IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

SEFEDIN AMIDI, etc., et al.,

Plaintiffs,

-vs-

JUDGE GALLAGHER
CASE NO. 493065
VOLUME II

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

Defendants.

- - - -

Continued 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 9:00 a.m. on Thursday, August 14, 2003, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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WITNESS INDEX

EXHIBIT INDEX

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:

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

A. Yes.

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

A. Thank you.

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

A. No, I did not.

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

A. Yes.

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

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

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

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

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

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

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

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

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

the preparation process, to my knowledge.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

A. That's a very fair statement.

Q. Okay.

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

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

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Q. I believe this is Bates stamped page 137. Doctor, if you would look at Exhibit Letter E, do you know who would have entered the information on this exhibit?

A. Not specifically, no.

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

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

Q. Are those registered nurses; do you know?

A. They include registered nurses.

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

A. To the best of my knowledge, yes.

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

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

A. Yes.

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

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

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

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

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

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

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

A. Correct.

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

- - - -

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

- - - -

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

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

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

A. Correct.

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

A. That's correct.

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

A. Yes.

Q. And then what does it say underneath there?

A. No warmth and no pitting.

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

A. I don't believe so.

Q. Had it been brought to your attention along with the other information, you would not have gone forward with the surgery, correct, the other information being the cigarette smoking and the being on antibiotics?
A. Active infection, correct.
Q. You've indicated that you think that Ms. Amidi more likely than not died from sepsis as a result of her cellulitis, correct?
A. Yes.
Q. She would not have developed sepsis and died from her cellulitis had she not had the surgery on March 22nd, 2001, correct?
A. I don't know the answer to that.
Q. Do you believe it's more likely -- strike that. Let me phrase it this way. Do you believe she would have developed sepsis and died on March 27th from her cellulitis had she not had surgery on March 22nd, 2001?
A. That's a better question. I still don't know the answer to that. I don't think that she -- I can't tell you that she would have died from sepsis related to her cellulitis on March 27th.
Q. Well, can you explain to me your thinking as to the mechanics of how her cellulitis caused the

sepsis for which she died from?

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

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

A. That's possible.

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

A. I don't know the answer to that question.
Q. Do you believe that the surgery was a contributing cause to her death?
A. The surgical procedure?
Q. Yes. And I'm not talking about, for purposes -- I'm not implying for purposes of this question that there was anything -- that your surgical technique caused her death. For purposes of this question I'm asking if the surgery --
A. In general.
Q. -- in general.
A. It's possible.
Q. Would you agree that the negligent failure of the medical staff at MetroHealth Medical Center to provide you with important information regarding Ms. Amidi's preoperative condition was a cause of her death?

MR. MALONE: Objection.

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

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

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

A. No.

Q. No symptoms associated with bacteremia, correct?

A. To my knowledge, no.

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

A. That's true.

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

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(Thereupon, Plaintiffs' Exhibit C 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

any --

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

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

A. Not necessarily.

Q. Who would keep it?

A. The clinician who saw the patient.

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

A. Yes. Generally. Generally.

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

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

Q. Is that charted anywhere by you?

A. I don't recall.

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

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

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

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

A. Yes, I did.

Q. Do you --

A. Have the criteria?

Q. Yes.

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

Q. That's what you gave --

A. Jim, correct.

Q. Jim. All right.

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

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

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

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

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

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

A. That's correct.

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

A. Evolved over time.

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

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

saw the patient.

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

A. Yes. Yes.

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

A. That's correct.

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

A. Not to my knowledge, no.

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

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

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

MR. CONWAY: We can mark this as

Exhibit D.

- - - -

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

- - - -

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

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

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

A. Yes, sir.

Q. I just wanted to --

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

MR. CONWAY: Right. Bates stamp page 11.

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

A. Yes.

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

dictated?

A. I didn't dictate that discharge summary.

Q. Who dictated it?

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

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

A. Reviewed that and signed it, yes.

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

A. No, I don't.

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

A. Dictated into the record.

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

A. Medical record.

Q. -- admission record, correct?

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

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

A. Yes.

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

- - - -

(Thereupon, Plaintiffs' Exhibit G was marked for purposes of identification.)

