that the patient **was** receiving pure oxygen at that point in time. And so one can assume that the patient was being mechanically ventilated with pure oxygen during that fifteen-minute period of time.

Q Any other assumptions you make about the fifteen-minute period?

A I think that we can assume, since there was -- that CPR didn't start until 1:14, that during that fifteen-minute period of time there was, in fact, evidence of cardiac activity on the electrocardiogram, that there was evidence of a blood pressure and pulse,

and that there was evidence of a pulse oximeter reading, but what those values are I don't have any way of knowing.

Q Are you able to make an assessment of whether the standard of care was met in that time not knowing what was going on?

A Standard of care with respect to what?

Q The care and treatment rendered by the health care providers?

A Well, of course, the vital signs wouldn't give me that information anyway. *So* it's my -- I don't have any reason to believe that the standard of care with respect to the patient's care was not met at that time.

Q At what point, Doctor, was Dewey's condition irreversible, that is, at a point in time when he was destined to be in a coma no matter what was done for him?

A Well, that would'be true at the point in time that he was resuscitated back to a sinus rhythm.

Q And what time would that have been?

A 1345, I believe the damage had been done by then. Now, I need to couch that in that there's evidence that once you have reprofusion of the brain and so on that there's an ongoing damage. So I don't

believe that all the damage had occurred before then, but I believe that his fate was sealed in terms of what his ultimate outcome would be by that time.

Q Well --

A And whether it was at 1330 I can't say,

Q Well, you understood that he was walking, talking, had his mental abilities with him prior to going into surgery, true?

A Well, I didn't understand that he had that, but I had no reason to assume that he didn't.

Q **All** right. And you understood that after the surgery he doesn't?

A Yes.

Q At what point do you believe everything that could be done was being done and there was nothing that could stop his condition?

A Well, I believe everything that was -- that everything that could be done was being done by 12:45 when Adamek entered the room, whatever the time was, 12:46, 12:45. However, I believe then that there was a series of events that resulted in his cardiac arrest which then led to his brain damage.

That doesn't specifically answer your question with regard to time, but I don't think I can be any more specific than that.

Q Okay. Well, if you would, tell me then what were the significant events that led to the cardiac arrest?

And what I'm trying to do with this question, Doctor, is simply to find out why Dewey's in the condition that he's in right now. What happened? What was the pathophysiological process that put him in the condition he's in right now?

A I think that was the cardiac arrest, the period of time during which his brain was inadequately profused with oxygenated blood.

Q When did he have the cardiac arrest?

A 1:14 is as close as could be determined from these records.

Q And what caused the cardiac arrest?

A Now, we don't have documentation to tell us that specifically. I believe that from the testimony we know that between 12:45 and 1:14 the patient developed what appeared to be pulmonary edema, more likely than not severe heart failure, and that then resulted in cardiac arrest.

Q Okay. Well, what caused the pulmonary edema, Doctor?

A Heart failure, I believe.

Q And what caused -- well, so the heart

failure, the severe heart failure then came before the pulmonary edema, true?

A Probably, but not absolutely necessarily. If there was a period of time when the patient had obstruction to spontaneous breathing with significant respiratory effort, then it's possible that he could have developed a negative pressure pulmonary edema in addition to his heart failure.

Q But more likely than not it was the heart failure that then led to the pulmonary edema?

A Let me say it's more likely than not that those were the two etiologic factors.

Q All right.

A And if there were -- if there was a likelihood or information to indicate that there was an obstruction of the airway during spontaneous respiratory efforts, I would not be prepared to say that heart failure led to the pulmonary edema more likely than the negative pressure pulmonary edema.

I think that if the airway were obstructed for a period of time that that would be a more likely cause.

Q Well, is there any evidence in the record that there was any obstruction to the airway?

A There is some indirect evidence, yes.

Q Tell me what that is.

A There are multiple references to the patient having difficulty with the extubation process.

Q All right. What else?

A And that usually means airway obstruction.

Q Okay. What else?

A That's about it.

Q All right. So the evidence we have that there was some type of airway obstruction was the difficulty, as reflected in the records, with Dewey's extubation process?

A Yes.

Q All right. Now, what evidence in the record do we have of the heart failure?

A We have evidence that he had pulmonary edema, and people tend to equate that to left ventricular failure or heart failure, congestive heart failure.

