THE STATE OF OHIO COUNTY OF ASHTABULA
IN THE COURT OF COMMON PLEAS JUDGE VETTEL

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JAMES LOVETT, Administrator of the Estate of DOROTHY M. LOVETT,

Doc 302

Plaintiff,

-vs-

MEMORIAL HOSPITAL OF GENEVA, et al,

Defendants.

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Deposition of JOHN B. McCABE, M.D., held at University Hospital, 750 East Adam Street, Syracuse, New York, on February 23, 1983, before Deborah S. Gosline, Court Reporter and Notary Public in and for the State of New York.

APPEARANCES:

For the Plaintiff:

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# I N D E X



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# E H I B I T



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JOHN B. McCABE, M.D., having been called as a witness, being duly sworn, testified as follows:

EXAMINATION BY MR. MELLINO:

E Would you state your full name for the record.?

A. John Bernard McCabe.

Q. And what's your address?

A. Home address is 4447 Swissvale, S-W-I-S-S-V-A-L-E Drive, Manlius, M-A-N-L-I-U-S, New York.

P Dr. McCabe, as you know, my name is Chris Mellino. I represent the Plaintiff in this action. I'm going to be asking you a number of questions this afternoon.

And I would only ask two things of you, one is you answer verbally so the Court Reporter car! take down all your answers, and the other thing is if you don't understand anv of my questions, please ask me to rephrase them so we understand each other.

A. Okay.

MR. MELLINO: Why don't you mark that as Exhibit 1.

(EXHIBIT NUMBER 1 MARKED FOR IDENTIFICATION THIS DATE.)

Q. Dr. McCabe, I'm handing you what's been marked as Exhibit 1 which is a copy of your C.V. which I have been

provided by Mr. Dapore.

Can you tell me if that C.V. is up to date, accurate?

A. This is dated July, '87. So there are a couple of additions in terns of some activities or publications that would need to be updated. But essentially all the information is correct, relatively up to date.

MR. DAPORE: Do you have a current one?

TEE WITNESS: No, that's the most current one that I have printed. I do redo then once a year. So this thing --

Q. All right. You said there were publications that are not on here?

A. Yes, if you, actually there are some publications which were pending at the time this was written that have been printed since then. For instance, this has been printed (indicating) in the Journal of Emergency Medicine. This is now scheduled for May of this year (indicating). This is scheduled for April of this year. And then there would be a couple different articles that have been submitted. but not yet published.

I can provide you with a list of those, if necessary.

Q. Would you do that, please?

A. Sure.

Q. What is your current position?

A. Current position is Associate Director of critical care and emergency medicine here in the University Hospital. And then I'm an Associate Professor of critical care and emergency medicine at the medical school here.

Q. What do you do in those positions?

A. In those positions I have clinical responsibility, teaching responsibility, and administrative responsibility. I currently work about 20 hours a week here in the emergency department as attending physician at University Hospital.

I spend probably an equal number of hours doing administrative duties to oversee the operation of the emergency department here at University Hospital.

And then an equal number of hours in a mixture of research and teaching activities for medical students, residents here at the medical school complex.

P Eave youtestified before on behalf of, well, as an expert in a medical malpractice case?

A. I have not testified! in court. I have given deposition before, medical malpractice.

Q. In how many other cases?

A. One other to deposition.

Q. What did that case involve?

A. It is an emergency department patient, multiple trauma with cervical spine injury.

Q. Did you testify on behalf of the Plaintiff or the Defendant?

A. That's a Plaintiff.

Q. Are there other cases that vou have reviewed?

A. Other cases that I have reviewed, I will guess probably in the neighborhood of eight, ten, twelve maybe at the most. That would all be over the last four years. Some were in that time frame.

Q. Are any of those cases still pending?

R It is my understandinq that one cr two of them are still pending. But I've not been asked to do deposition in any of them. So I have not had recent contact with any of those cases.

Q. Can you give me a breakdown on which side you have reviewed the cases for?

A. I will guess it is pretty close to 50/50, maybe a slight edge towards the Defendant's side. But pretty much 50/50.

Q. How did you become involved in this case?

A. In this case I got a call from Dr. Ken Winer

(phonetic) who is a physician that I know in emergency medicine in Ohio through my time when I lived in Ohio. And he simply asked me if I would be willing to have him give my name to this firm (indicating) and to have me review a case. I sail! I would be willing to do that.

And then I'm not sure who the ,initialphone contact came from, --

THE WITNESS: Whether it was yourself --

MR. DAPORE: It was ne.

A. He gave me brief details of the case and asked if I would be willing to review the material.

Q. What hospital is Dr. Winer associated with?

A. I'm not sure of the exact hospital. He's associated with multiple hospitals in the Cleveland area, is an emergency physician, but I don't know his exact hospital detail. I know him more through my dealings with the Ohio Chapter of The American College of Emergency Physicians.

Q. Have you reviewed any cases on behalf of Jacobson, Maynard, Tuschman & Kalur --

A, No.

Q. -- prior to this? Have you ever been a Defendant in a lawsuit?

MR. COAK EY: Objection,

MR. DAPORE: Objection. You can answer.

A. No.

Q. What were you asked to do in this case?

A. I was asked to review the records that were sent to me and to gather an opinion regarding this emergency department care that was rendered in this case. And then I discussed that with Mr. Dapore.

Q. Did you know Dr. Conant?

A. No, I did not.

Q. How about Dr. Jeniac (phonetic)?

A. I know Dr. Jeniac through my dealings with the Ohio Chapter of The American College of Emergency Physicians.

Q. When did you live in Ohio?

A. I lived in Ohio from July of 1979 until roughly July 1st, 1337.

Q. Now, in your report you indicate you reviewed the emergency department records from Geneva Memorial Hospital and the autopsy report, says the opinions of Dr. Bitterman (phonetic) and Dr. Jeniac, I assume that means their reports?

A. I had a copy of letters from both those individuals.

Q. And also the deposition of Mr. Lovett?

A. Correct.

Q. Did you review anything else?

A. I'm not sure if you said it. There was a record from the Richmond Heights Clinic, three emergency department visit records, the two fetters, Dr. Bitterman and Jeniac, the autopsy report, and Mr. Lovett's deposition. I think that was all that was sent initially to me.

Q. What have you reviewed since then?

A. I've also reviewed a deposition from a nurse in the emergency department whose name I can't --

MR. DAPORE: Robinson.

A. Robinson.

Q. Were you told anything, any facts of this case by anybody?

MR. DAPORE: Objection.

P Other than what's contained in the documents you reviewed?

A. My information pertaining to the case has come from my discussions with Mr. Dapore and! from the materials that have been sent that I reviewed.

And I should also say from probably a one-minute phone conversation with Dr. Winer when I initially had the contact.

Q. Well, did you rely on anything for the purpose of rendering your opinion that was told to you by Mr. Dapore

that was not contained in any of the records or depositions?

A. No.

Q. Did you ever review any statements made by Dr. Conant?

A. No.

Q. Were you ever told anything about what he said happened in this case?

A. Not to the best of my knowledge, no.

Q. Did you review any medical literature to either prepare your report or to testify today?

A. Not specifically, no.

Q. What do you mean by not specifically?

A. Well, let me rephrase that. No, I did not take any books or journals out in order to prepare for today's deposition.

Q. How about to prepare your report?

A. At the time that I prepared the report, I think I probably did do some background reading in some of the current emergency medicine textbooks.

Q. What textbooks would you consider authoritative on this subject?

A. Well, it is hard to give you one textbook that's authoritative. Emergency medicine practice is multiple

journals. And current practice, there are probably half a dozen textbooks that specifically relate to emergency medicine

Q Well, what are they?