- - - -

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

A. At the end of the surgical procedure.

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

A. The first one says asthma.

Q. Right. Then what is the next one?

A. Clinical sleep apnea.

Q. And the third one is?

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

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

A. Same.

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

A. Insulin resistance.

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

A. Yes.
Q. And what is the purpose in the surgeon noting these preoperative diagnoses on this sheet?
A. It gives you the indications for surgery.
Q. How would a history of cellulitis be an indication for bariatric surgery?
A. It's part of the spectrum of disease that morbidly patients are prone to and helps us to justify our proceeding to operation on them. This is one of the ways that we characterize patients who have clinically significant obesity and we use the -- at least I use the NIH criteria that were developed to look -- to guide obesity into several categories.

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

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

A. Yes.
Q. Whose handwriting is these entries in, specifically the history of cellulitis?
A. That's my handwriting.
Q. That's your signature down at the bottom?
A. Such as it is.
Q. And this would have been filled out immediately after the surgery?
A. That's correct. As soon as I break scrub.
Q. When did you first think that Ms. Amidi's condition was caused by her cellulitis?
MR. MALONE: Which condition?
A. Which condition?
Q. You're right. I'll rephrases that. When did you first think that Ms. Amidi's sepsis was caused by cellulitis?
A. When we obtained blood cultures that documented that she had gram-positive organisms in her bloodstream.
Q. And when was that, Doctor?
A. Sometime after she was admitted into the intensive care unit.
Q. Did you ever put in writing your thoughts that possibly her condition of cellulitis was causing her sepsis?

A. I don't think I ever specifically said that.
Q. To your knowledge, did any of the other medical professionals or consults that were treating Ms. Amidi indicate to you that they felt that an underlying condition of cellulitis was causing her sepsis?
A. As you specifically put it, I don't believe so. But can we look at the medical records?
Q. Sure.
A. I can't find anywhere in the record where I specifically say that or that anybody else specifically says that.
Q. Is there anyplace you can point me to where it was implied by anybody that an underlying condition of cellulitis was responsible for her sepsis?
A. No. In fact, there is only one brief mention by one of the consultants that to consider other possible sources of infection, but that's it.
Q. Other sources of infection other than what?
A. Than wound infection. The original complication that prompted the concern about a postoperative infection was the drainage of the fluid from her wound. We were concerned that was a wound infection.

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

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

A. To my knowledge, no.

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

A. Yes.

Q. And do debridement if necessary?

A. If necessary.

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

A. No.

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

A. Correct.

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

correct?
A. It's possible.
Q. That's a risk of wound infection, correct?
A. It's possible, yes.
Q. Doctor, have you attended any seminars, conferences or received any training involving bariatric surgery?
A. No.
Q. Have you --
A. Well, let me rephrase that. I think we discussed earlier that my training in bariatric surgery has been part of my surgical education since I was a resident. We did talk about that.
Q. When you were a resident, you received some training in bariatric surgery?
A. Correct.
Q. What years were you a resident?
A. '77 to '81. And we talked about the type of operation we did at that time.
Q. Right. And then we talked that you began doing bariatric surgery, I believe, in what year?
A. Here?
Q. Yes.
A. 1996.
Q. Not counting the time when you were a resident?

A. No.
Q. The answer to the last question?
A. No.
Q. Is no. Okay. Have you trained -- not counting your time as a resident, have you ever trained under a more experienced bariatric surgeon?
A. No.
Q. Specifically since 1996?
A. No.
Q. From 1996 on, how did you educate and train yourself in the field of bariatric surgery?
A. Well, I'm current with the literature from the standpoint of reading what's in the literature about bariatric surgery, but I don't have any other specific bariatric surgical procedures that I can point to.
Q. What bariatric literature do you rely upon?
A. The general surgical literature.
Q. Put out by whom?
A. Well, it depends. There is a fair amount of literature that's published in JAMA, for example, about obesity. And there are other surgical journals, SG&O, Surgical, Gynecology, Obstetrician. And the Journal of the American College of Surgeons.

Q. Do you ever read and rely upon the different journals published by bariatric surgeon associations?
A. I haven't, no.
Q. What is your reasoning for not reading those?
A. I don't think I'm missing by reading what I'm reading.
Q. I think where we left off the last deposition was you had read into the record your 10:05 a.m. note from March 24th. That's when we --
A. Okay.
Q. You have here and this in your handwriting, hypovolemia, question mark and then there is ETIOL?
A. Etiology.
Q. Meaning that you are unsure of the etiology of her condition at that time; is that correct?
A. Correct.
Q. What was your differential diagnosis as of 10:05 a.m. on March 24th when you see the patient?
A. Can you ask that question again. I'm sorry.

