

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

SEFEDIN AMIDI, etc.,  
et al.,

Plaintiffs,

-vs-

JUDGE GALLAGHER  
CASE NO. 493065

WILLIAM FALLON, JR., M.D.,  
et al.,

Defendants.

- - - -

Deposition of WILLIAM F. FALLON, JR., M.D.,  
taken as if upon cross-examination before Juliana  
M. Lawson, a Notary Public within and for the  
State of Ohio, at MetroHealth Medical Center  
Legal Department, 2500 MetroHealth Drive,  
Cleveland, Ohio, at 2:15 p.m. on Tuesday, July 8,  
2003, pursuant to notice and/or stipulations of  
counsel, on behalf of the Plaintiffs in this  
cause.

- - - -

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SCANNED  
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On behalf of the Plaintiffs;

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On behalf of the Defendants.

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E X H I B I T I N D E X

EXHIBIT MARKED

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1                    WILLIAM F. FALLON, JR., M.D., of lawful  
2                    age, called by the Plaintiffs for the purpose of  
3                    cross-examination, as provided by the Rules of  
4                    Civil Procedure, being by me first duly sworn, as  
5                    hereinafter certified, deposed and said as  
6                    follows:

7                    CROSS-EXAMINATION OF WILLIAM F. FALLON, JR., M.D.

8                    BY MR. CONWAY:

9                    - - - - -

10                    (Thereupon, Plaintiffs' Exhibits A  
11                    and B were marked for purposes of  
12                    identification.)

13                    - - - - -

14                    Q.    Doctor, my name is Tom Conway.    I represent the  
15                    estate of Royanne Amidi.    I'm going to be taking  
16                    your deposition today.

17                    Have you previously given a deposition?

18                    A.    Yes.

19                    Q.    Approximately how many times?

20                    A.    Five.

21                    Q.    I'd like to go over just a few procedural rules  
22                    before we begin.    I'm going to be asking you  
23                    questions regarding your knowledge of this case.  
24                    I don't want you to answer any question you don't  
25                    understand.    If you don't understand a question,

1           have me repeat it or somehow indicate you don't  
2           understand. I'll be glad to rephrase it. Okay?

3   A. That's fine.

4   Q. If you do answer a question, I'm going to assume  
5           and rely upon the fact that you understood the  
6           question. Is that fair?

7   A. That's fair.

8   Q. If at any time you want to take a break in the  
9           deposition to speak with your attorney who is  
10          seated right here or for any other matter, just  
11          let us know on the record and I'll be glad to  
12          take a break.

13   A. Thanks.

14   Q. If at any time you want to talk to your attorney  
15          regarding anything, feel free to do so.

16   A. Yes.

17   Q. If any time you want to amend, subtract, delete,  
18          supplement any answer you have previously given,  
19          feel free to do so. Let us know and you can go  
20          on the record and put whatever you want on the  
21          record.

22   A. All right.

23   Q. And you understand your deposition, your  
24          testimony is being taken down by the court  
25          reporter. It's under oath. It has the same

1 legal significance as if you were in front of a  
2 judge and jury. Do you understand that?

3 A. I understand that.

4 Q. You have had an opportunity to speak to your  
5 attorney prior to this deposition; is that  
6 correct?

7 A. I have.

8 Q. You have had an opportunity to review the chart  
9 of Royanne Amidi prior to this deposition. Would  
10 that be correct?

11 A. Yes.

12 Q. If at any time you want to refer to the medical  
13 records your attorney has in front of him, feel  
14 free. I'm not going to be looking at any notes.  
15 Feel free to look at whatever you need to look  
16 at.

17 Doctor, are you a member of any trauma  
18 surgeon and/or critical care organizations?

19 A. Yes, I am.

20 Q. Approximately how many?

21 A. I would say I belong to three organizations that  
22 are related to trauma. One of which is related  
23 to critical care.

24 Q. Do the memberships in these organizations provide  
25 you an opportunity to receive and exchange useful

1 information with your colleagues who practice in  
2 that same area of specialization?

3 A. Yes.

4 Q. Do those organizations issue guidelines which you  
5 find reasonable and prudent and help you in your  
6 practice of medicine within those areas of  
7 specialization?

8 A. Those organizations, one of those organizations  
9 is a leader in the provision of guidelines.

10 Q. Which organizations?

11 A. That would be East.

12 Q. These different organizations will promulgate  
13 guidelines or protocols that you would find  
14 useful in your practice of medicine. Would that  
15 be correct?

16 A. Yes.

17 Q. Have you ever been an officer in any of these  
18 different organizations?

19 A. Yes.

20 Q. For instance, which organization, what type of  
21 officer?

22 A. I was president of East.

23 Q. And during what years?

24 A. I don't recall. It's on my CV.

25 Q. That's fine. Were you active in all these

1 organizations?

2 A. Yes.

3 Q. Did you find it useful in your practice of  
4 medicine to be active in these organizations?

5 A. Yes.

6 Q. You're a member of the American College of  
7 Surgeons?

8 A. Yes.

9 Q. Are you familiar with their recommendations  
10 regarding bariatric surgery?

11 A. Yes.

12 Q. Are you a member of the International Community  
13 of Bariatric Surgeons?

14 MR. MALONE: The international  
15 community? Do you mean in the loose  
16 setting or is there some specific  
17 organization?

18 MR. CONWAY: There's an  
19 organization.

20 A. No, I'm not.

21 Q. Are you a member of the American Society for  
22 Bariatric Surgery?

23 A. Not presently.

24 Q. Are you a member of the American Organization of  
25 Bariatric Surgeons?



1 A. No.

2 Q. How long have you been performing bariatric  
3 surgery?

4 A. In its various aspects, since I was a resident in  
5 surgery. And that dates back to 1976.

6 Q. How about roux-en Y gastric bypass operation?

7 A. That operation is a relatively newer operation  
8 and I started doing that in 1996. I think. Yes.  
9 1996.

10 Q. Are you a member of any association or  
11 organization of bariatric surgeons?

12 A. No.

13 Q. Have you applied to become a member of any of  
14 those organizations?

15 A. Yes.

16 Q. Which ones have you applied to become a member  
17 of?

18 A. The American Society of Bariatric Surgery.

19 Q. When did you first apply to become a member  
20 there?

21 A. Several years ago.

22 Q. Why aren't you a member, if you know?

23 A. You need two recommendations from other bariatric  
24 surgeons and I didn't know anybody who belonged  
25 to the organization.

1 Q. When did you first put your application in?

2 A. I don't remember.

3 Q. Do you know two members now of that?

4 A. I know one.

5 Q. Who is that?

6 A. That's a person who is in practice in Wisconsin  
7 who is a colleague of mine in the trauma --  
8 committee on trauma.

9 Q. Are there any type of tests or boards that you  
10 have to take in order to become a member of the  
11 American Society of Bariatric Surgeons?

12 A. To my knowledge, no.

13 Q. Why do you feel it beneficial for you to become a  
14 member of that organization?

15 A. To communicate with colleagues who are doing this  
16 operation, who are taking care of patients who  
17 are bariatric surgery patients.

18 Q. So the only reason you are not a member is you  
19 need two members to sponsor you into that  
20 organization?

21 A. That's correct.

22 Q. Any other organization or society or association  
23 of bariatric surgeons you've attempted to join?

24 A. No.

25 Q. Have you attended any type of continuing medical

1 education training regarding bariatric surgeries?

2 A. No.

3 Q. Have you considered doing so?

4 A. No.

5 Q. Why not?

6 A. I'm not quite sure I understand what you're  
7 asking.

8 Q. Well, different organizations put on training or  
9 educational seminars to help bariatric surgeons  
10 become better at what they do. You're aware of  
11 that?

12 A. Yes.

13 Q. For instance, all those different organizations  
14 have conferences and teaching seminars, you're  
15 aware of that?

16 A. That's correct.

17 Q. My question is you've indicated that you've never  
18 attended any type of continuing medical  
19 education, training seminar regarding bariatric  
20 surgery. And I'm just asking why not?

21 A. Well, it's been part of my practice, the scope of  
22 my practice as a surgeon, a critical care surgeon  
23 for the last 25 years.

24 Q. Have you mentored under anyone or have you had a  
25 mentor in the area of bariatric surgery?

1 A. No.

2 Q. You are the chief of the bariatric surgery  
3 division at MetroHealth Medical Center?

4 A. I'm one of the two people who do bariatric  
5 surgery at the MetroHealth Medical Center. We  
6 don't have a specific division. It's part of the  
7 division of trauma, critical care, burns and  
8 flight.

9 Q. Who is the other physician that does those  
10 surgeries?

11 A. Dr. Gagliardi.

12 Q. How long has Dr. Gagliardi been performing those  
13 surgeries?

14 A. I don't know the answer to that. He was a  
15 resident in surgery at Ohio State and learned how  
16 to do bariatric surgery as part of his residency,  
17 as did I. And so I assume he's been doing that  
18 for the time he's been a resident in surgery.  
19 He's been a member of our faculty for the last  
20 three years.

21 Q. If there was a senior physician, would it be you  
22 or Dr. Gagliardi?

23 A. I'm the senior physician.

24 Q. Does Dr. Gagliardi have more experience in  
25 bariatric surgery than you?

1 A. No.

2 Q. Is he a member of any of these bariatric surgeon  
3 organizations, to your knowledge?

4 A. I don't know the answer to that.

5 Q. Have you ever spoken with him regarding that  
6 subject?

7 A. Which?

8 Q. Joining a --

9 A. Oh, yes. We're both trying to become members.  
10 The American Society of Bariatric Surgery and it  
11 has to do with, again, having people who you know  
12 who recommend you and write a letter.

13 Q. Are you familiar with the National Institute of  
14 Health guidelines for treating obesity?

15 A. Yes.

16 Q. Do you find those guidelines to be reasonable and  
17 prudent?

18 A. Yes.

19 Q. Have you read any of the guidelines or literature  
20 that has been generated by the American Society  
21 of Bariatric Surgeons?

22 A. I've read some of their literature, yes.

23 Q. Have you read any of their guidelines?

24 A. I don't believe so.

25 Q. Are you familiar with the Cleveland Center for

1           Bariatric Surgery located at St. Vincent Charity  
2           Hospital?

3       A.   Yes.

4       Q.   Do you know any of the physicians there?

5       A.   Not personally, no.

6       Q.   In the community, what is the reputation of the  
7           Cleveland Center for Bariatric Surgery, if you  
8           know?

9       A.   I can tell you what I do know about the Cleveland  
10           Center for Bariatric Surgery and that is that  
11           they don't take care of Medicaid patients because  
12           all of their Medicaid patients are referred to  
13           me. That's what I know about their practice.

14      Q.   Do you know their practice or level of competency  
15           regarding the performing of -- performance of  
16           bariatric surgery and the treatment of obese  
17           patients?

18      A.   No.

19      Q.   Do you know a Dr. Helmut Schreiber?

20      A.   I know of him. I know his name.

21      Q.   What do you know his reputation to be in the  
22           community?

23      A.   I have no opinion about that.

24      Q.   How about Dr. I.M. Sonpal, S-O-N-P-A-L. Do you  
25           know that doctor or have you heard of him?

1 A. No.

2 Q. You are aware that Dr. Helmut Schreiber is the  
3 director of surgery for Cleveland Bariatric  
4 Surgery at St. Vincent?

5 A. No, I wasn't aware of that.

6 Q. I assume prior to performing your surgery on  
7 Royanne Amidi, were you aware the doctors at the  
8 Center for Bariatric Surgery determined that  
9 Royanne Amidi was not a good surgical candidate  
10 and, in fact, refused to perform bariatric  
11 surgery on her?

12 A. No, I was not aware of that.

13 Q. Is that something that would have been useful  
14 information for you to be aware of prior to your  
15 surgery on March 22nd?

