IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

CASE NO. 397309

COPY

BESSIE M. BROOKS, individually
and as Administrator of the
Estate of LEE THOMAS BROOKS,

Plaintiff,

vs.

THE CLEVELAND CLINIC FOUNDATION,
et al.,

Defendants.

_____/

1150 Campo Sano
Miami, Florida
Friday, November 17, 2000
12:30 p.m.

DEPOSITION OF MOISES JACOBS, M.D.

Taken before CAROL LENETT, Shorthand Reporter and Notary Public in and for the State of Florida at Large, pursuant to a Notice of Taking Deposition filed in the above cause.

A P P E A R A N C E S:

ON BEHALF OF THE PLAINTIFF

BECKER & MISHKIND CO., L.P.A.
Skylight Office Tower
1660 W. 2nd Street
Suite 660
Cleveland, Ohio 44113
By: HOWARD D. MISHKIND, ESQUIRE
(216) 241-2600

ON BEHALF OF THE DEFENDANT

REMINGER & REMINGER
The 113 St. Clair Building
Suite 700
Cleveland, Ohio 44113
By: JAMES M. KELLEY, 111, ESQUIRE
(216) 687-1311

I N D E X

* * * * *

Thereupon:

MOISES JACOBS, M.D.

was called as a witness and, after having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. MISHKIND:

Q. Would you please state your full name for the record.

A. Moises Jacobs.

Q. You are a physician, correct?

A. Yes.

Q. Doctor, your place of birth is Havana, Cuba, true?

A. Yes.

Q. You're a United States citizen, true?

A. Yes.

Q. You have had your deposition taken before, true?

A. Yes.

Q. Do you have available in your office a current curriculum vitae that you could provide me?

A. We can ask.

MR. MISHKIND: We will *go* off the record for a moment.

(Brief interruption.)

BY MR. MISHKIND:

Q. How many years have you been doing medical-legal reviews?

A. I don't know. Probably less than five or six. I really don't remember.

Q. You've been asked that question before in depositions, true?

A. Not how many years I've been doing it, no.

Q. You haven't?

A. No.

Q. How many cases have you reviewed over the number of years that you have been reviewing cases?

A. I get to see a lot of cases. So I guess I review a lot of cases, but I don't take many on.

Q. Let's talk over a five-year period.

Tell me how many cases over a five-year period you have reviewed?

A. 30 or 40 maybe.

Q. Of those 30 to 40 cases, what percent of them have been for the defense?

A. Most of them for the defense.

Q. When you say, "most of them for the defense" in excess of 80 percent for the defense?

A. No, because when. I review them I may not take them on when -- depending on the case.

Q. Well, specifically, Doctor, when you're asked to review cases tell me of the cases that you have reviewed, the 30 to 40 percent of those cases, how many of them have been reviewed regardless of what your ultimate conclusions are? How many of them have you reviewed at the request of defense attorneys?

A. I think probably three-fourths, more or less.

Q. When you use the term 80 percent, would that be a fair statement?

A. That's a pure guess. I could tell you the majority but it's a guess.

Q. When you testified before, you weren't guessing as to the percent, were you?

A. I would tell people that I'm not sure what the number is.

Q. So that your testimony would be that you probably reviewed, as opposed to guessing, that you probably reviewed three-fourths to 80 percent for the defendant?

A. Probably, yes, sir.

Q. So that's an accurate statement?

A. Probably yes, sir.

Q. You have never testified at trial for a plaintiff in a medical malpractice case, have you?

A. I have.

Q. Is that very recently?
A. I think either last year or the year before.
Q. Last year as in 1999?
A. Right. I think it was 1999.
Q. And what state or county was that?
A. Washington, D.C.
Q. Who was the attorney that you were working for in that case?
A. That I don't remember, sir.
Q. What was the name of the patient?
A. I don't remember. I have to go back and look at them.
Q. You have a record of that?
A. Probably my secretary, yes.
Q. That's the only plaintiff's case that you ever testified in trial on behalf of the plaintiff, true?
A. Yes.
Q. You believe that was sometime in 1999?
A. I think so, yes, sir.
Q. Assuming we have enough time, and we're not rushed at the end of the deposition, I would like you to have your secretary check and find out the name of the attorney that you did work for.
A. Yes.
Q. You have testified at trial on behalf of

doctors in the past, true?

A. Yes, sir.

Q. How many times have you testified in trial?

A. Just before you asked me that question I was trying to remember because I figured it would be coming. Six or seven, maybe.

Q. How many times have you testified at deposition?

A. Depositions are more than that. I don't keep records of that.

Q. I'm not suggesting you necessarily keep records, but since you've been deposed before I would assume that when that question is asked, and I'm not coming up with a unique question, that you have given answers under oath in response to those questions, and I'm asking you the same way, in terms of what is the estimate, if you will, in terms of the number of times that you've testified at deposition?

A. Probably the estimate, 25.

Q. Other than the one case that you testified in Washington, D.C. as plaintiff's expert, have you ever given a deposition in a plaintiff's case where your deposition was taken as a plaintiff's expert?

A. There was one other case that I can recollect and I don't remember the name of the lawyer.

Q. Do you remember how many years ago that was?
A, Maybe three or four.
Q. Was it here in Florida?
A, Yes,
Q. Was it in Dade County?
A. The case?
Q. Yes.
A, The deposition was here in Dade County.
Q. Where was the case filed?
A. That -- I don't remember that either. I don't remember. There was a case in California, I'm trying to remember if that is the one but I can't give an accurate statements.
Q. Is it fair to say of the approximate 25 depositions that you've given, twice you've testified at deposition as a plaintiff's expert, the one that you testified at trial in Washington, and this other case that might possibly be a California case?
A. I don't know if it's accurate but it's fair.
Q. If I'm over --
A. By one or two at the most.
Q. Fair enough.
You worked with attorneys up in Ohio, true?
A. Yes.
Q. You worked with the Reminger & Reminger firm

in the past?

A. Yes.

Q. And Reminger & Reminger sent you a number of cases, true?

A. Yes, sir.

Q. You testified previously that they have sent you tough cases, haven't they?

A. Yes.

Q. How many times, in fact, have you been called upon by the Reminger & Reminger firm to review cases?

A. Ten. That's a guestimmate also.

Q. Is that a reasonable estimate? Might be off by either one or two either way?

A. Probably.

Q. How many times have you worked with Mr. Kelley before?

A. I met him on one other case. I don't remember if you were the lawyer for --

MR. KELLEY: Just so you're aware Howard, I hopped on a case when I was at Jackson, Maynard with Peter Vuadouris. That's where he met me. I was at the table but he never questioned me.

BY MR. MISHKIND:

Q. Do you remember the name Vuadouris?

A. Difficult to forget Peter.

Q. I'll stipulate to that.

In any event, it's most likely the situation where you met Mr. **Kelley?**

A. I'm pretty sure. It has to be, yes.

Q. Has Mr. Kelley sent over cases to review other than the Brooks case?

A. I can't -- I'm going to ask him because I can't remember.

Q. Just do the best you can because I'm taking your deposition, not Mr. Kelley's.

A. I'm going to say no.

Q. But you were acknowledging that you have been sent approximately ten cases by the Reminger & Reminger firm, true?

A. Yes, sir.

Q. You have given depositions in other cases for the Reminger & Reminger firm, true?

A. Yes, sir.

Q. And, in fact, you testified at trial up in Ohio as an expert defending a doctor that the Reminger & Reminger firm was defending, true?

A. Yes, sir.

Q. Tell me --

MR. KELLEY: I was at Jacobson Maynard at the time.

THE WITNESS: I don't keep track of firm's name, I apologize. I don't know if it was Reminger & Reminger or Jacobson and Maynard, but I have testified up in Ohio. I think I testified three times in Ohio, and it was two and half years ago, to the best of my recollection.

BY MR. MISHKIND:

Q. All of these cases were defending doctors, true?

A. Yes, sir.

Q. How many cases do you believe you reviewed over the years for the Jacobson, Maynard law firm?

A. Probably included in those ten -- I included everything from my -- in my mind what was Jacobson or Reminger, I didn't differentiate.

Q. Do you know how it is that the Jackson, Maynard firm or the Reminger & Reminger defense firm got your name?

A. They sent me a case about three or four years ago or five years ago, whenever it was, and they liked the way things came out, and they thought I made a good witness, I guess.

Q. That was one of those tough cases they sent you, true?

A. I think so.

Q. In fact, Doctor, you've reviewed cases for attorneys in other states besides Florida and Ohio, true?

A. Yes.

Q. You indicated Washington, D.C. and California, true?

A. Yes, sir.

Q. How many other states have you actually testified in cases that were pending in those other states?

A. Trial.

Q. Trial or deposition?

A. I know there was one in Georgia, a deposition from Georgia. I'm sure there are a couple more, sir. Not too many.

Q. Your charge for today for your deposition is how much?

A. Usually it's $500 an hour.

Q. Am I going to be charged the usual rate or am I going to be charged a different rate?

A. Usual. Going to be charged usual and customary.

Q. And your charge for review of medical-legal matters is it still $400 an hour?

A. Yes.

Q. That's how much you've been charging

Mr. Kelley, $400 an hour?

A. That's correct. I really don't know.

MR. KELLEY: If you charged me five, I'll ask for a refund.

BY MR. MISHKIND:

Q. I'm asking what you charge.

A. Between 4 and $500, basically.

Q. And your charge for trial testimony, what is your charge per day for trial testimony?

A. Probably about $5,000 per day.

Q. In fact, you charge somewhere between $5,000 and $7,000 a day, depending upon the case, correct?

A. That's true yes, sir.

Q. You also get paid travel expenses on top of that, true?

A. Yes, sir.

Q. Have you at any time advertised your services as an expert witness?

A. No.

Q. Have you made your name available to any companies that provide expert witnesses?

A. No, sir.

Q. I have a report that was written by you on October 11 to Mr. Kelley. It's a two-page report.

Is that two-page report, dated October 11,

the only letter that you've written to Mr. Kelley?

A, Yes, sir,

Q. There is nothing else that you've written to him since or before?

A, No.

MR. KELLEY: Except maybe a bill,

BY MR. MISHKIND:

Q. Other than billing?

A, I didn't write it though.

Q. Tell me prior to October **11** when you were first engaged to participate in this case?

A, Maybe one or two months before that,

Q. You have all the material with you today that you have reviewed?

A, Yes.

Q. In a moment I'm going to take a look at that, You don't have to pull it up yet.

You got your entire file with you today?

A, Yes, sir,

Q. Has anything been removed from the file in terms of content of material that you have reviewed?

A. No, One of the notebooks that was individual pages it fell apart and all the pages are there now.

MR, KELLEY: The medical records fell apart,

BY MR. MISHKIND:

Q. During your meeting with Mr. Kelley, were there any items that were removed by way of written documents?

A e No.

Q. Have you been provided with any summaries of any of the deposition testimony?

A. There is some depositions there, and I don't think we have any summaries in them.

Q. When is the last time you testified in trial anywhere?

A. Probably the Washington, D.C. case,

Q. When was the last time your deposition was taken?

A. Maybe sometime last year. It may be a while since the last deposition. I don't remember exactly, sir.

Q. Did you testify at trial in the Hollick case?

A, No, The Hollick case. Dr. Hollick?

Q. Right.

A. No.

Q. You remember your deposition being taken in that case?

A, Yes, Is that last year by the way?

Q. Do you remember your deposition being taken

since then?

A. I don't remember. May have. Maybe sometime early this year. I really don't know.

Q. Fair enough.

How many cases in the year **2,000** have you been asked to review?

A. Six.

Q. Do you have six active cases currently that you're involved in in one way or another?

A. What happens is somebody might send me a report, and three months later they say, you know, we settled that case. So probably right now I think there are two other cases.

Q. And the Brooks case is the third?

A. I'm trying to think because -- yes, sir.

Q. And the other two cases are defense cases, true?

A. Yes.

Q. When you wrote your report to Mr. Kelley, there were no references to any depositions having been reviewed in the October 11, letter, true?

A. If I didn't write them, they were not reviewed at the time.

Q. Have you reviewed any depositions in the October 11 report?

A. Yes, sir.

Q. In a moment I'll take a look at the material and we will summarize on the record.

I want to find out in terms of preparing this report what information you relied on.

Am I correct in stating on the record that you were relying on the hospital records as opposed to the hospital records plus deposition testimony?

A. Correct.

Q. The curricular vitae that you handed to me is current as of November '99.

You are a laparoscopic surgeon, true?