We also know that he had instability of his blood pressure, bradycardia, PVCs. All of those could have been a reflection of heart failure as well as of severe hypoxemia.

Q So, is it your opinion that the left ventricular dysfunction set in motion then the

pulmonary edema?

A Well, because there's a possibility that negative pressure pulmonary edema results from left ventricular function ultimately, I would answer yes to that question. I think that that would cover both bases.

Another way of looking at it is a severe after-load of the left ventricle was the ultimate cause of his pulmonary edema one way or the other.

Q Now, does the overload of the left ventricular occur within a matter of seconds?

A It can, especially with an obstructed airway it can happen literally in seconds.

Q But you don't have a way of telling in this case one way or the other, do you?

A If that was the etiology?

Q Yes.

A Well, there's just the presumptive evidence that that might have happened. It can also happen if there's a sudden after-load imposed on the left ventricle, for example, severe hypertension.

We don't have any information that would indicate that this patient developed profound hypertension with emergence from anesthesia, but that's also a possibility.

Q But the left ventricular dysfunction can occur progressively over a period of time or it can occur spontaneous, true?

A Well, I'm not sure that that's an either/or proposition. Certainly it can happen rapidly, as I just described. It also can happen slowly and insidiously with time.

Q And we don't know in this case by what process it was?

A No, but we have no information. According to the anesthesia record, he had a pretty steady anesthetic course up until approximately 12:30 with little alteration in pulse and certainly no unacceptable variation in blood pressure, no alteration in end-tidal carbon dioxide tension, which is a fairly sensitive reflection of cardiac output.

So I have no reason to believe -- and pulse oximetry as well. So I have no reason to believe that he had anything other than a perfectly stable course until approximately 12:30, and I don't believe there's any evidence that he did.

Q Doctor, can we agree that whether the cause was a left ventricular dysfunction that then set in motion the pulmonary edema, or, on the other side, it was an obstructed airway that set in motion the

irreversible process, regardless of how we come down on that issue, if Dewey would not have been operated on that morning he would not be in the condition he is today?

MS. REINKER: Objection.

A I think that's more likely than not true.

Q All right. Have there been occasions in your practice, Doctor, where you have requested a cardio consult prior to surgery?

A Yes.

Q Have you instructed residents in the propriety of so requesting if their judgment so indicates?

A We have an agreement in our group now that residents do not make such requests, that such requests will be made, for the most part, after consultation with the surgical attending by the anesthesiology attending.

It was felt by the group practice that we were obtaining too many cardiology consults imposing too much of a strain on our cardiologist colleagues, and, therefore, we have an agreed that there would be discussion before such consults are requested. That's not always the case, but generally.

Q Have there been instances where you have

an internist who is taking care of the patient, you have a surgeon, and then, of course, a member of the anesthesia team, and collectively there is a decision made to have a cardio consult on a patient prior to surgery?

A I'm sure that has happened.

Q And clearly the anesthesiologist is in a position to ask for a cardio consult even if the internist doesn't see fit to get one, true, if you believe it's in the patient's best interest?

A You could ask. Now I'm not sure in our practice if you would get it.

Q Well, is that because of the constraints of managed care, the bureaucracy?

A Yes.

Q That's not saying it wouldn't be in the best interest of the patient?

A Correct.

Q All right. Doctor, in marching through all the facts and circumstances of this case, I take it then that you have no criticisms from the standard of care standpoint of Dr. Adamek, true?

A That's correct.

Q And is that likewise true of the residents in the case?

A Not necessarily.

Q Tell me. Where is the standard of care violations with regard to the residents?

A It is my opinion that something happened sometime about 12:30 that is not clearly reflected or accurately reflected in the anesthetic record. There's information that is recorded that is not compatible with the testimony as given.

Specifically, there is an indication that the patient suffered heart failure between 12:30 and 12:45, decrease in cardiac output, and yet the end-tidal C02 rose to 38 millimeters of mercury, almost a 20 percent increase over previously recorded values. And with a decrease in cardiac output one would expect that value to fall, not to increase.

There's a profound decrease in oxygen saturation in spite of the fact that the inspired oxygen concentration had been increased from 50 percent to 100 percent oxygen.