16 A. I don't know the answer to that question.

17 Q. Were you aware, Doctor, that Royanne Amidi had  
18 consulted with physicians at the Cleveland Center  
19 for Bariatric Surgery prior to coming to you?

20 MR. MALONE: Did you provide this  
21 information in response to our discovery  
22 interrogatories about other healthcare  
23 providers? Because this is all news to me.  
24 This was specifically asked where else had  
25 she been and I've never heard any of this.

1 Was that given to us in response to  
2 discovery?

3 MR. CONWAY: I don't know if it  
4 was or not, Jim. Donna put together this  
5 line of questions.

6 MR. MALONE: I think this line of  
7 questioning is inappropriate if not having  
8 disclosed this information to us in  
9 advance, but I'm going to permit you to  
10 continue. But I remind if you have records  
11 from this place, I'm entitled to them.

12 MR. CONWAY: I assumed -- and I'm  
13 apologize if not -- the entire records were  
14 given to you. That's my way of doing it.

15 THE WITNESS: I'd like to go off  
16 the record, if we could, and take a break.

17 MR. CONWAY: Sure.

18 - - - -

19 (Thereupon, a recess was had.)

20 - - - -

21 MR. CONWAY: I've checked through  
22 my office regarding our discovery  
23 responses. We did provide the names of the  
24 medical providers which I'm asking Dr.  
25 Fallon about. Apparently, Mr. Malone is



1           indicating that he did not receive actual  
2           records from St. Vincent Charity Hospital,  
3           but you did receive them from Tri-City.

4           MR. MALONE: I have those, but I  
5           can't honestly tell you if they came from  
6           you. Portions of those records were in Dr.  
7           Fallon's file.

8           MR. CONWAY: What I would do is  
9           get you a complete copy of all the records  
10          I have here so you have everything.

11          MR. MALONE: All right.

12                       - - - -

13                       (Thereupon, a discussion was had off  
14                       the record.)

15                       - - - -

16                       (Thereupon, the requested portion of  
17                       the record was read by the Notary.)

18                       - - - -

19          A. I don't believe I was.

20          Q. Would that be information that you would want to  
21              know about?

22          A. Yes.

23          Q. Did you ask Royanne Amidi whether or not she had  
24              consulted with any other bariatric surgeon prior  
25              to coming to you?

- 1 A. No, I didn't.
- 2 Q. Why not?
- 3 A. I don't know. I don't usually ask that question.
- 4 Q. Royanne's bariatric surgery was elective surgery,
- 5 correct?
- 6 A. That's correct.
- 7 Q. Meaning she didn't need to immediately have that
- 8 surgery, right?
- 9 A. It was not an emergency, if that's what you are
- 10 saying.
- 11 Q. So it did not have to be done on March 22nd or
- 12 even March 30th, correct?
- 13 A. That's correct.
- 14 Q. Prior to performing surgery, were you aware that
- 15 she had an infection which she was being treated
- 16 with an antibiotic Cephalexin,
- 17 C-E-P-H-A-L-E-X-I-N, 500 milligrams, at the time
- 18 you operated on her?
- 19 A. I was aware she had cellulitis and I was under
- 20 the impression it had resolved.
- 21 Q. My question was were you aware that she was at
- 22 the time of your surgery still taking her ten-day
- 23 course of antibiotics which had been started on
- 24 March 15th?
- 25 A. No, I was not aware of that.

1 Q. Would that have been information you would have  
2 wanted to know about prior to your surgery?

3 A. Yes.

4 Q. Did you take a history and physical from your  
5 patient prior to operating on her?

6 A. Yes.

7 Q. Did you ask her whether she was on any type of  
8 antibiotic?

9 A. I don't believe I asked her that question  
10 specifically.

11 Q. Is that a question that a reasonable and prudent  
12 surgeon should ask his patient?

13 A. That she's on antibiotics?

14 Q. Whether or not the patient is on antibiotics.

15 A. Yes.

16 Q. Had you known that she was still taking her  
17 ten-day course of antibiotics that were started  
18 on March 15th, 2002, would you have postponed  
19 your surgery?

20 A. Yes.

21 Q. And why would you have done that?

22 A. Because of the risk of infection associated with  
23 that.

24 Q. What type of different bariatric surgeries are  
25 available for a patient such as Royanne Amidi?

1           You chose the roux-en Y gastric bypass?

2       A.   That's correct.

3       Q.   What other type of gastric surgeries are  
4           available for an obese patient such as Royanne  
5           Amidi?

6       A.   There probably is no other operation that is as  
7           good for weight loss for her condition.

8       Q.   Are there some other type procedures that are  
9           available?

10      A.   Yes, there are others available.

11      Q.   Do you perform any of those?

12      A.   No.

13      Q.   Have you ever performed any of those?

14      A.   Yes.

15      Q.   Which ones have you performed other than the  
16           roux-en Y gastric bypass?

17      A.   The vertical banded gastroplasty was surgery of  
18           choice in the late '80s, early '90s.

19      Q.   Did you ever perform that?

20      A.   Yes.

21      Q.   How many times approximately?

22      A.   I don't remember. Prior to that there was an  
23           operation that was the predecessor to the  
24           vertical banded gastroplasty. And it involved  
25           stapling against the proximal portion of stomach

1 and was -- either created a small opening into  
2 the stomach or created a roux-en. Those were the  
3 original of those restrictive procedures. I  
4 performed those when they were en vogue.

5 Some people do laparoscopic procedures. This  
6 procedure laparoscopically I do not. I do it  
7 open because I like to be able to visualize the  
8 area I'm operating on. There are more complex  
9 operations, but for a risk benefit ratio they  
10 don't achieve any more advantage from a weight  
11 loss perspective.

12 Q. What was your understanding -- let me go back.  
13 What was your understanding, if any, of the  
14 infection for which Royanne Amidi was being  
15 treated with antibiotics at the time of her  
16 surgery?

17 A. My understanding was that she had had an episode,  
18 she had had cellulitis and that it had been  
19 treated.

20 Q. Who did you gain that information from?

21 A. I don't recall.

22 Q. But you did not ask Royanne Amidi whether or not  
23 she was still taking antibiotics, correct?

24 A. No. My question specifically to her the week of  
25 surgery was has there been any change in your

1           medical condition.

2       Q.   And when was that question asked of her?

3       A.   We bring -- the Monday before she was operated  
4           on.   In her clinical visit, the Monday before she  
5           was operated on.

6       Q.   And that change would be relative to what prior  
7           date, when you are asking has there been any  
8           change in your medical condition?

9       A.   This whole process of getting these patients  
10           ready for the surgery and approved for surgery  
11           can take quite some time from the moment when we  
12           first see the patients and judge them appropriate  
13           candidates until the time when we actually get  
14           them back in to do their operation.   So we've  
15           taken it upon ourselves to bring them in the week  
16           of their surgery in order to assure ourselves  
17           their health status is stable and hasn't  
18           deteriorated.   There was a number of things she  
19           was required to do, including stop smoking, and I  
20           wanted to make sure those things had happened.

21      Q.   Do you have an opinion as to whether Royanne  
22           Amidi was a compliant patient?

23      A.   Yes, I do have an opinion.

24      Q.   What is your opinion?

25      A.   She wasn't.

1 Q. She was not?

2 A. That's correct.

3 Q. And in what specific ways was she non-compliant?

4 A. She told me that she had stopped smoking. I  
5 don't do this operation on people who are smokers  
6 because of the risks associated with that. And  
7 she knew that from the very beginning and she  
8 told me that she had stopped smoking.

9 Q. How do you know she did not stop smoking?

10 A. I don't know that for a fact, but everybody else  
11 has documented that she was a smoker. Her  
12 physical examination at the time of her admission  
13 to the hospital says that she was a smoker.

14 Q. And if you don't operate on smokers, why was she  
15 allowed to go to the surgery then?

16 A. I was not aware that she was still smoking. She  
17 told me that she wasn't.

18 Q. But yet, according to the records, you're  
19 indicating that she told other people that she  
20 was currently smoking?

21 A. That's correct. That's correct.

22 Q. Is that rule that you have about not doing this  
23 operation on patients who smoke, has that been  
24 communicated to your staff at the bariatric --  
25 your bariatric staff here at Metro?

1 A. Yes.

2 Q. Should your nurses or physician assistants or  
3 residents, whoever took that information, should  
4 they have conveyed that information to you?

5 A. That's correct.

6 Q. Would that be below the standard of care for them  
7 if they did not convey that information to you?

8 A. It would be troublesome. Yes, it would be.

9 Q. It would be below the standard of care, right?

10 A. It would be troublesome.

11 Q. Troublesome is not a good thing, is it?

12 A. No, it's not.

13 Q. All right. In what other ways do you believe  
14 that Royanne Amidi was not compliant?

15 A. She gained weight between the time that we saw  
16 her and the time that we operated on her.

17 Q. And she was told not to?

18 A. That's a -- that's a worrisome sign because  
19 people don't -- people who are not willing to --  
20 they are aware of a diet that they are supposed  
21 to be on before they're operated on. One of the  
22 things we do is send them to a nutritionist. The  
23 nutritionist talks to them about low carb, low  
24 fat diets, how to calculate the percentage of  
25 calories from fat. They're all instructed in



1           this and they're instructed in the methodologies  
2           for doing this. And what we see as a result of  
3           that is that people's weight actually decreases  
4           before we operate on them.

5       Q. But you would have been aware that she put on  
6           weight prior to your surgery, correct?

7       A. I should have been, yes. I was not.

8       Q. How do you know for sure that she did put on  
9           weight prior to surgery?

10      A. The weight from the first visit and the weight  
11          from her visit in the week that she came in.

12      Q. Who would have taken her weight during that visit  
13          in the clinic?

14      A. The nurses would have.

15      Q. Should the nurses have communicated her weight  
16          gain to you?

17      A. Yes.

18      Q. And obviously that would be another standing  
19          order you would have for your staff at the --  
20          your bariatric staff?

21      A. That's correct.

22      Q. Would that be below the standard of care for  
23          those nurses not to communicate her weight gain  
24          to you?

25      A. Yes.

1 Q. What other ways was Royanne Amidi non-compliant?

2 A. I don't believe I know of any other ways.

3 Q. Had you known that she had gained weight, would  
4 you have operated on her on March 22nd?

5 A. Possibly, but I would have wanted to know what  
6 the circumstances were that were related to the  
7 weight gain.

8 Q. Had you known that she was still smoking,  
9 according to whatever records you looked at,  
10 would you have still performed that operation  
11 upon her on March 22nd?

12 A. No, I would not.

13 Q. Why not?

14 A. Because of the implications for her health after  
15 the surgery. This is an operation that decreases  
16 your ability to breathe normally because of the  
17 pain that's associated with the incision. And  
18 her obesity also decreases her ability to breathe  
19 normally. That's already -- that's not going to  
20 go away in the five or six hours after the  
21 operation. And she has a history of reactive  
22 airway disease, which also is a troublesome  
23 factor in her healthcare system.

24 Q. Is anyone in the bariatric clinic here at Metro  
25 responsible for getting a list of medications

1           that the patient is taking prior to surgery?

2       A.   Not anybody in the bariatric center, no.

3       Q.   Who is responsible for finding out whether or not  
4           a patient is on antibiotics, such as Royanne  
5           Amidi?

6       A.   The people who are in the presurgical evaluation  
7           area.   So everybody who was in operation would go  
8           through the presurgical evaluation area and they  
9           would be responsible for determining that.

10      Q.   Do they have a duty to report the fact that a  
11          patient is currently on antibiotics?

12      A.   Yes.

13      Q.   Did any of these people report that fact to you?

14      A.   No.

15      Q.   Would those people in the presurgical area be  
16          below the standard of care if they failed to ask  
17          Royanne Amidi whether or not she was on  
18          antibiotics?

19      A.   Yes, they would be.

20      Q.   Would they be below the standard of care if they  
21          failed to report to you that she was on  
22          antibiotics?

