

1 IN THE COURT OF COMMON PLEAS

2 CUYAHOGA COUNTY, OHIO

3 SEFEDIN AMIDI, etc.,
4 et al.,

5 Plaintiffs,

6 -vs-

JUDGE GALLAGHER
 CASE NO. 493065
 VOLUME II

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

9 Defendants.

10 - - - -

11 Continued deposition of WILLIAM F. FALLON, JR.,
12 M.D., taken as if upon cross-examination before
13 Juliana M. Lawson, a Notary Public within and for
14 the State of Ohio, at MetroHealth Medical Center
15 Legal Department, 2500 MetroHealth Drive,
16 Cleveland, Ohio, at 9:00 a.m. on Thursday, August
17 14, 2003, pursuant to notice and/or stipulations
18 of counsel, on behalf of the Plaintiffs in this
19 cause.

20 - - - -

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W I T N E S S I N D E XPAGE

CROSS-EXAMINATION
WILLIAM F. FALLON, JR., M.D.
BY MR. CONWAY..... 98

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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 Q. Doctor, we're going to continue your
10 deposition --

11 A. Yes.

12 Q. -- at this time. The same understandings we had
13 at the beginning of the last depo obviously apply
14 to this one. If you want to take a break at any
15 time, let me know.

16 A. Thank you.

17 Q. Doctor, did you have a chance to read over your
18 deposition transcript in the interim time period?

19 A. No, I did not.

20 Q. You did not. Was it provided to you at all?

21 A. Yes.

22 Q. But you have chosen not to look at it?

23 A. Time constraints were such that I was unable to
24 do it.

25 Q. Doctor, would you agree that as Ms. Amidi's

1 surgeon and attending physician in this case, you
2 are forced to rely upon the medical personnel in
3 your overall care and treatment of her?

4 A. Yes. I think the medical personnel that -- an
5 operating surgeon is a victim of all the medical
6 personnel and is dependant upon all the medical
7 personnel that help you take care of the patient
8 from the referral process through the preparation
9 process.

10 Q. And medical personnel we're talking about would
11 be residents, it would be nurses, nurses
12 assistants, medical technicians and so forth?

13 A. I guess my vision for that is both intramurally
14 and extramurally. The reason we operate on
15 people is because they're referred to us by their
16 primary care doctors. They are evaluated by
17 appropriate consultants and then prepared for
18 surgery as part by the physicians and nurses and
19 other members of the team that are in the
20 hospital.

21 Q. The other members of the team that are in the
22 hospital, you're referring to nurses, nurses
23 assistants, residents that were employed by
24 MetroHealth Medical Center, correct?

25 A. Yes. Although, the residents aren't involved in

1 the preparation process, to my knowledge.

2 Q. But they would be involved in assessing the
3 patient postsurgically and would have a
4 responsibility to keep you dated as to any
5 significant events that are occurring with the
6 patient's condition, correct?

7 A. Yes.

8 Q. You rely upon those individuals, whether the
9 nurses, nurses assistants, residents or other
10 physicians to timely provide you with significant
11 information so as to allow you to make reasonable
12 and prudent clinical decisions regarding Ms.
13 Amidi's care and treatment, correct?

14 A. Yes.

15 Q. Those clinical judgments that you would have to
16 make in your relying upon others for information
17 would include whether or not to proceed with a
18 scheduled surgery, correct?

19 A. Yes.

20 Q. It would also include how to treat postsurgical
21 complications, correct?

22 A. I don't understand what you mean by that
23 question.

24 Q. Well, let's say that there are some complications
25 postsurgically. You're dependant upon the

1 nurses, residents to provide you with information
2 so that you can reach a clinical judgment on how
3 to treat somebody postsurgically if they have
4 complications?

5 A. I'm relying on them to notify me of the patient's
6 condition so I can make the judgment about
7 whether there's postsurgical complications and
8 what best needs to be done for it.

9 MR. MALONE: Let me just interpose
10 an objection. I think that question
11 assumes something that is false. And that
12 is it assumes the doctor doesn't see the
13 patient himself to make his own judgment
14 based on his own information.

15 MR. CONWAY: Oh, I'm not implying
16 that.

17 Q. I'm saying there's a time period where the nurses
18 and residents are your eyes and ears, correct?

19 A. That's a very fair statement.

20 Q. Okay.

21 MR. CONWAY: If we could mark this
22 as Exhibit Letter E.

23 - - - -

24 (Thereupon, Plaintiffs' Exhibit E
25 was marked for purposes of identification.)

1 - - - -

2 Q. I believe this is Bates stamped page 137.

3 Doctor, if you would look at Exhibit Letter E, do
4 you know who would have entered the information
5 on this exhibit?

6 A. Not specifically, no.

7 Q. What type of individual would be responsible for
8 taking this information and filling out this
9 preoperative assessment form?

10 A. The people who work in the preoperative
11 assessment area of the hospital. I don't know
12 exactly who would be responsible for filling this
13 information out.

14 Q. Are those registered nurses; do you know?

15 A. They include registered nurses.

16 Q. In any event, would those be employees from
17 MetroHealth Medical Center that were responsible?

18 A. To the best of my knowledge, yes.

19 Q. Certain information here, the fact that it's
20 written down here, that the patient is on
21 Cephalexin, 500 milligrams, twice daily, that the
22 patient smoked, smoked tobacco approximately one
23 half pack per day and that there was a history of
24 cellulitis in her legs, that would have, I
25 believe, according to your prior testimony, would

1 have been information that you would have wanted
2 to know prior to surgery; is that correct?

3 A. Yes.

4 Q. That information was not provided to you,
5 correct?

6 A. I don't believe so. I knew she had a history of
7 cellulitis. I did not know she was on active
8 antibiotics. I don't recall knowing that.

9 Q. And you did not know she was currently smoking
10 either, correct?

11 A. Well, the deal was she wasn't supposed to smoke.
12 If I had known she was smoking, we wouldn't have
13 done the surgery, among other things.

14 Q. So had you known that there was a history of
15 cellulitis and that she was currently being
16 treated with antibiotics as well as the fact that
17 she was still smoking, you would not have
18 performed the surgery?

19 A. Right. She would not have met the criteria that
20 I thought we agreed upon for her to be optimally
21 prepared for surgery.

22 Q. So you would have cancelled the surgery had this
23 information been brought to your attention,
24 correct?

25 A. Correct.

1 MR. CONWAY: Let's mark this as
2 Exhibit F.

3 - - - -

4 (Thereupon, Plaintiffs' Exhibit F
5 was marked for purposes of identification.)

6 - - - -

7 Q. This is Bates stamped page 138. Are you familiar
8 with this particular form, physical examination
9 form?

10 A. This is the other piece of the form you just gave
11 us.

12 Q. So this would also be part of the preoperative
13 assessment, correct?

14 A. Correct.

15 Q. Under the entry extremities, the abnormal box is
16 checked, correct?

17 A. That's correct.

18 Q. And it appears to say bilateral leg edema, some
19 erythema, left leg, correct?

20 A. Yes.

21 Q. And then what does it say underneath there?

22 A. No warmth and no pitting.

23 Q. This information was not brought to your
24 attention prior to surgery either, was it?

25 A. I don't believe so.

1 Q. Had it been brought to your attention along with
2 the other information, you would not have gone
3 forward with the surgery, correct, the other
4 information being the cigarette smoking and the
5 being on antibiotics?

6 A. Active infection, correct.

7 Q. You've indicated that you think that Ms. Amidi
8 more likely than not died from sepsis as a result
9 of her cellulitis, correct?

10 A. Yes.

11 Q. She would not have developed sepsis and died from
12 her cellulitis had she not had the surgery on
13 March 22nd, 2001, correct?

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

15 Q. Do you believe it's more likely -- strike that.
16 Let me phrase it this way. Do you believe she
17 would have developed sepsis and died on March
18 27th from her cellulitis had she not had surgery
19 on March 22nd, 2001?

20 A. That's a better question. I still don't know the
21 answer to that. I don't think that she -- I
22 can't tell you that she would have died from
23 sepsis related to her cellulitis on March 27th.

24 Q. Well, can you explain to me your thinking as to
25 the mechanics of how her cellulitis caused the

1 sepsis for which she died from?

2 A. Her cellulitis led to bacteremia. And bacteremia
3 is a vascular spread of the infection. And that
4 was responsible for her, quote, unquote, sepsis.
5 And that's what we were treating at the same time
6 that we were looking for surgical causes of
7 infection, which we never did find. And that --
8 the lack of response to the treatment that we
9 instituted for her sepsis related to her
10 cellulitis and bacteremia is what I think was
11 responsible for her demise.

12 Q. Well, the reason that you would not have
13 performed surgery on Ms. Amidi had you known she
14 had a history of cellulitis, was still being
15 treated with antibiotics was because you would
16 know that the risk of performing a surgery on a
17 patient in that condition would increase the risk
18 of her developing sepsis and possibly causing her
19 death, correct?

20 A. That's possible.

21 Q. Can you give me an opinion to a reasonable degree
22 of medical probability as to whether or not you
23 believe that Ms. Amidi would have developed
24 sepsis and died from cellulitis had she not had
25 the surgery on March 22nd?

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

2 Q. Do you believe that the surgery was a
3 contributing cause to her death?

4 A. The surgical procedure?

5 Q. Yes. And I'm not talking about, for purposes --
6 I'm not implying for purposes of this question
7 that there was anything -- that your surgical
8 technique caused her death. For purposes of this
9 question I'm asking if the surgery --

10 A. In general.

11 Q. -- in general.

12 A. It's possible.

13 Q. Would you agree that the negligent failure of the
14 medical staff at MetroHealth Medical Center to
15 provide you with important information regarding
16 Ms. Amidi's preoperative condition was a cause of
17 her death?

18 MR. MALONE: Objection.

19 A. Well, I'm not sure what you mean by the phrase
20 negligent failure. I think if we had had all the
21 information with regards to her current health
22 status at the time that she presented for
23 surgery, including the information about
24 infection that was actively treated, being
25 treated, we would not have operated on her. And

1 whether that would have changed the natural
2 history of her -- if we didn't operate on her,
3 the series of events that happened wouldn't have
4 occurred. But whether not operating on her would
5 have made a difference in terms of her bacteremia
6 and cellulitis, I'm unclear.

