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

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IN THE COURT OF COMMON PLEAS

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Doc. 116
591

LENORE LIND, et al., plaintiffs,

vs. : Case No. 93CV110798

COMPREHENSIVE HEALTH CARE of OHIO, INC., et al., defendants,

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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 an THURSDAY, JANUARY 12, 1995, commencing at 4:11 p.m. pursuant to notice,

# *FLOWERS & VERSAGI*

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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.
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Joseph Feltes, Esq.
Lynn L. Moore, Esq.
John P. Gallagher, Esq.
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files: f&v

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# INDEX

WITNESS: MICHAEL A. FLYNN, M.D.



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NO EXHIBITS MARKED

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(FOR EVERY WORD INDEX, SEE APPENDIX)

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MICHAEL A. FLYNN, M.D.

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

CROSS-EXAMINATION

BY MR. MELLINO:

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

A. Michael A. Flynn.

Q. Did you bring your file with you today?

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

Q. Yes.

A. Yeah.

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

A. This is it.

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

A. It's totally it, yes.

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

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

from meetings were out of there.

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

A. That's correct.

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

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

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

A. I was not.

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

A. As I was telling Mr. Orth, the only other additional obligation there is I am president-elect of Summit County Medical Society as of this month. It's not on there. I don't know if it's germane. That's the only addition that I would update.

Q. Do you know any of the defendants in this case?

A. No, E don't.
Q. Have you ever been retained by Mr. Orth or his firm to testify as an expert in a malpractice case before?
A. I have never testified, I have reviewed some charts in the past years for Mr. Orth, three or four in a five to seven year period. I don't think I have given a deposition for any of his clients.
Q. Have you written reports after you reviewed the material?
A. Yes. Yes, I have.
Q. How is it you first came in contact with Mr. Orth?
A. I believe it was a cocktail party somewhere, wasn't it. We have mutual friends.
MR. ORTH: By God, I think it was. Back in the days when I went to cocktail parties, so that's been a while.
Q. So you know Mr. Urth socially as well as professionally?
A. I wouldn't really say that. I mean, we would see each other at mutual friends Christmas parties or such, but I never socialized with him, nor have our wives I don't think.
Q. How many times have you reviewed cases in a

medical malpractice setting as an expert witness?
A. Oh, probably once or twice a year in the past ten years.
Q. Were any of these on behalf of the patient?
A. Yes, it has been; not with Mr. Orth's firm, but a Columbus firm I did review on behalf of a patient.
Q. That was one case?
A, That was. I think that's it.
Q. That's the only case?
A. The one.
Q. The one?
A, Yes. Keep it quiet it. No, that's all right.
Q. How many times have you given a deposition as an expert in a malpractice case?
A. Oh, three or four, you know.
Q. Do you remember when those were?
A. Geez, maybe prior to this day, two years ago; and maybe a year before that, three-year span in between, you know. I don't -- I'm not an expert, expert. I mean, I don't solicit or I am not on any list, I think not, you know, to provide testimony.
Q. Who took your deposition two years ago?
A. I can't remember the guy's name in -- it was

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

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

A, Yes,

Q. What firm retained you in this case?

A, Well, I am saying I'd have to go back and I don't remember. I know the lawyer who 1 dealt was a man by the name of Gradisar.

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

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

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

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

Q. Are you insured by PIE?

A, Yes, I am.

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

A. Yes,

Q. Not a court case?

A. Correct.
Q. You have never been involved in a court case involving a Cleveland patient or hospital?
A, No, I have not,
Q. The other cases that you looked at other than this Columbus case, have they all been from the Akron area, Summit County?
A, Yes, they have,
Q. Have you ever been sued for medical malpractice?
A, Yes, I have,
Q. How many times?
A, In 23 years about three times, I would say about three. You know, there are suits that were dropped, but I mean as far as follow through to completion, probably three times,
Q. Those are all in Summit County?
A, Yes,
Q. When was the most recent one?
A, I just settled a case out of -- case with P.I.E. in November, October or November of last year,
Q. What were the allegations against you in that case?
A. A second unnecessary surgery where a patient

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

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

A. Probably five or six years ago.

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

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

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

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

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

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

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

A, Have I been retained?