23      A.   Yes.

24      Q.   Do you know who ordered the Heparin discontinued?  
25          You can look at whatever chart you want to.   She

1           was put on Heparin at one point because there was  
2           a concern she may be suffering from a pulmonary  
3           embolism; is that correct?

4   A.   That's correct.

5   Q.   There then came a point in time when the Heparin  
6           was discontinued?

7   A.   I will -- I ordered that.

8   Q.   What time did you order that discontinued?

9   A.   I don't recall.

10   Q.   Can you look at the chart and piece together on  
11           what date or what time you would have issued that  
12           order that Royanne's Heparin be discontinued?

13   A.   The Heparin drip was discontinued on 3-24-02 at  
14           0945. I don't know whose signature this is.  
15           It's not my signature.

16   Q.   Is it a resident of yours?

17   A.   I don't know.

18   Q.   Would that Heparin have been discontinued with  
19           your approval?

20   A.   Yes.

21   Q.   By the way, you were Royanne Amidi's surgeon in  
22           this case, correct?

23   A.   That's correct.

24   Q.   And you were also her attending physician during  
25           her hospitalization between March 22nd and March

1 26th, the time of her death?

2 A. That's correct.

3 Q. So you would have been the physician who was  
4 responsible for her overall care and treatment;  
5 is that correct?

6 A. That's correct.

7 Q. Obviously, you would have the ability to bring in  
8 experts or consultants in certain areas of  
9 medicine if you so chose to, correct?

10 A. That's correct.

11 Q. And you could choose whether or not to defer to  
12 their expertise in a certain area; is that  
13 correct?

14 A. That's correct.

15 Q. But ultimately her care and treatment is your  
16 responsibility; is that right?

17 A. That's correct.

18 Q. Did you have residents working under you at the  
19 time as well?

20 A. Yes.

21 Q. Approximately how many residents were working  
22 under you?

23 A. I don't know the answer to that.

24 Q. Are you familiar with the residents' signatures  
25 from --

1 A. I'm not familiar with that signature, no.

2 Q. As of the time the Heparin was discontinued  
3 at 9:45 a.m. on March 24th, what was your  
4 differential diagnosis as to Royanne Amidi's  
5 condition?

6 A. I'd have to look at the medical record to see  
7 if --

8 Q. Please, look at whatever you like. I need to  
9 know.

10 MR. MALONE: Do you want notes?

11 THE WITNESS: Progress notes.

12 Yes.

13 A. Well, I have a note that is written 20 minutes  
14 later.

15 Q. What time is that note timed?

16 A. It's 20 minutes later. 1005.

17 Q. And what does that note say, Doctor?

18 A. It says, "Seen on rounds. Interval events  
19 reviewed and agree. Issues, awake and alert  
20 despite hypotension and tachycardia. ABG, which  
21 stands for arterial blood gas, 7.37. pCO2 of 44.  
22 pO2 of 78. Bicarb of 25. Hemodynamically  
23 consistent with hypovolemia. Has been tachy to  
24 150 since last p.m. Blood pressure decreased.  
25 Hematocrit in the morning of 36.6. GI, minimal

1 NG output. GU, minimal output. VQ scan isn't  
2 consistent with PE. Input ABG this a.m., pCO2 of  
3 58. PO2 of 77. HCO3, 24.9. HCT, hematocrit,  
4 34. Chest x-rays. Small left pleural effusion.  
5 Assessment, respiratory compromise.  
6 Hypoventilation. Asthma and smoking. Reactive  
7 airway disease. Would probably benefit from  
8 BIPAP."

9 Q. What is BIPAP?

10 A. It's a pressure, a non-intubated pressure  
11 ventilation mode. "Hypovolemia. Question  
12 etiology. Responding to volume and will start  
13 blood. Plan, pulmonary consult vis-a-vis  
14 management. CPAP/BIPAP, consider intubation.  
15 Volume resuscitation, including blood. Intensive  
16 care monitoring. Condition critical."

17 Q. And so after reading your note, what did you feel  
18 was causing her hypotension, tachycardia, her  
19 overall condition?

20 A. I didn't know what was causing her hypotension  
21 and tachycardia at that particular point in time.  
22 I thought she was hypovolemia.

23 Q. What do you think was causing that?

24 A. I didn't know.

25 Q. Would you agree that the most common cause of

1 death from roux-en Y gastric bypass surgery are  
2 infection secondary to staple line suture leaks,  
3 respiratory problems and pulmonary embolism?

4 A. Which are you talking about?

5 Q. That those are the --

6 A. Big three?

7 Q. Yes.

8 A. Yes.

9 Q. And that those three causes of death are  
10 recognized and well-known risks of roux-en Y  
11 gastric bypass surgery. Would you agree with  
12 that?

13 A. That's correct.

14 Q. Would you agree the most common life-threatening  
15 post-surgery complication is the leaking of  
16 gastrointestinal fluids from sutured or stapled  
17 surgical connections?

18 A. Would you repeat that again?

19 Q. Yes. Would you agree the most common  
20 life-threatening post-surgery complication is the  
21 leaking of gastrointestinal fluids from sutured  
22 or stapled surgical connection lines?

23 A. I would have to agree with that.

24 Q. Would you agree that if those complications are  
25 not immediately addressed, they may cause serious



1 infection, peritonitis, abscess and death?

2 A. Yes.

3 Q. Do you agree with leakage also occurring from one  
4 of those sites, whether sutured or stapled,  
5 increased pain, back pain and left shoulder pain,  
6 increased anxiety and restricted breathing are  
7 all telltale symptoms of a leak?

8 A. I'm sure you can see those, but I wouldn't say  
9 they are telltale symptoms.

10 Q. What causes the -- what causes left shoulder  
11 pain?

12 A. It's referred pain. It's diaphragmatic  
13 irritation.

14 Q. You're aware of that as a surgeon, correct?

15 A. Yes.

16 Q. Would you agree that an individual who has  
17 sustained a leak from the site of sutures or  
18 stapling, that leak can often be diagnosed by a  
19 plain x-ray film?

20 A. No, it would not. I think it's very difficult to  
21 diagnose that by plain x-ray film.

22 Q. Well, if there's a leak, you're going to end up  
23 with free air, correct? And that would show up  
24 on an x-ray film?

25 A. Not necessarily.

1 Q. Does it show up on an x-ray film?

2 A. Free air shows up on an x-ray film. But you're  
3 making the cause-and-effect relationship that a  
4 leak is going to cause free air is not  
5 necessarily the case.

6 Q. Does it often cause free air?

7 A. It can. I don't know if it causes it with any  
8 degree of frequency. I've only had a couple of  
9 leaks.

10 Q. And how were those leaks diagnosed?

11 A. They were diagnosed by gastrografen swallows.

12 Q. And, in fact, that's one of the major diagnostic  
13 tools if a surgeon suspects a leak is to --

14 A. Correct.

15 Q. Is to perform that test?

16 A. Some of us do it routinely.

17 Q. First of all, was an abdominal x-ray considered  
18 by you in this particular case?

19 A. No.

20 Q. Was a gastro --

21 A. Grafen swallow.

22 Q. Considered by you?

23 A. No.

24 Q. Why?

25 A. No. Because in my opinion, this was not the --

1           that was not the etiology of her problems. It  
2           doesn't usually present this soon after major  
3           surgery. It usually -- after this kind of  
4           surgery, it usually occurs four, five, six days  
5           later.

6       Q.   What do you base that on?

7       A.   Past experience.

8       Q.   Have you had patients who have leaked before?

9       A.   Yes.

10      Q.   How many patients have you had leak within a day  
11           or two following your surgery?

12      A.   None.

13      Q.   So this would be the first?

14      A.   If this, indeed, was a leak, this would be the  
15           first. It would be highly unusual in my  
16           experience.

17      Q.   Do you know what the medical literature says  
18           regarding the frequency of the leaks following  
19           roux-en Y gastric bypass surgery?

20      A.   I can't say that I know that.

21      Q.   Would that be something important for you to know  
22           the rate of frequencies of those in deciding what  
23           your differential diagnosis should be should a  
24           patient start presenting with symptoms such as  
25           Royanne Amidi?

1 A. No. It's part of the overall differential  
2 diagnosis, but you worry about different things  
3 at different times.

4 Q. Would you agree that more likely than not Royanne  
5 Amidi died of progressive sepsis and the  
6 resultant cardiopulmonary collapse?

7 A. Yes.

8 MR. MALONE: I'm going to show an  
9 objection. There is no autopsy in this. I  
10 don't know how you can know anything with  
11 any probability.

12 Q. Would you agree with that?

13 A. Yes.

14 Q. And sepsis, what was the base cause of her  
15 sepsis?

16 A. In my opinion, it was her cellulitis.

17 Q. What would be the mechanism for her cellulitis  
18 causing this progressive sepsis?

19 A. Bacteremia.

20 Q. And what in the medical records or labs do you  
21 point to that would explain how her cellulitis  
22 caused bacteremia and then led to her sepsis and  
23 death?

24 A. We have evidence in the blood cultures that she  
25 had heavy growth of grand positive organisms in

1 the bloodstream.

2 Q. Would those be consistent with a wound infection  
3 or a leak at the site of your anastomosis?

4 A. Which?

5 Q. Either one of them.

6 A. Neither.

7 Q. Neither. What would you expect if there was a  
8 wound infection or a leak at the site of the  
9 anastomosis?

10 A. Different types -- well, different types of  
11 organisms if the GI tract was leaking and a  
12 positive culture from the wound if it was a wound  
13 infection.

14 Q. Could you still have a wound infection with a  
15 negative culture?

16 A. It's possible.

17 Q. Could you have a wound infection with a negative  
18 culture in light of the fact that antibiotics  
19 might have been started before the culture was  
20 taken?

21 A. It's possible.

22 Q. Would you agree that more likely than not Royanne  
23 Amidi was also suffering from an intra-abdominal  
24 source of sepsis?

25 A. No.

1 Q. What leads you to the conclusion that she wasn't?

2 A. I have no evidence to document that that indeed  
3 was the case based on my clinical evaluation of  
4 the patient at the time.

5 Q. If, in fact, according to your belief that that  
6 was sepsis caused by bacteremia as a result of  
7 her preexisting cellulitis, those conditions  
8 would still be your responsibility to treat  
9 during her hospitalization for her surgery,  
10 correct?

11 A. Yes.

12 Q. Would you agree to minimize morbidity and  
13 mortality related to leak it's imperative to  
14 recognize a leak can occur after any gastric  
15 bariatric operation?

16 A. Yes.

17 Q. And I believe you already hit on this. It then  
18 becomes the obligation of the surgeon to perform  
19 a gastrografen swallow when a leak is suspected,  
20 correct?

21 A. Correct. I told you that some of us do that  
22 routinely.

23 Q. Do you do it routinely?

24 A. Yes.

25 Q. Was it done in this case?

1 A. She didn't make it to the point where I do it  
2 routinely.

3 Q. When do you?

4 A. Day five.

5 Q. Day five?

6 A. Day five.

7 Q. Is that written down anywhere? Do you have that  
8 in any type of written protocol?

9 A. I don't know. I don't believe so.

10 Q. Do you have written protocols for the bariatric  
11 unit, whether it just be you and your doctor,  
12 that you would give to your staff?

13 A. No. We have -- yes, we do have some basic rules  
14 and regulations that are written down, but  
15 nothing that specifies the specific aspects of  
16 patient care.

17 Q. What are the basic rules, basically, that are  
18 written down? Just give me an example. I'll ask  
19 your attorney for them. I think I've already  
20 asked for them. But give me a flavor for what we  
21 are talking about.

22 A. The screening criteria for preoperative  
23 preparation. The mechanisms that we go through  
24 for contacting all the different specialists who  
25 need to see the patient and make sure that they

1           are okay to have an operation. And then the  
2           routines for how we see the patients before we  
3           operate on them and then day of surgery routines.