A. You would like nares of books?

Q. Yes.

A. That are all currently out on the topic of emergency medicine?

Q. That you would consider authoritative.

A. Well --

P Doesn't have to be an exhaustive list.

A. Current books that are used in the emergency department would be Rosen's Principals and Practices of Emergency Medicine, Callaham's Current Practice in Emergency Medicine, Trunkey's Current Practice of Emergency Medicine, Swartz Principals and Practices of Emergency Medicine.

None as a single reference that is the authoritative book.

Q. Maybe you answered this already, you said you spent 20 hours of clinical practice in the emergency room here?

A. Uhm-hmm.

Q. Do you actually treat patients or do you supervise?

A. I do both.

Q. What is the standard f care for signing out a

patient against medical advice?

A. The standard of care from the emergency department here specifically you are asking?

Q. *Yes.*

A. I think in order to sign out a patient against medical advice, it is required that the patient understand the need and the request, suggestion for admission, that they be aware of their diagnosis, and be aware of the potential complications of leaving against medical advice. And they need to understand and accept full responsibility of the consequences of their action.

Q. How often have you signed out a patient aqainst medical advice?

A. Well, that's difficult to say. I would say it is an uncommon occurrence. I mean it is not a rare event.

But, you know, probably in my clinical practice I would guess once or twice a month that type of a situation comes up.

Q. When you say that type of situation, would that be a situation where somebody actually leaves the hospital or where they don't want to be admitted?

A. I would say the setting where a patient doesn't want to be admitted is certainly more frequent. When I say

that type of event, one which involves a discussion and/or a signing out of somebody against medical advice.

Q. Where they actually sign out and leave the hospital?

A. Would be a little less frequent.

Q. Less frequent than once or twice a month?

A. Sure. Again, I can't give you a specific number, That's a best guess.

Q. What's atropine?

A. In the context of this case or in general?

Q. In general.

A. It is an agent that's used for many purposes. It increases heart rate. So we use it as a cardiac medication in the setting of cardiac arrest.

It is also used to dry, for instance, mucosal membranes and decrease secretions. So it is used as a pre-anesthetic agent.

Also has some effect on muscle relaxation. So it is mostly used to settle the GI tract, for instance.

Q. Do you know why it was given in this case in the October 5th visit to the emergency room?

A. I, I can't state for sure not having been the treating physician. It is not an uncommon agent to be given in GI pain for the reasons I just stated.

Q. What is Demerol?

A. Demerol is a narcotic analgesic agent given for relief of pain.

Q. Atropine is not a narcotic?

A. No.

Q. What effect does Demerol have on a person's ability to sign out against medical advice?

MR. COAKLEY: Objection.

MR. DAPORE: Objection. You can go ahead and answer, if you can state it in general.

A. In general, again, the main effect of Dernerol or any narcotic agent is to relieve pain. It certainly can have a sedating effect on patients as well.

Q. Do you have an opinion in this case to a-reasonable degree of medical probability whether the Denerol given Mrs. Lovett made her incompetent to sign the medical release form?

A. Yes, I do.

Q. What is your opinion?

A. From review of the materials that have been given to me, my opinion is that it did not.

Q. What is your opinion based on?

A. My opinion is based on the review of depositions and other materials that were given to me which would seem

to indicate from other's testimony that the patient appeared competent at the time that she signed the AMA form and actually left the hospital against medical advice.

Q. What facts are there in the record that leads you to believe she appeared competent?

A Specifically the testimony of Nurse Robinson that the patient appeared competent at the time the form was signed, appeared aware of the consequences of leaving, and did not seem to be impaired to the point that she was unable to siqn the release form.

Q. Did you read her testimony where she stated that it was inappropriate or against hospital procedure to have patients sign an AMA form after giving them Dernerol?

MR. DAPORE: Objection.

MR. COAKLEY: Objection.

MR. DAPORE: If you want to give a specific reference to the deposition page and the question and answer, you can repose the question.

FIR. MELLINO: Well, I asked him if he was aware of that testimony. If that's not the testimony, then if he's not aware --

MR. COAXLEY: You arc? asking if he

remembers that testimony from the deposition of Nurse Robinson?

MR. MELLINO: Yes.

A. Could you rephrase the question?

Q. Sure. Do you remember Nurse Robinson testifying that it was against hospital procedure to have a patient siqn an AMA form after being given Demerol?

A. I don't remember testimony that there was, it was aqainst a specific hospital policv or procedure, no.

Q. Do you remember her saying it is not something they normally do?

A. I don't remember if it was said in that particular way, no.

Q. What do you remember her saying about it?

MR. COAKLEY: Objection.

MR. DAPORE: If you want to refer to the deposition, you may do so, Doctor. You don't have to go --

9 Absolutely, if you want to refer to anything --

A. I would be happy to see if we can find a passage.

MR. DAPORE: If you have a specific passage you want to direct the Doctor's attention to, please do.

MR. COAKLEY: I don't think it is fair to make this a memory contest as to what the deposition says.

MR. DAPORE: Do you have a specific passage?

MR. MELLIMO: No.

MR. CGAKLEY: Well --

Q. What do you remember her saying about giving Demerol?

MR. DAPORE: He's not going to answer that question unless you have a specific passage that you want to refer him to. I am not going to have him play the recollection game of everything that was contained within her deposition.

MR. MELLINO: I asked if he remembered her saying it was against procedure. He said not specifically.

MR. DAPORE: That's not what he testified to, that question.

MR. MELLINO: I think it was. I don't want to argue abcut what his --

Q. Do you know what the procedure is at Geneva Hospital for having patients sign out against medical advice

after the giving of Demerol?

A No. I'm not aware of th policies or proced ıres at Geneva Hospital.

Q Is that something that you do at this hospital?

A. Are you asking is there a specific policy with regards to that?

MR. DAPORE: Objection to what policy is set up in this hospital. It is irrelevant to this case. It does not purport to be a standard of care for the care and treatment of patients. And to that extent I will tell him not to answer the question.

MR. MELLINO: I would like to ask him what he does.

MR. DAPGRE: You can't, because that's not the standard, what he **does.**

MR. MELLINO: It is a discovery deposition.

MR. DAPORE: That's quite all right, it is a discovery deposition. But what he does or what this hospital does is in no way relevant to this case.

MR. MELLINO: Certainly it is evidence as to the standard of care.

MR. DAPORE: It isn't evidence as to the standard of care. That's the specific question If you want to ask him --

MR. MELLINO: If --

MR. DAPORE: If you want to ask him what he feels the standard of care is.

MR. MELLINO: I may ask him later on. I am asking what he does.

MR. DAPORE: Ee won't answer that question

BY MR. MELLINO:

Q. Do you have written procedures in this hospital concerning signing out against medical advice?

MR. DAPORE: Objection. You can answer the question.

A. I believe there is a written policy with regards to t at.

Q. Does it allow a patient to sign out against medical advice after being given Demerol?

A. I don't believe the policy specifically addresses that point.

Q. In the times that you have signed out a patient against medical advice, have you done it after giving Dernerol?

A. YOU are asking me if all the patients I have ever

discharged in the last 10 years from an emergency department, did any **of** them get Dernerol?

Q. Not discharged, siqned out aqainst medical advice.

A. Did any *of* them have Demerol prior to their discharge? That's **a** very difficult answer for me to go back.

MR. DAPORE: Only if you can recall.

A. **I** cannot recall specifically any patients that had.

Q. **Your** opinion is that there is nothing wrong with giving Dernerol, then having a patient sign out against medical advice, **Demerol** in a dose *of* 75 milligrams?

