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.

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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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W I T N E S S I N D E X

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EXHIBIT MARKED

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

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

BY MR. CONWAY:

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

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

Have you previously given a deposition?

A. Yes.

Q. Approximately how many times?

A. Five.

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

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

A. That's fine.

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

A. That's fair.

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

A. Thanks.

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

A. Yes.

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

A. All right.

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

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

A. I understand that.

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

A. I have.

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

A. Yes.

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

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

A. Yes, I am.

Q. Approximately how many?

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

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

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

A. Yes.

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

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

Q. Which organizations?

A. That would be East.

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

A. Yes.

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

A. Yes.

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

A. I was president of East.

Q. And during what years?

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

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

organizations?
A. Yes.
Q. Did you find it useful in your practice of medicine to be active in these organizations?
A. Yes.
Q. You're a member of the American College of Surgeons?
A. Yes.
Q. Are you familiar with their recommendations regarding bariatric surgery?
A. Yes.
Q. Are you a member of the International Community of Bariatric Surgeons?

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

MR. CONWAY: There's an organization.

A. No, I'm not.
Q. Are you a member of the American Society for Bariatric Surgery?
A. Not presently.
Q. Are you a member of the American Organization of Bariatric Surgeons?

A. No.
Q. How long have you been performing bariatric surgery?
A. In its various aspects, since I was a resident in surgery. And that dates back to 1976.
Q. How about roux-en Y gastric bypass operation?
A. That operation is a relatively newer operation and I started doing that in 1996. I think. Yes. 1996.
Q. Are you a member of any association or organization of bariatric surgeons?
A. No.
Q. Have you applied to become a member of any of those organizations?
A. Yes.
Q. Which ones have you applied to become a member of?
A. The American Society of Bariatric Surgery.
Q. When did you first apply to become a member there?
A. Several years ago.
Q. Why aren't you a member, if you know?
A. You need two recommendations from other bariatric surgeons and I didn't know anybody who belonged to the organization.

Q. When did you first put your application in?
A. I don't remember.
Q. Do you know two members now of that?
A. I know one.
Q. Who is that?
A. That's a person who is in practice in Wisconsin who is a colleague of mine in the trauma -- committee on trauma.
Q. Are there any type of tests or boards that you have to take in order to become a member of the American Society of Bariatric Surgeons?
A. To my knowledge, no.
Q. Why do you feel it beneficial for you to become a member of that organization?
A. To communicate with colleagues who are doing this operation, who are taking care of patients who are bariatric surgery patients.
Q. So the only reason you are not a member is you need two members to sponsor you into that organization?
A. That's correct.
Q. Any other organization or society or association of bariatric surgeons you've attempted to join?
A. No.
Q. Have you attended any type of continuing medical

education training regarding bariatric surgeries?
A. No.
Q. Have you considered doing so?
A. No.
Q. Why not?
A. I'm not quite sure I understand what you're asking.
Q. Well, different organizations put on training or educational seminars to help bariatric surgeons become better at what they do. You're aware of that?
A. Yes.
Q. For instance, all those different organizations have conferences and teaching seminars, you're aware of that?
A. That's correct.
Q. My question is you've indicated that you've never attended any type of continuing medical education, training seminar regarding bariatric surgery. And I'm just asking why not?
A. Well, it's been part of my practice, the scope of my practice as a surgeon, a critical care surgeon for the last 25 years.
Q. Have you mentored under anyone or have you had a mentor in the area of bariatric surgery?

A. No.
Q. You are the chief of the bariatric surgery division at MetroHealth Medical Center?
A. I'm one of the two people who do bariatric surgery at the MetroHealth Medical Center. We don't have a specific division. It's part of the division of trauma, critical care, burns and flight.
Q. Who is the other physician that does those surgeries?
A. Dr. Gagliardi.
Q. How long has Dr. Gagliardi been performing those surgeries?
A. I don't know the answer to that. He was a resident in surgery at Ohio State and learned how to do bariatric surgery as part of his residency, as did I. And so I assume he's been doing that for the time he's been a resident in surgery. He's been a member of our faculty for the last three years.
Q. If there was a senior physician, would it be you or Dr. Gagliardi?
A. I'm the senior physician.
Q. Does Dr. Gagliardi have more experience in bariatric surgery than you?

A. No.
Q. Is he a member of any of these bariatric surgeon organizations, to your knowledge?
A. I don't know the answer to that.
Q. Have you ever spoken with him regarding that subject?
A. Which?
Q. Joining a --
A. Oh, yes. We're both trying to become members. The American Society of Bariatric Surgery and it has to do with, again, having people who you know who recommend you and write a letter.
Q. Are you familiar with the National Institute of Health guidelines for treating obesity?
A. Yes.
Q. Do you find those guidelines to be reasonable and prudent?
A. Yes.
Q. Have you read any of the guidelines or literature that has been generated by the American Society of Bariatric Surgeons?
A. I've read some of their literature, yes.
Q. Have you read any of their guidelines?
A. I don't believe so.
Q. Are you familiar with the Cleveland Center for

Bariatric Surgery located at St. Vincent Charity Hospital?