7 Q. Prior to her surgery on March 22nd, 2001, from
8 your review of the medical records and from your
9 perspective as being her surgeon, did she have
10 any indications whatsoever that she was suffering
11 from bacteremia?

12 A. No.

13 Q. No symptoms associated with bacteremia, correct?

14 A. To my knowledge, no.

15 Q. Certainly if you would have noticed overt
16 symptoms of bacteremia or any widespread bodily
17 infection, you would not have gone forward with
18 the surgery; is that correct?

19 A. That's true.

20 Q. Well, can we agree that the -- strike that. I
21 would like to show you what has been marked for
22 identification as Exhibit Letter C.

23 - - - -

24 (Thereupon, Plaintiffs' Exhibit C
25 was marked for purposes of identification.)

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Q. Is this a dictated note from you?

MR. MALONE: Wait a second.

MR. CONWAY: Sure.

A. Yes.

Q. And that's your signature at the bottom, correct?

A. Yes.

Q. You have social history, she smokes one pack per day for 15 years, correct?

A. Yes.

Q. And obviously you had elicited that history from her, correct?

A. Yes.

Q. And then at the bottom, taking into account all of the information you gathered from her, your assessment was that she is a good candidate for surgical treatment of her obesity, correct?

A. That's correct.

Q. Your plan, the treatment plan is nutritional evaluation and follow up with my office?

A. Correct.

Q. Do you have any evidence that, in fact, she did receive a nutritional evaluation in this case?

A. I don't know. I would think that she would have.

Q. In your review of the records, did you find

1 any --

2 A. The nutrition evaluation is not a part of the
3 inpatient medical record.

4 Q. Is that a part of the medical record that the
5 bariatric department would keep?

6 A. Not necessarily.

7 Q. Who would keep it?

8 A. The clinician who saw the patient.

9 Q. Would that clinician have been a MetroHealth
10 Medical Center employee?

11 A. Yes. Generally. Generally.

12 Q. I'm just wondering how -- obviously you want
13 these things done before surgery is performed.
14 How do you follow up to make sure that she, in
15 fact, received the nutritional evaluation prior
16 to doing your surgery?

17 A. The nutritional evaluation is usually
18 communicated to me directly verbally.

19 Q. Is that charted anywhere by you?

20 A. I don't recall.

21 Q. Would you have gone forward with your surgery if
22 you knew that there had been no nutritional
23 evaluation?

24 A. No. She wouldn't have met our criteria.

25 Q. Now, you indicated last time that you felt, and I

1 believe, correct me if I'm wrong, that there may
2 be some written criteria or preoperative
3 checklist that your department has in writing?

4 A. Yes, I did.

5 Q. Do you --

6 A. Have the criteria?

7 Q. Yes.

8 A. Yes. In response to your request for records --

9 Q. That's what you gave --

10 A. Jim, correct.

11 Q. Jim. All right.

12 A. Now, that's the current version of the criteria
13 that we use in the office and it's like a child,
14 it grows up. And it's the descendant of whatever
15 we use in the past. I could not find anything
16 from this time period that I could show you.

17 Q. So there's no way we would know exactly what the
18 written criteria was back in 2002, correct?

19 MR. MALONE: I don't think there
20 was any written criteria. I think that's
21 what he's telling you. It may be written
22 now. But he could find nothing --

23 A. No. I disagree. We at least in the very
24 beginning had a piece of paper that we took all
25 the information from the patients over the phone

1 with and then that served as the beginning
2 process for our evaluation. But in terms of the
3 specific form that we used at that particular
4 point in time and we now have patients fill that
5 out, which we didn't in the past.

6 Q. Just so I'm clear, the -- we don't have and
7 there's no way you have available to you as of
8 today's date a -- the written checklist form that
9 would have been available back in March of 2002,
10 correct?

11 A. That's correct.

12 Q. What you have right now is your current form that
13 you use, which it's your testimony was obviously
14 updated or evolved?

15 A. Evolved over time.

16 Q. Okay. Evolved from the one you had in March
17 2002?

18 A. Yes. That's fair. And our nutrition evaluation
19 at the time consisted of instruction in the
20 postoperative diet and instructions in the kinds
21 of foods that would bother you after you had the
22 surgery and the things that you need to avoid as
23 part of your intake beforehand as well as an
24 eating history. But that would have been
25 communicated to me directly by the clinician who

1 saw the patient.

2 Q. Now, at the time of this note right here, her
3 body weight was 452 pounds. That's back on
4 September 24th for your dictated note?

5 A. Yes. Yes.

6 Q. And then we see at the preoperative point in time
7 when she's being assessed her weight is now 467
8 pounds?

9 A. That's correct.

10 Q. That information was not brought to your
11 attention either, was it?

12 A. Not to my knowledge, no.

13 Q. Is that important information for you to have
14 prior to beginning a surgery on a bariatric
15 patient, whether or not there's been a weight
16 increase and the extent of the weight increase?

17 A. We have come over time to recognize that people
18 who gain weight in the interval between the time
19 that you see them initially and time that you
20 operate on them are not the most compliant
21 patients overall. So to answer your question,
22 today, based on my experience, the answer is yes.

23 Q. Going back, if I've shown you -- I don't know if
24 I've shown you Exhibit D.

25 MR. CONWAY: We can mark this as

1 Exhibit D.

2 - - - -

3 (Thereupon, Plaintiffs' Exhibit D
4 was marked for purposes of identification.)

5 - - - -

6 MR. MALONE: Have you got the rest
7 of it? This is just page one.

8 MR. CONWAY: That's all I'm
9 referring to.

10 Q. It says clinical resume. Is this part of the
11 discharge summary?

12 A. Yes, sir.

13 Q. I just wanted to --

14 MR. MALONE: It's one page of a
15 three-page document.

16 MR. CONWAY: Right. Bates stamp
17 page 11.

18 Q. Obviously you have the complete medical records
19 available to you during this deposition, correct,
20 Doctor, if you need to look at anything else to
21 put in context, right?

22 A. Yes.

23 Q. Feel free to do so. Going to social history.
24 The patient smoked less than one half pack per
25 day. Is this part of the discharge summary you

1 dictated?

2 A. I didn't dictate that discharge summary.

3 Q. Who dictated it?

4 A. Whoever was on the -- probably the resident whose
5 name is listed on the chart.

6 Q. Since you were the attending physician, would you
7 have?

8 A. Reviewed that and signed it, yes.

9 Q. Do you know what date you signed this
10 discharge --

11 A. No, I don't.

12 Q. The information that this patient -- excuse me.
13 The information that the resident --

14 A. Dictated into the record.

15 Q. -- dictated into the record would have come from
16 the patients's --

17 A. Medical record.

18 Q. -- admission record, correct?

19 A. It would come from the medical record that's
20 available to them at the time of discharge.

21 Q. And that same medical record would have been
22 available to you, too, correct?

23 A. Yes.

24 MR. CONWAY: Let's go to exhibit
25 letter G.

1

- - - -

2

(Thereupon, Plaintiffs' Exhibit G

3

was marked for purposes of identification.)

4

- - - -

5

Q. This is a surgeon's report that is filled out by
the surgeon before or after the surgical
procedure?

7

8

A. At the end of the surgical procedure.

9

Q. And other preoperative diagnosis, the third entry
down says -- well, what does the second entry
down say first under asthma?

10

11

12

A. The first one says asthma.

13

Q. Right. Then what is the next one?

14

A. Clinical sleep apnea.

15

Q. And the third one is?

16

A. That's, the first two letters are an abbreviation
for history of. And the second word is
cellulitis.

17

18

19

Q. And then where it says postoperative diagnosis,
what is that word written there?

20

21

A. Same.

22

Q. And then preoperative diagnosis under history of
cellulitis says what?

23

24

A. Insulin resistance.

25

Q. And then the final entry is obesity, correct?

1 A. Yes.

2 Q. And what is the purpose in the surgeon noting
3 these preoperative diagnoses on this sheet?

4 A. It gives you the indications for surgery.

5 Q. How would a history of cellulitis be an
6 indication for bariatric surgery?

7 A. It's part of the spectrum of disease that
8 morbidly patients are prone to and helps us to
9 justify our proceeding to operation on them.
10 This is one of the ways that we characterize
11 patients who have clinically significant obesity
12 and we use the -- at least I use the NIH criteria
13 that were developed to look -- to guide obesity
14 into several categories.

15 I try to limit my practice to obesity that
16 has medical implications in terms of their -- the
17 incidence of chronic medical problems associated
18 with the obesity. So I document, I try to
19 document that there is medical problems as a
20 cause of their obesity, otherwise I wouldn't do
21 their surgery.

22 Q. So correct me if I'm wrong, it would not be
23 uncommon for one of these patients that you're
24 performing bariatric surgery on to have a history
25 of cellulitis; is that correct?

1 A. Yes.

2 Q. Whose handwriting is these entries in,
3 specifically the history of cellulitis?

4 A. That's my handwriting.

5 Q. That's your signature down at the bottom?

6 A. Such as it is.

7 Q. And this would have been filled out immediately
8 after the surgery?

9 A. That's correct. As soon as I break scrub.

10 Q. When did you first think that Ms. Amidi's
11 condition was caused by her cellulitis?

12 MR. MALONE: Which condition?

13 A. Which condition?

14 Q. You're right. I'll rephrases that. When did you
15 first think that Ms. Amidi's sepsis was caused by
16 cellulitis?

17 A. When we obtained blood cultures that documented
18 that she had gram-positive organisms in her
19 bloodstream.

20 Q. And when was that, Doctor?

21 A. Sometime after she was admitted into the
22 intensive care unit.

23 Q. Did you ever put in writing your thoughts that
24 possibly her condition of cellulitis was causing
25 her sepsis?

1 A. I don't think I ever specifically said that.

2 Q. To your knowledge, did any of the other medical
3 professionals or consults that were treating Ms.
4 Amidi indicate to you that they felt that an
5 underlying condition of cellulitis was causing
6 her sepsis?

7 A. As you specifically put it, I don't believe so.
8 But can we look at the medical records?

9 Q. Sure.

10 A. I can't find anywhere in the record where I
11 specifically say that or that anybody else
12 specifically says that.

13 Q. Is there anyplace you can point me to where it
14 was implied by anybody that an underlying
15 condition of cellulitis was responsible for her
16 sepsis?

17 A. No. In fact, there is only one brief mention by
18 one of the consultants that to consider other
19 possible sources of infection, but that's it.