- - - -

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

- - - -

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

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

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

A. No.

Q. -- that you would look for?

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

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

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

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

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

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

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

A. Yes.

Q. You would?

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

Q. But obviously an infection can explain that as

well?
A. Yes. I'm not denying.
Q. In light of this CBC in a postsurgical patient, would you agree the standard of care requires empiric antibiotic coverage until cultures are proven?
A. That's one thing we would do, is to start antibiotics for a patient like that.
Q. Does the standard of care require that?
A. I'm not sure I know the answer to that. But if we were concerned she had infection, we would have started antibiotics. If we thought this was a stress response, we would not.
Q. What type of antibiotics -- would you start empiric antibiotics until you could narrow it down to the specific cause of infection?
A. That's a definition of empiric therapy, yes.
Q. Just in reading through here, there was treatment with Adenosine? Is that pronounced correctly?
A. Yes.
Q. Are you aware of that treatment that she received I think on March 23rd?
A. Yes.
Q. And that was not your idea, was it?
A. No.

Q. I didn't think so. That was your resident's idea?
A. Well, I don't know the answer to that. There was a critical care attending in-house. And he could very well have and probably did authorize that therapy. I can put the events together having been there myself as a critical care attending, but were found tachycardia masquerading as supraventricular tachycardia or SVT would be one of the reasons we would use Adenosine. But it's not a primarily surgical choice of treatment of choice.
Q. And certainly she wasn't suffering from SVT, correct?
A. I don't believe so.
Q. What are you aware the signs and symptoms -- what are the common signs and symptoms of a PE?
A. They can be silent. A PE is pulmonary embolism. And chest pain, respiratory distress, hypoxia, hypotension, death are common symptoms associated with PE.
Q. Would it be fair to say that a PA 02 would generally be less than 100 in a patient suffering from a PE?
A. Could definitely be.

Q. Ms. Amidi had a PA 02 of 147 on oxygen with wheezing. That would be an atypical presentation for a PE, would you agree?

A. Not on oxygen. Not everybody with a pulmonary embolism who is on supplemental oxygen will have very low oxygen content. You certainly can if you have a very bad p02 pulmonary embolism. The confounding factor there is the oxygen therapy.

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

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

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

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

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

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

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

Q. Would a patient typically be tachycardic?

A. Yes.

Q. Would the patient typically be hypotensive?

MR. MALONE: Did you say hyper or hypo.

Q. Hypo.

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

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

A. Sure can.

Q. So --

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

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

A. Correct.

Q. What else?

A. I think that's about it.

Q. And then when the patient actually becomes hypotensive?

A. That's septic shock.

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

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

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

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

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

MR. MALONE: Objection. Go ahead.

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

Q. When did sepsis first become a part of your

differential diagnosis?
A. Probably postoperative day number three, because I opened the wound.
Q. Which would be what date?
A. 3-25.
Q. When was the first time you considered getting an infectious disease consult involved in Ms. Amidi's care and treatment?
A. I don't remember the exact day we ordered that.
Q. I believe it was ordered on March 25th.
A. Then that would be the day we had in her care.
Q. And you would not have considered getting an infectious disease consult involved prior to that date?
A. No. We got many consultants involved, but it sort of reflects what I thought was going on at the time. Pulmonary people were the first folks involved. Cardiologists were the second people involved and then ID was involved third.
Q. There are infectious disease specialists that work at Metro General?
A. Yes.
Q. And who was the infectious disease consult that actually --
A. I don't know that name.

MR. MALONE: It's Dr. Hanrahan. She's a female.

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

A. On March 23rd?

Q. Right.

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

Q. When did you start her on empiric antibiotic?

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

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

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

A. What date did you say again?

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

A. I'm sorry. You said when?

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

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

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

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

A. No.

Q. Do you know why not?

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

Q. Does Flagyl treat anything other than fungal infection?

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

Q. And what causes pseudomembranous colitis?

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

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

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

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

A. Absolutely.
Q. Do you recall discussing with Dr. Finley his recommendations regarding antibiotic use after he saw the patient on March 24th?
A. No, I don't specifically recall that.
Q. Does any reason stick out in your mind why, if he recommended Flagyl, it would not have been given to the patient at the same time these other antibiotics were given?

