

THE STATE of OHIO, :
 : SS:
COUNTY OF LORAIN. :

IN THE COURT OF COMMON PLEAS

Doc. ~~44~~
571

LENORE LIND, et al., :
 plaintiffs, :
 :
 vs. :
 :
COMPREHENSIVE HEALTH CARE of :
 OHIO, INC., et al., :
 defendants, :

Case No. 93CV110798

Deposition of MICHAEL A. FLYNN, M.D.,

a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, Registered Professional Reporter, Certified Legal Video Specialist, Notary Public within and for the State of Ohio, at the offices of Robert F. Orth, Esq., 1500 One Cascade Plaza,, Akron, Ohio, taken on THURSDAY, JANUARY 12, 1995, commencing at 4:11 p.m. pursuant to notice,

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16 JANUARY 1995

Robert F. Orth, Esq.
1500 One Cascade Plaza
Akron, Ohio 44308

RE: Lenore Lind, et al., vs Comprehensive Health Care of
Ohio, Inc., et al.

Bear Mr. Orth:

Since you are receiving the deposition transcript of
Michael A. Flynn, M.D. taken on January 12, 1995, please have
Dr. Flynn read and sign same.

Notations, if any, should be made on the errata sheet at the
back of the transcript and not within the body of the
transcript. Once read and signed, please forward a copy of
the errata sheet back to this office for further
disbursement.

Reading and signing should occur within seven days of receipt
of this letter or under the Ohio Rules of Civil Procedure
signature will, be deemed "waived."

Thanking you in advance for your anticipated cooperation in
this matter. Any questions concerning this procedure, please
feel free to call.

Sincerely,
FLOWERS & VERSAGI COURT REPORTERS

Frank P. Versagi, RPR, CLVS

cc: Christopher M. Mellino, Esq. ←
Gerald R. Horning, Esq.
Joseph Feltes, Esq.
Lynn L. Moore, Esq.
John P. Gallagher, Esq.
Robert Q. Quandt, Esq.
John R. Scott, Esq.
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I N D E X

WITNESS: MICHAEL A. FLYNN, M.D.

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NO EXHIBITS MARKED

(FOR EVERY WORD INDEX, SEE APPENDIX)

MICHAEL A. FLYNN, M.D.

1 of lawful age, a witness herein, called by the
2 plaintiffs for the purpose of cross-examination
3 pursuant to the Ohio Rules of Civil Procedure,
4 being first duly sworn, as hereinafter certified,
5 was examined. and testified as follows:
6

7
8 CROSS-EXAMINATION

9 BY MR. MELLINO:

10 Q. Would you state your full name please,
11 Doctor?

12 A. Michael A. Flynn.

13 Q. Did you bring your file with you today?

14 A. I brought the documents that I was given by
15 Mr. Orth; is that what you're asking?

16 Q. Yes.

17 A. Yeah.

18 Q. That's what is contained in the black folder
19 in front of you?

20 A. This is it.

21 Q. Those are all the documents that you received
22 from Mr. Orth?

23 A. It's totally it, yes.

24 Q. Do you mind if I take a look at it?

25 A. No. I wasn't not sure if my other minutes

1 from meetings were out of there.

2 Q. The only deposition that you reviewed in this
3 case was the deposition of Dr. Paresch Patel?

4 A. That's correct.

5 Q. And the only expert reports that you reviewed
6 were Dr. Mazell and Dr. Tucker?

7 A. I read the whole thing once, my which was
8 some months ago. My last review of this was
9 yesterday, was Dr. Paresch Patel's deposition and
10 some of the nurses' notes. I don't believe I read
11 any others.

12 Q. You weren't provided with any of the expert
13 reports from the experts that were retained by the
14 various defendants in this case?

15 A. I was not.

16 Q. You were kind enough to provide me with a
17 copy of your CV before the depo, is this current
18 and up-to-date, your CV?

19 A. As I was telling Mr. Orth, the only other
20 additional obligation there is I am president-elect
21 of Summit County Medical Society as of this month.
22 It's not on there. I don't know if it's germane.
23 That's the only addition that I would update.
24 Q. Do you know any of the defendants in this
25 cases?

1 A. No, I don't.

2 Q. Have you ever been retained by Mr. Orth or
3 his firm to testify as an expert in a malpractice
4 case before?

5 A. I have never testified, I have reviewed some
6 charts in the past years for Mr. Orth, three or
7 four in a five to seven year period. I don't think
8 I have given a deposition for any of his clients.

9 Q. Have you written reports after you reviewed
10 the material?

11 A. Yes. Yes, I have.

12 Q. How is it you first came in contact with
13 Mr. Orth?

14 A. I believe it was a cocktail party somewhere,
15 wasn't it. We have mutual friends.

16 MR. ORTH: By God, I think
17 it **was**. Back in the days when I went to cocktail
18 parties, so that's been a while.

19 Q. So you know Mr. Orth socially as well as
20 professionally?

21 A. I wouldn't really say that. I mean, we would
22 see each other at mutual friends Christmas parties
23 or such, but I never socialized with him, nor **have**
24 our wives I don't think.

25 Q. How many times have you reviewed cases **in a**

1 medical malpractice setting as an expert witness?

2 A. Oh, probably once or twice a year in the past
3 ten years.

4 Q. Were any of these on behalf of the patient?

5 A. Yes, it has been; not with Mr. Orth's firm,
6 but a Columbus firm I did review on behalf of a
7 patient.

8 Q. That was one case?

9 A, That was. I think that's it.

10 Q. That's the only case?

11 A. The one.

12 Q. The one?

13 A, Yes. Keep it quiet it. No, that's all
14 right.

15 Q. How many times have you given a deposition as
16 an expert in a malpractice case?

17 A. Oh, three or four, you know.

18 Q. Do you remember when those were?

19 A. Geez, maybe prior to this day, two years ago;
20 and maybe a year before that, three-year span in
21 between, you know. I don't -- I'm not an expert,
22 expert. I mean, I don't solicit or I am not on any
23 list, I think not, you know, to provide testimony.