20 Q. Other sources of infection other than what?

21 A. Than wound infection. The original complication
22 that prompted the concern about a postoperative
23 infection was the drainage of the fluid from her
24 wound. We were concerned that was a wound
25 infection.

1 I think everyone agreed that it was, my
2 medical opinion from the medical record, we all
3 felt that strongly she had gram-positive sepsis
4 and we were trying to figure out why she had
5 gram-positive sepsis. The medical specialists
6 were concerned with pulmonary sources of her
7 infection. Certainly given her respiratory
8 failure.

9 Q. At any point in time, did cultures grow out gram
10 negative?

11 A. To my knowledge, no.

12 Q. Doctor, would you agree that wound infections are
13 treated by opening the skin incision and draining
14 the infection?

15 A. Yes.

16 Q. And do debridement if necessary?

17 A. If necessary.

18 Q. A wound infection will not resolve if treated
19 with antibiotics alone?

20 A. No.

21 Q. Unless the wound is drained and debrided; is that
22 correct?

23 A. Correct.

24 Q. If not treated in a timely manner, a surgical
25 wound infection can cause sepsis and death,

1 correct?

2 A. It's possible.

3 Q. That's a risk of wound infection, correct?

4 A. It's possible, yes.

5 Q. Doctor, have you attended any seminars,
6 conferences or received any training involving
7 bariatric surgery?

8 A. No.

9 Q. Have you --

10 A. Well, let me rephrase that. I think we discussed
11 earlier that my training in bariatric surgery has
12 been part of my surgical education since I was a
13 resident. We did talk about that.

14 Q. When you were a resident, you received some
15 training in bariatric surgery?

16 A. Correct.

17 Q. What years were you a resident?

18 A. '77 to '81. And we talked about the type of
19 operation we did at that time.

20 Q. Right. And then we talked that you began doing
21 bariatric surgery, I believe, in what year?

22 A. Here?

23 Q. Yes.

24 A. 1996.

25 Q. Not counting the time when you were a resident?

1 A. No.

2 Q. The answer to the last question?

3 A. No.

4 Q. Is no. Okay. Have you trained -- not counting
5 your time as a resident, have you ever trained
6 under a more experienced bariatric surgeon?

7 A. No.

8 Q. Specifically since 1996?

9 A. No.

10 Q. From 1996 on, how did you educate and train
11 yourself in the field of bariatric surgery?

12 A. Well, I'm current with the literature from the
13 standpoint of reading what's in the literature
14 about bariatric surgery, but I don't have any
15 other specific bariatric surgical procedures that
16 I can point to.

17 Q. What bariatric literature do you rely upon?

18 A. The general surgical literature.

19 Q. Put out by whom?

20 A. Well, it depends. There is a fair amount of
21 literature that's published in JAMA, for example,
22 about obesity. And there are other surgical
23 journals, SG&O, Surgical, Gynecology,
24 Obstetrician. And the Journal of the American
25 College of Surgeons.

1 Q. Do you ever read and rely upon the different
2 journals published by bariatric surgeon
3 associations?

4 A. I haven't, no.

5 Q. What is your reasoning for not reading those?

6 A. I don't think I'm missing by reading what I'm
7 reading.

8 Q. I think where we left off the last deposition was
9 you had read into the record your 10:05 a.m. note
10 from March 24th. That's when we --

11 A. Okay.

12 Q. You have here and this in your handwriting,
13 hypovolemia, question mark and then there is
14 ETIOL?

15 A. Etiology.

16 Q. Meaning that you are unsure of the etiology of
17 her condition at that time; is that correct?

18 A. Correct.

19 Q. What was your differential diagnosis as of 10:05
20 a.m. on March 24th when you see the patient?

21 A. Can you ask that question again. I'm sorry.

22 - - - -

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

25 - - - -

1 A. Well, this is postoperative day number two and
2 it's the morning after the chest pain, VQ scan to
3 rule out pulmonary embolism. And my assessment,
4 that's what the A stands for, is respiratory
5 compromise postop, complicated by obesity.

6 Hypoventilation, asthma, smoking. Would
7 probably benefit from BiPAP, which is an extra
8 non -- it's an external breathing device that
9 keeps the airways open. Hypovolemia. Question
10 etiology. Responding to volume and will start
11 blood means to me that I think that she is behind
12 from the resuscitation that -- following surgery.
13 And so I asked for a pulmonary consult because
14 those are the folks who run the BiPAP stuff and
15 volume resuscitation. And then intensive care
16 monitoring.

17 Q. Doctor, as of this date with the pulmonary
18 embolism ruled out as being the cause of her
19 problems, wouldn't a leak or wound infection be
20 the next two most common surgical
21 complications --

22 A. No.

23 Q. -- that you would look for?

24 A. No. Because we look for surgical complications
25 in relative time frames. The complications

1 happening on postoperative day number two are
2 primary pulmonary. Wound infection and
3 anastomotic leak are something that present
4 later, five to seven to ten days later after
5 surgery.

6 Q. How do you interpret a CBC with a white blood
7 count of 25.1 with 40 bands?

8 A. Again, it depends on the context and what --

9 Q. Well, within the context of that being the
10 results of Ms. Amidi's blood work, which was
11 drawn, I believe, on the evening of March 23rd.

12 A. Certainly infection is a possibility. So is
13 stress response.

14 Q. Would you expect bandemia of 40 with a stress
15 response?

16 A. Yes.

17 Q. You would?

18 A. Yes. You can see it. All a bandemia indicates
19 is that the white cells are departing the bone
20 marrow and are in an immature form. So whatever
21 stimulus for that to happen is significant. And
22 so stress, especially given the events that we
23 were dealt with in the first day-and-a-half after
24 surgery, can explain that.

25 Q. But obviously an infection can explain that as

1 well?

2 A. Yes. I'm not denying.

3 Q. In light of this CBC in a postsurgical patient,
4 would you agree the standard of care requires
5 empiric antibiotic coverage until cultures are
6 proven?

7 A. That's one thing we would do, is to start
8 antibiotics for a patient like that.

9 Q. Does the standard of care require that?

10 A. I'm not sure I know the answer to that. But if
11 we were concerned she had infection, we would
12 have started antibiotics. If we thought this was
13 a stress response, we would not.

14 Q. What type of antibiotics -- would you start
15 empiric antibiotics until you could narrow it
16 down to the specific cause of infection?

17 A. That's a definition of empiric therapy, yes.

18 Q. Just in reading through here, there was treatment
19 with Adenosine? Is that pronounced correctly?

20 A. Yes.

21 Q. Are you aware of that treatment that she received
22 I think on March 23rd?

23 A. Yes.

24 Q. And that was not your idea, was it?

25 A. No.

1 Q. I didn't think so. That was your resident's
2 idea?

3 A. Well, I don't know the answer to that. There was
4 a critical care attending in-house. And he could
5 very well have and probably did authorize that
6 therapy. I can put the events together having
7 been there myself as a critical care attending,
8 but were found tachycardia masquerading as
9 supraventricular tachycardia or SVT would be one
10 of the reasons we would use Adenosine. But it's
11 not a primarily surgical choice of treatment of
12 choice.

13 Q. And certainly she wasn't suffering from SVT,
14 correct?

15 A. I don't believe so.

16 Q. What are you aware the signs and symptoms -- what
17 are the common signs and symptoms of a PE?

18 A. They can be silent. A PE is pulmonary embolism.
19 And chest pain, respiratory distress, hypoxia,
20 hypotension, death are common symptoms associated
21 with PE.

22 Q. Would it be fair to say that a PA O2 would
23 generally be less than 100 in a patient suffering
24 from a PE?

25 A. Could definitely be.

1 Q. Ms. Amidi had a PA O2 of 147 on oxygen with
2 wheezing. That would be an atypical presentation
3 for a PE, would you agree?

4 A. Not on oxygen. Not everybody with a pulmonary
5 embolism who is on supplemental oxygen will have
6 very low oxygen content. You certainly can if
7 you have a very bad pO2 pulmonary embolism. The
8 confounding factor there is the oxygen therapy.

9 Q. Were any clotting studies done prior to putting
10 Ms. Amidi on Heparin?

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

12 Q. Would standard of care require that the clotting
13 studies be done with a postsurgical patient prior
14 to putting the patient on Heparin for a suspected
15 PE?

16 A. No. The way you phrase the question, I would say
17 no. Typically what happens is that you do
18 everything at the same time. So blood is drawn
19 for clotting studies. The Heparin bolus is
20 started and arrangements are made for a scan of
21 some sort. All of those are done simultaneously.

22 Q. What are the basic signs and symptoms of a
23 postoperative patient who is suffering from
24 sepsis?

25 A. I think you're going to have be more specific

1 about what you -- do you mean by the basic signs
2 and symptoms.

3 Q. Would a patient typically be tachycardic?

4 A. Yes.

5 Q. Would the patient typically be hypotensive?

6 MR. MALONE: Did you say hyper or
7 hypo.

8 Q. Hypo.

9 A. No. That would be a definition of septic shock.

10 Q. Well, on your way to septic shock you go through
11 being septic?

12 A. Sure can.

13 Q. So --

14 A. But there are agreed upon definitions for what
15 sepsis is and septic shock is. And septic shock
16 is sepsis plus hypotension. Sepsis is fever,
17 tachycardia, elevated white blood cell count.

18 Q. Let's go with just sepsis. They have fever,
19 tachycardic, elevated white blood cell count?

20 A. Correct.

21 Q. What else?

22 A. I think that's about it.

23 Q. And then when the patient actually becomes
24 hypotensive?

25 A. That's septic shock.

1 Q. And when looking at the medical records, when do
2 you believe that Ms. Amidi first entered into
3 septic shock, what date?

4 A. Well, she was hypotensive right from the very
5 beginning, which is very atypical for the
6 progression from sepsis to septic shock. And we
7 were looking for other sources of her
8 hypotension. Because in our experience, or at
9 least in my experience, it's unusual to see
10 somebody progress to hypotension without some
11 evidence of, clear-cut evidence of sepsis.

12 Q. You don't believe there was clear-cut evidence of
13 sepsis in this case?

14 A. No. At least initially when we were taking care
15 of her, I do not.

16 Q. Do you agree that from postop day one,
17 retrospectively looking at it, that Ms. Amidi was
18 suffering from sepsis which was progressing to
19 septic shock?