And pure left ventricular failure, heart failure, will not produce profound hypoxemia in the face of pure oxygen breathing. So that the severe pulmonary dysfunction and right to left intrapulmonary shunting I do not believe was a result of pure heart failure.

The patient was never allowed to breathe entirely spontaneously according to this record, was always given controlled mechanical ventilation or assisted mechanical ventilation, and yet PC02 rose and PO2 fell. I don't think those are compatible with an unobstructed airway and truly assisted or controlled mechanical ventilation.

Q Is it your testimony then, Doctor, that the resident anesthesiologist failed to understand or appreciate an obstruction in the airway?

A I don't know if he failed to appreciate it, I think he failed to document it. And I think that there is certainly a possibility that that occurred, and that the patient was inadequately ventilated for significant period of time between 12:30 and 12:45.

Q Between 12:30 and 12:45 would a competently trained anesthesiologist looking at this data have appreciated it to the degree to have been able to do something about it?

A It depends upon what precipitated it and I don't know what that was.

Q Well, let's assume that it, in fact, was the obstructed airway as one of the possibilities that you indicated. Then how could a competently trained anesthesiologist approach that and manage that

differently than was done?

A Well, the way one would manage that is to clear the airway and make sure that there was a patent clear airway present, and then provide positive pressure ventilation with pure oxygen.

Q Now, is it your testimony then that the data we are receiving between 12:30 and 12:40 is inconsistent with the left ventricular dysfunction that then caused the pulmonary edema?

A No, I think that there certainly could have been a series of events between 12:30 and 12:45 that would then precipitate severe left ventricular failure and severe pulmonary edema with the resultant events.

Q Could you state for me as clearly as possible where the residents would have deviated from the -- the resident would have deviated from the standard of care between this period of 12:30 and 12:40?

A It would be based upon the different possibilities of what might have caused airway obstruction.

If the, whatever retained the tracheal tube was removed in anticipation of extubation of the trachea, for example, if the tape had been removed in

order to expedite removal of the tube, and if the patient then in thrashing about kinked the tube so that it no longer would allow the patient to have a clear airway, then literally a period of twenty to thirty seconds of obstructed breathing could precipitate severe left ventricular dysfunction pulmonary edema which could put this whole process -- could explain the whole process later.

Obviously, if the tubk was removed from the trachea in an obese patient, an attempt to shove the tube back down blindly might result in an obstructed airway, or a failed attempt to re-establish the airway in a timely fashion could also cause that.

So there are a number of possible causes for airway obstruction and inadequate respiration that could cause pulmonary edema and left ventricular failure.

Q **All** during a period when the resident was front line?

A Yes.

Q Now, the indications which you just outlined, from removing the tube too quickly and putting it back in, the kinking in the tube, all of that, what should the resident have done? Should he have immediately summoned the attending, or should he

have engaged in immediate activity? What did the standard *of* care require under those instances?

A Standard of care would dictate that the resident should some of this have happened, and I realize there is no testimony to say that it did, would immediately call for help and ask for the attending to return.

But in anticipation that the attending might not come for five or six minutes, in another room or something, just say, "Get some help in here now."

Q Should he engage in any activity prior *to* that?

A Attempts to relieve the airway obstruction.

Q All right. And specifically, Doctor, the data which is not compatible is the 02 saturation and what e1se?

A The end-tidal C02.

Q All right. And what else?

A I believe that the erroneous indication of 7 milligrams of Norcuron being administered was never satisfactorily explained.

Q All right.

A And I believe that the, and I may be incorrect here, but I believe a surgical resident and

operating room nurse both referred to extubation, and then, of course, the indication on the code sheet that the patient was intubated at 12:30.

Q Do you believe there was a failed extubation?

A Well, of course a failed extubation would be a non-extubation.

Q Well, do you believe there was an extubation then, Doctor?

A I think that there was a period of time when this patient did not have an adequate airway.

Q .And should have?

A And should have.

Q Now, if the surgeon were in attendance during this period, does he bear any responsibility?

A It's a possibility, but it would -- in this particular case?

Q Yes.

A No.

Q Okay. Doctor, finally, how many active cases do you have now?

A I don't know.

Q You don't know. What's the next -- do you have any idea, I mean, are we talking hundreds or ten's or --

A No, no, it's not hundreds. As you well know, some cases go on for four or five years. I have one in Atlanta that's at least five years old.