4   Q. And you do have those in writing?

5   A. I believe so.

6   Q. Are those issued by you and Dr. Gagliardi or by  
7       MetroHealth?

8   A. They're from our office.

9   Q. I'd like to show you what has been marked for  
10       identification as Plaintiff's Exhibit A. That's  
11       the death certificate that you signed in this  
12       case, correct?

13   A. That's correct.

14   Q. You've signed death certificates before, correct?

15   A. Yes.

16   Q. You are familiar with how they were filled out?

17   A. Yes.

18   Q. In this particular case, you list in box 30a, the  
19       immediate cause of death was cardiac pulmonary  
20       failure?

21   A. That's correct.

22   Q. Why didn't you list a baseline cause underneath  
23       cardiac pulmonary failure in boxes a, b or d?

24   A. I don't know.

25   Q. Isn't that something you should do?



1 A. Yes.

2 Q. Is that your handwriting, cardiopulmonary  
3 failure?

4 A. No, it is not.

5 Q. Whose handwriting is that?

6 A. I don't know.

7 Q. This is your handwriting up here?

8 A. That's my signature, yes.

9 Q. Is it supposed to be the physician who is signing  
10 that who fills out the cause of death?

11 A. Yes.

12 Q. And that was not done in this case, was it?

13 A. No.

14 Q. Showing you what has been marked for  
15 identification as Plaintiff's Exhibit B. In  
16 reviewing this case prior to trial -- excuse me.  
17 Strike that. In reviewing the records prior to  
18 this deposition, I presume you came across this  
19 radiology report?

20 A. Yes.

21 Q. It indicates that on March 23rd, 2002 at 8:38  
22 p.m. a lung perfusion scan was done, correct?

23 A. Yes.

24 Q. And would Dr. Tandon had been a resident under  
25 your supervision at that time?

1 A. Yes.

2 MR. MALONE: Tandon you said?

3 MR. CONWAY: He's at the top.

4 MR. MALONE: I see it.

5 Q. So I assume with your concurrence and -- a  
6 determination was made that this patient needed a  
7 VQ scan?

8 A. I did not order that test. One of my colleagues  
9 who was on that night ordered that test. But I  
10 would have agreed with that.

11 Q. That prior to ordering this test on the  
12 differential diagnosis, the physician should have  
13 been considering the possibility of a pulmonary  
14 embolism by Royanne, correct?

15 A. That's correct.

16 Q. This test basically rules out the existence of a  
17 pulmonary embolism, correct?

18 A. This test, the results of this test are low  
19 probability for pulmonary embolism.

20 Q. Right.

21 A. What you just said is not that.

22 Q. What did I just say that is different?

23 A. That it rules out. It means that it is highly  
24 unlikely that she has a pulmonary embolism.

25 Q. So this test which was performed on March 23rd,

1           2002 at 8:30 p.m. makes it very unlikely that  
2           Royanne Amidi is suffering from a pulmonary  
3           embolism, correct?

4   A.   That's correct.

5   Q.   To the point that a decision was made subsequent  
6           to this to discontinue her Heparin, correct?

7   A.   That's correct.

8   Q.   Now, obviously if you or any other physician was  
9           still giving serious consideration to the fact  
10          she may be suffering from a pulmonary embolism,  
11          you would not have discontinued her Heparin; is  
12          that correct?

13  A.   That's correct.

14  Q.   Now, as of March 23rd, at around 8:30 p.m.,  
15          following this VQ scan, in light of the most  
16          common complications that a patient can suffer  
17          following roux-en Y gastric bypass surgery, did  
18          you consider that she may be suffering from  
19          intra-abdominal sepsis as a result of a leak or a  
20          wound infection?

21  A.   I thought that she -- I didn't think she -- that  
22          she had intra-abdominal sepsis, it's part of the  
23          differential. It was on the top of my list.

24  Q.   Is it written down anywhere by you in any of your  
25          progress notes prior to March 25th that you were

1           considering the possibility that she may have  
2           sustained a leak?

3       A.   I'd have to look in the medical record.   Could  
4           you reask your question?

5       Q.   Sure.   Well, let me hear what it was, first.

6                               -   -   -   -

7                               (Thereupon, the requested portion of  
8                               the record was read by the Notary.)

9                               -   -   -   -

10      A.   Prior to March 25th, no.

11      Q.   Would it be fair to say that you did not consider  
12           the possibility that she sustained a leak prior  
13           to March 25th?

14      A.   It would be fair to say that I didn't write it  
15           down that she possibly had a leak.   I still don't  
16           believe that she did have a leak.   It wasn't part  
17           of where I was going with this patient's care.

18      Q.   So do you have an independent recollection of  
19           this patient?

20      A.   Yes.

21      Q.   Have you had any other patients die following  
22           bariatric surgery?

23      A.   Within their hospital -- postsurgical hospital  
24           stay?

25      Q.   Yes.

1 A. No.

2 Q. Have you had other patients die from  
3 complications?

4 A. Yes.

5 Q. Approximately what percentage of --

6 A. Less than one percent.

7 Q. So prior to March 25th then, your answer would be  
8 that you did not believe that she was suffering  
9 from -- you did not believe there was a  
10 possibility that she was suffering from a leak;  
11 is that correct?

12 A. That's correct.

13 Q. Because if you believed there was a possibility  
14 she was suffering from a leak, you would do that  
15 gastrografen --

16 A. Gastrografen swallow.

17 Q. Are you familiar with different recommendations  
18 that exist for facilities performing bariatric  
19 surgery?

20 MR. MALONE: What?

21 A. I'm not sure I understand what you mean by that.

22 Q. Different organizations, such as the American  
23 College of Surgeons, has recommendations or  
24 requirements or guidelines for facilities which  
25 perform bariatric surgery?

1 A. Yes.

2 Q. Are you familiar with those? For instance, with  
3 the American College of Surgeons' recommendations  
4 for facilities performing bariatric surgery?

5 A. I know that they exist.

6 Q. Have you read them?

7 A. I've seen them, yes.

8 Q. Did you find them reasonable and prudent at the  
9 time you reviewed them?

10 A. I don't think I reviewed them -- they're  
11 reasonable and prudent. I don't remember  
12 reviewing them to the point where I was making  
13 judgments about them.

14 Q. Well, presumably when you were reviewing them or  
15 read them, it would cross your mind whether or  
16 not MetroHealth Medical Center was complying with  
17 those guidelines. Would that be fair?

18 A. Yes.

19 Q. Because those recommendations would be something  
20 you'd at least take into consideration in how you  
21 run your bariatric center here, correct?

22 A. Sure. Sure.

23 Q. Following surgery such as Royanne Amidi has -- or  
24 had in this particular case, is it standard for  
25 the patient to go to a floor as opposed to the

1 ICU following this type of surgery here at  
2 MetroHealth?

3 A. Depends. We evaluate the patient in the  
4 post-anesthesia care unit to look at their  
5 constitutional symptoms and their recovery from  
6 anesthesia and make a decision at that point  
7 whether they can go to the floor or they can go  
8 to the intensive care unit. Since we run our own  
9 intensive care units because we are intensivists,  
10 it's easy for us to make that determination.

11 Q. Well, let's go to -- well, given her findings in  
12 the postop unit prior to her going to the floor,  
13 you don't find any of the -- signs of symptoms  
14 that she was displaying at that point were to the  
15 point of her going to the ICU?

16 A. No. In retrospect, I would have loved to have  
17 her in the intensive care unit. It wouldn't have  
18 made any difference in the interval of care  
19 between the time she was to the floor and the  
20 time she did make it to the unit. But in  
21 retrospect, I would have loved her to be in the  
22 unit.

23 Q. When did you first start performing this  
24 particular type surgery, roux-en Y?

25 A. 1996.

1 Q. Prior to -- when did you first -- when did there  
2 become a bariatric department? I'm using that  
3 word loosely.

4 A. The reason the bariatric department is part of my  
5 division, which is trauma, critical care, burns  
6 and the flight program.

7 Q. When did MetroHealth Medical Center first start  
8 advertising that they were performing bariatric  
9 surgeries?

10 A. We don't advertise.

11 MR. MALONE: I'm going to object.

12 There's no advertising for that.

13 A. We don't.

14 Q. In looking at a letterhead, is there something on  
15 that letterhead which indicates that you and Dr.  
16 Gagliardi do bariatric surgery?

17 A. Yes.

18 Q. How long has that been promoted, that the two of  
19 you perform bariatric surgery?

20 A. Probably since the time of his arrival.

21 Q. Which was?

22 A. Three years ago.

23 Q. So that would be about the year 2000?

24 A. Yes.

25 Q. What area of trauma surgery is your specific



1 interest?

2 MR. CONWAY: And I'm just going to  
3 put on the record that question was written  
4 out for me. That would not have been mine,  
5 but since everyone is laughing --

6 MR. MALONE: We're only laughing  
7 because trauma surgery is a specialty unto  
8 itself. When a guy comes into the hospital  
9 bleeding from the belly, you don't get to  
10 say I don't do that kind of case because I  
11 only do head trauma.

12 Q. What I'm asking is I understand you have done  
13 work with spinal cord injury; is that correct?

14 A. They're part of the kinds of patients I take care  
15 of, correct.

16 Q. Do you have a certain area of research in writing  
17 within the field of trauma surgery?

18 A. I've written about a broad variety of trauma  
19 topics. It's -- there are 60 plus papers, 50  
20 plus papers, CV that list primarily trauma  
21 topics.

22 Q. Have you done any writing on bariatric surgery?

23 A. Yes, I have.

24 Q. How many articles have you written on bariatric  
25 surgery?

1 A. One book chapter, one book.

2 Q. One book?

3 A. One book.

4 Q. What is the name of the book?

5 A. The Thinking Persons Guide To Exercise and Weight  
6 Loss. It's an Internet book that we're  
7 publishing.

8 Q. Is it published yet?

9 A. I don't know. I don't believe so.

10 Q. Is there a way to get a copy of it?

11 A. I have a copy. I can give it to Jim.

12 Q. And then a book chapter in what book?

13 MR. MALONE: I don't mind  
14 providing this, but if it isn't published  
15 yet, it's probably not protected by  
16 copyright, so I assume you would protect  
17 his proprietary right as it exists,  
18 otherwise you have to get a court order.

19 MR. CONWAY: I just want to see  
20 what it says. I'm not going to distribute  
21 it or --

22 MR. MALONE: I assume not. But I  
23 have to say that he put the book together,  
24 he wrote it, it's a proprietary right.

25 A. That's not a book chapter. It's a paper. Paper

1 published in Healthcare Quality I think is the  
2 journal that published it.

3 Q. Do you have a copy of that?

4 A. Yes.

5 Q. Could you possibly provide that to Jim Malone as  
6 well?

7 A. Sure. We've also had a research grant for  
8 bariatric research.

9 Q. Is there any type of board certification that  
10 gets issued to a bariatric surgeon?

11 A. To my knowledge, no.

12 MR. MALONE: You mean specific to  
13 bariatric surgery, other than general  
14 surgery board certification?

15 MR. CONWAY: Correct.

16 Q. Generally you're board certified?

17 A. I'm board certified in general surgery and  
18 surgery critical care.

19 Q. How many total gastric bypass surgeries have you  
20 performed in your career?

21 A. I don't know the answer to that.

22 Q. Do you have an approximation?

23 A. I would say 75 to a hundred.

24 MR. MALONE: I think we gave you  
25 that in the answers to interrogatories,

1 Tom. I mean, by year. We broke it out for  
2 you.

3 MR. CONWAY: All right.

4 Q. Well, how many do you typically do in a year  
5 then?

6 A. I try to do no more than one or two a week and so  
7 that averages out to about 30 or 40 a year.

8 Q. How many total gastric bypass operations are  
9 performed monthly at Metro?

10 A. Somewhere in the neighborhood of five to ten.

11 Q. Is MetroHealth a bariatric approved center by any  
12 organizations that you're aware of?

13 A. Not to my knowledge.

14 Q. Is that something you have sought to attain?

15 A. Not currently, no.

16 Q. Why not?

17 A. Program in evolution.

18 Q. Did any of your residents who were working under  
19 you in this particular case have experience with  
20 bariatric patients?