24 Q. Who took your deposition two years ago?

25 A. I can't remember the guy's name in -- it was

1 a Columbus firm and a Columbus patient. Gradisar
2 was one of the attorneys in the firm down there,

3 Q. Was this the patient's case that you looked
4 at?

5 A, Yes,

6 Q. What firm retained you in this case?

7 A, Well, I am saying I'd have to go back and I
8 don't remember. I know the lawyer who I dealt with was
9 a man by the name of Gradisar.

10 Q. That's the person who retained you? Gradisar
11 retained you in that case?

12 A, Yes, he was the patient's attorney firm,
13 What are we saying?

14 Q. Have you ever given any depositions in the
15 Cleveland area or cases involving patients in the
16 Cleveland area?

17 A. No, I have been on expert panels for PIE but
18 that's been group things and that -- I only did
19 that once,

20 Q. Are you insured by PIE?

21 A, Yes, I am.

22 Q. So that would have been an internal thing for
23 PIE?

24 A. Yes,

25 Q. Not a court case?

1 A. Correct.

2 Q. You have never been involved in a court case
3 involving a Cleveland patient or hospital?

4 A, No, I have not,

5 Q. The other cases that you looked at other than
6 this Columbus case, have they all been from the
7 Akron area, Summit County?

8 A, Yes, they have,

9 Q. Have you ever been sued for medical
10 malpractice?

11 A, Yes, I have,

12 Q. How many times?

13 A, In 23 years about three times, I would say
14 about three. You know, there are suits that were
15 dropped, but I mean as far as follow through to
16 completion, probably three times,

17 Q. Those are all in Summit County?

18 A, Yes,

19 Q. When was the most recent one?

20 A, I just settled a case out of -- case with
21 P.I.E. in November, October or November of last
22 year,

23 Q. What were the allegations against you in that
24 case?

25 A. A second unnecessary surgery where a patient

1 had a gallstone, if it would have been found the
2 first time, would not have necessitated a second
3 operation.

4 Q. How about the most recent before that one,
5 when was that?

6 A. Probably five or six years ago.

7 Q. What were the allegations against you in that
8 case?

9 A. Man with two hernias who said I should have
10 fixed both of them. You know, I am not on trial
11 here.

12 He presented with one, we addressed
13 it, diagnosed and fixed it, and he came back -- and
14 which procedure was done under local, and he said
15 well, you didn't fix this other one. So I said
16 what other one, and he had a little nub in his
17 upper midline.

18 Q. What were the allegations against you in the
19 first lawsuit?

20 A. I did a breast biopsy and we put a drain in
21 the wound, came by to discharge the patient, the
22 drain was gone, quote gone, assumed that the
23 resident had taken it out; five years later the
24 lady got a mammogram, showed this little piece of
25 rubbery drain in her axilla, which she was unaware

1 of until she found that, and that's been bothering
2 her she said. That's it,

3 Q. Have you ever been retained as an expert in a
4 malpractice by the anybody from the law firm of
5 Buckingham, Doolittle?

6 A, Have I been retained?

7 Q. Retained as an expert witness?

8 A. No, I can't recall whether I would have
9 given a letter, an opinion, but I don't think so,
10 I don't think,

11 Q. Do you have any opinion based on your review
12 of the material in this case as to what the cause
13 of Lenore Lind's cardiorespiratory arrest was?

14 A, I think she had sepsis, generalized sepsis,
15 and I would think that was from pneumonia as one
16 would reconstruct retrospectively this case,

17 Q. The sepsis was from pneumonia?

18 A. That's my impression.

19 Q. Can you state that to a reasonable degree of
20 medical probability?

21 A, Well, I can say it -- it wasn't in the
22 abdomen, one would assume that it is not in the
23 urinary tract, no evidence of a meningitis or
24 central nervous system source, she did have lung
25 **infiltrates and respiratory difficulties, so that**

1 you know, I would -- if I was marking this on an
2 exam, I would put down pneumonia as the cause,

3 Q. Do you have an opinion based upon reasonable
4 medical probability as to whether or not she had an
5 intra-abdominal process occurring on May 7th?

6 A. I would think it would have been unclear, and
7 you know, as a surgeon I deal with these situations
8 and I -- it is a subtle thing. You can be
9 95 percent assured there is or isn't a source of
10 infection, but to my knowledge we have no
11 technology that will tell you 100 percent that with
12 any kind of test that it is not a source of the
13 infection. So I could appreciate the dilemma of
14 the surgeon dealing with this lady.

15 Q. Well, now that you have the benefit of
16 hindsight, are you able to state whether or not she
17 had anything going on in her abdomen on May 7th?

18 A. Hindsight, the fact that I read the operative
19 report, yeah, I have a opinion that this was not
20 the source of the infection,

21 Q. When you say it was not the source of
22 infection, just so I understand, you are saying it
23 was not the source of the sepsis that you believe
24 caused her arrest?