Q. Retained as an expert witness?

A. No, I can't recall whether I would have given a letter, an opinion, but I don't think so, 1 don't think,

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

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

Q. The sepsis was from pneumonia?

A. That's my impression.

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

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

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

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

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

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

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

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

A. Correct.

Q. Did she have any process at all going on in her abdomen at that time?
A, Well, they described on CT scan that there was a little fluid in the pelvic recess and that there was a gas pattern compatible with paralysis of the intestinal loops, that, you know, that would -- I mean that would be a verifiable fact that you can rely on with the scan; but the problem -- the problem with studies and what's going on or what one would find to be sure that it wasn't an infectious process there, is that all those abdominal visceral changes are secondary to the septic events: hypoxemia, the low blood pressure, that type of thing, you know, they are there, they are effects rather than causes of infection; and an infection that would be in the abdomen, you would almost except to find dead bowel or abscessed cavities or pockets, something, perforation, but --
Q. Do you have an opinion as to what was causing her low blood pressure?
A, I think her pneumonia, her septic situation,
Q. When did she become septic?
A, I think to review, what I have reviewed in the doctor's deposition and record is that she was

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

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

Q. She came in septic you're saying?

A. Well --

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

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

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

A. I would say yes,

Q. What do you base that on?

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

Q. What's the treatment for someone in her

condition who has sepsis?
A. I.V.'s, I.V. antibiotics, respiratory toilet, plus/minus ventilator assistance, continued search for an occult source of problem that needed to be arrested.
Q. What do you mean by plus/minus ventilator assistance?
A. If it was sustained -- unsustainable where she was not maintaining sufficient oxygenation, sometimes even a ventilator can't reverse that; but those types of things, where she is doing too much work to maintain marginal oxygen saturation, work of ventilation.
Q. Then she should be on a ventilator?
A. That would be a very prime indication to put a patient on a ventilator, yes.
Q. So you are saying she should have been on a ventilator then on May 7th?
A. No, I am not saying that.
I'm saying -- I thought your question was that how would you manage somebody that was in respiratory failure, that's, you know -- I don't know that I reviewed any documents that tell me what the status of, you know, was she in need of ventilatory support, She had been

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

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

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

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

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

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

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

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

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

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

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

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

A. Correct.

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

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

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

A. Correct.
Q. If her blood pressure was 80 over 49 and her pulse was 150 and respirations were in the 50's and her pulse ox reading was 86, would that be respiratory failure?
MR. ORTH: What page are you looking at, Chris?
MR. MELLINO: 988,
A, What time were you looking at, what time slot?
Q. Well, I was just asking somebody with these values would be in respiratory failure, somebody in her condition?
A. Yes,
Q. Okay.
A. Respiratory distress/failure, I would agree,
Q. That's somebody that should be put on a ventilator?
A, Somebody that would benefit from being on a ventilator, yes,
Q. Well, would the standard of care require that she be put on a ventilator?
A. Yeah, but given the fact if they're predisposing to pulmonary disease where they carried precarious oxygen saturation and they lived

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

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

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

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

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

Q. But in her case it was reversible obviously?

A. She survived, yes.
Q. Well, if the dehydration was causing -- well, strike that.
Can low blood pressure cause hypoxemia?
A. Yes.
Q. If you do fluid resuscitation to correct the low blood pressure, how long would that take?
A. I think you would -- if you just simply bolus the patient with say half a liter, 500 cc's rapidly, you ought to be able to appreciate a trend within a 15 to 30 minute period of time as to whether you were doing the right thing by adding more fluids to her system. You want to know if she's making urine.
Q. Wow long would you wait to see if the trend was -- if you're doing the right thing?
A. Like I say, you would -- you ought to expect some improvement in a matter of the time it took to get that quick bolus in. I mean, so you -- if you gave it over 15, 15 to 20 minutes, you ought to see an improvement in that 20 to 30 minute time frame, if this is true hypovolemia and not complicated hypovolemia, which I am talking about third spacing or leaking that fluid you're putting in.

