State of Ohio,)
) ss:
County of Cuyahoga.)

- - -

IN THE COURT OF COMMON PLEAS

- - -

Christopher S. Long, etc.,)
)
Plaintiff,)
) Case No. 321518
vs.)
)
Cleveland Clinic Foundation,)
)
Defendant.)

- - -

DEPOSITION OF DENNIS HERNANDEZ, M.D.

MONDAY, JUNE 7, 1999

- - -

The deposition of Dennis Hernandez, M.D., called by the Plaintiff for examination under the Ohio Rules of Civil Procedure, taken before me, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at the offices of Roetzel & Andress, One Cleveland Center - 10th Floor, Cleveland, Ohio, commencing at 1:05 p.m., on the day and date above set forth.

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APPEARANCES:

On Behalf of the Plaintiff:

Jeanne M. Tosti, Esq.
Becker & Mishkind
Skylight Office Tower - Suite 660
Cleveland, Ohio 44113

On Behalf of the Defendant:

John V. Jackson, II, Esq.
Ingrid Kinkopf-Zajac
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One Cleveland Center - 10th Floor
Cleveland, Ohio 44114

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DENNIS HERNANDEZ, M.D.
called by the plaintiff for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS EXAMINATION

BY MS. TOSTI:

Q. Doctor, would you please state your name for us?
A. I am Dr. Dennis R. Hernandez.
Q. And where are you currently residing?
A. It is at Number 8 Puerto Rico Street, Loyola Grand Villas, Quezon City, Philippines.
Q. And that is your residential address that you have given me?
A. Yes.
Q. Do you have a current business address?
A. It is at the Philippine General Hospital, University of the Philippines. That is in Manila.
Q. And in August of 1996, was your business address at the Cleveland Clinic?
A. Yes.
Q. And in August of 1996, were you an employee at the Cleveland Clinic Foundation?
A. Yes, you can call it that way.
Q. At that same time period, were you providing

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professional services for anyone else besides Cleveland Clinic, in August of '96?
A. No.
Q. Have you ever had your deposition taken before?
A. No.
Q. I am sure Mr. Jackson has spoken to you about some of the ground rules for the deposition. I am going to just review some of them for you.
This is a question and answer session, it is under oath. It is important that you understand the questions that I ask you.
A. Uh-huh.
Q. If you don't understand them, if I have phrased them inartfully, just let me know and I will be happy to repeat the question or to state it in another way.
A. Okay.
Q. If you don't ask me any questions about the question that I have asked you, I am going to assume that you have understood the question and that you are able to answer it.
It is also important that you give all of your answers verbally, because our court reporter can't take down head nods or hand motions.

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A. All right.
Q. It is also important that you allow me to ask my complete question, and then give your answer, because if we both talk at the same time, the court reporter can't take us both down.
A. Okay.
Q. At some point, Mr. Jackson may choose to enter an objection for the record. You are still required to answer my question unless he instructs you not to do so.
Do you understand those?
A. Yes.
Q. Have you ever been named as a defendant in a medical negligence suit?
A. No.
Q. Have you ever had your hospital privileges called into question, suspended or revoked?
MR. JACKSON: I will object, but go ahead and answer. I am going to object to these kind of questions.
A. No.
Q. And in August of 1996, were you licensed to practice in the State of Ohio?
A. Yes.
MS. TOSTI: 'would you please mark this

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as an exhibit.
(Thereupon, Plaintiff's Exhibit 1 (Hernandez) was marked for identification.)
BY MS. TOSTI:
Q. Doctor, counsel has provided me with a copy of your curriculum vitae, and I would like you to just look it over and tell me if it is up-to-date, and if there are any additions or corrections that you would like to make to that document that the court reporter has marked as Plaintiff's Exhibit 1 for us.
A. It is very much accurate.
Q. Now, Doctor, I see that on your curriculum vitae, under examinations passed, it indicates that you passed your United States medical licensure exam in 1993.
A. Yes.
Q. Were you required to do anything additional to obtain Ohio licensure?
A. Not that I remember.
Q. Did that allow you to practice in any state in the United States?
A. Yes.
Q. Has your license in the United States ever been called into question --

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MR. JACKSON: Objection. You may answer.
Q. -- suspended or revoked?
A. No.
Q. And do you currently have a license that would allow you to practice in the United States proper?
A. Yes.
Q. Have you ever acted as an expert in a medical-legal proceeding?
A. No.
Q. And have you ever given testimony in a medical-legal proceeding?
A. No.
Excuse me, is that here, or back home?
Q. In the United States, have you ever?
A. No.
Q. Outside of the United States, have you ever given testimony?
A. Yes.
Q. What type of a case did you give testimony in?
A. Most of these are medical-legal problems, what you call trauma.
MR. JACKSON: People who were injured