20 MR. MALONE: Objection. Go ahead.

21 A. Well, sitting here today, I know that that
22 explains what happened to her. Looking at my
23 notes from the time of her surgery, it was part
24 of our differential diagnosis, but not initially.

25 Q. When did sepsis first become a part of your

1 differential diagnosis?

2 A. Probably postoperative day number three, because
3 I opened the wound.

4 Q. Which would be what date?

5 A. 3-25.

6 Q. When was the first time you considered getting an
7 infectious disease consult involved in Ms.
8 Amidi's care and treatment?

9 A. I don't remember the exact day we ordered that.

10 Q. I believe it was ordered on March 25th.

11 A. Then that would be the day we had in her care.

12 Q. And you would not have considered getting an
13 infectious disease consult involved prior to that
14 date?

15 A. No. We got many consultants involved, but it
16 sort of reflects what I thought was going on at
17 the time. Pulmonary people were the first folks
18 involved. Cardiologists were the second people
19 involved and then ID was involved third.

20 Q. There are infectious disease specialists that
21 work at Metro General?

22 A. Yes.

23 Q. And who was the infectious disease consult that
24 actually --

25 A. I don't know that name.

1 MR. MALONE: It's Dr. Hanrahan.

2 She's a female.

3 Q. Were blood cultures -- on March 23rd, were blood
4 cultures or wound cultures ever obtained?

5 A. On March 23rd?

6 Q. Right.

7 A. Probably not wound cultures, although, I don't
8 know the answer to that. Again, if we're going
9 to the start somebody on empiric antibiotic
10 therapy, which I believe we did, then you would
11 get a baseline set of blood cultures.

12 Q. When did you start her on empiric antibiotic?

13 A. I would imagine she started that first day, but I
14 don't know the answer to that.

15 Q. Is there any way I could find out from looking at
16 the chart when empiric antibiotic coverage was
17 started?

18 MR. MALONE: Look at 3:35 on the
19 24th. 1535, blood cultures obtained and
20 sent at 1600, Ciprofloxacin.

21 A. What date did you say again?

22 Q. It's 3-24, I believe following Dr. Finley's
23 pulmonary consult.

24 A. I'm sorry. You said when?

25 Q. It was, I believe, Dr. Finley had a pulmonary

1 consult on March 24th in the afternoon. And I'm
2 just wondering, do you know when antibiotics were
3 first administered, empiric antibiotics?

4 A. It appears 3-24-02, 4:35 p.m.

5 Q. Now, Flagyl was not administered at that time,
6 was it?

7 A. No.

8 Q. Do you know why not?

9 A. It's not typically part of an empiric antibiotic
10 therapy. So we would not have started her
11 without evidence of fungal infection.

12 Q. Does Flagyl treat anything other than fungal
13 infection?

14 A. To my knowledge, no. No. It treats
15 pseudomembranous colitis.

16 Q. And what causes pseudomembranous colitis?

17 A. It's a bacterial infection of the colon secondary
18 to antibiotic usage.

19 Q. Was that particular antibiotic recommended by Dr.
20 Finley in his March 24th, 4:00 consult note?

21 A. Without looking at his note, I don't know.

22 Q. Well, I assume, I mean, even though you have
23 consults involved, you still remain responsible
24 for the overall care and treatment of the
25 patient?

1 A. Absolutely.

2 Q. Do you recall discussing with Dr. Finley his
3 recommendations regarding antibiotic use after he
4 saw the patient on March 24th?

5 A. No, I don't specifically recall that.

6 Q. Does any reason stick out in your mind why, if he
7 recommended Flagyl, it would not have been given
8 to the patient at the same time these other
9 antibiotics were given?

10 MR. MALONE: I'm going to show an
11 objection. I think you're misstating -- he
12 said consider Flagyl involvement. He
13 didn't say recommend. There was no Flagyl
14 recommendation. Read the note.

15 A. My response to that, to your question would be
16 that, again, from the likelihood standpoint, I
17 would not have been concerned of either
18 pseudomembranous colitis or a fungal infection at
19 this -- strike that. I can't say strike that.
20 Can I? Yeah. Flagyl is used by some people as
21 part of a broad spectrum antibiotic therapy and
22 it is not necessarily a fungal medication. But
23 there are a number of -- I misspoke earlier. I'm
24 sorry about that.

25 There are a number of empiric antibiotic

1 regimens out there, Cipro, Flagyl being one of
2 them. We chose Cipro. It's just personal
3 choice.

4 Q. On March 25th, when you opened the wound, what
5 was your reasoning for opening the wound?

6 A. Because it was seeping.

7 Q. And describe the drainage.

8 A. It was dirty brown drainage.

9 Q. What does that indicate to you as bariatric
10 surgeon?

11 A. I was -- considered that was a wound infection.

12 Q. What was your interpretation of what you found?

13 A. That it wasn't.

14 Q. It was not?

15 A. No.

16 Q. What was causing the dirty brown drainage?

17 A. In my opinion, it was resolving -- it was
18 dissolving hematoma in the wound secondary to
19 blood clots that were probably worsened by her
20 Heparin dosage. So I thought it was an
21 infection. That's why I sent it off for culture
22 and gram stain. And that's why they all came
23 back negative. In light of that interpretation
24 and what it looked like, I felt that that was
25 blood clot that had been dissolved by the Heparin

1 bolus dosage that she had received for her
2 empiric treatment of pulmonary embolus.

3 Q. Were sputum cultures ever taken?

4 A. I believe so.

5 Q. And do you recall what the results of those were?

6 A. Not off the top of my head, no.

7 Q. Would be the relevance of sputum cultures
8 regarding whether or not there was either a wound
9 infection or a leak?

10 A. Neither.

11 Q. Wouldn't?

12 A. It wouldn't be relevant to either.

13 Q. Not?

14 A. Because they're not related to either one of
15 those things. Sputum cultures that are positive
16 would be more indicative of a primary pulmonary
17 infection. That would require treatment.

18 Q. And I guess the point I'm getting at is was there
19 anything -- there is any evidence of any sputum
20 cultures being taken and the results of which
21 would be relevant to whether or not she was
22 suffering from a pulmonary infection?

23 A. I don't think so.

24 Q. Was that ever considered?

25 A. Yes. Absolutely. In fact, everybody who saw her

1 initially thought she had a pulmonary infection.
2 Given the fact that she had significant pulmonary
3 compromise immediately after surgery, that was
4 one of the concerns.

5 Q. Now, portable chest x-rays can be performed,
6 correct?

7 A. Yes.

8 Q. Was there anything -- I assume there was a chest
9 x-ray performed?

10 A. Yes.

11 Q. And was there anything that came back from the
12 reading of that chest x-ray which suggested in
13 your opinion that she was suffering from a
14 pulmonary infection?

15 A. She on chest x-ray had patterns that were
16 consistent with ARDS according to several people.

17 Q. At what point in time?

18 A. Early on.

19 Q. And ARDS can be the result of sepsis; is that
20 correct?

21 A. Yes.

22 Q. When do you believe -- well, getting back to
23 March 25th, that was the date you first suspected
24 that she may be suffering from sepsis, correct?

25 A. That's correct.

1 Q. At what time did you first feel she was suffering
2 from sepsis?

3 A. I can't tell you exactly what time, but my note
4 is dated from 0900.

5 Q. Would that have been after or before you opened
6 up the surgical wound?

7 A. That note is describing that whole aspect of her
8 care. So new finding this a.m., dirty brown
9 drainage from wound. So that would be the time
10 that I worried about a wound infection as the
11 etiology of this.

12 Q. And after, in your opinion, you ruled out this as
13 being a wound infection?

14 A. Well, I don't think it's that simple that you can
15 rule it out. I'm mean, certainly when we opened
16 it up and sent it off for culture it was an
17 atypical manifestation of a wound infection.
18 Wound infections have a tendency to look and
19 behave in three specific ways. And this was not
20 any one of those three specific ways.

21 Q. What are the three specific ways?

22 A. Well, one there is an erythema of the tissues
23 around the wound and there is either golden,
24 thick secretions that drain from the wound or
25 thin, grayish secretions that drain from the

1 wound or there is inflammation of the tissues
2 with some evidence that the tissues don't look
3 normal. And those are the three major ways we
4 see wound infections presented.

5 Q. And is it your opinion that those were lacking?

6 A. They weren't present, but at least initially I
7 did not understand why -- in retrospect, I think
8 that's -- the Heparinization is what caused that
9 fluid to occur in the wound. And it was related
10 to blood clot or hematoma that builds up in a
11 wound space that was perhaps worsened because of
12 the Heparin.

13 Q. Let's go to March 25th around 9:00. You go in
14 and you're obviously suspicious there could be a
15 wound infection. You open up the wound and you
16 have cultures taken. Is that correct?

17 A. Correct.

18 Q. The presentation for this being a wound infection
19 is very atypical based upon --

20 A. It's unusual.

21 Q. Unusual. And the cultures come back negative?

22 A. Yes.

23 Q. When or at any time did your differential
24 diagnosis include leak?

25 A. Well, I can tell you that I was not thinking of a

1 leak at this particular point in time.

2 Q. Because you would have ordered a gastro --

3 A. Grafin.

4 Q. -- swallow, correct?

5 A. No. If I thought she had a leak, I would have
6 taken her back to the operating room.

7 Q. So up until the time she died, you never
8 suspected a leak; is that correct?

9 A. That's correct.

10 Q. Otherwise, standard of care would have required
11 you to take her back to the operating room?

12 A. No. That's not true. Standard of care is --
13 with regards to managing a leak is divide it into
14 diagnostics and therapeutics. There are many of
15 us who use other methods to diagnose the presence
16 of a leak, including the gastrografin swallow and
17 then treat those infections by percutaneous
18 drainage. In somebody -- and I have done that in
19 the past with people who I've suspected had leaks
20 and actually ended up having them. Not managed
21 them operatively.

22 But in someone who is this sick who we think
23 has a leak, those tests are probably -- it would
24 be in my opinion the better part of valor to take
25 somebody to the operating room and to explore

1 them to see if there's a leak.

2 Q. So we can agree that at no time up until the time
3 of her death did you ever believe that she had a
4 leak?

5 A. That's a fair statement.

6 Q. And that it was not even on your differential
7 diagnosis?

8 A. Well, I don't know if it was not on my
9 differential diagnosis. It's one of the
10 complications that happens after this operation.
11 So all of the complications that happen after
12 this operation ever are part of the cognitive
13 function of evaluating and treating patients who
14 are not doing well after surgery.

