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

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IN THE COURT OF COMMON PLEAS

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CHRISTOPHER S. LONG, ETC.,	)	
Plaintiffs,	)	
-v-	)	Case No. 321518
CLEVELAND CLINIC FOUNDATION,	)	
Defendant.	)	

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DEPOSITION OF CHARLES J. HEARN, D.O.

Wednesday, February 10, 1999

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Deposition of CHARLES J. HEARN, D.O., called for examination by the Plaintiffs under the Ohio Rules of Civil Procedure, taken before me, Robert A. Cangemi, a Notary Public in and for the State of Ohio, at the Cleveland Clinic Foundation, Cleveland, Ohio, commencing at 9:30 p.m., the day and date set forth.

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COMPUTER-AIDED TRANSCRIPTION

APPEARANCES:

On Behalf of the Plaintiffs:

JEANNE M. TOSTI, ESQUIRE
Becker & Mishkind
660 Skylight Office Tower
Cleveland, Ohio 44113

On Behalf of the Defendant:

JOHN V. JACKSON, III ESQUIRE
INGRID KINKAPF-ZAJAC, ESQUIRE
Roetzel & Andress
1375 E. 9th Street
Cleveland, Ohio 44114

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CHARLES J. HEARN, D.O.

called by the Plaintiffs for examination under the Ohio Rules of Civil Procedure, after having been first duly sworn, as hereinafter certified, was examined and testified as follows:

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EXAMINATION

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BY MS. TOSTI:

Q Doctor, would you please state your name for us, your complete name?

A Charges J. Hearn, D.O.

Q And your home address?

A 22827 Lake Road, Number 2, Rocky River, Ohio 44116.

Q Is that an apartment?

A It is a condo.

Q And in August of 1996, was your business address here at the Cleveland Clinic?

A Yes, it was.

Q And your current business address, is that the Cleveland Clinic?

A Yes, it is.

Q And in August of 1996 you were an employee of the Cleveland Clinic Foundation?

A Yes.
Q Have you ever had your deposition taken before?
A Yes.
Q How many times?
A Once.
Q And why was your deposition being taken? By that, I mean, was it as a treating physician, a defendant, an expert?
A Defendant.
MR. JACKSON: No. You were a treating physician.
A Treating physician.
Q Was it a case in which the Cleveland Clinic was a defendant?
A Yes.
Q What was the allegation of negligence in that case?
MR. JACKSON: Objection, but answer, if you can.
A I believe it was a surgical related death.
Q Do you know what type of surgery?
A An aortic valve surgery.
Q Do you know the name of the patient?

A Michael Broadwater.
Q And how was that case resolved? In other words, did it go to trial?
Was there a settlement?
MR. JACKSON: Do you know?
Q Was it dismissed?
A I do not know the case at this point in time.
Q I want to review a few things as far as depositions go. I am sure Mr. Jackson talked to you.
This is a question and answer session that's under oath, and it is important that you understand the questions that I ask you.
If you don't understand them, if I have asked a confusing question, tell me, and I will be happy to rephrase it or repeat it.
Otherwise, I am going to assume that you understand the question that I have asked you, that your able to answer it.
It is important that you give all of your answers verbally, because the Court Reporter can't take down head nodes or hand motions.
If at any point you would like to refer to medical records -- I am sure Mr. Jackson has provided you with a

copy -- feel free to do so.

At some point he may choose to enter an objection. You are still required to answer my question, unless he instructs you not to, okay?

A I understand.

Q Have you ever been named as a defendant in a medical negligence case?

A No.

Q Have you ever had your hospital privileges called into question, suspended or revoked?

MR. JACKSON: Objection. Go ahead.

A No.

Q And in August of 1996 you were lincensed to practice medicine in the State of Ohio, is that correct?

A That is correct.

Q And were you licensed in any other states at that time?

A No.

Q And are you currently licensed in any other states?

A No.

Q Has your medical license in Ohio ever been suspended, revoked, or called in question?

MR. JACKSON: Objection. Go ahead, answer.

A No.

Q Have you ever acted as an expert in a medical/legal proceeding?

A No.

Q Have you ever given testimony, other than the one deposition that you previously mentioned, in a medical/legal matter?

A No.

MS. TOSTI: Would you mark this as Plaintiffs' Exhibit No. 1?

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(Plaintiffs' Exhibit No. 1 was marked for identification.)

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BY MS. TOSTI:

Q Defense counsel provided me just now with a copy of your curriculum vitae.

I would like you to just take a look at it and tell me if there is any additions or corrections that you would like to make to that to have it up-to-date.

A It is correct.

Q Do you have any additional publications that are currently in progress?

A I have one, possibly two, that have been submitted.

Q What is the subject matter of those?

A Transesophageal echocardiography.

