

State of Ohio,)

County of Cuyahoga.)

Doc 273

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IN THE COURT OF COMMON PLEAS

- - -

DEWEY GLEN JONES, et al.,)

Plaintiffs,)

v.)

Case No. 306012

Judge Lillian Greene

MERIDIA HURON HOSPITAL,)

et al.,)

Defendants.)

- - -

THE DEPOSITION OF JAMES D. MALONEY, M.D.

FRIDAY, JULY 25, 1997

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The deposition of JAMES D. MALONEY, M.D., a witness herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Lauren I. Zigmont-Miller, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at the offices of Reminger & Reminger, The 113 St. Clair Building, Cleveland, Ohio, commencing at 1:15 p.m., the day and date above set forth.

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<p>1 APPEARANCES:</p> <p>2</p> <p>3 on behalf of the Plaintiffs:</p> <p>4 CHARLES H. ALLEN, ESQ. the Keenan Law Firm The Keenan Building 148 Nassau Street, N.W. Atlanta, Georgia 30303 (404) 523-2200</p> <p>7 JACK LANDSKRONER, ESQ. PAUL GRIECO, ESQ. The Landskroner Law Firm 55 Public Square, Suite 1040 Cleveland, Ohio 44113-1904 (216) 241-7000</p> <p>1 On behalf of the Defendant Meridia Huron Hospital:</p> <p>2 JAMES S. CASEY, ESQ. Reminger & Reminger The 113 St. Clair Building Cleveland, Ohio 44114 (216) 687-1311</p> <p>6 On behalf of the Defendants Winston Ho, M.D., and Lakeland Medical Group:</p> <p>7 STEPHEN WALTERS, ESQ. Reminger & Reminger The 113 St. Clair Building Cleveland, Ohio 44114 (216) 687-1311</p> <p>1 On behalf of the Defendant Peter Adamek, M.D:</p> <p>2 SUSAN REINKER, ESQ. Jacobson, Maynard, Tuschman & Kalur 1001 Lakeside Avenue, Suite 1600 Cleveland, Ohio 44114 (216) 736-8600</p>	<p>1 INDEX</p> <p>2 PAGES</p> <p>3</p> <p>4 CROSS-EXAMINATION BY</p> <p>5 MR. ALLEN 5</p> <p>6</p> <p>7 - - -</p> <p>8</p> <p>9</p> <p>10 PLAINTIFFS' EXHIBITS MARKED</p> <p>11 1 and 2 5</p> <p>12 3 60</p> <p>13</p> <p>14 - - -</p> <p>15</p> <p>16</p> <p>17 OBJECTIONS BY</p> <p>18 MR. CASEY 37, 48, 49(2), 50, 51, 56,</p> <p>19 57, 70, 71, 72, 99, 102(2), 103, 120 121, 122,</p> <p>20 123(2)</p> <p>21 MR. JONES 74, 79, 103</p> <p>22 MS. REINKER 54</p> <p>23</p> <p>24</p> <p>25 - - -</p>
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<p>1 On behalf of the Defendant Rafal Badri, M.D:</p> <p>2 MARK JONES, ESQ. Jacobson, Maynard, Tuschman & Kalur 1001 Lakeside Avenue, Suite 1600 Cleveland, Ohio 44114 (216) 736-8600</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>1 (Thereupon, Plaintiffs' Exhibits 1 and 2</p> <p>2 to the deposition of James D. Maloney,</p> <p>3 M.D., were marked for purposes of</p> <p>4 identification.)</p> <p>5 - - -</p> <p>6 JAMES D. MALONEY, M.D.,</p> <p>7 a Witness herein, called for examination by the</p> <p>8 Plaintiffs, under the Rules, having been first duly</p> <p>9 sworn, as hereinafter certified, deposed and said as</p> <p>10 follows:</p> <p>11 CROSS-EXAMINATION</p> <p>12 BY MR. ALLEN:</p> <p>13 Q. Doctor, could you state your name for the</p> <p>14 record?</p> <p>15 A. James D. Maloney.</p> <p>16 Q. And the CV we've marked as Exhibit 1, can</p> <p>17 you just look and tell me if that's up to date?</p> <p>18 A. It is the most up-to-date one that I have.</p> <p>19 It's within several months or six months or so.</p> <p>20 Q. Do you have any articles outstanding or</p> <p>21 about to be published?</p> <p>22 A. Yes.</p> <p>23 Q. Anything that relates to this case?</p> <p>24 A. No.</p> <p>25 Q. If you could, just sort of describe for me</p>

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1 your present position, what you do.

2 A. I'm the director of cardiac

3 electrophysiology and pacing for what's now Columbia

4 Mercy Medical Center and for the NEOUCOM Medical

5 School, and I have a title of professor of medicine

6 with the medical school. Then I am in association with

7 a group of cardiologists referred to as Ohio Heart Care

8 in Canton, Ohio.

9 Q. On a daily basis where do you spend most

10 of your time, in a hospital setting or in the office

11 setting?

12 A. I rotate with my other colleague who does

13 cardiac electrophysiology. We rotate every two weeks.

14 For two weeks I would be mainly in the hospital and

15 then the next two weeks mainly in the clinic.

16 Q. Mainly where?

17 A. In the clinic, in the outpatient area.

18 Q. Okay. Cardiac electrophysiology is what?

19 A. It is a subspecialty area of cardiology

20 that looks after heart rhythm problems, a fast heart

21 beating, slow heart beating, those types of things.

22 Q. How much of your time is spent in that

23 area, cardiac electrophysiology, is it a hundred

24 percent of your time?

25 A. No. Every patient that you see, of

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1 course, has a heart and the heart pumps as well as has

2 electricity, so it's every patient we see has all sorts

3 of cardiologic problems. I would guess 70 to 80

4 percent of my clinical practice deals with patients

5 that primarily have a rhythm problem associated with

6 their other heart disease.

7 Q. And out of those patients, how many of

8 them have pacemakers or end up getting a pacemaker?

9 A. Five percent end up getting a pacemaker.

10 Of all the ones I see, maybe ten percent. Another five

11 or ten percent get implantable defibrillators, another

12 30 percent get various medications for heart rhythm

13 problems.

14 Q. Is it strictly a referral practice where

15 doctors refer patients to you?

16 A. No, no. It's patient referral, physician

17 referral, it is interconsultation between my colleagues

18 and I within the group.

19 Q. How much time do you spend with

20 residents -- do you teach residents?

21 A. Certainly less now. Probably --

22 MR. ALLEN: Any time you

23 need to take a break.

24 MR. CASEY: we're going to

25 go off the record for a minute so the

1 doctor can return a call.

2 (Thereupon, there was a brief recess.)

3 BY MR. ALLEN:

4 Q. I believe the last question I asked about

5 your history with residents and teaching. You

6 explained to me that you haven't done much of it

7 lately, I believe, or less of it.

8 A. As much. In the area that I am now we

9 don't have cardiology fellows. There are medical

10 residents around and so we do not have a resident or a

11 cardiology fellow on our service. We do all of the

12 care without that kind of support, and we care for all

13 types of cardiologic problems.

14 Of course, if we have a specialized

15 intervention to be done with an angioplasty-type

16 cardiologist, we call the angioplasty doc to take that

17 over, but we still manage the patient. If he has a

18 problem, an electrical problem, he would ask me to come

19 in and take care of it. I'm basically a cardiologist

20 and a clinician. 85-90 percent of my time is spent as

21 a practicing clinician.

22 Q. How long has that been the case, the last

23 year, two years?

24 A. The last three to four years. Prior to

25 that I was in Houston and I had more educational

1 responsibilities, but still all of that time I've been

2 a practicing clinician.

3 Q. So the other 15 percent of your time today

4 is spent doing what?

5 A. Administration, like that telephone call

6 and writing a paper here and there.

7 Q. What percentage of your time do you devote

8 to doing medical-legal reviews?

9 A. One or two percent, three percent.

10 Q. Now, do you have any plans in the near

11 future to change, professional plans to change, move?

12 A. I do; I'm contemplating it. I have

13 nothing on paper. I'm being offered what I think is a

14 very nice position managing and clinically directing

15 several EP practices in multiple hospitals, but this is

16 still unofficial.

17 Q. In the Ohio area?

18 A. Yes, in the Ohio area, in the Greater

19 Cleveland area.

20 Q. When were you first contacted to review

21 this case?

22 A. January, December, six months ago.

23 Q. Do you know how Mr. Casey got your name?

24 A. Not for certain. I have a thought

25 process. I guess I didn't ask that. I met a lawyer in

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1 this firm by the name of Malone. I was a defendant in
2 a case that did not come to trial and I guess that's
3 how they got my name.

4 Q. Mr. Malone b you?

5 MR. CASEY: Represented the
6 Cleveland Clinic.

7 A. Represented the Cleveland Clinic.

8 Q. But the case was involved care that you
9 had rendered to a patient, correct?

10 A. Yes.

11 Q. How long ago was that?

12 A. Eight months ago.

13 Q. Did you say that case never came to trial;
14 is that correct?

15 A. That's correct.

16 Q. Did it settle?

17 A. No. They withdrew the complaint as best I
18 know.

19 Q. Other than that time, have you been sued
20 before?

21 A. Yes. Another case at the Cleveland Clinic
22 where many of us were listed, and that case also did
23 not come to trial and I'm not -- I think it was settled
24 for something like \$10,000.

25 Q. How long ago was that?

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1 A. I'm guessing about 1985, '84.

2 Q. Other than those two instances you've
3 never been sued before?

4 A. No.

5 Q. Have you had an occasion to work with
6 anybody else from Mr. Malone's firm or Mr. Casey's
7 firm?

8 A. I have met another gentleman who has asked
9 me to review a case, and so I guess the answer is yes.

10 Q. That's since you've reviewed the Dewey
11 Jones case?

12 A. Yes.

13 Q. Other than those instances, any other
14 times that you've met with or worked with any of the
15 lawyers from Mr. Casey's firm?

16 A. Not that I'm aware of.

17 Q. On your CV is there any literature that
18 you've written that has anything to do with the
19 standard of care issues in this case?

20 A. Not directly. Much of the literature
21 deals with treating patients with bad hearts and so
22 indirectly it would relate.

23 Q. But as far as specific standard of care
24 issues that involve this case, failure to refer a
25 cardiologist, would there be anything in your

1 literature that would have anything to do with when to
2 refer or how to refer or get a cardiology consult?

3 A. For this type of problem, not that I'm
4 aware of.

5 Q. And as far as your literature set forth in
6 your CV and the issue of causation, is there anything
7 set forth in your literature that could relate to the
8 causation issues surrounding this case?

9 A. I'm not sure I really understand what you
10 mean by causation.

11 Q. Well, what happened to Dewey Jones and why
12 it happened when he came out of surgery that left him
13 in the state he's in today.

14 A. Much of the literature that I've written
15 involves problem-solving for cases for cardiovascular
16 disease processes, and if that's problem-solving it
17 certainly in some way relates to this case, not
18 directly, indirectly. I don't know how to answer that
19 question.

20 Q. Does anything in the literature set forth
21 talk about pulmonary edema in any way, causes of?

22 A. Causes of, heart failure in pulmonary
23 edema is one manifestation. Some of the cases, some of
24 the clinical reports relate to the treatment and
25 management of heart failure, particularly associated

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1 with rhythm disorder.

2 Q. And if I understand what you said
3 correctly, there are some articles in here that relate
4 to heart failure and the subsequent cause of pulmonary
5 edema, correct?

6 A. No. They relate to patients that have
7 sick hearts, that have heart failure, and so it's the
8 management of those patients, it's the prognosis of
9 those patients, it's the survival rate looking at a
10 particular group of patients that we have seen at the
11 Cleveland Clinic or elsewhere over a four, five or ten
12 year period.

13 Q. Can you show me those articles that you
14 believe have outlined in them what you just said, or
15 are all your articles included in that?

16 A. I can show you some that relate to the
17 heart failure and prognosis, I guess.

18 Q. Just give me the number beside it.

19 A. There is one article that -- actually,
20 it's listed as publication 166, Long-term follow-up of
21 heart transplant recipients requiring permanent
22 pacemakers. There is an article, 162, Non-thoracotomy
23 versus thoracotomy implantable defibrillators;
24 intention-to-treat comparison of clinical outcomes.
25 There is No. 59, multi-center study.

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1 Q. No. 155?

2 A. 159. Sudden death in recipients of
3 first-generation implantable cardioverter
4 defibrillators; analysis of terminal events. Those are
5 a few examples.

6 Q. Any others that stand out as you just --

7 A. Not any more so than those.

8 Q. I assume you've never had your staff
9 privileges suspended or declined?

10 A. No.

11 Q. And I assume you've never been treated for
12 mental disorder, alcohol or drug abuse?

13 A. No.

14 Q. Have you ever testified or written on tort
15 reform?

16 A. No.

17 Q. Now, you belong to the American College of
18 Cardiology?

19 A. Yes.

20 Q. Have you held any national offices or
21 committee positions with the group?

22 A. Yes; committee positions, not national
23 offices.

24 Q. Tell me which ones.

25 A. The Cardiac Pacing and Electrophysiology

1 Electrophysiology. In one of the manuscripts here for
2 the ACC and the American Heart Association we again
3 developed the training requirements, recommended
4 training requirements for cardiology fellows getting
5 specialized training in heart rhythm management, both
6 pacing and electrophysiology.

7 Q. Have you ever written on the effects of
8 abdominal surgery and patients with congestive heart
9 failure?

10 A. No.

11 Q. Have you ever written on the effects of
12 abdominal surgery with a patient with congestive heart
13 failure and hypertension?

14 A. No.

15 Q. What about the same question With a
16 patient with cardiomegaly, morbid obesity or sleep
17 apnea?

18 A. No.

19 Q. Have you ever written an article on the
20 use of Swan-Ganz catheters inpatient intraoperatively?

21 A. Several abstracts. We never published
22 that. That came from the Mayo Clinic, my experience
23 back in 1974 or '75 when we actually participated in
24 the early introduction of Swan-Ganz catheter
25 utilization.

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1 Committee for the ACC. The current committees that I'm
2 on relate to the RUC committee, which is an AMA
3 committee, I'm the ACC representative to the American
4 Medical Association committee that assesses physician
5 payment for different procedures and relative value
6 payment system. I am on an economics committee for the
7 ACC.

8 I think those are my current committee
for the ACC at this time.

10 Q. Any other committees that you've held
11 that you can tell me about?

12 A. Yes. When the ACC just had a pacemaker
13 committee before it merged with the electrophysiology
14 committee I was on their pacing committee. I was on
15 the committee for directors of cardiac pacing
16 electrophysiology training programs for the ACC. I
17 think that's about it.

18 Q. What about any regional offices?

19 A. For the ACC?

20 Q. For the ACC, yes.

21 A. No regional offices.

22 Q. Have you had an opportunity to formulate
23 any guidelines or technical bulletins for the ACC?

24 A. Yes, but mainly in association with NASPE,
25 which is the North American Society of Pacing and

1 Q. But nothing has been published, correct?

2 A. Only in abstract form.

3 Q. Is there any way that I could find it?

4 A. I may have it listed in the abstracts
5 here. I'll have to look.

6 Q. Would you do that real quick?

7 A. Indirectly there's one article when I was
8 director of the CCU or associate director of the CCU at
9 the Mayo Clinic. Prognostic factors in post-myocardial
10 infarction with ventricular septal defects, 56, but
11 that's the incorrect use of Swan.

12 Q. That was that?

13 A. No. 20.

14 Here we go. No. 11, abstract beginning
15 with Radtke-Rutherford, et al. with Maloney in there.

16 Hemodynamic profiles in unstable angina pectoris, a
17 prospective study, presented at the Sixth Asian-Pacific
18 Congress of Cardiology in 1976. That was all using our
19 Swan-Ganz data.

20 Q. You're working out of Columbia Mercy
21 Medical Center, correct?

22 A. Yes.

23 Q. How big is that hospital, how many beds do
24 you have?

25 A. I believe about 430 beds at the moment.

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1 Q. How many cardiologists on staff there?

2 A. **Thirty, 35.**

3 Q. Have you ever been head of cardiology or
4 chief of staff at that hospital?

5 A. **No, not those positions.**

6 Q. In 1994 do you-know how many beds Meridia
7 Huron had?

8 A. **I believe I read it somewhere, 200, 225.**

9 **I believe that number comes to mind.**

10 Q. Do you know how many cardiologists they
11 had on staff there?

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

13 Q. Do you know the number of residents they
14 had on staff?

15 A. **I recall reading that they had internal
16 medicine residents, anesthesia residents and general
17 surgical residents. Numbers I don't know.**

18 Q. But you know they had those three areas.
19 They didn't have any --

20 A. **To my recollection, those were the three I
21 remember.**

22 Q. Do you know the number of general surgeons
23 they had on staff at Meridia Huron in '94?

24 A. **I remember reading that question being
25 posed in probably a deposition. I don't have firsthand**

1 lawyers?

2 A. **Only informally.**

3 Q. In what manner was that?

4 A. **As of today.**

5 Q. Have you ever given a speech to a group of
6 insurance adjustors or people?

7 A. **Actually, yes.**

8 Q. When was that?

9 A. **Probably four or five years ago. There
10 were also physicians there and the presentation was
11 published and it was published as an insurance -- your
12 term, what was it, insurance something or other?**

13 Q. Adjustor.

14 A. **Adjustors, I don't know. Insurance
15 people, that's all I know who they were.**

16 Q. What were you speaking of?

17 A. **Heart rhythm management, supraventricular
18 tachycardiac, tachycardia and bradycardia. I gave an
19 overview of all aspects of heart rhythm management and
20 kind of the state-of-the-art talk.**

21 Q. What insurance group was that?

22 A. **I have no idea.**

23 Q. Was it in the State of Ohio?

24 A. **The talk was given in Florida, I believe,
25 or somewhere down south as I recall.**

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1 knowledge of knowing how many, no.

2 Q. Do you know the availability of
3 echocardiograms at that hospital in 1994?

4 A. **My understanding is that they had ready
5 availability of echos.**

6 Q. Meaning at any time?

7 A. **During working hours presumably, unless
8 you call an emergency, yes.**

9 Q. To run an echocardiogram you need a
10 technician, correct?

11 A. **That's correct.**

12 Q. You wouldn't need a cardiologist to run
13 the test, correct?

14 A. **A cardiologist who is expert in echos can
15 also do it without the tech, so, yes, you can do it
16 either by a cardiologist or a tech or both.**

17 Q. But normally then it's read afterwards by
18 a cardiologist, correct?

19 A. **That's correct.**

20 Q. Did you know the availability of
21 cardiologists to read the echos in October of 1994,
22 what the availability was at Meridia Huron?

23 A. **Specifically, no, I don't know how many
24 cardiologists were credentialed to read echos.**

25 Q. Have you ever spoken to a group of

1 Q. Is that published on your CV?

2 A. **Probably not.**

3 Q. You spoke for what, an hour, some-
4 like that?

5 A. **Hour and 15 minutes,**

6 Q. Now, did you ever have an opportunity to
7 read materials on how you give a deposition for a
8 medical-legal case?

9 A. **No, I've never done that. I probably
10 should.**

11 Q. Likewise, you haven't seen any videos?

12 A. **No, I have not.**

13 Q. You haven't gone to any conferences or
14 seminars relating to that?

15 A. **No, I have not.**

16 **Do they have seminars like that, I
17 guess?**

18 Q. They have seminars for everything, right?

19 Have you ever reviewed or testified on
20 medical-legal cases in the State of Ohio other than
21 this case?

22 A. **Yes.**

23 Q. You told me about the case that we'll soon
24 be reviewing. Excluding that case, how many times have
25 you reviewed medical-legal cases in the State of Ohio?

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1 A. Probably about four. Two of them are just
2 beginning and one was about three years ago.

3 Q. The one three years ago was where?

4 A. Cincinnati.

5 Q. Did that have to do with
6 electrophysiology?

7 A. With cardiology. With that particular
8 patient it dealt with a pacemaker problem.

9 Q. Then the two that are beginning besides
10 this one, where are those?

11 A. There is a case that I was asked to review
12 in Youngstown related to a patient that had a sudden
13 death, acute sudden death episode, survived, got an
14 implantable defibrillator and then had an infection.

15 Q. You're giving testimony for the doctor?

16 A. In that case, yes.

17 Q. In the other case are you giving testimony
18 for the doctor?

19 A. Which other case, the one in Cincinnati?

20 Q. You said two that you're beginning, one in
21 Youngstown.

22 A. And the one we mentioned with this firm.

23 Q. With this firm?

24 A. With this firm.

25 Q. So we have the one with this firm, the

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1 other one with the firm we have the one you're here
2 for today, correct?