25 A. Correct.

1 Q. Did she have any process at all going on in
2 her abdomen at that time?

3 A, Well, they described on CT scan that there
4 was a little fluid in the pelvic recess and that
5 there was a gas pattern compatible with paralysis
6 of the intestinal loops, that, you know, that
7 would -- I mean that would be a verifiable fact
8 that you can rely on with the scan; but the
9 problem -- the problem with studies and what's
10 going on or what one would find to be sure that it
11 wasn't an infectious process there, is that all
12 those abdominal visceral changes are secondary to
13 the septic events: hypoxemia, the low blood
14 pressure, that type of thing, you know, they are
15 there, they are effects rather than causes of
16 infection; and an infection that would be in the
17 abdomen, you would almost expect to find dead bowel
18 or abscessed cavities or pockets, something,
19 perforation, but --

20 Q. Do you have an opinion as to what was causing
21 her low blood pressure?

22 A, I think her pneumonia, her septic situation,

23 Q. When did she become septic?

24 A, I think to review, what I have reviewed in
25 the doctor's deposition and record is that she was

1 in and out of it, you know, responding somewhat to
2 her fluid antibiotics. Who knows what kind of
3 secretions her lung were re-accumulating that would
4 allow more bacteria to flourish or resistance
5 strains to develop. I don't know.

6 But you know, she same in sick and
7 with a suspicion she may have had an abdominal
8 source, and you know, I couldn't from what I
9 reviewed give you a specific onset as to -- seemed
10 to me that she came in that way.

11 Q. She came in septic you're saying?

12 A. Well --

13 Q. My question was: When did she become septic?

14 A, I can't give you a valid answer from the
15 material I've reviewed as to pinpoint that with an
16 opinion.

17 Q. Was she septic on the 7th, on May 7th?

18 A. I would say yes,

19 Q. What do you base that on?

20 A. Hypotension, tachycardia, and you know, a
21 continuation of failure to thrive, really. She
22 really had not, from what I read, demonstrated that
23 her problem had been solved; otherwise, I don't
24 think these tests would have been pursued,

25 Q. What's the treatment for someone in her

1 condition who has sepsis?

2 A. I.V.'s, I.V. antibiotics, respiratory toilet,
3 plus/minus ventilator assistance, continued search
4 for an occult source of problem that needed to be
5 arrested.

6 Q. What do you mean by plus/minus ventilator
7 assistance?

8 A. If it was sustained -- unsustainable where
9 she was not maintaining sufficient oxygenation,
10 sometimes even a ventilator can't reverse that; but
11 those types of things, where she is doing too much
12 work to maintain marginal oxygen saturation, work
13 of ventilation.

14 Q. Then she should be on a ventilator?

15 A. That would be a very prime indication to put
16 a patient on a ventilator, yes.

17 Q. So you are saying she should have been on a
18 ventilator then on May 7th?

19 A. No, I am not saying that.

20 I'm saying -- I thought your
21 question was that how would you manage somebody
22 that was in respiratory failure, that's, you know
23 -- I don't know that I reviewed any documents that
24 tell me what the status of, you know, was she in
25 need of ventilatory support, She had been

1 extubated prior, somebody obviously made the
2 judgment that she didn't need to be re-intubated on
3 the 7th. I don't --

4 Q. Well, was she in respiratory failure on
5 the 7th?

6 A. To look at her oxygen saturations, they were
7 good in that morning, 98, 97 percent, Her
8 pressures, I don't -- they were a little low to me,
9 95 range; but you know, just on the basis of those
10 parameters, I'd say that she was okay, These are
11 things you got to see the patient I guess to know.

12 Q. Well, do you have an opinion based on
13 reasonable medical probability as to whether or not
14 she was in respiratory failure on May 7th?

15 A. I don't have an opinion as to whether she
16 was.

17 Q. If she was in respiratory failure, should she
18 have been on a ventilator given her condition?

19 A. By definition I guess we already said if
20 she's really in failure, yes, she should be on a
21 ventilator,

22 Q. How do you define somebody that's in
23 respiratory failure?

24 A, I think I -- just to reiterate, somebody that
25 even is working too hard to maintain normal oxygen

1 saturations, which you know, in that pre-transport
2 or pre-test time frame, her oxygen saturations were
3 good, her pressure was a little low to me, that
4 would not by definition make her in respiratory
5 failure.

6 If she was breathing 30 times a
7 minute and heaving and flaring her nostrils and
8 those levels were deteriorating, that's somebody
9 that would benefit from ventilative support.

10 Q. When you say her pressure, you're talking
11 about her blood pressure?

12 A. Correct.

13 Q. Well, what about after she came back from the
14 HIDA scan, was she in respiratory failure?

15 A. Looking at the I.C.U. notes I could not -- I
16 can't tell right now as to, you know, these things
17 happen in a matter of minutes, so exactly what she
18 was like, what was the time frame when she came
19 back from the HIDA scan to say she was in -- I
20 can't answer the question as to whether she was in
21 failure at that time.

22 Q. But you said that if her pulse ox dropped and
23 her blood pressure dropped and her respiration
24 increased, that she would benefit from being put on
25 a ventilator, correct?

1 A. Correct.

2 Q. If her blood pressure was 80 over 49 and her
3 pulse was 150 and respirations were in the 50's and
4 her pulse ox reading was 86, would that be
5 respiratory failure?

6 MR. ORTH: What page are
7 you looking at, Chris?

8 MR. MELLINO: 988,

9 A, What time were you looking at, what time
10 slot?

11 Q. Well, I was just asking somebody with these
12 values would be in respiratory failure, somebody in
13 her condition?

14 A. Yes,

15 Q. Okay.

16 A. Respiratory distress/failure, I would agree,

17 Q. That's somebody that should be put on a
18 ventilator?

19 A, Somebody that would benefit from being on a
20 ventilator, yes,

21 a. Well, would the standard of care require that
22 she be put on a ventilator?

23 A. Yeah, but given the fact if they're
24 predisposing to pulmonary disease where they
25 carried precarious oxygen saturation and they lived

1 with those, I don't know; but if she was normal
2 before, yes, she should have been put on a
3 ventilator.

4 Q. I think you mentioned that one of the
5 treatments for someone that had sepsis that was in
6 a similar condition as Mrs. Lind, would have been
7 I.V., I.V. fluids, would that be one of the
8 treatments?