Q Doctor, you are currently Board certified in anesthesiology, is that correct?

A That is correct.

Q Did you pass that on your first try?

A Yes, I did.

Q There is one manuscript that you have listed here that is entitled minimally invasive aortic valve surgery, anesthetic considerations.

Is that a publication that deals with the specifics of minimally invasive aortic valve surgery?

A That publication deals with the specifics regarding the anesthetic management of patients undergoing that procedure.

Q Have you ever taught or given a lecture or a formal presentation on the subject matter of bleeding complications with cardiothoracic surgery?

A I do not have a lecture of that nature that is prepared.

Q Tell me what you reviewed for this deposition.

A I reviewed the chart, as well as all of the records

related to the chart for this case.

Q And in regards to the medical chart, did you review all of it or certain portions of it?

A I reviewed the preoperative anesthetic assessment form, as well as the anesthetic record for case, which I participated in.

Q Would that have been James Long's first surgery in which the aortic valve was replaced?

A That is correct.

Q Have you reviewed any textbooks or articles in preparation for this deposition?

A No.

Q Have you spoken to any physicians in preparation for this deposition?

A No.

Q And since this case was filed, have you discussed this case with any physicians?

A No.

Q Other than with counsel, have you discussed this case with anyone else?

A No.

Q Do you have any personal notes or a personal file on this case?

A No.

Q And have you ever generated any such

notes?
A No.
Q Are there any publications that you feel have particular relevance to the issues in this case?
A There is no one specific publication that I am aware of.
Q Prior to the time of James Long's aortic valve replacement, which was August 20th of 1996, had you ever provided anesthesia on an aortic valve replacement that was done via minimally invasive procedure?
A Yes.
Q How many times, approximately?
A I can't tell you the exact number.
Q Do you recall when you first started doing anesthesia for minimally invasive procedures?
A I couldn't tell you the specifics of that. I would possibly guess early in 1996.
Although, I can't be one hundred percent sure.
Q Do you know how many minimally invasive aortic valve replacements have been done at the Cleveland Clinic, other than James Long's case?
A I don't know the specific number.
Q Do you know approximately?

A I could guess at possibly thirty.

MR. JACKSON: Don't guess. If you have a good estimate, go ahead, that's okay.

A For publications which I was the primary author at the time of the writing was thirty-some ~~papers~~ patients. I don't remember the specific number.

Q Now, Doctor, do you make adjustments in the anesthesia induction of a patient or management of a patient when they are undergoing minimally invasive procedures, as opposed to standard median sternotomy type procedures? Is an adjustment made in the anesthesia technique?

A I am not sure what you ~~mena~~ mean by adjustment.

Q Is there a difference in the way that the anesthesia is provided to a patient because of the technique that is being used surgically?

A There's no specific change in the medications that are chosen. That's a choice made by the attending anesthesiologist, if you will.

The monitoring is the same. And the basic anesthesia is unchanged.

Q Now, in regards to the article that you have on your CV, minimally invasive aortic surgery anesthetics, can you give me a highlight as to

what the anesthetic considerations are that appear in that article?

A I am not sure. Do you want me to repeat the whole article to you?

Q Just the basic areas that are referred to in that article.

MR. JACKSON: Can you do that?

A I can go through the whole article, if you like. I don't know that I can give you highlights.

Basically the anesthetic considerations remain the same for a patient undergoing median sternotomies, as do for the patient undergoing a minimally invasive procedure.

The chances are that the anesthesiologist cannot see the patient's heart beating because of the small incision.

~~Just~~ because the incision is small does not mean that the monitoring or the ability to resuscitate ~~that~~ is changes, ordinarilly, and that the same vigilance, if not more, is required for these type of procedures than with conventional median sternotomies; did that answer your question?

Q Did you do a preoperative anesthesia evaluation of James Long?

A Yes.
Q When did you do the preop anesthesia evaluation?
A That was performed in the operating room.
Q Just prior to the surgery then on the 20th?
A That is correct.
Q Is that generally when the preoperative evaluations are done for these types of patients, just prior to the surgery in the operating room; is that standard?
A That depends on the patient.
Q And when you say depends on the patient, what does it depend on?
A There are multiple factors that determine when an anesthetic assessment is performed on any patient in this institution.

Some of the factors that may change when that assessment is performed would be factors such as whether or not the patient is admitted, and if that was the case, it may be performed the night before the patient comes in on an outpatient basis.

The assessment may be performed up to a couple of weeks in advance of an operation, or it could be performed in the operating room, as well.

Q In James Long's case, what was the reason his was done in the operating room?

A The assessment done in the operating room is done by staff anesthesiologist.

The assessments done out of the operating room are typically done by an anesthesia resident or fellow.