A. A general surgeon.

Q. Your surgeries are laparoscopic, true?

A. Yes, sir.

Q. Tell me what percent of your surgery by circumstance happens to be laparoscopic?

A. Probably 60 percent.

Q. Have you ever had your privileges revoked, suspended or brought into question?

A. No.

Q. You have been named as a defendant in a medical malpractice case in the past, true?

A. Yes, sir.

Q. One time?

A, Three times, I think,

Q. Do you have any cases currently pending against you?

A. There is one where I was a second assistant in a patient that had a previous gallbladder a week prior. They took her to surgery and two surgeons, I was not involved with that patient at all, and in the middle of the case they call me in to help the patient.

I was there for an hour and a half and never saw the patient before, never saw the patient after, and never named. Everyone in the lawsuit was trying to get me out of it.

Q. You feel you should not be in that case?

A, Not in that way, no, sir,

Q. Is there anything more pending against you also?

A. I hope not.

Q. The others that were filed against you have since been resolved?

A. Yes, sir.

Q. One the case was settled, true?

A. Yes, sir.

Q. Monetary payment was made in that case?

A. Yes.

Q. What about the other case?

A. Settled also.

Q. In your CV you have a number of speaking and teaching appointments that are referenced, true?

A. Yes, sir,

Q. And a number of publications, true?

A. Yes, sir.

Q. Do any of the speaking engagements or publications have any relevance, in your opinion, to any of the issues that are pertinent or material to this case?

A. I don't understand, I'm sorry. Say it again.

Q. I'll break it down into maybe a smaller portion.

Of the publications that you authored yourself or co-authored, are any of them relevant to the subject matter of the opinions that you hold in Mr. Brooks' case?

If ou need to look at your CV to answer that question, I'll be happy to hand it to you,

A. Probably not directly related to this case.

Q. Is there any indirect relationship to any of the issues that you intend to testify to at the trial next month in Cleveland that have any relevance to --

A, That's why I hesitate a little bit because sometimes you give a lecture about complications and one

of those complications is bleeding, et cetera, and that's why I hesitated in saying yes or no.

Q. Why don't we do this. Why don't I mark this as Plaintiff's Exhibit 1 and hand it to you, we'll go off the record and you'll look at this, and I'll also take a look at your material in the meantime, and we will try and kill two birds with one stone.

(Brief recess,)

(Thereupon, the document referred to was marked for identification as Plaintiff's Exhibit 1.)

BY MR. MISHKIND:

Q. Doctor, you have had a chance to look at Plaintiff's Exhibit 1, which is a copy of your CV, true?

A. Yes, sir,

Q. And I think my question was to ask you whether any of the publications or speaking and testifying points have any relevance to the subject matter that you are providing expert opinions in?

A. I don't think they do, no.

Q. That would be directly or indirectly, true?

A. Some of those complications, some of these lectures on complications, and I'm sure those complications are through bleeding, but basically, yes, it would be a very, very small amount of a relation.

Q. You would certainly stand by what you have

stated in these publications if there are statements in there about post-operative bleeding, true?

A. Yes.

Q. Have you reviewed any medical literature in formulating any of the opinions that you expressed in your report?

A. No.

Q. Are there any studies or articles or book chapters that you believe to be subjective of any of the opinions that you have expressed in your report?

A. No.

Q. As far as material that you have reviewed relative to medical literature, have you reviewed anything since your October 11 report?

A. No.

Q. Do you intend to do any medical literature review between now and the time of trial?

A. I don't think so, no.

Q. I'm again referring to your report, dated October 11.

You were kind enough to let me take a look at the material that you have been provided, and I see the volume of records which have sort of come out of their hinges. Is that what you had when you prepared your report, true?

A. Yes, sir.

Q. You have a number of depositions that have been sent to you since your October 11 report, true?

A. Yes, sir.

Q. Have you read all those depositions over?

A. I read one or two total and completely. The rest I skimmed because it's just -- I've skimmed most of them.

Q. Let me ask you, are you in a position if I ask you specific questions about testimony in each of the depositions, and I will acknowledge for the record that it appears that these depositions were sent to you by Federal Express on November 7, which would be ten days ago, at least they left Cleveland on November 7. When they arrived here I'm not sure.

A. They came in batches. I think the last one was a week ago but they came in batches.

Q. And you have a number of depositions in the November 7 Federal Express, and have you reviewed those depositions that came down on November 7?

A. I reviewed enough to be able to answer.

Q. I don't see that you have a copy of the deposition of Nurse Martinez.

A. I reviewed the nurse that is from India. I don't remember ever reading Martinez.

Q. Do you know who Nurse Martinez is?

MR. KELLEY: I don't think I have Martinez' depo. Have you gotten it?

MR. MISHKIND: Sure.

MR. KELLEY: I got them piecemeal and I don't know why but I don't know if I received it yet, to be honest.

BY MR. MISHKIND:

Q. In any event, I did from the court reporter. You obviously have not seen Nurse Martinez' deposition, true?

A. No.

Q. As you sit here now, do you know who Nurse Martinez is?

A. I know there was a nurse that was taking care of the patient, and I think her name was Martinez.

Q. When was that nurse, according to your review, taking care of Mr. Brooks?

A. I think the day that they put the peg in. One of those shifts. When I read the nurse's notes, I think I saw Martinez. I have to go back and check.

Q. As you sit here now, do you know what shift that nurse was involved, Nurse Martinez?

A. Probably the shift before the lady from India, I don't remember the name, the Indian nurse

worked.

Q. Other than the depositions which you have reviewed, and you read over Dr. Grunfist?

A. Yes.

Q. Do you know Dr. Grunfist?

A, No, sir.

Q. Do you know her by reputation?

A. No.

Q. Let me ask you, to save some time, do you know any of the doctors that depositions you have reviewed?

A, No.

Q. Dr. Brezinski, is a gastroenterologist. Do you know Dr. Brezinski?

A. No.

Q. Do you know Dr. Preston, whose deposition I see is in the material?

A. I do not.

Q. Have you ever lectured at Cleveland Clinic Foundation?

A, No.

Q. Do you know any physicians from the Cleveland Clinic Foundation?

MR. KELLEY: In Cleveland or Florida?

BY MR. MISHKIND:

Q. In Cleveland. Thank you.

A. I know some physicians, but I don't know them personally, but I know it's a wonderful clinic and they're all very reputable.

Q. You recognize, even though it's a wonderful facility, and they're all reputable, that doctors at the Cleveland Clinic, as well as doctors at any other institution, can make mistakes?

A. Yes, sir.

Q. When they makes mistakes, they should be held accountable and responsible for their mistakes, true?

A. I agree with that.

Q. If mistakes in diagnosis or treatment led to the death of a patient, that institution as good as it may be, should be held accountable, true?

A. Yes, sir.

Q. Now, Cleveland Clinic, Fort Lauderdale, do you have any association or relationship to --

A. I know them from reputation, but that's about it.

Q. You're not a gastroenterologist, are you?

A. No, sir.

Q. Board certified in general surgery, correct?

A. Yes, sir.

Q. Are you board certified in trauma?
A. No.
Q. You board certified in vascular surgery?
A. No, sir.
Q. Do you know Dr. Joseph Dimine?
A. No.
Q. You read his reports over or have you read his report?
A. I don't think I read his report.
Q. Were you aware that there was a surgeon involved in this case that has provided opinions on behalf of the plaintiff?
A. I knew there was a plaintiff's expert, yes, sir.
Q. How many experts are you aware of from the plaintiff's side?
A. I know that there was a rheumatologist, and I knew of the surgeon, but I haven't read his report, you know. I can tell you something, I have a lot of trouble remembering these people's names. They're all weird names. It's not Jones or Smith. So my mind -- and sometimes I get them mixed up. So I apologize if I'm slow in answers.
Q. Doctor, the only reason I'm asking these questions, you realize that serving as an expert witness

is an important role, correct?

A. Yes.

Q. And that the foundation for your opinions is something that is important before arriving at an opinion, true?

A. Yes.

Q. Just like the foundation for working up a patient and arriving at sufficient information to make a diagnosis before you treat a patient, there are certain steps that have to be taken, correct?

A. Yes, sir.

Q. There are certain circumstances where you have more time to act and certain circumstances where the diagnosis can be quicker depending on the gravity of the situation, true?

A. Yes.

Q. And if a patient has an intra-abdominal bleed that can kill the patient, obviously the gravity of that situation demands that the diagnosis be made as quickly as possible, true?

A. Yes, sir.

Q. And that definitive and appropriate treatment be provided as quickly as possible, correct?

A. Yes, sir.

Q. And you have no doubt that the Cleveland

Clinic Foundation had the wherewithal to make the right diagnosis and treat the patient in a timely manner; do you?

A. Do I have a doubt?

Q. Do you have a doubt that they had the ability to make the right diagnosis and treat the patient in a timely manner?

A. No.

Q. And that diagnosis and treatment, they had the ability to make that diagnosis whether it was in the middle of the night or the middle of the day, true?

A. True.

Q. You are not a board certified internist, are you?

A. No.

Q. You are not a board certified rheumatologist, correct?

A. No, sir.

Q. Nor are you a board certified neurologist, correct?

A. No.

Q. You don't treat patients with polymyositis, true?

A. Not as a primary doctor, no, sir.

Q. And I take it you're not intending to provide

opinions on the issue of the long term prognosis for Mr. Brooks had he survived the incident in which we are here to talk about; is that correct?

A. I think he was a very sick man but I don't know much about the disease itself, no, sir.

Q. Do you intend to provide an opinion how long Mr. Brooks would have lived had he not sustained the multi-system organ failure?

A. No, sir.

Q. Are you intending to provide any opinion as to what the quality of Mr. Brooks' life was immediately before coming into the hospital?

A. In that regard the answer is yes. He was very sick when he came to the hospital. He didn't have much quality.

Q. How long had he been, according to your review, poor quality of life?

A. Poor quality is a very subjective term. What I'm referring to is that he was not always alert and oriented, and he had a lot of difficulty with polymyositis. Was not comfortable. He was -- from the review of records, and from what I could gather, he wasn't such a happy man, and I don't know how long that was going on.

Q. How long had he had difficulty with the

polymyositis according to your review as an expert in this case?

Am I have to go back and look at the records. They mention several times. It's been going on for a while, I have to look and see,

I think from looking back, and looking at the physical, approximately a month before he came -- been in the hospital,

Q. You've never talked with the family of Mr. Brooks, true?

A. No, sir,

Q. You've not seen the deposition transcript from the family either?

A, No.

Q. As far as the quality of life that he had or the enjoyment of life that he had and his family had prior to his entering the hospital, you cannot comment at all about what Mr. Brooks' life was like as a 65-year old gentleman?

A, I can only comment, and these are very subjective ideas, he was -- he used to abuse alcohol in the past. So I think that your past was not so happy at times, and then the fact that he's been sick with multiple problems, including heart bypass, and the fact he has myositis, and not always alert and sometimes

confused and complains of pain and not cooperative.

Q. What?

A. Sometimes he was not cooperative with the doctors and staff. That's what I'm referring to. You asked the quality of life and that's it. Not in any other terms.

Q. You would certainly agree with me that the person in the best position to talk about the quality of life that Lee Brooks enjoyed would be family members?

A. Yes.

Q. You talk about abusing alcohol.

Was Mr. Brooks having problems with alcohol that was in any way, shape or form, affecting the quality of his life in 1998?

A, I don't know, I can't answer that. I'm just stating that he had an alcohol abuse in the past

Q. Let me reverse that and ask you whether or not you have any evidence that would permit you under oath to suggest that Mr. Brooks' quality of life and his well being was negatively impacted in 1988 as a result of the alcohol?

A. I don't know if in his case his alcohol abuse led to multiple other problems, medical problems in that regard. That's the only --

Q. Can we agree that based upon what you have,

and as you're sitting as an expert about to testify in this trial we have in less than a month, that you can't indicate, to a reasonable degree of probability, that the alcohol that was historical in nature was having any adverse affect on Mr. Brooks in May and June of 1998, true?

A. I don't -- I can state, again going back to the time that he had some type of confusion and he was not cooperative, I don't know if that's a result of the alcohol or not.

Q. Do you have any basis to state to a probability that it was or can we agree, as you sit here today, that you have no medical basis to state to a probability that Mr. Brooks' existence and quality of life in May and June of '98 were being negatively impacted by a past history of alcohol?