9 A. Yeah. Yes, it would be; and she obviously
10 has, as described, an ileus where her gut was not
11 working, so she needs hydration, and it's an
12 excellent route for antibiotic administration, so
13 I.V. therapy would be pretty essential.

14 Q. Would the hydration through I.V. therapy also
15 raise her or bring her blood pressure back up to
16 normal range?

17 A. Sometimes, Sometimes if sepsis is severe
18 enough, the capillaries are poisoned enough, fluid
19 will go right in the air lung spaces and typically
20 make them worse, you can chase your tail; and
21 that's why people with severe sepsis die, because
22 it can be irreversible if the damage to the lung
23 alveoli is severe enough; so just to fill the tank
24 doesn't always work,

25 Q. But in her case it was reversible obviously?

1 A. She survived, yes.

2 Q. Well, if the dehydration was causing -- well,
3 strike that.

4 Can low blood pressure cause
5 hypoxemia?

6 A. Yes.

7 Q. If you do fluid resuscitation to correct the
8 low blood pressure, how long would that take?

9 A. I think you would -- if you just simply bolus
10 the patient with say half a liter, 500 cc's
11 rapidly, you ought to be able to appreciate a trend
12 within a 15 to 30 minute period of time as to
13 whether you were doing the right thing by adding
14 more fluids to her system. You want to know if
15 she's making urine.

16 Q. Wow long would you wait to see if the trend
17 was -- if you're doing the right thing?

3.8 A. Like I say, you would -- you ought to expect
19 some improvement in a matter of the time it took to
20 get that quick bolus in. I mean, so you -- if you
21 gave it over 15, 15 to 20 minutes, you ought to see
22 an improvement in that 20 to 30 minute time frame,
23 if this is true hypovolemia and not complicated
24 hypovolemia, which I am talking about third spacing
25 or **leaking** that fluid **you're putting in.**

1 Q. Was she third spacing or Peaking?

2 A. I did not review any actual x-rays. I did
3 not see any data that would indicate tissue edema
4 or pigment edema and anasarca, so I can't answer
5 the question.

6 Q. If the patient is third spacing or leaking,
7 what effect would that have then on the fluid
8 resuscitation?

9 A. Well, on specifically on fluid resuscitation,
10 you know, it would make it -- it would prolong
11 getting the beneficial effect; and as I said, it
12 could make, overall make the patient worse.

13 Q. If the patient had low blood pressure which
14 was causing hypoxemia, how long would it take after
15 you got the blood pressure back up to a normal
16 level to correct the hypoxemia?

17 A. If she had normal lungs, it would be rather
18 quick, within the hours's time span. It's a pure
19 transport problem of oxygenated blood back to the
20 tissue, you would get a quick response.

21 Q. How long did you say?

22 A. 30 minutes. I mean, if you -- you had
23 hypovolemic patients and they're not picking up
24 oxygen because they're not getting good perfusion
25 **through the** lungs, once **you** improved the **pressure**

1 in the system, it will be able to pick up the
2 oxygen and these people respond quite quickly.

3 Q. That's with somebody with normal lungs?

4 A. That would be somebody with normal lungs.

5 Q. She didn't have normal lungs?

6 A, It would be my impression that she does not,

7 Q. How long would it take in a person that was
8 in her condition?

9 A. May never happen, but certainly a prolonged
10 situation,

11 Q. Can you give me some kind of range?

12 A, It is a variable, how sick the alveolar are,
13 whether they are smokers, whether she has
14 pre-existing conditions, you know, it could take
15 weeks.

16 Q. Would you expect that it would take more than
17 a couple hours?

18 A, With someone like her?

19 Q. Yes.

20 A. Yes, Yes, I would expect it would take more
21 than a couple hours,

22 *a.* What are the risks in transporting an
23 unstable patient from the I.C.U. to the radiology
24 department?

25 A. Well, that's a good question because, you

1 know, it's hard to know reviewing this chart
2 whether that event may have been in progress,
3 whether she was moving or -- moved or not.

4 Complications, lines can be
5 disconnected, patients lay around unattended, you
6 know, they are disrupting sutures, clots, trying to
7 move a big habitus body into narrow x-ray chambers,
8 you know, all kind of things happen, can happen.

9 Q. Well, you raised that issue in your report,
10 You mentioned that there is probably protocols you
11 say that are accepted protocols for transferring
12 unstable patients anywhere in the hospital,

13 Did you check to determine if there
14 were such protocols at Elyria Memorial Hospital?

15 A. No, I did not,

16 Q. You don't know what the protocols are for
17 transferring unstable patients there?

18 A. At Elyria Memorial?

19 Q. Yes,

20 A, Nom

21 Q. Okay.

22 A. I just think in general there are things that
23 are routinely done.

24 Q. Getting back to the fluid resuscitation for a
25 minute.

1 If you have a patient that you
2 believe is hypoxemic due to low blood pressure and
3 you think the low blood pressure is caused by
4 dehydration so you start fluid therapy, how would
5 you determine if that's working, if that's
6 correcting the hypoxemia?

7 A. Well, the simple things are degree of
8 alertness of the patient, their mentation, the
9 color of their skin, the warmth of their skin, the
10 adequacy of their urinary output, you know, those
11 are simple clinical things --

12 Q. Yes.

13 A. -- to check.

14 Q. Are there laboratory studies that you can do?

15 A, Well, yes. Well, lab studies wouldn't -- I
16 think the more dynamic parameters would be central
17 monitoring, central lines, wedge pressure, you
18 know, pulmonary wedge catheter.

19 Q. Would blood gases assist at all?

20 A. Yes, certainly; but I mean, you're talking
21 about hypovolemia or low dehydration, you know. If
22 you -- you could improve that situation and still
23 not see a marked dynamic improvement in your oxygen
24 saturation in somebody with sick lungs.