21 A. Yes.

22 Q. Prior experience?

23 A. Yes.

24 Q. And how do you know that?

25 A. Because the -- we're part of the Case Western

1 Reserve University integrated surgical residency  
2 and there are a number of surgeons at Case who  
3 also do bariatric surgery.

4 Q. What we can probably do, the quickest way would  
5 be near the end of the depo is just go through  
6 your progress notes and/or your resident notes  
7 and if you can recognize a certain resident, I  
8 can ask you a question about him at that point.  
9 All right?

10 A. That's fine.

11 Q. All right. Now, you've indicated or agreed with  
12 the proposition that the three top postoperative  
13 complications associated with high mortality from  
14 roux-en Y gastric bypass are sepsis, gastric leak  
15 and PE, correct?

16 A. Yes.

17 Q. Do you know what percentage total those  
18 complications are in relation to the total amount  
19 of surgeries done?

20 A. Across the country?

21 Q. Yes.

22 A. No.

23 Q. Do you know how Ms. Amidi was referred to you?  
24 And look at whatever records you need.

25 A. From her primary care doctor.

1 Q. And what was your initial impression of her?

2 A. That she needed the operation.

3 Q. Did you put her on any type of diet or attempt a  
4 trial diet with her prior to her surgical date?

5 A. I did not. We talked earlier about what we do  
6 when they visit the nutritionist. We're not any  
7 more compulsive about that than that.

8 Q. There's guidelines out there, and I don't know if  
9 you are aware of them or not, that indicate that  
10 a diet should be tried, a patient should be put  
11 on a diet by the surgeon prior to the surgeon  
12 going ahead with the operation. Do you subscribe  
13 to that theory or not?

14 A. There are multiple -- these people have come to  
15 you having had multiple attempts at losing weight  
16 and including multiple attempts at dieting. The  
17 reason you are operating on this disease process  
18 is because they can't lose weight any other way.  
19 So to put somebody on a diet as part of their  
20 preparation for surgery is highly unlikely to be  
21 successful.

22 Q. Have you ever had a patient come in who has been  
23 obese where you have attempted to control their  
24 weight through dieting prior to scheduling  
25 surgery?

1 A. Yes.

2 Q. And have you ever been successful?

3 A. It doesn't work.

4 Q. Does it ever work for you?

5 A. It has never worked.

6 Q. Patients who come to a surgeon for surgical  
7 correction of their overweight problems at times  
8 can be desperate. Would you agree with that?

9 A. Yes.

10 Q. Have you had patients before Royanne Amidi who  
11 have come to you after going to another bariatric  
12 surgeon?

13 A. I don't know the answer to that question.

14 Q. Is that something your staff should be asking  
15 these patients?

16 A. Why?

17 Q. To find out whether or not you're the first  
18 surgeon they've come to or whether they've been  
19 turned down by other surgeons I suppose would be  
20 a reason. I mean, do you have -- so you do not  
21 ask them that information?

22 A. Routinely, I do not.

23 Q. Had you known that she had been turned down by  
24 another bariatric surgeon, would you have done  
25 anything different in your preparation for

1 surgery with Mrs. Amidi?

2 A. I would have asked her to provide me with the  
3 information from that doctor's office about the  
4 reasons for their turning her down.

5 Q. Would you have picked up the phone and spoken  
6 with that surgeon?

7 A. No.

8 Q. No?

9 A. No.

10 MR. MALONE: I don't think you are  
11 even allowed to do that today with HIPAA.

12 MR. CONWAY: HIPAA --

13 MR. MALONE: But the  
14 physician/patient privilege is still  
15 intact. He can't just call up another  
16 doctor and say what do you know about so  
17 and so.

18 MR. CONWAY: I know, Jim, but he  
19 can perhaps ask the patient to give the  
20 reasons --

21 MR. MALONE: That's what he said  
22 he would do. He would ask the patient to  
23 give the reasons for the turndown if there  
24 was a turndown.

25 A. We have a process for obtaining medical records.



1 Q. Right. The way you do that, you could also, I'm  
2 sure in other cases where you have a patient  
3 where you want to talk quickly to another doctor,  
4 ask for their written permission and speak to a  
5 doctor, correct?

6 A. Yes. And I typically do that with the group of  
7 patients I operate on who have had bariatric  
8 procedures that have resulted in complications.  
9 Because that's the other aspect of my practice,  
10 is the reoperative bariatric surgery. I fix  
11 other people's mistakes.

12 Q. Have you done -- that was a question -- you have  
13 done reoperative --

14 A. Yes. About 25 percent of the cases I do are  
15 reoperative bariatric surgery.

16 Q. Have you had complications from those?

17 A. Yes.

18 Q. Are you aware of a certain level of expertise or  
19 experience that a number of these organizations  
20 recommend for physicians who are doing these  
21 reoperations?

22 A. Yes.

23 Q. Do you conform to their guidelines?

24 A. I believe so.

25 Q. What did you calculate Royanne Amidi's BMI to be?

1 A. When she first saw us, her BMI was 88.

2 Q. At one point, it was 91 prior to her surgery,  
3 correct?

4 A. Probably when she gained the additional weight  
5 prior to surgery that would be -- it's not  
6 unreasonable.

7 Q. Is BMI of 91 a contraindication for this type of  
8 surgery?

9 A. I don't believe so.

10 Q. You don't?

11 A. No.

12 Q. Is there any BMI that would be a contraindication  
13 for this type of surgery?

14 A. I don't necessarily think it would be necessarily  
15 the BMI. You could have a six-foot-one person  
16 with a BMI of 90 and they would be in the  
17 600-pound range. You could have a five-foot-one  
18 person and a BMI of 90 and be in the 400-pound  
19 range. The way I do the operation, the exposure  
20 is okay regardless of how big they are.

21 Q. Are there any specific preoperative consults or  
22 evaluations that you order prior to doing surgery  
23 on a patient?

24 A. Yes. We obtain nutrition consults, we obtain  
25 pulmonary consults, we obtain cardiology consults

1           and psychiatric consults. Those are the  
2           routines.

3       Q. Was there a psychiatric consult done in this  
4       case?

5       A. I don't believe that was our routine at that  
6       point in time.

7       Q. Was there a nutritional consult done?

8       A. Yes.

9       Q. There was one ordered. Was it actually done?

10      A. I believe so. It wouldn't be in the medical  
11      record.

12      Q. If it wasn't done, would that have been below the  
13      standard of care for one of your office staff?

14      A. Yes.

15      Q. Was there a pulmonary consult done in this  
16      particular case?

17      A. I think so.

18      Q. And cardiac?

19      A. I think so. I may not have done a cardiac  
20      consult to her, but I'm pretty sure I did a  
21      pulmonary consult to her.

22      Q. Do you now do cardiac consults on these patients?

23      A. Yes.

24      Q. Do you recommend that a psychological profile be  
25      done on a patient like this? Would that be

1           considered part of your psychiatric consult?

2       A.   It is now.

3       Q.   Did you do it back then?

4       A.   I don't recall.

5       Q.   Did you have any reservations at all about doing  
6           surgery on Mrs. Amidi?

7       A.   Yes.

8       Q.   What were those reservations?

9       A.   Her underlying constitutional health status. But  
10           there are no options for these patients.

11      Q.   What type of consent form did you have Mrs. Amidi  
12           sign for this particular surgery? Was it just a  
13           general surgical consent form?

14      A.   Yes.

15      Q.   The American Organization of Bariatric Surgeons  
16           recommends a separate and detailed presurgery  
17           consent form be provided patients who are  
18           undergoing bariatric surgery. Do you agree with  
19           that guideline or --

20      A.   Sure. I don't think it's necessarily standard of  
21           care.

22      Q.   Did you explain the risks of this procedure to  
23           Royanne Amidi?

24      A.   I believe so.

25      Q.   Did you explain there's the risk of the -- you

1        used staples in this case, correct, or -- sutures  
2        or staples at the site of the anastomosis?

3        A.    Which one? There are two anastomoses. There  
4        are -- there's a staple line across the stomach  
5        and then there's the anastomosis of the stomach  
6        pouch to the roux-en.

7        Q.    Are those anastomoses -- are you using sutures  
8        for those?

9        A.    I staple the stomach. There's a bariatric  
10        stapler that I used to staple the stomach. I  
11        reinforce the staple line with suture on either  
12        end. That's to prevent breakdown of that staple  
13        line. I staple the jejunostomy, the roux-en and  
14        I oversew that with suture. And I handsaw the  
15        gastrojejunostomy, two layers.

16       Q.    Do you explain the -- in this particular case,  
17       did you explain the risk to Mrs. Amidi that those  
18       suture and/or staple lines could leak?

19       A.    Yes.

20       Q.    Did you explain the risk of infection if those  
21       should leak?

22       A.    Yes.

23       Q.    Did you explain the risk of wound infection to  
24       her?

25       A.    Yes.

1 Q. Who conducted the immediate preoperative physical  
2 examination?

3 A. One of our nurse practitioners in the presurgical  
4 evaluation area.

5 Q. So at the time of surgery, would you have been  
6 aware of her weight being 467 pounds?

7 A. Yes.

8 Q. Were you aware that during the preoperative exam  
9 itself notations indicate left leg erythema?

10 A. No.

11 Q. What could be the cause of left leg erythema?

12 A. It could be cellulitis.

13 Q. Did anybody bring that finding to your attention  
14 prior to the surgery beginning?

15 A. No.

16 Q. Had they brought that to your attention prior to  
17 surgery, would you have gone forward with the  
18 surgery?

19 A. I would have evaluated the area and seen if it  
20 was an acute inflammatory change or whether it  
21 was chronic and venostasis sort of changes and  
22 made a decision based on that. In light of the  
23 fact that she was still on antibiotics at the  
24 time of surgery, if I was aware that she had  
25 other -- she had -- she was on antibiotics and

1 she had other clinical signs of an acute  
2 infection, I would have cancelled her surgery.

3 Q. But nobody brought either of those factors to  
4 your attention?

5 A. No. Multiple people evaluated her extremities  
6 during this whole process and it wasn't  
7 considered to be acute, I assume.

8 Q. Right. But don't those medical personnel who are  
9 doing that, whether it be a resident or a nurse,  
10 doesn't the standard of care require them to  
11 report these signs or symptoms to you so that you  
12 can make the determination on whether to go  
13 forward or not?

14 A. Yes.

15 Q. And none of them did that, did they?

16 A. No.

17 Q. So they would have been below the standards of  
18 care, correct?

19 A. Yes.

20 Q. What was the name of the operative procedure that  
21 you used, utilized in this particular case?

22 A. It's a gastric bypass roux-en Y.

23 Q. So I have been calling it by the correct name?

24 A. Yes.

25 Q. I'm just double-checking that I know what I'm

1 asking. Who is Dr. Anastasior Konstantakos?

2 A. He was at the time a chief resident of surgery.

3 Q. Do you know where he is now?

4 A. He's in a cardiovascular training program  
5 somewhere. I think in Boston.

6 Q. And as of March 22nd, 2002, what level of  
7 practice was he at?

8 A. He was a PGY 5.

9 Q. What is that?

10 A. Chief resident.

11 Q. Had he done bariatric surgery before?

12 A. Yes.

13 Q. What was his actual involvement during the  
14 surgical procedure?

15 A. He's my first assistant.

16 Q. Did you perform the entire surgical procedure?

17 A. Yes.

18 Q. Who closed the surgical incision?

19 A. The surgical site?

20 Q. Yes.

21 A. He and I did together.

22 Q. Were you present during the entire surgical  
23 procedure from incision to closure?

24 A. Yes, I was.

25 Q. Is there some type of checklist or form that has



1 to be filled out by the surgeon indicating that  
2 he was present during the entire surgery? Does  
3 MetroHealth have such a form?