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for whom you have cared?
THE WITNESS: Yes.
MR. JACKSON: So you are talking perhaps a lawsuit that would have been filed, where one of your patients is involved?
THE WITNESS: Yes, but I am not a defendant. Most of these are trauma patients.
MR. JACKSON: These would be claims against somebody --
THE WITNESS: Yes, someone else.
MR. JACKSON: They get in an accident.
THE WITNESS: Yes.
BY MS. TOSTI:
Q. But none of the cases in which you gave testimony were you a defendant --
A. No.
Q. -- in the case, where an accusation of negligence was brought against you?
A. No, no.
Q. Doctor, while you were in the United States, did you ever receive Board certification in any medical specialty?
A. No.
Q. And in regard to your place of residence, do

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you have any type of a Board certification?
A. Yes. That is from the Philippine Medical Board, the general surgery Board, and the thoracic and cardiovascular surgery Board.
Q. Now, from your curriculum vitae, it would appear from the time that you graduated medical school in the Philippines, all of your experience was in the Philippines until you did a Fellowship at Cleveland Clinic beginning in 1995; is that correct?
A. That is correct.
Q. And then the period of time that you were in the United States, was that from 1995 to 1997?
A. That is correct.
Q. And you then returned to the Philippines after that?
A. That is correct.
Q. The Fellowship in cardiovascular surgery that you did at Cleveland Clinic Foundation, did that have a specific time limit to it, when you began the Fellowship?
A. It is on a yearly basis. The contract is for a year, but they -- you can extend to about two or three years, depending on how you feel, how prepared you are.
Q. And at the end of 1997, did you request to

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extend your contract for a Fellowship?
A. No: not any more.
Q. It was your decision?
A. Yes.
Q. Did Cleveland Clinic offer to allow you to extend your contract?
A. Yes.
Q. Doctor, what is your current position that you hold?
A. I am an associate professor in surgery at the cardiothoracic surgery department of the University of the Philippines, and the teaching hospital is Philippine General Hospital in Manila. And I also am head of training of the program.
Q. In August of 1996, what was your title at Cleveland Clinic?
A. I was a second year Fellow, cardiothoracic surgery.
Q. And as a second year Fellow in August of '96, what were your duties and responsibilities?
A. Basically I would be assigned with a staff man, take care of his patients, do pre-ops, start his cases, would help him through the case. I would take care of them postop, too.
On the average, about every four days, we

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would go on call, that is night call, that is from 7:00 p.m. to 7:00 a.m. And in between, there were schedules wherein you were on call from 7:00 a.m. to 7:00 p.m., which during your call, you take care of the ICU, all patients in the ICU and on the regular floors upstairs.
Q. I just want to be clear on this. It sounds like there were two different types of call that you took, one in which you had responsibility on call for the regular floor, as well as the ICU, and then other times you just had on call for the regular floors?
A. No. When you are on call, it is the whole hospital.
Q. And you were on call every fourth day?
A. Yes, usually fourth day.
Q. For about a twelve hour period?
A. Yes.
Q. Now, what was the reason that you decided to come to the Cleveland Clinic for the Fellowship?
A. Well, the Clinic has a name. Back home, the Cleveland Clinic has established itself, also, as the premier cardiovascular center, and we, being staff at the teaching hospital, we are encouraged to get into these kinds of programs.

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Q. Prior to your Fellowship at Cleveland Clinic, had you participated in any minimally invasive cardiac surgery?
A. No.
Q. And while you were at Cleveland Clinic, did you participate in any minimally invasive --
A. Yes.
Q. -- cardiac surgery?
A. Yes.
Q. Let me finish my question, and then give your answer.
When is the first time that you had an opportunity to participate in minimally invasive cardiac surgery?
A. I believe it was April of **'96.**
Q. Did you ever assist Dr. Cosgrove in a minimally invasive procedure?
A. Yes.
Q. In a minimally invasive valve replacement procedure?
A. Yes.
Q. Now, you had indicated previously that as part of your Fellowship, you were assigned with a staff physician. Was there one particular staff physician that you were assigned to when you were in

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your Fellowship?
A. We stay with a particular staff for three months on a rotation basis. So in your term, like I was assigned to about four or five staff people. And I rotated with Dr. Cosgrove.
Q. I am sorry, I didn't hear.
A. I rotated with Dr. Cosgrove.
Q. And in August of 1996, at the time that James Long had his surgery, who was the staff person that you were assigned to?
A. I believe it was Dr. Joseph Sabik.
Q. Do you currently do minimally invasive valve replacement surgery in your practice today?
A. Not yet.
Q. And why is that, Doctor?
A. We still need some equipment, we still have to upgrade.
Q. Doctor, you have, on your curriculum vitae, listed several papers that you have either presented or published.
Do any of those deal with the subject matter of bleeding complications following cardiothoracic surgery?
A. No.
Q. Do you have any additional publications,

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other than those that are listed on your curriculum vitae?
A. No.
Q. Have you ever participated in any research dealing with the subject matter of bleeding complications after cardiothoracic surgery?
A. No.
Q. Have you ever taught or given formal presentations on that subject matter?
A. No.
Q. Tell me what you have reviewed for this deposition today?
A. Just the depositions that were sent to me by our lawyer, Attorney Jackson, and the chart, section of the chart.
Q. What section of the chart did you review?
A. What do you call this?
Basically the op notes and the monitoring sheets.
Q. I am sorry?
MR. JACKSON: Monitoring.
A. The op notes and the monitoring sheets.
Q. Monitoring sheets.
Could you tell me whose depositions you reviewed?