Q As to the anesthesia evaluation that you did, did you write down your assessment anywhere?

A The preoperative anesthetic assessment is in the chart, written in the chart.

Q Could you show me your assessment; where it is?

A It is right here.

Q And did James Long present any problems in regards to anesthesia management for his valve surgery?

A The problem that we encountered, which is documented in the chart, is a dental injury during the intubation.

Q But in regards to the assessment, was there anything in the assessment that caused you to change, or that you had to give extra consideration to, that was out of the ordinary in regards to what you would do for anesthesia induction for this patient?

A No.
Q When is the first time that you came in contact with James Long?
A The day of the operation.
Q And, Doctor, were you the anesthesiologist that provided anesthesia to James Long during his aortic valve surgery?
A The initial surgery, yes.
Q And were you in the room the whole time during James Long's surgery?
A I was not in the room the whole time, as I frequently have multiple rooms to supervise.
Q Can you tell me what portion of the surgery you were in the room for?
A I was present for the placement of all of the monitors and lines of the patient, as well as the induction of the patient.

I also performed the transesophageal echo examination, and would have been present during the separation of the bypass, as well as transportation to intensive care.

Q Doctor, do you go in and out of the room --
A Yes.
Q -- when you are supervising?
A Yes.

Q From what you told me, you were there at least at the beginning. You were also there at the end, when they removed him from coronary bypass; is that what I understood you to say?

A I was present at the separation from cardiopulmonary bypass.

Q How many rooms are you supervising?

A Two.

Q And in this particular instance, when you were not in the room, who was responsible for the anesthesia management?

A Either an anesthesia fellow or a nurse anesthetist.

Q In this case, who was that?

A In this case the nurse anesthetist would have been Gates, and the fellow would have been Gupta.

Q What is Dr. Gupta's first name?

A I don't recall.

Q Is Dr. Gupta still with the Cleveland Clinic Foundation?

A No.

Q Did a Dr. Williams assist with the anesthesia at any time?

A That name is unfamiliar to me.

Q What about Dr. Koch?
A Dr. Koch did not participate in the anesthetic management of Mr. Long during his initial operation.
Q Did James Long's size present any problems in doing his surgery by minimally invasive technique, that you are aware of?
A I am not an expert in surgery, and it would be inappropriate for me to comment on the surgical technique in patients.

However, we did have a problem with his intubation, which was related to his size.
Q And what problem, if you can just describe that in a little more detail for me; you mentioned that there was a problem in which I believe a cap or something came off?
A Yes.
Q What was the problem that you had in doing intubation?
A The difficulty was visualizing the glotis for the placement of an endotracheal tube.
Q And was that related in anyway to his body size?
A That was related to his body anatomy.
Q What was the problem, Doctor?

A The problem in intubating the patient was to visualize his glotis to place the endotracheal tube, and to displace the tongue out of the way.

And during that process, his bridge was damaged by a metal instrument.

Q But in regard to visualizing the glotis, were you having difficulty hyperextending his neck or moving the tongue out of the way?

What was the difficulty?

A I don't recall specifically.

Q Are there any increased risks for bleeding complications associated with the type of homograft mini-root procedure that was done on James Long, as opposed to if it was done by a median sternotomy procedure?

A I am not sure what you are asking me.

Q I am asking you if there is an increased risk for bleeding complications when the procedure is done via minimally invasive, as opposed to median sternotomy?

A I am unaware that the risks are significantly different.

Q Do you have an independent recollection of James Long as you sit here, beyond what you see here, in the medical records that you have reviewed?

A I remember this individual from talking with him

preoperatively.

Q Now, Doctor, in August of 1996, was it standard practice to do a transesophageal echo on a patient before and after cardiopulmonary bypass?

A What are you referring to, a standard practice?

Q All patients that underwent this type of procedure would have a transesophageal echo done before and a transesophageal echo done after; is that standard?

A It is very common that patients that present for valve surgery obtain an echo preoperatively, intra-operatively, as well as postoperatively, in this institution.

Q In August of 1996 were most patients having that done?

A I would say that would be an accurate assumption.

Q And when they are done before bypass and after bypass, who is reponsible for doing the echos?

A That varies between anesthesia personnel, if they are in the room, that are capable of doing it, or the cardiologist, if he is immediately available.

Q And why are those done before bypass and after

bypass?

A They can be done for a multitude of reasons, to assess ventricular function; to confirm the diagnosis made preoperative of the valve or the coronary lesion, or for sizing or measurement purposes, to assess ventricular function and valvular function post-bypass, those are some of the reasons.

Q And in James Long's case why was it done?

A Mr. Long would have had an echo placed to size the homograft, in addition to monitor his ventricular function, as it was not normal preoperatively.