Q Is that the Budda case?

A It's a baby.

Q Francis Budda, pediatrician, neonatologist?

A He may be involved.

Q Henry Green, Bill Bird?

A You got it, that's it.

Q Okay. We are slow in Atlanta, Doctor.

A Yes. Lots of records, though. It would just be pure speculation how many cases there are. There are several dozen.

Q When is the next deposition you have scheduled?

A I don't know.

Q Do you have any trial appearances other than this one?

A Well, this one is potentially real soon, I understand.

Q Next week.

A I don't know. I don't have my calendar with me. It would be recorded there. Nothing in the next week or two.

Q Okay, Have you ever reviewed any cases or worked with Susan's firm before?

A Yes.

Q And --

A Well, her firm in Cleveland, I don't believe so. But I used to live in Columbus, Ohio and I did some work when I lived in Columbus. And subsequently I have received some cases from there, but I don't know how many.

Q Any idea how many from that firm?

A From which firm, from the firm in Columbus?

Q From her firm.

A The whole firm including all the different cities where they are?

Q Yes.

A I don't know exactly.

Q I mean we're talking --

A More than two, less than five I think.

Q Okay. Any of those reach a deposition stage?

A I don't remember. I thought Jim Brazeau was in that firm, but he's not, and I have given depositions for him in Toledo.

I have not given deposition for Ms.

Reinker or Mr. Arnold. Those are the two names that stand out. I don't think I have been deposed by Gayle Arnold or by an attorney involved in a case with him, so I don't know if there was a deposition or not.

Q Okay. Any of the other lawyers in the case?

A In this case?

Q Yes. And you can, if you will take Dr. Kaplan's deposition, I believe the designation of counsel will be on the second page.

A Where is that? I don't have Kaplan's.

Q Oh, I'm sorry.

A This is Beverly O'Neill.

Q I'm sorry. Maybe it's in there, Susan.

MS. REINKER: Somewhere in here.

A Let's see. I would recognize the firm perhaps.

Q Right.

A I have not done any work with your firm. I don't think Landscroner & Phillips I have. Reminger & Reminger, I think I have reviewed a case for them at least once. I know that name, but I have no idea what the case might have been. Like I said --

Q Okay.

A -- I lived in Columbus for three years

so --

Q I believe there's another firm there listed, isn't there?

A Oh.

Q Isn't the Jacobson firm listed?

A That's her firm.

MS. REINKER: That's my firm.

MR. KEENAN: Okay. All right. That's all the questions I have, Doctor. Jim?

MR. MALONE: We have no questions for the Doctor at this time. Steve?

MR. WALTERS: Doctor, I just might have one.

CROSS-EXAMINATION

BY MR. WALTERS:

Q This is Steve Walters, Doctor. I represent Dr. Ho.

A Doctor who? Dr. Ho. Okay.

Q Does the internist in a case, Doctor, have the right to rely on the proposition that the anesthesiologist will make *or* do a clearing of the patient for an anesthesia?

A Well, of course I can't testify specifically to the standard of care for an internist with respect to what an internist might expect of the

anesthesiologist.

However, I believe that the anesthesiologist certainly has a right to expect that the history and physical examination and the impression and recommendation of the internist is accurate.

Q But would it be reasonable to also go the other way, that the internist would have the right to expect that the anesthesiologist would do the job of clearance as you have previously stated?

A Not if the internist is asked to clear the patient for surgery or clear the patient for anesthesia or both. I believe that the internist then has an obligation to do just that, and I don't believe that they could then turn around and say, well, I anticipate that the anesthesiologist will actually perform that function.

Q That's not what I am saying, Doctor. I am just trying to see -- let me ask you this. Why don't you tell me what the standard of care is for an anesthesiologist when he first evaluates a patient for purposes of providing general anesthesia?

A Boy, that's a far-reaching question. Are you asking me the standard of care with regard to deciding whether or not the patient should be cleared for an anesthetic?

Q Yes.

A I think that the anesthesiologist is obligated to conduct a relevant history and physical, and to take into account the information provided from the pre-operative evaluation of other physicians and the laboratory in deciding whether or not the patient is in optimal condition for the operative procedure.

And once that decision **is** made, then the anesthesiologist must decide how to conduct the anesthetic in the safest and most appropriate manner.