MR. COARLEY: There are two different questions on the table. Please --

MR. DAPORE: That's Dot what he testified to. That's the way you are framing the question as if he testified *to* that. If you want *to* rephrase the question and ask him if **it** *is* his opinion.

MR. COAKLEY: I also object on the basis that there are two questions being asked of the doctor at the same time. First you asked if Demerol generally, then you asked of a specific dosage. **I** think you should break the question down.

MR. MELLINO: Are you auys done now?

MR. DAPORE: Uhm-hmm. You asked a compound question.

MR. MELLINO: I was just clarifying what I meant by Demerol.

MR. COAKLEY: Then tell the doctor you want -- we can check, there were two questions. First you asked about Denerol generally, then vou asked about 75 mg's. So --

MR. MELLINO: I never finisher! the one question.

MR. COAKLEY: I'm objecting because I think the question is unclear.

MR. MELLINO: I guess you want to spend the afternoon here if you want to object to everything.

MR. COAKLEY: No. That's the first objection I have had.

BY MR. MELLINO:

P Doctor, what's your opinion on the use of Demerol in signing out against medical advice?

A. A very difficult question to answer. I think if you go back to the ground rules that I gave you for signing out a

patient against medical advice, it is appropriate that they be competent to understand the consequences of their action and be appropriately able to understand the disease process that they have. And to that extent, any medication be it Dernerol or something else which has now altered their ability to understand and to comprehend the consequences of their action makes their discharge against medical advice difficult given the ground rules that I gave you to begin with.

And in that context it is very difficult for me to answer does giving drug X and in this dose make it inappropriat to discharge somebody. That has nothing to do, you are not giving me any idea of time frame, illness, competency to understand which goes to my original discussion of against medical advice. That really is the crux of the issue.

Q. Well, we can agree Dernerol affects a person's ability to understand?

A. I don't think I said that.

MR. COAKLEY: You did not.

Q. I didn't say you said that. I said can we agree on that? Apparently not.

A. Denerol in some patients in some time frame may indeed alter a patient's mental status, yes.

Q. Well, under what circumstances do you think it a ters

someone's mental status?

A. When after giving it their mental status is different than prior to giving it.

Q. And what evidence is there in this record that her mental status did not change? Do you know what her mental status was before the giving of the Demerol?

A. Not having seen the patient, I don't have that. I have the testimony of others, specifically, again, Nurse Robinson, that the patient appeared to be competent and able to understand and sign the AMA form in the emergency department after having received a dose of Demerol.

Q. That's the only basis for your opinion that the Demerol did not change her or did not affect her ability to comprehend is Nurse Robinson's testimony?

A. I think that and coupled with a practice experience which doesn't, I mean there is a prevailing opinion that once you have received Demerol or something like that you are automatically incompetent and impaired. And clinically, that's not the case.

Q. Well, I assume you have some idea what the effect of Demerol would be on a woman the size and weight of Mrs. Lovett?

A. I don't know if I have her size and weight.

MR. DAPORE: From the autopsy, it indicates 135 pounds, 5 feet, 7 inches. That's from the autopsy report.

A. That's an average-built person. And certainly the dose of Demerol was not excessive. I mean this is a relatively standard size dose for a person of her size.

Q. All right. When it was given with the purpose -- do you know why it was given?

A. I presume it was given to alleviate her pain.

P Do you know if it was successful in doing that?

A. I don't know from reading the materials that I have reviewed.

Q. And would a dose that size in that size person have any effect on their ability to understand?

A. What you are asking ne to say is an always or a never. And I think that's impossible to say.

Q. So it could have had an effect on her ability to understand?

A. It certainly might not have.

Q. But it could have?

A It is possible that in a dose for that person it might have had an effect on her mental status, yes.

Q. Are you aware of testimony of both Nurse Robinson

and Mr. Lovett that she slipped or fell when she came out of the bathroom that night?

A. I believe the record shows that she nearly slipped and she did not fall, if memory serves me correctly.

Q. That she slipped and nearly fell. Do you think the Demerol had anything to do with that?

A. I think it is impossible for me to tell from the review of the records.

Q. Is it appropriate within the standard of care to involve a family member in the decision to sign out against medical advice?

A. I think there may be times when that's appropriate. I don't think it is the standard of care that it has to be done in every case.

Q. What about in this case?

A. Again, I think the times when it is appropriate are when the physician feels the patient needs to stay, cannot convince the patient of that, then it is appropriate to use whatever means are available to you as a physician if you feel strongly enough abcut an admission to qet that patient to stay. And certainly involvement of family is appropriate.

Q. Weren't *those* circumstances present here?

A. I think so, yes.

Q. So it would have been appropriate for Dr. Conant to involve the husband in the decision?

A. What I guess the question is -- what do you mean by involve?

Q. Well, should he have had him sign the AMA form?

A. I don't believe so.

Q. Should he have explained the diagnosis to him?

A. I think it is appropriate for family members to understand diagnoses, to understand the wishes of their family member, and to understand the consequences of their action.

Q. Where is that documented in the record that Dr. Conant did that?

A. I don't believe it is specifically documented in the emergency department record that I can, that I am aware of.

MR. COAKLEY: By the records, are you referring to the records he reviewed?

MR. MELLINO: No, I was referring to the hospital record. And you can feel free to review them if you like.

MR. DAPORE: You mean a direct reference

to a conversation with Mr. Lovett himself, is that what you are asking?

MR. MELLINO: I am asking where it is reflected in the record that the diagnosis was explained to Mr. Lovett.

A. I don't believe it is.

Q. Is it reflected anywhere in the record that the diagnosis was explained to Mrs. Lovett?

A. I believe it is both in the record itself where it states patient advised admission and also in the release form which states that I acknowledge that I have been informed of the risk involved and hereby release attending physician, et cetera.

Q. Well, what is it a risk of that's being warned of in there, in the AMA form?

A. Well, I can only presume that the diagnosis and the associated risks of leaving the hospital were explained to the patient. Clearly one can't have a form that covers every potential complication of leaving aqainst medical advice as those complications vary depending upon the reason that someone is requesting admission.

Q. Well, shouldn't that be reflected in the chart then?

A. Shouldn't what?

Q. That the risks were explained to her.

MR. DAPORE: Objection. He just answered that it is on the face sheet and in the form itself she signed.

MR. MELLINO: Not what the risks were.

MR. DAPORE: Do you want to read that again?

A. I acknowledge that I have been informed of the risk involved.

Q. Right. What does that mean?

A. That I acknowledge that I have Seen informed of the risk involved.

a What's the risk?

A. The risk of leaving aqainst medical advice.

Q. Yes. But what is it? Is it death, what is --

MR. COAKLEY: You are being argumentative with him now, Chris.

MR. MELLINO: I thought I would join in with you guys.

Q. What's the risk that she's being warned against?

MR. DADORE: Is it specifically enumerated, each individual risk? Is that the question you are asking the doctor?

MR. MELLINO: NO.

Q. Do you understand the auestion?

A. NO.

Q. What was the risk of her leavinq the hospital that night?

MR. DAPORE: Based on what?

Q. Based upon her condition.

MR. DAPORE: Does that help you answer the question?

A. Based on my review of the medical record, there are many risks associated with her Leaving and a tentative diagnosis that was placed here, certainly fever, vomiting, dehydration, a worsening abdominal condition and potential for death.

Q. And those risks are not spelled cut anywhere in the chart: am I correct in that?

A. I don't see those risks specifically enumerated in the chart.

Q. And the risk of death would certainly be greater than the risk of a fever; would that be correct?

A. What do you mean by greater? I'm not sure.

Q. More life-threateninq?

A. Certainly.

Q. Would it have been appropriate for the risks that were told to the patient, the actual risks of her leaving the hospital, would it have been appropriate for those to have been recorded in the chart?