Q Now, in regard to the anesthesia sheet, is there a particular point in time when these transesophageal echos are done, that is recorded on the anesthesia sheet?

A No.

Q Is there a particular time when it is usually done in regards to the procedure?

A The transesophageal echo probe is placed after the intubation of the patient and suctioning of the stomach by NG tube; between the time of the placement of the probe and the placement on bypass, the times vary.

Q And the one that is done after removal

from bypass, is it done after, immediately after the --

A It is usually done prior to the separation from bypass and after separation of the bypass.

Q And you were the individual that did the transesophageal on James Long prior to him being placed on cardiopulmonary bypass, is that correct?

A Yes. I was the staff that performed the intraoperative TE before the cardiopulmonary bypass.

Q On that particular transesophageal, what were your findings for Mr. Long?

A The findings of the echo demonstrated moderate dysfunction of the left ventricle, moderate left ventricular dysfunction, and severe bicuspid and aortic valve stenosis.

Q And there was a transesophageal that was done after the patient or at the time the patient was coming off of bypass; is there any difference in the findings on that?

A Yes, there is a difference.

Now there is a homograft in place. The left ventricular function is normal by this report.

Q Now, I believe on the sheet that you are looking at, Doctor, Dr. Koch's name is listed.

A Yes.
Q Dr. Koch was in the surgical suite at the time to do that transesophageal echo?
A That is what is demonstrated by this report.
Q Dr. Koch is also an anesthesiologist, is that correct?
A Yes.
Q Would Dr. Koch have had any reponsibilty for the anesthesia on this case, if she was doing that post cardiopulmonary bypass transesophageal echo?
A No.
Q She would just come into the room to assist with that, the echocardiogram, and be out?
A That would be correct.
Q Doctor, on the anesthesia record, if you can flip to that, in the upper left-hand corner there's a listing. It says ASA status; what does that refer to?
A ASA status is a classification of the patient. It relates to the extent of co-existing disease.
Q And James Long is listed as having an ASA status of four; what does that mean?
A An ASA status of four would identify a patient that had severe disease which limited his daily

activities.

Q And in regards to anesthesia management, listing him as a four, does that have any implications for your anesthesia management?

A No.

Q Now, near the bottom of the page, there is a notation that is written in there, surgery delay; what does that mean?

A That identifies a period of time that we were waiting for the staff surgeon.

Q And in this instance, how long was that?

A About one hour and fifteen minutes.

Q And were you waiting for Dr. Cosgrove at this point in time; is that who you were waiting for?

A He is the staff surgeon on this case.

Q Now, what time did James Long undergo anesthesia induction?

A Approximately 11:20.

Q And on the left-hand side of the page there's an area that says anesthesia time, with 9:20 written into it; what does that 9:20 refer to?

A That refers to the time the patient was met by the anesthesia team.

Q Now, on page 2 of the anesthesia record, in the center of the page there is an area where there is a

notation that says CPB, which I assume stands for cardiopulmonary bypass.

Do you see that area?

A Yes, I see that area.

Q And there's four boxes that have CPB written into it.

Then there is an area where there appears to be, I think some blood gases, then CPB in the box following it.

Why is there a change from the initials of cardiopulmonary bypass to blood gases, and then back to the cardiopulmonary bypass?

What does that mean?

A In this case the patient was separated from cardiopulmonary bypass, and shortly after returned to cardiopulmonary bypass.

Q He was taken off the bypass, then put back on?

A That is correct.

Q And in this particular instance why was he put back on cardiopulmonary bypass?

A I do not recall the specifics regarding that decision.

That was a surgical decision.

Q Did James Long have any complications during his

surgery?

A Are you referring to surgical complications or are you referring to anesthetic complications?

Q Any complications that you are aware of, Doctor.

A I am aware of a dental injury that Mr. Long sustained during his intubation.

Q Are you aware of any other complications?

A No.

Q Did you become aware at any time that James Long had a bleeding episode during surgery?

A No, I do not recall that information.

Q Dr. Cosgrove never mentioned that he was having bleeding in the aortic suture line at any time during the surgery?

MR. JACKSON: I am going to object. That's not what he said.

Go ahead, answer.

A I don't recall that specific conversation.

Q Doctor, there's an area on the anesthesia sheet that looks to be about 1600 hours; what is James Long's blood pressure recorded at that time?

A From the trend, it would be a mean arterial pressure of approximately 65 millimeters of mercury.

Q I am looking at a checkmark that appears to be on a line that is marked at 80; is that a systolic pressure of 80 at about 1600 hours?

A That would be a systolic blood pressure.

Q Of 80?

A Yes.

Q 65 millimeters of mercury. What caused him to have his blood pressure go down to 80 at that point in time?

A It could be a multitude of factors.

Q Well, in this case, what do you think caused it to go down to 80?