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

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

There are a number of empiric antibiotic

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

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

A. Because it was seeping.

Q. And describe the drainage.

A. It was dirty brown drainage.

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

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

Q. What was your interpretation of what you found?

A. That it wasn't.

Q. It was not?

A. No.

Q. What was causing the dirty brown drainage?

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

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

Q. Were sputum cultures ever taken?

A. I believe so.

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

A. Not off the top my head, no.

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

A. Neither.

Q. Wouldn't?

A. It wouldn't be relevant to either.

Q. Not?

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

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

A. I don't think so.

Q. Was that ever considered?

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

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

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

A. Yes.

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

A. Yes.

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

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

Q. At what point in time?

A. Early on.

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

A. Yes.

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

A. That's correct.

Q. At what time did you first feel she was suffering from sepsis?
A. I can't tell you exactly what time, but my note is dated from 0900.
Q. Would that have been after or before you opened up the surgical wound?
A. That note is describing that whole aspect of her care. So new finding this a.m., dirty brown drainage from wound. So that would be the time that I worried about a wound infection as the etiology of this.
Q. And after, in your opinion, you ruled out this as being a wound infection?
A. Well, I don't think it's that simple that you can rule it out. I'm mean, certainly when we opened it up and sent it off for culture it was an atypical manifestation of a wound infection. Wound infections have a tendency to look and behave in three specific ways. And this was not any one of those three specific ways.
Q. What are the three specific ways?
A. Well, one there is an erythema of the tissues around the wound and there is either golden, thick secretions that drain from the wound or thin, grayish secretions that drain from the

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

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

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

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

A. Correct.

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

A. It's unusual.

Q. Unusual. And the cultures come back negative?

A. Yes.

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

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

leak at this particular point in time.

Q. Because you would have ordered a gastro --

A. Grafin.

Q. -- swallow, correct?

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

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

A. That's correct.

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

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

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

them to see if there's a leak.

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

A. That's a fair statement.

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

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

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

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

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

Q. Correct?

A. That's what I'm saying.
Q. Okay. Why on the death certificate did you not indicate that you felt cellulitis was involved in causing her death?
A. I don't know.
Q. Whose decision was it not to have an autopsy performed?
A. The family.
Q. And do you know why?
A. Religious reasons.
Q. And you don't have a problem with that, do you? I mean, certain families for religious reasons --
A. It happens all the time. We would have liked to have an autopsy.

MR. MALONE: Off the record.

- - - -

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

- - - -

(Thereupon, a recess was had.)

- - - -

Q. And the way you would rule out if you did suspect a leak would be that gastrografin swallow?
A. That's one way, yes.
Q. And what are the other ways?

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

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

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

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

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

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

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

Q. And that would have been available at Metro,

correct?

A. Yes. Yes.

Q. What about CT?

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

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

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

Q. Did you have those back in 2001?

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

Q. 2002. I'm sorry.

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

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

A. Both of those are the same people. Part of the same department.
Q. Right. They're both pulmonologists.
A. Yes.
Q. Dr. Finley would be attending and Southwell would be the fellow?
A. Fellow.
Q. All right. Do you agree with Dr. Finley's assessment where he gives his differential diagnosis of sepsis as being involved?
MR. MALONE: Where are you in the note?
MR. CONWAY: Like fifth line from the bottom. His handwriting is very small.
Q. Clinical course is suggestive of sepsis versus --
MR. MALONE: Massive PE.
Q. -- massive PE.
A. I wouldn't disagree with that.
Q. So he as of March 24 has sepsis on his differential diagnosis?
A. He does. I have CPAP on my mind. That's why he was asked to see her.
Q. And I believe he states the likely sources at that time of sepsis would be from pneumonia, urosepsis or wound infection?