Q It was your testimony that the anesthesiologist has to satisfy his or herself that the patient is in optimum condition for purposes of anesthesia, correct?

A Yes, but that would not be independent of the internist. In fact, if the internist says that in my opinion this patient is in stable and optimal condition, that the anesthesiologist has every right to assume that that's accurate information.

Q I'm not trying to is dance on a pin here, Doctor. I'm just wondering if the anesthesiologist also has that independent responsibility?

A You mean in addition to the internist?

Q Yes.

A I think if the internist has stated that

this patient is in stable condition and doesn't present any undue risk for anesthesia and surgery, that the anesthesiologist could depend upon that opinion.

Q Is that what happened in your case based upon your understanding of the facts here?

A Is that what happened in what case?

Q -- case.

MS. REINKER: We missed that, Steve. Could you repeat the question?

BY MR. WALTERS (resuming):

Q Is that what happened in this case based upon your understanding of the facts?

A My understanding is that this patient was seen by Dr. Ho. Dr. Ho outlined the patient's condition, claimed that, as he stated, "The patient is well-known by me from previous admissions," and that he felt that the patient was in appropriate condition for going to the operating room for his operative procedure.

Q And I assume you have no reason to disagree with that, is that correct?

A With his assessment?

Q Yes.

A Well, I was not provided with the information that some of the experts had regarding his

prior hospital admissions, evaluations, and so on, and so I do not have the information to disagree with that.

Q Okay. Fair enough.

MR. WALTERS: That's all I have. Thanks, Doctor.

MS. REINKER: Is that it?

MR. KEENAN: Nothing further.

MS. REINKER: Okay. I guess we can hang up with you guys.

(The deposition was concluded at 3:50 p.m.)

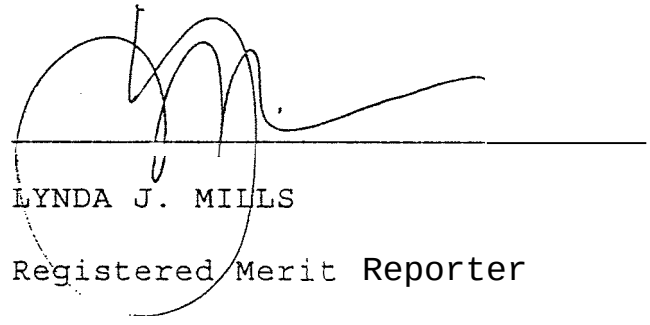
CERTIFICATE OF OATH

STATE OF FLORIDA

COUNTY OF HILLSBOROUGH

I, the undersigned authority, certify that JOHN B. DOWNS, M.D., personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 7th day of August, **1997.**



LYNDA J. MILLS

Registered Merit Reporter

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Commission No. CC617077

Expires: May 27, 2001

REPORTER S DEPOSITION CERTIFICATE

STATE OF FLORIDA

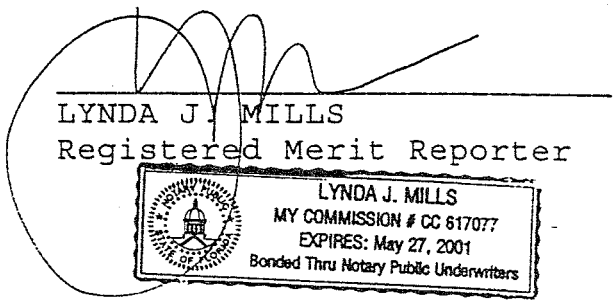
COUNTY OF HILLSBOROUGH

I, LYNDA J. MILLS, RMR, certify that I was authorized to and did stenographically report the foregoing deposition of JOHN B. DOWNS, M.D.; that a review of the transcript was not requested; and that the transcript is a true and complete record of my stenographic notes.

I further certify that I am not a

relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 7th day of August, 1997.



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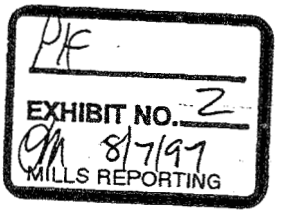

June 12, 1997

Susan Reinker, Esquire
Jacobson, Maynard, Tuschman & Kalur
Attorneys At Law
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114-1787

Dear Ms. Reinker:

As requested, I have reviewed the hospital records of Mr. Dewey Jones for his admission to Meridia Huron Hospital on 10-17-94. Also, I have reviewed the deposition transcripts of Peter Adamek, M.D. and Nicholas Sanchyshak, D.O., and reports from Drs. Greendyke, Kaplan, Greenhouse, Semigran, Kahn, Tompson, Orloff, Nearman, and Rapkin.