A. If *you* are asking me if every risk that was explained to the patient should be written specifically on the chart, I don't think that's appropriate.

Q. What about the **major** risks?

A. I think the physician's attempt is to document he advised admission, to explain to the patient, and if the patient is competent, to have the patient sign stating they have been informed and they understand the risk. I think that's appropriate.

Q. Well, you have already told me there is a lot more involved in signing out against medical advice than just being advised of admission; isn't that right? You said the patient has *to* be aware of the diagnosis and have an appreciation of the risks?

A. Yes, that's correct.

Q. There is nothing in this chart *to* tell us that Mrs. Lovett understood what the diaqnosis was or what the specific risks of her leaving the hospital that night were, her diagnosis --

MR. DAPORE: Objection. He already testified to that, that there is documentation.

Q. I said of the specific risks.

MR. DAPORE: He already testified to that as well.

P Can you answer the question, Doctor?

A. Would you repeat the question?

Q. Sure. Is there anything in the chart that reflects that Mrs. Lovett was advised of the specific risks of leaving the hospital with her condition on October 5th?

A. And by specific you mean a list of the myriad of things that could potentially happen to her?

Q. Well, the risks you have enumerated for me earlier, the risk of the worsening abdominal condition, death?

A. Those items are not specifically listed! on the chart.

Q. So you don't know whether she was told of those risks or not?

MR. DAPURE: Objection. He can't make that judgment.

A I can't answer whether she was specifically informed, of what individual risks she might have been informed of.

Q. You just don't know: do you?

A. Of the specific items that were told to her?

Q. Right.

A. No.

Q. You don't know whether she was told what her diagnosis was; do you?

A. I only know what was told to her through the deposition of others who were involved in telling her.

Q. Well, is there anything in Nurse Robinson's deposition that said she was informed of the specific risks of her condition, of leaving with her condition?

A. I believe Nurse Robinson testified that the specific diaqnosis was told to her, and not in a specific manner, but in general terms they did discuss the risks of leaving. I don't remember that real specifics of every potential complication were listed in Nurse Robinson's deposition either.

Q. What is cholecystitis?

A. It is inflammation of the gall bladder.

Q. That's what they thought her condition was when she was in the hospital?

A. That's correct.

P In the emergency room?

A, During the visit of 10/5/86.

Q. And it turned out that wasn't her condition; correct?

A. Correct, from the autopsy report that was not.

Q. I take it that her, the physical findings on the October 5th admission were consistent with other diagnoses?

MR. DAPORE: Do You understand the question?

THE WITNESS: No.

A. If *you* would repeat --

Q. Were the physical findings in the emergency **room** on October 5th consistent with other diagnoses besides the one made?

A. Given the, just physical exam findings, yes, they are consistent with other diagnoses.

Q What other diagnoses?

A. Ulcer disease, pancreatitis, gastritis, probably the major diagnoses to consider.

MR. DAPORE: Is that in addition to the cholecystitis?

THE WITNESS: In addition to cholecystitis, yes. I'm sorry, I thought the question was in addition to.

Q. What about peritonitis, would that be consistent with that?

A. I don't think the exam findings on 10/5 are consisten

with peritonitis.

Q. Are they inconsistent with peritonitis?

A. Yes.

Q. You could rule out peritonitis based on those findings?

A. Peritonitis generally presents with an abdomen that's rigid, extremely tender, rebound tenderness. There are many findings that are not present here that would suggest the diagnosis of peritonitis. So I don't believe the patient had peritonitis.

Q. Could you rule out peritonitis based upon the physical findings contained in the chart or would you need to do more --

A No. I think you could rule it out by the, on the basis of physical exam findings in this chart.

Q. Do you have an opinion as to when the perforation occurred?

A. Yes, I believe it occurred at sometime following this visit of 10/5/86.

Q. When do you think it occurred?

A There is no way to be sure of the time. But my best estimate would be at the time when she became more acutely ill in the middle of the night and then exhibited,

you know, severe or findings more consistent with ruptured viscus and perit nitis.

Q. What were the symptoms that were consistent with the ruptured viscus?

A. An acute worsening of her pain which Mr. Lovett describes as sometime more in the middle of the night.

Q. You believe that his testimonv was there was an acute worsening of pain sometime in the night?

A. As I recall, at one point the patient screamed out, became more uncomfortable, I believe, and became unresponsive shortly thereafter.

Q. Is it appropriate to give narcotics when somebody presents in the emergency room with abdominal pain of unknown etiology?

A. We are talking about a patient with no diagnosis or no potential diagnosis, is that --

Q. Yes.

A. So *you* are asking if it is inappropriate to give Dernerol to someone when you have no idea what might be causing their abdominal pain?

Q. Right.

A. I think until one has an understanding of at least a differential diagnosis of probable causes, yes, it is

inappropriate to give Dernerol.

Q. It is inappropriate to give Demerol?

A. When you have no idea what is, what is wrong with the patient. Once a patient has been examined and you have some idea, there are certain conditions when Demerol is appropriate.

Q. 'Why is it inappropriate to give it?

A. Why is it inappropriate to give it?

Q. Right.

A. Because there are some acute surgical conditions which will require going to the operating room riqht away where it might interfere with other medications that would need to be given paraoperatively, that is around the time of the operation. Until one has a feeling for what's wrong or potentially might be wrong with a patient, you don't want to make their pain go away, because it may make it more difficult for you to arrive at a set of differential diagnoses.

Q. Can Demerol mask symptoms of what you may be looking for?

A. Demerol takes pain away. And it may alter the pain pattern in a patient.

Q. And makes it more difficult to diaqnose?

A. If the diagnosis that you are relying upon includes

the pattern and the change in their pain, it may make it more difficult, because it may alter the natural course of pain in that patient.

Q. All right. And do you feel it was appropriate for Dorothy Lovett to get Demerol on the October 5th admission or emergency room visit?

A. It is appropriate from the point of view of a patient with pain with a probable diagnosis of acute cholecystitis for Demerol to be given for pain relief.

Q. When was the Demerol given?

A. According to this emergency department record, it was administered at 7:40 p.m.

Q. Was that before or after she saw Dr. Conant?

A. I don't know that I have any indication in the record from which I can make a judgment.

MR. DAPORE: For the record, this is all his handwriting.

Q. You don't know?

A. I can't tell. I mean there are no times for me to understand. I don't have a copy.

THE WITNESS: Is that the complete emergency department record?

MR. DAPORE: Yes. Those are his records.

And those are the times taken off by the nurse at which they were given or which they were done.

A. The only thing that would lead me to say that was after is there is atropine given at 7:10 and presumably that's written as a physician order. I think it would be extremely unlikely that that was given prior to examination.

So at 7:30 I would have, 7:40 I would have to assume the patient had been seen by Dr. Conant.

Q. So you are assuming that the Demerol was given after the patient already had been examined by Dr. Conant?

A. Yes.

Q. Would it have been inappropriate to give it before he examined her?

A. Would it be inappropriate to give Demerol prior to the examination of a patient in the emergency department, yes.

Q. I'm sorry, you probably answered this before. But what in the physical findings on the admission or the emergency room visit on October 5th would cause you to rule out peritonitis?

A. The abdomen is flat. Actually the major things are the description which really does not describe what we call an acute surgical abdomen, which is an abdomen which is tense with

rebound tenderness, typically peristalsis would be absent in peritonitis. So this description is not of someone with peritonitis.

Q. Okay. You would look for somebody with a distended abdomen?

A. Not necessarily. Sometimes it will be distended, sometimes not, depending on the etiology of peritonitis.

Q. How long does it take for the abdomen to become distended after the perforation occurs?

A. The abdomen would not necessarily become extended just from a perforation. There are many causes. It is simply an inflammation of the inside of the abdomen.