A. Yes.

Q. Do you know any of the physicians there?

A. Not personally, no.

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

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

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

A. No.

Q. Do you know a Dr. Helmut Schreiber?

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

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

A. I have no opinion about that.

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

A. No.
Q. You are aware that Dr. Helmut Schreiber is the director of surgery for Cleveland Bariatric Surgery at St. Vincent?
A. No, I wasn't aware of that.
Q. I assume prior to performing your surgery on Royanne Amidi, were you aware the doctors at the Center for Bariatric Surgery determined that Royanne Amidi was not a good surgical candidate and, in fact, refused to perform bariatric surgery on her?
A. No, I was not aware of that.
Q. Is that something that would have been useful information for you to be aware of prior to your surgery on March 22nd?
A. I don't know the answer to that question.
Q. Were you aware, Doctor, that Royanne Amidi had consulted with physicians at the Cleveland Center for Bariatric Surgery prior to coming to you?

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

Was that given to us in response to discovery?

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

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

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

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

MR. CONWAY: Sure.

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(Thereupon, a recess was had.)

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

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

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

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

MR. MALONE: All right.

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

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

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A. I don't believe I was.

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

A. Yes.

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

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

Q. Would that have been information you would have wanted to know about prior to your surgery?
A. Yes.
Q. Did you take a history and physical from your patient prior to operating on her?
A. Yes.
Q. Did you ask her whether she was on any type of antibiotic?
A. I don't believe I asked her that question specifically.
Q. Is that a question that a reasonable and prudent surgeon should ask his patient?
A. That she's on antibiotics?
Q. Whether or not the patient is on antibiotics.
A. Yes.
Q. Had you known that she was still taking her ten-day course of antibiotics that were started on March 15th, 2002, would you have postponed your surgery?
A. Yes.
Q. And why would you have done that?
A. Because of the risk of infection associated with that.
Q. What type of different bariatric surgeries are available for a patient such as Royanne Amidi?

You chose the roux-en Y gastric bypass?
A. That's correct.
Q. What other type of gastric surgeries are available for an obese patient such as Royanne Amidi?
A. There probably is no other operation that is as good for weight loss for her condition.
Q. Are there some other type procedures that are available?
A. Yes, there are others available.
Q. Do you perform any of those?
A. No.
Q. Have you ever performed any of those?
A. Yes.
Q. Which ones have you performed other than the roux-en Y gastric bypass?
A. The vertical banded gastroplasty was surgery of choice in the late '80s, early '90s.
Q. Did you ever perform that?
A. Yes.
Q. How many times approximately?
A. I don't remember. Prior to that there was an operation that was the predecessor to the vertical banded gastroplasty. And it involved stapling against the proximal portion of stomach

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

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

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

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

Q. Who did you gain that information from?

A. I don't recall.

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

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

medical condition.

Q. And when was that question asked of her?

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

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

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

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

A. Yes, I do have an opinion.

Q. What is your opinion?

A. She wasn't.

Q. She was not?
A. That's correct.
Q. And in what specific ways was she non-compliant?
A. She told me that she had stopped smoking. I don't do this operation on people who are smokers because of the risks associated with that. And she knew that from the very beginning and she told me that she had stopped smoking.
Q. How do you know she did not stop smoking?
A. I don't know that for a fact, but everybody else has documented that she was a smoker. Her physical examination at the time of her admission to the hospital says that she was a smoker.
Q. And if you don't operate on smokers, why was she allowed to go to the surgery then?
A. I was not aware that she was still smoking. She told me that she wasn't.
Q. But yet, according to the records, you're indicating that she told other people that she was currently smoking?
A. That's correct. That's correct.
Q. Is that rule that you have about not doing this operation on patients who smoke, has that been communicated to your staff at the bariatric -- your bariatric staff here at Metro?

A. Yes.
Q. Should your nurses or physician assistants or residents, whoever took that information, should they have conveyed that information to you?
A. That's correct.
Q. Would that be below the standard of care for them if they did not convey that information to you?
A. It would be troublesome. Yes, it would be.
Q. It would be below the standard of care, right?
A. It would be troublesome.
Q. Troublesome is not a good thing, is it?
A. No, it's not.
Q. All right. In what other ways do you believe that Royanne Amidi was not compliant?
A. She gained weight between the time that we saw her and the time that we operated on her.
Q. And she was told not to?
A. That's a -- that's a worrisome sign because people don't -- people who are not willing to -- they are aware of a diet that they are supposed to be on before they're operated on. One of the things we do is send them to a nutritionist. The nutritionist talks to them about low carb, low fat diets, how to calculate the percentage of calories from fat. They're all instructed in

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

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

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

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

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

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

A. The nurses would have.

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

A. Yes.

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

A. That's correct.

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

A. Yes.

Q. What other ways was Royanne Amidi non-compliant?
A. I don't believe I know of any other ways.
Q. Had you known that she had gained weight, would you have operated on her on March 22nd?
A. Possibly, but I would have wanted to know what the circumstances were that were related to the weight gain.
Q. Had you known that she was still smoking, according to whatever records you looked at, would you have still performed that operation upon her on March 22nd?
A. No, I would not.
Q. Why not?
A. Because of the implications for her health after the surgery. This is an operation that decreases your ability to breathe normally because of the pain that's associated with the incision. And her obesity also decreases her ability to breathe normally. That's already -- that's not going to go away in the five or six hours after the operation. And she has a history of reactive airway disease, which also is a troublesome factor in her healthcare system.
Q. Is anyone in the bariatric clinic here at Metro responsible for getting a list of medications

that the patient is taking prior to surgery?