Q. Was she third spacing or Peaking?
A. I did not review any actual x-rays. I did not see any data that would indicate tissue edema or pigment edema and anasarca, so I can't answer the question.
Q. If the patient is third spacing or leaking, what effect would that have then on the fluid resuscitation?
A. Well, on specifically on fluid resuscitation, you know, it would make it -- it would prolong getting the beneficial effect; and as I said, it could make, overall make the patient worse.
Q. If the patient had low blood pressure which was causing hypoxemia, how long would it take after you got the blood pressure back up to a normal level to correct the hypoxemia?
A. If she had normal lungs, it would be rather quick, within the hours's time span. It's a pure transport problem of oxygenated blood back to the tissue, you would get a quick response.
Q. How long did you say?
A. 30 minutes. I mean, if you -- you had hypovolemic patients and they're not picking up oxygen because they're not getting good perfusion through the lungs, once you improved the pressure

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

Q. That's with somebody with normal lungs?

A. That would be somebody with normal lungs.

Q. She didn't have normal lungs?

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

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

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

Q. Can you give me some kind of range?

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

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

A, With someone Pike her?

Q. Yes.

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

Q. What are the risks in transporting an unstable patient from the I.C.U. to the radiology department?

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

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

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

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

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

A. No, I did not,

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

A. At Elyria Memorial?

Q. Yes,

A, Nom

Q. Okay.

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

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

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

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

Q. Yes.

A. -- to check.

Q. Are there laboratory studies that you can do?

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

Q. Would blood gases assist at all?

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

In other words, if you were pushing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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( Answer read. )

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

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

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

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

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

A. That could have been done, sure,
Q. Do you have an opinion based on your review of the records as to whether or not she should have been sent down for the CT scan without protecting her airway on the afternoon of May 7th?
A, Based on her oxygen saturation and the stable trend of her hypotension, that would be a clinical decision; and in retrospect, you know, you certainly could say this might not have happened,

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

If there was an indication to intubate her, to me it would have been as valid to be considering it right there at the bed rather than whether she was going to be moved or not, but that's --
Q. You are saying if there was a valid reason to intubate, that should have been done regardless of whether they're going to send her to a CT scan?
A. That's what I'm saying, exactly,
Q. What difference is there in the duties that you that. a doctor owes to his patients when he is a

consultant as opposed to an attending?
A. Well, I mean, it pretty much mirrors my opinion of reading the case and the deposition, I think it is primarily the -- most certainly comes back to the assigned responsible physician, and the next order to my mind is the guy with the most expertise on the team for the problem,
I am never often overruled on a surgical decision by a nephrologist or pulmonologist, and I don't think very often that I ever overrule the opinion of a nephrologist or pulmonary physician in treating, you know, different problems on a shared patient.
so -- but the chain of responsibility to me is the expert on the scene or on the case,
Q. So are you saying that if -- say if you didn It -- hypothetical -- if Dr. Paresh Patel was the attending and Dr. Dacha was just a consultant, that it was -- still would have been Dr. Dacha's responsibility for the decision to --
A, I think the dynamics of physicians working together, I think we naturally tend to lean to the expertise of say if the lady's kidneys weren't working, the opinion of the nephrologist; if it was

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

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

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

A. Right.

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

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

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

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

Q. Right,

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

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

A, 1 mean, whether he wanted it or not, I would say that some degree of judgment was expected of him.

Q. Of who, of --

A, The pulmonologist.

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

MR. ORTH: Objection, Go ahead and answer.

A, Would you repeat the question?

---

( Question read, )

---

MR. ORTH: Objection,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

wrote an order for no sedation?
A, I am not.
Q. Do you have an opinion as to whether or not it would be below the standard of care for a nurse to give Demerol after an order was written in a chart that the patient not be given sedatives?
MR. FELTES: Objection.
MR. ORTH: Objection.
A. If you want me to look at the notes pre and prior to that, you know. Basically as a general tenet, no; no, you don't want nurses violating orders, probably won't get much of an argument there.
Q. Is a patient who has an acute abdominal condition, is that a contraindication to giving Demerol?
THE WITNESS: Would you repeat the question?
---
( Question read, )
---
A, Well, the two sides of the coin are: it is -- no matter how it alters the physical finding, it is not going to alter what you are going to do; so yeah, you **can give it in** those **situations in**

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

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

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

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

Q. What are you talking about?

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

Q. You are talking about if she did?

A. If she,
Q. This is hypothetical? If she got 50 milligrams oral, you are talking about?
A, I was assume that's an I.M. dose, she should not have got it orally, she probably wouldn't have absorbed it all.
Q. When are you talking about her getting it?
A. When are you talking about her getting it?
Q. I was asking a general question if one of the contraindications to Demerol is someone who has an abdominal condition?
A, Well, the problem is, it can mask that transitional area where you're truly evaluating the patient whether or not you can operate on them, so you probably would not want to give them any Demerol,

If you think that it is something that; would Bet them breathe a little easier or be in less pain, you would not be afraid to give it. It's not going to physiologically do anything detrimental; but I mean 50 milligrams to this lady would be probably a homeopathic dose, that's a supposition.
Q. How about a patient with renal failure, is that a contraindication to Demerol?