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A. Dr. Cosgrove's, Dr. Muelbach, Dr. Hearn, Dr. Colleen Koch, and a nurse -- what is her name -- Nurse --
MR. JACKSON: Hrobat.
A. -- Hrobat.
Q. Have you consulted with any physicians in preparation for this deposition?
A. No.
Q. And other than with counsel, have you discussed the 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 personal notes or a personal file?
A. No.
Q. Are there any publications that you believe have particular relevance to the issues in this case?
A. No.
Q. In the first eight hours after minimally invasive valve replacement surgery, what signs or symptoms would suggest that a patient was having excessive bleeding from an operative site?

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MR. JACKSON: Would you read that back for me.
(Record read.)
THE WITNESS: Answer that?
MR. JACKSON: GO ahead.
A. It would be an increasing trend in blood output in the chest tubes.
Q. Anything else, Doctor?
A. Hypotension would be one. Low cardiac outputs, low cardiac index and low CVP.
Q. Would there be any trend in the hemodynamics that would suggest that there was excessive postoperative bleeding at the operative site, any particular trend that you would keep an eye out for?
A. That would be probably a declining or decreasing blood pressure.
Q. Anything else?
A. Coupled with increasing chest tube output.
Q. What hemodynamic trends would suggest cardiac tamponade after minimally invasive cardiac surgery?
A. Why cardiac tamponade in particular?
Q. Well, that is my question.
Assuming there is cardiac tamponade, what trends would suggest that to you, after minimally invasive valve replacement surgery?

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A. First of all, you will have a declining blood pressure, and your cardiac index would be going down, way down below 2. The CVP would go up mor than 20, 30, and some neck vein engorgement. That would more or less give you an idea. PA pressures would also be increasing, pulmonary artery pressures.
Q. Do you have an independent recollection of James Long, as you sit here today? Aside from what you reviewed in the record, do you remember him?
A. Yes. He was a big guy. I don't really recall his age, except from what I read, he was about 50 years old. That is basically what I could remember of him before I was called in to see him.
Q. When is the first time that you came in contact with James Long?
A. That would be about -- I remember Muelbach, it is about 10:30 in the chart.
Q. Let me withdraw that question and ask you another question.
Was the first time that you saw James Long on the evening of his valve replacement surgery, just prior to the time that he went back for reoperation?
A. Yes.
Q. And I believe the nurses notes reflect that

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you are at the bedside sometime around 11:10 p.m.
A. Yes.
Q. Is that approximately the time --
A. Yes.
Q. -- that you first saw James Long?
A. That is what I remember, yes.
Q. Did you have any responsibilities whatsoever in regard to his initial valve replacement surgery?
A. No.
Q. You weren't in the surgical suite --
A. No.
Q. -- you didn't see him preoperatively?
A. No.
Q. Now, on the evening of August 20th, 1996, which is the evening of his valve replacement surgery, could you tell me what your duties and responsibilities were in regard to the cardiothoracic ICU?
A. I was manning both Unit 53 and Unit **54,** Mr. Long being in Unit 54. And also, I believe, two units on the 10th floor, G-100 and G-101.
Q. And Units 100 and 101, what type of units are those?
A. These are regular floors where patients are -- from the ICU, that is where they are sent for

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recovery.
Q. Is it a recovery area?
A. It is a general unit, they call it, prior to discharge. That is where they stay for a longer time.
Q. Would these be non intensive care units, Unit 100 and 101?
A. Yes.
Q. Approximately how many patients are on those units?
A. Oh, about 50, at least.
Q. The two units combined would be 50 patients?
A. Yes.
Q. And Unit 53 and **54,** are those intensive care units?
A. Those are intensive care units.
Q. And on the evening of August 20th of 1996, were you on call for all of the units that you have just described?
A. Yes.
Q. And that would be that twelve hour period of on call?
A. Yes.
Q. So would it be correct to say that you started your on call at 7:00 p.m. to 7:00 a.m., or

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did you start at 7:00 a.m. and went to 7:00 p.m.?
A. That would be -- theoretically that would be 7:00 p.m. to 7:00 a.m. However, there are times wherein you come in late, because we do cases with other staff. And it is only when you are finished with your cases with the other staff that you go into the ICU.
Q. Then let me ask you this question:
On August 20th of 1996, at what point in time did you come on call?
A. I can't remember exactly what time.
Q. Was it sometime in the evening on August 20th?
A. Yes.
Q. And did you anticipate working through the night, then --
A. Yes.
Q. -- as being the on call person?
A. Yes.
Q. Now, when you were on call for the ICUs, were you required to make rounds in the ICU on any type of a regular basis?
A. In general, we do. But it depends, for example, if there is a patient that needs closer monitoring in another unit, you sort of stick to

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that patient more closely than the others.
Q. And on the evening of August 20th of 1996, did you make rounds in the unit that Mr. Long was a patient?
A. Yes.
Q. What time did you make rounds?
A. I can't remember exactly what time, I cannot.
Q. Do you know how many times you made rounds that evening in the unit that Mr. Long was a patient?
A. This business was three years ago. But on the average, what I do is, as you come in, you see all the patients, talk to the nurses. If there are patients who are sick, very sick, I call in the chief resident of that service and ask him what to watch out for, something like that. At 11:00 or 12:00, I make my rounds again, and in the morning at 5:00. In between, you stick to patients who are sick, and literally sit beside them.
Q. On the evening of August 20th of '96, was there any particular patient that you considered sick, that needed your close attention, as you just described?
A. Most of them were in ***G-53.*** That unit had heart transplant cases and mechanical hearts. And

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these are the patients who are generally sicker than the regular open heart procedures that are being done in the Clinic.