A. Not anybody in the bariatric center, no.

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

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

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

A. Yes.

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

A. No.

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

A. Yes, they would be.

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

A. Yes.

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

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

A. That's correct.

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

A. I will -- I ordered that.

Q. What time did you order that discontinued?

A. I don't recall.

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

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

Q. Is it a resident of yours?

A. I don't know.

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

A. Yes.

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

A. That's correct.

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

26th, the time of her death?
A. That's correct.
Q. So you would have been the physician who was responsible for her overall care and treatment; is that correct?
A. That's correct.
Q. Obviously, you would have the ability to bring in experts or consultants in certain areas of medicine if you so chose to, correct?
A. That's correct.
Q. And you could choose whether or not to defer to their expertise in a certain area; is that correct?
A. That's correct.
Q. But ultimately her care and treatment is your responsibility; is that right?
A. That's correct.
Q. Did you have residents working under you at the time as well?
A. Yes.
Q. Approximately how many residents were working under you?
A. I don't know the answer to that.
Q. Are you familiar with the residents' signatures from --

A. I'm not familiar with that signature, no.
Q. As of the time the Heparin was discontinued at 9:45 a.m. on March 24th, what was your differential diagnosis as to Royanne Amidi's condition?
A. I'd have to look at the medical record to see if --
Q. Please, look at whatever you like. I need to know.

MR. MALONE: Do you want notes?

THE WITNESS: Progress notes. Yes.

A. Well, I have a note that is written 20 minutes later.
Q. What time is that note timed?
A. It's 20 minutes later. 1005.
Q. And what does that note say, Doctor?
A. It says, "Seen on rounds. Interval events reviewed and agree. Issues, awake and alert despite hypotension and tachycardia. ABG, which stands for arterial blood gas, 7.37. pCO2 of 44. pO2 of 78. Bicarb of 25. Hemodynamically consistent with hypovolemia. Has been tachy to 150 since last p.m. Blood pressure decreased. Hematocrit in the morning of 36.6. GI, minimal

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

Q. What is BIPAP?

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

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

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

Q. What do you think was causing that?

A. I didn't know.

Q. Would you agree that the most common cause of

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

A. Which are you talking about?

Q. That those are the --

A. Big three?

Q. Yes.

A. Yes.

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

A. That's correct.

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

A. Would you repeat that again?

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

A. I would have to agree with that.

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

infection, peritonitis, abscess and death?
A. Yes.
Q. Do you agree with leakage also occurring from one of those sites, whether sutured or stapled, increased pain, back pain and left shoulder pain, increased anxiety and restricted breathing are all telltale symptoms of a leak?
A. I'm sure you can see those, but I wouldn't say they are telltale symptoms.
Q. What causes the -- what causes left shoulder pain?
A. It's referred pain. It's diaphragmatic irritation.
Q. You're aware of that as a surgeon, correct?
A. Yes.
Q. Would you agree that an individual who has sustained a leak from the site of sutures or stapling, that leak can often be diagnosed by a plain x-ray film?
A. No, it would not. I think it's very difficult to diagnose that by plain x-ray film.
Q. Well, if there's a leak, you're going to end up with free air, correct? And that would show up on an x-ray film?
A. Not necessarily.

Q. Does it show up on an x-ray film?
A. Free air shows up on an x-ray film. But you're making the cause-and-effect relationship that a leak is going to cause free air is not necessarily the case.
Q. Does it often cause free air?
A. It can. I don't know if it causes it with any degree of frequency. I've only had a couple of leaks.
Q. And how were those leaks diagnosed?
A. They were diagnosed by gastrografin swallows.
Q. And, in fact, that's one of the major diagnostic tools if a surgeon suspects a leak is to --
A. Correct.
Q. Is to perform that test?
A. Some of us do it routinely.
Q. First of all, was an abdominal x-ray considered by you in this particular case?
A. No.
Q. Was a gastro --
A. Grafin swallow.
Q. Considered by you?
A. No.
Q. Why?
A. No. Because in my opinion, this was not the --

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

Q. What do you base that on?

A. Past experience.

Q. Have you had patients who have leaked before?

A. Yes.

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

A. None.

Q. So this would be the first?

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

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

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

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

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

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

A. Yes.

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

Q. Would you agree with that?

A. Yes.

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

A. In my opinion, it was her cellulitis.

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

A. Bacteremia.

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

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

the bloodstream.

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

A. Which?

Q. Either one of them.

A. Neither.

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

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

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

A. It's possible.

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

A. It's possible.

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

A. No.

Q. What leads you to the conclusion that she wasn't?
A. I have no evidence to document that that indeed was the case based on my clinical evaluation of the patient at the time.
Q. If, in fact, according to your belief that that was sepsis caused by bacteremia as a result of her preexisting cellulitis, those conditions would still be your responsibility to treat during her hospitalization for her surgery, correct?
A. Yes.
Q. Would you agree to minimize morbidity and mortality related to leak it's imperative to recognize a leak can occur after any gastric bariatric operation?
A. Yes.
Q. And I believe you already hit on this. It then becomes the obligation of the surgeon to perform a gastrografin swallow when a leak is suspected, correct?
A. Correct. I told you that some of us do that routinely.
Q. Do you do it routinely?
A. Yes.
Q. Was it done in this case?