A. Correct.
Q. On March 24th, what was done to rule out --
A. Those things?
Q. -- those things as causing sepsis?
A. A part of what we would have done is order cultures of all of those things.
MR. MALONE: Did you answer the question?
A. I believe I did.
MR. MALONE: I don't know if we're waiting for another question or --
Q. Okay.
A. Was that a sufficient answer?
Q. Sure. There is your attending note of March 26th, which you indicate, give a diagnosis of presumed sepsis.
A. Yes.
Q. It's the 10:55 note, correct?
A. That's correct.
Q. Do you want to read that?
A. 3-26-02, attending postoperative day number four, 10:55. Seen on rounds. Report from ID, infectious disease. Pulmonary reviewed and appreciated. Interval events reviewed. On E, which is examination, remains intubated,

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

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

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

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

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

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

A. Yes.

Q. Go ahead.

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

antibiotics.

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

A. Yes.

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

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

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

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

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

A. In a court or in deposition?

Q. In deposition?

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

MR. CONWAY: We can do it that way.

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

MR. CONWAY: I'm not disagreeing.

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

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

A. Yes.

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

A. Two that I can remember.

Q. One you state would be for the plaintiff?

A. I'm sorry.

Q. One would be for the patient?

A. Yes. I think so.

Q. And that was a trauma case?

A. Both of them were trauma cases.

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

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

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

A. Yes. Two cases that I can recall.
Q. Now, you've been a defendant, named defendant in different medical malpractice cases, correct?
MR. MALONE: Objection.
A. Yes.
Q. Did any of those cases involve bariatric surgery?
A. Yes.
Q. How many of them involved bariatric surgery?
A. One.
Q. Is that case still pending?
A. No.
Q. Did that settle?
A. Yes.
MR. MALONE: Actually, it was dismissed.
A. Dismissed, is that what it was?
MR. MALONE: It was dismissed without settlement. It wasn't settled as to Dr. Fallon.
A. And that was a reoperative bariatric case, which is kind of a different kettle of fish.
MR. MALONE: Totally different.
Q. In that case though, I assume that you were dismissed individually; is that correct?
MR. MALONE: The whole case was

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

MR. CONWAY: Okay.

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

A. Obesity.

Q. Obesity. Okay. I misunderstood you.

A. Sorry.

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

A. I believe I did make those available.

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

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

MR. MALONE: It's not your fault.

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

just to make sure the record is clear on it. We've gone over a couple of your notes so far.

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

A. Which one?

Q. Attending note.

A. There are two of them on that page.

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

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

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

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

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

A. That's correct. That's not 9:00 a.m. That's 9:00 p.m.
Q. Sorry. That was obviously written by one of your residents?
A. That's correct.
Q. What was -- and you would have, in evaluating and mentoring and supervising your residents, would have been aware of what their charting was in this case, correct?
A. At the time that the note was written, no. I would have checked that the next day.
Q. And what is your understanding what that note says?
A. That everything is fine.
Q. Can you read that note?
A. Sure.
Q. Okay.
A. It says 3-22-02, 9:00 p.m., blue surgery postop check. It is a SOAP, S-O-A-P. Patient complains of --

MR. MALONE: Dry mouth.

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

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

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

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

A. That's the gastrografin swallow that I typically get five days following surgery to evaluate the anastomosis.

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

A. It looks like the same resident's signature. Again it's a SOAP note. Patient doing well but this a.m. complained of left shoulder and chest pain. Something. Lasting approximately ten minutes. Relieved with MS04 and Toradol. EKG obtained and unchanged from prior. Pain completely resolved. ABG obtained on two liters 02 nasal cannula. I don't know what that says.

Pulse 120. Respiratory rate 20. Blood

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

Q. And then you write an attending note?

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

Q. P.m.?

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

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

A. Yes.

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

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

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

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

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MR. MALONE: Two liters, nasal cannula.

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

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

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

A. That's probably a nursing note.

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

MR. MALONE: That would be this.

A. Yes.

Q. And who wrote that?

A. I don't know.

Q. Would that have been one of your residents?

A. Yes.

Q. What does that say?

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

Q. Unlikely ST?

A. Yeah.

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

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

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

A. I think so, yes.

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

events?

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

Q. How about the impression of the resident?

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

MR. MALONE: Is that Dopamine or Heparin?

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

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

MR. MALONE: You mean in the margin.

Q. Yes.

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

MR. CONWAY: I think I got it.

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

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

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

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

A. Yes.

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

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

can't read it.