4 A. We're required to fill out the operative sheet  
5 and to write a note in the medical record.

6 Q. Did you, in fact -- have you ever been involved  
7 in surgeries where you have not been present  
8 during the entire surgery?

9 A. I'm not sure where you're going with that  
10 question? What do you mean by that?

11 Q. I mean, have there been surgeries where you have  
12 to leave the surgical operating room and you have  
13 not been present during the entire surgery?

14 MR. MALONE: Are you talking about  
15 skin closure, the end of the case?

16 Q. I'm talking about any type of procedure.

17 A. I don't do that. So the answer is no.

18 Q. So you have never left an operating room to have  
19 a chief resident close for you?

20 A. No.

21 Q. And you're sure that was not done in this  
22 particular case?

23 A. You mean close the surgical incision?

24 Q. Yes.

25 A. No, it was not done in this case.

1 Q. Have you ever had chief surgical residents do  
2 that for you?

3 A. No. I always close the wound. I may not close  
4 the skin, but I always close the wound.

5 Q. After closing the wound, did you leave here prior  
6 to closing --

7 A. I do not remember. But most likely, I did not.

8 Q. Why do you say most likely you did not?

9 A. Because I wrote a note saying I was present for  
10 the operation. I may have been in the room  
11 writing notes when they were closing the skin  
12 with the skin staple gun. But I am always in the  
13 room.

14 Q. Did this operation take longer than you thought  
15 it would take?

16 A. It usually takes -- I don't know how long it  
17 took. Let me see. Wait a minute. That's the  
18 note -- before the case. That's the note --  
19 that's the time after the case. No. It usually  
20 takes an hour for every hundred pounds they  
21 weigh. That's a ballpark figure.

22 Q. Was the incision length that you used in this  
23 particular case longer than you thought would  
24 have been necessary prior?

25 A. No, no.

1 Q. Do you recall a conversation with the Amidis  
2 prior to surgery regarding the length of the  
3 surgical incision?

4 A. I don't recall that conversation.

5 Q. Do you recall conversations prior to this  
6 surgery, specific conversations with Mr. or  
7 Mrs. Amidi?

8 A. The conversations I recall talking to them in the  
9 clinic before when they came in for their  
10 presurgical evaluation.

11 Q. What do you recall about that conversation?

12 A. I recall asking her if her health had changed in  
13 any way and her telling me no. And I recall the  
14 fact that I asked -- specifically asking her if  
15 she had stopped smoking because her husband --  
16 their clothes reeked of cigarette smoke. And so  
17 I was very concerned that she was still smoking  
18 and she said no.

19 I use a standard incision. I tell everybody  
20 about it because it's a little unusual. I do it  
21 through an extended right subcostal incision.  
22 It's a chevron. I do that to everybody. I don't  
23 use a midline incision. So I tell everybody  
24 about that because it's a little unusual if you  
25 are from a surgical standpoint.

1 Q. Do you recall any other specifics of that  
2 conversation?

3 A. No.

4 Q. And what I'm trying to do -- just so I'm not  
5 beating around the bush. I'm trying to find out  
6 if you have a specific recollection of any  
7 conversations before the actual surgery.

8 So that would be the extent of your  
9 recollection of talking with them prior to the  
10 surgery?

11 A. That's correct.

12 Q. How did the overall surgery go in your opinion?  
13 Were there any complications?

14 A. No. The surgical procedure was, I think, pretty  
15 much standard.

16 Q. It says during the procedure one of the lesser  
17 curvature veins was bleeding which required  
18 oversewing with sutures. Is this bleeding a  
19 common occurrence for this type of surgery?

20 A. Yes.

21 Q. Is it standard practice to oversee the bleeders?

22 A. It's my standard practice. Other people perhaps  
23 will do it differently, but my practice is always  
24 to put a stick tie in.

25 Q. It also indicates there was -- oversewing of

1 sutures was also required at the distal side of  
2 the transected bowel due to friability. That was  
3 your note, correct?

4 A. Uh-huh, uh-huh. That was dictated by the  
5 operative -- the surgeon who is operating with  
6 me.

7 Q. And signed off by you?

8 A. Yes.

9 Q. So you agreed with his conclusions?

10 A. Yes.

11 Q. Were you worried about potential postoperative  
12 complications, such as rupture at the point of  
13 that friability?

14 A. No. I always oversee my staple lines.

15 Q. I'm more concerned with the issue of friability  
16 at that specific area.

17 A. When you cut across the bowel with a stapler, it  
18 typically bleeds. There are a number of ways of  
19 controlling that. I choose to oversee those with  
20 suture.

21 Q. Does the area that -- the fact that area is  
22 friable in your opinion increase the risk of a  
23 possible rupture at that site?

24 A. No.

25 Q. There's also another part in your operative

1 notes, slight venous hyperthemia on distal end of  
2 transected jejunum. What does that mean?

3 A. Typically after you transect the small bowel  
4 where you are going to fashion your two  
5 anastomoses, as you separate the small bowel,  
6 there's venocongestion that occurs as a sequence  
7 of that separation. That's what is being  
8 described there. It occurs commonly.

9 Q. Does that increase any type of postoperative  
10 complication rate?

11 A. I don't think so.

12 Q. You're familiar with the amount of pain  
13 medication that Mrs. Amidi was on immediately  
14 postop, correct?

15 A. Not off the top of my head I'm not.

16 Q. Look at whatever you need to look at.

17 MR. MALONE: Do you have any idea  
18 how much longer you're going to be?

19 MR. CONWAY: It's probably going  
20 to be a while, Jim.

21 MR. MALONE: Meaning what?

22 MR. CONWAY: We started about --

23 MR. MALONE: 2:15.

24 MR. CONWAY: No, we did not.

25 MR. MALONE: 2:15 I came out and

1 got you.

2 MR. CONWAY: It's probably going  
3 to be a three-hour depo all total. Do you  
4 want to do it in two installments, fine.

5 MR. MALONE: I didn't dream you  
6 would be this long. I have commitments and  
7 I've got to --

8 A. I'm not sure where I would look to find the --

9 MR. CONWAY: Wait a second. It  
10 will get distracted.

11 MR. MALONE: Off the record.

12 - - - -

13 (Thereupon, a discussion was had off  
14 the record.)

15 - - - -

16 Q. Did you assess Mrs. Amidi in the PACU?

17 A. No.

18 Q. Is that something you normally do?

19 A. No.

20 Q. Why not?

21 A. The anesthesiologists normally do that.

22 Q. Have you ever assessed any of your patients in  
23 the PACU?

24 A. Yes.

25 Q. What is the criteria for you assessing a patient

1           versus not assessing?

2       A.   When I'm the critical care attending, I'm  
3           oftentimes called upon to make decisions about  
4           whether patients need to go to the intensive care  
5           unit or whether they're safe to go to the floor  
6           or whether they need to stay in the PACU  
7           overnight. In that situation, I evaluate the  
8           patient in the PACU.

9       Q.   Whose decision would that have been as to whether  
10           or not Royanne Amidi goes to the ICU following  
11           the PACU in this case?

12      A.   If the anesthesiologist felt uncomfortable with  
13           the patient going to the floor and would not  
14           release the patient, he or she would contact the  
15           intensivist, surgical intensivist on call and it  
16           would be that person's decision whether the  
17           person stayed in the PACU or went to the floor or  
18           went to the intensive care unit.

19      Q.   While in the PACU, Mrs. Amidi's heart rate went  
20           to the 130s with a blood pressure of 123 over 82,  
21           but it sustained in the 130s. Were you ever  
22           notified of that sustained tachycardia?

23      A.   No.

24      Q.   Should you have been?

25      A.   Yes.



1 Q. Was it below the standard of care that no one did  
2 notify of you that sustained tachycardia?

3 A. No, I don't believe so. As long as somebody knew  
4 about it.

5 Q. But you still should have been made aware of it?

6 A. Yes.

7 Q. What is the expected and acceptable urinary  
8 output for this type of postop patient?

9 A. We like to see one to two cc's of kilogram of  
10 urinary output. That's for ideal body weight.  
11 So in her particular case, somewhere in the  
12 neighborhood of 20 to 25 cc's would have been  
13 acceptable.

14 Q. Were you concerned that she had put out only 120  
15 cc's of urine over a two-and-a-half-hour period?

16 A. No.

17 Q. Is that a low amount of urine output?

18 A. It's an average amount of urine output.

19 Q. For this type of patient?

20 A. Yes.

21 Q. What would be on your differential diagnosis for  
22 tachycardia, decreased urinary output and  
23 borderline high blood pressure in a patient such  
24 as Royanne Amidi immediately postop?

25 A. I don't think all three of those things are

1 explained by the same phenomenon. I would  
2 consider pain as etiology of the high blood  
3 pressure and the tachycardia. I would also think  
4 that volume problems could be related to the low  
5 urine output and the tachycardia.

6 Q. Could bleeding -- would bleeding be on your  
7 differential diagnosis?

8 A. That's the cause of hypovolemia, yes.

9 Q. How about sepsis?

10 A. For high blood pressure, no.

11 Q. How about for the tachycardia?

12 A. Could be.

13 Q. Low urinary output can also signal sepsis?

14 A. Yes.

15 Q. Because the kidneys are shutting down, correct?

16 A. Yes.

17 Q. What steps were taken to deal with Mrs. Amidi's  
18 tachycardia and blood pressure of 123 over 82  
19 immediately postop, are you aware?

20 A. I don't know an answer to that.

21 Q. Were you involved in any of that decision-making?

22 A. I don't recall.

23 Q. Do you want to look at a chart?

24 A. I don't think it would help.

25 Q. Were you aware that postoperative night number

1           one, that would be the evening of March 22nd,  
2           that Royanne Amidi required over three liters of  
3           IV fluid resuscitation?

4   A.   I don't recall if I was aware of that.   It  
5           wouldn't be unusual.

6   Q.   In your opinion, there's nothing unusual about  
7           that?

8   A.   No.

9   Q.   In reviewing your records, does it indicate  
10          whether or not you were ever called or updated  
11          during the first night regarding Royanne Amidi's  
12          condition?

13   A.   I don't know the answer to that.

14   Q.   Is there any way the chart would indicate that  
15          for you?

16   A.   I don't think so.   Is that documented in the  
17          progress notes?   Is that what you want me to look  
18          at?

19   Q.   I need you to look at whatever you feel  
20          comfortable in looking at.

21                   MR. MALONE:   What do you want to  
22                   know, if he was notified of what?   Of her  
23                   condition?

24                   MR. CONWAY:   Yes.   First  
25                   postoperative night number one.

1 MR. MALONE: The day of surgery,  
2 that would be day of. POD would be the  
3 next one. POD 1.

4 A. It doesn't say anywhere that I was notified.

5 Q. In her case, did you have residents rounding on  
6 her to check on her status periodically?

7 A. Yes.

8 Q. Do they have a responsibility to contact you with  
9 any changes or significant observations they have  
10 regarding her condition?

11 A. Yes, yes.

12 Q. Was there anything in reviewing the medical  
13 records from the conclusion of your surgery  
14 through the end of that first day that you felt  
15 that the resident should have notified you of?

16 A. No.

17 Q. Did you have morning rounds on March 23rd in  
18 which you saw Royanne Amidi?

19 A. Yes.

20 Q. What was your impression at that time? Do you  
21 have a progress note that you could read?

22 A. Yes. My progress note from 10:35 that morning of  
23 3-23-02 says, "Attending postop day number one,  
24 awake, alert. Episode of chest pain, this a.m.,  
25 resolved. NG tube in place. Scant drainage.