3 A. Correct.

4 Q. You have one out of Youngstown, that's
5 three. And then one in Cincinnati about three or four
6 year ago?

7 A. That's correct.

8 Q. So that's a total of four?

9 A. That's correct.

10 Q. You've never given testimony on the part
11 of a plaintiff?

12 A. Yes.

13 Q. Was it a case that involved something that
14 the doctor had done wrong, standard of care violation
15 on the part of a doctor?

16 A. Yes.

17 Q. Tell me about that case.

18 A. Well, there are two cases. The one case
19 in Cincinnati is that particular case, and it also
20 involves a manufacturer. The patient got a pacemaker,
21 the pacemaker malfunctioned and there was a lawsuit
22 developed from that.

23 The other case took place in Seattle,
24 Washington and it related to a patient with
25 cardiomyopathy, heart failure, an episode of near

1 sudden death treated with medication and then a
2 subsequent episode of near sudden death with brain
3 damage.

4 Q. Who was the plaintiff lawyer that hired
5 you?

6 A. Where?

7 Q. In Seattle.

8 A. Lou Gilligan, I guess, would be the name.

9 Q. Just so I make sure I got the numbers -- I
10 don't mean to be repetitive -- I count two for the
11 plaintiff, two for the defendant, and then one other
12 one for the defendant, is that correct, so I got five?

13 A. I was coming to four, but -- in Ohio or
14 Seattle?

15 Q. In Ohio.

16 A. There are two for the plaintiff, I guess,
17 Seattle and Ohio one, and three -- that's correct, four
18 in Ohio. A total of about five, that's about right.

19 Q. Total of five overall?

20 A. Five that we've talked about.

21 Q. Other than the State of Ohio, have you
22 testified in other places?

23 A. Yes.

24 Q. What other states have you testified in?

25 A. New Mexico and in Maryland, Baltimore,

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1 Maryland.

2 Q. How many cases in New Mexico?

3 A. One.

4 Q. Maryland?

5 A. One.

6 Q. Plaintiff, defendant?

7 A. Those were both defendants.

8 Q. Would those also have to do with
9 pacemakers?

10 A. No. It had to do with sudden death in
11 one, and that's in New Mexico; and the other one dealt
12 with an extraction of a pacing device which resulted in
13 a surgical complication.

14 Q. How long ago was the one in New Mexico?

15 A. About 1993.

16 Q. Who was the lawyer that hired you in that
17 case?

18 A. I don't know.

19 Q. Do you know the name of any of the
20 defendants or the plaintiff, do you recall any of that?

21 A. I believe the physician's name was Baddi
22 in New Mexico.

23 Q. Other than Mr. Casey's firm, have you
24 worked for the other firm involved in this case before?

25 A. No, not that I'm aware of.

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1 Q. Do you know Susan Reinker who is on the
2 phone?
3 A. I do not.
4 Q. And the other firm would be Reminger firm.
5 MR. GRIECO: Jacobson.
6 Q. I'm sorry.
7 A. I didn't know they were here.
8 Q. Jacobson, Maynard, Tuschman.
9 A. I don't know. I've had no association.
10 Q. Do you know any of the following doctors,
11 Dr. David Rapkin, R-A-P-K-I-N?
12 A. Not to my knowledge. I can't put a name
13 with a face.
14 Q. Dr. John Conomy?
15 A. Yes, I do know him. He and I were
16 colleagues at the Cleveland Clinic.
17 Q. When did you first meet Dr. Conomy?
18 A. Well, I first went to the Cleveland Clinic
19 in 1981 and he was there. I probably really didn't
20 meet him until about 1984 or '85.
21 Q. When is the last time you've seen him?
22 A. 1993 probably.
23 Q. Dr. Cascorbi?
24 MR. CASEY: Yes, Helmet
25 Cascorbi.

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1 A. The name is not familiar to me.
2 Q. How about Dr. Howard Nearman?
3 [REDACTED]
4 Q. How about Dr. Richard Seligson?
5 [REDACTED]
6 Q. Dr. John Downs?
7 A. I do not know him.
8 Q. How about Dr. Joe Bussey?
9 A. The name is familiar, but I know a Bussey
10 family.
11 Q. Dr. Joel Kaplan?
12 A. No.
13 Q. Dr. Marc Semigran?
14 A. No.
15 Q. Dr. Alvin Kahn?
16 A. No.
17 Q. Dr. Francis Barnes?
18 A. No.
19 Q. Dr. Robert Greendyke?
20 A. No.
21 Q. Dr. Charles Greenhouse?
22 A. No.
23 Q. Dr. Marshall Orloff?
24 A. No.
25 Q. Dr. Paul Thompson, cardiologist?

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1 A. No.
2 Q. Dr. Terry Winkler?
3 A. That name is familiar.
4 Q. Now, when is the last time you've given a
5 deposition?
6 A. I'm scheduled to give a deposition in
7 Youngstown. I guess the last time I gave a deposition
8 was in Maryland about 1995 or so.
9 Q. When was the last time you appeared in
10 trial?
11 A. Maryland, 1995.
12 Q. How many trial appearances do you have
13 total for medical malpractice cases?
14 A. I want to say three. It could be four, I
15 guess.
16 Q. The number of depositions you've given, in
17 all the cases we just talked about you've given
18 depositions for those, five total?
19 A. I believe so.
20 Q. Plus the two out of state, New Mexico
21 and --
22 A. Yes.
23 Q. Have you reserved a date for this trial to
24 testify in this trial?
25 A. I haven't. My secretary may have, but I

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1 haven't.
2 Q. Have you ever been retained by an attorney
3 witness finder up?
4 [REDACTED] I'm aware of.
5 Yes, how much is it an hour for
6 deposition time?
7 A. \$450.
8 Q. To review a case?
9 A. The paperwork review?
10 Q. Yes.
11 A. \$300.
12 Q. Trial testimony, how much?
13 A. \$450.
14 Q. When was the last time that changed, did
15 that just recently change?
16 A. Actually, yes. Compared to the Maryland
17 case, it's been decreased by \$150.
18 Q. All across the board?
19 A. No. My past experience was that we just
20 charged one fee.
21 Q. \$400 an hour was your past history, right?
22 A. Yes.
23 Q. Now, what percentage of income went in
24 your pocket last year for medical-legal cases?
25 A. Five percent, three percent, two percent.

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1 Q. How many hours have you spent reviewing
2 this case?
3 A. I haven't tabulated it here. Counting
4 some review yesterday and today, I don't know, 10, 12,
5 15 hours.
6 Q. How many hours did it take you to come up
7 with your opinion for you wrote your letter
8 which we'll get to in a minute?
9 A. Seven or eight.
10 Q. And you have yet to bill anybody to date;
11 is that correct?
12 A. I believe that's correct.
13 Q. And you have all the information you need
14 obviously to form your opinions today, correct?
15 A. Yes.
16 Q. Have you ever testified that the standard
17 of care required a medical doctor to get a cardiology
18 consult?
19 A. No.
20 Q. Have you ever given opinions as to the
21 standard of care required of an internal medicine
22 doctor, a surgeon or an anesthesiologist to delay
23 surgery because of the patient's medical condition?
24 A. Could you restate that, the beginning?
25 Q. Have you ever given opinions that the

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1 standard of care required that a doctor, either an
2 internist, a surgeon or an anesthesiologist, delay
3 surgery based upon the medical condition of the
4 patient?
5 A. In a legal situation?
6 Q. Right.
7 A. No, not that I'm aware of.
8 Q. Have you ever testified that the standard
9 of care required the use of a Swan-Ganz catheter during
10 an operation?
11 A. No.
12 Q. Have you ever testified that the standard
13 of care required a physician not to operate on a
14 patient because his medical condition was unstable?
15 A. No.
16 Q. Is there any specific authoritative
17 literature upon which you base your opinion on the
18 standard of care in this case?
19 A. No.
20 Q. Is there any authoritative literature on
21 which you base your opinion as to causation in this
22 case?
23 A. No.
24 Q. When you reviewed this case you assumed
25 that the records were entirely correct?

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1 A. As a physician you never make that
2 assumption, and entirely, no, no, I would not make that
3 assumption.
4 Q. So you take into effect that some things
5 that you read in the medical records could be
6 incorrect?
7 A. It could be incorrect; it could be
8 misstated; it could be misinterpreted; it could be
9 absent.
10 Q. But as far as the medical records, have
11 you ever written a record to a medical record,
12 something that was incorrect?
13 A. Have I?
14 Q. Yes.
15 A. Absolutely.
16 Q. When was the last time you did that?
17 A. I don't recall.
18 Q. Would that be a breach of the standard of
19 care to write --
20 A. No.
21 Q. Have you ever seen the standard of care
22 breached by a doctor?
23 A. I believe so.
24 Q. Have you ever reported it that the doctor
25 breached the standard of care?

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1 MR. WALTERS: Reported it to
2 whom?
3 MR. ALLEN: Anybody.
4 MR. WALTERS: In regards to
5 what?
6 MR. ALLEN: That the
7 standard of care was breached.
8 MR. WALTERS: I want to
9 clarify. Are you talking about his
10 testimony, previous experience or with
11 regard --
12 BY MR. ALLEN
13 Q. I think you understand my question.
14 MR. WALTERS: I don't.
15 A. As a practitioner?
16 Q. As a practitioner. Have you ever seen --
17 A. Have I seen things done or start to be
18 done that I thought should not be done, the answer is
19 yes.
20 Q. That would be a breach of the standard of
21 care?
22 A. Those are not terms that I use in medical
23 practice.
24 Q. So you've seen things done that you
25 thought should not be done?

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1 A. I've seen that.

2 Q. When you've seen that, have you told the
3 doctor not to do that or have you gone up the chain and
4 told his superiors that he was doing something that you
5 felt was incorrect?

6 A. We would discuss it generally with the
7 physician. It's in a teaching teamwork environment.
8 You bounce each other's ideas off one another and come
9 out with what you consider is the most appropriate
10 thing.

11 Q. So you've never had to rise to the level
12 in which you felt you had to get another doctor or
13 somebody else to intervene?

14 A. I haven't that I can recall.

15 Q. Doctor, what does within a reasonable
16 degree of medical certainty mean to you?

17 A. I'm led to believe that in legal
18 terminology it means 51 percent likelihood or more.
19 That's my understanding.

20 Q. So when we talk about that, we're not
21 talking about possibilities or likelihood or
22 speculation or guess, we're talking 51 percent?

23 A. That's my understanding.

24 Q. Within a reasonable degree of medical
25 certainty, what was the cause of Dewey Jones'

1 arrest?

2 A. Cardiopulmonary collapse is a relatively
3 sudden decrease in his cardiovascular function and his
4 pulmonary function, and they were very much intertwined
5 between each other. Presumably his systemic pressures
6 dropped markedly, his cardiac output dropped, his
7 intravascular pressures equalized at about 40 or 50
8 millimeters of mercury. That's what I mean by that
9 type of collapse.

10 Q. When did the intravascular pressure
11 equalize at 40 to 50?

12 A. They were not being measured at the time
13 that this presumably occurred. At that period of time
14 when his heart rate was said to be quite slow, severely
15 bradycardia, when he had markedly decreased
16 oxygenation, we know when there is no cardiac output or
17 essentially no cardiac output in that type of state
18 then the pressures within the lung and within the
19 vascular system go to about 40. It was a transient
20 near death episode. That's when those pressures go
21 down to that level.

22 Q. So within a reasonable degree of medical
23 certainty you could tell me that it was Within 40 at
24 that time?

25 A. Well, that's usually what any of us would

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1 postoperative arrest in your opinion?

2 A. One, ... a
3 cardiac arrest; number two, the cause of his
4 cardiopulmonary collapse was multi-factorial.

5 Q. Explain to me what multi-factorial means.

6 A. More than one factor played a role.

7 Q. In Dewey Jones' case, thank you.

8 And in this situation the

9 cardiopulmonary collapse was multi-factorial as it
10 related to Dewey Jones. What came into play that led
11 to his cardiopulmonary collapse?

12 A. Hypoxia, an underlying cardiomyopathy that
13 was relatively mild to moderate as a structural
14 abnormality, pulmonary hypertension and cor pulmonale
15 aggravated by his obesity. Those are the three major
16 things, and his hypertension.

17 Q. What is the difference between cardiac
18 collapse and a cardiac arrest?

19 A. We cardiologists think of a cardiac arrest
20 as being defined as an interruption of effective
21 cardiac output due primarily to the heart, not
22 secondarily to some other factor, and most commonly
23 that is associated with rhythm abnormalities, either
24 ventricular fibrillation or ventricular asystole.

25 Q. What's pulmonary collapse versus pulmonary

1 do if we suddenly had a marked diminution of our
2 cardiopulmonary function down to almost a death state
3 and no cardiac output. If I stopped your heart for a
4 minute then the pressures that you would have would
5 equalize out to about 40.

6 Q. What precipitated the cardiopulmonary
7 collapse?

8 A. I believe it was the hypoxia. Then the
9 question is what precipitated the hypoxia, and I am not
10 sure that I have that answer. It's the hypoxia that we
11 have recorded where his oxygen saturations went from 99
12 down to 90 and then 89, and at that point there was, if
13 I recall correctly, a 15 or 20 minute gap where we
14 don't know what was happening, but we're told that he
15 had severe bradycardia then and he was getting some
16 cardiopulmonary resuscitation and then he recovered.

17 Q. So you can't tell me what caused that
18 15-minute window in which the oxygen sats dropped to 89
19 percent: is that correct?

20 A. I can give you an idea of what happened,
21 but the one very objective piece of information we have
22 is that he developed hypoxia.

23 Q. Right. But my question, the hypoxia, you
24 can't tell me what created the hypoxia; is that true?

25 MR. CASEY: objection. Are

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1 you asking him to a reasonable degree of
2 probability again?

3 MR. ALLEN: Yes.

4 MR. CASEY: What does he
5 likely believe was causing the hypoxia?

6 MR. ALLEN: Sure.

7 BY MR. ALLEN:

8 Q. Do you understand that question?

9 A. Not totally. Why don't you ask it again.

10 Q. All right. Within a reasonable degree of
11 medical certainty, what caused Dewey Jones to go into
12 that hypoxic state at the time we're talking il

13 A. ~~was~~
14 time they were reversing the anesthesia, and there were
15 comments either in the record or in some depositions
16 that the patient was bucking, coughing with an
17 endotracheal tube in place. That coughing could be
18 caused by the hypoxia and it could also aggravate or
19 cause the hypoxia, but at that point in time he was
20 just not getting enough oxygen into his system to
21 oxygenate the blood.

22 When that occurs, particularly in
23 somebody with pulmonary hypertension to begin with, you
24 get vasoconstriction in the pulmonary vasculature and
25 even more pulmonary hypertension, and you, in fact,

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1 begin to get right heart failure. The hypoxia in an
2 animal or in man will cause a reflex mechanism of
3 paradoxical bradycardia, which actually probably
4 further aggravates the problem, not definitely
5 aggravates the problem.

6 Q. The pulmonary edema stems from that event,
7 correct?

8 A. That's my understanding.

9 Q. As far as this time frame, is it your
10 belief Dewey Jones was intubated or extubated at that
11 time?

12 A. As best I can tell, he was intubated.

13 Q. And you base that opinion upon?

14 A. There is no statement that he was
15 extubated.

16 Q. In the medical records or in deposition?

17 A. I'm referring to the medical records. I
18 haven't heard all the depositions, but to my knowledge,
19 both from depositions and from the medical records,
20 they were ready to extubate but the tube was not
21 withdrawn from the patient.

22 Q. What is your definition of extubation,
23 doctor

24 Removing the endotracheal tube from the
25 patient.

1 Q. Have you reviewed the life care plan in
2 this case?

3 A. Nu. I don't know what a life care plan
4 is.

5 Q. Do you plan on offering opinion as to life
6 expectancy of Dewey Jones?

7 A. Yes.

8 Q. Give me your opinions as to how long you
9 felt Dewey Jones would have lived had he not had the
10 surgery.

11 A. Well, I believe that he had, again,
12 several cardiovascular problems that were occurring
13 simultaneously. Number one, he had hypertension that
14 he appeared not to care for when he was out of the
15 hospital, but which came under very rapid control
16 usually when he went into the hospital. So he had
17 severe hypertension when not taking his medicine.

18 He also has, I believe, an underlying
19 cardiomyopathy that seems to be not classic for that
20 resulting from hypertension but more of a primary
21 muscle abnormality. So that's a second problem he has.
22 If that's indeed the case -- and I believe in the
23 records there was a note that his mother had a similar
24 problem -- but if that's indeed the case, it adds to
25 his poor prognosis.

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1 The third thing that he has is his
2 marked obesity, pulmonary hypertension and right heart
3 failure. I guess we would call that cor pulmonale or
4 Pickwickian syndrome. All three of those things have
5 significant risk factors if not managed, and even if
6 they are managed.

7 If you would just take cardiomyopathy
8 alone and look at the prognosis of people with primary
9 cardiomyopathy classified as dilated cardiomyopathy --

10 Q. Not caused by hypertension?

11 A. Not caused by hypertension.

12 If you would put all those people
13 together and go from the point of diagnosis, then there
14 would be probably -- the Mayo Clinic series would say
15 probably about a 30 percent one-year mortality, maybe a
16 60 or 70 percent five-year mortality, probably a 90
17 percent ten-year mortality.

18 Q. So is that 51 percent in life
19 expectancy -- to a reasonable degree of medical
20 certainty, how long would he have lived?

21 A. Well, he may, in fact, be on borrowed
22 time. If we went from the time of his diagnosis from
23 the old records of 1987 -- and I think that's the date
24 I saw the cardiomyopathy -- he's already ten years, I
25 guess, so he's pushing the envelope now. But three or

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1 four more years.

2 Q. So your belief was three or four more
3 years, meaning Mr. Jones would have died in October of
4 1997; is that correct?

5 A. Three or four more years, I was thinking
6 of from the ten years we are now, from the '87 to '97.

7 Q. So you think he would have died at the age
8 of what?

9 A. 35, 36, 37. Since he's alive now I would
10 think that, and that is assuming that he would take
11 care of these medical problems. Now, I know they're
12 being taken care of now, but --

13 Q. So within a reasonable degree of medical
14 certainty, you believe Dewey Jones, had the surgery not
15 occurred and he kept on the way he had and his previous
16 history, would have died within three years of October
17 of 1994; is that correct?

18 A. I think that's about correct. I would
19 think he probably had a 75 to 85 percent chance of
20 dying by this time if we start from 1987, and that's
21 even -- and maybe even earlier, particularly since he
22 had this history of not taking care of his medical
23 problems.

24 Q. So within a reasonable degree of medical
25 certainty, three more years from the date of the

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1 surgery is your opinion as to life expectancy?

2 A. I think that's reasonable, short of a
3 transplant. And the transplant would probably have to
4 be a cardiopulmonary transplant, depending on his
5 lungs.

6 Q. Is he a candidate for that?

7 A. At 300 pounds plus you could not -- no,
8 the answer would be no. Certainly not in Houston and
9 not in Cleveland.

10 Q. If he had lost some weight and become a
11 candidate for it, would that have given him a normal
12 life expectancy?

13 A. It would have given him -- not normal, not
14 at all. It would have given him an 80 percent survival
15 after one year of transplant, maybe 85 percent, and
16 then probably overall a 70 percent survival at seven to
17 ten years, and then he would probably have to have
18 another one.

19 Q. At the end of ten years?

20 A. Ten, 15 years.

21 Q. And now the state Dewey is in today --
22 tell me how you understand Dewey to be presently.

23 A. I don't have very much information on
24 that. I'm just told that he is in a nursing home and
25 he is in a vegetative state.

1 Q. Do you have an opinion as to how long he
2 would live in his present state within a reasonable
3 degree of medical certainty?

4 A. Assuming that he is being given multiple
5 medications, his hypertension should not be a problem,
6 his actual cardiac work will be diminished because he
7 is on a respirator. But he is very vulnerable to the
8 complications of chronic bed rest, Foley catheters,
9 infection, et cetera.

10 Again, I would think that his
11 prognosis, the likelihood of him dying over the next
12 three to four years is very high, certainly greater
13 than 51 percent, probably greater than 80 percent.

14 Q. Do you have an opinion within a reasonable
15 degree of medical certainty that Dewey Jones will be
16 alive a year from today?