A. The answer to that is, I don't know.

Q. Fair enough.

Have you been asked, besides literature, which we talked about, have you been asked to review any additional materials between now and the time of trial?

A. No, sir.

MR. KELLEY: The only thing as the depos keep coming in, I don't have the family members depos yet either, but as they keep coming in I'll keep sending

those down.

BY MR MISHKIND:

Q. Doctor, I would ask, just for the record, and as a housekeeping matter, if any of the opinions that you intend to provide at trial should be changed in any respect by what you learn from those depositions, would you please immediately advise Mr. Kelley so he can let me know before -- certainly before you fly up to Cleveland and take the witness stand?

A. Yes, sir.

Q. The purpose of my deposition here today is to find out the opinions you hold and the basis for those opinions. Not to find out about that after the direct examination has been finished by Mr. Kelley, fair enough?

A. Yes, sir.

Q. Doctor, have you ever inserted a peg tube?

A. No, sir.

Q. Have you ever been called upon to perform an exploratory laparotomy on a patient that had a complication following a peg tube?

A. Yes, sir.

Q. On how many occasions?

A. Again, I'm going to guess. I would tell you seven cases over the last maybe once a year, once every two years. Maybe ten cases over the last ten years.

Q. Any cases that you've experienced over those years similar in any respect to Mr. Brooks?

A. No, sir.

Q. Did any of those patients that you were called upon to do exploratory laparotomies for I presume for intra-abdominal bleed?

A. They were not for intra-abdominal bleed. These were for -- they were like a gastrotomy tube had pulled away, and we have an open tube on the abdominal cavity, basically.

Q. Have you been called upon to do an exploratory laparotomy where there was an intra-abdominal hemorrhage following a peg tube placement?

A. I have been called to evaluate patients who had some -- thought that they were bleeding intra-abdominal after peg tubing.

Q. What steps did you take to evaluate those patients?

A. The way that the diagnosis was made, if I remember, because it's not a very common occurrence and it only happened to me once. We order a cat scan, and the cat scan showed obviously bleeding, obvious blood from that place but the patient just stabilized, stopped bleeding, and we didn't take him to surgery.

Q. Where was the bleeding coming from?

A. We didn't take him to surgery. So we don't know.

Q. At the time that cat scan was done the patient had already stabilized?

A. I think -- I don't know if it happened at the time that it was done or right during this time. When we decided what to do we noticed he stabilized and we stopped.

Q. A cat scan was done on a stat basis, true?

A. Yes, sir.

Q. You were looking to rule out any type of intra-abdominal hemorrhage, true?

A. Yes.

Q. Or confirm it?

A. Right.

Q. And the fact that the patient stabilized was a good sign, correct?

A. Yes, sir.

Q. Mr. Brooks never stabilized, did he?

A. I think Mr. Brooks' blood pressure stabilized. I don't think he as a whole stabilized.

Q. When do you think his blood pressure stabilized?

A. From looking at the report, the blood pressure was a hundred, give or take. Sometimes higher

or lower. It was around a hundred.

Q. He remained in shock, did he not, from 2:20 all the way up to the time that he was taken to surgery?

MR. KELLEY: 2:25 you mean.

BY MR. MISHKIND:

Q. I think it's 2:25.

A. I think from 2:25 on Mr. Brooks was a very, very sick man the whole time.

Q. He was in hypovolemic shock from 2:25 on, true?

A. I think so.

Q. Do you know how long before 2:25 a.m. Mr. Brooks was in shock?

A. It seems to me from reviewing some of the notes it happened right around 2:20.

2:25 when he started to bleed, the nurses were there and they caught it very quickly.

Q. We will talk about the specifics about that in a moment.

I want to get an overview of the situation that the patient stabilized and didn't need emergency surgery.

A. Correct.

Q. Have you talked to any of the doctors or nurses that were involved in this case?

A. No.

Q. Have you consulted with anyone, any one of your colleagues concerning this case?

A. No, sir.

Q. In looking at the depositions and the records I perused through, actually they're more than that. I leafed through, all six pages. I don't see notes or dog ears or anything indicating anything highlighted or pointed out in the review, true?

A. Yes.

Q. Do you have any written notes that you prepared as you were reviewing all of the records?

A. No, sir. The only thing, but I threw it away, was I tried to write down some of the times on the hemoglobins when I started looking at it, but I threw it away a long time ago, one little sheet of paper.

Q. Why did you throw it away?

A. It was hanging around and you can see with all those papers I didn't want more.

Q. Did you throw it away or did you lose it?

A. Probably threw it away.

Q. When you prepared the report, did you prepare it yourself?

A. Yes, sir.

Q. Typed it yourself?

A. No, sir.
Q. Dictated it?
A. I actually wrote it out and gave it to my secretary.
Q. Then she gave you back a draft of the report?
A. Yes.
Q. Then you made some changes to the report?
A. I don't remember making any changes to the report.
Q. So the report, once she typed it out, was exactly how you signed it and sent it to Mr. Kelley?
A. As far as I remember.
Q. Did you discuss the contents of your report with Mr. Kelley before signing the report?
A. I think -- I don't know. I read it to him. I don't know if it was after I signed it or before.
Q. So you called him up on the phone, told him I finished reviewing the case, and read to him what you were about to send up to him, true?
A. He actually called me and said he wanted a report when I was through with it. When I was finishing the report I called him up.
Q. After finishing the report, you called him up and read him what you were going to send to him, correct?
A. Yes, sir.

Q. And then proceeded to send the report to him after your conversation?

A. Yes, sir.

Q. Given the material I looked at, I don't see any reference to any cover letter from Mr. Kelley that would indicate the specific issues that you were asked to address; is that true?

A. I don't remember any cover letter except to the fact that this is a case, Brooks versus whatever. That was about it.

Q. What is your understanding as to the assignment or what issue or issues you were asked to address in this case?

A. I thought I was looking at it from the surgical, I'm a surgeon. He wanted me to look at it from the surgeon's point of view.

Q. Your intent is to testify as it would relate to the surgical care of this patient?

A. Basically, yes. That's what I'm looking at, the events leading up to it and the surgery.

Q. Doctor, based upon your review in this case, is there any indication in the medical records of any of the physicians or the nurses contacting general surgery to consult in this case prior to 5:30 in the morning on June 5, 1998?

A. I read the depositions where someone said they contacted earlier but in the medical records all I saw was 5:30.

Q. Whose deposition is it that you reviewed that said they contacted general surgery?

A. I think the resident that came into the floor, the one that resuscitated, that said she told the nurse to call surgery.

I don't remember the name. I have to look.

Q. Would you agree with me, however, that there is no indication in the records from any of the nurses or any of the other physicians that were involved that would permit you to confirm her statement that general surgery was contacted prior to 5:30 in the morning, true?

A. That's true.

Q. And there are a number of people there, nurses, there is a number of residents involved, and none of them make mention of general surgery being consulted ASAP until 5:30 a.m., true?

A. I think the comment or the fact that he made about bleeding, intra-abdominal bleeding, but as far as calling general surgery the first I see is 5:30.

Q. There is no reference to general surgery coming up to see the patient either on the medical floor or the medical intensive care unit at any time earlier

than 5:30, true?

A. That's true. As far as I read, it's true.

Q. In fact, from everything that you have reviewed on general surgery or the resident doctor, the general surgeon didn't actually come up to see the patient until some time at or around six a.m., true?

A. According to the medical records it was six o'clock.

Q. Would you agree with me, that general surgery should have been contacted prior to 5:30 once it was determined that Mr. Brooks had an intra-abdominal hemorrhage?

MR. KELLEY: Objection to the part of the question that is "once it was determined."

BY MR. MISHKIND:

Q. Go ahead.

A. The way I look at this record, sir, I'm not even sure they should have been contacted then. I think this patient, once this patient arrested and then -- I think it's stated as hypotension, and went to a full code in a matter of an hour and a half, two hours, I think think that patient was not going to survive.

Q. Once the patient arrested your opinion there was no need to contact surgery?

A. My opinion is that a general surgeon would

have made no difference. In fact, when they took him to surgery he was not bleeding and the patient ultimately died anyway.

Q. We will talk about what was discovered at the time of surgery, but we can agree that he was not taken to surgery. He wasn't prepared to go to surgery until 10:45 a.m., correct?

A. Correct.

Q. He was in the O.R. with the surgery starting sometime shortly after 11 a.m., true?

A. Yes.

Q. And general surgery, the resident was not consulted or did not consult in terms of coming up and assessing this patient until at least 6 a.m., true?

A. Yes, sir.

Q. Now, I'm going to ask you again, would you agree that general surgery should have been consulted prior to 5:30 with the request for the consultation if, in fact, it was felt by the medical team that was treating this patient that the most likely explanation for his shock and his hypotensive condition was that he had an intra-abdominal bleed, true?

A. My opinion is that general surgery made no difference in this case.

Q. I'm not suggesting for purposes of my

question that they did or didn't, but you would agree with me that there was a point in time where this patient was being treated by the medical team and had not arrested, true?

A. There is a point in time where he was being treated, was hypotensive, probably unstabilized but had not arrested, correct, yes, sir.

Q. During that period of time when he was hypotensive, unstabilized, the vital signs, as well as his labs, would suggest that the patient was in shock, true?

A. Yes, sir.

Q. And the most likely explanation, given the procedure that had been done earlier that morning, and given the fact that the EKG did not show that he had a heart attack, the most likely explanation was an intra-abdominal hemorrhage, true?

A. I think as an ongoing process you don't say the most likely explanation is hemorrhage.

Like I stated a while ago, bleeding from a peg is very unusual, very, very unusual. This gentleman had multiple problems that started. He developed acute hemolysis from his blood from one of the medications. He had a heart attack that the EKG was normal.

What if he threw a pulmonary embolus, what if

he was in DIC, and someone commented in their evaluation --

Q. We're going to talk about that, but my question to you, Doctor, and I appreciate you're bringing that up, and believe me we're going to talk about those items.

If general surgery was consulted, as is suggested by one of the doctors at 2:45 to 3:00 a.m. and the labs were back, there was knowledge that the patient's hemoglobin had dropped not only by arterial blood gases but by a CBC from approximately 13.9 in the afternoon to down to 8.6 to 9, that the patient was remaining hypotensive, notwithstanding being given a bolus of saline, that the patient was demonstrating abdominal distension, and assuming all this information which would be available was shared with general surgery, would you expect that a reasonable and prudent general surgeon would come up and see the patient?

A. I guess in the best of all worlds the answer is yes, of course.

Q. And certainly if there is nothing preventing that general surgeon from coming up to see the patient with those facts you would agree that the standard of care would require that general surgery come up to consult on that patient, true?

A. It all depends on what transpired in that conversation, because if you're the medical doctor and you call me as a surgeon and tell me I have a patient who is very hypotensive, hemoglobin dropped four points, and we don't know if he had a heart attack, we don't know -- all those other conditions we talked a little while ago, I would tell you why don't you figure this out before I even take this man to surgery because I could probably hurt him a lot more if you're wrong or I'm wrong. I take the man to surgery with no intra-abdominal bleed.

Q. Once you got the EKG back, and you're satisfied the patient is not having a heart attack or some ischemic incident going on, would you agree that general surgery, with a drop of hemoglobin of that level, with abdominal distension, with the patient remaining hypotensive, that general surgery should consult and see the patient even if it's in the middle of the night?

MR. KELLEY: Object. The beginning of your question is totally contrary to what he told you earlier. You said if an EKG rules out ischemia. EKG does not rule out ischemia, Howard, you know that. I don't want that fact that was a long time ago in the question to be lost. Barring that objection you can answer.

MR. MISHKIND: Before he answers, if the evidence that one would be looking at to determine

whether or not there was an infarction or any myocardial ischemia going on if that was satisfactorily with by the medical team, and that the medical team from their assessment felt that there was an intra-abdominal bleed as the most likely cause for the patient's hypotension and shock, and general surgery were contacted in the 2:45 to 3:00 o'clock time period, would you agree that a reasonable and prudent general surgeon should come up and see the patient?

MR. KELLEY: Objection, you can answer.

THE WITNESS: You said something which caught my ear, but if they said the diagnosis of intra-abdominal bleed yes, the general surgeon should be contacted. That is part of the last thing once they made that diagnosis, but you also referred to abdominal distension, and you know if every time a patient who is sick like this gentleman developed abdominal distension and hypotension they call a general surgeon, you know, they call me to establish why and what caused it, the distension or -- not just cardiac, ruling out cardiac problems, but all the other problems.