15 But in my opinion, this patient did not have
16 a leak and never in the time that she was sick
17 and being resuscitated and being treated
18 demonstrated the things that I would look for for
19 a leak. But I must admit that we did struggle to
20 figure out exactly what was going on with her.

21 Q. You did nothing to rule out a leak; is that a
22 fair to state?

23 A. I did no specific test designed to look
24 specifically for a leak.

25 Q. Correct?

1 A. That's what I'm saying.

2 Q. Okay. Why on the death certificate did you not
3 indicate that you felt cellulitis was involved in
4 causing her death?

5 A. I don't know.

6 Q. Whose decision was it not to have an autopsy
7 performed?

8 A. The family.

9 Q. And do you know why?

10 A. Religious reasons.

11 Q. And you don't have a problem with that, do you?
12 I mean, certain families for religious reasons --

13 A. It happens all the time. We would have liked to
14 have an autopsy.

15 MR. MALONE: Off the record.

16 - - - -

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

19 - - - -

20 (Thereupon, a recess was had.)

21 - - - -

22 Q. And the way you would rule out if you did suspect
23 a leak would be that gastrografin swallow?

24 A. That's one way, yes.

25 Q. And what are the other ways?

1 A. We talked about that laparotomy. Those are the
2 two major things that you would do. I suppose
3 you could do endoscopy, but it's risky after
4 immediate operation. Endoscopy can cause more
5 harm than good. So the risk would be not to use
6 that.

7 Q. Was any type of radiology imaging available that
8 would aid in the diagnosis of a leak?

9 A. CT scan and the gastrografin swallow is a
10 radiographic imaging study. It is used with the
11 CT scan.

12 MR. MALONE: She couldn't get in
13 the scanner. That's documented.

14 A. Well, and my response to that would be for some
15 of these people they're just too big to put in
16 the scanner. There are weight limits for the
17 stretcher and then there are dimension limits for
18 the donut they have to fit through.

19 Q. Are there certain types of radiology scanning
20 equipment that can be -- that are available for a
21 patient Ms. Amidi's size?

22 A. Neuroscopic, from a diagnostic imaging
23 standpoint, the best test for her would have been
24 a gastrografin swallow, I believe.

25 Q. And that would have been available at Metro,

1 correct?

2 A. Yes. Yes.

3 Q. What about CT?

4 A. Because of her size -- you remember earlier in
5 her course, she had the VQ scan. The concern
6 regarding the pulmonary embolism. We have now
7 developed a protocol to look for pulmonary
8 embolism using CT scans. She couldn't have that
9 because of her size. That's why they chose the
10 ventilation perfusion scan. Which is a lesser
11 kind of a test, but acceptable. It's an older
12 standard.

13 Q. Are there CT scans that are designed and made for
14 patients the size of Ms. Amidi?

15 A. There are CT scans designed for patients who are
16 overweight and who are large and we have those.

17 Q. Did you have those back in 2001?

18 A. Yes. Yes. I believe so. 2002.

19 Q. 2002. I'm sorry.

20 A. Yes. I think that she just didn't fit in the
21 scanner.

22 Q. Okay. Going to the consultation section of the
23 chart, Doctor, there was a consult by Dr. Finley
24 as well as apparently by a pulmonology fellow,
25 Southwell it appears.

1 A. Both of those are the same people. Part of the
2 same department.

3 Q. Right. They're both pulmonologists.

4 A. Yes.

5 Q. Dr. Finley would be attending and Southwell would
6 be the fellow?

7 A. Fellow.

8 Q. All right. Do you agree with Dr. Finley's
9 assessment where he gives his differential
10 diagnosis of sepsis as being involved?

11 MR. MALONE: Where are you in the
12 note?

13 MR. CONWAY: Like fifth line from
14 the bottom. His handwriting is very small.

15 Q. Clinical course is suggestive of sepsis versus --

16 MR. MALONE: Massive PE.

17 Q. -- massive PE.

18 A. I wouldn't disagree with that.

19 Q. So he as of March 24 has sepsis on his
20 differential diagnosis?

21 A. He does. I have CPAP on my mind. That's why he
22 was asked to see her.

23 Q. And I believe he states the likely sources at
24 that time of sepsis would be from pneumonia,
25 urosepsis or wound infection?

1 A. Correct.

2 Q. On March 24th, what was done to rule out --

3 A. Those things?

4 Q. -- those things as causing sepsis?

5 A. A part of what we would have done is order
6 cultures of all of those things.

7 MR. MALONE: Did you answer the
8 question?

9 A. I believe I did.

10 MR. MALONE: I don't know if we're
11 waiting for another question or --

12 Q. Okay.

13 A. Was that a sufficient answer?

14 Q. Sure. There is your attending note of March
15 26th, which you indicate, give a diagnosis of
16 presumed sepsis.

17 A. Yes.

18 Q. It's the 10:55 note, correct?

19 A. That's correct.

20 Q. Do you want to read that?

21 A. 3-26-02, attending postoperative day number four,
22 10:55. Seen on rounds. Report from ID,
23 infectious disease. Pulmonary reviewed and
24 appreciated. Interval events reviewed. On E,
25 which is examination, remains intubated,

1 ventilated. Paralyze the vital signs. Remains
2 hyperdynamic. Febrile to 40, now 40.6. There
3 are coffee grounds from NG tube. Wound dressing
4 change.

5 Q. What did you feel the coffee grounds from the NG
6 tube were from?

7 A. That was blood. That's was blood looks like
8 coming from the NG tube.

9 Q. How would the blood have got -- where would the
10 blood have come from in your opinion?

11 A. It's from the surgical site. There's a staple
12 line across the stomach and there's an
13 anastomosis between the stomach and small
14 blood --

15 Q. Is that normal for blood to be coming up from the
16 NG tube --

17 A. Yes.

18 Q. Go ahead.

19 A. Wound dressing change. ABG. Respiratory
20 acidosis. Adequate oxygenation. Bicarb 27. H
21 and H, which is hemoglobin and hematocrit, 12 and
22 38. WBC, 9.7. Then it says A slash, which means
23 assessment. Hyperdynamic with gram-positive and
24 parentheses is were presumed sepsis. Planned,
25 which is the P, continued supportive care slash

1 antibiotics.

2 Q. Were you made aware of the ID, the infectious
3 disease note of --

4 A. Yes.

5 Q. And that indicates that the blood culture from
6 March 24th was positive for what? Is that
7 gram-positive?

8 A. It says GPC, which is a typical definition for
9 gram-positive cocci and clusters and coag
10 negative staph.

11 Q. What would the coag negative staph most probably
12 be?

13 A. Staphylococcus organism. Those are gram-positive
14 organisms.

15 Q. Have you ever testified as an expert in a medical
16 malpractice case?

17 A. In a court or in deposition?

18 Q. In deposition?

19 MR. MALONE: I'm going to show an
20 objection. He's testifying as an expert
21 today. I assume you mean a retained expert
22 other than the matter he's already
23 involved.

24 MR. CONWAY: We can do it that
25 way.

1 MR. MALONE: So we know what we're
2 talking about. I think when a doctor
3 testifies, he's testifying as an expert.
4 Whether he's a fact witness or an --

5 MR. CONWAY: I'm not disagreeing.

6 A. I've done that occasionally in the past and I've
7 done it primarily for trauma-related issues.

8 Q. And have you ever testified on behalf of a
9 patient in a medical malpractice case, either
10 deposition or trial?

11 A. Yes.

12 Q. How many cases have you been retained as an
13 expert witness in over the years approximately?

14 A. Two that I can remember.

15 Q. One you state would be for the plaintiff?

16 A. I'm sorry.

17 Q. One would be for the patient?

18 A. Yes. I think so.

19 Q. And that was a trauma case?

20 A. Both of them were trauma cases.

21 Q. And the other case, would that have been on
22 behalf of a physician or a hospital?

23 A. I don't believe I've ever done that.

24 Q. So the other one would have been on behalf of a
25 patient as well?

1 A. Yes. Two cases that I can recall.

2 Q. Now, you've been a defendant, named defendant in
3 different medical malpractice cases, correct?

4 MR. MALONE: Objection.

5 A. Yes.

6 Q. Did any of those cases involve bariatric surgery?

7 A. Yes.

8 Q. How many of them involved bariatric surgery?

9 A. One.

10 Q. Is that case still pending?

11 A. No.

12 Q. Did that settle?

13 A. Yes.

14 MR. MALONE: Actually, it was
15 dismissed.

16 A. Dismissed, is that what it was?

17 MR. MALONE: It was dismissed
18 without settlement. It wasn't settled as
19 to Dr. Fallon.

20 A. And that was a reoperative bariatric case, which
21 is kind of a different kettle of fish.

22 MR. MALONE: Totally different.

23 Q. In that case though, I assume that you were
24 dismissed individually; is that correct?

25 MR. MALONE: The whole case was

1 dismissed. He was dismissed. There was no
2 settlement. It was dismissed. And then as
3 it was to be renewed, then there was a
4 settlement, the terms of which were
5 confidential. But it was made by the
6 hospital. Nothing involved Dr. Fallon's
7 work.

8 MR. CONWAY: Okay.

9 Q. Now, there were terms that I had -- that were
10 mentioned in the prior deposition that dealt with
11 your writing in the area of bariatric surgery.

12 A. Obesity.

13 Q. Obesity. Okay. I misunderstood you.

14 A. Sorry.

15 Q. Are those items you can still make available to
16 your attorney?

17 A. I believe I did make those available.

18 MR. CONWAY: Are those -- I told
19 you I have stuff. I have not had a chance
20 to look at it.

21 A. I just gave it to him this morning. I apologize
22 for that.

23 MR. MALONE: It's not your fault.

24 Q. If we can, real quick, why don't we just go
25 through handwriting that I've not gotten from you

1 just to make sure the record is clear on it.

2 We've gone over a couple of your notes so far.

3 There's a 3-21-02 note. If you want to --

4 A. Which one?

5 Q. Attending note.

6 A. There are two of them on that page.

7 Q. Why don't we start at the -- go ahead then and
8 just read through it.

9 A. That page 3-21-02. The first attending note is
10 timed 0815. Patient well-known to me. She has
11 severe clinically significant obesity and our
12 plan is to perform a gastric bypass Roux-en the
13 second note is 11:48. Gastric bypass Roux-en I
14 was present for the operation.