Mr. Jones was a 32 year old black male, when he was admitted to the Surgical Service with a chief complaint of headache and epigastric pain, after he was seen in the Emergency Department. In the Emergency Department, his blood pressure was 188/120, he was awake, coherent and in no acute distress. He was not diaphoretic and had unlabored respirations with clear bilateral breath sounds. A pulse oximeter reading was 99%. Laboratory data was unimpressive, except for an increase in alkaline phosphatase and bilirubin, indicating the possibility of some hepatic dysfunction. He was admitted to Dr. Badri's service. On admission, blood pressure had decreased to 180/110 and was reported as low as 13/92, earlier. Procardia 20mg p.o. was administered in the Emergency Department, prior to his admission to the hospital.

The admitting surgical resident noted a *history* of hypertension, congestive heart failure and S/P gun shot wound to the neck. Admission medications included Procardia, Capten, Lasix, nitroglycerin and digoxin. Physical examination revealed obesity (308 lbs.), clear lungs and regular heart beat. He had 2+ pitting edema of the extremities.

By the next day, his blood pressure had decreased slightly to 160/100 and Dr. Ho, an Internist who had treated the patient in the past, was consulted. A 2-D echocardiogram, to assess cardiac function, was planned. The next day, the 2-D echocardiogram still was planned. The bilirubin and alkaline phosphetase remained elevated. A laporascopic cholestectomy was planned for the next day. A chest x-ray revealed an enlarged heart, but no congestive heart failure.

Dr. Ho stated that the patient is ". . . well known by me from previous hospital admission in September.", noted the above and confirmed that lung fields were clear. He felt that the patient's blood pressure ". . is very well controlled now and should nat be a problem perioperatively." He also noted ". . . he has no clinical signs of congestive heart failure." Dr. Ho also noted the pending 2-D echocardiogram report and agreed with a pulmonary consultation, because of the patient's history of "sleep apnea." His note ended "He is medically cleared for

surgery." Dr. Ho suggested that the patient was intravascularly volume depleted and should receive some intravenous fluid, because of an orthostatic decline in blood pressure, which ranged from 130/90 to 116/80.

For the first time, an anesthesiologist saw the patient on the morning of the planned operative procedure at 8:00 a.m. Mr. Jones blood pressure was 162/100 and his lungs were clear to auscultation, bilaterally. A history of hypertension, congestive heart failure, sleep apnea and obesity were noted. The chest x-ray did not reveal congestive heart failure, but did reveal cardiomegaly. Dr. Adamek reviewed the preoperative evaluation and initialed the report.

The graphic record by Nursing contained blood pressure recordings of 182/98, 180/100, 168/90, 158/88, 128/94, 1281100, 132188, 140/100, and 162/100. The nursing assessment mentioned pedal edema Pulse oximetry was performed and the nurses noted a drop in saturation to 87 % when Mr. Jones was asleep, but with an immediate increase to 90 % upon his arousal.

The patient was anesthetized by Dr. Sanchyshak under attending supervision. The procedure was uneventful from 0900 H to approximately 1215 H, when anesthetic reversal began. Estimated blood loss was 450 ml and fluid replacement consisted of 2100 ml of crystalloid solution Pulse oximetry readings ranged from 99 to 100 %, until 1230 H, when the oximeter value decreased to 90 % while the patient breathed 100% oxygen, with controlled mechanical ventilation. At approximately 1315 H, the patient exhibited bradycardia with occasional PVC and a Code was called. Chest compression was conducted on three occasions, which lasted for 2 minutes, 2 minutes and 3 minutes, respectively. Atropine, epinephrine and Lasix were administered, with permanent return of pulse at 1325 H. Mr. Jones was tranferred to the Intensive Care Unit, where pulmonary artery pressure ranged &om 44 to 65/23 to 35, with a pulmonary artery occlusion pressure (PAOP) of 18 and 17. Cardiac output was 15.0 to 13.3 LPM. Cardiac index was greater than 5 LPM/M^2 most of the time. These values reveal a moderately elevated PAOP with a very high cardiac output, indicating fairly good left ventricular function, and confirming that earlier insertion of a pulmonary artery catheter would not have altered therapy, intraoperatively. The pulmonary hypertension is not unexpected in an obese individual, with a history of sleep apnea A chest x-ray in the Intensive Care Unit revealed diffuse pulmonary edema. The patient suffered severe hypoxic neurologic injury, from which he has not recovered.