Q. And on that evening in question of August 20th, then, the majority of your time that evening was spent in G-53; is that correct?

A. Yes.

Q. And you do not recall specifically how many times you made rounds in Unit 54 where Mr. Long was that evening, correct?

A. Yes.

Q. Once James Long was admitted to the cardiothoracic intensive care unit, did you have primary responsibility for assessing and monitoring his postoperative status on the evening of August 20th?

A. I am sorry, but I wasn't there when he was admitted.

Q. After his admission, after you --

A. Took over.

Q. -- went on call, did you have primary responsibility for assessing and monitoring his postoperative status that evening?

A. I would say.

MR. JACKSON: Do you understand what

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she is asking?

What she wants to know, were you the doctor who was most responsible for assessing patients in this unit and monitoring the patients in this unit?

THE WITNESS: That depends if Muelbach is there.

MR. JACKSON: Tell her that, then. That is what she needs to know.

Q. Let me rephrase my question, then. On the evening of August 20th, after you went on call, who had responsibility, primary responsibility, for assessing and monitoring James Long?

A. That would be me, except if the chief resident is there, in which case, this case, Muelbach was around, so he was sort of sticking around and watching Mr. Long.

MR. JACKSON: So your answer is, in this case, it would have been Dr. Muelbach?

THE WITNESS: Yes.

BY MS. TOSTI:

Q. Now, you said that you spent most of your time that evening in another intensive care unit --

A. Yes.

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Q. -- rather than the one that James Long was in?

A. Yes.

Q. So what knowledge do you have in regard to when Dr. Muelbach was in the ICU where James Long was a patient?

A. I think I saw him until about 9:00 or 10:00 in the evening, after which he left, and he gave me a call, I think it was on a cell phone, sometime like 10:30, maybe a bit later, and he asked me to watch the patient closely.

Q. Why did he ask you to watch the patient at 10:30?

A. There was probably some concern.

Q. Well, what was the concern that he expressed to you?

A. That he had a bleed before. The guy had a big heart, you have to watch the pressures, keep it below 100, that was his concern.

Q. And when did he have this bleed?

A. I think intraoperatively.

Q. So Dr. Muelbach expressed some concern about the intraoperative bleed, and he wanted you to watch James Long sometime after 10:30 or so --

A. Yes.

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Q. -- for any additional bleeding?

A. If there was any.

Q. And did you physically see Dr. Muelbach in Unit 54 at the bedside with James Long any time before 10:30?

A. I believe so.

Q. And what time do you think you saw him there?

A. I cannot remember.

Q. How many times do you think you saw him there?

A. Maybe once.

Q. I don't want to misrepresent what you are telling me.

Was it your feeling that up until you received that phone call from Dr. Muelbach sometime around 10:30, that he was assuming primary responsibility for Mr. Long's care?

A. Yes.

Q. On the evening of August 20th, did you leave the hospital at any time?

A. No.

Q. Now, Doctor, prior to the time that you saw James Long around 11:00 o'clock that evening, you are uncertain as to how many times you were in the ICU unit; is that correct?

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A. Yes, I can't count.
MR. JACKSON: So the record is clear on that, Doctor, because that is going to look funny, when you say, I can't count, you mean you can't count the number of times you were there; is that what you are saying?
THE WITNESS: Yes.
BY MS. TOSTI:
Q. Do you know whether you had done any type of an assessment on James Long at any time prior to the time that you saw him around 11:00?
A. Most likely, I would be called in, yes, I think there would have been an assessment. Because during the -- when I entered the unit, we look at all the patients, I mean, all the beds in each unit that you are responsible for.
Q. So it is likely you did --
A. Yes.
Q. -- an initial assessment --
A. Yes.
Q. -- because that is what you usually do?
A. Yes.
Q. And that would be when you come on call initially?
A. Yes.

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Q. And you don't have any recollection of that initial assessment that you did --
A. No.
Q. -- of James Long?
A. It actually didn't strike me as a case that you really need to sit down beside. That was why.
Q. There is a portable chest x-ray report in the records that was done sometime around a little after 6:00. Do you have any recollection of ever reviewing that x-ray?
A. No, I don't remember, although I would have seen the x-ray, but I don't remember it.
Q. When they do portable chest x-rays, do they keep the films in the unit?
A. Yes.
Q. And so when the Fellow making rounds sees the patient, that would be available to you?
A. Yes.
Q. At any time prior to the time that you saw James Long on the evening of August 20th, did you have any conversations with Dr. Cosgrove?
A. No.
MR. JACKSON: obviously regarding Mr. Long?
MS. TOSTI: Correct.