15 Q. Going through here, the next time then there's an
16 op note on 3-22-2001. That would have been by
17 the surgical resident; is that correct?

18 A. One of the house staff would have done that. It
19 looks like the medical student wrote the note,
20 then it was cosigned by one of the residents. I
21 assume that's a resident's signature.

22 Q. And that's on 3-22. Let's go to -- there's a
23 3-22-02, 9:00 a.m. note, which blue surgery team
24 was the surgery team you were in charge of; is
25 that correct?

1 A. That's correct. That's not 9:00 a.m. That's
2 9:00 p.m.

3 Q. Sorry. That was obviously written by one of your
4 residents?

5 A. That's correct.

6 Q. What was -- and you would have, in evaluating and
7 mentoring and supervising your residents, would
8 have been aware of what their charting was in
9 this case, correct?

10 A. At the time that the note was written, no. I
11 would have checked that the next day.

12 Q. And what is your understanding what that note
13 says?

14 A. That everything is fine.

15 Q. Can you read that note?

16 A. Sure.

17 Q. Okay.

18 A. It says 3-22-02, 9:00 p.m., blue surgery postop
19 check. It is a SOAP, S-O-A-P. Patient complains
20 of --

21 MR. MALONE: Dry mouth.

22 A. Pain controlled with PCA, which is a patient
23 controlled analgesia unit. O, which is
24 objective, 36.6, which is a temperature. 129,
25 29, 122 over 63. 97 percent on two liters. 200

1 cc's of urine output per Foley. DLR at 200 cc's
2 an hour. Lungs clear of auscultation. CV,
3 regular rate and rhythm. Abdomen soft, mildly
4 tender. Dressing, clean, dry and intact. That's
5 the C slash D slash I.

6 Then it says 29-year-old female, status post
7 gastric bypass. Doing well, pain controlled,
8 continue IV fluids. Upper GI Monday.

9 Q. And the upper GI is a test you planned on doing
10 whatever the following Monday was?

11 A. That's the gastrografen swallow that I typically
12 get five days following surgery to evaluate the
13 anastomosis.

14 Q. The other note by blue surgery is also on
15 3-22-02. It looks like it's written by the same
16 resident. What does that note say?

17 A. It looks like the same resident's signature.
18 Again it's a SOAP note. Patient doing well but
19 this a.m. complained of left shoulder and chest
20 pain. Something. Lasting approximately ten
21 minutes. Relieved with MS04 and Toradol. EKG
22 obtained and unchanged from prior. Pain
23 completely resolved. ABG obtained on two liters
24 O2 nasal cannula. I don't know what that says.

25 Pulse 120. Respiratory rate 20. Blood

1 pressure 130 over 70. Lungs CTA, clear to
2 auscultation. CV, regular rate and rhythm.
3 Abdomen soft, non-distended, mildly tender.
4 Extremities -- I don't know what that says. And
5 then it says 29-year-old status post gastric
6 bypass. Shoulder, chest pain likely. MSK, will
7 monitor. Tachy and low urine output. Something,
8 with lactated ringers and follow urine output.
9 May have ice chips. May have chips of ice today.
10 Upper GI Monday.

11 Q. And then you write an attending note?

12 A. Right. It says awake and alert. This is at
13 10:35.

14 Q. P.m.?

15 A. A.m. 24 around the clock. Awake. Alert.
16 Episode of chest pain this a.m., resolved. NG
17 tube in place. Scant drainage. Plan, increased
18 activity today.

19 Q. Then I think the next note that would have been
20 written by you or a resident under you would be
21 the 3-23-02, 6:00 p.m. note. Is that correct?

22 A. Yes.

23 Q. And that is -- could you read that.

24 A. It says 3-23-02, surgery, 6:00 p.m. Patient
25 found to have heart rate equal 150. Blood

1 pressure 80 over 60 on floor. No complaints of
2 shortness of breath or chest pain. Urine output
3 250 cc's first shift. Stats, 94 percent, two
4 liters nasal cannula --

5 - - - -

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

8 - - - -

9 MR. MALONE: Two liters, nasal
10 cannula.

11 A. On examination, patient is sitting up,
12 comfortable, no complaints. Chest with good air
13 movement. I think that's cardiac exam. Chest
14 tachy, regular. Extremities warm, well perfused.
15 EGN, sinus tachycardia is within 150s, regular
16 rate. Question SVT.

17 Then the impression is tachycardic,
18 hypotensive, hypoxic. Transfer to ICU 3B.
19 Concern of pulmonary embolus. Given tachycardic,
20 and mild -- plan to obtain VQ scans. ABG, HCT,
21 hematocrit, fluid -- discussed with Dr. Yowler
22 and Dr. Fallon.

23 Q. The transfer note, was that written by anyone
24 under your --

25 A. That's probably a nursing note.

1 Q. Then we have the 3-23-02 9:00 p.m. blue surgery
2 addendum note.

3 MR. MALONE: That would be this.

4 A. Yes.

5 Q. And who wrote that?

6 A. I don't know.

7 Q. Would that have been one of your residents?

8 A. Yes.

9 Q. What does that say?

10 A. Events, patient without response to 12 milligrams
11 Adenosine IV push. Unlikely --

12 Q. Unlikely ST?

13 A. Yeah.

14 Q. Therefore, unlikely ST, what does that say?

15 A. You got me. It looks like it's either is likely
16 ST or the mark that says therefore. And then it
17 lists the blood gas of 7.37, pCO 2 of 49, pACO 2
18 of 147. That's a base excess or base deficit,
19 1.3 on looks like a hundred non-rebreather, an A
20 gradient 500 and then it lists laboratory tests.

21 Q. Why don't we go down and, of course, white right
22 there, that's white blood cell count of 25.2; is
23 that correct?

24 A. I think so, yes.

25 Q. And then we can go down to number three, under

1 events?

2 A. VQ scan indeterminate or intermediate
3 probability. It's positive for two wedge defects
4 in the right lung. 20 to 50 percent something.
5 Correlates with 20 to 80 percent probability of
6 PE.

7 Q. How about the impression of the resident?

8 A. Given the two arrows, which I assume means a
9 markedly increased A, a gradient and clinical
10 presentation with indeterminate VQ scan. Will
11 continue Dopamine drip for PE, presumptive
12 diagnosis. Will obtain lower extremities duplex
13 tomorrow. Persistent tachycardia --I don't know
14 -- versus pre-op. Question still intravenous
15 dry. Continue IV fluid resuscitation.
16 Leukocytosis with bandemia, question stress
17 related. Repeat in a.m.

18 MR. MALONE: Is that Dopamine or
19 Heparin?

20 A. That's Heparin. Heparin drip for PE.

21 Q. Then we have once again one of your residents'
22 notes on 3-24-02. Blue surgery -- what does that
23 say in the left-hand column?

24 MR. MALONE: You mean in the
25 margin.

1 Q. Yes.

2 MR. MALONE: It's partially cut
3 off on our copy. Is it cut off on yours as
4 well?

5 MR. CONWAY: I think I got it.

6 A. What typically they will do is they will write
7 the medications down in the side bar. Those are
8 some of the medications that are being used. Why
9 they listed it there, I don't know.

10 Q. Is the patient febrile at that time? Does the
11 patient have fever?

12 A. No. 38, 37 is the temperature. You would define
13 being febrile as being greater than 38.5.

14 Q. And she's still tachycardic at 140s, correct?

15 A. Yes.

16 Q. Going below all the different lab values, I think
17 starting with neuro, if you could read from that
18 part down.

19 A. It says GCS of 15. That's normal. Everybody in
20 the room has a GCS of 15. CV is regular. Tachy,
21 it says S1, S2. I don't know what that means. I
22 mean, those are the heart sounds. I don't know
23 why he mentioned those. Respiratory positive for
24 diffuse wheezing. Poor air entry. GI, no bowel
25 sounds. Wound with something, ecchymoses -- I

1 can't read it.

2 No erythema. No even duration postop day
3 number two, Roux-en-Y gastric bypass. Course
4 complicated by hypoxia. Tachycardia, oliguria.
5 VQ scan enter May approximately. Neuro is
6 stable.

7 Continue, it looks like Toradol and MSO4,
8 which is morphine sulphate, PCA, which is patient
9 controlled analgesia. CV, hypotensive again this
10 a.m. I don't know what that says. Persistent
11 tachycardia. Question echo. Question -- sorry.
12 Check echo. Question RV strain. Question volume
13 status.

14 Q. What is RV strain?

15 A. Right ventricular strain.

16 Q. Are these abnormal renal findings?

17 A. Not specifically. Creatinine 1.4 is probably
18 within the normal range.

19 Q. And what is the last line you see down there?

20 A. Probably sepsis.

21 Q. What line is that?

22 A. It's right before the signature, the last line.
23 I think that's what that says.

24 Q. And who made that statement of probably sepsis?

25 A. One of the residents.

1 Q. Would that resident have reported to you?

2 A. Yes.

3 Q. Did the resident make you aware of his diagnosis
4 that this was probably sepsis?

5 A. I'm sure he probably did.

6 Q. Do you know what time that resident's note was?

7 A. No.

8 Q. Would it have been before your attending note of
9 3-24-02 at 10:05?

10 A. Most likely.

11 Q. And we've had you read that note I think twice
12 into the record?

13 A. I believe so.

14 MR. MALONE: It's right after the
15 9:00 p.m. note.

16 A. The only question you asked me was it before this
17 note and I said yes.

18 Q. Do you know what that resident's name was?

19 A. No, sir.

20 Q. Do you know if that resident is still at Metro?

21 A. No, I don't.

22 Q. Then you've read in the 10:05 note. I guess
23 could you -- is that also your 3-24-02, 11:05
24 note? This is also your attending note, right?

25 A. Yes.

1 Q. Could you read that one?

2 MR. MALONE: I think he's read
3 these, but we'll do it again.

4 A. 11:05, progressive respiratory insufficiency
5 slash failure with worsening, increasing pCO2 to
6 75, despite non-invasive measures. Support the
7 decision, supported the decision to intubate the
8 patient in order to obtain airway control. This
9 was performed by anesthesia per my request.

10 Q. Then going further we have a 3-24-02, the blue
11 surgery chief. And that would have been left
12 subclavian, this is on --

13 A. Yes, I see it.

14 Q. Can you read that.

15 A. Left subclavian, something. Attempted.
16 Unsuccessful. Unable to cannulate vein.
17 Subcutaneous tissue. Chest x-ray ordered.