17 A. I would think that if you were gambling
18 and he's alive today, particularly if you expend
19 effort -- I don't know his actual condition today, but
20 assuming he doesn't have a malignant type of infection
21 going on, the likelihood of living the next year is
22 probably quite good.

23 Q. So it's greater than 51 percent?

24 A. I would think so.

25 Q. What about two years from today?

1 A. Less.

2 Q. Less than 51 percent?

3 A. Less than one year. As I said before,
4 probably three to four years in that kind of state is
5 as good as one can get.

6 Q. So within a reasonable degree of medical
7 certainty, you believe Dewey Jones will live three
8 years from today, is that your --

9 A. I can accept that statement.

10 Q. So you agree.

11 Now, tell me, have you asked that any
12 additional studies or workup be done to evaluate
13 Mr. Jones?

14 A. No, I have not.

15 Q. You understand that the standard of care
16 can be breached yet cause no damage; do you understand
17 that concept?

18 A. Certainly.

19 Q. Did you identify any breaches of the
20 standard of care in which your opinion caused no damage
21 when you reviewed the records of Dewey Jones'
22 hospitalization of October 17th?

23 A. Not that I'm aware of.

24 Q. Upon your initial review, Doctor, were
25 there any areas of the records or depositions which

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1 caused you concern, that is, you believe there was a
2 problem area that needed further review, even if you
3 later decided a breach did not occur at that point?

4 MR. CASEY: I don't think I
5 understand that question.

6 A. Could you rephrase that, please?

7 Q. Upon your initial review were there any
8 areas of the records or in the depositions which caused
9 you concern, that is, you believe there was a problem
10 area that needed further review, even if later you
11 decided a breach of the standard of care did not occur
12 at that point?

13 A. I guess the answer would be yes to that.
14 I did review the echocardiogram. That wasn't available
15 in the record as far as I recall. I certainly have
16 looked over the intraoperative course and the
17 anesthesia surgical records carefully, and there are
18 some questions I have about their nomenclature that I
19 need review of that, more clarification, I suppose.

20 Q. And you further investigated those areas,
21 correct?

22 A. I have not talked to the anesthesiologist
23 or the surgeon and so I haven't fully investigated
24 those things, no. That's not my job, I don't think.

25 Q. But intraoperatively what areas are you

1 could have been reversed within one or two minutes we
2 would not have had the problem.

3 Q. Do you believe that they should have had
4 the ability to reverse the hypoxia within one or two
5 minutes?

6 A. Should have, I'm not sure how to interpret
7 that. Yes, I believe that we should certainly have
8 that ability and it would be nice if the ability was
9 available at that time. I'm not sure how you put your
10 emphasis on those words.

11 Q. Should Meridia Hospital have had the tools
12 and the people available to reverse the hypoxia within
13 a minute or two of this occurring?

14 MR. CASEY. Objection.

15 A. I think they did have the people and the
16 tools there, but the hypoxia was not reversed soon
17 enough.

18 Q. What would have been soon enough to have
19 caused Dewey Jones no subsequent damage?

20 A. We like to think that if one develops
21 anoxia -- no oxygen circulating in the system, and he
22 had some certainly -- three to four minutes is probably
23 the maximum that you want to go to before you have
24 irreversible damage.

25 Q. And at what point would the standard of

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1 talking about?

2 A. Intraoperatively, well, when the patient
3 developed the hypoxic episode we need to find out more
4 clearly exactly what medications were given or not
5 given at that time and how far along one was with the
6 reversal of anesthesia.

7 There was a 15 or 20 minute blank
8 period in the anesthesia record. I can certainly
9 understand that everyone was rushing around trying to
10 take care of the patient, but it was not filled in
11 retrospectively. I'm not sure if that's the right way
12 to do it or not. That needs to be clarified in my
13 mind.

14 Q. Why does it need to be clarified?

15 A. So I have a better understanding of how
16 the resuscitative efforts were carried out, I guess.

17 Q. Why is that important to your opinion?

18 A. I'm not sure it's important to my opinion.
19 It's important for me to know how fast people responded
20 to this medical emergency and the exact pathophysiology
21 that set it off and, in fact, corrected it.

22 Q. Do you have an opinion that the people did
23 not respond quick enough to the medical emergency?

24 A. Sure you
25 There's no question in my mind that if the hypoxia

1 care have required Dewey Jones' hypoxia to have been
2 reversed, how many minutes?

3 MR. CASEY. Objection.

4 into that. They were trying to reverse it immediately
5 as best I can look at the record.

6 Ask that question again, please.

7 Q. So, in your opinion, is there a time in
8 which the standard of care would have required the
9 medical providers to have reversed Dewey Jones' hypoxic
10 event?

11 MR. CASEY: Objection.

12 You're assuming that they could.

13 A. To answer your question from a medical
14 perspective, as we said previously, one needs to
15 reverse the hypoxia within four minutes or so to avoid
16 central nervous system damage. Whether it's a standard
17 of care issue from the medical standpoint is not what
18 I'm addressing right now with you.

19 Q. So you do not have an opinion as to
20 whether the standard of care required it to be reversed
21 within 10 minutes, within 15 minutes, within any time
22 frame?

23 A. Well, certainly the standard of care is if
24 you are going to have a viable patient you must reverse

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1 it in a set amount of time, and the general time period
2 for complete anoxia for a cardiac arrest, meaning no
3 blood being circulated with no oxygen, is three to four
4 minutes, and that's in a warm state without
5 pre-treatment with various medications.

6 In a relative hypoxic state then you
7 have much more time, and it depends -- it depends on
8 how much oxygen is getting to the brain to tell you how
9 much time you have. He had a relative hypoxia, not an
10 absolute hypoxia.

11 Q. So his relative hypoxia to oxygen levels
12 of 89 percent, how much time did he have for --

13 A. At 89 percent they could spend all day.

14 Q. Do you have an opinion as to how far the
15 oxygen saturations dropped on Dewey Jones to cause his
16 brain damage?

17 A. It had to drop much lower than 89 percent,
18 and the drop -- it's not just the drop that's
19 important, but it's the relative amount of cardiac
20 output and how much of that is being transported to the
21 brain.

22 Q. So do you have an opinion as to how much
23 time it took for Dewey Jones to develop irreversible
24 damage in the state that he was in?

25 MR. CASEY: Objection. We

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1 know exactly. Called the code at 1:14.

2 BY MR. ALLEN.

3 Q. To a reasonable degree --

4 A. I'm not sure how to answer that question.

5 MR. CASEY: Do you
6 understand it, Doctor?

7 THE WITNESS: No.

8 A. Ask it again, please.

9 Q. You tell me that it took three to four
10 minutes to develop brain damage from a complete anoxic
11 event, correct?

12 A. Yes.

13 Q. In the state and condition that Dewey
14 Jones was in, how long did it take Dewey Jones to
15 develop irreversible brain damage?

16 A. In this situation I would speculate, I
17 guess, that it probably took 20 minutes, 25 minutes.

18 Q. Would you expect the standard of care to
19 be that they should have been able to reverse Dewey
20 Jones' hypoxic state within 25 minutes?

21 MR. CASEY: Objection.

22 A. It's not -- I couldn't make that judgment
23 as a standard of care. I would say that in order to
24 have a good result, assuming the hypoxia was that
25 severe, if you don't reverse it in that time or less

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1 you are going to have a bad outcome.

2 Q. How long did it take them -- I'm sorry.

3 A. In medicine we don't like bad outcomes.

4 Q. Can you tell me how long it took them to
5 reverse Dewey Jones' hypoxic state?

6 A. I would have to look at the record, I
7 guess.

8 MR. CASEY The anesthesia
9 record?

10 THE WITNESS: Yes.

11 A. The relative hypoxia according to the
12 chart began in the interval time at 12:30, 12:45. I
13 can't tell you which time, which side of that envelope
14 we're in. The hypoxia was essentially the same,
15 slightly worse, 89 percent in the time frame of 12:45
16 to 1:00, but that is still enough oxygen if his cardiac
17 output is adequate, and we think cardiac output
18 certainly should be adequate because the heart rate and
19 blood pressure were adequate.

20 Q. What were they at that time, Doctor?

21 A. It looks like his blood pressure had gone
22 up five or ten points or so. If I try and read this,
23 close to 180 over 85 to 95 or so.

24 Q. And his cardiac?

25 A. Heart rate?

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1 Q. Heart rate, yes.

2 A. Heart rate, a few points above a hundred.
3 I would judge by the point of 110. So he is developing
4 a little bit of tachycardia response -- looking back a
5 little bit -- tachycardia response and a little bit of
6 epinephrine released, hypertensive response, certainly
7 not bad at all. That's when they're beginning to try
8 and reverse the anesthesia. So we are not even in a
9 jeopardized central nervous system state at that point
10 in time.

11 Q. At 1:00?

12 A. At 1:00, according to the record. Then at
13 1:15, according to the record, from 1:00 to 1:15 we
14 don't have an oxygen saturation, and we have a note
15 slightly to the right of that that he is having
16 bradycardia, and we don't have a blood pressure
17 notation. At about that time I think they are calling
18 for the cardiopulmonary resuscitation team to come in
19 and they may or may not be doing cardiopulmonary
20 massage.

21 I would have to correlate these two to
22 know at exactly that time, which again can support
23 cerebral circulation to a degree. But basically from
24 1:00 until 1:15, somewhere in between -- actually, from
25 1:00 until 1:30 is the critical time. It's 25, 30

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1 minutes depending on how one looks at that data.
2 That's the time that the cerebral hypoxia presumably is
3 taking its major effect.

4 After that time it appears from the
5 record that his heart rhythm is restored, he has a
6 sinus rhythm that's restored, he has a blood pressure
7 that's restored, and he should be perfusing his
8 cerebrum as well as other organs.

9 MS. REINKER: I need to
10 interrupt at this point because I need to
11 leave. I would just like to note a
12 continuing objection on the record to any
13 anesthesia opinion testimony from this
14 witness, who as far as I know does not
15 practice anesthesia. That being said, I
16 need to depart.

17 MR. ALLEN: okay. Thank
18 you very much.

19 MS. REINKER: Thank you.

20 BY MR. ALLEN:

21 Q. So, Doctor, the record indicates that no
22 central nervous system damage was incurred to Dewey
23 Jones up to 1:00, correct, brain damage?

24 A. The record doesn't indicate that.

25 Q. In your opinion?

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1 A. In my opinion, the supporting data from
2 the record would strongly suggest that brain damage was
3 not taking place up until 1:00, if this is 1:00.

4 Q. Then, in your opinion, brain damage
5 occurred between 1:00 and 1:30, correct?

6 A. That's correct.

7 Q. Now, you told me that you didn't have the
8 echo when you first reviewed the case; is that correct?
9 What were your concerns about the echocardiogram?

10 A. My concern, I guess not concern, I wanted
11 to know what the echocardiogram showed that I believe
12 was taken a day or two before his surgery. I had a
13 chance to review that, and, in fact, from my review the
14 ventricular function is significantly better with that
15 echocardiogram compared to the echocardiogram taken
16 back in of the same

17 Q. Was Dr. Ho aware of the
18 echocardiogram results?

19 A. I don't know.

20 Q. Do you know if he knew about it before
21 surgery?

22 A. I do not know that he did not know or that
23 he did know before surgery.

24 MR. CASEY which echo are
25 you talking about, the 8-25?

1 MR. ALLEN: The
2 echocardiogram of October.

3 MR. CASEY: 18th?

4 MR. ALLEN: 18th.

5 BY MR. ALLEN:

6 Q. The echocardiogram of October 18th,
7 Dr. Ho, to your knowledge, was unaware of the echo
8 before surgery, correct?

9 A. I have no knowledge of that one way or the
10 other.

11 Q. And you have no knowledge as to whether
12 the other physicians, Dr. Adamek or Dr. Badri, were
13 aware of the echocardiogram before surgery?

14 A. No. I do know it was taken and I also
15 know that it really confirmed their clinical
16 impressions that his cardiovascular function was much
17 better than than it was with his previous one or two
18 hospitalizations.

19 Q. Why order the echocardiogram and not read
20 it?

21 MR. CASEY objection.

22 Q. What's the m or that?

23 A. By reading it I guess you mean without
24 knowing what the information shows you?

25 Q. Yes.

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1 A. Post-procedure, post-surgery the
2 information is still valid and good. Pre-surgery it
3 would be nice to have that piece of information also,
4 and that's what I'm sure it was ordered for, but the
5 information is still valuable afterwards.

6 Q. But the echocardiogram did not give them
7 any information pre-surgery to support the fact that
8 Dewey Jones was medically cleared for surgery, correct?

9 MR. A You're talking
10 about the 10-18 echo?

11 MR. ALLEN: 10-18.

12 A. not aware surgeon or
13 internist knew of the echo results prior to surgery;
14 I'm also not aware that they didn't know of the

15

16 Q as far as the previous echo that was
17 done in August, would you have medically cleared this
18 patient based on that checkup that was
19 than the one in October

20 MR. CASEY: Objection.

21 A. Depends on what it's for, I guess, and
22 based on all of his other clinical data.

23 MR. CASEY: Are you asking
24 if he would have cleared him for surgery
25 in August?

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1 MR. ALLEN Based on the
2 August echocardiogram.
3 MR. CASEY: I need a
4 clarification before I have him answer.
5 Are you saying whether or not he would
6 have cleared him in August for surgery, or
7 are you saying would he have cleared him
8 for surgery in October based on the August
9 echo?
10 MR. ALLEN correct.
11 MR. CASEY: which one?
12 MR. ALLEN: The last one.
13 MR. CASEY Do you
14 understand what he's asking you, Doctor?
15 THE WITNESS: I believe so.
16 **A. Ask that again.**
17 Q. I'll start it again. Do you *think* it was
18 appropriate for Dr. Ho to medically clear Dewey Jones
19 for surgery on October 20th based upon an August
20 echocardiogram that, in your opinion, was worse than
21 the actual echocardiogram performed in October?
22 **A. The basis of whether someone is ready for**
23 **surgery or not is not dependent and not based solely on**
24 **an echocardiogram, it's based on the clinical data. So**
25 **if the clinical data in October permitted the internist**

1 **A. Yes, then I had a big file from Lutheran**
2 **Hospital from about 1989 or '90 up until the present.**
3 Q. These are the depositions that you
4 reviewed?
5 **A. Yes.**
6 Q. You've read all of these?
7 MR. CASEY: I'm not sure
8 these are all of them. These are some
9 that he had at his house and he brought
10 with him.
11 BY MR. ALLEN:
12 Q. You reviewed the deposition of Dr. Adamek?
13 **A. Yes.**
14 Q. You reviewed the deposition of
15 Dr. Semigran?
16 **A. Yes.**
17 Q. You reviewed the deposition of Dr. Badri?
18 **A. Yes.**
19 Q. You reviewed the medical report of
20 Dr. Semigran?
21 **A. Yes.**
22 MR. ALLEN: Mark this as
23 Exhibit 3.
24 (Thereupon, Plaintiffs' Exhibit 3 to the
25 deposition of James D. Maloney, M.D., was

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1 **to assess the cardiovascular function compared to a**
2 **couple months earlier and say he's ready for surgery --**
3 **if indeed I saw that same patient, if I saw that same**
4 **patient in August with the August echo, would I clear**
5 **him for surgery, for the same gallbladder surgery**
6 **presumably is the question.**
7 **I guess the answer would be no, but it**
8 **would not be based on the echo as much as it would be**
9 **based on the fact that he had fulminant mainly right**
10 **heart failure and that had to be improved significantly**
11 **as best one could do that, and, in fact, it was**
12 **improved significantly. Over that month or two**
13 **interval the patient diuresed nearly 40 pounds and was**
14 **much better from a cardiovascular standpoint in October**
15 **than he was in August.**
16 Q. What medical records did you review to
17 form your opinions today?
18 **A. most are**
19 **(indicating). All of the Huron records -- I don't**
20 **recall the exact dates -- August of '94, September of**
21 **'94 and October of '94, and I remember seeing some**
22 **records from UH that went into maybe November, I don't**
23 **know.**
24 MR. CASEY: And I sent him
25 the Lutheran Hospital stuff, too.

1 marked for purposes of identification.)
2 BY MR. ALLEN
3 Q. Did you review the deposition of
4 Dr. Winston Ho?
5 **A. Yes, some time ago.**
6 Q. Did you review any other depositions?
7 **A. I don't recall.**
8 MR. CASEY **I think** I sent
9 him the residents' depositions, but I can't be
10 sure.
11 Q. To the best of your recollection?
12 **A. I don't remember seeing them.**
13 Q. Did you see the deposition of Dewey's
14 brother McCloud?
15 **A. I don't think so.**
16 MR. CASEY I did not send
17 him McCloud's depo!
18 Q. All the marks on Exhibit 3, were those all
19 put on there by you?
20 **A. Probably, yes.**
21 Q. Did you make that at the time that you
22 reviewed the case? Did you do that at the time you
23 initially reviewed his report, did you make those marks
24 at the initial time you reviewed his report?
25 **A. I only reviewed it once, so I guess so.**

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1 Q. The purpose of you making those marks is
2 to draw your attention to important areas?

3 A. Some of that, and also to keep me awake
4 when I'm reading these kinds of things.

5 Q. So you read these things late at night?

6 A. At night.

7 Q. Is that when you usually do your reviews
8 is late at night?

9 A. Or early in the morning.

10 Q. Did you generate any materials after you
11 reviewed --

12 A. A letter, just a letter that --

13 Q. That's marked as Exhibit 2, is that the
14 letter?

15 A. Yes, I believe so.

16 Q. That's the only letter that you produced?

17 MR. CASEY: There's a
18 second one.

19 A. There is that statement in the back.

20 MR. CASEY: I wanted to
21 have a supplement.

22 BY MR. ALLEN:

23 Q. Supplement being the statement about the
24 life expectancy, okay.

25 Other than Exhibit 2, do any other

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1 drafts of this document exist?

2 A. No.

3 Q. Did you prepare this exhibit yourself?

4 A. I did.

5 Q. You typed it?

6 A. My secretary did.

7 Q. And then you sent it to Mr. Casey?

8 A. She did.

9 Q. Did you review any literature before you
10 wrote that opinion letter?

11 A. A little bit, very little, but yes.

12 Q. What did you review?

13 A. I reviewed an old issue of Harrison's
14 textbook of medicine. I looked at a, for me a new
15 acquisition of a cardiology textbook that's several
16 years old, Mayo Clinic Textbook of Cardiology.

17 Q. You looked at Harrison's to review what in
18 particular?

19 A. One thing was sleep apnea. I didn't know
20 that the definition of ten seconds was their major
21 criteria of yes or no. I read a little bit about
22 obesity and cor pulmonale and the results of
23 hypoventilation.

24 Q. What is your criteria for sleep apnea,
25 less than ten seconds?

1 A. I depend on the diagnosis of sleep apnea
2 from our neurologist and pulmonologists that do those
3 tests. You know, it's a clinical judgment. Ten
4 seconds, I'm sure they have some statistical data to
5 back that up, but I would think that nine seconds would
6 be just as valid, and certainly 11 or 12 would not be
7 invalid. We do the same thing in cardiology, make an
8 arbitrary statistically sound measurement to be a
9 cutoff between positive and negative.

10 Q. When were the depositions sent to you
11 originally?

12 A. I got two or three here and there. I
13 think the last one I got was yesterday or the day
14 before.

15 Q. Which one was that, Dr. Semigran?

16 A. That's correct.

17 Q. Did you get a chance to read his entire
18 deposition?

19 A. I think I read the entire deposition late
20 at night.

21 Q. When were you sent the records?

22 A. Boy, probably about three months ago or
23 so.

24 Q. And it all came at one time?

25 A. No, no. I think I got the records first

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1 and then at least some of the depositions came later,
2 and then the last deposition that I read was two days
3 ago.

4 MR. CASEY: And the echo
5 tape in between, the echo tape, as well.

6 BY MR. ALLEN.

7 Q. I take it October 17, 1994 -- tell me, on
8 admission to the hospital can you identify for me any
9 and all risk factors that Dewey Jones had that put him
10 at risk for abdominal surgery, medically at risk?

11 A. Would you give me that date again?

12 Q. October 17th, which is the date he came
13 into the emergency room.

14 A. And your question again was, identify --

15 Q. All the risk factors that Dewey Jones had
16 for surgery.

17 A. Risk factors are all relative. Being
18 alive is a risk factor for going to surgery and dying.
19 Certainly obesity is one. In my reading of one of
20 these texts that I mentioned, obesity as an independent
21 variable supposedly is not a risk factor, but as a
22 multi-varying analysis I guess it is a risk factor.
23 Obesity is certainly one.