BY MR. MISHKIND:

Q. And I don't disagree with you, but if the medical team that is caring for the patient has sufficient clinical information, laboratory data,

diagnostic studies that have been done, and based upon the examination of the patient they contact general surgery and provide all the information that is available at the time, would you agree that general surgery, even if it's the resident in the middle of the night should come up and evaluate and see that patient?

A. Because of the resident is why you would have a general surgeon there so quickly in the middle of the night.

I think that if I was called, okay, whether I was at home or in the hospital, I want to, okay, find -- let me put that on -- get me an x-ray, you know, let me know what is going on. You ruled everything out, at least you're telling me you're ruling it out. I want you to tell you what I need done. Get me an x-ray of the abdomen, let's make sure, like we did with my patients, we got a cat scan. That's --

Q. You would want a cat scan?

A. I would absolutely want a cat scan done.

Q. In fact, if the general surgeon hypothetically was contacted and given all that information, and didn't suggest that a cat scan be done, that would be below the standard of care, wouldn't it?

A. No. Just one of the x-rays could be a KUB, to let me know, yes, if there is an intra-abdominal

bleed. A cat scan can to do it fast but if it's KUB, there is no abdomen distension or bowel distension but you see like a hazy picture, you might think there is fluid in the abdominal cavity.

Q. Why, if you can't get the KUB because there are problems with other cases going on, and they're backed up and can't get it down, what do you do under those circumstances? Do you let the patient continue to bleed if you have high enough differential that it's an intra-abdominal hemorrhage?

A. During this time, if we're referring to this case?

Q. Yes.

A. During this time, and they continue to try and stabilize this patient, let's see if he has an intra-abdominal bleed, if you take that patient to surgery and that status of shock you just talked about, once they place him on the general anesthesia chances are he's going to be with a history of cardiac problems, he doesn't do well, and you might kill that patent if you take him to surgery before his time.

Q. Doctor, he was not responding the kind of ways you would want to in terms of perfusion with the saline, was he?

A. I think his blood pressure maintained around

100, yes, sir.

Q. Did this patent need transfusions? Blood transfusions?

A. Yes, sir.

Q. Would you agree that, Doctor, in all fairness, that Mr. Brooks should have received blood transfusions sooner than he did?

A. I think if you're looking back in the records and I look at -- when I looked at this chart I looked at it in two ways, and that's the way I reviewed the records. What would I be doing as I was going through it and it is a step-wise fact until you say, okay, we got to give this man blood, and they have reached that conclusion around four o'clock, give or take, or three o'clock; I don't remember the time.

MR. KELLEY: Three o'clock.

BY MR. MISHKIND:

Q. Three o'clock. He was typed 4:49. An hour and fifty minutes later they gave him the first blood.

Would you agree this man needed to be transfused sooner than 4:49 a.m. in all fairness?

A. And was the blood available at the time?

Q. Assume the blood was available and he's typed at three o'clock and/or 2:58, whatever the type is, would you agree that in all fairness this man should have had

that blood transfusion sooner?

A. Probably. Would it have made a lot of difference in the long run; I don't know.

Q. But you can't say it wouldn't have made a difference, correct? You can't rule out, and listen to the questions firs so in fairness you hear my question.

Number one, we can agree that Mr. Brooks should have received blood transfusions sooner than they were given in this case, true?

MR. KELLEY: Are we talking cross matched blood like in an emergency situation or just uncrossed matched blood?

BY MR. MISHKIND:

Q. Let's deal with that. When he was given the blood at 4:49 it was not cross matched was it?

A. No.

Q. And, in fact, at three a.m. there is no indication that they attempted to do any cross matching. They just typed him, correct?

A. Correct.

Q. They could have typed and cross, uncrossed at three o'clock, true?

A. But that's -- the answer to your question is yes, but that's one of the things they were not so sure that this man -- I'm looking at his record. It was

typed at three o'clock. The should be aware that something is going on maybe, but they hadn't come to the conclusion that he was bleeding to the point that he needed to be transfused.

Q. At three a.m. they know his blood type is what?

A. I don't remember, sir. I have to go back.

Q. And if they can't cross match someone you can give blood on an emergency basis, correct?

A. You're saying give him uncrossed matched blood?

Q. On an emergency basis you can give someone a certain type of blood which is not matched or not cross matched, correct?

A. You basically, the way I was taught, and the way I practice, is that I give uncrossed matched blood in a life or death situation. That's the only time.

Q. And you realize that there is certain blood types that you can give to a patient that substantially reduces the likelihood of any type of a hemolytic catastrophe occurring, correct?

A. I think, and I know, but I'm not a hematologist, and I don't remember, to be honest with you, the types and crosses, but the way I do it, the way I practice and the way I think is the correct way, you do

not give uncrossed matched blood unless it's life or death because I've seen people die from the wrong blood transfusions.

Q. If the people that were caring for him at three o'clock knew or should have known that he had a major intra-abdominal bleed, and they knew his blood type but they didn't, for whatever reason, cross match him at that time, if the standard of care hypothetically required the patient be given blood to treat a major intra-abdominal bleed you give uncrossed blood under those circumstances, true?

A. Two questions about your question. You said they knew he was bleeding intra-abdominal.

Q. Knew or should have known I said.

A. How could they know. You can't predict the future. So you can suspect, but you can't predict the future.

Q. Why would you have suspected at three a.m. given all the information available, doctor?

A. You know, I would not have thought of bleeding from the peg, that would be the last thing on my mind.

Q. What would you have thought of?

A. Some medical conditions -- it's so uncommon to bleed from a peg. They place thousands and thousands

of pegs. I don't know the statistics. I know it's very very uncommon.

Q. What about when a patent has been pulling on the peg and taken off all of the dressing from it about an hour and half, and all of a sudden the patient goes into severe shock, doesn't that cause or shouldn't that cause people that are caring for the patient to think that if the patient is pulling on it and taken all the dressing off, and then within a two-hour time period or hour and 45 minutes, the patient goes into significant shock, that the peg tube is the cause of the bleed?

A. Do you know who gets most of these pegs by far and away?

Q. Why don't you tell me?

A. Again, this is just from my own experience. I can't quote you literature.

People who have altered mental status or some type of coma, or people who can't swallow, who are confused, very debilitated, and these people were continuously pulling on the pegs, continuously pulling on the pegs, and yet not many of those bleed.

So just because he's pulling on a peg doesn't mean -- what you might have happen -- you pull the peg out, and those are some of the cases that I've been involved with in my taking these patients to surgery, but

bleeding is such a non-entity when it comes to a peg that it would not be my first idea, and the abdomen distention you keep referring to, any metabolic procedures can give you an ileus of the intestines where the intestines blow up and you get the abdominal distention.

Q. What else caused the patient at 2:25 a.m. to have a blood pressure of 90 over 80 where at midnight the blood pressure is 136 over 77, his respiratory rate has gone from 20 to 50, he is not tachycardiac with a pulse going from 111 up to 120. What else -- and with abdominal distention and with a hemoglobin drip from 13.9 in the afternoon to 8.6 to 9.

You as a surgeon are given that information, and also told that a patient two hours earlier had manipulated or attempted to manipulate the pegs and taken off all the dressing and was complaining of pain, what are you going to say, Doctor, under those circumstances?

MR. KELLEY: Object. He specifically denied pain two hours earlier.

MR. MISHKIND: I'm talking about at 2:25.

BY MR. MISHKIND:

Q. In other words, all that information at 2:25 is provided, and are you going to tell me that you don't feel that this patient needed to have a surgical consult

at that point?

A. I'm going to tell you, as a surgeon, that that patient needed to be worked up before you consider surgery.

Q. And that work up would be what?

A. What they did here.

Q. Tell me what would be the standard of care in terms of work up of a patient.

A. I think you have to rule out some metabolic problems, cardiac problems, pulmonary problems. You have to just go down the list, and then once you get to it's this, it's not this, it's not this, then basically you're faced with the surgical problem, but if you take this patient to surgery without making that exact diagnosis, then you would be asking me why did they take that patient to surgery because the patient probably would have died.

Q. When do you think it would be reasonable to take the patient to surgery?

A. When he was stabilized. You try and stabilize these people. Not everybody that bleeds goes to surgery.

Q. When would you have started transfusing this patient?

A. MR. KELLEY: So we're clear, with our without

cross matching?
BY MR. MISHKIND:
Q. Correct. When would you have given transfusions?
A. I think the way I looked at his condition -- can I look at this again?
MR. KELLEY: Sure.
THE WITNESS: I think with the hemoglobin of eight and a half or nine, whatever it was at three o'clock I would not transfuse this patient basically until I knew that this man was bleeding.
So somewhere between here and the time he arrested, when he made that diagnosis, is where I would start transfusing the patient.
The problem, if you wait and cross match him when he arrested, then it's going to take you two more hours. So I agree they give him uncrossed blood when they did.
BY MR. MISHKIND:
Q. Sometime between three and four a.m.?
A. Sometime between the time that the hemoglobin of nine, and from what I recollect the blood pressure remained fairly stable. I mean can we look at it?
MR. KELLEY: And the code is 4:10.
THE WITNESS: So he basically, when they get

there and start resuscitating him, which is around 2:30 give or take, but at three o'clock they get his hemoglobin back to 8.9.

MR. KELLEY: One at 8.9 and one at 9.1.

THE WITNESS: That was what time more or less; I don't remember3

BY MR. MISHKIND:

Q. Just assuming at three a.m., for purposes of answering my question because I think that's what we were talking about in terms of three a.m. and 4:10 a.m. you want to know, as you're looking at these vitals signs, knowing that he's not been transfused at this point, are you suggesting to me that his blood pressure and his heart rate were such that this patient did not, in your opinion, need to be transfused?

A. In retrospect, going back over the chart the answer is yes. Going forward, and not even going back over the chart, I'm assuming they're taking care of -- this patient's blood pressure at 3:10 is 169 over something or hundred -- that's a good blood pressure.

Q. What was it at three a.m. doctor?

A. 75. Still acceptable blood pressure.

Q. What was it at 2:53?

A. 76, but what was it at 2:57?

Q. But you don't know at 2:57 what it's going to

be but you know at 2:50 it was 82 over 50. You knew three minutes later it's 76 over 50. You know that his pulse is 125, he is tachycardiac and hypotensive, and he's in shock, true?

A. But let me go back.

Q. Can you answer my question first?

MR. KELLEY: You asked four questions and you ended with a question, but the lecture before that, and how this starts, was him looking at blood pressure, to be fair.

BY MR. MISHKIND:

Q. I'm always being fair.

My question to you: Was he tachycardiac and hypotensive at 2:53?

A. I don't know how correct the blood pressure is in a patient that has an irregular heart rhythm. Not the blood pressure, the pulse, I apologize, if you have an irregular heart rhythm.

He had an irregular heart beat, didn't he? You can take your blood pressure if you have an atrial fib, and it may be 170, may be 170, but your heart is beating. Your actual pulse is a lot less than that.

I don't know how accurate these pulses are, and how to interpret these pulses in that setting, and I look at the blood pressure, and to answer the question, I

think this man was in a slow shock, slow shock all the way through, I really do, but I don't know if it was blood or because he had a heart attack or all of the other reasons we talked about.

Q. Would you agree that it would have been preferable to have given this patient transfusions sooner than what was done in this case?

MR. KELLEY: Object.

BY MR. MISHKIND:

Q. Would you agree with me, Doctor, that it would have been preferable during the time period between 2:00 a.m. or 2:25 a.m. and prior to 4:49 when he was given transfusions, that it would have been preferable to have given this man transfusions sooner?

MR. KELLEY: Object to the form of the question. He already told you there were two ways to look at it. Retrospectively and prospective. You asked which one you were looking for, and you left it out of the question.

MR. MISHKIND: Your objection is noted.

MR. KELLEY: Just make sure, Doctor, if you understand you have a difference you should qualify it because his question does not.

THE WITNESS: Going back a little, looking at the chart, yes, we should have given him blood at 2:30

Actually, going on what happened during this case you can't just go and give blood to someone. You have to make sure he needs it.

BY MR. MISHKIND:

Q. I understand. Can we at least agree, even if you're looking at it or your testimony is you're looking back at it after the fact, you would agree with me that at 2:30 Mr. Brooks should have been transfused with unmatched blood, true?

MR. KELLEY: Objection.

THE WITNESS: If we look at the chart, I don't think he should have had the peg. None of this would have happened.