18 Q. Then we have critical care progress notes. The
19 critical care note of the -- what is this? PN,
20 critical care PN?

21 A. PN stands for progress note.

22 Q. Of 3-24-02 at looks like 4:15.

23 A. It does.

24 Q. On 3-24-02, that individual on the next page
25 under ID evaluation puts no antibiotics but

1 questions whether urosepsis?

2 A. Yes.

3 Q. Would you have been made aware of his impression
4 back on the 24th?

5 A. Yes. That's a system description. So thinking
6 about the ID as a system, that's how that note is
7 written. They write -- their style of writing is
8 a little different than the general surgical
9 style of writing. So they go by the areas where
10 they're concerned.

11 And first area of concern is the respiratory
12 system. So it's listed on the other page, then
13 they go through all the other areas. And every
14 patient in the intensive care unit will have
15 exactly that same style of format for reporting
16 information about their status. So it is not
17 only an examination or an impression, it's also a
18 where are we currently.

19 Q. Based upon the -- at least under the ID section
20 of possible urosepsis, was there any
21 consideration given to bringing in an infectious
22 disease specialist on the 24th?

23 A. I don't believe so. I think what we did that
24 particular point in time was send off the
25 urinalysis to make sure we were covering that

1 particular aspect of her care. That's why that
2 note would be written on there.

3 Q. And then I think we've gone -- now we're down to
4 3-25-02. Your attending note. I think is that
5 7:00 or 9:00 a.m.?

6 A. You know, I don't know.

7 Q. 3-25-02. Attending, postop day three.

8 A. Interval tests reviewed. Remains hyperdysuric.
9 Requiring pressers. New finding this a.m. Dirty
10 brown drainage from wound. Necrotic fat and
11 dirty brown fluid. C&S -- may require antibiotic
12 change.

13 Q. What would be the significance of necrotic fat?

14 A. The fact that she had an incision there. You get
15 changes in the fat any time you do an operation.

16 Q. Could necrotic fat be consistent with a wound
17 infection?

18 A. Sure.

19 Q. Then we go to blue surgery team at appears 8:30
20 a.m. on March 25th. So maybe your note was at
21 7:00 a.m.?

22 A. Probably.

23 Q. So March 25th, 2002 at 8:30 a.m. We don't need
24 to go through the lab values, but starting under
25 neuro.

1 A. It says paralyzed with something. Lungs, course
2 breath sounds bilaterally. The paralytics are
3 common after someone has been intubated
4 emergently. Cardiovascular, regular,
5 tachycardia. Tachy, S1, S2. That means he
6 appreciates the S1, S2 on the exam. The two
7 heart sounds.

8 Wound open this a.m. with release of copious
9 amounts of murky brown fluid. Significant area
10 of dusky adipose tissue, bluntly debrided away.
11 Culture sent. Extremities, anasarca.

12 Q. Going down.

13 A. Assessment, plan. Postop day number three.
14 Roux-en-Y gastric bypass. VQ scan officially
15 read as low probability for PE. Heparin drip
16 dc'd yesterday. Patient intubated and Swaned
17 yesterday for respiratory failure -- despite
18 aggressive volume replacement.

19 Neuro, chemically paralyzed. Continue
20 something drip for now. Persistent -- CV,
21 persistent tachycardia. Question etiology.
22 Blood pressure more stable. Neo off. Something
23 to off. Titrate leave on drip against a mean
24 arterial pressure of 65. Respiratory, maintain
25 full vent support for now. Check chest x-ray.

1 GI, NG tube to gravity. The rest of that note --
2 of that page is unclear.

3 The note continues on the next page. Heme,
4 status post two units of PRBC. Hematocrit
5 stable. No evidence of bleeding. Heparin drip
6 off. ID, chest x-ray pending. Febrile 38
7 something. White blood cell count, decreased
8 today -- day number two, empiric therapy. Wound
9 clearly infected. Begin Dakin's and something.
10 IV consult today. Prophylaxis, Zantac, begin sub
11 Q Heparin. Check DVT scan today.

12 Q. So this would be a blue surgery resident as well?

13 A. Correct.

14 Q. Is that the same blue surgery resident that wrote
15 the 3-24-02?

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

17 Q. But whoever wrote the 3-25-02 note says that the
18 wound is clearly infected, correct?

19 A. In their opinion, yes. Empirically we were
20 considering that to be a wound infection because
21 we started her on Dakin's, which is a substance
22 that we use to treat infection in an incision.

23 Q. If you could, if you could just start with that,
24 do you see as you're going forward any other
25 attending notes written by you or any residents

1 under your supervision as we finish up 3-25 and
2 then into 3-26?

3 A. No. The next note that's written by me or my
4 team is on 3-26-02 at 10:55.

5 Q. And did you read this whole one before?

6 MR. MALONE: I think he did.

7 A. Yes.

8 Q. On 3-26-02, there is a -- it looks like blood
9 culture times one and then pulmonary consult
10 attending. Then it has an arrow going gram --
11 can you read that?

12 A. Where are you at?

13 Q. Right here.

14 MR. MALONE: Blood culture times
15 one.

16 A. Gram-positive cocci.

17 Q. Would gram-positive cocci be consistent with a
18 wound infection?

19 A. Yes. It's unusual to not have it cultured from
20 the wound, however.

21 Q. And the next note that would have been written by
22 you or one of your residents?

23 A. Are you asking me or telling me?

24 Q. No. I'm sorry.

25 A. The next note is blue surgery chief. It's timed

1 11:20. Called to see patient for loss of blood
2 pressure and cyanosis of face. Unable to obtain
3 evidence of perfusion. No pulses or doppler
4 signals obtainable.

5 Patient treated for PEA, ACLS and CPR
6 protocol initiated. Multiple doses of
7 Epinephrine and the Atropine given. Epinephrine
8 drip started. Patient went into asystole.
9 Patient pronounced dead at 11:10 p.m. Dr. Fallon
10 and family made aware. Family refused autopsy.

11 Q. Doctor, going back to the note written by your
12 resident on 3-24-02, where -- this would have
13 been the note before your 3-24-02, 10:05 a.m.
14 note. What was your response to his assessment
15 that the patient was suffering from probable
16 sepsis the morning of 3-24-02?

17 A. I don't recall what my response was. My
18 responses to the events that had happened to the
19 patient up to that point in time would have been
20 documented in that 10:05 note from 3-24-02. And
21 in that, I discuss her respiratory compromise
22 postop and the hypovolemia and then my plan at
23 that point in time is listed as we've discussed.
24 Pulmonary consult. Volume resuscitation.
25 Intensive care monitoring and that she's in

1 critical condition.

2 Q. So, I mean, going by your note of 10:05 a.m., is
3 it fair to say that you were not considering that
4 she was suffering from sepsis?

5 A. I think the first -- I think what my note
6 documents, what was first in my mind, foremost in
7 my mind was her respiratory failure. That's what
8 my concern was.

9 Q. Is that the extent of the charting?

10 A. Yes.

11 Q. As far as progress notes that you and your --

12 A. Yes.

13 Q. There's no mention up until the date of her death
14 that you believe that her sepsis was caused by
15 cellulitis?

16 A. No.

17 Q. That's fair?

18 A. That's fair.

19 Q. And there's nothing on the death certificate
20 which indicates --

21 A. No.

22 Q. -- your thinking that this was cellulitis?

23 A. No.

24 Q. Can you give me a date when you came to the
25 conclusion that Ms. Amidi's sepsis was caused by

1 cellulitis?

2 A. I can't tell you specifically a date. I think we
3 felt that she had gram-positive bacteremia or
4 gram-positive sepsis and that would have been
5 part of the etiology, possible etiology for
6 gram-positive sepsis. But I can't tell you
7 specifically that, no.

8 Q. But that gram-positive could also be consistent
9 with a wound infection as well?

10 A. Lots of things it could be consistent with. It
11 could be consistent with a pulmonary infection.
12 I mean, when you think about gram-positive
13 organisms as being external organisms that live
14 on the skin, live in the urine, live in the GI
15 tract, rather than internal organisms that are
16 part of the inside part of the body.

17 Q. In looking, did she have -- I mean, what were the
18 indications that she was suffering from some type
19 of pulmonary infection as of the date of her
20 death?

21 A. Pulmonary infection?

22 Q. Yes.

23 A. She, the first thing that happened to her was
24 pulmonary failure. And her chest x-ray was
25 always abnormal from -- almost from the very

1 beginning. And so those are two indications for
2 pulmonary failure, secondary infection as being
3 part of the differential diagnosis.

4 Q. But pulmonary failure can occur from different
5 sources other than lungs and pulmonary system?

6 A. Certainly. It can occur without infection.

7 Q. What is -- and I need to find out. That's why
8 I'm asking these questions. This is the only
9 chance I get to talk to you prior to trial. And
10 I want to know what your thinking or opinion is
11 as to how her cellulitis in this particular case
12 developed into sepsis causing septic shock and
13 her death.

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

15 Q. Was it because of her weakened condition because
16 of the surgery?

17 A. I don't think there's a weakened condition
18 associated with surgery. I think her condition
19 was weakened before her surgery. Massively obese
20 patients have skin folds in areas of the body --
21 have as part of their premorbid conditions, have
22 the possibility of having chronic infection
23 within the fatty tissue that just does not look
24 like a normal infection.

25 If you got a cut on your arm and it got

1 infected, it would be very obvious. A fat
2 person, morbidly obese patient can have skin
3 infections just like that and we refer to what is
4 sort of a smouldering infection. You just don't
5 see it.

6 Q. Would that infection manifest itself in a raised
7 white blood cell count?

8 A. Sure could.

9 Q. Was there a white blood cell count taken of Ms.
10 Amidi prior to her surgery?

11 A. Yes.

12 Q. And what did that show?

13 A. It was -- I think it was normal. And her white
14 count after her surgery was all over the board.
15 It was high, it was low, it was normal.

16 Q. I think, I mean, your reference range goes up to
17 11 at Metro. I think it was 11.8.

18 A. Yes.

19 Q. If I'm wrong, I'm wrong on that. But it was not
20 abnormal. Would you agree with that?

21 A. Yes. But we do see that in the face of these
22 chronic smouldering infections.

23 Q. Well, obviously a doctor at some point felt it
24 was medically indicated to treat her some type of
25 infection with antibiotics, correct?