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Q. I am sorry, regarding Mr. Long and his surgical procedure.
A. No.
Q. Did you recall speaking to Dr. Hearn or Dr. Yared anytime prior to the time that you saw Mr. Long?
A. No.
Q. On the evening of August 20th, you have mentioned one conversation that you had with Dr. Muelbach. Did you have any other conversations with any other doctor about Mr. Long's condition?
A. No.
Q. So you talked to Dr. Muelbach sometime around 10:30?
A. Yes.
Q. And then there was no other physician that you spoke to during the night?
A. No.
Q. And you don't recall talking to Dr. Muelbach more than that one time at 10:30 at night?
A. Yes.
Q. On that evening, did you receive any phone calls from the nursing staff --
A. Yes.
Q. -- in regard to Mr. Long?

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A. Yes.
Q. When did you receive those calls?
A. That was sometime like 11:10, I got paged from one of the nurses. Yes, I think, I believe the nurse was instructed by Dr. Muelbach for me to check on the patient.
Q. Do you know who the nurse was that called you?
A. I don't really recall. But from the --
MR. JACKSON: Don't guess. If you know, tell her. But don't guess, please.
A. (Continuing) I don't know.
Q. So the only phone call that you received from any of the nursing staff was sometime around that 11:00 o'clock - 11:10 time period, correct?
A. Correct.
Q. Over the course of the evening, did you make any phone calls to the ICU regarding James Long's condition, on the evening of August 20th, '96?
A. I don't recall.
Q. When you received the phone call around 11:00 o'clock that evening from one of the nurses, what was the content of that conversation?
A. I remember she told me to check on the patient, I was instructed by Dr. Muelbach, and to

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give him a call if there is any problem.
Q. And at that point when you received the call, where were you?
A. G-53.
Q. What did you do after you received that call?
A. I went there immediately.
Q. And what did you do after you got into the unit where Mr. Long was a patient?
A. You will normally look up the patient's condition, look at his monitoring, the monitoring sheets, the medications, see chest tube outputs.
Q. Is that what you did in this case?
A. Yes.
Q. And what were your findings?
A. Well, it is hard to say without looking at the charts, but --
Q. Doctor, if there is anything in the records that Mr. Jackson has provided to you that you would like to look at, feel free to do so.
A. Yes.
Slightly hypotensive, but within the range, the acceptable range. Good urine output, and I noticed the chest tube output.
Previous to it, he had *250*. Other than that, it didn't strike me much.

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Q. So after you assessed him in regard to his hemodynamics, was there anything concerning to you?
A. When was this one (indicating)? The second one.
At that point, yes, it is 11:10, he had dumped 350 ccs of blood.
Q. So the output of his chest tube was concerning?
A. Yes.
Q. What about his hemodynamic monitoring values, was there anything there that was concerning to you?
A. They were within the acceptable limits, except that he was on Levo and Epinephrine.
Q. And were those within acceptable limits, considering the fact that he was on those two medications?
A. Yes.
Q. And after you did your assessment of Mr. Long and reviewed the items that you mentioned, what was within your differential diagnosis for him?
A. He was bleeding, or he bled.
Q. And that was based on the --
A. Chest tube output.
Q. -- chest tube drainage.
Now, Doctor, there is, at 1850 hour, which is

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at Line E on the flow sheet, a point in time when his blood pressure drops down to, I believe 75/46.
A. Uh-huh.
Q. And I believe also his cardiac index drops to *2.0* at that time.
A. Uh-huh.
Q. Could bleeding from his anastomosis site cause those types of changes in a patient?
MR. **JACKSON:** The question is, is it possible?
MS. TOSTI: Yes.
A. It is possible, but there are other things to consider.
Q. And what would be those other things to consider?
A. Because if you will blame bleeding alone as the cause, that would have been a significant bleed, enough to dry him up. So there is a possibility here of a lot of things that could have happened here, he is probably dry or hypovolemic, that is one, he is dilated, he is febrile, so many things to consider. You cannot blame bleeding alone.
Q. And in Mr. Long's case, what do you think caused his blood pressure to drop to that point at 1850 hour, on Line E?

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A. Probably he is hypovolemic. Because they are giving volume to him, and he responded after being given *500* ccs of lactated Ringer's.
Q. Now, were you notified of that low blood pressure?
A. I wasn't in the unit at this time yet.
Q. Was that during the time period when Dr. Muelbach was still around?
A. Yes. Dr. Muelbach and the other resident on call.
Q. Who was the other resident on call?
A. I don't remember the person exactly.
Q. Was there more than one person usually on call for the intensive care units on most evenings?
A. There are two.
Q. There were two.
Were they both cardiothoracic Fellows?
A. Yes.
Q. So there was some other cardiothoracic Fellow that was on call for the unit that Mr. Long was a patient on that evening, correct?
A. That was before I came in.
Q. Oh, I see.
A. That was before I came in.
Q. But at the time that you were on call, was