A I can only speculate.

MR. JACKSON: Don't speculate. If you can, give her a reasonable answer to that.

A I can tell you at that point in time we are running the three vasodialators, according to this record, which may be reponsible for that pressure.

Q And which three vasodialators are you running?

A Isoflurane, which is an anesthetic agent, sodium nitroprusside and nitroglycerin.

Q What was the third one?

A Nitroglycerin?

Q Now, what was the time that James Long came off of cardiopulmonary bypass for the last time?
A From the anesthetic record, it is 1540.
Q Now, Doctor, in that same time period, 1600 hours, it appears, if I am reading this correctly, that his pulse was up over one hundred or at one hundred; am I reading that correctly?
A That appears to be the pulse at 1600.
Q And what would cause his pulse to go to that level of one hundred?
A Multiple factors.
Q And in this case, what do you think the multiple factored were?
A Sodium nitroprusside can cause a reflex tachycardia. Low blood pressure can causes reflex tachycardia. Vasodilitation, regardless of the mechanism, can cause tachycardia.
Q Do you have any knowledge of a suture breaking or a suture coming lose during this surgery that caused bleeding?
A No.
Q Why did Mr. Long receive Protamine?
A Protamine is a reversal for heparin.
Q Is that standard in patients that have this type of surgery?

A Most patients who receive large doses of heparin receive Protamine reversal.

Q And in this case, how much protamine did Mr. Long receive?

A A told of 500 milligrams.

Q And is that a fairly standard dose for patients that undergo this type of surgery, if they require Protamine?

A There is no standard dose.

Q Do most patients that require Protamine receive a dose of 500 milligrams?

A Protamine is a drug which is titrated. Each patient is different in the amount they receive.

Q Is that dosage that Mr. Long received within the range of what most patients receive, less or greater than what most patients receive?

A Related to Mr. Long's body weight, that dose is in the average range for most patients his size.

Q Did Dr. Gupta at anytime speak to you about the bleeding that occurred during James Long's surgery?

A No.

Q What was James Long's condition at the time that he left the surgical suite?

A Condition in regards to -- what are you asking me?

Q I am asking you what his condition was at the time that he left the surgical suite; was he having any problems, that you were aware of?

A When James Long left the surgical suite, he was still under the influence of the anesthesia and arrived in intensive care with stable hemodynamics.

Q Did you accompany him to the Intensive Care Unit?

A Yes, I did.

Q Did you provide any information to Dr. Yared in the Intensive Care Unit?

A I do not recall specifically speaking with Dr. Yared.

Q Did you give Dr. Yared or someone in the Intensive Care Unit a report?

A There is a report that's given between the anesthesia time, delivering the patient, and accepting intensive care personnel.

Q I asked if you gave a report to anyone in the Intensive Care Unit.

A I don't specifically recall that conversation.

Q Dr. Hrobat wrote an order to keep James Long's

pressure below one hundred systolic; do you know why that was necessary?

A I don't recall.

Q Is that a typical order for a patient that has had this type valve surgery?

A Each surgeon and each patient receives a different order from each surgeon. I cannot comment on the surgical management.

Q Dr. Yared wrote an admission note to the Intensive Care Unit in which he indicated that this patient had had some bleeding in the OR.

Did you transmit any information regarding bleeding that Mr. Long had in the OR to anyone in the Intensive Care Unit?

A I don't specifically recall that conversation.

Q Doctor, did you see James Long at any time after he went to the Intensive Care Unit?

A Yes, I did.

Q And when was that?

I am speaking after his first surgery.

MR. JACKSON: Do you have the whole chart here?

MS. TOSTI: Probably, but I have got my notations in it, so I am not going

to give it to the Doctor.

MR. JACKSON: If you can't find it, tell her that, Doctor.

A I can't find it from what I have.

Q What are you looking for?

A For the postanesthesia care note that I wrote.

Q At what point in time did you see Mr. Long?

A I saw Mr. Long after his operation. If I had the note in front of me, I could tell you the date and the time.

Q Did you see him on the evening of the 20th, after his surgery?

A I did not see him until at least the following morning.

Q Did you participate in anyway in his second surgery?

A No.

Q So your anesthesia note would have been written after his second surgery, because I believe he returned to surgery that evening?

A I cannot comment, because I do not have the record in front of me, or the chart.

Q I don't recall seeing an anesthetic note, either,

but you believe it was the following day that you wrote the note?

A My typical practice is seeing the patient the day after their anesthetic. Whether or not that was after his return to the operating room, I cannot comment.

Q Did you have any conversations with Dr. Cosgrove or Dr. Mullbach regarding any bleeding complications that James Long had during surgery?

A I don't recall those conversations.