24 Q. Would you categorize him as morbidly obese
25 or obese, or does it make any difference?

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1 A. Well, let's say that in August he weighed
2 350 pounds. At first I read, I guess, he was 5'10",
3 somebody said 5'11", at one place I saw 5'8". So he
4 should be weighing 170 or 180 at max, and he is a fair
5 amount over that. I would call it morbid obesity.

6 I would have to look at the term
7 morbid. I would get that by definition that means
8 obesity that has morbidity related to it, and, yes, I
9 think he had morbidity related to it. He had a
10 pulmonary hypertension, he had his cor pulmonate. I'm
11 sure that the obesity aggravated his labile
12 hypertension. I'm sure that the obesity played a role
13 in his sleep apnea.

14 Q. Is that it?

15 A. You better rephrase the question, I
16 forget.

17 Q. Risk factors.

18 A. Risk factors for surgery.

19 Q. Congestive heart failure?

20 A. Certainly he had both right -- he had
21 histories of both right and left heart failure, and
22 those two were somewhat independent of one another,
23 those are both risk factors. He had a history of
24 peripheral edema. I think on one occasion he had
25 unilateral leg edema that was much greater at one of

1 A. I think that's about it. I think his
2 kidneys functioned well. I think that when his blood
3 pressure came under control his fluid balance improved
4 markedly.

5 Q. Did you see when you reviewed the records
6 if he had a previous history of a myocardial
7 infarction?

8 A. It is my opinion that, no, he has never
9 had a myocardial infarction and that he is not
10 vulnerable to that since he has normal coronaries and
11 his cardiac problem is a cardiomyopathy and not
12 ischemic heart disease.

13 Q. When you were asked to give your opinion,
14 were you asked to give your opinion strictly for the
15 hospital or were you asked to give your opinions for
16 all the doctors involved in this case?

17 A. I'm sure that I really didn't get that
18 straight. I was under the impression that I was mainly
19 giving my opinion regarding this patient's care and
20 particularly in relationship to the surgery, and I
21 thought it was the surgery, then I was later asked to
22 give an opinion regarding the prognosis of this
23 gentleman.

24 Q. So you were more focused on the surgery --

25 A. That's correct.

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1 the Bedford admissions or something like that than at
2 another time.

3 So presumably he had venous
4 insufficiency. Probably chronic venous hypertension
5 could do it, break down some valves. Certainly you
6 want to think about previous thrombophlebitis, that's a
7 risk factor.

8 I'm not sure how many I mentioned.
9 Left heart dysfunction, cardiomyopathy, right heart
10 dysfunction.

11 Q. Obesity?

12 A. Obesity by itself, significant labile and
13 marked systolic and diastolic hypertension,
14 hypoventilation and probably Pickwickian syndrome. He
15 probably had some glucose intolerance with a heavy
16 person like this that may make him more vulnerable to
17 infections, which is another risk factor related to any
18 kind of surgery.

19 Noncompliance with medication is a risk
20 factor. He had a history, I believe -- and I'm not
21 sure how strong his history is -- of a transient
22 left-sided weakness. Whether this was a
23 cerebrovascular phenomenon or something else, I'm
24 uncertain.

25 Q. Anything else you can think of?

1 Q. -- when you first reviewed the case?

2 A. The surgery. Oh, and then somewhere along
3 the line I was told I should also look at the internist
4 and whether his recommendation as well as the
5 anesthesiologist's and the surgeon's for moving towards
6 surgery was appropriate or not.

7 Q. Have you talked to anybody else besides
8 Mr. Casey in his firm regarding your opinions?

9 MR. CASEY And Mr. Malone.

10 Anybody besides me and Mr. Malone have
11 you talked to?

12 A. About my opinions?

13 Q. Yes.

14 A. No.

15 Q. Have you talked to anybody in the other
16 law firms about your opinions?

17 A. No.

18 Q. Is it your opinion that the standard of
19 care was breached when Dewey Jones was medically
20 cleared based upon the clinical factors of his October
21 17th hospital stay and a review of the August 1994
22 echocardiogram?

23 A. No, I think it's my opinion that standard
24 of care was not breached in relationship to his
25 referral to surgery.

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1 Q. If, in fact, he had been medically cleared
2 based upon his clinical factors, clinical presentation
3 and the August 1994 echocardiogram, would that have
4 been a breach of the standard of care?

5 MR. JONES: I'm sorry.

6 That was a little too soft for me to hear
7 the whole thing. Could you read it back
8 for me?

9 THE NOTARY: Question:
10 "If, in fact, he had been medically
11 cleared based upon his clinical factors,
12 clinical presentation and the August 1994
13 echocardiogram, would that have been a
14 breach of the standard of care?"

15 (Thereupon, there was a brief recess.)

16 THE NOTARY: Question:
17 "If, in fact, he had been medically
18 cleared based upon his clinical factors,
19 clinical presentation and the August 1994
20 echocardiogram, would that have been a
21 breach of the standard of care?"

22 MR. CASEY: I object.

23 "hat's the same question as the last
24 question.

25 A, you

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1 Q. That's what I rephrased.

2 A. Will you ask it again, please?

3 MR. ALLEN would you read
4 it back again?

5 THE NOTARY Question:
6 "If, in fact, he had been medically
7 cleared based upon his clinical factors,
8 clinical presentation and the August 1994
9 echocardiogram, would that have been a
10 breach of the standard of care?"

11 MR. CASEY I object. He
12 already said he believes that he was
13 properly cleared for surgery.

14 You can answer.

15 BY MR. ALLEN

16 Q. Are you with me?

17 A. I think so. On his clinical factors alone
18 he could have been cleared for surgery and it would
19 have been appropriate. From my review and from the
20 report of the echo of August, certainly the report
21 using our term waffled on the quality of the echo, not
22 uncommon because getting good quality echo in somebody
23 that's 300 pounds or 350 pounds back then is tough.

24 From that echo alone you would be very
25 concerned, but if you put that echo on top of the

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1 clinical data going from August until November,
2 October, and particularly with even some information
3 known about '91, '92, '93, you would probably clear him
4 for surgery.

5 In fact, if I recall, the cardiac cath
6 data of '92 or thereabouts gave him an ejection
7 fraction of zero percent I believe, which is about the
8 same as the echo. Particularly when you get down in
9 the lower percent ejection fraction the data becomes

11 So again, from the clinical data alone,
12 knowing that he had improved markedly over those two to
13 three months and knowing that he had a problem that had
14 to be operated on either today, tomorrow or next week
15 and knowing that he was in the best shape that you, we,
16 the physician has seen him in, I would clear him for
17 surgery.

18 Q. When was the first time Dr. Ho had seen
19 Dewey Jones?

20 A. It's my understanding that it was in
21 August.

22 Q. Do you know whether or not Dr. Ho reviewed
23 Dewey's past medical records before medically clearing
24 him in October?

25 MR. CASEY: objection. As

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1 to which records, Charles?

2 MR. ALLEN Any of his
3 previous records.

4 A. I don't know that for certain. I don't
5 recall. I'm sure it's probably in his deposition, I
6 just don't recall what he said there. But I do know
7 that he was aware of his medical case and course in
8 August and he was aware of his medical case and course
9 in September and he was aware of his medical course in
10 October. Those are three points that can give him some
11 very reliable clinical assessment capability.

12 Q. He became aware of those three time frames
13 from what personal knowledge?

14 A. I believe so.

15 Q. Do you know what time or do you know when
16 Dr. Ho contacted Mr. Jones' primary physician, Dr.
17 Azim, and discussed whether or not Dewey was a
18 candidate for surgery?

19 A. No, I don't.

20 Q. Do you know if Dr. Badri or Dr. Adamek had
21 discussed Dewey's care, previous medical history with
22 Dr. Azim?

23 A. With Dr. Azim, no, I don't.

24 Q. What is your definition of biliary
25 obstruction?

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1 A. Obstruction of the biliary tract, either
2 partial or complete.

3 Q. What causes that?

4 A. It can be a tumor, it can be a gallstone,
5 it can be a suture, it can be -- those are the primary
6 things.

7 Q. Do you have an opinion of whether Dewey
8 Jones had biliary obstruction during the October 17th
9 admission?

10 MR. JONES: Objection.

11 A. I have an opinion that he was having
12 symptoms of cholecystitis, which was associated with
13 right upper quadrant pain, nausea, vomiting, so, yes, I
14 think that he very well would have some obstruction at
15 that time.

16 Q. What other symptom did he have consistent
17 with cholecystitis that you recall?

18 A. Well, symptoms, signs and symptoms, the
19 nausea, the vomiting. I am not aware that they
20 specifically noted that he had a fever. We're talking
21 about symptoms though, aren't we?

22 Q. Right.

23 A. Diaphoresis, I guess, would be a symptom.
24 I don't recall that specifically. Mainly the right
25 upper quadrant -- looking at the records that were

1 A. Well, let's see. The submitted diagnosis
2 from the surgeon is cholecystitis and cholelithiasis.
3 The gallbladder shows recent hemorrhage in the wall.
4 Findings may represent early developing acute
5 cholecystitis, although little or no acute inflammation
6 was observed. So the surgeon clearly thought that it
7 was cholecystitis and the pathologist said the signs
8 were limited.

9 Q. So this was not chronic cholecystitis,
10 correct?

11 A. No, I can't say that. I'm not sure how
12 you would define chronic.

13 Q.
14 A. Occurred multiple times over a period of
time. Probably in the literature, certainly the
pathology literature would have a set number of days or
17 weeks that we would say something that goes from
18 chronic to subacute to acute. It implies over a period
19 of time.

20 Q. In your opinion, is not chronic; is
21 that correct?

22 A. No, I can't say that.

23 Q. You don't have an opinion?

24 A. Oh, I do -- if I recall correctly, even
25 when he went into the hospital in September he had some

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1 written down, the right upper quadrant pain and some
2 laboratory studies that were slightly abnormal.

3 Q. Do you know if he had tenderness or
4 rebound or that right upper quadrant pain?

5 A. He had tenderness. I don't specifically
6 recall whether they stated rebound or not.

7 Q. Do you have an occasion to read pathology
8 reports that relate to gallbladders?

9 A. Yes.

10 Q. Do you feel that you can offer an opinion
11 as to whether the status of this pathology report is
12 being consistent or inconsistent with cholecystitis or
13 biliary obstruction?

14 A. I think it can be consistent with that.

15 As I recall, the pathologist stated that the
16 inflammation was minimal or something similar to that.
17 We should probably pull it out and read it, but it was
18 not -- it was certainly not a gangrenous gallbladder.

19 Q. Based upon that pathology report you have
20 an opinion as to the severity of his cholecystitis?

21 A. From a clinical standpoint I think it was
22 significant. I'm a clinician, not a pathologist, so I
23 guess I would have to go on clinical signs.

24 Q. Based upon the pathology, you can't give
25 me an opinion, correct?

1 nausea and vomiting and some vague symptomatology that
2 very well could be the same thing. We know he had
3 gallstones there and he had multiple gallstones, and we
4 know that they probably take two to three to four years
5 to develop or more and during that period of time they
6 are likely to be symptomatic, and, in fact, even cause
7 problems where he doesn't recognize the symptomatology.
8 I'd call it chronic. Certainly the stone presence
9 means he had chronic disease within his gallbladder.

10 Q. So are you telling me that Dewey Jones on
11 October 17th presented to Meridia Huron with chronic
12 cholecystitis in your opinion?

13 A. In my opinion, he presented with
14 symptomatic gallbladder disease.

15 Q. Now, hypertension is controlled when you
16 don't have to use medication; is that a fair statement?

17 A. You better rephrase that.

18 Q. All right. To have controlled
19 hypertension, does that mean that you do not have
20 hypertension when you are not on medication; is that
21 correct? Is there a correlation between controlled
22 hypertension and medication?

23 A. There can be; not necessarily.

24 Q. So when you're on -- if you're
25 hypertensive and you have medication and you're on

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1 medication, is that controlled hypertension?

2 A. No, that's hypertension and you're on
3 medicine.

4 Q. What is controlled hypertension?

5 A. Controlled hypertension is someone who is
6 hypertensive but in which his blood pressure is being
7 maintained in an acceptable and desirable level,
8 presumably in a normal tensive range.

9 Q. What range?

10 A. Depends on what country you live in and
11 what race you are, but in the United States we like to
12 say 140/90 or less. In Southeast Asia that's
13 hypertensive.

14 Q. Will hypertension decrease on bed rest?

15 A. Frequently; not always, but frequently.

16 Q. Most of the time, correct?

17 A. You'd have to define what most is. 51
18 percent?

19 Q. Yes.

20 A. I think that it will get -- it will either
21 stay the same or get better, it won't get worse with
22 bed rest, if you're truly resting.

23 Q. A Swan-Ganz catheter can yield information
24 as to aggression of pulmonary edema, true?

25 A. If you get wedge pressures, yes.

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1 Q. Now, do you believe Dewey Jones was a
2 candidate for any alternatives?

3 A. Therapy?

4 Q. Therapy, other than a cholecystectomy.

5 A. Regarding his heart?

6 Q. Regarding his gallbladder.

7 MR. JONES: Objection.

8 A. I guess I would have to know what the
9 alternative therapies are. Continued medical
10 management would be one alternative, no therapy
11 whatever would be another. In fact, at least with his
12 high blood pressure that's what he chose most of the
13 time.

14 Q. How about percutaneous drainage of the
15 gallbladder?

16 A. I'm not sure that his gallbladder was
17 overly distended, and so -- I've seen that done once or
18 twice. It's usually when you're worried about
19 perforation of the gallbladder. In the old days when
20 you were afraid to do surgery because of additional
21 risks. As a non-surgeon, I would guess that would not
22 be a likely diagnosis or a likely therapy for this
23 gentleman.

24 Q. Based upon?

25 A. Probably he didn't have a markedly

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1 distended gallbladder to drain and technically its
2 probably -- I'm not a surgeon, I don't do that kind of
3 thing.

4 MR. CASEY: Doctor, I don't
5 want you to guess.

6 BY MR. ALLEN:

7 Q. Do you know anything about success rates
8 of that therapy?

9 A. The success rate of decompressing the
10 gallbladder so it doesn't rupture is pretty high if you
11 decompress it. It doesn't cure the whole problem, it's
12 palliative.

13 Q. What about ultrasonic lithotripsy, was
14 Dewey a candidate for that?

15 A. We had several patients at the Clinic when
16 that was being evaluated and used. I think I would
17 have to defer to an internist that deals with this
18 stuff a lot to say what the exact criteria for
19 lithotripsy of a gallstone is, but multiple small
20 stones I think is essentially a contraindication or a
21 non-indication for it. The therapy for gallstones -- I
22 haven't seen it used as therapy in the last seven
23 years.

24 Q. Is it your opinion that Dewey was in
25 active congestive heart failure before surgery?

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1 A. I'm not sure what this word active means.

2 Q. Is there a difference between active and
3 non-active?

4 A. We cardiologists don't use that term.

5 Q. If you have congestive heart failure, you
6 have congestive heart failure?

7 A. Yes, and then you can either have
8 compensated or non-compensated. That's kind of what I
9 think you're getting at. I think that at the time he
10 was

11 failure -- which is both right heart failure and left
12 heart failure -- was compensated and in better
13 than at time he had been seen over the
14 last three or four months, and it was, in fact, even
15 better than when he had his heart cath back in 1992. I

16 just don't have all the data to know about the Bedford
17 admission, but he was markedly improved in October
18 compared to September and August. So it was
19 compensated.

20 Q. Did you attribute to his congestive
21 heart failure getting better during that time frame
22 between August and October?

23 A. I would guess, number one, he was probably
24 scared and, number two, I assume that he finally was
25 taking his medicines. I'm also assuming that he did

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1 not go on a crash starvation diet. So the fact that he
2 diuresed 30 to 40 pounds in that interim tells us that
3 his heart was compensating and able to reverse the
4 mechanisms that caused fluid retention and so he was
5 diuresing. That's good.

6 Q. Don't you believe that during that time
7 frame Dewey was compliant with his medication and,
8 thus, getting better?

9 A. I'm assuming that he probably was. I
10 don't know that for a fact, but I assume that's
11 probably the case. He was also on some different
12 medicine, I believe, or -- Dr. Ho had changed his
13 medicines and the residents had changed some of his
14 medicines both in August and September, I believe.

15 Q. So it's your belief that Dr. Ho saw him in
16 October and saw him in August and in September of '94?

17 A. Dr. Ho, his medical team, he and his
18 medical team were involved with his care in August at
19 Huron Hospital. I'm sure residents were involved with
20 his therapy and they were being directed and certainly
21 he was directly involved in September and directly
22 involved in October.

23 Q. Can you categorize for me the level of
24 heart failure Dewey had at the time of surgery?

25 A. By categorizing, yes, it's less heart

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1 failure than he had two weeks or a month before.

2 Q. Was it mild, was it moderate?

3 A. If we're talking about -- it was improved.
4 We talk about ventricular function. Now, he still had
5 moderate ventricular dysfunction in my opinion at that
6 time, but he was compensated for that. He still had --
7 the moderate dysfunction was probably both right and
8 left heart. Again, I think that probably the left
9 heart was much more compensated at that time than the
10 right heart.

11 Q. Explain to me how the body compensates or
12 the heart compensates.

13 A. You decrease the heart -- first of all,
14 you decrease the stresses on the heart. On the left
15 heart one of the major stresses can be hypertension,
16 and he had multiple blood pressure recordings over
17 those months and years before when he would be out of
18 control at 220/120, 130, diastolics that were very,
19 very high. When he came in in October his blood
20 pressures were closer to the range of just normal to
21 mildly hypertensive, significant decreases in diastolic
22 pressure.

23 So if the heart only has to push half
24 as hard to get blood out then you don't have blood
25 backing up and increasing the stiffness of the heart

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1 and the pressure in the left ventricle and diastolic
2 pressure that goes back into the lung. So that's how
3 the left heart gets better.

4 Q. If I interrupt. So the left heart doesn't
5 have to work as hard?

6 A. Doesn't have to work as hard. Then the
7 left heart has all sorts of other signals that it sends
8 to the body, hormonal and neurogenic signals. It says,
9 kidneys, you don't have to think that you have to
10 retain more fluid now to help me the heart do better,
11 and so you diurese those fluids. That's another
12 important way of the diuresis. Lasix and a few other
13 medicines are helpful. The Procardia, et cetera, was
14 helpful in lowering the blood pressure.

15 On the right side of the heart he
16 certainly did not have a lot of the edema that he had
17 before, and the chronic stasis changes and the venous
18 insufficiency was probably in large part due to chronic
19 recurrent severe right heart failure due to pulmonary
20 hypertension. I think he still had some of that.

21 The echo demonstrated that his right
22 ventricle was enlarged; he had paradoxical motion that
23 says the right ventricle is enlarged. The sleep apnea,
24 the hypoxia that you would get causes worsening of the
25 pulmonary hypertension, and if you decrease these

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1 things then the pulmonary hypertension decreases and
2 you have less fluid retention due to right heart
3 failure. It becomes a circle and a cycle.

4 Q. Was he at any risk for going into severe
5 congestive heart failure during the October admission?

6 A. During the October?

7 Q. Admission.

8 A. I think he was -- he's in a risk of going
9 into severe heart failure from 1991 or '90 on.

10 Q. Any time?

11 A. Any time. In fact, he did it multiple
12 times. Again, marked -- he needed something to push
13 him over. As far as stressing the left ventricle he
14 has his hypertension, and as far as stressing the right
15 ventricle he had his pulmonary obstructive sleep apnea
16 phenomenon that aggravates pulmonary hypertension.

17 Most likely complicating both of these
18 two problems is his underlying cardiomyopathy. Does he
19 have a primary independent muscle disorder of the
20 ventricle and what evidence do we have? Well, he's had
21 this for a long time, his mother apparently died by
22 history in his history of cardiomyopathy. It's
23 certainly frequently family.

24 Q. Do you know at what age his mother died?

25 A. I do not. It was relatively young, I

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1 believe. At first I thought she was still alive for a
2 while. I think that it was when he was relatively
3 young. I recall somewhere in one of the history notes
4 he was raised by an uncle or just his father or
5 something, so I have the impression that she was
6 relatively young, probably under 40.