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there another cardiothoracic Fellow on call with you, besides Dr. Muelbach?
A. Yes. But he would be taking the other units, 51 and 52.
Q. I just want to be clear on this.
So for Unit **54,** where Mr. Long was a patient, you were the only cardiothoracic Fellow on call for that unit?
A. When I came in.
Q. Yes.
A. Before I came in, there was another guy. I don't remember who it was.
Q. I am just talking about when you were there.
A. Yes.
Q. You were the only person on call for Unit **54?**
A. Yes.
Q. What is the usual amount of chest tube drainage per hour for a patient that has undergone the type of surgery that James Long underwent?
MR. JACKSON: objection.
Go ahead.
A. The average, is that for the whole twelve hour period?
Q. Let's start with the first eight hours. What would you normally see, as far as chest tube

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drainage for a patient that has had the type of surgery that James Long has had?
A. There is no actual amount that you can say an average amount, because it would be affected by so many factors. The mere fact that the surgeon who closes the chest or closed the chest did not suck out the chest cavity, he would have lots of blood left there, and the patient, as he comes up to the unit, would be technically dumping blood after he has been moved.
So you have to look at the trend of what is coming out. It is not an absolute value.
If you will look at the trend, usually for the first eight hours, it will be about 50 to a hundred.
Q. When we look at James Long's ICU flow sheet, it indicates, in the first two hours that he is in the unit, from 1730 hour to 1930 hour, that he has, I believe, 400 ccs of drainage, and it is in increasing increments of 50, then a hundred, and then 250.
Is that a typical amount of drainage for chest tubes in a patient that has had this type of surgery?
A. I would say it is.

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Q. And that wouldn't be any cause for concern, that the amount of drainage was increasing over the first two hours that the patient was in the unit?
A. Yes, you would be concerned, but it is within the limit. But the thing is, you watch, after another hour, if it comes down to 50, and then 50, then you sort of let down your guard.
Because the 250 here might just be a dump from probably moving the patient, or the patient starts to wake up and mobilizes fluids inside his lung, or the chest cavity, and that is going to reflect it.
MR. JACKSON: Just so the record is clear, that 250 was at --
THE WITNESS: 1930.
Q. 1930 hour.
If the patient has that type of increasing chest tube drainage, and then has a blood pressure that begins to fall over a period of time, does that make a heightened concern for bleeding?
MR. JACKSON: Are you talking specifically on this sheet; is that what you are asking him?
MS. TOSTI: Yes.
MR. JACKSON: what time are you asking

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about the blood pressure, then?
Q. (Continuing) This patient has, I believe, increasing drainage from 1730 to 1930, and then develops a decline in his blood pressure at about 1950 hour over a period of time.
Given that type of drainage, followed by the decrease in blood pressure, would that be -- would there be a heightened concern that the patient was bleeding?
A. I would not blame this chest tube output as the cause of hypotension, because he put out 400, and a 400 cc output will not be enough to cause a drop in blood pressure of this amount.
Q. Now, Doctor, if you look on the right-hand side of the flow sheets, there are some hemoglobins and hematocrits that are listed out.
A. Yes.
Q. And there is a drop in the hemoglobin and hematocrit from a beginning point, I believe, 12.1 and **36,** I think it is --
A. Uh-huh.
Q. -- to -- well, evenutally it is 10.5 and 31 and then 9.2 and **27.**
A. Uh-huh.
Q. Would that amount of decline in the

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hemoglobin and hematocrit raise any concerns that this patient was having excessive pdstoperative bleeding?
A. A drop in hematocrit is not only due to bleeding, if that is what you are asking. Because if you will notice in the chart, he has been -- he has been given lactated Ringer's. And in that situation, you will be diluting the blood. So at the same time the hematocrit is going to go down.
Q. My question is, what you see on James Long's flow sheet, would that raise any concern for this patient?
A. No.
Q. Doctor, at Line L of the flow sheet, at, I believe it is 2110 hour, James Long's CVP is at 19 and his cardiac index is at 2.0 with a systemic vascular resistance of 663.
What would cause his CVP to be high, his cardiac index to be low, with that systemic vascular resistance?
A. You know, his CVP really hasn't changed much from the time he came in. It was 17, and now it is 19.
He is dilated. Probably still -- he was dilated here, probably is still dilated at that moment.
Q. Would you expect to see a cardiac index of 2.0 with that systemic vascular resistance, just from the dilation?
A. Sometimes you can, yes.
Q. Now, at Line O of the flow sheet, the nurses have indicated that he had a chest tube drainage of 250 ccs in a one hour time period. Were you notified of that 250 cc drainage?
A. I believe I wasn't.
Q. If a patient had -- in Mr. Long's case, should the 250 ccs of drainage at that point in time have raised a concern that he was bleeding excessively?
A. It is of concern. But then again, we are watching, just watching.
Q. And what would you be watching for?
A. If there is progression of bleeding.
Q. Do you know whether or not James Long was seen by a physician at that point in time when he had the 250 ccs of drainage?
A. No, I wouldn't know.
Q. Should he have been seen by a physician when he had that amount of drainage?
THE WITNESS: should I answer that?