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

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

Q. What is RV strain?

A. Right ventricular strain.

Q. Are these abnormal renal findings?

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

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

A. Probably sepsis.

Q. What line is that?

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

Q. And who made that statement of probably sepsis?

A. One of the residents.

Q. Would that resident have reported to you?
A. Yes.
Q. Did the resident make you aware of his diagnosis that this was probably sepsis?
A. I'm sure he probably did.
Q. Do you know what time that resident's note was?
A. No.
Q. Would it have been before your attending note of 3-24-02 at 10:05?
A. Most likely.
Q. And we've had you read that note I think twice into the record?
A. I believe so.
MR. MALONE: It's right after the 9:00 p.m. note.
A. The only question you asked me was it before this note and I said yes.
Q. Do you know what that resident's name was?
A. No, sir.
Q. Do you know if that resident is still at Metro?
A. No, I don't.
Q. Then you've read in the 10:05 note. I guess could you -- is that also your 3-24-02, 11:05 note? This is also your attending note, right?
A. Yes.

Q. Could you read that one?

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

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

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

A. Yes, I see it.

Q. Can you read that.

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

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

A. PN stands for progress note.

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

A. It does.

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

questions whether urosepsis?

A. Yes.

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

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

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

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

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

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

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

A. You know, I don't know.

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

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

Q. What would be the significance of necrotic fat?

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

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

A. Sure.

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

A. Probably.

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

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

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

Q. Going down.

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

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

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

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

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

A. Correct.

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

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

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

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

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

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

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

Q. And did you read this whole one before?

MR. MALONE: I think he did.

A. Yes.

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

A. Where are you at?

Q. Right here.

MR. MALONE: Blood culture times one.

A. Gram-positive cocci.

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

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

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

A. Are you asking me or telling me?

Q. No. I'm sorry.

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

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

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

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

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

critical condition.

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

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

Q. Is that the extent of the charting?

A. Yes.

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

A. Yes.

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

A. No.

Q. That's fair?

A. That's fair.

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

A. No.

Q. -- your thinking that this was cellulitis?

A. No.

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

cellulitis?

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

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

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

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

A. Pulmonary infection?

Q. Yes.

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

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

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

A. Certainly. It can occur without infection.

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

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

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

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

If you got a cut on your arm and it got

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

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

A. Sure could.

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

A. Yes.

Q. And what did that show?

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

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

A. Yes.

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

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

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

A. Absolutely.
Q. What type of antibiotic was that she was receiving treatment for?
A. Well, we started her on antibiotics.
Q. Not your antibiotics. What was the antibiotic when she came in?
A. She was on a gram-positive treatment drug. She was on a cephalosporin.
Q. Is that a -- where is that on the range of potency as far as --
A. It's a good drug. In fact, we gave her that same antibiotic in surgery. It's part of our perioperative empiric therapy. She got that same drug as part of her operative procedure.
Q. Don't you think it's more likely than not that had Ms. Amidi's surgery been cancelled on March 22nd and she would have went home, that more likely than not she would not have died on March 27th?
A. I think that's probably a reasonable statement.

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

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

doctor at Metro ever.

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

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

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

MR. CONWAY: All right.

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

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

MR. MALONE: Are you done?

MR. CONWAY: Yes, Jim. I have

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

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

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

- - - -

(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 5th day of September A.D. 20 03.

Juliana Lawson

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

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000137

PLAINTIFF'S EXHIBIT E 3/14/08

PENGAD-Bayonne, N. J.

MetroHealth Medical Center

PRE-OPERATIVE ASSESSMENT

☐ Healthy ASA I/II Focused
☐ Comprehensive: ASA II, III, IV, V

0366876 2534239 03/19/02
PRE SURGICAL EVAL 023050271
AMIDI, ROYANNE 03/28/1972 F
35324 ELM Rd
GRAFTON OH 44044
H(440)748-0102 O( )

Date 3/19/02 Date of Surgery 3/22/02
Surgeon: Dr. Fallon PCP
Surgical Diagnosis Morbid obesity
Surgical Procedure gastric bypass

Yes	No	
☐	☐	(Pediatric) Exposure to recent communicable disease (Specify
☐	☐	(Pediatric) Immunizations up to date

Source of Information: ☒ Patient ☐ Family ☐ Medical Records ☐ Interpreter ☐ Other
Patient: ☐ Single ☒ Married ☐ Divorced ☐ Widowed

History of Present Illness: This 29 y.o. W ☐ Male ☒ Female

Pain/Discomfort (Scale 1-10) Related to Surgical Diagnosis	c morbid obesity
☐ Present 0/10	
☐ Location	
☐ Description	
☐ Duration	
☒ Reviewed with patient describing pain and their role in pain management	