Q. How was it caused in this case?

A. You mean how was it caused as evidenced at the time of her death?

Q. Yes. Is that something different than --

MR. DAPORE: You are asking him a couple of different questions.

Q. Answer the first one.

MR. DAPORE: Rephrase the question, please.

Q. How was it caused, the peritonitis?

A. Peritonitis at the time of her autopsy was secondary to rupture of an ulcer, and I don't remember the

exact location of it, duodenal ulcer.

Q. And are you differentiating that? I don't understand the reason for your distinction of that.

I understand your distinction for pointing to the autopsy. Is that your opinion as to the cause of peritonitis in this case?

A. I'm not sure I understand the question,

Q. I asked you what the cause of peritonitis was.

A. The only way I can make a judgment as to the cause of peritonitis is through the autopsy record.

Q. Okay.

A. At the time of autopsy, she had peritonitis, which was presumed to be secondary to a rupture of a duodenal ulcer.

Q. And you have no reason to dispute that?

A. I have not seen the autopsy. I have just the records to review. I can't dispute that.

Q. Did she have symptoms of peritonitis from the visit to the emergency **room** on October 4th?

A. Symptoms of peritonitis are very non-specific. Abdominal pain is a symptom of peritonitis. So in that broad sense, *yes.* Abdominal. pain is one of the symptoms of peritonitis.

On the other hand she did not have physical findings

that were consistent with the diaqnosis of peritonitis.

Q. Were they inconsistent with the diaqnosis of peritonitis?

A. I think I have already testified that they were.

MR. COAXLEY: You are talking about October 4th.

MR. MELLINO: The first visit.

A. No. I believe she had no symptoms consistent with peritonitis.

Q. On October 4th?

A. On the October 4th visit to Geneva Hospital.

Q. What's the mortality rate for somebody that is diagnosed as having perforated viscus?

MR. DAPORE: Under what circumstances, for how long?

MR. MELLINO: If he needs those qualifications, he can certainly ask.

A. I can't answer, Perforated viscus is a very general term. Depends upon the viscus that's ruptured, the acuteness of its rupture, the patient's age, underlying medical condition. It is impossible for me to make a mortality figure for you.

Q. Is it something that's usually diagnosed fairly

quickly?

A. You are speaking specifically of what entity, ruptured viscus?

Q. Yes.

A. Again, ruptured viscus is generally, yes, an acute presentation that is relatively easily recognized.

Q. Do you know what the mortality rate is for someone who is operated on for a perforated viscus?

A. No, I don't. Aqain, I think it is, I mean it is impossible to give you a number based on that question. I think there are *so* many other variable factors.

Q. Do you have an opinion as to a reasonable degree of medical probability whether Dorothy Lovett needed surgery when she presented at the emergency room on October 5th?

A. At the time of the visit to the emergency department on October 5th, there is nothing that I can see in the record that would have necessitated immediate surgery, if that's the question.

Q. Do you have an opinion as to what her condition was on October 5th when she presented at the emergency room?

MR. DAPGRE: How do you mean that, retrospectively, prospectively? Which one, prospectively or retrospectively.

MR. MELLINO: He was not there. So it would have to be retrospectively.

A. I'm not sure. Maybe you would have to explain to me what you mean by condition. I have reviewed the records. So I have an opinion of what was written that she looked like. I'm not sure what you mean by condition.

Q. Well, we know that she didn't have cholecystitis which was the diagnosis at that time.

A. We know in retrospect following an autopsy that she didn't have cholecystitis. That's not to say that diagnosis of cholecystitis was inappropriate at the time of her admission

P I didn't say it was. And you testified earlier that in your opinion she didn't have a perforation at that time?

A. Correct.

Q. So I guess I'm asking you what her condition was at that time.

A. By condition you mean the specific disease entity that might have caused her to come to the emerqency department?

P Yes.

A. I think certainly given the history and physical exam findings that are present on the chart, that a diagnosis of acute cholecystitis is appropriate.

Q. You think that's the disease process that brought

her to the emergency room on October 5th?

A. You are asking a very difficult question, because in retrospect with the review of the autopsy records I know it is not the disease entity that caused her to come. So how do you want me to answer it?

Q. I said retrospectively. It should be an easy question to answer.

MR. DAPORE: No, it is not.

A. I think I have already answered.

MR. DAPORE: He answered the question. And I'm going to instruct him not to answer again.

MR. MELLINO: He answered what question?

Q. Of whether cholecystitis was a disease process that brought her to the emergency room on October 5th?

MR. DAPORE: He feels that it was an appropriate diagnosis based upon some records.

MR. MELLINO: I never asked him that question.

MR. DAPORE: You did ask him the question. You have asked him what the autopsy contains as far as a cause of death. And the cause of death is listed in the autopsy as a perforated

duodenal ulcer.

MR. MELLINO: Tony, we can spend the whole afternoon here if you are going to keep interrupting and testifying. He didn't answer the question that I asked him.

MR. DAPORE: He's told you what's in the autopsy. He told you what's in the records. Now he can't tell you anything different between the two.

MR. MELLINO: Be already said that cholecystitis was not the disease or --

MR. DAPORE: He said cholecystitis in retrospect is not what she had when she came into the hospital on October 5th. That's what he's testified to.

MR. MELLINO: Then I asked what disease brought her there. He said cholecystitis. He said it was not an inappropriate diaqnosis based on the records. In answer to my question of what the disease process was that brought her, he didn't answer my question.

MR. DAPORE: Perhaps you should rephrase your question in a form in which it can be

answered then.

MR. MELLINO: Well, I don't understand why he can't answer the question.

MR. DAPORE: Rephrase your question.

BY MR. MELLINO:

Q. What was the disease process that brought Dorothy Lovett to the emergency room on October 5th?

A. In retrospect knowing the results of the autopsy which showed that the patient had an ulcer which at some point prior to her death perforated, it certainly is possible that the pain she was experiencing at the time of the visit of 10/5 was pain secondary to a duodenal ulcer.

Q. And if an electrolyte study had been done or temperature been taken or a blood count been taken or orthostatic pulse change taken, would those have assisted in making a diagnosis of pain secondary to a duodenal ulcer?

MR. COAKLEY: Could we have those listed again or just repeat them? Would you repeat the question for me, please?

(Whereupon, the pending question was read back by the Court Reporter.)

MR. COAKLEY: Thank you.

A. Maybe we can take them one at a time rather than all

at once. It seems silly to answer the question yes or no.

If the question is would any of these have assisted the emergency physician in making a diagnosis of pain secondary to a duodenal ulcer, electrolytes, no, CBC, probably not.

You may have to read back to me.

Q. Temperature.

A. Temperature, no. Patients with duodenal ulcers alone with pain have no reason to have altered temperatures, If one expected the patient to be severely dehydrated, perhaps that may have, orthostatics would allow you to determine that easily. Doesn't differentiate dehydration from volume loss such as not eating or drinking well or from that associated with blood loss.

And there are things in the record which would make us not suspect an acute blood loss such as the fact there was no melanin, no hematemesis is found in the blood.

Q. Are there any indications in the record she was dehydrated?

A. Does say that mucus membranes were dry. But then it is, it also states skin turqor was good. So that really in some ways is kind of a conflicting piece of information. Mucus membranes can often be dry from many things. But if a patient becomes dehydrated, generally the skin turgor becomes

also not so good.

Q. Well, if it is conflicting, would it have been helpful to do more tests?

A. Well, with skin turgor being good, you know, it is less likely that the patient's truly dehydrated.

Q. But you just don't know from this physical finding there?

A. Well, it is, again, mucus membranes dry is a subjective view. And so it is not exactly clear what that means.

At the same time the patient's pulse was not elevated, which one might expect if a patient was severely dehydrated.