BY MR. MISHKIND:

Q. Forgetting the fact if he needed the peg or not, at 2:30, and going back, and knowing ultimately what happened to the patient, once he hit hypodynamic status, it was known to everybody to have changed, can we agree that at 2:30, even though you may be looking at it retrospectively at 2:30, it would be preferable to transfuse him?

MR. KELLEY: Objection.

THE WITNESS: And I wouldn't agree to that because sometimes you can hydrate these people and resuscitate him with other means without giving people

blood.

BY MR. MISHKIND.

Q. You start, before giving transfusions, you see what crystalloids will do, correct?

A. Correct.

Q. And if crystalloids don't, after a certain period of time, take the patient out of shock, then you have to consider transfusions, true?

A. I think when that does not happen, you need to make sure that the heart is okay and the lungs are okay, because usually in people who bleed actively giving them blood this takes -- brings them out of shock and he never came out of shock.

Q. And he needed ultimately to have a transfusion, true?

A. If he doesn't get transfused at four or whatever time it was he would have died.

Q. Okay.

Based upon your review of this case, at Cleveland Clinic they have got general surgery resident doctors available 24/7, correct?

A. I am not familiar. I imagine so, yes, sir. From this record, but I don't know how they work over there.

Q. Cleveland Clinic is a tertiary facility that

has general surgeons on call or on staff, maybe their own staff to handle all types of medical emergencies 24 hours a day, seven days a week, true?

A. Yes.

Q. If general surgery is contacted because the medical team, whether it's GI or medical services, is concerned that a patient has an intra-abdominal bleed, such a consultation should be reflected in the patient's records, true?

MR. KELLEY: Objection.

THE WITNESS: Yes.

BY MR. MISHKIND:

Q. Such a request for a consultation should be reflected in the report, true?

A. Should be, but sometimes during a code when you're resuscitating, things are not always placed on the record, sir.

Q. Part of the management of a patient that is in shock involves managing their airway, correct?

A. Correct, sir.

Q. Can we agree that Mr. Brooks was not intubated until after he went into respiratory arrest?

A. I have to look at the records but I imagine what you're telling me is true.

Q. Would you agree, based upon his vital signs

starting at 2:25 and going forward, that Mr. Brooks should have been intubated sooner than 4:15 a.m.?

A. No.

Q. Why not?

A. Why should he have been intubated because your blood pressure is low, and we're using the term shock in loose terms, but it's not like it was a cardiac arrest, a full cardiac arrest. It was a low blood pressure, and people can talk to you and bleed normally with low blood pressure and tell me about his respiratory care from twelve midnight forward.

Q. Was he tachypnea?

A. He was tachypnea yes, sir.

Q. What was causing him to have such a high respiratory rate?

A. Probably his low blood pressure but I don't know it's clear from the way the question is asked.

Q. It was pretty clear, Doctor, when the patient was pulling on his peg, and had taken off all the bandages what was his blood pressure at the time?

A. You mean around midnight?

Q. Well, according to your review of the nurse's testimony, did she observe him pulling on the peg and/or attempt to manipulate the peg tube and having taken off all the bandages?

A. Can we look at the nurse's notes?

MR. KELLEY: Sure.

THE WITNESS: Says 24:55.

BY MR. MISHKIND:

Q. Which she explained to be 12:55 a.m.?

MR. KELLEY: She said that's when she wrote the note.

BY MR. MISHKIND:

Q. That's when she wrote the note to the vital signs that were taken at twelve midnight at 24:00. Who took those according to your careful review in this case?

A. I believe that was the Indian nurse, because she said she walked around while the other nurse was giving rounds.

Q. But your careful review in this case would suggest that the 24:00 vital signs that are recorded there were recorded by the nurse, true?

A. I can go back and check if it's not true.

Q. Again, you're testifying under oath based on review of important information, that's why I'm asking.

MR. KELLEY: It's not a memory game.

BY MR. MISHKIND:

Q. Of course it isn't. You only received the deposition recently, and I'm asking whether the 24:00 vital signs were done by the Indian nurse?

A. Can we go back and look at her testimony?

Q. You don't have a recollection as you sit here right now?

A. I don't remember right now because I recollect her saying that she said hello to her patient around midnight or something like that, while the other nurse is going off duty and giving reports to the other nurses. I don't know if that nurse took it right before. I think she said she did it herself.

Q. Fair enough. Can we agree that her testimony was that she took those vital signs or someone took those vital signs at twelve midnight, and it was after twelve midnight that she was in to see the patient and discovered the patient pulling on the peg tube and the bandages off?

A. I'm going to read the 24:55 note.

Q. You can read it silently. You don't need to read it into the record. The report is long enough.

A. What was the question?

MR. MISHKIND: Read.

(The question referred to was read by the reporter.)

THE WITNESS: Yes.

BY MR. MISHKIND:

Q. What were the patient's vital signs when the

nurse came in sometime after twelve midnight and discovered the patient having pulled or manipulated the peg tube and having taken off all bandages?

MR. KELLEY: He's asking what the vitals were.

BY MR. MISHKIND:

Q. Let me make it easier for you, Doctor, because I'm not trying to trick you but can we agree --

A. You're doing a good job.

Q. I'm not trying to trick you at all. That's not my job. My job is to obtain information as it relates to your opinions.

Let me put it to you this way. Can we agree that the nurse did not check the patient's vital signs at the point in time that she discovered that he had manipulated the peg tube and taken off all the dressing, true?

A. Why should she?

Q. I'm not asking why she should or shouldn't. Can we agree she did not reassess the patient's vital signs at that particular time?

A. It depends. She did not take his blood pressure but he did have an apical heart beat.

Q. At what time?

A. That was at the 24:55 note. And the beat

sounds diminished she evaluated the patient.

Q. What is an apical heart rate? Is that normal?

A. Basically, you listen by hand or stethoscope and listen to the heart.

Q. Is that a normal heart rate?

A. That's irregular. That's when the underlying problem happened before.

Q. What was causing the apical heart rate at that time?

A. No. Everybody has an apical heart rate.

Q. What was causing the irregular --

A. That's his underlying cardiac problem.

Q. You don't know what his blood pressure was at that time, do you?

A. I don't think she wrote it, no.

Q. And you don't know what his pulse was?

A. It was irregular.

Q. You don't know what the number was, correct?

A. Correct, but that's why I told you a little while ago that I don't trust that pulse because it's an irregular pulse.

Q. Do you have any explanation as to why the patient's vital signs in this case, Doctor -- I'll wait until -- you're reading. I don't know if you can read

and listen at the same time.

Do you know in this case that the patient's vital signs were not checked for a period from 4:10 in the afternoon until midnight?

MR. KELLEY: He's talking about June the 4th, the date the peg was placed, I assume.

BY MR. MISHKIND:

Q. Yes.

A. I have to go back and look at the orders and what their criteria may be. Vitals can shift one-eighth every hour.

Q. Doctor, can we agree that if the vital signs are to be taken every four hours, that the nurses did not comply with the orders?

A. If they're every four hours, and they did not take them, they did not comply with the orders.

Q. That's certainly not good nursing care if the doctor says take them every four hours and you have an eight hour gap between vital signs, true?

A. I couldn't say that they did not comply with the orders.

Q. But orders are there to be complied with by nurses, true?

A. Yes, sir.

Q. And orders are given by doctors for reasons,

true?

A. Sometimes, no.

Q. We want to believe that doctors give orders for reasons, true?

A. I think we are all on -- this is again my life, my -- the way I practice, you know. We always write vital sign requests, but why should I wake a patient in the middle of the night to take the blood pressure. We do sometimes things out of habit then necessary.

Q. Between 4:10 p.m. and midnight, how much waking up would they have had to have done to comply with the request?

A. I just gave you the example writing that --

Q. Let me ask you this, Doctor.

Can we agree that you know of no reason in this case that nurses could not have complied with the orders of recording the vital signs every four hours in this case, true?

A. Someone didn't record it once.

Q. Do you know of any reason why they could not record the vital signs in compliance with the orders between 4:10 on June 4 and midnight?

A. All I know is that the patient maybe didn't want them to take a blood pressure.

Q. Does it say in the records the patient refused to allow blood pressure to be taken, that's why we couldn't do it?

A. It doesn't say that, no, sir. You're asking me, and I'm trying to give you an answer.

Q. I'm asking you, Doctor, do you see anything, based on your being an expert in this case, and providing information to help you, do you see anything in that regard that would permit you to tell me why the nurses did not comply with the order of taking the vital signs every four hours during the time period I'm talking about, from 4:10 up to midnight going into June 5th?

A. I do not.

Q. And, in fact, do you know what the order was before it became Q4?

A. No. But I can check.

Q. As you sit here now, you don't recall?

A. No.

Q. Define for me shock. How is that?

A. That's a very difficult word to define because, you know, someone sees a killing going outside and oh, my God, I'm in shock look at what I saw, and obviously that's not the shock we're talking about here, but I think that when blood pressure is below normal -- I think when blood pressure is below normal it starts to

affect the other organs, I think that's an early definition of shock and in easy terms to understand,

Q. Can we agree that by three a.m. doctors at the Cleveland Clinic that were responsible for caring for Nr. Brooks knew Mr. Brooks' blood count, true?

A, By three in the morning yes, sir,

Q. They knew his blood pressure?

A, Yes, sir,

Q. They knew his pulse, correct?

A, Correct,

Q. They had signs of the response that the saline provided, true?

A, Correct.

Q. And he was remaining hypotensive, true?

A, Not always.

Q. I'm talking about three a.m.

A, Three in the morning blood pressure is the first, That's borderline in my book, It's 76, I call hypotensive. 95 is probably okay.

Q. They had lavaged the peg tube at the time?

A, Correct.

Q. They lavaged the peg tube because they were concerned about the possibility of a bleed, correct?

A, Correct.

Q. And when they lavaged the peg tube, can we

agree, Doctor, in fairness that these doctors were doing the right thing because they felt that there might be a bleed causing the patient to be in shock?

A. Correct.

Q. When they lavaged the peg tube and did not drawback any blood, the only source, if in fact it was a bleed, would be intra-abdominal opposed to inside the stomach, true?

A. It would be something besides the bleed giving him low hemoglobin.

Q. If they felt that the patient had a bleed based upon everything I just said, and they elected to lavage the peg tube and the peg tube basically lavaged and no blood being drawn out from the stomach, can we agree the mostly likely explanation if it was a bleed would be intra-abdominal?

A. Yes, sir.

Q. Can we agree that if it was an intra-abdominal bleed, doing an EKG is not going to resolve the problem?

A. If it's an intra-abdominal bleed, doing an EKG would not solve the problem, correct.

Q. By their account, they knew his blood type, correct?

A. They typed him at that time.

Q. They had done the blood and knew his blood type, true?

A. Yes.

Q. I think 2:45 they did the blood type. The results were reported shortly thereafter.

MR. KELLEY: I thought it was 3:00 and 3:08.

MR. MISHKIND. I think it was initially drawn.

MR. KELLEY. 2:25.

MR. MISHKIND. 2:56.

BY MR. MISHKIND.

Q. We can take the same thing in that general range.

My question to you is: Since they're drawing blood, they initially have arterial blood gas. They then draw blood, they see the patient's vital signs, they start him on saline, they see what kind of response they have when they actually draw the blood and type him.

Was there anything preventing them from typing and cross matching at that time?

A. That's what I referred to a little while ago. I think if they would have thought he was having an intra-abdominal bleed they would have typed and crossed him at that time.

Q. Again, I'm not trying to repeat this. I want

to make sure I have a firm understanding of your opinions before we leave today, if they had a firm understanding, or should have had a firm understanding, and we will let someone else make the determination as to that.

I understand what you're saying to me, but if, in fact, they should have had a firm understanding at that time that there was an intra-abdominal bleed, and they type the patient at the time, they should cross match the patient at that time as well, true?

MR. KELLEY: Object.

THE WITNESS: If they think he's bleeding?

BY MR. MISHKIND:

Q. Yes.

A. And they think he's bleeding then I think they should have typed and crossed.

Q. If on that scenario, if they typed and cross matched him at 2:45 or 2:00 whatever, 2:47, would you agree that blood would have been ready certainly by the time that they finished that initial fluid bolus that the patient was receiving?

A. That I could not tell you. It depends on the availability of blood.

Q. How long does it take to type and cross match and have blood available at your hospital?

A. It depends on the availability of blood and

the type of blood the patient has.