25 In other words, if you were **pushing**

1 to get a better oxygenation number by giving
2 fluids, you could really go over the hill and hurt
3 them, so that would be something; but if they got
4 better, that would be good. If they didn't, giving
5 them more would not apt to improve the situation.

6 Q. Can you have pulse ox readings in the 90's
7 but still be hypoxemic?

8 A. I think you can, yeah. It depends on the pH
9 of the patient, how much in blood saturation you're
10 getting relative to the pH; shouldn't be in too
11 much trouble at that point but you are getting
12 pretty close to where the curve falls pretty
13 precipitously. You get in the mid 80's, it would
14 be alkalotic, you would not be getting a lot of
15 oxygen where you need it at the cell level,

16 Q. Was Mrs. Lind hypoxic on May the 7th?

17 A. Certainly according to some of these
18 numbers, 69, that I noticed on that chart, would be
19 hypoxic in anybody's ball game.

20 Q. How about prior to the -- to 2:00 on that
21 day?

22 A. It would be my -- see, it's tough to put it
23 altogether how she looked, how hard is she working
24 to keep those 90's, but certainly those are
25 adequate, The pressure is not, you know, good,

1 I mean, you got a sick patient, but
2 you know, they seem to have been stable at that
3 Level.

4 Again, you know, is she making
5 urine, are there any vasopressors involved with
6 this treatment, I did not review to that extent.

7 Q. Do you have any opinion as to whether or not
8 she should have been sent down for CT scan that
9 afternoon, the afternoon of May 7th?

10 A. I think she's a very sick lady and I think
11 that certainly you are, as we mentioned earlier, in
12 that bind of being positive that the source of
13 infection is not in the abdomen, certainly a CT
14 scan could be of great help if you found something
15 positive on the study to undergo the risk of the
16 operation, so, yeah, I would.

17 If it were my patient, I would
18 definitely want to have had that scan. The fact
19 that it didn't show a whole lot, you know, that's
20 one of the -- of these damn things that's too bad,
21 still doesn't get you off the hook that there may
22 not be a problem in there, so -- but for her to
23 need it, I would say yeah, it was needed,

24 Q. Well, did it need to be done that afternoon?

25 A. I don't know enough about the patient, you

1 know, for me to say; just on the basis of the
2 records, does not mirror the parameters I use to
3 make decisions. I got -- I'd have to see the
4 patient .

5 MR. NELLINO: Could you read
6 me back the answer.

7 -----
8 (Answer read.)

9 -----

10 Q. You're saying the record doesn't mirror the
11 parameters that you use to make these decisions?

12 A. Right. E would have to see the patient.

13 You asked me specifically would I
14 send this patient for a scan at this time, have to
15 be done this day; this may be a situation there
16 where I say I would proceed without it. I have
17 had -- have opened patients in the I.C.U. that are
18 so extreme because of their size or fractures or
19 are unstable to be moved.

20 But to answer the question, could
21 it be delayed, I can't give you an honest answer
22 from my experience.

23 Q. It could have been -- it could have been done
24 by intubating her and putting her on a ventilator
25 prior to sending her down there, correct?

a A. That could have been done, sure,

2 Q. Do you have an opinion based on your review
3 of the records as to whether or not she should have
4 been sent down for the CT scan without protecting
5 her airway on the afternoon of May 7th?

6 A, Based on her oxygen saturation and the stable
7 trend of her hypotension, that would be a clinical
8 decision; and in retrospect, you know, you
9 certainly could say this might not have happened,

10 But again, like I say, the case of
11 moving a patient in her bed with monitoring her
12 pressure, her oxygen saturation, her EKG monitor,
13 you know, what's different other than the patient
14 is moving.

15 If there was an indication to
16 intubate her, to me it would have been as valid to
17 be considering it right there at the bed rather
18 than whether she was going to be moved or not, but
19 that's --

20 Q. You are saying if there was a valid reason to
21 intubate, that should have been done regardless of
22 whether they're going to send her to a CT scan?

23 A. That's what I'm saying, exactly,

24 Q. What difference is there in the duties that
25 you that. a doctor owes to his patients when he is a

1 consultant as opposed to an attending?

2 A. Well, I mean, it pretty much mirrors my
3 opinion of reading the case and the deposition, I
4 think it is primarily the -- most certainly comes
5 back to the assigned responsible physician, and the
6 next order to my mind is the guy with the most
7 expertise on the team for the problem,

8 I am never often overruled on a
9 surgical decision by a nephrologist or
10 pulmonologist, and I don't think very often that I
11 ever overrule the opinion of a nephrologist or
12 pulmonary physician in treating, you know,
13 different problems on a shared patient.

14 SO -- but the chain of
15 responsibility to me is the expert on the scene or
16 on the case,

17 Q. So are you saying that if -- say if you
18 didn't -- hypothetical -- if Dr. Paresh Patel was
19 the attending and Dr. Dacha was just a consultant,
20 that it was -- still would have been Dr. Dacha's
21 responsibility for the decision to --

22 A, I think the dynamics of physicians working
23 together, I think we naturally tend to lean to the
24 expertise of say if the lady's kidneys weren't
25 working, the opinion of the nephrologist; if it was

1 primarily a respiratory problem, we would be
2 leaning and expect to get input from the
3 pulmonologist or the intensivist,

4 That's -- I mean, that's kind of in
5 the real world I work in, those are the dynamics.

6 Q. Well, your last paragraph of your report you
7 say that there are accepted protocols for the
8 transferring of unstable patients anywhere in the
9 hospital, unless Dr. Patel specifically agreed to
10 supervise this, I cannot see that it would be his
11 responsibility as a consultant?