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MR. JACKSON: YOU can.
A. Maybe, yes.
Q. Do you know a nurse by the name of Kathy Zilka?
A. I remember her.
Q. Did you at any time on the evening of August 20th of '96 speak to a nurse named Kathy Zilka?
A. I don't remember any, but she probably was the one who called me in to see Mr. Long at 11:10.
Q. Why do you think she probably was the one?
A. Because she was the nurse on call there for this patient, so she would be the one to page me.
Q. There has been testimony in this case that she was there precepting a new student -- I am sorry -- a new nurse that was in orientation, and I just want to be clear as to whether you have any recollection as to who you actually spoke to, whether it was Ms. Zilka, or some other nurse?
A. I have no recollection. I would assume it would be Ms. Zilka.
Q. Doctor, tachycardia can be a sign of hemorrhage, correct?
A. Yes.
Q. Do you have an opinion as to why James Long's heart rate was over a hundred from about 1930 hour

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until he was taken back to surgery?
A. Well, tachycardia is a sign of so many causes. Some of them, as reflected here, would be hyperthermia, where he was febrile, got a temperature of 38.4.
The other thing is he might be waking up at this point. So tachycardia is not a very good gauge of hypertension and blood loss in this situation.
Q. Beginning at about 1950 hour, he has a progressively downward trend of his blood pressure that goes through 2130 hour.
I am sorry, it goes to about 2030 hour, and remains under 90 systolic until 2130 hour.
MR. JACKSON: what was the starting point again?
Q. (Continuing) I believe 1950 hour, it drops below 90 systolic, and it stays under 90 systolic until 2130.
Do you know of any reason why his blood pressure remained low, under 90 systolic, for that time period?
A. It can be the effect of Nipride. His peripheral vascular resistance is low probably at that point. It was Nipride at that point, previous to that, where it was just turned off, where he was

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febrile. That would be the possible things that might cause it.
Q. Doctor, also during that time period, he had Levophed and Epinephrine running.
A. Yes.
Q. Wouldn't you expect that that would bring his blood pressure up above 90 systolic?
A. Not immediately, though, but it can bring it up.
Q. And there were increasing doses of those two medications during that time period.
A. Yes.
Q. Would that raise a heightened concern that he may be having some type of bleeding problem?
A. No, but you see he responded to it, also with the fluids that were being given. The fact that the person responds to it, then I would accept.
Q. Looking over the flow sheet from the time he came in until the time that he left the ICU, are there any trends there that would indicate to you that this patient was having problems with excessive postoperative bleeding, aside from the chest tube drainage? Is there anything else that is concerning here?
A. No.

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Q. Did you have any conversations with Dr. Yared on the evening of August 20th, 1996?
MR. JACKSON: Regarding Mr. Long?
MS. TOSTI: Yes, regarding Mr. Long.
A. No.
Q. When you came in to see James Long sometime around 11:00 o'clock, were there any other physicians that were in the unit seeing Mr. Long or came into the unit while you were there?
A. That would be anesthesia staff, when we decided to bring him down for OR.
Q. Did you know who that was from anesthesia that came into the unit?
A. I don't remember exactly who the persons are.
Q. Who made the decision to return James Long to surgery?
A. Dr. Cosgrove.
Q. Now, you indicated that you had received a phone call from the nurses asking you to come in and check on Mr. Long, that you had gone into the unit to do so, and learned of the chest tube drainage that he had.
When you assessed him and found that he had, I believe, 350 ccs of chest tube drainage, how was the decision then made that he would go to surgery?

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And by that I mean, did you call Dr. Cosgrove, Dr. Muelbach? What was the process that was used to make the decision?
A. After I assessed this patient, as I was called, in the back of my mind I thought we had to come down, bring him down to the OR.
So I called Dr. Muelbach, I paged him, and he returned my call, and I believe he was on his cell phone. And I told him to come back, because he just dumped 350 ccs of arterial blood.
At that moment, after that, I called Dr. Cosgrove to inform him about his patient, and Dr. Cosgrove's decision was to bring him down immediately.
At that point, I called up the team, and that would include the anesthesia staff, the perfusionist, the nurses, and I instructed one of the nurses to inform the family of the situation and explain to them that we have to bring him down, because he has a bleed.
Q. While he was in the unit while you were there, did he become hemodynamically unstable at any time?
A. No.
Q. The nurses have indicated that he has a mean

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arterial pressure of 45 at, I believe it is 2330 hour, at Line S.
A. Yes.
Q. Does that indicate that he is hemodynamically stable?
A. The last pressure that I remember, before he came down, was 80 systolic, and that was -- I asked the anesthesiologist who was there with me to take his pressure before we came down, and his reading was 80.
Q. That 45 that is recorded there, is that a number that would show that he is hemodynamically unstable, if it is correct?
A. That would be borderline.
Q. Did you accompany him to surgery?
A. Yes.
Q. And after he entered the surgical suite, did his condition change at any time?
A. I believe it was when we were at the table, he was on the operating table, and I was prepping him, or I was putting Betadine on his chest, when the anesthesiologist told us that he had a very low pressure.
Q. Do you know what his pressure was at that point?