Q. What was his blood type?

A. I don't remember.

Q. Check and tell me then.

A. A positive.

Q. Same question then if they type and cross match him --

A. Let me -- hold on. Let me double check.

Q. That's all right. Your apology is accepted.

A. A positive.

Q. Again, my question was: If the type and cross match had been done at 2:45ish time period, would you agree that blood would have been ready by the time that they finished the initial fluid bolus?

A. I can't. I don't know how the Cleveland Clinic Blood Bank works, and I don't know if they had the blood available or not.

Q. Has anything been provided to you, Doctor, that would permit you to say that blood would not be available in a rapid manner?

A. No.

Q. In fact, assuming the Cleveland Clinic is like most tertiary care facilities, how long should it take to have the blood available?

A. I am going to give you a generic answer.

Possibly an hour. Between an hour and an hour and a half.

Q. If it's needed on an emergency basis then you could provide a patient with unmatched blood, correct?

A. If it's for life or death, yes.

Q. Can we agree that a patient in shock should be put on a heart monitor?

A. Yes, sir.

Q. Do you see the indication?

A. He was on the floor. They were resuscitating him and they took him to ICU.

Q. He's on the floor at 2:25 when the first doctors arrive. He's not taken to or he doesn't have an arrest, we'll talk about in a moment, until 4:10. Between 2:25 and 4:10 he's in shock, correct?

A. I'm sorry. 2:25 and 4:10 he's in shock.

Q. Correct?

A. Basically, yes, sir.

Q. He was not on a monitor between 2:25 and 4:10, was he?

A. Not that -- not that I could see in the medical records.

Q. You would agree, would you not, that a patient that is in shock should be on a monitor?

A. He should be.

Q. Do you have any explanation in this case why he wasn't on a monitor?

A. The only thing I can think there was an ongoing resuscitation, and when there is an ongoing resuscitation, everybody is doing something -- everybody is doing something, and they were taking his blood pressure very quickly.

Q. That's the only explanation that you can provide to me?

A. At three in the morning, in the middle of the night, and I think things got done fairly quickly, to tell you the truth.

Q. That was not my question.

Other than what you told me, do you know of any other reason this patient was not on a cardiac monitor once the doctors were called in, Dr. Goldman, Dr. Lazarus arrived between 2:25 time period and 4:10 when he experiences an arrest. Why wasn't he on a cardiac monitor?

A. I don't know why.

Q. You would certainly agree with me that it would be preferable to have him on a cardiac monitor, true?

A. It's preferable.

Q. Do you know what type of blood is given if a patient can't be cross matched in a sufficient period of time?

A. I'm trying to remember if it was positive but I don't remember.

(Brief discussion.)

BY MR. MISHKIND:

Q. If at three a.m., hypothetically, you were contacted and you were told by the medical team that there was a high likelihood that the patient had an intra-abdominal bleed, that the patient's peg tube had been lavaged, that the patient had been pulling on the peg tube previously, that he dropped his hemoglobin to the level that he had, that he was remaining hypotensive, tachycardiac, was not bleeding into the stomach, can we agree that this patient needed to be taken promptly to the operating room?

MR. KELLEY: Objection, asked and answered. You can answer.

THE WITNESS: No.

BY MR. MISHKIND:

Q. I want you to tell me now, as succinctly as you can, on was basis you disagree with that statement.

MR. KELLEY: Objection, asked and answered.

THE WITNESS: Specifically, in this case, you

need to make sure that the patient needs an operation, number one.

That he won't stop bleeding, number two. That the actual bleeds are intra-abdominal and make that diagnosis.

BY MR. MISHKIND:

Q. When do you think this patient stopped bleeding?

A. Probably sometime around four or five, and that's a guess. I have no way of really, really knowing if he stopped. I think he stopped bleeding at four or five.

Q. How many units of blood was he given?

A. I know he was given four uncrossed match. Let's count them.

Q. When you do that, I want you to tell me every single basis upon which you made that statement, under oath, that you believe he stopped bleeding at four or five a.m.

I want to fully appreciate that and understand that.

A. Just so that -- because I don't want to make assumptions. So she would agree he got four uncrossed matched; you don't have a memory?

Q. I do, Doctor, but I'm not the one testifying.

You're the one that reviewed the report carefully and providing opinions.

A. To the best of my ability here, he received four uncrossed units. He got that between 4:00 and 5:30 the morning, give or take. Between 4:50 and 5:30, he got four units of blood, and to the best that I can see afterward he received three more units at around 9:00 o'clock in the morning, okay.

Now, during this whole time he's been getting a lot of saline, which will give you a delusional affect. He has blood gases here -- where are those, the CBCs?

Hemoglobin on 4:35 was 6.3. So he gets -- right around that time he starts getting his four uncrossed units. He's getting blood throughout the whole thing, and then he gets a total of seven units. He gets four at that time, between 4 and 5:30, and he gets three more later by the time he goes to the he O.R. -- by the time we have a CBC. So --

Q. Doctor, let me caution you may be answering out loud. The court reporter, any time you open your mouth, unless we tell her otherwise, the court reporter has to take it down. If you're thinking silently -- off the record.

(Brief discussion.)

BY MR. MISHKIND:

Q. Ready to answer the question?

A. Yes, sir.

Q. Fire away.

A. He got four units of blood approximately, starting around 4:50, and the hemoglobin at 4:20 was 6.3. When he goes to surgery, after he got there, his hemoglobin is 12 and his hematocrit is 36.

They basically -- we don't -- the H&H in those 6 hours, if he was still bleeding, actively bleeding, you don't expect the hemoglobin to have gone from 6 to 12. So maybe I heard them say four and five or five and six or five and seven. Somewhere before surgery he stopped bleeding, but his hemoglobin would not have kept on going up the way it did.

Q. Tell me why he stopped bleeding.

A. People stop bleeding for whatever reasons. That's why many times I don't have to operate, they just stop spontaneously, whether because the blood pressure was low, whether because the artery goes into spasm, the blood vessels into spasm.

Q. If you were consulting in this case at 5:30 or between 5:30 and 6 o'clock, what would you have done?

A. I would have been gotten a cat scan, sir.

Q. The cat scan was not obtained in this case,

was it?

A. No.

Q. In fact, Dr. Grunfist said the cat scan was not necessary, correct?

A. I would have gotten the cat scan to document exactly that he was bleeding because I would not want to take a patient to the O.R. in such a terrible condition.

Q. You would agree with me that you read Dr. Grunfist's testimony --

A. Yes, sir.

Q. -- when she was told that someone was recommending a cat scan and she said, "Not necessary," correct?

A. Because the assumption was he was bleeding, which he was, and I'm trying to tell you that I'm not so sure I would have operated on this gentleman after five o'clock.

Q. So you would have gotten a cat scan, correct?

A. Yes.

Q. And what most likely would that cat scan have shown at that time?

A. It would confirm the diagnosis. It would have shown exactly there is blood everywhere or the spleen is ruptured or make a diagnosis that -- something I could hang my hat on more before I took him to surgery.

Q. Would you have wanted that cat scan stat?

A. Yes.

Q. And stat in a hospital like a Miami Heart or a Cleveland Clinic, a facility that has 24/7, how long would a stat cat scan take where you're considering the possibility of doing emergency surgery?

A. It would take anywhere -- some cat scan machines take up to half an hour to do a -- and you're talking an hour or hour and a half.

Q. Doctor, wouldn't you agree that most tertiary care facilities that have cat scans where a surgeon is considering doing emergency surgery, that a cat scan can be obtained in a 15 to 30 minute period under normal circumstances?

A. Normal means a patient is not on a respirator, not intubated, that you have to have four or five people with you. Normal being a patient that is fairly stable maybe, but the cat scan, the request, takes up to 30 or 40 minutes. So even under the best circumstances you're up to an hour.

Q. You could have gotten a cat scan and what likely would that cat scan have shown?

A. I just don't know in my heart that taking this man to surgery would have -- in fact, I know, it wouldn't do any good retrospective or prospective.

Q. Do you think taking him to surgery harmed him?

A. I think after five o'clock, the second arrest -- he was doomed at the four o'clock arrest in my mind.

Q. Might as well make funeral arrangements for him at four o'clock?

A. I treat conservatively. You check his hemoglobin, H&H, which at the time of surgery was 12 and 36.

Q. At the time of surgery will 3,000 cc's of blood clot?

A. Yes.

Q. And in addition anesthesia shows 1,200 cc's of blood loss as well, correct?

A. But I think the 3,000 included the 1,200.

Q. That's the way you read it?

A. That's what I understood.

Q. How did you understand that?

A. Because when you suction the blood the anesthesiologist looks at the blood loss. It was is in the abdomen.

Q. Just before you respond, you're understanding that when anesthesia refers to 1,200 cc's of EBL, estimated blood loss, that would be incorporated into the

3,000 cc's blood clot that Dr. Grunfist referred to?

A. That's the way I interpret.

Q. What percent of the total circulated blood is 3,000 cc's?

A. Probably, fifty percent.

Q. So you think the patient stopped bleeding sometime between five and seven a.m.?

A. Somewhere around there, yes, sir. I have no way of telling absolutely it was 12 o'clock or 7:30, but yes, around there.

Q. What would the outcome have you been in this case if Mr. Brooks had been taken to surgery before four a.m.?

A. Before he was resuscitated?

Q. Well, at four a.m. do you think Mr. Brooks experienced a cardiac arrest?

A. I think he had an arrest. I don't know whether it was cardiac or it was an arrest injury.

Q. If fact, you would agree with me that at 4:10 a.m. the records would suggest that it was a respiratory arrest, true?

A. I don't know if it would make a difference whether it's cardiac or respiratory, sir.

Q. Bear with me. Whether it was a difference or not, would you agree that the report at 4:10 a.m. does

not indicate that he sustained a cardiac arrest, true?

A. Where is this?

MR. KELLEY: Right there.

THE WITNESS: Oh, because they said, "No cardiac arrest."

BY MR. MISHKIND:

Q. Correct.

A. That's what it says, correct.

Q. And it says, "Respiratory arrest," correct?

A. Yes, sir.

Q. There is no CPR initiated, correct?

A. To my recollection there was known.

Q. And he was intubated to manage his airway, correct?

A. Correct.

Q. Certainly it's preferable to manage the airway of a patient before they go into respiratory arrest if, in fact, you can appreciate their hydrodynamic status worsening, true?

A. Say that again.

Q. If a patient goes into respiratory arrest at a given point, but you know as you're progressing along that a patient is in shock and is getting worse from the standpoint of managing the patient, it's preferable to intubate the patient so as to avoid a respiratory arrest,

true?

A. I guess preferable but not -- I mean as long as they're breathing, they're breathing.

Q. Do you know why they intubated the patient at 4:16 p.m.?

A. No.

Q. Let me make it easier.

Would you agree they intubated the patient to manage the patient's airway --

A. I think --

Q. -- at 4:16?

A. Correct.

Q. Why wasn't the patient's airway managed prior to 4:16 a.m.?

MR. KELLEY: Object to that negative inference. If you want to ask how was his airway being managed prior to that, it's obvious it's a nasal cannula.

BY MR. MISHKIND:

Q. In your opinion, was his airway being managed adequately before 4:16 a.m.?

A. Yes, sir.

Q. You don't have to look further. I'll move on. That answer is fine for me.

What is abdominal compartment syndrome?

A. I don't know what that is.

Q. You don't3

A. No.

Q. Not familiar with it?

A. No.

Q. When you have an intra-abdominal bleed, would you agree that you have increased abdominal pressure?

A. Yes, sir.

Q. And would you agree that that can cause compression of the renal veins, the lungs and the inferior vena cava?

A. It depends on how much.

Going back to your other question if I may, depends on how much blood you get increased abdominal pressure.

If you have a little bleeding it requires a lot of blood, if the object is to increase the intra-abdominal pressure.

Q. Do you think this man, based on the drop of his hemoglobin to the afternoon, until the time that they matched it, had enough of an intra-abdominal bleed to cause increased abdominal pressure?

A. I'm sure he did yes, sir.

Q. And increased abdominal pressure, with the kind of drop and the blood he had, can cause compression of the renal veins, the lungs and inferior vena cava,

true?

A. I never heard of that, sir. I can tell you the increased abdominal girth will compress the lungs because of the pushing up of the diaphragm.

Q. How long do you believe that Mr. Brooks had been bleeding before his hemoglobin was checked at 2:45 a.m.?

A. I think when he started complaining of abdominal pain, and he had the drop in pressure, I think right around that time he started to bleed.