Q Did you have any conversations with either of them about the complications of bleeding that he had while he was in the Intensive Care Unit?

A I don't recall those conversations either.

Q If a patient has bleeding from an aortic suture line which has been reinforced during surgery, would there be a heightened concern for bleeding in the post-op period for the patient?

A That is a possibilty.

Q And, Doctor, if James Long had bleeding complications during the surgery, such as bleeding from an aortic suture line, would you agree it is important that he be watched closely for post-op bleeding?

A That would be a concern, yes.

Q Do you review the postoperative orders for a patient when they are being transferred to the Intensive Care Unit?

Do you look over the surgical orders that are written?

A No.

Q Do you consult with the surgeons at all in regards to what those post-op orders are going to be?

A On ocassion.

Q And in James Long's case, did you consult with Dr. Mullbach or Dr. Cosgrove in regards to his postoperative orders?

A I don't recall.

Q Do you know why he had an order written to keep his systolic blood pressure below 100?

MR. JACKSON: He answered that before.

Go ahead.

A I don't know the specifics about why that order was written.

Q Doctor, if a post-op aortic valve replacement patient develops cardiac tamponade, what changes would you make in the hemodynamic parameters?

A There could be many changes.

Q What characteristically occurs with cardiac

tamponade?

A Cardiac tamponade can manifest as low cardiac output syndrome.

It can manifest as hypotension.

It can manifest on the transesophageal echo, if that was performed postoperatively.

It can manifest as equalization of pressures within the chambers of the heart.

There are a multitude of signs that can occur.

Q Doctor, I would like you to look at the ICU flow sheet that's in the record, or where the hemodynamic parameters are listed.

I would like you to look at the initial parameters from when he was admitted to the Intensive Care Unit, and were any of those initial values on admission of any concern to you?

A There is nothing there that would identify an emergent cardiac process needing immediate intervention.

Q Are any of them causes for concern in regard to him needing close monitoring?

A Our patients are closely monitored in the Intensive Care Unit.

Q The values that you see there are all desirable

values for this patient?

MR. JACKSON: Object to your word "desirable." I don't know what that would mean.

BY MS. TOSTI:

Q That means whatever the doctor feels is appropriate for this patient are represented by the values that are there in that initial assessment.

The hemodynamic parameters, are those all within the range that was desirable for the patient, from the perspective of you as an anesthesiologist?

MR. JACKSON: Objection to desirable. If you are talking about acceptable, I think that is a different word.

Desirable may mean different things. Go ahead, answer, Doctor if you can.

A We are running drugs to keep the blood pressure low at this time, and I can't comment to the specifics about why that was done.

I don't recall.

These numbers are not numbers of alarm to me.

Q Were those all acceptable values for that patient?

A Acceptable? What is your definition of

acceptable?

Q Doctor, it is your definition. You were the treating physician that was the anesthesiologist coming off this case.

I am asking you, in a patient that has those initial hemodynamic parameters, are those acceptable to you?

A Yes, they are acceptable, yes. These are acceptable.

Q Is a transesophageal echo helpful in diagnosing cardiac tamponade in post-op cardiac patients?

A Yes.

Q Doctor, this patient's blood pressure at 1750 hours falls to, I believe, 75 over 46. His arterial pressure drops to 55.

The cardiac index is down to two, and the peripheral vascular resistance, I think, is 52.2; what would cause his parameters to drop like that?

MR. JACKSON: What time is that again, please?

Q 1750 hours.

A Those are signs of low cardiac output syndrome.

Q Could bleeding cause those changes?

A Bleeding is a possibility.

Q And other than low cardiac output syndrome, what would cause him to have a low cardiac output syndrome?
A Cardiac tamponade at this point is a possibility.
Q So those changes would be consistent with cardiac tamponade?
A Yes, they would be consistent.
Q Now, if a transesophageal echo had been done at that point in time, is it likely that cardiac tamponade, if it was there, would be seen on a transesophageal echo?
A It could be diagnosed by a transesophageal echo at that time.
Q Do you think that a transesophageal echo should have been done at that point in time for this patient?
MR. JACKSON: Objection. You can answer.
A A transesophageal echo at this time would be a reasonable intervention.
Q Now, James Long's blood pressure again falls at 1950 hour and continues to go down to be 2030 hours; do you know what caused those changes in this patient?

A I was not present at that time.
Q Doctor, when James Long's blood pressure is falling around 1950 hours, and it is down in the 70's, and Levophed and Epinephrine are running, shouldn't that raise a suspicion that this patient was bleeding?
MR. JACKSON: Objection. Go ahead and answer, Doctor.
A I do not have enough information to tell from this that the patient is bleeding.
I can tell you that the interventions that were made and the resulting hemodynamics are worrisome that the bleeding is an ongoing process at this time, in addition to cardiac tamponade.
Q What would be the rationale for giving this patient the Levophed and Epinephrine? Why did he require the Epinephrine and Levophed?
A Epinephrine is a drug given to maintain the cardiac output, in addition to maintaining mean arterial pressure.
Q What is the expected amount of chest tube drainage per hour on patients undergoing this type of surgery?
A It varies widely.
Q Is drainage of 250 CC's in an hour concerning?