Following review of the previously mentioned material, it is my opinion that:

1) Records exist, which were not made available to me and which were not available to the anesthesiologists conducting the preoperative evaluation, which document Mr. Jones longstanding history of congestive heart failure. The acceptable standard of care did not dictate that the anesthesiologist administering anesthesia to Mr. Jones review records of prior hospital admissions, prior to inducing a general anesthetic, because of the medical clearance provided by Dr. Ho. Prior to inducing general anesthesia, the anesthesiologist had no reason to question the

adequacy of the preoperative evaluation by Dr. Ho, who cleared the patient for surgery. There was no information in the patient's chart to suggest that delay of the procedure io obtain further consultation (for example, for cardiology), or other medical records, was indicated.

2) Intraoperative fluid administration tu Mr. Jones was appropriate, for this procedure. If anything, the patient may have required a larger infusion of crystalloid for replacement of extracellular sequestration. It is more likely than not that fluid administration played no significant role in Mr. Jones postoperative pulmonary edema.

3) When the pulse oximeter reading decreased, Dr. Sanchyshak was administering 100% oxygen by controlled mechanical ventilation to Mr. Jones. Further, such administration was facilitated by the administration of a muscle relaxant. Little eise could have been done by Dr. Sanchyshak, or Dr. Adamek, to improve oxygen saturation, at that time.

4) A pulmonary artery catheter was not mandated by the acceptable standard of care. Further, insertion of a pulmonary *artery* catheter, prior to induction of general anesthesia or during the conduct of the general anesthetic, would not have altered fluid therapy.

5) The attending supervision of Dr. Sanchyshak, a resident with nearly 16 months of anesthetic experience, was appropriate. There is no mandate €or the attending anesthesiologist to be physically present in the operating room, at all times, during the administration of an anesthetic to a patient scch as Mr. Jones.

6) Invasive monitoring (for example pulmonary artery catheterization, radial artery catheterization, transesophageal echocardiography, etc.) would have been acceptable for this procedure. However, such measures are not used routinely for laparoscopic or open cholestectomy *in* patients such as Mr. Jones and the acceptable standard of *care* does not dictate the necessity for such monitoring. Further, there is no evidence that such monitors would have altered the treatment administered, or the outcome.

7) When cardiorespiratory dysfunction became evident, Dr. Sanchyshak summoned Dr. Adamek, who responded rapidly and was in attendance in a very short time. He then supervised the resuscitation effort. Cardiopulmonary resuscitation was conducted appropriately, efficiently and effectively as evidenced by post-resuscitation cardiac function, which was documented to be adequate by pulmonary artery pressure monitoring and cardiac output measurement. Post-resuscitation *cerebral* dysfunction is common and not an indication of inappropriate resuscitation effort, or technique.

8) End-tidal carbon dioxide tension measurement and pulse oximeter readings indicated adequate ventilation, intraoperatively. Postoperatively, mechanical ventilation and oxygen therapy were such that oxygenation always was acceptable and adequate. Relative hypoventilation with slightly increased carbon dioxide tension was of no physiologic consequence.

It is my opinion that Dr. Adamek did not deviate from an acceptable standard of care in his care and treatment of Mr. Dewey Jones, *at* any time. Further, it is my opinion that Mr. Jones suffered from an acute onset of pulmonary edema with right-to-left interpulmonary shunting of blood and arterial hypoxemia, upon recovering from anesthesia. Etiologic factors which may be responsible for such events *are* manifold and complex. Clearly, hypoxemia secondary to right-to-left interpulmonary shunting *of* blood and pulmonary edema may occur *in* the absence of negligent medical *care,* which was the *case* with Mr. Jones on 10-20-94.

Sincerely yours,

John B. Downs, M.D.

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RE: Harvey Jones
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