12 A. Right .

13 Q. I guess my question is: If he was the
14 attending, would then it have been his
15 responsibility?

16 A, Just -- just going to have two doctors on the
17 scene now making the decision? I mean, I
18 understand there were four doctors.

19 Q. So if you had four doctors, but Dr. Patel is
20 the attending and Dr. Dacha is the consultant?

21 A. Would it have been Dr. Patel's
22 responsibility?

23 Q. Right ,

24 A, Yes, I would think it would be his
25 responsibility,

1 Q. Would it also be Dr. Dacha's responsibility
2 as the pulmonologist or would it not have been his
3 responsibility since he was just a consultant?

4 A, I mean, whether he wanted it or not, I would
5 say that some degree of judgment was expected of
6 him.

7 Q. Of who, of --

8 A, The pulmonologist.

9 Q. Okay. Well, if a consultant who is not a
10 pulmonologist sees a patient and recognizes that
11 that patient is very sick, possibly septic and in
12 respiratory failure, and the patient is not on a
13 ventilator, would he have a duty to do something
14 about that?

15 MR. ORTH: Objection, Go
16 ahead and answer.

17 A, Would you repeat the question?

18 -----

19 (Question read,)

20 -----

21 MR. ORTH: Objection,

22 A, I would think, yes. If, you know -- if he
23 were following the dynamics of this case; and I
24 mean, you can see a very sick patient and not be
25 following him closely enough to know that that is a

1 deterioration rather than a stabilized or plateaued
2 sick patient, where, you know, you wouldn't be as
3 tuned in as a consultant to -- other than somebody
4 said to you, listen, this lady is really going down
5 the tubes, we got to do something; but you know,
6 when you come on the scene with colleagues who are
7 primarily following the case, you're not -- you're
8 probably not going to have the astuteness to see
9 this as a problem in progress versus a chronic sick
10 lady,

11 So I would find it hard to blame
12 this physician that he did something wrong by not
13 saying, hold the fort, put this lady on a
14 ventilator, you know. That's my opinion. That's
15 what I wrote down after reading his deposition and
16 what transpired with the lady,

17 Q. That would have been Dr. Dacha's
18 responsibility?

19 A. Somebody that was following and primarily
20 responsible for that lady, yeah; somebody that was
21 seeing her two or three times a day,

22 Q. So it wouldn't necessarily have been -- had
23 to be a pulmonologist, it could have been any
24 physician that was seeing her and following her?

25 A. You know, I mean, when you sign an to take

1 care of the patients, part of your responsibility
2 is to see those trends and attend that patient or
3 get off the case.

4 So you know, this was not perceived
5 to be a surgical problem by the surgeon and so he
6 wasn't bird dogging this case and it wasn't his
7 case, so I don't know how you can expect him to see
8 all these subtleties of a deteriorating patient
9 when --

10 Q. But my question is: You would expect --

11 A. If he recognized it and he thought the lady
12 was going to arrest, it seems like a rather obvious
13 questions, yes, that's his work, that's his
14 responsibility; but I would think that he wasn't in
15 that position.

16 Q. Well, do you know who was, based on your
17 review of these records?

18 A, No, I don't. I don't.

19 Q. Do you have any opinion based on your review
20 of the records as to whether or not the nurses
21 should have given Demerol to the patient on May 6th
22 and the morning of May 7th?

23 A, I did not review that, the chart in that
24 detail. I don't have an opinion.

25 Q. Are you aware of the fact that Dr. Dacha

1 wrote an order for no sedation?

2 A, I am not.

3 Q. Do you have an opinion as to whether or not
4 it would be below the standard of care for a nurse
5 to give Demerol after an order was written in a
6 chart that the patient not be given sedatives?

7 MR. FELTES: Objection.

8 MR. ORTH: Objection.

9 A. If you want me to look at the notes pre and
10 prior to that, you know. Basically as a general
11 tenet, no; no, you don't want nurses violating
12 orders, probably won't get much of an argument
13 there.

14 Q. Is a patient who has an acute abdominal
15 condition, is that a contraindication to giving
16 Demerol?

17 THE WITNESS: Would you
18 repeat the question?

19 -----

20 (Question read,)

21 -----

22 A, Well, the two sides of the coin are: it is --
23 no matter how it alters the physical finding, it is
24 not going to alter what you are going to do; so
25 yeah, you **can give it in those situations in**

1 which -- where you're not afraid of the temporary
2 muting of the physical findings; if you're in a
3 quandary about the diagnosis, you probably wouldn't
4 want to do it because it can delay physical
5 findings,

6 Q. Well, the physicians were in a quandary about
7 the diagnosis, weren't they?

8 A, I don't think the surgeon was. I mean, you
9 know, in -- again in retrospect nothing was found,
10 So you know, his impression of what had been going
11 on that 24, 48 hours would tend to add strength to
12 his argument that it probably wasn't there; but you
13 know, giving 50 of Demerol to a 250 pound lady with
14 a lot of third spacing, probably 10 percent of that
15 dose would have gotten into her system to make a
16 difference, so it was I think a non-issue in that
17 particular situation,

18 If it was given intravenous,
19 certainly it would be a different story, I don't
20 think it altered the clinical evaluation of the
21 patient.

22 Q. What are you talking about?

23 A, I'm talking about if she got 50 of Demerol
24 and the dose per her size.

25 Q. You are talking about if she did?

1 A. If she,

2 Q. This is hypothetical? If she got
3 50 milligrams oral, you are talking about?

4 A, I was assume that's an I.M. dose, she should
5 not have got it orally, she probably wouldn't have
6 absorbed it all.

7 Q. When are you talking about her getting it?

8 A. When are you talking about her getting it?

9 Q. I was asking a general question if one of the
10 contraindications to Demerol is someone who has an
11 abdominal condition?