A All chest tube drainage is concerning; however, that number is somewhat high.
Q Why would James Long's chest tube drainage be increasing from 50 to 100 to 250 cc's per hour from 1730 hours to 1930 hours?
MR. JACKSON: Objection. You can answer.
A Not being there at the bedside and having observed the chart, to base a comment on ongoing bleeding would be a recent causative factor.
Q Would that be a concern with that amount of chest tube drainage from 30 to 100 to 250?
A Yes, it would be a concern.
Q And if you were caring for this patient, would you have done a transesophageal echo at that point in time --
MR. JACKSON: I object.
Q -- to check for tamponade?
MR. JACKSON: Object. The doctor is not looking at the entire chart. He told you he wasn't there.
If you think you can answer in absence of having all of that information, go ahead, Doctor.
I don't think that's a fair question to

this Doctor, given what he has in front of him and what he has reviewed.

Go ahead.

BY MS. TOSTI:

Q You may answer, Doctor.

A My responsibility to the patient are in the realm of resuscitation.

If I was present at this time, I would be resuscitating this patient. In a addition, a transesophageal, to make a diagnosis; in addition to the presence of a surgeon at the bed space would be a reasonable multi-team approach.

Q Doctor, looking over all of the hemodynamic values that are there, do you see any trends that would be consistent with a patient that's bleeding?

A I see a period of time from 2010 to 2050 where blood pressures of 55 to 58 is charted.

This could coincide with ongoing bleeding at that time.

Q What is your understanding as to what happened to James Long that caused him to go back to surgery?

MR. JACKSON: State your understanding, if you know, Doctor.

A From reading the surgical note that was dictated,

it is my understanding that there was a problem with the distal anastomosis of the aortic valve homograft that was placed.

Q Now, Doctor, I am going to ask you a series of questions, and if you have no opinion on it, just tell me that.

Do you have an opinion as to at what point in time James Long suffered an ischemic injury to his brain?

A I can't comment.

Q Did you speak to the family of James Long at any time after his first surgery?

A I don't recall.

Q Do you recall speaking to the family at any time after either of his surgeries?

A I don't recall.

Q Do you have an opinion as to what caused James Long's postoperative bleeding?

A I have a dictated surgical note that states there was a problem with the distal anastomosis of aortic valve homograft.

Q Do you have an opinion as to what point in time if any James Long's neurological condition was irreversible?

A I can't comment.

Q Was James Long's case ever discussed in any type of staff meeting?

MR. JACKSON: Object to that. If you are talking about a morbidity-mortality conference or something of that nature, to let him answer whether or not it was discussed at something like that would be the extent of the discussion.

You can answer that question, was it discussed at some type of conference like that?

A I don't recall specifically. Because of his dental injury, it would be marked as a morbidity-mortality conference for the department of anesthesia, and therefore the chart would be reviewed from that nature.

MR. JACKSON: That nature being the dental injury?

THE WITNESS: Yes.

BY MS. TOSTI:

Q Do you have opinion as to James Long's reasonable life expectancy, if he had not suffered hypotension and a severe ischemic brain injury?

A I can't comment.

Q Are you critical of anyone that rendered care to James Long?

A No.

MS. TOSTI: I have no further questions for you, Doctor.

I thank you for your time this morning.

MR. JACKSON: He will read it.

- - - - -

(Deposition concluded.)

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Charles J. Hearn, D.O.

(Please sign and date.)

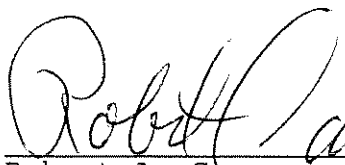
The State of Ohio,)
County of Cuyahoga.) SS: CERTIFICATE
)

I, Robert A. Cangemi, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named CHARLES J. HEARN, D.O., was by me first duly sworn to testify the truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him/her was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a computer, and the foregoing is a true and correct transcript of the testimony so given by him/her as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney of either party or otherwise interested in the event of this aciton.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio on this 22nd day of March, 1999.



Robert A. Cangemi, Notary Public
in and for the State of Ohio.
My Commission expires 3-5-02.