7 Q. That's important when you base your
8 opinions as to life expectancy?

9 A. Not necessarily.

10 Q. The history of the mother?

11 A. It doesn't help.

12 MR. CASEY: Plus it's a
13 wrong impression, Doctor. She just died
14 in '95 or '96.

15 BY MR. ALLEN:

16 Q. If of fluids or fluidity of the
17 body not to diurese would add to the pressure of the
18 heart, correct?

19 A. Say that again.

20 Q. Increasing of fluids, the building up of
21 fluids in the body, does that add pressure on to the
22 heart?

23 A. Yes and no. You can have diastolic
24 dysfunction and systolic dysfunction. The heart needs
25 a certain filling pressure. It's like priming the

1 compliant. You'd have to answer all those questions
2 first.

3 Q. Did you take into effect that he had lost
4 30 pounds in the last couple months before the
5 hospitalization when you arrived at your figure for
6 life expectancy?

7 A. Yes.

8 Q. On the morning of October 20, 1994 Dewey
9 Jones was a high risk operative patient, correct?

10 A. Ask that again.

11 Q. On the morning of October 20, 1994 Dewey
12 Jones was a high risk operative patient?

13 MR. CASEY From what
14 standpoint?

15 A. Relative to most 33 year-old patients
16 undergoing surgery for gallbladder disease I guess I
17 would say yes, relative to most cardiac patients
18 surgery, severe was
19 in the moderate group. It's relative.

20 Q. Was he at high risk for developing
21 pulmonary edema during the procedure?

22 A. Again, he developed certainly a pulmonary
23 edema. He had multiple risk factors that could
24 contribute to this. Was he at high risk, yes, he was
25 at high risk, but he was probably at less high risk

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1 pump. If indeed you are getting a diuresis then
2 sometimes additional fluid is just what you need. If
3 the primary problems are hypertension that are
4 stressing the left heart and systemic hypertension on
5 the left heart, pulmonary hypertension on the right
6 heart, and if you counteract both of those things with
7 taking your medicine, et cetera, then a fluid load is
8 not bad at all.

9 Q. But if you're not taking those medicines
10 then the fluid load would be harsh on the heart?

11 A. Certainly could be. Probably more than
12 the fluid load is the salt load. You can have lots of
13 fluid with little salt and you can get away with it;
14 you can have a lot of salt and little fluid and not get
15 away with it.

16 Q. The fact that Dewey Jones became compliant
17 with his medications the last three months, two or
18 three months before he entered the hospital in October
19 of 1994, would that not lead you to believe that he
20 would have sustained the compliance after he had been
21 discharged?

22 A. No, that wouldn't lead me to believe that
23 necessarily, and I'm not sure how compliant he was
24 during those three months. I also don't even know the
25 social background of if he was compliant why he was

1 than any time over the last three months.

2 Q. He had sleep apnea syndrome; is that
3 correct?

4 A. That's what the records say.

5 Q. That would put you at a high risk for
6 developing pulmonary edema, correct?

7 A. One can develop both with the sleep apnea,
8 per se, pulmonary hypertension, but you can also have
9 probably some increased capillary alveolar permeability
10 associated with hypoxia that can give you some
11 pulmonary edema, and then you can also get obstructed
12 or start coughing and have a negative respiratory
13 problem that sucks fluid into the lung, which is
14 non-cardiac pulmonary edema.

15 Yes, those things are possible;
16 however, with a tube through then you don't get
17 obstruction and then you should not be excessively
18 vulnerable to those kinds of complications from sleep
19 apnea.

20 Q. As long as you don't attempt to extubate?

21 A. Well, let's say that as long as you don't
22 obstruct the airway then the problem of obstruction,
23 which is the primary problem with sleep apnea, cannot
24 occur.

25 Q. And attempting to extubate is one way of

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1 obstructing the airway?

2 A. That's one of it.

3 Q. Now, I Jones, would he ever give any
4 supplemental oxygen before surgery?

5 A. I believe so.

6 Q. When was that?

7 A. My guess would be that probably it's a
8 standing order for cardiac patients to have p.r.n.
9 oxygen, but I believe that there's something in the
10 record that the night before surgery or early that
11 morning he was given some supplemental oxygen. I don't
12 know the exact cause. At our institution every cardiac
13 patient comes down on oxygen.

14 Q. Every cardiac patient?

15 A. Going to surgery. They usually make sure
16 they're well oxygenated before intubation.

17 Q. When did Dr. Adamek know that Dewey Jones
18 was on oxygen before surgery?

19 A. I don't know.

20 Q. Do you know when Dr. Badri knew that he
21 was on supplemental oxygen?

22 A. I don't know when they knew, no.

23 Q. You don't know that about Dr. Ho either,
24 correct?

25 A. No.

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1 Q. So if I told you that none of the doctors
2 knew that he was on supplemental oxygen before surgery,
3 do you think that affected Dewey Jones' medical
4 management during surgery?

5 A. No.

6 Q. As a cardiologist you medically clear
7 patients for surgery, correct?

8 A. Say that again.

9 Q. As a cardiologist do you medically clear
10 patients for surgery?

11 A. Yes; even non-cardiac patients I medically
12 clear for surgery.

13 Q. So if you were called in
14 as a cardiologist to consult on Dewey Jones, would you
15 have told them that it was a waste of time?

16 A. If I were asked to consult on him would I
17 tell them it's a waste of time? No, I don't think so.
18 I would probably consult with him and do what I'm asked
19 to do.

20 Q. So if they asked you to, you would have
21 come and consulted him?

22 A. Sure.

23 Q. You can't think of any reason why any
24 other cardiologist wouldn't consult if asked, correct?

25 A. I'm sure that there's some medical and

1 some economic reasons for consulting, and he certainly
2 fulfills those.

3 Q. Does Minoxidil cause fluid retention?
4 A. Yes, along with Procardia and almost every
5 vasodilator that we use.

6 Q. What would be the ideal blood pressure
7 that you would want to maintain in Mr. Jones during
8 surgery?

9 A. It depends on what his blood pressure was
10 beforehand. You would like to have him within normal
11 range, you would not want to keep his blood pressure
12 excessively low. In people that have marked
13 hypertension if you lower their blood pressures too
14 much they have vasoconstriction and it's thought that
15 you can make them end-organ ischemic even when they
16 are, quote-unquote, in regular normal tensive range.
17 But with all that it would be nice to have them
18 somewhere in the range of 150, 160 over 90 to 100 all
19 the way down to 110 over 80 or so, that would be a nice
20 range.

21 Q. So 150 to 110 systolic?

22 A. Or 160, 170 to 110.

23 Q. And pre-surgery, that being if his
24 pre-surgery blood pressure was 162/100?

25 A. I think it's pre-surgery you're talking

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1 about when he came into the hospital.

2 Q. No, just before surgery, just before they
3 started to operate.

4 A. What question are you asking?

5 Q. If it was 162/100 at that time.

6 A. It wouldn't bother me.

7 Q. Would it be the same range we just talked
8 about?

9 A. That would not interfere with the surgery.

10 Q. I'm saying, the ideal blood pressure
11 ranges that you just gave me, assuming that his blood
12 pressure was 162/100 just before surgery, those ideal
13 blood pressure ranges would still hold true.

14 A. I think so. When you're really talking
15 about hypertension, you're talking about peripheral
16 vascular resistance really and end cardiac output. You
17 would like peripheral resistance to be relatively
18 normal and then the blood pressure measurement is an
19 indirect measurement of that.

20 Q. Let's talk about Swan-Ganz for a second.
21 Now, that allows you to measure and maintain arterial
22 blood pressure during surgery, correct?

23 A. No.

24 Q. What does it allow you to do?

25 you measure pressures

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1 the heart; it allows you to do a cardiac output if you
2 have another parameter to help you, an arterial line
3 somewhere. Then it enables you to chart those changes
4 in pressure over time.

5 The changes in pressure or the pressure
6 that you're looking at, if you have all of the lumens
7 connected that you're monitoring simultaneously, you
8 would have a right atrial pressure. pulmonary artery
9 pressure, you could have -- then if you blow up the
10 balloon or extend the catheter out further you can get
11 a pulmonary artery wedge pressure, which is an indirect
12 reflection of left atrial pressure.

13 Q. So if you have a Swan-Ganz catheter, would
14 you agree with me that you are always able to control a
15 patient's blood pressure with the proper use of
16 vasodilators and nitrates during surgery?

17 A. No.

18 Q. Why not?

19 A. You can never always do anything.

20 Q. More than likely?

21 A. Do what now?

22 Q. Would you more than likely be able to
23 control the patient's blood pressure in surgery?

24 A. Yes. In fact, even without the Swan-Ganz
25 catheter you're more than likely to control the blood

1 Q. It was in JAMA or the annals?

2 A. I believe so.

3 Q. Annals of what?

4 A. Internal medicine.

5 MR. CASEY: Let's go off
6 the record.

7 (Thereupon, there was a brief recess.)

8 BY MR. ALLEN

9 Q. When you looked at the surgical notes and
10 records did you note that Dewey lost about 400 cc's of
11 blood?

12 A. I believe I noted that. 420 or something
13 like that

14 Q. Is that a large amount?

15 A. I think that's a pretty small amount.

16 Q. If a Swan-Ganz had been placed in Dewey
17 Jones at about 11:00 a.m. what would the readings have
18 shown in your opinion?

19 A. 11:00 a.m., at this particular time, well,
20 I guess they probably, in my opinion, would have shown
21 essentially a normal wedge pressure.

22 Q. Which would have been what?

23 A. Oh, somewhere from 12 to 18 millimeters of
24 mercury left ventricular end diastolic pressure, 19 or
25 so or 20.

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1 pressure of the patient during surgery.

2 Q. How is that?

3 A. You measure the blood pressure and you
4 have some understanding of the physiology and you
5 adjust medications as necessary.

6 Q. Is a Swan-Ganz a better predictor of blood
7 pressure?

8 A. Predictor of blood pressure, no.

9 Q. Is it a better predictor of whether a
10 patient would go into pulmonary edema than just
11 measuring the blood pressure?

12 A. It is a way of monitoring the left heart
13 pressure if you get wedge pressures or if you look at
14 the pulmonary, artery and diastolic pressure. It is a
15 way to do that.

16 There's an interesting study that just
17 came out using Swan-Ganz catheters. I believe it was
18 either in JAMA or the annals recently where they
19 concluded that the use of Swan-Ganz catheters in
20 intensive care units for managing fluids had a higher
21 mortality rate than the absence of its use. With this
22 they were saying don't be fooled by the numbers, use
23 your clinical judgment.

24 Q. When was this?

25 A.

1 Q. What are you basing this upon?

2 A. On my clinical assessment of the fact that
3 his left ventricular function was essentially
4 normalized when he went into surgery, and I see nothing
5 hemodynamically that would change that. In fact, with
6 all the vasodilatation that one gets with the drugs,
7 the anesthetics that are used along with the surgical
8 procedure, per se, they're probably lower. So that
9 would be one measurement.

10 What else would you like to know?

11 Q. Would that have changed between 11:00 and
12 1:00 in your opinion?

13 A. 11:00 and 1:00?

14 Q. Yes.

15 A. Yes, it would have changed very abruptly.
16 When he went asystolic -- when he got marked
17 bradycardia I'm sure his cardiac output dropped
18 significantly. I assume --

19 MR. CASEY: I question
20 was before 1:00.

21 A. Oh, before 1:00. Probably when his
22 pressures went up slightly here when he was waking up,
23 the adrenaline would come back.

24 Q. 11:30?

25 A. This was at 12:30 or so.

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1 Q. So you would expect the wedge pressure to
2 have been what?

3 A. Go up two or three points. A lot of
4 adrenaline coming back. Adrenaline can either make the
5 wedge pressure go down or up. With his hypertension
6 and knowing his ventricle, I would guess the wedge
7 pressure went up two or three points.

8 Q. Do you use Swan-Ganz catheters yourself?

9 A. Quite infrequent now. We use them in our
10 EP laboratory and in the cath labs to do right heart
11 caths, diagnostic right heart caths. They're easy to
12 slip in and out for monitoring patients in the CCU and
13 things like that quite infrequently.

14 Q. Intraoperatively?

15 A. Intraoperatively the cardiac surgeons use
16 it, but for general surgery I have not had a patient go
17 to surgery and come out of surgery with a Swan-Ganz in
18 over the last two years. I've sent several severe
19 heart patients for gallbladder surgery during that
20 time.

21 Q. Without a Swan-Ganz?

22 A. Yes. If you really know what the
23 pressures are and know how you're going to treat them,
24 a Swan doesn't tell you anything, it just gets in the
25 way. If you don't know what's happening then it can be

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1 helpful. If the things are unexpected, marked
2 hemodynamic change, it's of questionable help I guess.

3 Q. But your ability to look -- were you
4 looking at the blood pressures?

5 A. The blood pressure, the heart rate and
6 knowing his -- and his oxygen saturation.

7 Q. Knowing all that you're able to predict
8 what a Swan-Ganz would say?

9 A. Really, yes, you are.

10 Q. So I guess you don't use them very much as
11 you just stat --

12 A. That's right. I think the
13 anesthesiologist -- again, this is all from my

14 tell by the pressure it takes for ventilation, also how
15 much resistance they are beginning to meet within the
16 lung.

17 Q. Was the inadequate cardiac function With
18 the possible fluid overload and high blood pressure in

1 edema?

2 MR. CASEY: objection. He
3 already told you he didn't think there was
4 a fluid overload.

5 Go ahead, Doctor.

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1 A. I think that the pulmonary edema -- and
2 much of it was probably non-cardiac pulmonary edema --
3 occurred because of the hypoxia. The hypoxia caused
4 the marked bradycardia and we began to have very poor
5 cardiac output and we had those pressures begin to
6 equalize again towards 40, and that's what caused the
7 pulmonary edema, and it was reversed with a little bit
8 of epinephrine.

9 Q. Do you believe at any time during surgery
10 Dewey Jones got too much fluid?

11 A. I'm not aware of it.

12 Q. Did you see anything in the record to
13 indicate that Dewey had an allergic reaction to any
14 medications given to him?

15 A. No, I did not. During this particular
16 course, no, I did not.

17 Q. Did you see any evidence of ARDS?

18 A. Yes.

19 MR. CASEY: Before or
20 after?

21 MR. ALLEN At this time.
22 after.

23 A. His can be classified as ARDS.

24 Q. Response to?

25 A. His bilateral, pulmonary infiltrates with

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1 the cardiopulmonary collapse phenomena that he had
2 could be classified as adult acute respiratory distress
3 syndrome, and that is just a pathophysiologic process
4 caused by lots of things.

5 Q. In this case caused by the hypoxia?

6 A. That was a major trigger, I believe, the
7 hypoxia which then caused the bradycardia which then
8 caused the marked pulmonary edema.

9 Q. Preoperatively was there any evidence that
10 Dewey Jones had an elevated white blood count?

11 A. I don't believe so.

12 Q. Preoperatively was there any evidence that
13 Dewey Jones had a fever?

14 A. I do not recall it being mentioned as a
15 positive

16 Q. Were there any positive
17 blood cultures that came -- ?

18 A. I'm not aware of them. I do recall
19 reading about blood cultures being taken. It was my
20 understanding that they were not positive. I know the
21 patient was on some antibiotics as the usual course of
22 events for things like this.

23 Q. Was it the attempted extubation process
24 that led to the desaturation of the oxygen in Dewey
25 Jones?

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1 MR. CASEY objection;
 2 assuming facts not in evidence.
 3 BY MR. ALLEN
 4 Q. In your opinion?
 5 A. I'm not sure that there was an attempt at
 6 extubation.
 7 Q. So you don't have an opinion that possibly
 8 an attempted extubation caused the --
 9 MR. CASEY: Same objection.
 10 A. If indeed the endotracheal tube was
 11 removed, that would certainly be a cause for hypoxia,
 12 but the records suggest to me that the tube was not
 13 removed, and that's what I have to go by.
 14 Q. As far as his present condition, is he in
 15 a vegetative state or similar semi coma state?
 16 A. I do not have that specific knowledge.
 17 MR. CASEY Charles, I'm
 18 not going to ask him any of those
 19 questions.
 20 MR. ALLEN: Pain and
 21 suffering and --
 22 MR. CASEY: I will not be
 23 asking him any of those questions at
 24 trial.
 25 ///

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1 BY MR. ALLEN:
 2 Q. You don't expect to give that testimony?
 3 A. I hope not.
 4 Q. Doctor, assume that Dewey Jones is in a
 5 vegetative state due to pulmonary edema. Describe how
 6 a breach of the standard of care could have caused that
 7 pulmonary edema.
 8 MR. CASEY: objection.
 9 That's an improper question.
 10 You don't have to answer that question,
 11 Doctor; that's an improper question.
 12 Q. Hypothetically, a man in a vegetative
 13 state due to pulmonary edema, describe how a breach of
 14 the standard of care could have caused the pulmonary
 15 edema.
 16 MR. JONES: objection.
 17 MR. CASEY: same question.
 18 You can't ask him to guess as to what
 19 could have caused anything. He's told you
 20 what he believes happened in the case.
 21 I'm not going to let him speculate.
 22 Do you understand the question, Doctor?
 23 A. Ask it one more time, please, sir.
 24 Q. A man is in a vegetative state caused by
 25 pulmonary edema. Tell me how a breach of the standard

1 of care created the pulmonary edema.
 2 MR. CASEY. Now you're
 3 asking him how it did create --
 4 MR. ALLEN The standard of
 5 care, a breach of the standard of care.
 6 MR. CASEY If you
 7 understand the question, Doctor.
 8 A. I think I understand it. First of all, in
 9 my opinion, he is not in a vegetative state because of
 10 the pulmonary edema, he is in a vegetative state
 11 because of cerebral hypoxemia.
 12 How could cerebral hypoxemia occur
 13 hypothetically? One hypothetical case at a major
 14 institution that I was participating in occurred 10 or
 15 15 years ago when some OR surgical -- 15, 30 years
 16 ago -- some OR surgical rooms were hooked up and they
 17 mixed up what is gas versus oxygen and so the patient
 18 was not given oxygen while he was being given an
 19 anesthetic, and that creates a vegetative state,
 20 Long term high percentage oxygen can cause injury to
 21 the lung and ARDS, pulmonary edema, non-cardiogenic
 22 pulmonary edema phenomenon.
 23 What else can happen? One could have
 24 extubated this patient and then he could have developed
 25 laryngospasm, and laryngospasm you have no airway and

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1 you have hypoxia, you can have injury again to the
 2 alveoli that were already injured to begin with,
 3 vulnerable and pour out the ARDS kind of phenomenon
 4 again.
 5 If you get your bradycardia from any
 6 cause, and essentially a markedly transient, markedly
 7 reduced cardiac output all of the pressures go up and
 8 you could get a cardiac or at least a secondary cardiac
 9 pulmonary edema, and aggravating hypoxia would be a
 10 cause.
 11 Let's see if we have some more
 12 hypothetical cases. One could have -- as you do
 13 sometimes in asthma and probably in sleep apnea, one
 14 could have a tube in place and then the patient could
 15 start coughing, and the cough, of course, is not heard
 16 like a cough with a tube in like you and I hear, it's
 17 more like a bucking and you get massive negative
 18 pressures and that could cause, again, this negative
 19 pressure changes, the oncotic pressure within the
 20 alveoli and you get an outpouring of non-cardiac
 21 pulmonary edema which aggravates the hypoxia. Then the
 22 docs are trying to correct the hypoxia which was the
 23 initial problem and they cannot quickly enough get
 24 through this non-cardiac pulmonary edema to resaturate
 25 the patient's blood.

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1 Those are a few causes. I guess
2 another cause could be that he suddenly has no blood,
3 and even though you're giving him a hundred percent
4 oxygen it's not enough oxygen or oxygen carrying
5 capacity to oxygenate the end organs and the brain.
6 All of those things can happen and they can cause a
7 vegetative state.

8 Q. On the pathology reports -- turn to that
9 real quick -- it says, I believe, that the wall of the
10 gallbladder was two millimeters.

11 MR. CASEY: .2 centimeters.

12 A. Which is two millimeters.

13 Q. That's a thin gallbladder wall?

14 A. I would have to consult my pathology book
15 to say that. The right ventricle is two to three
16 millimeters.

17 Q. On a daily basis what percentage of your
18 time is spent medically clearing patients for
19 non-cardiac surgery?

20 A. Small percentage, but I would guess maybe
21 four patients a week.

22 Q. Out of how many patients a week do you
23 see?

24 A. A hundred.

25 Q. Now, why do you do that, you're asked to

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1 come in and consult; is that correct?

2 A. Most of the time they happen to be
3 patients that we're following and they have to go have
4 their cataracts fixed or they have to do this or they
5 have to do that, so we clear them. We clear them for
6 gallbladder surgery, for eye surgery, for peripheral
7 vascular disease along with cardiac surgery.