A. She didn't make it to the point where I do it routinely.
Q. When do you?
A. Day five.
Q. Day five?
A. Day five.
Q. Is that written down anywhere? Do you have that in any type of written protocol?
A. I don't know. I don't believe so.
Q. Do you have written protocols for the bariatric unit, whether it just be you and your doctor, that you would give to your staff?
A. No. We have -- yes, we do have some basic rules and regulations that are written down, but nothing that specifies the specific aspects of patient care.
Q. What are the basic rules, basically, that are written down? Just give me an example. I'll ask your attorney for them. I think I've already asked for them. But give me a flavor for what we are talking about.
A. The screening criteria for preoperative preparation. The mechanisms that we go through for contacting all the different specialists who need to see the patient and make sure that they

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

Q. And you do have those in writing?

A. I believe so.

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

A. They're from our office.

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

A. That's correct.

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

A. Yes.

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

A. Yes.

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

A. That's correct.

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

A. I don't know.

Q. Isn't that something you should do?

A. Yes.
Q. Is that your handwriting, cardiopulmonary failure?
A. No, it is not.
Q. Whose handwriting is that?
A. I don't know.
Q. This is your handwriting up here?
A. That's my signature, yes.
Q. Is it supposed to be the physician who is signing that who fills out the cause of death?
A. Yes.
Q. And that was not done in this case, was it?
A. No.
Q. Showing you what has been marked for identification as Plaintiff's Exhibit B. In reviewing this case prior to trial -- excuse me. Strike that. In reviewing the records prior to this deposition, I presume you came across this radiology report?
A. Yes.
Q. It indicates that on March 23rd, 2002 at 8:38 p.m. a lung perfusion scan was done, correct?
A. Yes.
Q. And would Dr. Tandon had been a resident under your supervision at that time?

A. Yes.

MR. MALONE: Tandon you said?

MR. CONWAY: He's at the top.

MR. MALONE: I see it.

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

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

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

A. That's correct.

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

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

Q. Right.

A. What you just said is not that.

Q. What did I just say that is different?

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

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

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

A. That's correct.

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

A. That's correct.

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

A. That's correct.

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

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

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

considering the possibility that she may have sustained a leak?

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

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

- - - -

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

- - - -

A. Prior to March 25th, no.

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

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

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

A. Yes.

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

A. Within their hospital -- postsurgical hospital stay?

Q. Yes.

A. No.
Q. Have you had other patients die from complications?
A. Yes.
Q. Approximately what percentage of --
A. Less than one percent.
Q. So prior to March 25th then, your answer would be that you did not believe that she was suffering from -- you did not believe there was a possibility that she was suffering from a leak; is that correct?
A. That's correct.
Q. Because if you believed there was a possibility she was suffering from a leak, you would do that gastrografin --
A. Gastrografin swallow.
Q. Are you familiar with different recommendations that exist for facilities performing bariatric surgery?

MR. MALONE: What?

A. I'm not sure I understand what you mean by that.
Q. Different organizations, such as the American College of Surgeons, has recommendations or requirements or guidelines for facilities which perform bariatric surgery?

A. Yes.
Q. Are you familiar with those? For instance, with the American College of Surgeons' recommendations for facilities performing bariatric surgery?
A. I know that they exist.
Q. Have you read them?
A. I've seen them, yes.
Q. Did you find them reasonable and prudent at the time you reviewed them?
A. I don't think I reviewed them -- they're reasonable and prudent. I don't remember reviewing them to the point where I was making judgments about them.
Q. Well, presumably when you were reviewing them or read them, it would cross your mind whether or not MetroHealth Medical Center was complying with those guidelines. Would that be fair?
A. Yes.
Q. Because those recommendations would be something you'd at least take into consideration in how you run your bariatric center here, correct?
A. Sure. Sure.
Q. Following surgery such as Royanne Amidi has -- or had in this particular case, is it standard for the patient to go to a floor as opposed to the

ICU following this type of surgery here at MetroHealth?

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

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

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

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

A. 1996.

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

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

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

A. We don't advertise.

MR. MALONE: I'm going to object. There's no advertising for that.

A. We don't.

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

A. Yes.

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

A. Probably since the time of his arrival.

Q. Which was?

A. Three years ago.

Q. So that would be about the year 2000?

A. Yes.

Q. What area of trauma surgery is your specific

interest?

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

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

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

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

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

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

Q. Have you done any writing on bariatric surgery?

A. Yes, I have.

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

A. One book chapter, one book.
Q. One book?
A. One book.
Q. What is the name of the book?
A. The Thinking Persons Guide To Exercise and Weight Loss. It's an Internet book that we're publishing.
Q. Is it published yet?
A. I don't know. I don't believe so.
Q. Is there a way to get a copy of it?
A. I have a copy. I can give it to Jim.
Q. And then a book chapter in what book?

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

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

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

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

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

Q. Do you have a copy of that?

A. Yes.

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

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

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

A. To my knowledge, no.

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

MR. CONWAY: Correct.

Q. Generally you're board certified?

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

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

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

Q. Do you have an approximation?

A. I would say 75 to a hundred.

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

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

MR. CONWAY: All right.

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

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

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

A. Somewhere in the neighborhood of five to ten.

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

A. Not to my knowledge.

Q. Is that something you have sought to attain?

A. Not currently, no.

Q. Why not?

A. Program in evolution.

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

A. Yes.

Q. Prior experience?

A. Yes.

Q. And how do you know that?

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

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

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

A. That's fine.

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

A. Yes.

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

A. Across the country?

Q. Yes.

A. No.

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

A. From her primary care doctor.

Q. And what was your initial impression of her?
A. That she needed the operation.
Q. Did you put her on any type of diet or attempt a trial diet with her prior to her surgical date?
A. I did not. We talked earlier about what we do when they visit the nutritionist. We're not any more compulsive about that than that.
Q. There's guidelines out there, and I don't know if you are aware of them or not, that indicate that a diet should be tried, a patient should be put on a diet by the surgeon prior to the surgeon going ahead with the operation. Do you subscribe to that theory or not?
A. There are multiple -- these people have come to you having had multiple attempts at losing weight and including multiple attempts at dieting. The reason you are operating on this disease process is because they can't lose weight any other way. So to put somebody on a diet as part of their preparation for surgery is highly unlikely to be successful.
Q. Have you ever had a patient come in who has been obese where you have attempted to control their weight through dieting prior to scheduling surgery?