12 A, Well, the problem is, it can mask that
13 transitional area where you're truly evaluating the
14 patient whether or not you can operate on them, so
15 you probably would not want to give them any
16 Demerol,

17 If you think that it is something
18 that; would Bet them breathe a little easier or be
19 in less pain, you would not be afraid to give it.
20 It's not going to physiologically do anything
21 detrimental; but I mean 50 milligrams to this lady
22 would be probably a homeopathic dose, that's a
23 supposition.

24 Q. How about a patient with renal failure, is
25 that a contraindication to Demerol?

1 A, With the stable pressure, no,

2 Q. How about a patient with substantially
3 decrease respiratory reserve?

4 A. Could be a problem,

5 Q. How about a patient with pre-existing
6 respiratory depression?

7 A. Could be a problem.

8 Q. All right. Are you saying you don't think
9 it's a problem with a patient that -- with renal
10 failure or is it?

11 A. It's going to be on board a long time and you
12 would certainly adjust the dose; but renal failure,
13 acute renal failure from a hypovolemia varies,
14 somebody being dialyzed or treated in that regard,
15 they get pain medicine.

16 Q. So if the patient has renal failure, the drug
17 is going to be on board a lot longer?

18 A. Yes.

19 Q. How much longer?

20 A, It's obviously dose related. I don't know.
21 with the clearance curve if it is half gone in an
22 hour in the normal person, it -- certainly you
23 would double it for -- until it is half gone, I
24 don't propose to give you an expert answer on that
25 without looking it up,

1 Q. Did she have substantially decreased
2 respiratory reserve?

3 MR. ORTH: What time?

4 Q. May 5th and 6th and 7th?

5 A. Again, I did not go over those I.C.U. notes
6 to that degree, I think anybody that has been
7 intubated and then extubated, they require close
8 monitoring. One makes a judgment that you can keep
9 them off of it, but some people fail the test on
10 occasions and have to be re-intubated.

11 Q. So you don't have an opinion as to whether or
12 not she had substantially decreased respiratory
13 reserve on the 5th or 6th?

14 A. My opinion is that she would have limited
15 reserve based on chest x-ray descriptions of
16 infiltrates and the high level of congestion.

17 Q. What about respiratory depression?

18 A. Respiratory depression is generally more a
19 symptom of septic shock, The natural response of
20 people with respiratory insufficiency is to either
21 breathe more rapidly or more deeply. Depression is
22 something that overwhelms that reflex, i.e., septic
23 hypotension.

24 So depression, respiratory
25 depression, did **she have** it, probably **she had** it

1 because of her septic parameters,

2 Q. And the adverse consequences of Demerol are
3 severe hypotension, respiratory depression,
4 respiratory arrest and cardiac arrest, right?

5 MR. QUANDT: Objection.

6 A, Overdose, yes, that would be.

7 Q. Only if overdosed?

8 A, Unless you're having an anaphylactoid
9 reaction to it, Overdose is a very broad term,
10 depends on size, age, but 50 milligrams in a lady
11 like this --

12 Q. Well, I'm again just talking in general, what
13 the adverse reactions of Demerol are?

14 A, Yeah, it can be. God, it's given a thousand
15 times a day.

16 Q. Sure. Not everybody has a adverse reaction
17 to the drug?

18 A, Yeah, right. Most people don't,

19 Q. Right. Otherwise they wouldn't give it?

20 A. Right,

21 Q. Why did the abdominal exploration become
22 necessary?

23 A, A patient that's failed to improve and that's
24 the problem with negative scans or HIDA scan, you
25 can still have a source of intra-abdominal sepsis.

2 The real area of weakness in scans are that people
3 can have dead bowel, they can flip a clot, a
4 gangrenous loop that's leaking feculent material
5 into the peritoneal cavity, it's a vascular event,
6 and it can be very subtle findings and does
7 necessitate ruling out a source of infection in the
8 abdomen.

9 It's a situation you never like to
10 be in but as surgeons we're called to see these
11 patients not infrequently, and it is a dilemma
12 where you end up doing, retrospective, unnecessary
13 laparotomies to rule out that being the source of
14 infection. Some of these five days later turn out
15 the patient has Legionnaires disease or something
16 like that, but at the time they will die if you
17 don't -- if you miss a source of intra-abdominal
18 sepsis that is correctable. Nobody can stand that
19 insult indefinitely.

20 So that is the dilemma and that's
21 why I think they were driven into the corner to
22 have to do this procedure.

23 Q. Is one of the risks of transporting a
24 unstable patient is that it might take longer to
25 give intervention if that becomes necessary?

A. Yes.

1 Q. If a person has a respiratory arrest or
2 cardiorespiratory arrest, how long should it take
3 to initiate therapy?

4 MR. ORTH: You mean in
5 what setting?

6 Q. In the hospital?

7 A. How long should it take?

8 Q. Yes,

9 A. Obviously it **can't** take longer than
10 four minutes.

11 Q. Why can't it take longer than four minutes?

12 A, Well, I mean, you just don't -- you got a
13 50 percent mortality rate at four minutes and about
14 an 80 percent at six minutes; but to answer the
15 question how soon should it been corrected, God, I
16 don't know, you know, 30 seconds, a minute,
17 two minutes.

18 Q. What about --

19 A, Actually, you know, less than 30 seconds if
20 somebody had an Ambu bag or mask to ventilate the
21 patient.

22 Q. What about if the person has respiratory
23 depression, their blood pressure drops and their
24 pulse ox drops, how long should it take for therapy
25 to be initiated?

1 MR. ORTH: Objection. Go
2 ahead and answer, if you can.

3 A, Yeah, if it is a sudden event, same sense of
4 urgency prevails. If it's a chronic situation, you
5 know, there is not that sense of urgency to do it
6 instantaneously.