8 Q. And it's usually a surgeon that's asking
9 you if they're okay or it's an internist; is that
10 correct?

11 A. Both.

12 Q. It could be an anesthesiologist asking
13 you?

14 A. very rarely. The anesthesiologists --
15 it's usually -- the anesthesiologist and the surgeons,
16 from my perspective, they're the last ones in the chain
17 and they have to agree that this patient is an
18 appropriate surgical candidate or it doesn't get done
19 regardless of what I say.

20 Q. But you've had anesthesiologists ask you
21 to medically clear a patient for a non-cardiac surgery,
22 correct?

23 A. Yes. Usually, though, after they've
24 already said, wait, hold it, I want another opinion
25 before we move forward or maybe I want a temporary

1 pacemaker before this happens or something like that.

2 For non-cardiac surgery, again, any internist that is
3 managing the patient and familiar with the physiology,
4 not just the cardiovascular system, but the GI system
5 and the brain, is involved with surgical clearances.

6 Q. Have you ever medically cleared a patient
7 like Dewey Jones?

8 A. Yes.

9 Q. When is the last time?

10 A. Probably the patient had surgery
11 yesterday. I think I participated in clearance last
12 week and she went -- this patient went for coronary
13 bypass surgery on a valve. That's the most recent one
14 I can think of.

15 Q. Have you ever medically cleared a patient
16 like Dewey Jones for surgery, for an elective surgery?

17 A. Yes.

18 Q. Would you say this was an elective
19 surgery?

20 A. It is relatively elective, yes, it's
21 certainly elective. It's the timing or the most
22 appropriate time to do the surgery in relationship to
23 that particular patient, so it's not an emergency, it's
24 elective.

25 Q. So the last time you medically cleared a

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1 patient like Dewey Jones for an elective surgery was
2 when?

3 A. Probably about two to three weeks ago. I
4 cleared a gentleman going to have a laparotomy, which
5 turned out to be a resection of his regional enteritis
6 after three previous abdominal surgeries.

7 Q. How often does that occur on a monthly
8 basis that you clear a patient like Dewey Jones for an
9 elective surgery?

10 A. Elective surgery, it depends on how many
11 other criteria I guess. You're saying like Dewey Jones
12 and for elective surgery. What was your question, how
13 many times?

14 Q. How often a month, once a month?

15 A. Easily.

16 Q. More than that, twice?

17 A. Twice is a good number.

18 Q. Twice is a fair number?

19 A. I think so.

20 Q. This is your opinion letter. I just
21 wanted to ask you a couple, clarify a few things for
22 me, if you would, Dr. D

23 In paragraph 1 it says, "The
24 general health of Mr. Jones is well known to
25 his physicians from past medical evaluations and

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1 pre-operative clinical assessments during the patient's
 2 last hospitalization at Meridia Huron Hospital"; is
 3 that correct, did I read that correctly?
 4 A. I believe you did.
 5 Q. Do you know for certain whether Dewey
 6 Jones was seen by Dr. Badri on his previous
 7 hospitalization?
 8 A. In September we're referring to, I
 9 presume?
 10 J. Figh.
 11 A. To my knowledge, he was not seen by
 12 Dr. Badri then, he was seen by Dr. Ho.
 13 Q. So his previous hospitalization the only
 14 physician that had seen him was Dr. Ho, correct?
 15 A. No, there were other physicians that saw
 16 him.
 17 Q. That were taking care of him in the
 18 October hospitalization?
 19 A. The only one I'm aware of is Dr. Ho in
 20 that line, but multiple physicians, I think, saw him in
 21 September.
 22 Q. But the only one that had seen Dewey Jones
 23 in September that also saw Dewey Jones in the October
 24 hospitalization was Dr. Ho?
 25 A. That's right. And he provided the

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1 continuity.
 2 Q. So he was not well known to his
 3 physicians, correct?
 4 A. I guess it depends on how we define
 5 physician or physicians. He was well known to his
 6 physician Dr. Ho, and I guess if Dr. Ho and the records
 7 being available to the hospital then he was well known
 8 also to the residents that reviewed his case as well as
 9 to the surgeon and the anesthesiologist who were
 10 participating as a team effort, as a team effort within
 11 that hospital unit.
 12 Q. So define physicians as in the
 13 paragraph of that sentence.
 14 A. Which paragraph is it?
 15 Q. Was well known to his physicians.
 16 A. Which paragraph?
 17 MR. CASEY: Paragraph 1.
 18 BY MR. ALLEN
 19 Q. We know to his physicians from past
 20 medical history and his history of
 21 assessments during the patient's last hospitalization.
 22 Who are you talking about?
 23 A. I'm talking about certainly Dr. Ho and
 24 then with the pieces of medical knowledge within the
 25 record, that knowledge that Dr. Ho and his team have is

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1 also available to anesthesia, the anesthesia resident
 2 that supports him, the surgeon and the surgical
 3 residents that are participating with him.
 4 Q. Now, the next two lines down, "His obesity
 5 has been refractory to multiple therapeutic plans that
 6 included diet and exercise, and you're not by that?"
 7 A. He was extremely obese in 1989 or '90 --
 8 whichever is the first actual medical record I have --
 9 and by history long before that. He was counseled with
 10 various ways of losing weight and he didn't achieve
 11 those. He is in morbid obesity group, therefore, we
 12 would say that he is refractory to the interventions
 13 that were undertaken for his losing weight.
 14 Q. Going down a little bit you said, "His
 15 blood pressure would appear to be a major problem as an
 16 outpatient but would come under rapid control when
 17 hospitalized." What do you attribute that to?
 18 A. The influence of bed rest is one. The
 19 primary influence is probably compliance, forced
 20 compliance with medication, and then there is forced
 21 compliance with diet. When he goes in the hospital he
 22 is on a salt-restricted program, et cetera, he is
 23 taking his medications and his blood pressure comes
 24 down. This is repeated not only in the Huron
 25 hospitalizations, but in the previous hospitalizations.

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1 Q. Anything else?
 2 A. I'm sure that there's more, but that's a
 3 good start.
 4 Q. His cardiac symptoms would appear directly
 5 related to the degree of his hypertension. I think we
 6 hit on that earlier, correct, hypertension would
 7 increase, rise, then it would put more stress on his
 8 heart; is that correct?
 9 A. That's correct.
 10 Q. And then that would occur when he was as
 11 an outpatient as opposed to an inpatient, correct?
 12 A. That's correct.
 13 Q. And would also rapidly subside when his
 14 blood pressure was brought into control.
 15 Is there any heart problem that Dewey
 16 Jones had that was not directly related to or caused by
 17 his blood pressure?
 18 A. I believe so.
 19 Q. What was that?
 20 A. As we mentioned earlier, I believe he
 21 probably has some underlying cardiomyopathy and diffuse
 22 abnormality of heart muscle, contractile elements and
 23 efficiency. The interesting thing also about this
 24 gentleman is that his overall cardiac output when
 25 pressured, his cardiac index is always good, super

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1 normal. In fact, he's got a high cardiac output. That
2 really further supports his ability once the stresses
3 of hypertension, et cetera, are removed to compensate
4 for his fluid retention and then diurese very rapidly
5 and come to almost a near asymptomatic state.

6 His cardiac indexes are running at five
7 and six liters per minute squared, and that's very good
8 even for a very obese person who's got cardiac reserves
9 still there.

10 Q. Now, can a patient bring their blood
11 pressure under control within two days, can he just in
12 two days have control of hypertension?

13 A. Can it be done, sure it can be done.

14 Q. Is that, in your opinion, what happened
15 here, within two days he had control of hypertension?

16 A. What statement are you referring to here?

17 Q. Just that, you know, you talk about the
18 fact that his problems with his heart were directly
19 related to his blood pressure being out of control and
20 then you tell us that you concur that you would have
21 recommended surgery for this patient during the same
22 hospitalization.

23 Is what happened is his blood pressure
24 got under control within two days of being admitted?

25 A. His blood pressure clearly came under

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1 control. In fact, on one or two occasions he actually
2 had some relative hypotension when he would stand up,
3 which would suggest that his vascular volume was
4 decreasing. But more importantly than that, he came
5 under control and improved control somewhere actually
6 after August. He was certainly better in September
7 than he was in August.

8 We do know that he has lost that nearly
9 40 pounds we've mentioned before, which, in my opinion,
10 would be fluid diuresis, which is a sign of continued
11 improvement. So he had continued to improve certainly
12 since September, probably since August, and when he did
13 come into the hospital, I believe, in October, yes, he
14 had some significant blood pressure elevations, but
15 they came down very quickly.

16 He had not gotten into as much trouble
17 as he had previously in August. He was stable and far,
18 far better, far better than from the left heart
19 standpoint in his hypertension, far better than he was
20 back in August.

21 Q. If I understand it, you attribute some of
22 his hypertension getting better due to the fact that he
23 was taking medications?

24 A. I presume that.

25 Q. Anti-hypertensive medications?

Page 16

1 A. I don't know if anyone was counting his
2 pills and putting them down his mouth, but we presume
3 so. He certainly was better.

4 Q. We know that when he was in the hospital
5 somebody was counting his pills, basically we know he
6 was taking his hypertensive medicine?

7 A. That's correct.

8 Q. Are you aware of any time in which his
9 hypertensive medications were discontinued during his
10 hospitalization?

11 A. I know that they were stopped prior to or
12 when he was NPO as a renal order at midnight, yes.

13 Sure, I'm aware of that.

14 Q. Is that appropriate?

15 A. Very common, very appropriate.

16 Q. So for Dewey Jones not to have his
17 anti-hypertensive medications before surgery, in your
18 opinion, made no difference as to the outcome?

19 A. Made no difference. In fact, the only
20 important thing is that the anesthesiologist knows that
21 when he is managing the patient. I guess we should ask
22 the question, when would he get his morning dose of
23 drug, 10:00 in the morning probably. At our place
24 Digitalis is given at 1:00 in the afternoon as its
25 daily dose.

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1 He's already gone to surgery. He
2 really hasn't been deprived of medicine, he just didn't
3 get his medicine earlier than he would normally get it,
4 unless he would get it at 7:00. Most hospitals don't
5 give the medicine out at that time.

6 The anesthesiologist can titrate his
7 therapy to manage the patient's blood pressure. In
8 fact, we saw where the patient came in with a very
9 satisfactory blood pressure with anesthesia, they
10 induced him with their anesthesia and he actually
11 developed a little bit of hypotension, which is very
12 common and which corrected itself, and he was
13 maintained stable throughout the surgical period.

14 Q. When was Dr. Adamek aware that Dewey Jones
15 was NPO the night before, taken off his
16 anti-hypertensive medications?

17 A. I don't have firsthand knowledge of that
18 and I don't recall reading it in the deposition.

19 Q. When are you aware of the first time
20 Dr. Adamek knew anything about Dewey Jones' medical
21 history?

22 A. Probably the morning of surgery.

23 Q. Before surgery?

24 surgery --

25 knife was struck.

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1 Q. It would have been appropriate for him to
2 know Dewey's medical history before surgery or before
3 the knife was struck?

4 A. It would be appropriate for an
5 anesthesiologist to know that, and I believe some
6 anesthesiologist saw him. Now, whether it's the same
7 fellow that saw him that was participating in his case,
8 I don't have that affixed in my mind. I think there's
9 some uncertainty about that. You'll have to ask him.
10 However, that happens to be the standard practice
11 within the Cleveland Clinic, Baylor College of Medicine
12 and other teaching institutions.

13 Q. So it would have made no difference had
14 Dr. Adamek known Dewey's previous conditions before
15 surgery in your opinion, correct?

16 A. I think that it's important from the
17 record for the anesthesiologist to know this
18 information, but, no, I don't think it would make any
19 significant difference.

20 Q. Isn't cholelithiasis basically the
21 definition of presence of gallstones in the
22 gallbladder -- do you know what cholelithiasis is?

23 A. Yes. Stones, stones in the gallbladder.

24 Q. You're aware that Dr. Badri was not
25 concerned with the risk of perforation before surgery?

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1 A. I'm not concerned about that risk before
2 surgery.

3 Q. And you understand that did not come into
4 play in Dr. Badri's mind, that there was a risk of
5 perforation, correct?

6 A. I would accept that.

7 Q. As it relates to Dr. Badri, is it critical
8 for the surgeon who calls for an internal medicine
9 consult to make sure that that consult was thoroughly
10 done? Do you understand?

11 A. You need to --

12 Q. Is it critical for a surgeon when he asks
13 for medical clearance from an internist, is it
14 important for him to follow up to make sure that it was
15 properly performed?

16 A. No. I guess I would take offense -- if I
17 was asked by a surgeon to do a consultation and if I
18 did that consultation and he came around and asked
19 everybody if I did it correctly, I would take offense
20 to that. I would think that if I told him my opinion
21 and if he has any questions about it he can ask me
22 about it and we can certainly argue or discuss any
23 aspects of the case.

24 No, it's not part of his direct
25 responsibility to question my every move. At the same

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1 time, it is up to each one of the physicians involved
2 to make an independent judgment, and either the
3 surgeon, the anesthesiologist or the internist can
4 counterman or at least put in a negative vote if he
5 feels strongly about surgery or not having the surgery.
6 It's the way the system works.

7 Q. Any of those could stop surgery?

8 A. Yes.

9 Q. And the fact that the surgeon asked you
10 for a consult is because he's relying on you and feels
11 that you are medically educated well enough and
12 experienced enough to give clearance if it's necessary?

13 A. That's correct.

14 Q. So in this case Badri was relying on
15 Dr. Ho in that same instance?

16 A. He was relying on Dr. Ho to take care of
17 the internal medicine aspects of the clearance. At the
18 same time, he was assessing the surgical aspects of the
19 clearance, and, in fact, there is a cross-fertilization
20 between those factors.

21 Q. Now, as an internist, if you call in a
22 phonology consult, do you then check to see if the
23 phonology had performed *their* consult before you
24 medically clear the patient?

25 MR. CASEY objection.

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1 ~~Are~~ you talking about this case?

2 MR. ALLEN Just
3 hypothetically, in general.

4 BY MR. ALLEN

5 Q. If you call in a pulmonology consult, you
6 make sure that the pulmonology consult is done, right,
7 before you medically clear the patient?

8 MR. CASEY: Objection.

9 A. Not always, not if I've already made up my
10 mind I will be moving forward. Now, if the
11 pulmonologist has some urgent great disagreement, you
12 know, he can contact me or stop it in one way or
13 another if he feels strongly.

14 I have gotten consults -- certainly
15 I've gotten consults without seeing the full report and
16 moving toward surgery, dermatology consult, neuro
17 consult. Sometimes you want the information just to
18 manage the postoperative course and you want them to
19 have a chance to see the patient before surgery so they
20 have a better feel.

21 In fact, in cardiology, in our little
22 world of arrhythmology I am frequently asked to see the
23 patient to manage his postoperative heart rhythm and
24 I'm asked to see him before the surgery. The surgeon
25 doesn't care what I want to say beforehand, he just

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1 says be around to manage this problem afterwards.

2 Q. So you bear no responsibility to make sure
3 that a pulmonology consult was completed if you call in
4 a pulmonology consult?

5 A. It depends on the reason why I'm calling
6 it in.

7 Q. Hypothetically, in this case if Dr. Ho had
8 asked for a pulmonology consult for his evaluation as
9 to whether to medically clear Dewey Jones and that
10 pulmonology consult was not completed nor did he know
11 if it was completed and he still medically cleared the
12 patient, would that be a breach of the standard of
13 care?

14 MR. CASEY: Objection.

15 A. That doesn't sound like a hypothetical
16 question. Was it a hypothetical question?

17 Q. It was a hypothetical question.

18 A. So Dr. Smith calls in Dr. Jones to see
19 Mr. Adams, right?

20 Q. Do it however you want to do it. My
21 hypothetical is that --just follow with me on this
22 question. If you can't answer it, that's fine, we'll
23 strike another question.

24 Hypothetically, if the surgeon finds
25 and the facts show and it's discovered that when

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1 medically clearing Mr. Jones Dr. Ho did for a
2 pulmonology consult and when he medically cleared Dewey
3 Jones he did not follow up to find out whether the
4 pulmonology consult was done, completed, nor did he ask
5 pulmonology for their input before he medically
6 cleared, is that a breach of the standard of care?

7 MR. CASEY: objection. You
8 have to --

9 A. No.

10 Q. Because?

11 A. Depends on why the consult is being
12 called.

13 Q. If he's calling it as to whether or not to
14 medically clear the patient for surgery.

15 MR. CASEY: Objection.

16 A. If he is calling someone to say please
17 advise me whether I can or can't take this patient to
18 surgery and that's the question he's asking, the only
19 question he's asking, then he needs to get the answer
20 if he is going to depend on that answer.

21 Does he have to depend on that answer?
22 No; he's a physician, he doesn't have to depend on that
23 answer. But if he is calling that physician in, that
24 pulmonologist in to say, look, this guy's got bad
25 chronic pulmonary obstructive disease and I know he's

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1 going to be in trouble or most likely he's going to be
2 in trouble postoperatively, I want you to come around
3 to help us and be around, then he doesn't have to wait
4 to see that thing, his report, no, he just has to -- he
5 knows that the doc is around, he's been notified and
6 when he needs help the physician will be able to come
7 and help, and he will have a perspective of what the
8 patient looked like before the surgery. It happens all
9 the time. It's good medicine.

10 Q. But if he's medically relying on
11 pulmonology to help him determine whether Dewey Jones
12 is medically cleared for surgery, then, in your
13 opinion, it doesn't matter whether he waits for the
14 pulmonology consult or not?

15 A. If he is waiting for that consult to help
16 him make that decision?

17 Q. Right.

18 A. If the surgeon says go and if the
19 anesthesiologist says go -- which most
20 anesthesiologists really do acute pulmonary medicine in
21 intensive care units and are in fact equally or better
22 equipped to make that assessment -- if the
23 anesthesiologist who is actually managing the patient
24 says it's okay to go, then it's fine, he doesn't have
25 to wait for the pulmonologist to come in, absolutely

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1 not.

2 Q. Do you know who the anesthesiologist was
3 that evaluated Dewey Jones preoperatively?

4 A. I do not recall his name. It's my
5 understanding that it was not Dr. Adamek.

6 Q. It was a resident, correct?

7 A. I will accept that if that's true. Rosen
8 you say?

9 MR. CASEY: No, it was a
10 resident.

11 A. Oh, a resident. A resident almost always
12 sees the patient first, yes.

13 Q. What is your understanding as to when
14 Dr. Adamek was present for surgery?

15 A. Ask it again.

16 Q. When is it your understanding of when
17 Dr. Adamek was available in the surgical OR room during
18 Dewey Jones' surgery?

19 A. I believe he was in the room at the very
20 beginning of the surgical procedure.

21 Q. Did he stay throughout the surgery?

22 A. No.

23 Q. Was he there at the time frame around
24 11:30?

25 MR. CASEY: You want to ask

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1 12:30?

2 Q. 12:30?

3 A. I believe, reading his deposition, that he
4 came in, he was in and out of the room. He came in ten
5 minutes or so after the anesthesia resident called him
6 when the patient was developing his desaturation. Now,
7 the exact time, if I go from 12:30, I guess it was
8 12:45 plus or minus a couple minutes.

9 Q. Who are you insured by; who is your
10 insurance company?

11 A. I don't know.

12 Q. You don't know your insurance company?

13 A. No.

14 Q. It's not PIE?

15 A. I have no idea.

16 Q. Do you know who writes your checks to your
17 insurance carrier? You don't write your checks?

18 A. I don't.

19 Q. Who does?

20 A. Our group administrator.

21 Q. So you have no idea who your medical
22 insurance carrier is?

23 A. I went to a meeting and they gave us a
24 little course one time, but, no, I have no idea.

25 Q. At your hospital here at Columbia Mercy

1 wasn't Board certified?

2 A. Sure.

3 Q. Would you allow anybody in your family to
4 have surgery by a non-Board certified surgeon?

5 A. Depending, sure.

6 Q. Depending on what?

7 A. Lots of things. I'm not sure, but I think
8 DeBacki essentially had no formal training in cardiac
9 surgery. He was a peripheral vascular surgeon. He's a
10 pretty famous name. I'd let him operate. Of course,
11 he's 85, he still operates, but that's all right.

12 Grunsik, your famous cardiologist that
13 invented angioplasty coming from Switzerland at Atlanta
14 was not Board certified. He died in an airplane crash.
15 He taught lots of people.