A. Yes.
Q. And have you ever been successful?
A. It doesn't work.
Q. Does it ever work for you?
A. It has never worked.
Q. Patients who come to a surgeon for surgical correction of their overweight problems at times can be desperate. Would you agree with that?
A. Yes.
Q. Have you had patients before Royanne Amidi who have come to you after going to another bariatric surgeon?
A. I don't know the answer to that question.
Q. Is that something your staff should be asking these patients?
A. Why?
Q. To find out whether or not you're the first surgeon they've come to or whether they've been turned down by other surgeons I suppose would be a reason. I mean, do you have -- so you do not ask them that information?
A. Routinely, I do not.
Q. Had you known that she had been turned down by another bariatric surgeon, would you have done anything different in your preparation for

surgery with Mrs. Amidi?

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

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

A. No.

Q. No?

A. No.

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

MR. CONWAY: HIPAA --

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

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

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

A. We have a process for obtaining medical records.

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

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

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

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

Q. Have you had complications from those?

A. Yes.

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

A. Yes.

Q. Do you conform to their guidelines?

A. I believe so.

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

A. When she first saw us, her BMI was 88.
Q. At one point, it was 91 prior to her surgery, correct?
A. Probably when she gained the additional weight prior to surgery that would be -- it's not unreasonable.
Q. Is BMI of 91 a contraindication for this type of surgery?
A. I don't believe so.
Q. You don't?
A. No.
Q. Is there any BMI that would be a contraindication for this type of surgery?
A. I don't necessarily think it would be necessarily the BMI. You could have a six-foot-one person with a BMI of 90 and they would be in the 600-pound range. You could have a five-foot-one person and a BMI of 90 and be in the 400-pound range. The way I do the operation, the exposure is okay regardless of how big they are.
Q. Are there any specific preoperative consults or evaluations that you order prior to doing surgery on a patient?
A. Yes. We obtain nutrition consults, we obtain pulmonary consults, we obtain cardiology consults

and psychiatric consults. Those are the routines.

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

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

Q. Was there a nutritional consult done?

A. Yes.

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

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

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

A. Yes.

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

A. I think so.

Q. And cardiac?

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

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

A. Yes.

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

considered part of your psychiatric consult?
A. It is now.
Q. Did you do it back then?
A. I don't recall.
Q. Did you have any reservations at all about doing surgery on Mrs. Amidi?
A. Yes.
Q. What were those reservations?
A. Her underlying constitutional health status. But there are no options for these patients.
Q. What type of consent form did you have Mrs. Amidi sign for this particular surgery? Was it just a general surgical consent form?
A. Yes.
Q. The American Organization of Bariatric Surgeons recommends a separate and detailed presurgery consent form be provided patients who are undergoing bariatric surgery. Do you agree with that guideline or --
A. Sure. I don't think it's necessarily standard of care.
Q. Did you explain the risks of this procedure to Royanne Amidi?
A. I believe so.
Q. Did you explain there's the risk of the -- you

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

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

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. Who conducted the immediate preoperative physical examination?
A. One of our nurse practitioners in the presurgical evaluation area.
Q. So at the time of surgery, would you have been aware of her weight being 467 pounds?
A. Yes.
Q. Were you aware that during the preoperative exam itself notations indicate left leg erythema?
A. No.
Q. What could be the cause of left leg erythema?
A. It could be cellulitis.
Q. Did anybody bring that finding to your attention prior to the surgery beginning?
A. No.
Q. Had they brought that to your attention prior to surgery, would you have gone forward with the surgery?
A. I would have evaluated the area and seen if it was an acute inflammatory change or whether it was chronic and venostasis sort of changes and made a decision based on that. In light of the fact that she was still on antibiotics at the time of surgery, if I was aware that she had other -- she had -- she was on antibiotics and

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

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

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

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

A. Yes.

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

A. No.

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

A. Yes.

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

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

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

A. Yes.

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

asking. Who is Dr. Anastasior Konstantakos?

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

Q. Do you know where he is now?

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

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

A. He was a PGY 5.

Q. What is that?

A. Chief resident.

Q. Had he done bariatric surgery before?

A. Yes.

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

A. He's my first assistant.

Q. Did you perform the entire surgical procedure?

A. Yes.

Q. Who closed the surgical incision?

A. The surgical site?

Q. Yes.

A. He and I did together.

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

A. Yes, I was.

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

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

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

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

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

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

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

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

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

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

A. No.

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

A. You mean close the surgical incision?

Q. Yes.

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

Q. Have you ever had chief surgical residents do that for you?
A. No. I always close the wound. I may not close the skin, but I always close the wound.
Q. After closing the wound, did you leave here prior to closing --
A. I do not remember. But most likely, I did not.
Q. Why do you say most likely you did not?
A. Because I wrote a note saying I was present for the operation. I may have been in the room writing notes when they were closing the skin with the skin staple gun. But I am always in the room.
Q. Did this operation take longer than you thought it would take?
A. It usually takes -- I don't know how long it took. Let me see. Wait a minute. That's the note -- before the case. That's the note -- that's the time after the case. No. It usually takes an hour for every hundred pounds they weigh. That's a ballpark figure.
Q. Was the incision length that you used in this particular case longer than you thought would have been necessary prior?
A. No, no.