7 Q. What do you mean by a chronic situation?

8 A, 'Very sick patient that's piddling along with
9 low blood pressure and low urinary output, and just
10 this type of lady. E mean --

11 Q. Well, if her pulse ox dropped to 69, would
12 that require intervention?

13 A. Yes.

14 Q. How soon?

15 MR. FELTES: Objection.

16 A. Right away.

17 Q. What is right away? Can you quantify that?

18 A. As soon as you can get a ventilator and a
19 laryngoscope and somebody qualified to do it.

20 Q. So they should be intubated immediately?

21 A, I think if I was getting that level, I would
22 definitely be moving in that direction.

23 Q. So what time frame, one minute, two minutes,
24 30 seconds?

25 MR. ORTH: Objection.

1 A, Well, if it went from 67 to 65 to 64, I would
2 be more urgently pursuing the situation; if it was
3 67, 70, 67, she would benefit just because she's
4 working too hard and I would do it expeditiously;
5 if it is dropping, dropping, it's an emergency,

6 Q. Can you give me some kind of time frame which
a they should be intubated?

8 A. At 67.

9 Q. 69?

10 A. 69, if it was a chronic state, 30 minutes.
11 By the time you got all the right people and right
12 equipment and the laryngoscope with a good light in
13 it and suction available to clear the airway so you
14 can see what you're doing, I would press on and do
15 it,

16 Q. Well, when she dropped from the low 90's to
17 69 within five minutes, would that be a chronic
18 situation or would that be an acute situation?

19 A, I would view that as an acute situation.

20 Q. How soon would intubation be required then?

21 A, Time frame, short time frame, under
22 15 minutes.

23 Q. Is there intervention that should be done
24 prior to intubation if you're not going to intubate
25 for 15 minutes, should you be bagging the person

1 or --

2 A. You might. You might. You certainly have a
3 non-rebreathing mask at 100 percent on the patient,
4 doing those less aggressive things.

5 You know, there -- you pay a price
6 if you are not ready. Sometimes the stress of not
7 properly intubating the patient and causing them to
8 vomit and aspirate, and you know, you can be out of
9 business in a hurry, so you cannot just slip-dash,
10 this needs to be done. You do it to try to
11 minimize the risks, so you can do it successfully
12 the first time out.

13 Q. Does a doctor need to be present to carry out
14 all this intervention or at least to intubate?

15 A. Not in the -- well, I work in a hospital with
16 residents, so that's probably as low on the totem
17 pole as it goes; however, certainly paramedics do
18 intubations, I.C.U. nurses do intubations at some
19 areas, I'm sure; nurse anesthetists do it quite
20 frequently, really just a matter of trying to pick
21 the most qualified person in the arena to do it.

22 *a.* Well, should the doctor be at least notified
23 that this is going on?

24 A, I would be very upset if -- if I wasn't
25 notified.

1 Q. Would it be okay to wait 30 minutes before
2 they notified you or would you like to be notified
3 right away?

4 A. I certainly expect to know. I would
5 idealistically like to know there was a problem in
6 the first place, but I think it would be
7 appropriate, you know -- I probably would be a
8 little more benevolent to a referring doctor than I
9 would a resident, but I would want to know straight
10 away.

11 Q. Well, what if there was only nurses present,
12 would they be required to notify a physician?

13 A. I would say yes.

14 Q. Immediately or --

15 A. Yes.

16 MR. MELLINO: Okay. I don't
17 have anymore questions for you, Doctor.

18 MR. ORTH: Questions?

19 MR. FELTES: NO.

20 MISS MOORE: No questions.

21 MR. GALLAGHER: No questions.

22 MR. QUANDT: No questions.

23 MR. ORTH: Okay.

24 MR. QUANDT: Thank you,

25 Doctor.

1 THE WITNESS: You're
2 welcome.

3 MR. ORTH: Are you going
4 to waive signature or do you want to read it?

5 THE WITNESS: You're the
6 attorney, whatever you say.

7 MR. ORTB: Send it to me,
8 Frank, and I will get it to him, we'll either waive
9 it after he reads it or whatever,

10

11

12 (Deposition concluded; signature not waived,)

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ERRATA SHEET

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I have read the foregoing
transcript and the same is true and accurate.

MICHAEL A. FLYNN, M.D.

1 The State of Ohio, .

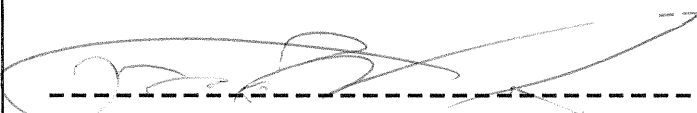
2 County of Cuyahoga, : CERTIFICATE:

3 I, Frank P. Versagi, Registered Professional
 4 Reporter, Certified Legal Video Specialist, Notary
 5 Public within and for the State of Ohio, do hereby
 6 certify that the within named witness, MICHAEL A.
 7 FLYNN, M.D., was by me first duly sworn to testify
 8 the truth in the cause aforesaid; that the
 9 testimony then given was reduced by me to stenotypy
 10 in the presence of said witness, subsequently
 11 transcribed onto a computer under my direction, and
 12 that the foregoing is a true and correct transcript
 13 of the testimony so given as aforesaid. I do
 14 further certify khat this deposition was taken at
 15 the time and place as specified in the foregoing
 16 caption, and that I am not a relative, counsel or
 17 attorney of either party, or otherwise interested
 18 in the outcome of this action.

19 IN WITNESS WHEREOF, I have hereunto set my hand and
 20 affixed my seal of office at Cleveland, Ohio, this
 21 16th day of January, 1995,

22

23

24 

 25 Frank P. Versagi, RPR, CLVS, Notary Public/State of
 Ohio, Commission expiration: 2-25-98.

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QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE
 THRESHOLD: 50

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