☐ NKA
☒ Allergies Compazine, Phenergan → "goes out of her mind"
If Latex Allergy Notify Surgery

List all Medications / Herbs / Vitamins:
(✓) Take on day of Surgery per Anesthesia Guidelines/Dr.'s approval
(+) Medication taken Morning of Surgery

(✓)	AM (+)	
		Albuterol inhaler prn
		OC's
		Glucophage 500mg tid
		Naprosyn 500mg qd
		Accu 10mg qd

Yes	No		
☐	☒	ASA/(NSAID)	Frequency / Stopped: 7 days until
☐	☒	Steroids past 6 months	

SOCIAL HISTORY

Yes	No	
☒	☐	ETOH social
☒	☐	Tobacco ½ ppd
☐	☒	Marijuana, Cocaine, etc
☐	☐	Patient instructed on pre-operative risks

FAMILY HISTORY
Mother: COPD
Father: obesity
Siblings: DM + HTN

PAST SURGICAL HISTORY
Cholecystectomy
Bilat. knee arthroscopies

ANESTHESIA HISTORY

Yes	No	
☒	☐	Previous Anesthesia
☐	☐	Difficult Intubation
☐	☒	Malignant Hyperthermia
☐	☒	Complications
☒	☐	Other: hard to wake up when sedated
☐	☐	Family Hx Anesthetic / Surgical Complications

HISTORY AND PHYSICAL VALID FOR 30 DAYS

026114001 (REV. 12/00)

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS
CHECK ONLY (✓) POSITIVE FINDINGS

☐ No Significant Past Medical History or Review of System

HEENT	HEPATIC	GASTROINTESTINAL
☐ TMJ	☐ Hepatitis	☒ (GERD) Hiatal Hernia
☐ Glaucoma	☐ Gallbladder Disease	☐ Bowel Disease
☐ Loose/Chipped Teeth	☐ Other	☐ Ulcers
☐ Dentures/Partials		☐ Abd pain
☐ Neck Problems	**SKIN INTEGRITY**	☐ Diarrhea/Constipation
☐ Hearing Deficit	☐ Lesions/Ulcers	☐ Nausea/Vomiting
☐ Vision Deficit	☐ Rashes	☐ Bleeding
☐ Present Cold Symptoms	☒ Other folliculitis	☐ Other
☐ Snoring	legs	
☒ Other migraines	**ENDOCRINE**	
CARDIOVASCULAR	☐ Thyroid Disease	**NUTRITIONAL**
☐ MI	☐ Diabetes	☐ Restrictive Diet
☐ Hypertension	☒ Other Insulin resistance	☒ Unintentional Weight Loss/(Gain)
☐ CHF	but not diabetic	
☐ Valvular Dis		**MUSCULOSKELETAL**
☐ Pacemaker		☒ Arthritis multiple joints
☐ Chest Pain		☐ Spinal Problems
☐ Palpitations	**NEUROLOGIC**	☐ Stiffness/Pain
☐ PND	☐ Epilepsy/Seizure	☐ Swelling
☐ Exercise Intolerance	☐ CVA/TIA	☐ Other
☐ Other	☐ Neuromuscular Dis.	
	☐ Psych. Illness	
	☐ Tremors	
	☐ Syncope/LOC	
	☐ Numbness	
PULMONARY	☐ Other	**FUNCTIONAL LEVEL**
☒ Asthma albuterol prn		☐ Impaired Mobility
☐ COPD/Emphysema	**HEMATOLOGIC**	☐ Walking Aids
☐ TB	☐ Sickle Cell Anemia	☐ Prosthesis
☐ Pneumonia Past 3 Months	☐ HIV + / AIDS	☐ Assistance with care
☒ Sleep Apnea not officially diagnosed	☐ Blood Clot (Type and Location)	☐ History of Falls/At Risk
☐ Oxygen Treatment	☐ Anticoagulation Treatment	☐ Developmental Delay
☒ Cough occ	☐ Transfusion within 3 Months	☐ Other
☐ Wheezing	☐ Bleeding Disorders	
☒ SOB	☐ Other	**PSYCHO/SOCIAL**
☐ Other		☒ Occupation/Education homemaker
GENITOURINARY	**REPRODUCTIVE**	☒ Support Person/System husband
☐ Renal Failure	☐ Contraception OC's	
☐ Dialysis	☐ LMP 3/19/02	**CANCER**
☐ BPH	Menstrual cycle ☐ Regular ☐ Irregular	☐ Location
☐ Voiding Difficulties/Incon	☒ G 1 P 0 SAB 1	☐ Radiation
☐ UTI/Hematuria	☐ Other	☐ Chemotherapy
☐ Self Catheterization		
☐ Other		