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

A. I don't recall that conversation.

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

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

Q. What do you recall about that conversation?

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

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

Q. Do you recall any other specifics of that conversation?
A. No.
Q. And what I'm trying to do -- just so I'm not beating around the bush. I'm trying to find out if you have a specific recollection of any conversations before the actual surgery.

So that would be the extent of your recollection of talking with them prior to the surgery?
A. That's correct.
Q. How did the overall surgery go in your opinion? Were there any complications?
A. No. The surgical procedure was, I think, pretty much standard.
Q. It says during the procedure one of the lesser curvature veins was bleeding which required oversewing with sutures. Is this bleeding a common occurrence for this type of surgery?
A. Yes.
Q. Is it standard practice to oversew the bleeders?
A. It's my standard practice. Other people perhaps will do it differently, but my practice is always to put a stick tie in.
Q. It also indicates there was -- oversewing of

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

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

Q. And signed off by you?

A. Yes.

Q. So you agreed with his conclusions?

A. Yes.

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

A. No. I always oversew my staple lines.

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

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

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

A. No.

Q. There's also another part in your operative

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

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

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

A. I don't think so.

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

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

Q. Look at whatever you need to look at.

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

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

MR. MALONE: Meaning what?

MR. CONWAY: We started about --

MR. MALONE: 2:15.

MR. CONWAY: No, we did not.

MR. MALONE: 2:15 I came out and

got you.

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

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

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

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

MR. MALONE: Off the record.

- - - -

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

- - - -

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

A. No.

Q. Is that something you normally do?

A. No.

Q. Why not?

A. The anesthesiologists normally do that.

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

A. Yes.

Q. What is the criteria for you assessing a patient

versus not assessing?

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

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

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

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

A. No.

Q. Should you have been?

A. Yes.

Q. Was it below the standard of care that no one did notify of you that sustained tachycardia?
A. No, I don't believe so. As long as somebody knew about it.
Q. But you still should have been made aware of it?
A. Yes.
Q. What is the expected and acceptable urinary output for this type of postop patient?
A. We like to see one to two cc's of kilogram of urinary output. That's for ideal body weight. So in her particular case, somewhere in the neighborhood of 20 to 25 cc's would have been acceptable.
Q. Were you concerned that she had put out only 120 cc's of urine over a two-and-a-half-hour period?
A. No.
Q. Is that a low amount of urine output?
A. It's an average amount of urine output.
Q. For this type of patient?
A. Yes.
Q. What would be on your differential diagnosis for tachycardia, decreased urinary output and borderline high blood pressure in a patient such as Royanne Amidi immediately postop?
A. I don't think all three of those things are

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

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

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

Q. How about sepsis?

A. For high blood pressure, no.

Q. How about for the tachycardia?

A. Could be.

Q. Low urinary output can also signal sepsis?

A. Yes.

Q. Because the kidneys are shutting down, correct?

A. Yes.

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

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

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

A. I don't recall.

Q. Do you want to look at a chart?

A. I don't think it would help.

Q. Were you aware that postoperative night number

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

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

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

A. No.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes, yes.

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

A. No.

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

A. Yes.

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

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

Plan, increased activity today."

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

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

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

A. Most likely, yes.

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

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

Q. Would you have been made aware of that?

A. Yes.

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

A. I need to take a break.

- - - -

(Thereupon, a recess was had.)

- - - -

A. The most common reason for her to be tachycardic in my opinion would be pain.
Q. Did you chart anywhere in your chart preoperatively that you recommended or told Mrs. Amidi to stop smoking?
A. No.
Q. Did you chart anywhere that -- telling her that if she did not stop smoking she would not be a surgical candidate?
A. No.
Q. Why didn't you chart those things?
A. I would not have told her that she would not be a surgical candidate. I would have told her I would not operate on her until she stopped smoking.
Q. Regardless, that was never charted, that conversation?
A. I don't believe so.
Q. Is that something you typically would chart?
A. I try to.
Q. Were you aware that left shoulder pain is indicative of possible gastric leak postoperatively?
A. Yes.
Q. Did that thought enter your mind on the morning

of March 23rd?

A. No, it did not.

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

A. I don't recall that.

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

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

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

A. No.

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

A. That's correct.

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

A. That's correct.
Q. Is there any -- are there any notes from any of your residents on March 23rd?
A. I believe so.
Q. Could you point those out to me? Do you usually read over your residents' notes and then sign off on them?
A. No. I typically write my own notes.
Q. Do you review the residents' notes to make sure that they're catching onto what they should be doing?
A. Yes.
Q. Were there any residents' notes written, any of your residents writing notes on March 23rd?
A. There's a note from 3-23-02 at six p.m. written by a surgery resident that's not my resident.
Q. Why would some other resident other than yours be writing a note?
A. 6:00, that's probably the coverage change. And there's a note from 3-23-02 by the team resident that's ahead of mine, but not timed. That is from one of the residents in my service.
Q. Is your service blue team?
A. Blue surgery, yes.
Q. And that note was not timed?