Patient might be somewhat hypotensive. So there are, patient had not been vomiting.

So there is really no reason to suspect severe dehydration based upon the rest of the history and other physical exam findings.

Q. Would the electrolyte study and temperature and CEC and orthostatic pulse change been helpful in diagnosing the condition if the ulcer had already ruptured?

MR. DAPORE: You have asked a different question now. You said changes in those,

changes in what?

MR. MELLINO: I didn't say changes.

MR. DAPORE: I believe your question was if those changed, would they be helpful in diagnosing if it was a perforated viscus. I don't know if that's what you meant to ask or not. But if it is, the change from what?

MR. MELLINO: Why don't you read the question back.

(Whereupon, the pending question was read back by the Court Reporter.)

MR. DAPORE: You did ask changes.

MR. MELLINO: Orthostatic pulse change, same thing I asked in the earlier question.

MR. DAPORE: I thought you were grouping them all together.

MR. MELLINO: You are interrupting. You are not listening.

MR. COAKLEY: It was a fair clarification.

MR. MELLINO: Nothing had to be clarified.

MR. DAPORE: You did, the way you asked the question, the way that question came out is you were lumping them all together.

MR. MELLINO: I am still lumping them all together.

MR. DAPORE: As changes in all of them.

MR. COAKLEY: Why don't you ask it again, Chris, please.

MR. MELLINO: Fine. Do you want to go back, I will ask every one of the questions again.

BY MR. MELLINO:

Q. Do you know what the question is, Doctor?

A. No.

MR. MELLIMO: Go ahead and read the question back.

(Whereupon, the pending question was read back by the Court Reporter.)

A. The question is if the patient had come to the emergency department with a perforated ulcer at the time that they had been there, would any of those tests have helped? I think --

Q. Helped make the diagnosis of perforated ulcer?

A. No. Probably the only thing that one might have seen would have been some non-specific elevation in the white blood cell count, again, not necessari y diagnostic of anythin

Q. But would the elevated -- what did you say, white count?

A. Uhm-hmm.

Q. Would that have prompted an emergency room doctor operating in the standard of care to do more tests to determine why the blood count was elevated?

A. Blood count is a very non-specific test. Can be elevated in gastritis, can be elevated in cholecystitis. And I don't think given the clinical picture here which is certainly consistent with cholecystitis it would necessarily have prompted any other study.

Q. Would the temperature have been elevated?

A In the very late stages of peritonitis it certainly is possible that the temperature might either be elevated or, in fact, be low in some patients.

Q. What would have been the purpose of admitting Dorothy Lovett to the hospital?

A. This is a patient who now in the course of three days has had three emergency department or clinic and emergency department visits for abdominal pain. At this point in time the patient is still complaining of apparently significant abdominal pain, has a presumed diagnosis of acute cholecystitis.

And admission would have been for I.V. hydration and f r furth r diagnostic workup to try to determine whether that was, in fact, the etiology of her pain.

Q. Couldn't the I.V. hydration therapy been done while she was in the emergency room?

A. It could have certainly been started while she was in the emergency room. But again, the main purpose of admitting to the hospital would have been for diagnostic evaluation.

Q. Couldn't more of a diagnostic evaluation have taken place in the emergency room?

A. If one is using a working diagnosis of cholecvstitis, the studies that are required are not available in every emergency department, The studies are ultrasound of the gall bladder, perhaps gall bladder series, upper GI series. These are things that are not routinely available in the emergency department.

Q. Do you know if they were available at Geneva Memorial Hospital on October 5th?

A. I don't know specifically. But I think it is fair to say that the average nontertiary care hospital does not have those diagnostic studies immediately available.

In addition, many of those tests are studies which

a patient needs to be prepared to get an optimal study. And so they logistically cannot be done in the emergency department.

Q. But you don't know whether they could have been done here in this case?

A. I don't know specifically.

Q. Wouldn't that be important in terns of rendering an opinion in this case?

A. Well, again, I have stated that I think it is fair given the size and the nature of, I mean this hospital not being a tertiary referral hospital, that most of those would not be available. And again, most of these studies are not available because of the fact patients do need to be properly prepped in order to have the studies done. So sub-optimal studies are obtained if you try to get them without any advance preparation of the patient.

Q. What kind of preparation needs to be done?

A. Often patients are NPO, that's nothinq to eat by mouth overnight. Bowels are cleaned for many radiologic studies in order to get rid of gas and stool that interferes with the study.

If I can back up one second, I have a vague recoliection, and I don't remember which deposition it is in,

of a discussion, maybe it is in Nurse Robinson's, a discussion about the fact that those studies would not be available until probably the Monday morning. I believe, maybe it is in Nurse Robinson's deposition.

But I would have to go back and find the specific passage.

Q. Are you aware of whether she could have been transferred to another hospital to have these diagnostic studies done?

A. I'm not aware of the transferral guidelines or arrangements of this particular hospital.

Q. Would that have been something that could have been done?

A. I think these are, the studies that I have just listed for you, ultrasound, gall bladder series, upper GI, which would have been the logica thing to do, these are things that are done at nearly every hospital. And I mean they are not tests that are, patients are routinely transferred for.

Q. Well, apparently there are some hospitals that don't do them on Sunday or Saturday night, and some that do?

A. Vast majority of hospitals I would say don't.

Q. So if the patient comes in with this kind of

condition on Saturday night, they have to wait until Monday to be diagnosed?

A. In some hospitals that's probably true. Again, not because nobody wants to do it, some of it is because of patient preparation. And some is because these are not diagnostic studies which generally are done acutely, because they are not for conditions which need to be acutely diagnosed in that sense.

Q. You don't think that was a case that needed to be acutely diagnosed?

MR. DAPORE: Objection. That's argumentative. If you want to rephrase the question.

MR. MELLINO: No, I don't.

Q. Do you want to answer it?

A. No.

Q. Was it important for her to have diagnostic studies done to determine what her condition was on October 5th, you would have the diagnosis made that night?

MR. DAFORE: In terms of what, what was known when she came into the emergency room on October 5th?

MR. MELLINO: Well, I think we know in

retrospect what it was.

Q. So w at was known on October 5th?

MR. DAPORE: Based on what's here on this emergency room record?

Q. Based on what her condition was when she came in on October 5th.

A. Given the information I have on the E.R. record of the 5th and findings consistent with the acute cholecystitis, I don't think there is a need to emergently in the middle of the night obtain any of the studies I have just listed as far as further diagnostic workup.

Q. It was not in the middle of the night though when she came in; was it?

A. I will rephrase it. At 9 o'clock at night, 8 o'clock at night.

Q. When she came in it was 7 o'clock; wasn't it?

A. Okay, at 7 o'clock at niqht. One has to build into the scenario that patient evaluation is not instantaneous. So she's there at 7 o'clock, a certain amount of time has to transpire €or evaluation.

Q. Sure. But it certainly was not the middle of the night?

MR. DAPORE: Is that a question?

A. No, it wasn't the middle of the night. I misspoke.

Q. Would an abdominal X-ray have assisted in the diagnosis of pain secondary tu a duodenal ulcer?

MR. COAXLEY: What time, please.

Q. 7 o'clock, October 5th, 1986.

A. In a patient with duodenal ulcer, with pain secondary to duodenal ulcer, an X-ray would not help in the diagnosis.

Q. In this patient we are talkinq though, at least that's what I want tu ask.

A. In this patient at the time of her emergency department evaluation, I don't believe an abdominal X-ray would have aided in the diagnosis.