16 Q. In your opinion, is Dewey Jones in his
17 present state less likely to develop infection at a
18 nursing home or if he's taken care of out of his own
19 home by an in-house nurse?

20 A. Depends on who you ask. I'm sure that the
21 nursing home would say that they're less likely to get
22 infection there because they have some actual training
23 and skills and volume of experience. I'm sure that any
24 individual might say that they could do something
25 better.

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1 Medical Center, there are gs an nts in
2 that hospital, correct?

3 A. Yes.

4 Q. Are all the at that it l
5 Board certified?

6 A. No.

7 Q. Is there not a policy as to whether they
8 need to be Board certified to be an attending, teach
9 the residents?

10 A. Boy, to teach residents, not that I'm
11 aware of, particularly depending on what subspecialty
12 it is and how long the person has been around. Mason
13 Sones who introduced coronary angiography before it got
14 to Atlanta wasn't Board certified. He taught me.

15 Q. Is there a policy at your hospital as to
16 whether or not you're to be Board certified?

17 A. There is a policy to do what, to practice?

18 Q. To teach residents.

19 A. No.

20 Q. Have you ever had surgery yourself?

21 A. Yes.

22 Q. Was the surgeon Board certified to perform
23 surgery?

24 A. I don't know. I presume so.

25 Q. Would you have surgery by a surgeon that

1 Q. Just asking you, Doctor.

2 A. Probably a trained facility would be less
3 likely to introduce nosocomial infections than an
4 untrained home environment.

5 Q. Have you had any conversations with any of
6 the defendant doctors in this case about this case?

7 A. No.

8 Q. Any conversations with any other medical
9 experts regarding this case?

10 A. Medical experts, no.

11 Q. That have been hired on this case?

12 A. No.

13 MR. ALLEN Thank you,
14 Doctor.

15 - - -

16 (DEPOSITION CONCLUDED.)

17 (SIGNATURE WAIVED.)

18 - - -

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1 STATE OF OHIO,)
2 COUNTY OF CUYAHOGA.) SS:
3 CERTIFICATE
4 I, LAUREN I. ZIGMONT-MILLER, Registered
5 Professional Reporter and Notary Public within and for
6 the State of Ohio, duly commissioned and qualified, do
7 hereby certify that the within-named witness, JAMES D.
8 MALONEY, M.D., was by me first duly sworn to tell the
9 truth, the whole truth and nothing but the truth in the
10 cause aforesaid; that the testimony then given by him
11 was reduced to stenotypy in the presence of said
12 witness, and afterwards transcribed by me through the
13 process of computer-aided transcription, and that the
14 foregoing is a true and correct transcript of the
15 testimony so given by him as aforesaid.
16 I do further certify that this deposition was
17 taken at the time and place in the foregoing caption
18 specified.
19 I do further certify that I am not a relative,
20 employee or attorney of either party, or otherwise
21 interested in the event of this action.
22 IN WITNESS WHEREOF, I have hereunto set my hand
23 and affixed my seal of office at Cleveland, Ohio, on
24 this 31st day of July 1997.
25 Lauren I. Zigmont-Miller, RPR and Notary
Notary Public in and for the State of Ohio.

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[illegible]

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1966-1967 Internship, Rotating
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1969-1971 Residency, Internal Medicine
Mayo Graduate School of Medicine, Rochester, Minnesota

1971-1973 Fellowship, Department of Cardiology
Mayo Graduate School of Medicine, Rochester, Minnesota

PROFESSIONAL APPOINTMENTS:

Present Position
1994-pres. Director, Timken Mercy Arrhythmia Center
Professor of Medicine, NEOUCOM
Staff, Ohio Heart Care, Inc.

Prior Positions
1993-1994 Director, Center for Cardiac Arrhythmia Services
and Electrophysiology, Section of Cardiology
Baylor College of Medicine and Affiliated Hospitals
The Methodist Hospital
Ben Taub General Hospital
The Veterans Administration Center Hospital
Houston, Texas

PLAINTIFF'S
EXHIBIT

1

7-25-97

- 1982-1993 Director, Electrophysiology Laboratory
Department of Cardiology
Cleveland Clinic Foundation, Cleveland, Ohio
- 1981-1992 Staff, Department of Cardiology
Cleveland Clinic Foundation, Cleveland, Ohio
- 1981 Professor of Medicine
Mayo Medical School, Rochester, Minnesota
- 1976-1981 Associate Professor of Medicine and Pediatrics
Director, Cardiac Pacing and Electrophysiology
Department of Cardiology, Mayo Medical School
Rochester, Minnesota
- 1973-1981 Consultant in Cardiovascular Diseases
Cardiac Pacing and Electrophysiology for Adult and
Pediatric Cardiology
Department of Medicine, Mayo Clinic
Rochester, Minnesota
- 1968-69 Clinical Assistant Professor of Medicine
Boston University, Boston City Hospital, Boston, Massachusetts

MILITARY SERVICE

- 1967-1969 Captain, United States Army
Natick Research and Development Lab
Natick, Massachusetts

PROFESSIONAL SOCIETIES;

- American College of Cardiology - Fellow
Electrophysiology/Electrocardiography Committee - Member
3/17/94-3/17/97
Pacemaker Committee, Member
Ad Hoc Committee on RBRVS and Clinical Cardiac
Electrophysiology
Ad Hoc Committee on Health Care Initiation, President
Training Directors Committee
Abstract Review Committee
American Heart Association - Fellow
Texas Affiliate Central Research Review Committee, 1993-94
American Medical Association
Ohio State Medical Association
North American Society of Pacing and Electrophysiology
President, 1991-92
Board of Trustees
Abstract Review Committee
Awards Committee
By-Laws Committee
Government Relations Committee (Therapeutic)
Membership Committee

NASPE/ESCWGA Committee
NASPEXAM, Inc.
Nominations Committee
Associate Editor, NASPETAPES Editorial Board
Physician Advisor, Clinical Allied Professionals (CAP) Committee
Chairman, Fellowship Training Program Directors
Program Chairman - National Meeting, San Diego, CA, 5/31-6/2/90
National Electrophysiology Society
Northeastern Ohio Society of Pacing and Electrophysiology: 1982-93
Founder: 1982
President: 1985-1992
Houston EP Society
International Society of Holter Monitoring

AWARDS:

1966 Mosby Book Award, Temple Medical School
1995 American Heart Association's Champions of the Heart-Heart Circle Recognition

EDITORIAL BOARDS:

Editor, Baylor Cardiac Arrhythmia Center: International Digest
Clinical Progress in Electrophysiology
Journal of Cardiovascular Electrophysiology
Journal of Interventional Cardiology

Manuscript Reviewer for:

American Heart Journal
American Journal of Cardiology
American Journal of Physiology: Heart and Circulation Physiology
Circulation
Chest
Clinical Progress in Electrophysiology and Pacing
Journal of the American College of Cardiology
Mayo Proceedings
Pacing and Cardiac Electrophysiology

Abstract Reviewer for:

American College of Cardiology
American Heart Association
North American Society of Pacing and Electrophysiology

ADVISORY COMMITTEES:

Independent Multicenter AICD Registry (Bilitch Report) 1982-1993
Physicians Advisory Council on Lead Performance, Medtronic, Inc. 1984-Present

CERTIFICATION AND LICENSURE:

Certification: American Board of Internal Medicine, 1972
Subspecialty Board in Cardiovascular Diseases, 1975

Licensure: Active: Texas (Distinguished Professors
License), 7/2/93
Ohio (35-04-6948), 12/7/81
Minnesota (19059), 2/20/70
Pennsylvania (9613), 7/17/67
Inactive: Massachusetts (30358), 10/26/67

current research activities:

- 1993-94 Principal-Investigator: "Investigational Plan Medtronic Model 7217B PCD Pacer-Cardioverter Defibrillator With Non-Thoracotomy Lead System." Medtronic.
- 1993-94 Principal Investigator: "Clinical and Cellular Electrophysiologic Profiles of Selected Antiarrhythmic Drugs" Pilot Study for SCOR (NIH)
- 1993-95 Principal Investigator: "Mode Selection Trial in Sinus Node Dysfunction" (MOST), NHLBI Brigham & Women's Hospital.
- 1993-97 Principal Investigator: "Multicenter Automatic Defibrillator Implant Trial" (MADIT), Cardiac Pacemakers, Inc.
- 1993-98 Principal Investigator: "Antiarrhythmics vs. Implantable Defibrillator (AVID), NHLBI.
- 1993-98 Co-Investigator: "Transvenous Cardioversion of Atrial Fibrillation in Human."
- 1993-98 Principal Investigator: "CPI Ventak P2 Endotak System Phase I," cardiac Pacemakers, Inc.
- 1993-98 Principal Investigator: "CPI Ventak PRX System Phase III," Cardiac Pacemakers, Inc.
- 1993-98 Principal Investigator: "CPI Ventak PRX Endotak System Phase II," Cardiac Pacemakers, Inc.
- 1993-98 Principal Investigator: "Investigational Plan for the Clinical Evaluation of the Transvenous Res-Q ACD System." IDEG920047, Intermedics.
- 1993-98 Principal Investigator: "Pacemaker Selection in the Elderly (PASE): A Quality of Life Study," Pilot Study.
- 1993-98 Co-Investigator: "Clinical Evaluation of the Medtronic Thera Dr Model #7940/7941/7942 Pacemaker Pulse Generators." Medtronic.
- 1993-98 Principal Investigator: "Comparison of the Safety and Efficacy of D-Sotalol and D,L-Sotalol in Patients with Life-Threatening VT/VF: A randomized, Double Blind, Multi-Center Study," Bristol Myers-Squibb.
- 1993-98 Co-Investigator: "Assessment of Cardioversion Utilizing Transesophageal Echocardiography" (ACUTE) Pilot Study.
- 1993-98 Principal Investigator: "Dose-Ranging Study of Oral Bidisomide vs. Placebo in Reducing the Recurrence of Symptomatic Atrial Fibrillation/Flutter and Paroxysmal Supraventricular Tachycardia" (NP8-92-02-046) Searle Scholars Program.

- 1993-98 Co-Investigator: "Efficacy and Safety of d-Sotalol Versus Placebo in the Maintenance of Sinus Rhythm following Pharmacologic or Electrical Cardioversion in Subjects with Sustained Atrial Fibrillation or Atrial Flutter." (CV102-018) Bristol Myers Squibb
- 1994-99 Principal Investigator: "An Open-Label Safety Study of Intravenous Amiodarone HCL in Patients with Life-Threatening Ventricular Tachycardia/Fibrillation." Wyeth-Ayerst Research.

TEACHING ACTIVITIES

- 1976-81 Director, Cardiac Electrophysiology and Pacing Fellowship Training Program
Mayo Medical School and Mayo Clinic Foundation, Rochester, Minnesota
- 1981-93 Director, Cardiac Electrophysiology and Pacing Fellowship Training Program
Cleveland Clinic Foundation, Cleveland, Ohio
- 1993-94 Director, Cardiac Electrophysiology and Pacing Fellowship Training Program —
Baylor College of Medicine, Houston, Texas
- 1994-pres. Director, Electrophysiology Cardiology Research Program;
Professor of Medicine, NEOUCOM

Sponsorship of Training Awards:

- 1984-85 Sponsor: NASPE Traveling Fellowship Award to F. Abi-Samra, M.D.
- 1984-86 Sponsor: Turkey Fellowship Award to Atila Emri, M.D.
- 1986-87 Sponsor: NASPE Traveling Fellowship Award to Fred Jaeger, D.O.
- 1989-92 Sponsor: Benson Fellowship Award to Elena Sgarbossa, M.D.
- 1990-91 Sponsor: NASPE Traveling Fellowship Award to Steven Moore, D.O.
- 1994-95 Sponsor: NASPE Fellowship in Cardiac Pacing and Electrophysiology Award to David J. Arnold, M.D. Ph.D.: "Correlation of Specific Sodium and Potassium Channel Blocking Profiles in Human Cardiomyocytes with Electrophysiological Profiles of Antiarrhythmic Drugs." Siemens Pacesetter Systems, Inc., \$30,000.

Thesis Advisor and Sponsor of Biomedical Research Training:

- 1985-88 Eugene Ching Yeh: Masters Thesis "The Effect of Atrio-Ventricular Synchrony on Stroke Volume During Ventricular Tachycardia in Man." Department of Biomedical Engineering, Case Western Reserve University, January, 1988.

- 1986-88 Bin Lu: Masters Thesis "A Microcomputer-Based System for Real-Time Beat-to-Beat Measurement of Intracardiac Conduction Time Intervals." Department of Biomedical Engineering, Case Western Reserve University, January 12, 1988.
- 1985-87 Frank Headley Melville: Masters Thesis "A Computer System for Mapping Endocardial Activation Sequences During Electrophysiologic Catheterization." Department of Biomedical Engineering, Case Western Reserve University, May 18, 1987.
- 1987-89 Dirar Shafiq Khoury: Masters Thesis "Continuous Right Ventricular Volume Assessment by Catheter Measurement of Impedance for Antitachycardia System Control." Department of Biomedical Engineering, Case Western Reserve University, May 14, 1989.

ORIGINAL PAPERS

1. Mdoncy JD, Ritter DG, McGoon DC, Danielson GK: Identification of the conduction system in corrected transposition and common ventricle at operation. *Mayo Clinic Proceedings* 1975; 50:387-394.
2. Okoroma EO, Guller B, Maloney JD, Weidman WH: Etiology of right bundle branch block pattern after surgical closure of ventricular-septal defects. *Am Heart J* 1975; 90:14-18.
3. Hartzler GO, Maloney JD: Supra-His alternate-beat Wenckebach dysrhythmia. *Mayo Clinic Proceedings* 1975; 50:475-488.
4. Hartzler GO, Maloney JD: Intra-His block with distal His pacemaker responsive to autonomic stimuli. *Mayo Clinic Proceedings* 1977; 52:46-50.
5. Pritchard DA, Maloney JD, Seward JB, Tajik AJ, Fairbairn JFII, Pairolero PC: Peripheral arteriovenous fistula: detection by contrast echocardiography. *Mayo Clinic Proceedings* 1977; 52:186-190.
6. Hartzler GO, Maloney JD: Cardioinhibitory carotid sinus hypersensitivity: intracardiac recordings and clinical assessment. *Arch Intern Med* 1977; 137:727-731.
7. Pritchard DA, Maloney JD, Barnhorst DA, Spittell JA Jr: Traumatic popliteal arteriovenous fistula: diagnostic methods and surgical management. *Arch Surg* 1977; 849-852.
8. Hartzler GO, Maloney JD, Curtis JJ, Barnhorst DA: Hemodynamic benefits of atrioventricular sequential pacing after cardiac surgery. *Am J Cardiol* 1977; 40:232-236.
9. McGoon DC, Danielson GK, Ritter DG, Wallace RB, Maloney JD, Marcelletti C: Correction of the univentricular heart having two atrioventricular valves. *3 Thorac Cardiovasc Surg* 1977; 74:218-226.
10. Maloney JD, Pairolero PC, Smith BF Jr, Hattery RR, Brakke DM, Spittell JA Jr: Ultrasound evaluation of abdominal aortic aneurysms. *Circulation* 1977; 56 (Suppl. II):80-85.
11. Hartzler GO, Maloney JD: Transesophageal atrial pacing in the Wolff-Parkinson-White syndrome. *Mayo Clinic Proceedings* 1977; 52:576-581.
12. Sieg K, Hagler DJ, Tritter DG, McGoon DC, Maloney JD, Seward JB, Davis GK: Straddling right atrioventricular valve in criss-cross atrioventricular relationship. *Mayo Clinic Proceedings* 1977; 52:561-568.
13. Hartzler GO, Maloney JD: Programmed ventricular stimulation in management of recurrent ventricular tachycardia. *Mayo Clinic Proceedings* 1977; 52:731-741.
14. Curtis JJ, Maloney JD, Barnhorst DA, Pluth JR, Hartzler GO, Wallace RB: A critical look at temporary ventricular pacing following cardiac surgery. *Surgery* 1977; 82:888-893.

15. Espinosa RE, Dlass DW, Maloney JD: Contribution of the electroencephalogram monitoring cardiac dysrhythmias. *Mayo Clinic Proceedings* 1978; 53:119-122.
16. Pritchard DA, Maloney JD, Bernatz PE, Symmonds RE, Stanson AW: Surgical treatment of congenital pelvic arteriovenous malformation. *Mayo Clinic Proceedings* 1978, 53:607-611.
17. Tabry IF, McGoon DC, Danielson GK, Wallace RB, Davis Z, Maloney JD: Surgical management of double-outlet right ventricle associated with atrioventricular discordance. *J Thorac Cardiovasc Surg* 1978; 76:336-344.
18. Danielson GK, McGoon DC, Wallace RB, Maloney JD: Surgery of corrected transposition. *International Congress Series No. 470, Proceedings of the VIII World Congress of Cardiology, S Hayase and S Murai Editors.* 1978;747-750.
19. Danielson GK, Tabry IF, Ritter DG, Maloney JD: Successful repair of double-outlet right ventricle, complete atrioventricular discordance associated with dextrocardia and pulmonary stenosis. *J Thorac Cardiovasc Surg* 1978; 76:710-717.
20. Anderson RH, Danielson GK, Maloney JD, Becker A E Atrioventricular bundle in corrected transposition (letter). *Ann Thorac Surg* 1978; 26:95-97.
21. Danielson GK, Maloney JD, Devloo RAE Surgical repair of Ebstein's anomaly. *Mayo Clinic Proceedings* 1979; 54:185-192.
22. Danielson GK, McGoon DC, Maloney JD, Ritter DG: Surgical septations of univentricular heart with outlet chamber. *Herz* 1979; 4:262-266.
23. Holmes DR Jr, Nissen RG, Maloney JD, Broadbent JC, Merideth J: Transvenous tined electrode systems: an approach to acute dislodgement. *Mayo Clinic Proceedings* 1979; 54:219-222.
24. Nissen RG, Holmes DR Jr, Maloney JD, Feldt RH, Danielson GK: Experience with permanent cardiac pacemakers in congenital heart disease. Montreal, Canada, *Proceedings of the VIth World Symposium on Cardiac Pacing. PACESYMP* 1979.
25. Holmes DR Jr, Maloney JD, Broadbent JC, Gersh B, Merideth J: Transvenous cines electrode systems; an approach to the problem of acute dislodgement. *Proceedings of the VIth World Symposium on cardiac Pacing. Montreal, Canada, PACESYMP, 1979; Chapter 31.*
26. Holmes DR Jr, Gersh BJ, Maloney JD, Merideth J: Followup experience with permanent endocardial tined pacemaker electrodes. *J Thorac Cardiovasc Surg* 1980; 79:565-569.
27. Miller FA Jr, Holmes DR Jr, Gersh BJ, Maloney JD: Permanent transvenous pacemaker implantation via the subclavian vein, *Mayo Clinic Proceedings* 1980; 55:309-314.
28. Holmes DR Jr, Hartzler GO, Maloney JD: Concealed retrograde bypass tracts and enhanced A V nodal conduction: an unusual subset of patients with refractory paroxysmal supraventricular tachycardia. *Am J Cardiol* 1980; 45:1053-1060.