A. Correct.
Q. I presume your residents are instructed to time their notes?
A. It's standard practice.
Q. Could you read both of those notes at the time?
A. Yes.
Q. Were you able to read them?
A. Yes.
Q. Why don't we go to the first note, 3-23-02, note from your resident on blue surgery.
A. Patient doing well, but this a.m. -- that's approximately 9:00 a.m. complained of left shoulder and chest pain. I don't recognize what those two words are. Lasted approximately ten minutes. Resolved with MS 04 and Toradol. EKG obtained and unchanged from prior. Pain, completely resolved. ABG obtained on two liters. Nasal -- I don't know what that is. Pulse 120. Respiratory rate, 20. Blood pressure, 130 over 70. Lungs clear of oscillation. Cardiovascular, regular rate rhythm. Evidence soft, non-distended, mildly tender in -- something.

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

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

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

A. Postoperative hypovolemia.

Q. The cause of that would have been what?

A. The operation.

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

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

Q. At 10:35?

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

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

A. Yes.

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

A. This is a nursing note.

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

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

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

A. No.
Q. Then we have a surgery note at 3-23-02 at six p.m. This would have been a covering surgical resident?
A. That's correct.
Q. Under what attending would this surgical resident be responsible to?
A. He would be responsible to all of us. He's the person who is on call in the hospital at night. One of the people.
Q. And in reading his note there, you can read his note, correct, Doctor?
A. Yes.
Q. Is there anything disconcerting about Royanne Amidi's condition as of 3-22 at six p.m.?
A. This is a note where she's transferred from the floor to the intensive care unit.
Q. That's based upon her continued tachycardia?
A. Physical findings. Yes.
Q. Her hypotension with the blood pressure. Based upon this, what was your differential diagnosis?
A. I was not there at the time. The critical care attending who was on call was there, Dr. Yowler. He's one of my partners.
Q. Did he contact you regarding your patient?

A. The resident did.
Q. What was your thinking as to what was causing these findings?
A. They were working her up for pulmonary embolism at that time.
Q. Would that have been number one on your differential diagnosis?
A. Yes.
Q. Would you have had surgical leak and/or infection as well on your differential diagnosis?
A. Not in the first 24 hours after surgery, no.
Q. And she's transferred to the ICU?
A. That's correct.
Q. The critical care consult note is written by Dr. Yowler?
A. That's correct.
Q. And his first impression is possible PE. And he recommends a VQ scan, correct?
A. Yes.
Q. Were you made aware of the results of the VQ scan that was taken on March 23rd at 8:38 p.m.?
A. Yes. But not at that point in time. The next day.
Q. The next day?
A. Yes.

Q. Presumably, Dr. Yowler would have been made aware immediately of those results, correct?
A. Correct. That's why the Heparin was started.
Q. Was the Heparin started prior to --
A. Yes.
Q. The Heparin was started prior to this VQ scan?
A. Yes.
Q. Whose order was it to start the Heparin?
A. That would have been his. That's standard practice.
Q. Whenever PE is suspected?
A. That's standard practice.
Q. Then following this VQ scan, the Heparin was discontinued?
A. That's correct.
Q. Why wasn't it immediately discontinued following the VQ scan?
A. If you look at the bottom of that form, the test was not read by the radiologist until sometime after it was performed.
Q. It was not read?
A. By the radiology attending until sometime after it was performed. So the original read in the middle of the night by the radiology residents was that it was an intermediate probability VQ

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

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

MR. MALONE: May or may not be. I'm going to object to the general proposition. Some are, some aren't. It depends on what institution they come from.

Q. Were your residents employed by MetroHealth Medical Center?

A. The surgical residents?

Q. Yes.

A. They are Case Western Reserve University residents.

MR. MALONE: That's the employer.

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

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

A. Correct.

Q. Through an agreement with MetroHealth Medical Center?

A. Correct.

Q. The physicians who work at MetroHealth Medical Center, such as the radiologists, are they employees of MetroHealth Medical Center?
A. Yes.
Q. There's no indication by Dr. Minotti on his final dictated report that he had to change any of the findings by his resident. Do you agree with my reading of that or not? I'm looking at the bottom here.
A. No. No.
Q. Is that something that is done by the attending, if they have reviewed the work of a resident and found it to be deficient or wrong?
A. I don't know the answer to that.
Q. Do you change your residents or do you make notations when you feel that your residents have erred in their evaluation of something in the chart?
A. No, not typically.
Q. Anyway, as you pointed out yourself in your testimony, the VQ scan was originally read as intermediate probability by the radiology resident?
A. That's correct.
Q. The evening of March 23rd, correct?

A. That's correct.
Q. And then Dr. Minotti, the attending, came in and presumably read it correctly as being low probability?
A. Yes.
Q. And it was based upon Dr. Minotti's final conclusion that --
A. The Heparin was stopped.
Q. The Heparin was stopped. All right. Do you give specific orders for residents to call you at home or wherever you may be if you're not physically at the --
A. No.
Q. -- hospital? Are they given an order for them to call you if there's any significant change in a patient's condition?
A. There's no order given. That's standard practice.
Q. But they're made aware of that, correct?
A. Yes.
Q. Did you consider transferring Mrs. Amidi to the ICU at any time during March 23rd?
A. Did I?
Q. Correct. Based upon her condition prior to --
A. I don't recall. It would have been part of the

discussion.

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

MR. MALONE: More aggressive diagnosis?

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

A. I thought her treatment was appropriate.

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

A. Yes.

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

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

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

A. No, I don't recall that.

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

A. Yes.

Q. What significance did you read into her white

blood cell count of 25.18 and her bandemia of 40?