1 A. Absolutely.

2 Q. What type of antibiotic was that she was
3 receiving treatment for?

4 A. Well, we started her on antibiotics.

5 Q. Not your antibiotics. What was the antibiotic
6 when she came in?

7 A. She was on a gram-positive treatment drug. She
8 was on a cephalosporin.

9 Q. Is that a -- where is that on the range of
10 potency as far as --

11 A. It's a good drug. In fact, we gave her that same
12 antibiotic in surgery. It's part of our
13 perioperative empiric therapy. She got that same
14 drug as part of her operative procedure.

15 Q. Don't you think it's more likely than not that
16 had Ms. Amidi's surgery been cancelled on March
17 22nd and she would have went home, that more
18 likely than not she would not have died on March
19 27th?

20 A. I think that's probably a reasonable statement.

21 MR. CONWAY: I don't believe I
22 have anything further.

23 MR. MALONE: It's only been
24 four-and-a-half hours. I congratulate you.
25 This is not the longest deposition of a

1 doctor at Metro ever.

2 MR. CONWAY: All I'm saying, we
3 started the last deposition at I think
4 approximately 2:15. We had numerous
5 interruptions because I deferred to the
6 doctor taking a break, he had a couple of
7 phone calls to answer. I had to call and
8 verify my compliance with the discovery
9 process.

10 We had a couple discussions as to
11 the length of that depo and I agreed that
12 we would stop and I think we stopped at
13 around --

14 MR. MALONE: 92 pages. He can't
15 do it in less than two hours. It's 92
16 pages for his transcript.

17 MR. CONWAY: All right.

18 MR. MALONE: So you make it sound
19 like you didn't have two hours worth of
20 questioning. You got two hours the first
21 session and two hours today.

22 MR. CONWAY: Did we take a little
23 bit of a break today, Jim?

24 MR. MALONE: Are you done?

25 MR. CONWAY: Yes, Jim. I have

1 made this as quick and as painless and as
2 courteous as I could.

3 MR. MALONE: You've been very
4 courteous. If you can't take a little
5 chiding about being long-winded, then I
6 will not chide you anymore. I thought you
7 were thick-skinned.

8 MR. CONWAY: And really, when we
9 walk out of here, I'm not going to hold any
10 grudge.

11 - - - -
12 (Thereupon, a discussion was had off
13 the record.)

14 - - - -

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

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2
3 C E R T I F I C A T E
4

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

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

17 IN WITNESS WHEREOF, I have hereunto set my
18 hand and seal of office, at Cleveland, Ohio, this
19 5th day of September A.D. 20 03.

20
21 
22 _____
23 Juliana M. Lawson, Notary Public, State of Ohio
24 1750 Midland Building, Cleveland, Ohio 44115
25 My commission expires October 3, 2007

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- ☐ Focused
☐ Comprehensive

PHYSICAL EXAMINATION

HT 5'0 WT 167.8 BMI 24.2 T 98.5 P 114 R 24 BP 110/70 Luff - Patient
 General Statement 294/10 WF M NAS Pulse Ox% 99 Gluc. 11

WNL ABN N/A

☒ Skin ☒ HEENT ☒ Neck
☒ Lung/Thorax ☒ Breast ☒ Cardiovascular
☒ Abdomen ☒ Musculoskeletal ☒ Neurological
☒ Extremities ☒ Genitalia/Rectal

Signature of Examiner:

Date Patient Test Results ☐ None Ordered ☒ Reviewed ☐ Pending

Date: 3/19/02

Date Time

PHYSICIAN NOTIFICATION/REFERRALS

Name

ANESTHESIA SECTION

Name

Pre-anesthetic evaluation: [Handwritten notes]
 ASA: [Handwritten notes]
 Medical History: [Handwritten notes]
 Physical Exam: [Handwritten notes]
 Anesthesia Plan: [Handwritten notes]
 Anesthetic: [Handwritten notes]
 Summary: [Handwritten notes]
 Interviewer Signature: [Handwritten signature]
 Date of Surgery/Anesthesia Notes: [Handwritten notes]
 Significant change in risk: [Handwritten notes]
 Risks and options discussed: [Handwritten notes]
 Patient agrees to procedure: [Handwritten notes]
 Anesthetic Plan: [Handwritten notes]
 Anesthesiologist Signature: [Handwritten signature]
 Date: 3/19/02



New Patient Consult - DATE: September 24, 2001 William F Fallon, Jr., MD
COMPREHENSIVE H/P - MODERATE MEDICAL DECISION COMPLEXITY
CPT 99254

DIAGNOSIS: CLINICALLY SIGNIFICANT OBESITY

S: Royanne Amidi (MHMR# 0366876) is a 29-year old female referred for consultation by Dr. Ksenich regarding evaluation of obesity. She complains of multiple medical problems. Her weight problems started at 4 years of age. Over the years, her weight has fluctuated despite her attempts to lose or stabilize it. Her highest weight, as an adult was 462 lbs. and the best weight, as an adult was 260-275 lbs.

- Her obesity has contributed to the development of additional medical problems, including hypertension, back/knee/joint pain (degenerative joint disease), gastroesophageal reflux, Androgen excess syndrome, irregular menses, hypercholesterolemia, and she had gallstones at the age of 17.
- Her surgical history is positive for cholecystectomy, and bilateral knee arthroplasty.
- Her exercise capacity is within normal limits. She gets short of breath walking and/or climbing stairs.
- She has a family history of obesity (father) associated with obesity-related medical problems such as hypertension, cardiomegaly, and DJD.

Social History: She smokes 1 pack per day for 15 years.
She occasionally uses alcohol. She is allergic to Compazine, and Phenergan. She currently takes Motrin, HCTZ, Potassium, and Vioxx.

O/E: Ht: 5'0" Wt: 452#s BMI: 88 BP: 153/86 HR: 91

General: Well-developed well nourished, no acute distress

HEENT -	Normal limits
Cardiovascular -	OTHER <u>RRR</u>
Respiratory -	OTHER <u>CTA</u>
Abdominal -	OTHER <u>obese, previous, cholecystectomy incision</u>
Musculoskeletal / Extremities -	3 plus edema
Back -	OTHER <u>tender to palp</u>
Skin -	OTHER <u>no infections</u>

ASSESSMENT: She is a good candidate for surgical treatment of her obesity.
PLAN: The treatment plan is a nutritional evaluation and follow up with my office.

William Fallon
William F Fallon, MD

000003



METROHEALTH MEDICAL CENTER
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998

Patients Name: AMIDI, ROYANNE
Medical Record #: 0366876
Encounter Number: 000405078049
Resident: STEVEN KOTZBAUER, M.D.
Attending: 058727 FALLON WILLIAM F.
Service: SURG
Division: 8-C

DATE OF ADMISSION: 03/22/02

DATE OF DISCHARGE: 03/27/02

HISTORY OF PRESENT ILLNESS: The patient is a 29 year-old, white female with morbid obesity, who was admitted for a gastric bypass Roux-en-Y surgery.

ALLERGIES: COMPAZINE AND PHENERGAN.

ADMISSION MEDICATIONS: Albuterol inhaler p.r.n., cephalexin 500 mg t.i.d., hydrochlorothiazide 50 mg q.d., potassium chloride 10 mEq q.d., oral contraceptive pills.

PAST MEDICAL HISTORY: Migraine headaches, asthma, hypertension, sleep apnea, GERD, arthritis.

PAST SURGICAL HISTORY: Cholecystectomy and bilateral knee arthroscopic surgeries.

SOCIAL HISTORY: The patient smoked less than 1/2 pack per day, denied alcohol abuse and denied any IV drug abuse.

FAMILY HISTORY: Positive for COPD and obesity.

PHYSICAL EXAMINATION: On physical exam, the patient's temperature was 98.5, pulse 114, respirations 24, BP 110/70 and pulse oximetry 99% on room air. The patient was in no acute distress. Lungs were clear to auscultation bilaterally. Heart sounds were distant and regular. Abdomen was obese, soft, nondistended, positive bowel sounds. Extremities showed bilateral edema.

HOSPITAL COURSE: The patient was operated on March 22, 2002, which a gastric bypass Roux-en-Y was performed without complications. Estimated blood loss was 550 cc; urine output 200 cc, fluids 2800 cc of crystalloid. The patient was extubated in the OR, transferred to the PACU and then to 8-C. On the morning of March 23, 2002, the patient complained of left shoulder and chest pain of sudden onset. The pain lasted approximately 10 minutes and resolved with morphine and Toradol. An EKG was obtained and an ABG was obtained on 2 L O2 of nasal cannula. The patient was continued to be n.p.o. with an NG-tube to gravity drainage. Later in the afternoon on March 23, 2002, the patient was found to have a heart rate in the 150s and BP of 80s over 60s on the floor. She did not complain of shortness of breath or chest pain. O2 saturations were 94% on 2 L of O2 nasal cannula. EKG showed sinus tachycardia in the 150s, which was regular. The patient was

CLINICAL RESUME

'1'

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MetroHealth Medical Center
SURGEON'S REPORT

SURGERY DATE: 03/27/03 OR: 03/27/03 OF SOCS NUMBER: 0366876

SURGICAL SERVICE:

General-Blue

ATTENDING SURGEON:

Dr. Fallon W.

PIN #

058727

CHIEF RESIDENT:

Dr. Konstantakos A.

PIN #

RESIDENT: medical student
Jason Wilson

PIN #

☐ Check ONLY if Resident NOT involved in service

RESIDENT/CLLSI

INPATIENT/OUTPATIENT

RESIDENT:

RECOVERY

03/27/03

SURGEON'S NOTES

PRE-OPERATIVE DIAGNOSIS:

Asthma

Chronic deep vein

H/O cellulitis

insulin resistance

Obesity

POST-OPERATIVE DIAGNOSIS:

Surge

PROCEDURE PERFORMED (LIST PRIMARY PROCEDURE FIRST - NO ABBREVIATIONS)

1. gastric bypass Rnyx w/

2.

3.

4.

5.

6.

7.

DISPATCHING SURGEON'S SIGNATURE:

Konstantakos

PIN #

ATTENDING SURGEON'S SIGNATURE:

Fallon 058727

☐ YES ☐ NO

(Billing Office Use Only)

PCP:

INSURANCE:

AUTH#

CODER:

025010801 REV. 5/97

CHART

000090