29. Marcelletti C, Maloney JD, Ritter DG, Danielson GK, McGoon DC, Wallace RB: Corrected transposition and ventricular septal defect. *Ann Surg* 1980; 191:751-759.
30. Holmes DR Jr, Gersh BJ, Shub C, Maloney JD, Merideth J: The value of redundancy in chronic bipolar pacemaker electrode systems. *PACE* 1980; 3:436-439.
31. Holmes DR Jr, Maloney JD, Feldt RH: The use of the percutaneous subclavian technique for permanent cardiac pacing in childhood. *Mayo Clinic Proceedings* 1980; 55:579-582.
32. Brown KA, Maloney JD, Smith HC, Hartzler GO, Ilstrup DM: Carotid sinus reflex in patients undergoing coronary angiography: correlation of degree and location of coronary artery disease with response to carotid sinus massage. *Circulation* 1980; 62:697-703.
33. Maloney JD, Nissen RG, McColgan JM: Open clinical studies at a referral center: chronic maintenance tocainide therapy in patients with recurrent sustained ventricular tachycardia refractory to conventional antiarrhythmic agents. *Am Heart J* 1980; 100:1023-1030.
34. Hay I, Duick DS, Vliestra RE, Maloney JD, Pluth JR: Thyroxine therapy in hypothyroid patients undergoing coronary revascularization: a retrospective analysis. *Ann Intern Med* 1981; 95:456-457.
35. Hayes DL, Maloney JD, Merideth J, Holmes DR Jr, Gersh B, Broadbent JC, Osborn MJ, Fetter J: Initial and early follow-up assessment of the clinical efficacy of the multiparameter-programmable pulse generator. *PACE* 1981; 4:417-431.
36. Choo MH, Holmes DR Jr, Gersh BJ, Maloney JD, Merideth J, Pluth JR, Trusty J: Permanent pacemaker infections: characterization and management. *Am J Cardiol* 1981; 48:559-564.
37. Choo MH, Holmes DR Jr, Gersh BJ, Maloney JD, Merideth J, Pluth JR, Trusty J: Infected pericardial pacemaker systems. *J Thorac Cardiovasc Surg* 1981; 82:794-796.
38. Kennel AJ, Callahan JA, Maloney JD, Zajarias A: Adult-onset familial infraHisian block. *Am Heart J* 1981; 102:447-452.
39. McGoon MD, Maloney JD, McGoon DC, Danielson GK: Long-term endocardial atrial pacing in children with postoperative bradycardia-tachycardia syndrome and little L, Maloney JD. The effect of atrio-ventricular synchrony on stroke volume during ventricular tachycardia. Presented at 9th Annual Scientific Session of North American Society of Pacing and Electrophysiology, May 1988, Los Angeles, CA.
40. Holmes DR, Osborn MJ, Gersh B, Maloney JD, Danielson GK: the Wolff-Parkinson-White syndrome: A surgical approach. *Mayo Clinic Proceedings* 1982; 57:345-350.
41. Eastway RJ, Maloney JD, Yiannikas J, Golding LAR: Electrophysiologically-guided surgical treatment of recurrent sustained ventricular tachycardia: variables influencing the decision to intervene. *Cleveland Clinic Quarterly* 1982; 49: 107-117.

42. Yiannikas J, Eastway RJ, MacIntyre WJ, Maloney JD, Go RT, Cook SA, Sufka B, Castle LW: Phase imaging: a new noninvasive method for diagnosis, localization of accessory pathways and serial assessment of therapy in patients with Wolff-Parkinson-White syndrome. *Cleveland Clinic Quarterly* 1982; 49:61-72.
43. Hearnes SF, Maloney JD: Pacemaker system failure secondary to air entrapment within the pulse generator pocket, a complication of subclavian venipuncture for lead placement. *Chest* 1982; 82:651-654.
44. Nishimura RA, Vliestra RE, Maloney JD, Merideth J: Early follow-up of lead performance in atrioventricular sequential systems. *PACE* 1982; 5:694-699.
45. Hearnes SF, Maloney JD: Pacemaker system failure secondary to air entrapment within the pulse generator pocket. A complication of subclavian venipuncture for lead placement. *Chest* 1982; 82:651-654.
46. Maloney JD, Castle LW, Eastway RJ, Sterba R, Moodie D, Gill C, McGoon M. "Long-term endocardial pacing in children with postoperative bradycardia-tachycardia syndrome following the Senning, Mustard, and Fontan operations". *Cardiac Pacing* 1983. Pgs. 585-589.
47. Hayes DL, Holmes DR Jr, Maloney JD, Neubauer SA, Ritter DG, Danielson GK: Permanent endocardial pacing in pediatric patients. *J Thoracic Cardiovasc Surg* 1983; 85:618-624.
48. Huhta JC, Maloney JD, Ritter DG, Ilstrup DM, Feidt RH: Complete atrioventricular block in patients with atrioventricular discordance. *Circulation* 1983; 67:1374-1377.
49. Walls JT, Maloney JD, Pluth JR: Clinical evaluation of a sutureless cardiac pacing lead: chronic threshold changes and lead durability. *Ann Thorac Surg* 1983; 36:328-331.
50. Eastway RJ, Castle LW, Maloney JD, Yiannikas J, Cooper JC, Morant VA: Dual chamber DDD pacing: initial and early follow-up assessment, problems, complications and limitations. *Cardiac Pacing* 1983; pgs. 477-482.
51. Levine PA, Belott PH, Bilitch M, Boal B, Escher DJ, Furman S, Griffin JC, Hauser RG, Maloney JD, Morse JD, Morse D, et al: Recommendations of the NASPE Policy Conference on pacemaker programmability and follow-up. *PACE* 1983; 6:1222-1223.
52. Levine PA, Castle LW, et al. "Proceedings of the Policy Conference of the North American Society of Pacing and Electrophysiology on programmability and pacemaker follow-up programs". *Clin Prog in Pacing and Electro-physiology* 1984. Vol. 2; pgs. 145-191.
53. Castle LW, Maloney JD, Morant VA, Ching E, and Gilli N. "DDD Pacing: Initial and Early Follow-up Experiences. Efficacy, Safety, and Reliability of the Teletronics 2251 Autima". *Vectors*. August, 1984.
54. Sedman AJ, Gal J, Mastropaolo W, Johnson P, Maloney JD, Moyer TP: Serum tocainide enantiomer concentrations in human subjects. *Br J Clin Pharmacol* 1984; 17:113-115 (Review),

55. Adams KV, Raju NV, Sterba R, Castle LW, Morant VA, Maloney JD: Electrophysiology determinants and clinical experience in termination of sustained ventricular tachycardia. *Cleve Clin Q* 1984; 51:47-53.
56. Detrano R, Maloney JD, Letherman J: Ventricular arrhythmias and serum potassium: is there a correlation in the arrhythmic patient? *Cleve Clin Q* 1984; 51:55-58.
57. Raju NV, Hart N, Maloney J, Zaide A, Adams K: Cardiac involvement in polymyositis: a case report and review of the literature. *Cleve Clin Q* 1984; 51:89-91.
58. Parsonnet V, Escher DJ, Furman S, Gillette PC, Goldman BS, Harthorne JW, Hauser RG, Levine PA, Maloney JD: Indications for dual-chamber pacing. *PACE* 1984; 7:318-319.
59. Schiavone WA, Lever HM, Maloney J: Atrial and ventricular programmed electrical stimulation in patients with symptomatic hypertrophic cardiomyopathy. *Cleve Clin Q* 1984; 51:601-609.
60. Maloney JD, Castle LW, Momt V, Sterba R: Sedation and pain management during pacemaker implantation, electrophysiologic testing, and related procedures. *Clin Ther* 1985; 8:84-89.
61. Boal BH, Escher DJ, Furman S, Hauser R, Maloney J, Parsonnet V, Raza ST, Tomatis L, Kruse IB, Bernstein AD: Report of the policy conference on pacemaker reuse sponsored by the North American Society of Pacing and Electrophysiology. *J Am Coll Cardiol* 1985; 5:808-810.
62. Boal BH, Escher DJ, Furman S, Hauser R, Maloney J, Parsonnet V, Raza S, Tomatis L, Kruse I: Report on the policy conference on ~~pacemaker~~ re-use sponsored by the North American Society of Pacing and Electrophysiology. *PACE* 1985; 8:161-163.
63. King-Rankine M, Maloney JD, Golding LA, Morris R: The initial case at The Cleveland Clinic Foundation of the automatic implantable cardioverter-defibrillator and review of the literature. *Cleve Clin Q* 1985; 52:75-80.
64. Beaver BB, Maloney JD, Castle LW, Momt VA, Keefe JM, Ching E: Design-dependent cross-talk in a second generation DDD pacemaker. *PACE* 1986; 9:65-77.
65. Fontaine JM, Maloney JD, Castle LW, Morant VA: Noninvasive assessment of ventriculo-atrial conduction and early experience with the tachycardia termination algorithm in pacemaker-mediated tachycardia. *PACE* 1986; 9:212-222.
66. Valenta H Jr, Nappholz T, Maloney J, Simmons R, Sandra FA, McElroy P: Correlation of heart rate with an intravenous, impedance, respiratory sensor. *Biomed Sci Instrum* 1986; 22:7-12.
67. Rafia SM, Ul-Haque I, Maloney J, Castle L, Sterba R, Morant V: Efficacy of amiodarone therapy in supraventricular tachyarrhythmia: role of electrophysiologic study. *The Alexandria Medical Journal* 1986; 28:125-133.

68. Schiavone WA, Maloney JD, Lever HM, Castle LW, Sterba R, Morant V: Electrophysiologic studies of patients with hypertrophic cardiomyopathy presenting with syncope of undetermined etiology. *PACE* 1986; 9:476-481.
69. Drummer E, Maloney JD, Castle LW, Sterba R, Yeh E: Catheter ablation of the atrioventricular conduction system to treat patients with atrial tachyarrhythmias, including patients with pacemakers. *Cleve Clin Q* 1986; 53:151-157.
70. Haggman DL, Maloney JD, Morant VA, Castle LW, King-Rankine M, Goormastic M: Mexiletine therapy in patients with chronic drug-resistant malignant ventricular arrhythmias. Clinical efficacy, safety, and side effects. *Cleve Clin Q* 1986; 53:171-179.
71. Nappholz T, Valenta H, Maloney J, Simmons T: Electrode configurations for a respiratory impedance measurement suitable for rate responsive pacing. *PACE* 1986; 9:960-964, 1986.
72. Pycha C, Gullledge AB, Hutzler J, Kadri N, Maloney J: Psychological responses to the implantable defibrillator: preliminary observations. *Psychosomatics* 1986; 27:841-845.
73. Cooper DM, Maloney JD, Cooper LA, Hodgeman JR, Castle LW: Immunological reversal of digitalis toxicity by Fab fragments of digoxin-specific antibodies. *Cleve Clin J Med* 1987; 54:43-48.
74. Bilitch M, Hauser RG, Goldman BS, Maloney JD, Harthorne JW, Furman S, Parsonnet V: Performance of implantable cardiac rhythm management device. *PACE* 1987; 10:389-398.
75. Tuzcu EM, Maloney JD, Sangani BH, Masterson ML, Hocevar KD, Golding LA, Starr NJ, Golish JA, Castle LW, Morant VA: Cardiopulmonary effects of chronic amiodarone therapy in the early postoperative course of cardiac surgery patients. *Cleve Clin J Med* 1987; 54:491-497.
76. Zaidi A, Maloney JD, Zaidi S, Gullledge AD: Cardiac pacing and the patient. *Psychiatr Med* 1987; 5:235-243.
77. Prior M, Masterson MM, Maloney JD: Sensitivity and specificity of invasive and noninvasive testing for risk of sudden death in Wolff-Parkinson-White syndrome (letter). *J Am Coll Cardiol* 1988; 11:894-895.
78. Wilson JH, Kyreakakis A, Maloney JD: Ventricular fibrillation induced with programmed stimulation: clinical substrate and prognosis. *J Electrophysiology* 1988; 2:303-314.
79. Bilitch M, Denes P, Goldman BS, Maloney JD, Harthorne JW, Griffin JC, Furman S, Parsonnet V: Performance of implantable cardiac rhythm management devices. *PACE* 1988; 11:371-380.
80. Abi-Samra F, Maloney JD, Fouad-Tarazi FM, Castle LW: The usefulness of head-up tilt testing and hemodynamic investigations in the workup of syncope of unknown origin. *PACE* 1988; 11:1202-1214.

81. Otero-Cagide M, Masterson ML, Wilkoff BL, Castle LW, Morant VA, Simmons TW, Maloney JD: Syncope of undetermined etiology: Value of procainamide administration during a nondiagnostic cardiac electrophysiologic study. *J Electrophysiology* 1988; 2:437-447.
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85. Tuzcu EM, Gilbo J, Masterson MM, Maloney JD: The usefulness of amiodarone in management of refractory supraventricular tachyarrhythmias. *Clev Clin J Med* 1989; 56:238-242.
86. Masterson M, Tarazi R, Sterba R, Maloney J, Castle L, Gill C: Preexcitation syndromes: surgical ablation therapy. The Cleveland Clinic experience. *Clev Clin J Med* 1989; 56:607-613.
87. Khoury D, Maloney J, McAlister H, Simmons T, Wilkoff B, Rudy Y: The impedance catheter: potential for differentiation between hemodynamically stable and unstable arrhythmias. *Proceedings of the Fifteenth Annual Northeast Bioengineering Conference* Editor: Soren Buus, Ph.D. 1989:1-2.
88. Maloney JD: Consequences of the Cardiac Arrhythmia Suppression Trial: calamity or clarity? (editorial). *Clev Clin J Med* 1989; 56:649-653.
89. Ballas SL, Rashidi R, McAlister H, Corbelli R, McCowan R, Wilkoff BL, Castle LW, Morant VA, Simmons RW, Maloney JD: The use of beep-0-grams in the assessment of automatic implantable cardioverter defibrillator sensing function. *PACE* 1989; 12:1737-1745.
90. Khoury D, McAlister H, Wilkoff B, Simmons T, Rudy Y, McCowan R, Morant V, Castle L, Maloney J: Continuous right ventricular volume assessment by catheter measurement of impedance for antitachycardia system control. *PACE* 1989; 12:1918-1926.
91. Mdoncy JD, Emre A: Cardiac pacing dilemmas: utilization, indications, and complications. *Current Opinion in Cardiology* 1989; 4:28-33.
92. Maloney JD, Detrano R, Jaeger FJ, Leatherman S, Morant VA, Castle L W: Potassium loading as adjunct treatment of repetitive ventricular arrhythmias. *Cleve Clin J Med* 1990; 57:223-231.

93. Masterson MM, Pinski SL, Wilkoff B, Simmons TW, Morant VA, Golding LR, Castle LW, Maloney JD: Pacemaker and defibrillator combination therapy for recurrent ventricular tachycardia. *Cleve Clin J Med* 1990; 57:330-338.
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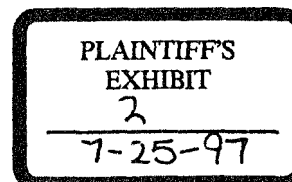
4-1-97

Jim Casey
Reminger & Reminger
The 113 St. Clair Building
Cleveland, Ohio 44114

Dear Mr. Casey:

After reviewing the materials (medical records and affidavits) that you provided me regarding the care of Mr. Dewey Jones, I have concluded the following:

1. The cardiovascular health of Mr. Jones was well known to his physicians from past medical evaluations and pre-operative clinical assessments during the patient's last hospitalization at Meridian Huron Hospital. At the time of his hospitalization, Mr. Jones was a thirty three year old obese male weighing more than 310 pounds and 5'8" in height. His obesity had been refractory to multiple therapeutic plans that included diet and exercise. He had been treated on multiple occasions in local hospitals for labile hypertension, recurrent congestive heart failure, obesity and cardiomyopathy. All of these conditions appeared to be chronic and were risk factors for premature cardiovascular death. His blood pressure would appear to be a major problem as an outpatient but would come under rapid control when hospitalized. His cardiac symptoms would appear directly related to the degree of his hypertension and would also rapidly subside as his blood pressure was brought under control. He had left ventricular dysfunction that appeared to be symptomatic only when his blood pressure was out of control.
2. Mr. Jones' condition(s) had been adequately stabilized prior to his gall bladder surgery, and the internist, anesthesiologist, and general surgeon assessed their aspects of the patient and all felt he was a satisfactory candidate for the necessary and required gall bladder surgery. I concur with this decision as an internist, a cardiologist and a cardiac electrophysiologist. Knowing this man's history and his current problem, I would have also recommended surgery for the patient during this same hospitalization.
3. Mr. Jones had recurrent symptoms of chronic recurrent cholecystitis and chronic cholelithiasis

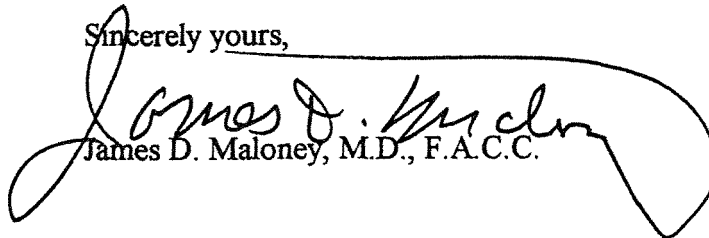


that had to be effectively treated and would best be treated by *surgical* intervention, because the complications of acute cholecystitis untreated in ~~this~~ same patient with a compromised health status posed even greater **risk**.

4. Mr. Jones tolerated the general anesthesia and surgical removal ~~of~~ the gall bladder Without **difficulty**. After completion of the *surgical* removal of the gall bladder and wound closure, Mr. Jones became hypoxic. The hypoxia and subsequent events occurred when preparations were being made to extubate Mr. **Jones**. The hypoxia preceded the reflex bradycardia and led to the subsequent pulmonary **infiltrations**. He did not experience a cardiac arrest, but rather developed reflex bradycardia and hypotension. These problems resolved rapidly when the heart rate and cardiac output **was** enhanced by medication, thereby demonstrating the presence of good cardiac reserve.
5. The pre-operative and **surgical** management of Mr. Jones was appropriate and well within the standard of care.

If a more detailed review of the **history** and subsequent hospital course is required, please let me **know**.

Sincerely yours,


James D. Maloney, M.D., F.A.C.C.

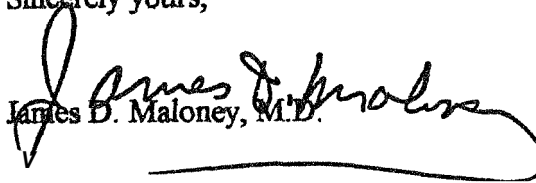
July 9, 1997

Jim Casey
Reminger & Reminger
The 113 St. Clair Building
Cleveland, Ohio 44114

Dear Mr. Casey:

As a supplement to my report of 4-1-97, I will be rendering an opinion regarding Mr Jones' life *expectancy* prior to the operation of 10-20-94.

Sincerely yours,


James D. Maloney, M.D.

HARVARD MEDICAL SCHOOL
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March 5, 1997

Paul Grieco
Landskroner & Phillips
55 Public Sq. Suite 1040
Cleveland, OH 44113

Re: Dewey Jones

I, Marc I. Senigran, am a licensed physician Board Certified in Cardiology. I have reviewed the records of Dewey Jones including the hospital records of 1991-1994 of the Community Hospital of Bedford and of 9/18-9/20/94 and 10/17-11/21/94 of the Meridia Hiron Hospital.

Mr. Jones is a 34 year old man with a history of severe hypertension and heart failure. An echocardiogram performed on 6/24/94 had revealed left ventricular dilation and moderate hypokinesis with overall depressed systolic function. Mild left ventricular hypertrophy was also noted. Mr. Jones was admitted to Meridia Hospital from 9/18-9/20/94 with hypertension and decompensated heart failure. He responded to intravenous diuretics and an increase in his vasodilator regimen.

Mr. Jones was again admitted to Meridia Hospital on 10/17/94 with abdominal pain due to cholelithiasis. He was hypertensive on admission, and minoxidil was added to his regimen. Intravenous fluids were administered, and on 10/20 he was taken to the operating room where he underwent a cholecystectomy. At the time of extubation after the procedure, the patient developed acute pulmonary edema and had a bradyarrhythmic cardiac arrest. He was resuscitated and re-intubated. His pulmonary edema was treated with intravenous Lasix, enalapril and transdermal nitroglycerin. At the time of placement of a PA line 4.5 hours later, his pulmonary artery wedge pressure was elevated at 18 mm/Hg and his cardiac index at 0.93 l/min/m². After several days of treatment, Mr. Jones's hemodynamics stabilized. Unfortunately, he remained unresponsive during the remainder of his Meridia hospitalization, likely due to cerebral anoxic injury at the time of cardiac arrest.

It is my considered opinion that the care given to Mr. Jones prior to surgery deviated from good and accepted medical practices in that (1) the vasodilator given to him, minoxidil, commonly leads to fluid retention, an effect which would be expected to exacerbate Mr. Jones's underlying heart failure; (2) Mr. Jones was given a large amount of intravenous hydration (DSW/0.25NS @ 120 ml/hr) beginning the evening prior to surgery despite his cardiomyopathy and tendency to volume overload; this added to his already high risk of developing pulmonary edema; 3) Mr. Jones was cleared for surgery despite the fact that an echocardiogram ordered on

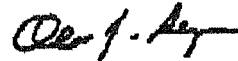
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EXHIBIT

3

7-25-97

4/10/8/94, which would have likely indicated the presence and severity of Mr. Jones' cardiomyopathy and helped guide his management, had not been performed. I believe that the non-emergent nature of the cholecystectomy would have allowed time for a complete cardiac evaluation, including the echocardiogram, to have been performed. It is more likely than not that, with a reasonable degree of medical certainty, the failure to appropriately manage Mr. Jones' cardiac condition led to his post-operative arrest.

Sincerely,



Marc J. Semigran MD