A. There are two things that could cause that. Stress could cause that, infection could cause that.

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

A. Yes.

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

A. I don't recall.

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

A. I don't recall that.

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

A. Yes.

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

A. Yes.

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

A. I believe the next morning.

Q. And why don't we go to that note. Is that that 10:05 note?
A. Yes. 3-24, 10:05.
Q. At that point, you indicate that the VQ scan not consistent with the PE, correct?
A. Yes.
Q. And that's based upon information that was made available to you by Dr. Minotti?
A. That's correct.
Q. Can you read that note into the record?
A. I thought we already read this into the note. Maybe not.
Q. We did the 10:35 one?
A. "Attending postoperative day number two, seen on rounds. Interval events, reviewed and agree. Issues, awake and alert dispute hypotension and tachycardia."

MR. MALONE: We did read this. This may be the page the court reporter wants.

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

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

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

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

A. No.

Q. Why not?

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

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

A. Yes.

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

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 OCH DATA CODING

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

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

State File No.

DECEDENT

1. Decedent's Name (First, Middle, LAST): Royanne AMIDI
2. Sex: Female
3. Date of Death (Month, Day, Year): March 27, 2002
4. Social Security Number: 279-74-4831
5a. Age-Last Birthday (Years): 30
5b. Under One Year: Months / Days
5c. Under 1 Day: Hours / Minutes
6. Date of Birth (Month, Day, Year): Feb.28,1972
7. Birthplace (City, County and State or Foreign Country): Cleve,Ohio
8. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No
9a. Place of Death (Check Only One): Hospital ☒ Inpatient ☐ ER/Outpatient ☐ DOA; Other ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. Facility Name (If Not Institution, Give Street and Number): MetroHealth Medical Center
9c. City, Village, Twp., or Location of Death: Cleveland
9d. County of Death: Cuyahoga
10. Marital Status - Married, Never Married, Widowed, Divorced (Specify): Married
11. Surviving Spouse (If Wife, Give Maiden Name): Sefedin Amidi
12a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use Retired): Housewife
12b. Kind of Business/Industry: Own Home
13a. Residence-State: Ohio
13b. County: Lorain
13c. City, Town, Twp., or Location: Grafton
13d. Street and Number: 35324 Elm Rd.
13e. Inside City Limits? ☒ Yes ☐ No
13f. ZIP Code: 44044
14. Was Decedent of Hispanic Origin? ☐ Yes ☒ No (If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)
15. Race-American Indian, Black, White, etc. (Specify): White
16. Decedent's Education (Specify Only Highest Grade Completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2

IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION →

PARENTS

17. Father's Name (First, Middle, Last): Ralph Bryant
18. Mother's Name (First, Middle, Maiden Surname): Sarah Giguere

INFORMANT

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

DISPOSITION

20a. Method of Disposition: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. Place of Disposition (Name of Cemetery, Crematory, or Other Place): Resthaven Memory Gardens
20c. Location City or Town, State: Avon,Ohio
20d. Date of Disposition: March 28,2002
21a. Name of Embalmer (First, Middle, Last): None
21b. License Number: N/A
22a. Signature of Funeral Director or Other Person: [signature]
22b. License Number (of Licensee): 6064
23. Name and Address of Facility (Include City, State and ZIP code): Craciun Funeral Home, 7200 Detroit Ave., Cleveland, Ohio 44102

REGISTRAR

24. Registrar's Signature: [signature]
25. Date Filed (Month, Day, Year): APR - 1 2002
26a. Signature of Person Issuing Permit:
26b. Dist. No.:
27. Date Permit Issued:

CERTIFIER

28a. Certifier (Check Only One): ☒ 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.
☐ 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: 11:01P M
28c. Date Pronounced Dead (Month, Day, Year): March 27, 2002
28d. Was Case Referred to Coroner? ☐ Yes ☒ No
28e. Signature and Title of Certifier: [signature]
28f. License Number: OH35065116-F
28g. Date Signed (Month, Day, Year): 3/27/02
29. (Type/Print) Name (First, Middle, Last) and Address of Person who Completed Cause of Death (Include City, State and ZIP code): William Fallon M.D. 2500 MetroHealth Dr. Cleveland, Ohio 44109

CAUSE OF DEATH

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) →	a. CARDIOPULMONARY FAILURE	
Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause Last (Disease or injury that initiated events resulting in death)	b. Due to (or as a Consequence of)	
	c. Due to (or as a Consequence of)	
	d. Due to (or as a Consequence of)	

Part II. *Other significant conditions* contributing to death but not resulting in the underlying cause given in Part I.

31a. Was an Autopsy Performed? ☐ Yes ☒ No
31b. Were Autopsy Findings Available Prior to Completion of Cause of Death? ☐ Yes ☒ No

32. Manner of Death: ☒ Natural ☐ Accident ☐ Pending Investigation
33a. Date of Injury (Month, Day, Year):
33b. Time of Injury: M
33c. Injury at Work? ☐ Yes ☐ No
33d. Describe How Injury Occurred:
33e. Place of Injury - At Home, Farm, Street, Factory, Office Building, etc. (Specify):
33f. Location (Street and Number or Rural Route Number, City or Town, State):

PLAINTIFF'S EXHIBIT 4 9/3/03

HEA 7717

THE METROHEALTH SYSTEM
METROHEALTH MEDICAL CENTER
DEPARTMENT OF RADIOLOGY

MR#: 0366876
Name: AMIDI, ROYANNE
DOB: 02/28/1972 Sex: F
Loc: B34501 Enc: 405078049
3BS
RADIOLOGY CONSULTATION
****

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.

RADIOLOGY

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
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