A, With the stable pressure, no,
Q. How about a patient with substantially decrease respiratory reserve?
A. Could be a problem,
Q. How about a patient with pre-existing respiratory depression?
A. Could be a problem.
Q. All right. Are you saying you don't think it's a problem with a patient that -- with renal failure or is it?
A. It's going to be on board a long time and you would certainly adjust the dose; but renal failure, acute renal failure from a hypovolemia varies, somebody being dialyzed or treated in that regard, they get pain medicine.
Q. So if the patient has renal failure, the drug is going to be on board a lot longer?
A. Yes.
Q. How much longer?
A, It's obviously dose related. I don't know. with the clearance curve if it is half gone in an hour in the normal person, it -- certainly you would double it for -- until it is half gone, I don't propose to give you an expert answer on that without looking it up,

Q. Did she have substantially decreased respiratory reserve?

MR. ORTH: What time?

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

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

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

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

Q. What about respiratory depression?

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

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

because of her septic parameters,
Q. And the adverse consequences of Demerol are severe hypotension, respiratory depression, respiratory arrest and cardiac arrest, right?
MR. QUANDT: Objection.
A, Overdose, yes, that would be.
Q. Only if overdosed?
A, Unless you're having an anaphylactoid reaction to it, Overdose is a very broad term, depends on size, age, but 50 milligrams in a lady like this --
Q. Well, I'm again just talking in general, what the adverse reactions of Demerol are?
A, Yeah, it can be. God, it's given a thousand times a day.
Q. Sure. Not everybody has a adverse reaction to the drug?
A, Yeah, right. Most people don't,
Q. Right. Otherwise they wouldn't give it?
A. Right,
Q. Why did the abdominal exploration become necessary?
A, A patient that's failed to improve and that's the problem with negative scans or HIDA scan, you can still have a source of intra-abdominal sepsis.

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

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

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

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

A. Yes.

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

MR. ORTH: You mean in what setting?

Q. In the hospital?

A. How long should it take?

Q. Yes,

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

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

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

Q. What about --

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

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

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

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

Q. What do you mean by a chronic situation?

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

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

A. Yes.

Q. How soon?

MR. FELTES: Objection.

A. Right away.

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

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

Q. So they should be intubated immediately?

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

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

MR. ORTH: Objection.

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

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

A. At 67.

Q. 69?

A. 69, if it was a chronic state, 30 minutes. By the time you got all the right people and right equipment and the laryngoscope with a good light in it and suction available to clear the airway so you can see what you're doing, 1 would press on and do it,

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

A, 1 would view that as an acute situation.

Q. How soon would intubation be required then?

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

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

or --

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

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

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

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

Q. Well, should the doctor be at Beast notified that this is going on?

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

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

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

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

A. I would say yes.

Q. Immediately or --

A. Yes.

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

MR. ORTH: Questions?

MR. FELTES: NO.

MISS MOORE: No questions.

MR. GALLAGHER: No questions.

MR. QUANDT: No questions.

MR. ORTH: Okay.

MR. QUANDT: Thank you, Doctor.

THE WITNESS: You're welcome.

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

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

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

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(Deposition concluded; signature not waived,)

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ERRATA SHEET

PAGE LINE

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

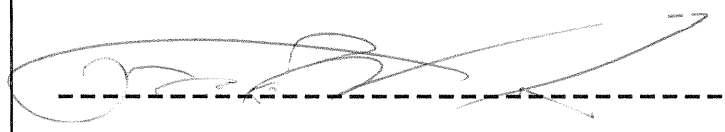
_____

MICHAEL A. FLYNN, M.D.

The State of Ohio, .
County of Cuyahoga, : CERTIFICATE:

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

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



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

**Look-See Concordance Report**

- - -

UNIQUE WORDS: **989**
TOTAL OCCURRENCES: **2,325**
NOISE WORDS: **385**
TOTAL WORDS IN FILE: **8,095**

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DATES **ON**

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POSSESSIVE FORMS **ON**

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MAXIMUM TRACKED OCCURRENCE THRESHOLD: **50**

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