1 Plan, increased activity today."

2 Q. Did you have any idea of what could have been  
3 causing the chest pain?

4 A. Yes. I thought it was the -- I thought it was  
5 incisional. The operation goes like this  
6 underneath the chest.

7 Q. Would this have been the first time you saw her  
8 following your surgery, 10:35 a.m. on the morning  
9 of the 23rd?

10 A. Most likely, yes.

11 Q. Was she still suffering from sustained  
12 tachycardia at the time you saw her on March  
13 23rd?

14 A. I don't know the answer to that. At 11:00 a.m.,  
15 the nursing note says vital signs stable, but I  
16 don't know what that means. Heart rate of 137.  
17 So that's tachycardia.

18 Q. Would you have been made aware of that?

19 A. Yes.

20 Q. And what would your differential diagnosis have  
21 been regarding what was causing that tachycardia?

22 A. I need to take a break.

23 - - - -

24 (Thereupon, a recess was had.)

25 - - - -

1 A. The most common reason for her to be tachycardic  
2 in my opinion would be pain.

3 Q. Did you chart anywhere in your chart  
4 preoperatively that you recommended or told Mrs.  
5 Amidi to stop smoking?

6 A. No.

7 Q. Did you chart anywhere that -- telling her that  
8 if she did not stop smoking she would not be a  
9 surgical candidate?

10 A. No.

11 Q. Why didn't you chart those things?

12 A. I would not have told her that she would not be a  
13 surgical candidate. I would have told her I  
14 would not operate on her until she stopped  
15 smoking.

16 Q. Regardless, that was never charted, that  
17 conversation?

18 A. I don't believe so.

19 Q. Is that something you typically would chart?

20 A. I try to.

21 Q. Were you aware that left shoulder pain is  
22 indicative of possible gastric leak  
23 postoperatively?

24 A. Yes.

25 Q. Did that thought enter your mind on the morning

1 of March 23rd?

2 A. No, it did not.

3 Q. Did you have any more hands-on contact with  
4 Royanne Amidi during March 23rd? Feel free to  
5 look -- did you see her in person anymore that  
6 day?

7 A. I don't recall that.

8 Q. If you had, would you have noted it in your  
9 progress notes?

10 A. I would -- no. Not necessarily. If I wrote a  
11 note once during the day -- if I went back and  
12 saw the patient several times, I would not have  
13 necessarily written another note unless there was  
14 a change in the condition.

15 Q. Do you have any other indications in looking at  
16 your chart that you saw her subsequently on March  
17 23rd to that 10:35 note?

18 A. No.

19 Q. And from reading your handwriting, that's the  
20 only note that you made on 10:35?

21 A. That's correct.

22 Q. Did any of your residents make any notes during  
23 March -- strike that. My last question was the  
24 10:35 note was your only note you wrote on March  
25 23rd, correct?

1 A. That's correct.

2 Q. Is there any -- are there any notes from any of  
3 your residents on March 23rd?

4 A. I believe so.

5 Q. Could you point those out to me? Do you usually  
6 read over your residents' notes and then sign off  
7 on them?

8 A. No. I typically write my own notes.

9 Q. Do you review the residents' notes to make sure  
10 that they're catching onto what they should be  
11 doing?

12 A. Yes.

13 Q. Were there any residents' notes written, any of  
14 your residents writing notes on March 23rd?

15 A. There's a note from 3-23-02 at six p.m. written  
16 by a surgery resident that's not my resident.

17 Q. Why would some other resident other than yours be  
18 writing a note?

19 A. 6:00, that's probably the coverage change. And  
20 there's a note from 3-23-02 by the team resident  
21 that's ahead of mine, but not timed. That is  
22 from one of the residents in my service.

23 Q. Is your service blue team?

24 A. Blue surgery, yes.

25 Q. And that note was not timed?



1 A. Correct.

2 Q. I presume your residents are instructed to time  
3 their notes?

4 A. It's standard practice.

5 Q. Could you read both of those notes at the time?

6 A. Yes.

7 Q. Were you able to read them?

8 A. Yes.

9 Q. Why don't we go to the first note, 3-23-02, note  
10 from your resident on blue surgery.

11 A. Patient doing well, but this a.m. -- that's  
12 approximately 9:00 a.m. complained of left  
13 shoulder and chest pain. I don't recognize what  
14 those two words are. Lasted approximately ten  
15 minutes. Resolved with MS 04 and Toradol. EKG  
16 obtained and unchanged from prior. Pain,  
17 completely resolved. ABG obtained on two liters.  
18 Nasal -- I don't know what that is. Pulse 120.  
19 Respiratory rate, 20. Blood pressure, 130 over  
20 70. Lungs clear of oscillation. Cardiovascular,  
21 regular rate rhythm. Evidence soft,  
22 non-distended, mildly tender in -- something.

23 Then assessment of plans, status, post  
24 29-year-old. Status, post gastric bypass.  
25 Shoulder, chest pain, likely musculoskeletal.

1 Will monitor. Tachy and low urine output with  
2 bolus with lactated Ringers. Follow urine  
3 output. Regular flora, chips of ice. Upper GI  
4 Monday.

5 Q. What is your thinking to what was causing her low  
6 urine output?

7 A. Postoperative hypovolemia.

8 Q. The cause of that would have been what?

9 A. The operation.

10 Q. The 3-23-02 is your attending note, correct?

11 A. There is a 3-23-02 note.

12 Q. At 10:35?

13 A. 10:35, that says attending postoperative day,  
14 number one.

15 Q. And I believe you've already read that one in?

16 A. Yes.

17 Q. Then 3-23-02. Who wrote that note; do you know?

18 A. This is a nursing note.

19 Q. P, chest pain. Would you have been aware of this  
20 nursing note, the contents of it?

21 A. Not necessarily. Since it's written 25 minutes  
22 after my note.

23 Q. Is there anything in that nursing note which you  
24 would have wanted to have been made aware of  
25 regarding Royanne's condition as of 11:00 a.m.?

1 A. No.

2 Q. Then we have a surgery note at 3-23-02 at six  
3 p.m. This would have been a covering surgical  
4 resident?

5 A. That's correct.

6 Q. Under what attending would this surgical resident  
7 be responsible to?

8 A. He would be responsible to all of us. He's the  
9 person who is on call in the hospital at night.  
10 One of the people.

11 Q. And in reading his note there, you can read his  
12 note, correct, Doctor?

13 A. Yes.

14 Q. Is there anything disconcerting about Royanne  
15 Amidi's condition as of 3-22 at six p.m.?

16 A. This is a note where she's transferred from the  
17 floor to the intensive care unit.

18 Q. That's based upon her continued tachycardia?

19 A. Physical findings. Yes.

20 Q. Her hypotension with the blood pressure. Based  
21 upon this, what was your differential diagnosis?

22 A. I was not there at the time. The critical care  
23 attending who was on call was there, Dr. Yowler.  
24 He's one of my partners.

25 Q. Did he contact you regarding your patient?

1 A. The resident did.

2 Q. What was your thinking as to what was causing  
3 these findings?

4 A. They were working her up for pulmonary embolism  
5 at that time.

6 Q. Would that have been number one on your  
7 differential diagnosis?

8 A. Yes.

9 Q. Would you have had surgical leak and/or infection  
10 as well on your differential diagnosis?

11 A. Not in the first 24 hours after surgery, no.

12 Q. And she's transferred to the ICU?

13 A. That's correct.

14 Q. The critical care consult note is written by Dr.  
15 Yowler?

16 A. That's correct.

17 Q. And his first impression is possible PE. And he  
18 recommends a VQ scan, correct?

19 A. Yes.

20 Q. Were you made aware of the results of the VQ scan  
21 that was taken on March 23rd at 8:38 p.m.?

22 A. Yes. But not at that point in time. The next  
23 day.

24 Q. The next day?

25 A. Yes.

1 Q. Presumably, Dr. Yowler would have been made aware  
2 immediately of those results, correct?

3 A. Correct. That's why the Heparin was started.

4 Q. Was the Heparin started prior to --

5 A. Yes.

6 Q. The Heparin was started prior to this VQ scan?

7 A. Yes.

8 Q. Whose order was it to start the Heparin?

9 A. That would have been his. That's standard  
10 practice.

11 Q. Whenever PE is suspected?

12 A. That's standard practice.

13 Q. Then following this VQ scan, the Heparin was  
14 discontinued?

15 A. That's correct.

16 Q. Why wasn't it immediately discontinued following  
17 the VQ scan?

18 A. If you look at the bottom of that form, the test  
19 was not read by the radiologist until sometime  
20 after it was performed.

21 Q. It was not read?

22 A. By the radiology attending until sometime after  
23 it was performed. So the original read in the  
24 middle of the night by the radiology residents  
25 was that it was an intermediate probability VQ

1 scan. The next morning when it was read by an  
2 attending, it was read low probability and based  
3 on that we stopped her Heparin.

4 Q. Now, the residents at MetroHealth Medical Center  
5 are employees of MetroHealth, correct? Are you  
6 aware?

7 MR. MALONE: May or may not be.

8 I'm going to object to the general  
9 proposition. Some are, some aren't. It  
10 depends on what institution they come from.

11 Q. Were your residents employed by MetroHealth  
12 Medical Center?

13 A. The surgical residents?

14 Q. Yes.

15 A. They are Case Western Reserve University  
16 residents.

17 MR. MALONE: That's the employer.

18 A. What you mean by employee I assume is that is  
19 their homeroom affiliation.

20 Q. But they're doing their residency work here at  
21 Metro?

22 A. Correct.

23 Q. Through an agreement with MetroHealth Medical  
24 Center?

25 A. Correct.

1 Q. The physicians who work at MetroHealth Medical  
2 Center, such as the radiologists, are they  
3 employees of MetroHealth Medical Center?

4 A. Yes.

5 Q. There's no indication by Dr. Minotti on his final  
6 dictated report that he had to change any of the  
7 findings by his resident. Do you agree with my  
8 reading of that or not? I'm looking at the  
9 bottom here.

10 A. No. No.

11 Q. Is that something that is done by the attending,  
12 if they have reviewed the work of a resident and  
13 found it to be deficient or wrong?

14 A. I don't know the answer to that.

15 Q. Do you change your residents or do you make  
16 notations when you feel that your residents have  
17 erred in their evaluation of something in the  
18 chart?

19 A. No, not typically.

20 Q. Anyway, as you pointed out yourself in your  
21 testimony, the VQ scan was originally read as  
22 intermediate probability by the radiology  
23 resident?

24 A. That's correct.

25 Q. The evening of March 23rd, correct?

1 A. That's correct.

2 Q. And then Dr. Minotti, the attending, came in and  
3 presumably read it correctly as being low  
4 probability?

5 A. Yes.

6 Q. And it was based upon Dr. Minotti's final  
7 conclusion that --

8 A. The Heparin was stopped.

9 Q. The Heparin was stopped. All right. Do you give  
10 specific orders for residents to call you at home  
11 or wherever you may be if you're not physically  
12 at the --

13 A. No.

14 Q. -- hospital? Are they given an order for them to  
15 call you if there's any significant change in a  
16 patient's condition?

17 A. There's no order given. That's standard  
18 practice.

19 Q. But they're made aware of that, correct?

20 A. Yes.

21 Q. Did you consider transferring Mrs. Amidi to the  
22 ICU at any time during March 23rd?

23 A. Did I?

24 Q. Correct. Based upon her condition prior to --

25 A. I don't recall. It would have been part of the



1 discussion.

2 Q. Upon transfer to the SIU, she was given a bolus  
3 of fluids and her CBC was checked. Do you feel  
4 that more aggressive treatment or diagnoses  
5 should have been offered at that point?