☐ Focused
☐ Comprehensive

PHYSICAL EXAMINATION

HT 5'0 WT kg 212.2 lb 467.8 BMI 91.3 T 98⁵ P 114 R 24 BP L 110/70 Lg cuff - medial R ______ Pulse Ox% 99 Time / Gluc. [illegible]

General Statement 23 y/o WF in NAD

ASA 3
[illegible]

WNL	ABN	N/A		
☒	☐	☐	Skin	
☒	☐	☐	HEENT	
☒	☐	☐	Neck	
☒	☐	☐	Lung/Thorax	Clear ̄s wheeze
☐	☐	☒	Breast	
☒	☐	☐	Cardiovascular	Distant heart sounds ∅ ⓜ auscultated
☒	☐	☐	Abdomen	Obese soft ⊕ BS
☒	☐	☐	Musculoskeletal	
☒	☐	☐	Neurological	
☐	☒	☐	Extremities	Bilat leg edema, some erythema Lt leg ∅ warmth ⓘ pitting
☐	☐	☒	Genitalia/Rectal	

Signature of Examiner: [illegible signature] Date: 3/19/03

Date ________ Patient Test Results ☐ None Ordered ☒ Reviewed ☒ Pending

Name

Date	Time	PHYSICIAN NOTIFICATION/REFERRALS

Name

ANESTHESIA SECTION

[redacted]

000138

PLAINTIFF'S EXHIBIT F 8/19/03

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____RRR_____
Respiratory –	OTHER ____CTA_____
Abdominal –	OTHER_obese, previous, cholecystectomy incision
Musculoskeletal / Extremities–	3 plus edema
Back –	OTHER tender to palp_____
Skin –	OTHER_no infections

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 F Fallon, MD

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.

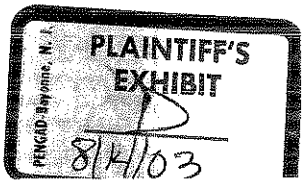
SOCIAL HISTORY: The patient smoked less than 1/2 pack per day, denied alcohol abuse and denied any IV drug abuse.

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

000011



MetroHealth Medical Center
SURGEON'S REPORT

SURGERY DATE	OR	ORSOS NUMBER
02/21/02	6	93370

SURGICAL SERVICE: General – Blue

4050780 49
0366876
AMICI, ROXANNE
F B W XXS 02/29/1972

ATTENDING SURGEON:	PIN #
Dr. Fallon W.	058727

☐ Check ONLY if Resident NOT involved in service

CHIEF RESIDENT:	PIN #	RESIDENT:	PIN #
Dr. Konstantakos, A. 1630		INPATIENT	
~~RESIDENT~~ medical student: Jason Wilson		RESIDENT: RECOVERY	03...

SURGEON'S NOTES

PRE-OPERATIVE DIAGNOSIS	ICD-9 CODE	POST-OPERATIVE DIAGNOSIS	ICD-9 CODE
Asthma			
Clinical sleep apnea			
H/O cellulitis		Same	
Insulin resistance			
Obesity			

PROCEDURE PERFORMED (LIST PRIMARY PROCEDURE FIRST – NO ABBREVIATIONS)	ICP-9 CODE	MODIFIER
1. Gastric bypass Roux en Y		
2.		
3.		
4.		
5.		
6.		
7.		

DICTATING SURGEON SIGNATURE	PIN #	ATTENDING SURGEON SIGNATURE	PIN #	BILLABLE SERVICE
Konstantakos		Fallon	058727	☐ YES ☐ NO

(Billing Office Use Only)

PCP:	INSURANCE:	AUTH#	CODER:

025010801 REV. 5/97

CHART

000090

PLAINTIFF'S EXHIBIT G 8/14/03
PENGAD-Bayonne, N.J.