Q. Of?

A. Of either acute cholecystitis or peptic ulcer disease.

Q. What about if the ulcer perforated previously to her arriving at the emergency room?

A. In a patient who has a perforated viscus, abdominal X-rays will be helpful in that the free air which has escaped from the viscus will be obvious on the examination.

Q. So it would have assisted then the diagnosis?

MR. DAPORE: Objection. That's not what he said. That's not the question you asked

previously.

MR. MELLINO: Well, what was the question that I asked previously?

MR. DAPORE: You asked whether a patient with peptic ulcer disease, and then with this patient based upon what was in this examination.

MR. COAKLEY: Then you changed to a patient with a perforated viscus.

MR. DAPORE: He said his opinion is she did not have a perforated viscus when she came in.

BY MR. MELLINO:

Q. What did you just say, it would assist with a diagnosis of a perforated --

MR. DAPORE: He answered the question. If there is ulcer disease, it would show free air.

MR. MELLINO: I didn't ask it.

MR. DAPORE: You asked it before that.

Q. I said would it show free air if there is a perforated viscus.

A. It may show free air.

Q. So it would assist in the diagnosis of peritonitis?

A No. It would assist, an abdominal film which shows free air is diagnostic of a perforated viscus. Peritonitis is an inflammatory condition secondary to many causes, one of which might be perforated viscus. One can have peritonitis without free air.

Q But Dorothy Lovett had a perforated viscus?

A At the time of her death.

Q Right.

A On autopsy she had a perforated viscus.

Q But if the perforation had occurred prior to her arriving at the emergency room at 7 o'clock on October 5th and an abdominal X-ray was taken, it would have shown free air:

A - If one wishes to make an assumption the actual perforation occurred prior to when she arrived at the emergency department. I have already testified I don't believe that to be true. If one assumes a perforation in any patient occurs prior to their arrival in the emergency department, then an X-ray should show free air.

Q And how would her treatment have been different if you assumed that there was free air and if you assumed that the X-ray had Seen taken?

A. Any patient presenting with free air requires surgical exploration to determine the cause of the free air.

Q. I'm sorry, I may have asked you this before. For what do you base your opinion on that the perforation occurred, you believe it occurred just prior to her death, riqht, during the night?

MR. DAPORE: He answered the question.

Q. That was based upon Lovett's testimony, your remembrance of Lovett's testimony she had acute pain during the night?

A. And also the findings here which I don't believe are consistent with perforation (indicating).

MR. COAKLEY: The record has to show what you are pointing to.

A. I'm sorry, the findings of the emergency department chart of 10/5 that I have reviewed.

Q. Okay. I'm going to ask you to assume she did not have worsening pain that night. Then would you have an opinion based on a reasonable degree of medical probability as to when the perforation occurred?

A. I'm not sure I understand the question.

MR. DAPORE: He wants you to assume that Mr. Lovett has not testified that there was increasing pain during the night.

MR. MELLINO: I want him to assume there

wasn't, there wasn't an increase in pain.

MR. DAPORE: That's what I said, that there was not, that he has not testified --

MR. MELLINO: You said Mr. Lovett testified --

MR. DAPORE: He has testified there was increasing pain. You want to take that and completely eliminate it from his mind.

MR. MELLINO: That's right.

A Then my answer has to be that her perforation would have occurred at some point following her visit which is documented in the 10/5/86 chart, because I don't believe that her findings at this point are consistent with perforated viscus.

Q. If the perforation had occurred just prior to her arriving at the emergency room, what would you expect her presentation to be?

A The patient with perforated viscus is a patient who generally presents with an acute surgical abdomen as I have described earlier. This lady does not have an acute surgical abdomen as described in the examination of 10/5/86.

Q. Even if it occurred just prior to her getting there, she would still have an acute abdomen?

A. Again, you want it 30 seconds before she walked in the door, two minutes, five minutes?

Q. Say within an hour.

A. Yes, signs of acute abdomen develop quickly. That's why it is called an acute abdomen. If you want to ask 30 minutes or 40 minutes or 20 minutes, it is an impossible question to answer, Patient is in the emergency department for in excess of an hour. I would expect if she had perforation, her exam symptom complex would be different.

Q. What was the cause of her cardiac arrest on the 6th?

A. It is I think impossible for me to give you a definite cause of death. Clearly the patient had a duodenal ulcer and peritonitis. Whether the peritonitis contributed to sepsis as a cause of death or whether there was a primary cardiac event secondary to the rupture and peritonitis, those are two reasonable causes.

I would probably more strongly argue that it was a cardiac death as it was a very brief period of time from when she got much worse until apparently the paramedics or ambulance crew I believe found her in asystole which would argue for a primary cardiac death probably secondary to abdominal disease.

Q. You don't believe if she was in the hospital at that time that she could have been resuscitated?

A. I think that's a question that's impossible for me to answer.

Q. Well, you stated in your report it wouldn't have made any difference.

MR. DAPORE: Improbability.

A. I think I stated that her diagnostic workup probably wouldn't have occurred. And to say she would have been resuscitated had she been in the hospital versus outside the hospital is purely speculative. I can't give you any numbers as to what her chance of survival in-hospital versus out would have been.

Q. What's your understanding as to when the tests could have been done, diagnostic tests?

A. Well, I think I testified earlier that in one of the depositions, and I wasn't sure of the exact location of it, that much of her diagnostic workup would probably not have occurred until the following Monday morning.

Q. This was Saturday night?

A. She was admitted Saturday night, I believe.

Q. So I guess the reason I asked you the question about resuscitation is that I assumed that she could be kept

alive until Monday morning and she could have been operated on at that time; is that an incorrect assumption?

A. That if the patient had a cardiac arrest in the hospital, if she was resuscitated, and if she had the diagnosis of ruptured viscus made, then she could have been operated on. I think that's a fair assumption if the surgical personnel were available at that time to do it, which I have no idea.

Q. Do you have an opinion as to whether or not if all these things you just listed occurred, if she probably would have survived?

A. I can't make an opinion regarding that.

(Discussion off the record.)

MR. MELLINO: Just a few more questions.

**BY MR. MELLINO:**

Q. Doctor, were there any diagnostic procedures that could have been done while she was in the emerqency room on October 5th other than the ones you have mentioned, the ultrasound that she needed preparation? Other than that, were there any other diagnostic procedures that could have been done while she was in the emergency room on October 5th?

A. Given her overall presentation, again, and the diagnosis of acute cholecystitis, I think if she were to be

admitted to the hospital, certainly as I said before, perhaps complete blood count would have been useful, electrolytes routinely as an admission procedure, although again, I don't think they would have helped in the specific diagnosis.

Perhaps amylase level, again, with the diagnosis of pancreatitis as I talked about earlier being one of many diagnoses that miqht be entertained.

I think those are the basic laboratory studies that could have been performed on someone with abdominal pain coming to the emergency department.

Q. How about an abdominal X-ray?

A. Well, again, I think the abdominal X-ray is useful if one suspects an obstruction or if one suspects or thinks perforation is likely. And those are the two major areas where the abdominal film, abdominal film out of the emergency department is helpful in seeing dilated loops of bowels consistent with obstruction and seeing free air consistent with perforation.

Q. Could those diagnostic studies have been done in the emergency room without her being admitted?

A. Certainly patients, if you look at her record of 10/4/86, those are many of the studies that were done prior to the time she was discharqed OR the 4th.

Q. And they took an abdominal X-ray on the 4th?

A. It is my understanding they took abdominal film from the 4th. Reported as normal except for a large amount of stool in the colon.