6 MR. MALONE: More aggressive  
7 diagnosis?

8 Q. Steps to diagnose what was causing her problems  
9 should have been taken at that point?

10 A. I thought her treatment was appropriate.

11 Q. Were you aware that CBC with a white blood cell  
12 count of 25.1 was drawn March 23rd?

13 A. Yes.

14 Q. What significance did that have to you when you  
15 were made aware of the results?

16 A. I didn't attach any specific significance to that  
17 white blood cell count.

18 Q. Do you know when you were made aware of the  
19 results of that white blood cell count?

20 A. No, I don't recall that.

21 Q. I think it was collected at 6:40 p.m. on March  
22 23rd. There was -- the bands were 40. That's  
23 called bandemia?

24 A. Yes.

25 Q. What significance did you read into her white

1 blood cell count of 25.18 and her bandemia of 40?

2 A. There are two things that could cause that.

3 Stress could cause that, infection could cause  
4 that.

5 Q. Did you consider the possibility that she was  
6 suffering from an infection as a result of  
7 postoperative complication?

8 A. Yes.

9 Q. When is the first time you considered she was  
10 suffering from postoperative infection?

11 A. I don't recall.

12 Q. Did any of your residents or any other physician  
13 at MetroHealth Medical Center make you aware of  
14 that WBC of 25.18 and bandemia of 40 the evening  
15 of March 23rd?

16 A. I don't recall that.

17 Q. Is that something you should have been made aware  
18 of?

19 A. Yes.

20 Q. Would it be below the standard of care for you  
21 not to have been made aware of that?

22 A. Yes.

23 Q. When is the next time that you saw, physically  
24 saw Royanne Amidi?

25 A. I believe the next morning.

1 Q. And why don't we go to that note. Is that that  
2 10:05 note?

3 A. Yes. 3-24, 10:05.

4 Q. At that point, you indicate that the VQ scan not  
5 consistent with the PE, correct?

6 A. Yes.

7 Q. And that's based upon information that was made  
8 available to you by Dr. Minotti?

9 A. That's correct.

10 Q. Can you read that note into the record?

11 A. I thought we already read this into the note.  
12 Maybe not.

13 Q. We did the 10:35 one?

14 A. "Attending postoperative day number two, seen on  
15 rounds. Interval events, reviewed and agree.  
16 Issues, awake and alert dispute hypotension and  
17 tachycardia."

18 MR. MALONE: We did read this.

19 This may be the page the court reporter  
20 wants.

21 A. "ABG, 7.37. PCO2 44. PO2, 78. Bicarb 25.  
22 Hemodynamically consistent with hypovolemia. Has  
23 been tachy to 150s since last p.m.. Blood  
24 pressure decreased. HCT a.m. 36.6. GI minimal.  
25 NG output. GI, minimal urine output. VQ scan

1 not consistent with PE. Input ABG this a.m. 7.25  
2 pCO2 of 58. pO2 of 77. HCO3, 24.9. HCT 34.  
3 Chest x-rays, small left pleural effusion.

4 "Postop, complicated by obesity,  
5 hypoventilation. Asthma and smoking. Reactive  
6 airway disease. Would probably benefit from  
7 BIPAP. We discussed BIPAP. Hypovolemia.  
8 Question etiology. Responding to volume and will  
9 start blood. Plan, pulmonary consult vis-a-vis  
10 management with CPAP/BIPAP, consider intubation,  
11 volume resuscitation slash blood in intensive  
12 care monitoring condition critical."

13 Q. You don't indicate anywhere in that note that you  
14 were considering the possibility of infection, do  
15 you?

16 A. No.

17 Q. Why not?

18 A. Because I didn't believe that she had infection.

19 Q. Differential diagnosis is to put together  
20 in your mind different possibilities,  
21 correct?

22 A. Yes.

23 THE WITNESS: I'm going to have to  
24 take another break.

25 MR. MALONE: Why don't we

reconvene this.

- - - -

(Thereupon, a discussion was had off  
the record.)

- - - -

WILLIAM F. FALLON, JR., M.D.

C E R T I F I C A T E

The State of Ohio, ) SS:  
County of Cuyahoga.)

I, Juliana M. Lawson, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 14th day of July A.D. 20 03.

  
Juliana M. Lawson, Notary Public, State of Ohio  
1750 Midland Building, Cleveland, Ohio 44115  
My commission expires October 3, 2007

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DO NOT WRITE IN  
MARGIN  
RESERVED FOR OOH  
DATA CODING

Reg. Dist. No. 1801  
Primary Reg. Dist. No. 001663  
Registrar's No. 001663

Ohio Department of Health  
VITAL STATISTICS  
**CERTIFICATE OF DEATH**  
TYPE OR PRINT IN PERMANENT BLACK INK

State File No.

a. \_\_\_\_\_  
b. \_\_\_\_\_  
c. \_\_\_\_\_  
d. \_\_\_\_\_  
e. \_\_\_\_\_

**DECEDENT**

IF DEATH OCCURRED  
IN INSTITUTION, GIVE  
RESIDENCE BEFORE  
ADMISSION →

1. Decedent's Name (First, Middle, LAST) <b>Royanne AMIDI</b>				2. Sex <b>Female</b>		3. Date of Death (Month, Day, Year) <b>March 27, 2002</b>	
4. Social Security Number <b>279-74-4831</b>		5a. Age-Last Birthday (Years) <b>30</b>		5b. Under One Year Months _____ Days _____		5c. Under 1 Day Hours _____ Minutes _____	
6. Date of Birth (Month, Day, Year) <b>Feb. 28, 1972</b>		7. Birthplace (City, County and State or Foreign Country) <b>Cleve, Ohio</b>					
8. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		9a. Place of Death (Check Only One) <input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
9b. Facility Name (If Not Institution, Give Street and Number) <b>MetroHealth Medical Center</b>				9c. City, Village, Twp., or Location of Death <b>Cleveland</b>		9d. County of Death <b>Cuyahoga</b>	
10. Marital Status- Married, Never Married, Widowed, Divorced (Specify) <b>Married</b>		11. Surviving Spouse (If Wife, Give Maiden Name) <b>Sefedin Amidi</b>		12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use Retired) <b>Housewife</b>		12b. Kind of Business/Industry <b>Own Home</b>	
13a. Residence-State <b>Ohio</b>		13b. County <b>Lorain</b>		13c. City, Town, Twp., or Location <b>Grafton</b>		13d. Street and Number <b>35324 Elm Rd.</b>	
13e. Inside City Limits? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13f. ZIP Code <b>44044</b>		14. Was Decedent of Hispanic Origin? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) <b>White</b>		15. Race-American Indian, Black, White, etc. (Specify)	
16. Decedent's Education (Specify Only Highest Grade Completed) Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>2</b>							

**PARENTS**

17. Father's Name (First, Middle, Last) <b>Ralph Bryant</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Giguere</b>	
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**INFORMANT**

19a. Informant's Name (Type/Print) <b>Sefedin Amidi</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, ZIP Code) <b>35324 Elm Rd. Grafton Ohio 44044</b>	
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**DISPOSITION**

20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of Cemetery, Crematory, or Other Place) <b>Resthaven Memory Gardens</b>		20c. Location City or Town, State <b>Avon, Ohio</b>	
20d. Date of Disposition <b>March 28, 2002</b>		21a. Name of Embalmer (First, Middle, Last) <b>None</b>		21b. License Number <b>N/A</b>	

**REGISTRAR**

22a. Signature of Funeral Director or Other Person <i>[Signature]</i>		22b. License Number (of Licensee) <b>6064</b>		23. Name and Address of Facility (Include City, State and ZIP code) <b>Craciun Funeral Home 7200 Detroit Ave. Cleveland, Ohio 44102</b>	
24. Registrar's Signature <i>[Signature]</i>		25. Date Filed (Month, Day, Year) <b>APR - 1 2002</b>			
26a. Signature of Person Issuing Permit <i>[Signature]</i>		26b. Dist. No.		27. Date Permit Issued	

**CERTIFIER**

28a. Certifier (Check Only One) <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date, and place; and due to the cause(s) and manner as stated. <input type="checkbox"/> Coroner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place; and due to the cause(s) and manner as stated.		28b. Time of Death <b>11:01P M</b>		28c. Date Pronounced Dead (Month, Day, Year) <b>March 27, 2002</b>		28d. Was Case Referred to Coroner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
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**CAUSE OF DEATH**

28e. Signature and Title of Certifier <i>[Signature]</i> <b>William Fallon</b>		28f. License Number <b>0435065116-F</b>		28g. Date Signed (Month, Day, Year) <b>3/27/02</b>	
29. (Type/Print) Name (First, Middle, Last) and Address of Person who Completed Cause of Death (Include City, State and ZIP code) <b>William Fallon, M.D. 2500 MetroHealth Dr. Cleveland, Ohio 44109</b>					

30. Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Type or print in permanent black ink.		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) → <b>CARDIOPULMONARY FAILURE</b>			
Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause Last (Disease or injury that initiated events resulting in death)			
a. Due to (or as a Consequence of)			
b. Due to (or as a Consequence of)			
c. Due to (or as a Consequence of)			
d. Due to (or as a Consequence of)			

**PLAINTIFF'S  
EXHIBIT**

**7/8/03**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				31a. Was an Autopsy Performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		31b. Were Autopsy Findings Available Prior to Completion of Cause of Death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
32. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could Not Be Determined		33a. Date of Injury (Month, Day, Year)		33b. Time of Injury <b>M</b>		33c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
33e. Place of Injury - At Home, Farm, Street, Factory, Office Building, etc. (Specify)		33d. Describe How Injury Occurred					
33f. Location (Street and Number or Rural Route Number, City or Town, State)							



THE METROHEALTH SYSTEM  
METROHEALTH MEDICAL CENTER  
DEPARTMENT OF RADIOLOGY

Attending MD: WILLIAM FALLON  
Requesting MD: RAJNISH TANDON

Diagnosis: MORBID OBESITY  
History: S/P GASTRIC BYPASS

NM LUNG PERFUSION/VENTILATION  
(MC) MNM234 03/23/2002

8:33 PM

Acc # 3015266

NM COMPUTER IMAGE MANIPULATION  
MNM331 03/23/2002 8:38 PM Acc # 3015282

TECHNIQUE: Inhalation images were obtained after the patient breathed for 5 minutes from a nebulizer containing 39.6 mCi of Tc-99m PYP. Following this, 5.4 mCi of Tc-99m MAA were injected intravenously and perfusion images were obtained. Only anterior images were obtained secondary to patient large body habitus.

NUCLEAR - SIMPLE DATA MANIPULATION: Simple automated, interactive computer data analysis and manipulation was performed for generation of data for interpretative analysis.

FINDINGS: Chest radiograph from the day of the scintigram is extremely limited but shows no large consolidation or effusion.

This exam is significantly limited by patient body habitus. Overall, the perfusion images show increased radiotracer uptake diffusely compared with the ventilation images. There is no obvious V/Q mismatch. Bilateral large matched defects are noted in the bases.

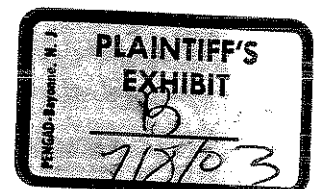
IMPRESSION:  
Low probability of pulmonary embolus within the limitations of the exam noted above.

Interpreted by: Anthony Minotti, M.D. Signed: Anthony Minotti, M.D.  
Aaron M.D. Wittenberg Signed: Anthony Minotti, M.D.  
I have reviewed the study and interpretation  
with the resident and agree with the findings.  
Authenticated on: 03/25/2002 8:04 AM by Anthony Minotti, M.D.  
Transcribed on: 03/24/2002 4:05 PM by Vicki Draganic  
Last Edited on: 03/25/2002 8:04 AM by Anthony Minotti, M.D.  
Finalized on: 03/25/2002 8:04 AM by Anthony Minotti, M.D.

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**RADIOLOGY**

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