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A. It was like palpatory.
It was at that point that Dr. Muelbach opened up his chest for rapid resuscitation, rapid -- yes, resuscitation.
Q. How much after you arrived in the surgical suite with James Long did Dr. Muelbach arrive?
A. He was with me as we came down.
Q. So you met him en route to the surgical suite?
A. Yes.
Q. And then did Dr. Cosgrove arrive at some point?
A. Yes. He -- I remember he came in as we were -- we just opened the chest, and he came in, and he was already dressed up for surgery, he was already scrubbed.
Q. Now, did you remain in the surgical suite during the surgical procedure that took place when he returned to surgery?
A. Only for a few minutes.
Q. And what was the reason that you left?
A. Because I was called for another patient upstairs to attend to.
Q. You were there when Dr. Muelbach opened his chest for resuscitation?

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A. Yes.
Q. Are you aware of any findings once that chest was opened, as to what the problem was with Mr. Long?
A. I helped Dr. Muelbach open his chest. and what I saw -- the pericardium wasn't full of blood, and it was not fibrillating.
He injected an ampule of Epinephrine directly into the myocardium, and the heart started to work and generate pressures. And that was basically the resuscitation.
At that point, Dr. Cosgrove asked me to move, and I unscrubbed. And in a few minutes -- and I heard -- I actually did not see the leak that was mentioned here in the distal anastomosis, but I heard they were describing it.
At that point, I was called by G-53 for a very sick patient, and I had to leave the operating room.
Q. Did you speak *to* any of James Long's family on the evening of August 20th of '96?
A. No.
Q. At any time after that evening, did you speak with any of the family members?
A. No.

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Q. And after that second surgery, did you provide any additional care to James Long?
A. No.
Q. Do you have an opinion as to what point in time James Long suffered ischemic injury to his brain?
A. I really can't pinpoint when it happened.
Q. Did you have any conversations with Dr. Cosgrove regarding what happened to James Long, other than the phone call that you made to him just prior to the time that he went to surgery?
A. There was only one, one conversation with Dr. Cosgrove. That was, I believe, in the morning. He just asked me what was the lowest pressure we recorded, or we sort of -- yes, recorded, before we opened him up.
And I mentioned to him that the pressure was palpatory, that is what the anesthesiologist told us as we were opening up his chest.
Q. And that was --
A. That was the lowest I can remember.
Q. And what was the number that you told Dr. Cosgrove?
A. That would be about 40 systolic.
Q. 40 systolic?

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A. Something like that.
Q. And that was before his chest was opened?
A. That was just about -- just prior to opening up the chest.
Q. Did you have, at any point after the surgery, any conversations with Dr. Muelbach in regard to what happened to James Long?
A. Just the operative finding.
Q. And what did you discuss with him regarding the operative finding?
A. I just asked him what was -- what exactly -- where exactly was the bleed.
Q. What did he tell you?
A. He told me it was in the distal anastomosis.
Q. And when did you have that conversation?
A. That was in the morning.
Q. Was there any conversation with Dr. Cosgrove or Dr. Muelbach in regard to James Long's condition over the course of the evening on August 20th?
A. No.
Q. Do you have an opinion as to what caused James Long's postoperative bleeding?
THE WITNESS: Can I have an opinion on that?
MR. JACKSON: Do you have an opinion?

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A. No, no.
Q. Do you have an opinion, if he was taken back to surgery earlier on the evening of August 20th of '96, whether he would have suffered an injury to his brain, whether it could have been avoided?
A. No.
Q. Do you have an opinion as to at what point in time, if any, James Long's condition was irreversible?
A. I can't point.
Q. Was there ever any discussion at any time at a staff meeting as to what happened to James Long on the evening of August 20th?
MR. JACKSON: objection.
Go ahead.
A. Not that I recall.
Q. Do you have an opinion as to James Long's reasonable life expectancy, if he hadn't suffered severe ischemic brain injury?
A. I didn't even know the person, so I can't give an opinion like that.
Q. And are you critical of anyone who rendered care to James Long?
A. Absolutely not.
MS. TOSTI: I don't have any further questions for you, Doctor. And I thank you

for your time today.
MR. JACKSON: He will read it.
We will need time, because it has to be sent to the doctor.

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(DEPOSITION CONCLUDED)

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Dennis Hernandez, M.D.

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CERTIFICATE

State of Ohio, } ss:
County of Cuyahoga. }

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named DENNIS HERNANDEZ, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 9th day of June, 1999.

Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.

My commission expires November 5, 2003.

*** Notes ***

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4. Philippine Board of Thoracic &
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1.Parietal Cell Vagotomy, Philippine General Hospital
Experience, 1989
2.Comparison of Single Layer Interrupted Inverting
Versus Single Layewr Continuous, End-on Sutured
Anastomosis in Rabbit Colon, 1991
3.Sigmoid Volvulus: A Plea for Early Surgery,
Published in the Asian Journal of Surgery, 1991

4. Pulmonary Embolisms : 25 Year Experience at the Cleveland Clinic, (for publishing) 1996
5. Intra-operative Dissecting Aortic Aneurysms: 20 Year Experience at the Cleveland Clinic