Q. But you don't think the standard of care requires that those tests have been done in this case?

A. I think in the evaluation of a patient with abdominal pain, the approach is history and physical examination, formulation of a differential diaqnosis, and then appropriate use of studies to either rule in or rule out those entities that you strongly consider.

It is not clear to me when those studies were done in this patient.

And whether that is because as I said in my letter she didn't want admission or whether that's because Dr. Conant decided not to do them, I have no way of knowing.

Q. But it could have been done even if she didn't get admitted?

A Certainly as evidenced from 10/4. There are studies that could have been done even if the patient were to be discharged.

Q. Well, I guess I got confused or I didn't understand your answer then. You don't know why they were not done, but

it doesn't matter in terms of your opinion whether they were done or not?

A. My opinion with regards to --

Q. To the standard of care in this case, whether it was met or not?

MR. DAPORE: Do you understand what he's asking you?

THE WITNESS: Yes and no.

A. I mean it makes a difference in terms of her interest in staying, not staying interest and having tests done, not done. So I guess it is fair to say the standard of care in a patient such as this who presents for diagnostic evaluation in the emergency department, allows tests to be performed, and will cooperate with the expected diagnostic results. I think it would be usual for the patient to have probably a CBC done. Although again, as I said, that's somewhat of a non-specific test. Other tests would be guided based upon the history and physical exam.

Again, I don't think there is any indication here, for example, abdominal films needed to be performed based upon her history and physical examination.

Q. Do you believe that would have been one of the diagnostic procedures done had she been admitted?

A. At some point if nothing else in preparation for say a small bowel series or barium enema or gall bladder series she would have had some abdominal X-rays performed, yes.

Q. Wouldn't the tests we have talked about, the CBC, electrolytes, and amylase, and even an abdominal X-ray, wouldn't they be important for the doctor, the results of those tests be important for him to explain the risk of leaving the hospital to the patient?

A. Not necessarily. I mean many of the tests that we have talked about are very non-specific tests again. The white blood cell count or complete count gives *you* some clues, but are not specific. Again, elevation of the white count doesn't necessarily mean she has cholecystitis or this or that.

So I don't think given the tentative diaqnosis of acute cholecystitis that you would need any laboratory data in order to explain the risk of leaving against medical advice to this patient, no.

Q. Do you believe that when Mr. and Mrs. Lovett left the emergency room on the 5th that they understood what the risks of leaving were?

A. The only way I can evaluate that is through the

depositions of others as to what they were told at the time they were in the emergency department.

And from the deposition particularly of Dorothy Robinson, it appears to me she was competent to be told, that multiple attempts were made to convince them this patient should stay, both to the husband and to the patient, and that they were understanding of the nature of the disease and the potential consequences.

Q. Well, what is your understanding of what risks they were told of?

I mean let me be more specific. I can see Mr. Dapore rising up.

MR. DAPORE: I am not going anywhere.

MR. MELLINO: I didn't mean you were going anywhere.

MR. DAPORE: I am not rising up.

Q. There was a conversation that took place, at least was testified to that took place outside the hospital, Mr. Lovett testified to it, and my recollection of Dorothy Robinson's or Nurse Robinson's testimony was that she didn't have any reason to believe that it didn't take place.

And that is that Mr. Lovett asked Dr. Conant if it was serious. And he said it could be if the gall bladder

ruptures and something to the effect that if the medications didn't work, they would have to go in and take the sucker out.

Is that your understandinq as to what risks were explained to the patient or is it more than that?

A Well, Mr. Lovett testifies to that. And in Dorothy Robinson's deposition, I don't think she's able to specifically recall that. But I believe, and we can look for a specific passage, that she stated that she discussed the diagnosis both with the husband and with the patient and informed them of the problems that might he associated with leaving. I don't recall any discussion of again specific risks. I mean I don't, I cannot tell you for sure that the patient was informed of a, b, c, and d as far as exact risks. I don't believe that that documentation exists in any of the material that I have gotten.

Q Okay. So since the only document we have is of this one conversation, I want you to assume for me that that is the only thing that at least Mr. Lovett was told or let's assume that is what both of them were told regarding the diagnosis and the risks.

Is that in your opinion or do you have an opinion if that was, if that was adequate to explain the risks to Lovetts?

FIR. COAKLEY: Objection.

MR. DAPORE: Objection.

MR. COAKLEY: Prior testimony was there were multiple discussions and you are limiting it to one discussion.

MR. MELLINO: That's fine.

BY MR. MELLINO:

Q. I am asking you to assume that was the only discussion that was ever had about the risks of her leaving the hospital.

A. You were asking me if the only thins that was ever said to the family members about the risk of her leaving the hospital-was that statement if the gall bladder bursts, we will have to rip the sucker out. That's not appropriate documentation of either disease and/or risk, if you assume that's the only thing that was said.

Q. And as far as all of the testimony in the records are concerned, that's the only conversation that we have specific, that we know what specific risks were discussed?

MR. COAKLEY: Objection.

Q. Is that right?

MR. DAPORE: Objection. You can answer.

A. I think there are multiple passages in Dorothy

Robinson's deposition, again, where specific risks were not mentioned, but that the topic of explanation of risk to the patient was discussed both with the patient and with the patient's husband.

Q. But there is nothing in Dorothy Robinson's deposition that you remember, anyway I mean it will speak for itself, that you remember where she specifically described the risks to Mrs. Lovett or Mr. Lovett?

A. No. I think as I testified multiple times today she stated that the risks were discussed with both Mrs. Lovett and Mr. Lovett. But as to the exact details of that discussion --

P We don't know what risks she discussed with them?

A. I don't know the specific risks, no.

Q. Would it have been appropriate for I.V. therapy to be carried out in the emergency room prior to her being discharged on October 5th?

A. Given the information in the medical records that I have here, I don't think that it is necessarily appropriate she have I.V. hydration or I.V. fluid therapy if she was leaving against medical advice.

Q. But even assuming she was leavinq against medical advice, she could have had the I.V. therapy and diagnostic

studies done in the emergency room without being admitted; is that right?

A. Well, I have already said any diaqnostic studies similar to the ones the previous day could have been performed

The point of admitting the patient with I.V. hydration is actually to give the bowel a rest and feed intravenously for a period of time. To have done that over a course of a one-hour stay in the emergency department would not probably have been particularly fruitful.

Q. Assume for me, if you would, that the injection of the Demerol made Mrs. Lovett incompetent to execute the AMA form, if that were true, if you assumed that to be true, do you have an opinion as to whether or not the standard of care was met in terms of her signing out against medical advice?

MR. DAPORE: Objection, you can answer the question.

A. I think if you assumed that the only discussion about leaving against medical advice occurred at the point when the patient was not competent to have that discussion, be it from Demerol or any other cause, then the execution of the document would be inappropriate.

In this specific case we don't know what discussion occurred prior to the time that the patient got the Demerol.

Patient is in the emergency department for a period of 40 minutes pr or to that.

It is not clear to me what discussion went on. Perhaps a qreat deal of discussion about her wishing to leave AMA occurred and a final decision was reached prior to the administration of the Dernerol. I have no way of knowing that.

So if you want to make the assumption that no discussion took place the entire time until the patient was in an incompetent state, then you have not fulfilled the principa AMA rules that I started with two hours aqo.

MR. MELLIMO: I don't have any other questions.

MR. COAKLEY: No questions.

MR. DAPORE: You have the right to have this transcript prepared and review it for accuracy. You can't change your comments, only review it. You can also waive that right to signature testing the Court Reporter's ability to take down the information.

I feel you can go ahead and waive it.

THE WITNESS: Fine, I will waive.

* * *

## CERTIFICATE

The foregoing is certified to be a true and correct transcript of the testimony in this proceeding.

Deborah S. Gosline
Notary Public

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