Q. What do you believe caused him to start bleeding?

A. I'd like to think and say, like everybody else, that tugging on the peg, but I have no way of proving that.

Q. Do you have an opinion, to a reasonable degree of probability, as to the most likely explanation in this case for why Mr. Brooks started bleeding?

A. The most likely cause I think is the patient tugging on the peg too.

Q. Why was Mr. Brooks' dressing changed on the peg tube at 9:45 p.m. on June 4th?

A. It says, "Dressing changed to peg two."

Q. Do you know why that was done?

A. It does not say.

Q. Would you agree that during the first 24 hours after peg two is placed, that the normal procedure is to leave the dressing alone, not to change the dressing, not to wash the area, true?

A. Sometimes, yes. Sometimes, no.

Q. In fact, the orders in this case where for the first 24 hours, you agree with that?

A. Yes, sir.

Q. And do you have any explanation in this case, based on your review, as to why at 9:45 the dressing had to be changed at 4:10 in the afternoon? They were dry on intake?

A. Doesn't say. I could give you a, you know, ten reasons why it could have been done but it doesn't say why.

Q. Would you agree that one of those explanations or possible explanations at 9:45 that something was going on below the dressing, in the sight or the location where the peg tube had been inserted?

A. Something going on. What does that mean?

Q. Some issue, perhaps a bleed that had started, perhaps some irritation to a vessel that was causing either some seepage or irritation?

A. Any of those things could account for it.

Q. We don't know what his blood pressure was or

his vital signs were at the time?

A. No.

Q. All we know the nurse changed the dressing, didn't make any other assessment of the patient at that particular time other than a dressing change?

A. But you know there was no -- why do you think -- well, you're asking the questions.

It's not uncommon for someone to change a dressing, you know, because of a little oozing, because of skin oozing from a blood vessel, or a little serous seepage or a leaking around the gastroscopy tube, those reasons, and if even if there was a little bleed from the skin, and that's why she changed it, it does not mean anything about intra-abdominal bleeding because nowhere else during this consult did anybody mention blood coming out of the peg tube, and we see that the patient was bleeding so much or so active that he should have bled out according to what you asked me.

Q. Is there any indication that the patient's continuing to have transfusions of blood, that there is any blood described by anyone out on to the abdomen or out on to the dressing?

A. Not that I can recollect.

Q. Doctor, if a patient has increased abdominal pressure, would you agree that that can stop the bleeding

as well?

A. Yes, sir.

Q. So in this case, assuming the patient developed increased abdomen pressure, that could have actually compressed the area that was bleeding and caused it to clot off, true?

A. It usually happens much more in retroperitoneal structures. Structures lying free within the abdominal cavity usually don't respond that way.

Q. Let me see if I can shortcut some of this. I may not.

Can we agree that the multi-symptom organ failure that Mr. Brooks sustained was directly and proximately related to the hypovolemic shock?

A. Yes, sir.

Q. When Mr. Brooks came into the hospital --

A. I'm sorry. Can I ask something.

MR. KELLEY: If you want to clarify an answer go ahead.

THE WITNESS: In Mr. Brooks' case, the answer is yes, but in someone with better protoplasm, I think once you correct -- once you correct a hypovolemia, they should respond and not develop multi-system failure.

BY MR. MISHKIND:

Q. I asked you before about his airway, and I

think it was Mr. Kelley that testified that the NG tube was being used and he was being provided --

A. A nasal cannula.

Q. Right. Was his airway stabilized prior to 4:10 or 4:15 a.m.?

A. I have a blood gas here from 6-5-98 at 2:45, and his PO2 is 84, and his PCO2 is 31, which are fairly okay, fairly mobilized.

Q. When is the next blood gases?

A. That's what I was looking for right here. 4:20 is the next one I see here, sir.

Q. And that's five minutes after his airway had been -- after he had been intubated?

A. Correct.

Q. And what was his PO2 at that time?

A. 507.

Q. PCO2?

A. 36.

Q. Was his airway stabilized, in your opinion, adequately, prior to 4:10 a.m.?

A. Yes. Until he arrested, yes, sir.

Q. You said a moment ago that based upon the CPR data sheet that we were talking about, that you would agree with me that the report would not suggest that he had a cardiac arrest but rather a respiratory arrest,

true?

MR. KELLEY. Objection, he said that's what it says.

MR. MISHKIND. Right. Based upon the records.

MR. KELLEY: I don't think that --

THE WITNESS. I also said it didn't make a difference.

BY MR. MISHKIND.

Q. Tell me why it doesn't make a difference in your opinion in this case?

A. Because an arrest -- an arrest, if you stop breathing they go together, airway breathing, circulation. So you can't just have breathing and not have airway and circulation, you can't -- all intermingle, interchange. In my mind they all go together.

Q. If this patient had been resuscitated with transfusions prior to 4:10 a.m., can we agree that more likely than not he would not have arrested?

MR. KELLEY: Object to form.

THE WITNESS: I can't agree with that because this is going back retrospective or prospective or just in general.

BY MR. MISHKIND:

Q. We know what happened. 4:10 I'm going to

suggest to you that my argument is a number of things should have been done before we got to 4:10 p.m. including giving transfusions.

I'm asking you if the patient had blood transfusions before 4:10 when some event occurred that caused his condition to deteriorate, would you agree with me that he probably would not have arrested at that time?

MR. KELLEY: Objection to form.

THE WITNESS: Let me answer this because in the way I'm thinking, if I'm hypovolemic or a person is hypovolemic, and they go into shock and you resuscitate them, usually they don't go into multi-system failure. They may not even arrest.

He didn't respond in the normal fashion. He arrested even after getting fluid. So I don't know if giving blood would have been a difference or not.

BY MR. MISHKIND:

Q. Would you agree that a patient that is hypovolemic, that is not responding to fluid, that a reasonable and prudent physician would suspect that it's an intra-abdominal bleed and normally giving blood transfusions is the next form of treatment of that shock?

MR. KELLEY: Objection to form.

THE WITNESS: Once everything is out and feeling comfortable that he's bleeding in, he doesn't

respond to fluid, you should transfuse the patient.

BY MR. MISHKIND:

Q. Would you agree that if blood transfusions were desired, and blood transfusions were, in fact, given because the patient was believed to have an intra-abdominal hemorrhage, the blood transfusions, hypothetically, were given before 4:10 a.m., would you agree that this patient at the very least would have had a better chance of avoiding the arrest?

MR. KELLEY: Objection, you can answer

THE WITNESS: I don't know. I'm going to say what I'm thinking then I'll answer the way -- the way I think you want me to answer.

I don't know at what point this became irreversible. I think if he get blood at 2:24 maybe that's not irreversible. So I don't know at what point it becomes irreversible, and theoretically, if he's bleeding, and he got blood, he should do better than he was from retrospect not prospect.

BY MR. MISHKIND:

Q. Your testimony a moment ago, if at 2:25 he got blood he probably would have done better?

A. Right. This is hypothetical. You can't just give blood at 2:25.

2:25 I don't think he needed blood. I'm

telling you if he got blood somewhere before it became irreversible, it would be better, and I don't know the time it became irreversible.

Q. Did it become irreversible at 4:10 a.m. when he experienced a cardiac or respiratory arrest?

A. I think it became irreversible before that.

Q. Before 4:10 a.m.?

A. Yes.

Q. Some time before 4:10 a.m. but some time after 2:25 a.m. he became irreversible?

A. I think so.

Q. Your opinion is that the arrest did not change the likely outcome?

A. That's exactly -- I think that's correct.

Q. Whether it was a cardiac arrest or pulmonary arrest, correct?

A. Yes.

Q. And whether general surgery delayed unreasonably in providing a consult, and unreasonably in taking him to surgery, your opinion is that it would not make a difference in terms of his morbidity and mortality?

A. I'm not sure of saying they delayed unreasonable.

If it's a hypothetical question, in my mind,

and reviewing the records, I don't think it would make a difference.

Q. You think he would sustain the multi-organ failure and died anyway?

A. Yes.

Q. To a reasonable degree of probability, that's your opinion?

A. I think so.

Q. Do you have any literature that you can cite me to or any studies that you've done that would support such a theory?

A. No, I don't, and I'm not God, and I don't know if that's correct or not, but I do know that at 4:10 it's a couple of culminating factors of low grade shock and probably somewhere before that it became irreversible.

Q. There in your report you reference I believe that there was a question of whether the patient was in DIC; do you remember that in your report?

A. Correct.

Q. You're not suggesting that you are of the opinion that a patient was in DIC, are you?

A. No. I got that from the report where they were going through the potential etiology sheet and one was DIC.

Q. There is an admission note, he was noted at PT, his PTT, and INR were elevated; do you see any lab reports to correlate with that?

A. I was referring to, I think one of the medical doctors who when he was going through the possible diagnosis commented on DIC in one of them. I'll try and find it for you right now.

Q. I'm not suggesting that you didn't read something correctly from a note. I'm asking you whether there is any labs that you have seen to correlate with the PT, PTT and INR being elevated?

A. You mean as far as being in DIC?

Q. Right.

A. No, sir.

Q. What I'm looking for, I guess, is if someone is saying that PT, PTT and INR are elevated, there are some labs that are drawn, correct?

A. Correct.

Q. I'd like you to point to me where in the laboratory work that doctor would have gotten an idea that the PT, PTT and INRs were elevated to make that type of statement?

MR. KELLEY: I think he has to find the note where the doctor says it first.

BY MR. MISHKIND:

Q. Let me try and make it easier for you, and you're searching in the report, and the report should refresh that. I believe what you're looking for, and without my pulling out my set of reports, is an IMC admission note, correct?

A. Yes.

Q. And there is a reference to PT, PTT and INR elevated.

I want to know if you have a lab report that is in the records that would correlate with such a statement?

A. Let look at the labs.

MR. KELLEY: Are you saying you don't have one, and you want to know where they got it from?

MR. MISHKIND: I have some records provided to me directly from the Cleveland Clinic, and a copy of the report you provided me in the box of reports.

MR. KELLEY: We're on a ghost hunt.

BY MR. MISHKIND:

Q. I'm just wondering how one could say that PT, PTT and INR are elevated without having some type of a lab. This is where I got it from. They were checking for a DIC -- DIC profile check, but would you agree with me that there is no lab to reflect an elevation in the

PT, PTT and INR to correlate with that3

A. PT 17.4, I'm reading from this, yes. PT 17.4, and it has an up arrow, and then INR 1.55 is an up arrow, PTT 71.7 and has an up arrow.

Q. Do you have a lab report that reflects that, where you able to find out?

A. I didn't find one. I haven't found one.

Q. Let me ask you this. It does not say what his platelets were, does it?

A. I can check the labs but in this note, if you're asking particularly to this, no, sir.

Q. Yes.

A. I don't see the platelets here, no.

Q. Let me ask you this. Are you of the opinion that he was in DIC before he went to surgery?

A. No.

Q. He was in DIC after the surgery, correct?

A. Absolutely.

Q. And would you agree with me that cause of the DIC was most likely the prolonged period of shock that the patient sustained?

A. Yes, sir.

Q. And that led to the hypoxia and injury that then led to these cascading of events, true?

A. Correct, sir.

Q. And would you agree even if this is not a hypothetical fashion, if he had been taken to surgery sooner, and the shock had been discovered earlier, that more likely than not he would have avoided the DIC?

MR. KELLEY: Objection.

THE WITNESS: I don't know. I can't agree with that, and I'm not trying to be against you here. Once you get blood transfusions you are set up for DIC without even shock, just getting multiple blood transfusions.

BY MR. MISHKIND:

Q. Not all patients that have blood transfusions go into DIC?

A. And my answer is not all patients who are in shock go into DIC.

Q. Right. But the DIC that he sustained was most likely due to the prolonged period of shock, true?

MR. KELLEY: Objection to the word "prolonged".

BY MR. MISHKIND:

Q. At most can you agree with me, Doctor, you disagree with me?

A. I agree his multi-system failure was a shock, and one of the things that failed was the clotting mechanism.

Q. When Mr. Brooks was admitted to the hospital, he had some acute renal failure, correct?

A. Let me go back and look for it.

He has a history of hypertension. He has a heart attack.

Q. I'm talking about the acute renal failure. You're thinking out loud.

A. No. I'm basically trying to document why he would get renal failure. He has hypertension, which could lead to renal failure, and a heart attack, which would get you some renal failure indirectly but it could.

Q. Let me ask, would you agree that the acute renal failure that he had on admission was mostly due to the rhabdomyolysis, polymyositis?