LAWYER'S NOTES

Page	Line	

DEPOSITION OF CHARLES HEARN, D.O.
LONG, etc. v. THE CLEVELAND CLINIC FOUNDATION

Page/Line	Description	Reason
3/12	Charles J Hearn D.O.	
11/5	for the publication in which	
11/6	thirty some patients	
11/14	mean	
12/15	The anesthesiologist	
12/18	Because the incision	
12/19	ability to resuscitate is changed	
12/21	procedures than with	
13/21	it may be performed the night before." If the patient	
17/2	I believe Dr Koch	
18/1	The problem intubating this patient	
18/2	glottis and place the endotracheal tube while	
18/3	displacing	
21/14	omit moderate left	
21/15	omit ventricular dysfunction severe bicuspid aortic	
~~12/A~~ 22/12	I do not believe so	
28/5	total	
29/5	I believe	
29/19	omit time anesthesia personnel	

Charles Hearn DO
CHARLES HEARN, D.O.

CURRICULUM VITAE

CHARLES J. HEARN, D.O.

I. PERSONAL DATA:

Address: 22827 Lake Road, #2
Rocky River, OH 44116

Date of Birth: February 4, 1958

Place of Birth: Quebec City, Quebec Canada
US Citizen Naturalization #11035917 Cleveland, Ohio

II. EDUCATION:

1972 - 1976
Central Catholic
Canton, Ohio
High School Diploma

1976 - 1980
St. Louis University
St. Louis, Missouri
Bachelor Arts Chemistry

1980 - 1982
Akron University
Akron, Ohio
Masters Program

1982 - 1986
Ohio University
Athens, Ohio
Doctor of Osteopathy

III. HOSPITAL TRAINING:

11/93 - 10/94
Fellowship in Echocardiography
Cleveland Clinic Foundation
Cleveland, Ohio
William Stewart, M.D. Director

10/90 - 1/91
Fellowship in Neuro Anesthesia
Cleveland Clinic Foundation
Cleveland, Ohio

7/90 - 10/90
Fellowship in Pain Therapy
Cleveland Clinic Foundation
Cleveland, Ohio

7/89 - 6/90	***Fellowship in Cardiothoracic Anesthesia*** Cleveland Clinic Foundation Dept. of Cardiothoracic Anesthesia Cleveland, Ohio
7/87 - 7/89	***Residency in Anesthesia*** Detroit Osteopathic Hospital Department of Anesthesiology Detroit, Michigan
7/86 - 7/87	***Rotating Internship*** Parkview Hospital Toledo, Ohio

IV. PAST PROFESSIONAL APPOINTMENTS;

1/91 - 2/93	***Assistant Staff*** Cleveland Clinic Foundation Dept. of Cardiothoracic Anesthesiology Cleveland, Ohio

V. PRESENT PROFESSIONAL APPOINTMENTS:

2/93 - present	***Staff*** Cleveland Clinic Foundation Dept. of Cardiothoracic Anesthesiology Cleveland, Ohio

VI. PROFESSIONAL ACTIVITIES AND HONORS:

National Boards:

Board Certification American Osteopathic College of Anesthesiologists #0648

Licensure:

State of Ohio #4519

Memberships:

American Society of Anesthesiologists
American Osteopathic Association
Ohio Society of Anesthesiologists
International Anesthesia Research Society
Society of Cardiovascular Anesthesiologists
American Osteopathic College of Anesthesiologists

Appointed Committees:

Cardiothoracic Resident Admission Committee
Committee on Continuing Medical Education
Anesthesia-surgery operating room task force

Professional Honors:

Who's Who in America, 1990

Community Activities:

None

VII. BIBLIOGRAPHY:

Manuscripts

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3. Capdeville M, Hearn C, Rice TW, Starr NJ: Left atrial metastasis of a large cell carcinoma of the lung in an asymptomatic patient: Transesophageal echocardiographic evaluation. J Cardiothor & Vasc Anesth 11 (4), 1997:492-494.

4. Capdeville M, Hearn C, Rice TW, Starr N. Left atrial metastasis of a large cell carcinoma of the lung in an asymptomatic patient: transesophageal echocardiographic evaluation. J Cardiothorac Vasc Anesth, Vol 11, No 4 (June), 1997: 492-4.

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Abstracts

1. Kraenzler E, Kirby T, Hearn C et al. Airway management of cystic fibrosis patients during double lung transplantation: single lumen endotracheal tubes are superior to double lumen endotracheal tubes. Presented at the Society of Cardiovasuclar Anesthesiologists, April 1993

Book Chapters

1. Kraenzler E, Hearn C. Anesthetic considerations for video assisted thoracic surgery. Atlas of Thoracoscopic Surgery. W.B. Saunders, 1994, pp 66-74.

VIII. RESEARCH IN PROGRESS:

None

IX. LECTURES:

Available upon request.

X. SCIENTIFIC EXHIBITS:

None

XI. REFERENCES

Available upon request.