A. I think that contributed to it, sure.

Q. And BUN and creatine levels were improving prior to the code, weren't they?

A. I don't have the labs here.

Q. If I represent to you that they were improving prior to the code, and stayed close to that level after the code, you would agree with me that his renal problems were not likely related to the events that occurred at the time of the code, true?

A. Correct.

Q. If my statement is accurate, it's accurate.

If not --

MR. KELLEY: Go ahead and phrase it as a hypothetical, it's fine.

BY MR. MISHKIND:

Q. I understand what you told me, Doctor, so far, that general surgery consult in your opinion would not have made any difference in this case for the reasons that you stated earlier, general surgery consult, correct?

A. Correct.

Q. In your report you said that general surgical consult was obtained at 6 a.m. correct?

A. Correct.

Q. Can we agree that when the general surgical consult was obtained at 6 a.m. the general surgery team did not know whether or not a consultation by them at that particular time was going to be too late, correct?

A. Unless someone's been telling them over the phone what had been going on, and they have been keeping them aware of the patient's condition, then they have no way of knowing.

Q. And certainly there is nothing indicated in the medical records from any of the attendings on the floor or in the medical intensive care unit, that they felt that there was any indicating or a need for a

general surgery consult, correct?

A. On the medical records there is no mention of a general surgical consult until about 5:30.

Q. I think we can agree, can we not, that even though you feel that a general surgery consult at 6 a.m. or thereafter didn't impact the outcome, you would agree with me, would you not, that it would have been preferable to have had a general surgery consult earlier than 6 a.m.?

A. I don't think it would have made a difference.

Q. Remember I prefaced that by, you know, would it have been preferable even though it would not make a difference. Would it have complied with the standard of care to have had a general surgery consult earlier than 6 a.m?

MR. KELLEY: Object to form.

THE WITNESS: It would have complied with the standard of care, yes.

BY MR. MISHKIND:

Q. In other words, even though it didn't make a difference in your opinion, it's based upon what was going on with this patient, you would agree with me that general surgery should have been consulted prior to 6 a.m., true?

MR. KELLEY: Objection, you just changed the question from if you know.

I want to make sure the witness does because it's a subtle change you made. First you went with the inference would it be okay if they did it.

Now you took the step if they didn't do it, it was beneath the standard of care. I want to make sure the record is clear.

THE WITNESS: I picked it up.

BY MR. MISHKIND:

Q. Without his help.

A. I don't think it was below the standard of care not to have seen the patient until 6 o'clock.

Q. Te**11** me why.

A. Because it didn't make a difference.

Q. That's the reason?

A. It didn't make a difference because by the time they would have taken this patient to surgery, he had arrested, and then he had to be resuscitated, et cetera.

Q. That is with hindsight. That's knowing what ultimately happened.

I'm asking you was it below the standard of care not to have obtained a general surgery consult prior to 6:00, and not knowing what was ultimately going to

happen, but should a general surgery consult have been obtained earlier than 6 a.m. to comply with the standard of care?

A. Not to comply with the standard of care, just because they didn't see him before 6 a.m. that it was below the standard of care.

Q. Why?

A. Because nothing was done differently.

Q. That's the basis for your answer?

A. It makes sense.

Q. Whether it makes sense or not that's the basis for your answer; is that correct?

A. They did all the appropriate tests, and we have someone testimony that they did try to call general surgery, and they were in contact via the phone a couple of times, although they were not necessarily there they knew exactly what was going on.

In fact, they ordered an x-ray or something, KUB in that regard, and so they were there basically, if they're not there physically, they were there.

Q. They needed to be there whether it was physically or otherwise, correct?

You're giving the benefit of the doubt to the statements in the deposition which you indicated to me is not supported by anyone else's statement, true?

A. It's not in the medical records, yes.

Q. Yet, you know, Dr. Danasec indicated that there is no evidence that general surgery was consulted or contacted at any time prior to his initiated consult at 5:30, true?

A. I think I remember him saying that. I don't remember who but someone said that.

Q. You said in your report the patient had to be resuscitated, and this was an ongoing process, true?

A. Correct.

Q. And resuscitation should have included transfusions of blood, correct?

MR. KELLEY: Object.

THE WITNESS: It did include transfusions of blood.

BY MR. MISHKIND:

Q. You don't believe that the transfusions of blood that he had had to be given earlier than 4:40 or 4:50 a.m.?

A. I think we're going back to retrospective things in hindsight.

MR. KELLEY: He wants prospective, should they have given blood. Did the standard of care require them to give blood.

THE WITNESS: I think prospective they did

not deviate from the standard of care.
BY MR. MISHKIND:
Q. I understand your position in this case, and I guess looking at it retrospectively, you would have preferred knowing what happened, you would have preferred to have blood upon board sooner, correct?
MR. KELLEY: Object to form. You can answer.
THE WITNESS: Yes.
BY MR. MISHKIND:
Q. And knowing what happened in this case, the patient would have had a better chance, albeit in your opinion, it probably would not make a difference, but a better chance of surviving, true?
MR. KELLEY: Objection to form.
THE WITNESS: Ask the question again.
BY MR. MISHKIND:
Q. Your opinion is that nothing done wouldn't have made any difference in this case, true?
A. Correct.
Q. But you also indicated it would have been preferable to have blood transfusions earlier than they were given, true?
MR. KELLEY: Objection, you left out of the fact retrospective. That this is a retrospective analysis.

THE WITNESS: In hindsight, yes, sir.
BY MR. MISHKIND:
Q. You would agree with the same scenario that had he been given transfusions earlier, he would have had a better chance at survival with earlier transfusions, true?
MR. KELLEY: Objection.
THE WITNESS: I don't know. That's what I'm hesitant to say. True, I don't think the man had many reserves, and I don't know whether -- I don't know if he overcame all his reserves or it would have helped him. So I would like to tell you yes, I think it would have, but I don't know if it would have in this gentleman.
BY MR. MISHKIND:
Q. You're not suggesting on the record that earlier transfusions would have harmed him, are you?
A. In this particular case?
Q. Yes.
A. No.
MR. MISHKIND: Now, just a couple more questions and we will be done.
MR. KELLEY: I don't believe you.
BY MR. MISHKIND:
Q. I would not go on record saying that unless I was truthfully getting close to the end.

You say Mr. Brooks had very little reserve and was unable to withstand very little bleeding.

Tell me what you mean by that statement.

A. If you look his hemoglobin was 13.3 in the afternoon. I think it was 13.3 not 13.9, and he dropped to a hemoglobin of 9, yet he goes into shock, you know, and most of us would have tachycardia, but maybe if we stood up our blood pressure would go to 50 or 60, but he was down. The blood pressure is maintained, but he maintained a blood pressure with a hemoglobin of 9.

People are walking around with a hemoglobin of 9 on a daily basis, and people go to surgery and start off with a hemoglobin of 13, and then end up sometime, an hour later, a hemoglobin of 9 not in shock.

Q. What caused him to have this very little reserve?

A. Probably all his multiple medical problems put together.

Q. Any one of greater significance than any others?

A. I think they're all significant.

Q. The fact that he the drop from the 13 in the afternoon, to 8.6 or 9 in a matter of 10 hours or whatever, you believe that if he had more reserves that this patient should have done better?

A. I think so, yes.

Q. The fact that he continued to bleed after that 8.6 or 9 hemoglobin was drawn, in fact, dropped down to 6.4?

A. Three.

MR. KELLEY: 8.

THE WITNESS: In the 6's.

BY MR. MISHKIND:

Q. Before he started to get transfusions you still believe that this patient had very little reserves that caused him to react differently then someone else would to that kind of a bleed3

MR. KELLEY: Before -- so the record is clear before blood transfusions he was getting saline.

BY MR. MISHKIND:

Q. Yes. He got the crystalloid and saline, but his hemoglobin was not increasing, correct?

A. No, it wasn't.

Q. Is your hemoglobin going to increase when you have an intra-abdominal bleed solely by giving crystalloid?

A. No. It will go down. You'll dilute it that it appears that it's going down when it's not really going down.

Q. If it's down before you start giving the

crystalloid, and you dilute it further, and it's truly an intra-abdominal bleed, that's going to cause a more significant shock to the patient, is it not?

A. On the contrary. The crystalloid adds volume to the blood vessels whenever red cells are around circulation, and that's my whole point, even though the hemoglobin was 8.9 or 9, and he got continuous liters of fluid, and it did drop, that is the dilution affect from receiving so much saline.

So probably instead of hemoglobin 6 and a half, to use a number, in reality it was probably closer to seven and half or eight, and that's sustainable with life and not even to have shock.

Q. So in your opinion if it's sustainable with life, and not even to cause shock, you felt at that point he didn't even need transfusions?

A. No. I didn't say that.

Q. That's seems to be what you're implying.

THE WITNESS: No. Just because the hemoglobin of seven and a half or eight does not cause shock, doesn't mean that you're going to feel as good if your hemoglobin is 12 or 13.

BY MR. MISHKIND:

Q. Would you transfuse if the patient was yours?

MR. KELLEY: Object to the form, asked and

answered several times.

THE WITNESS: In retrospect?

BY MR. MISHKIND:

Q. Yes.

A. Somewhere between four and five.

Q. In retrospective, how many units of blood would you have given him?

A. I think they may have over transfused him. Probably four or five.

Q. At the time that he was taken to surgery, the reason that his hemoglobin and hematocrits were normal because he had received essentially what?

A. Seven units.

Q. Seven units is what your count is, and he also received at least eight liters of crystalloid, correct?

A. Yes.

Q. And that would explain -- plus why the bleeding stopped at some point, that would explain why he was normalized in his hematocrits and hemoglobin?

A. Let's say number X, when you give so many liters of fluid you dilute it so that the hemoglobin of 14 at the time of surgery is diluted hemoglobin. So the real hemoglobin is probably 15 or 16 because he was over transfused.

Q. What happens when someone is over transfused?

A. Nothing. Probably people can go into congestive heart failure depending on the heart and makes the heart weaker. Other than that -- that I can think of right now.

Q. Doctor, I believe I'm done.

I'm looking at your report though, and I think we covered the opinions that you have in terms of looks like one of the opinions was patient had to be resuscitated, and this was on an ongoing basis, and they had to rule out other causes besides the blood; we talked about this, correct?

A. Correct.

Q. You expressed opinions that you hold with regard to that?

A. Yes.

Q. We talked about the issue of whether the patient was in DIC in terms of how that might impact the provision of blood and also talked about surgery, correct?

A. The only thing I would really like to see the labs, but basically if everything is the way we said it I agree with everything.

Q. You also told me as to why you don't think that earlier surgery would have made a difference?

A. Correct.

Q. And you also told me that you felt that he had very little reserves and was unable to withstand the bleeding based upon the hemoglobin levels at various stages, correct?

A. Yes, sir.

Q. You told me the basis for those opinions, correct?

A. Yes, sir.

Q. I believe that I covered all of the opinions that you have expressed in the report, correct?

A. I think so.

Q. Are there any other opinions that you're aware of that you're planning on testify to?

A. No.

Q. You never read Dr. Dinene's report in this case, the surgeon?

A. I don't think so.

MR. MISHKIND: I don't have any further questions for you. I will see you in a couple of weeks.

MR. KELLEY: He'll read.

(Thereupon, this deposition was concluded.)

(Thereupon, reading, signing and notice of filing was not waived.)

_____

Sworn and subscribed to before me
this day of , 2000.

_____
Notary Public in and for the
State of Florida at Large

CERTIFICATE OF OATH

STATE OF FLORIDA
COUNTY OF DADE

I, the undersigned authority, certify that MOISES JACOBS, N.D. personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 21st day of November 2000.

Carol Lenett

Carol Lenett
Notary Public - State of Florida
My Commission No. CC966270
Expires: October 19, 2004

CERTIFICATE OF REPORTER

STATE OF FLORIDA :
: SS
COUNTY OF DADE :

I, CAROL LENETT, Shorthand Reporter and Notary Public, do hereby certify that I reported the deposition of MOISES JACOBS, M.D. a witness called by the Plaintiff in the above-styled cause; that the said witness was duly sworn by me; that reading and subscribing of the deposition were not waived by the witness and by counsel for the respective parties; and that the foregoing pages, numbered from 1 to 117, inclusive, constitute a true and correct transcription of my shorthand report of the deposition by said witness.

I further certify that I am not an attorney or counsel connected with the action, nor financially interested in the action.

Dated this 21st day of November 2000.

CAROL LENETT, COURT REPORTER

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EXPIRES: Oct 19, 2004
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