DEPOSITION OF ARTHUR J. McCULLOUGH, JR., **M.D.**

Belinda Hall, Administratrix, etc. vs. Kaiser Permanente, et al.

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CONDENSED TRANSCRIPT AND CONCORDANCE
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THE STATE of OHIO,)
COUNTY of CUYAHOGA.) SS:
- - - - -
IN THE COURT OF COMMON PLEAS
- - - - -
BELINDA HALL, Administratrix)
of the Estate of Delmar Darrell,)
plaintiff,) Case No.
vs.) 363835
KAISER PERMANENTE, et al.,)
defendants.)
- - - - -
Deposition of ARTHUR J. McCULLOUGH, JR., M.D., a witness herein, called by the Defendant Kaiser Permanente as if upon cross-examination, and taken before David J. Collier, RPR, Notary Public within and for the State of Ohio, pursuant to agreement of counsel, and pursuant *to* the further stipulations of counsel herein contained, on Thursday, the 16th day of September, 1999, at 8:10 a.m., at the MetroHealth Medical Center, 2500 MetroHealth Drive, City of Cleveland, County of Cuyahoga and the State of Ohio.

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APPEARANCES,

ON BEHALF OF THE PLAINTIFF:
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ON BEHALF OF THE DEFENDANTS KAISER PERMANENTE, RAFAEL BENDEZU, M.D. and JAMES R. BROWN, M.D.:

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(McCullough Deposition Exhibit 1 marked for identification.)
- - - - -
ARTHUR J. McCULLOUGH, JR., M.D. of lawful age, having been first duly sworn, as hereinafter certified, was examined and testified as follows:
- - - - -
CROSS-EXAMINATION
BY MS. SANDACZ:
Q Will you state your full name for the record?
A Arthur J. McCullough.
Q First name is Arthur?
A Yes.
Q Doctor, my name is Beverly Sandacz, I'm here on behalf of Kaiser and OPMG physicians. My purpose today is to explore some of your opinions. You have been identified as one of the experts for the plaintiffs, and I want to get an understanding of some of your opinions, so my purpose today is just to explore those and get the basis of those opinions.
If at any time you don't

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understand a question that I put to you, please let me know and I will attempt to rephrase it, fair enough?
A Yes.
Q If you answer a question, I'm going to assume that you answered it truthfully and it was responsive to my question, fair enough?
A Yes.
Q I'm sure Mr. Hawal has indicated *to* you – he told me this is your first deposition, so --
A Never done one.
Q It is simply just a question and answer session. I'm sure that he told you that you do have to answer verbally because the court reporter is taking down my question and your response and cannot interpret any head nods or um-hum's or some sort of nonverbal gesture, fair enough?
A Yes.
Q If at any time you need to take a break, that's not a problem. The only other admission I have for you is please allow me to finish my question before you give your

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response, because it makes it difficult for the court reporter to make a clear record of the questions and answers
A Understood
Q And I will try to do the same for you, because I tend to jump in as well, I think that's just normal conversation, okay?
A Fine
Q Can you give me your professional address?
A MetroHealth Medical Center, 2500 MetroHealth Drive
Q Are you employed by MetroHealth?
A Yes, full time
Q Do you have any other employment outside of MetroHealth?
A No
Q What is the capacity of your employment here7
A I'm the division director of gastroenterology, professor of medicine at Case Western
Q As division director of ,gastroenterology, what does that entail?
A It means I have spent about 20 percent

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,of my time doing the administrative work of running an academic clinical GI division.
Q Okay. Tell me about the GI division. What does it encompass?
A We have five full-time physicians, two part-time physicians, and we will be hiring another two part-time physicians very soon. We perform all forms of gastroenterology.
Q And is that in-house or does it include outpatient, ambulatory surgery, et cetera?
A It's both the in-house service and the outpatient clinics here, both at Metro and at some of our satellite facilities.
Q Where are the satellite facilities?
A There is one is Strongsvilie, one in Westlake, one in Brooklyn, and one on West 150th Street.
Q And when you say they're satellites, are they still hospital set --
A They're owned by Metro.
Q And are they governed by the rules and regulations that are governed over Metro?
A I believe so.
Q So when JCHO comes in and accredits the

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hospital, do they govern those as well?
A I think so. I'm not sure of that.
Q Do you ever operate yourself under any of these satellites?
A No, I do not.
Q Do you ever do any patients on the outpatient surgery?
A Outpatient surgery?
Q Outpatient clinic. Sorry.
A Yes, absolutely.
Q What kind of procedures do you do in the outpatient clinic?
A I perform all gastroenterological procedures.
Q Including PEG tube insertion?
A Including PEG tube insertion.
Q Before we get too far into your practice, let me just ask you some other questions.
I have marked as Defendant's Exhibit 1 a curriculum vitae that was given to me. Can you just confirm that that is in fact a current and up-to-date --
A Well, it's not current.
Q Okay.

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A It's March.
Q All right.
A It changes at some -- with some regularity.
Q Is that your CV?
A Yes.
Q What, in addition to what's on there, has been changed or needs to be updated?
A Probably recent publications.
Q Is there any of those publications --
A Relevant to this?
Q Yes.
A I'm sorry. No.
Q That's okay. I tried to look through some of these numerous articles that you have here and I did not see any that is directed to PEG tube insertion. Am I correct in that?
A No, that's not correct.
Q Okay. Tell me which ones you have --
A I just have one. The first author's name was Stassen, it's number 8, and I believe if not the first it was one of the first descriptions of pneumoperitoneum described after PEG placement.

Q Yes. The title is "Another cause of 'benign' pneumoperitoneum" in Gastrointestinal Endoscopy?
A Yes.
Q Who is Dr. Stassen?
A Yes.
Q Here at Metro?
A Yes.
Q Any other articles, presentations, publications, abstracts, anything, case

surgery, and when you do PEGs now it's reaiized that you just get air in there and it's not a surgical problem, and so this prevented people from needlessly going to surgery to look for a problem that wasn't there.
Q That conclusion that you just told me, that now we believe that air is a common finding when this procedure is done, is that something that you concluded in that article or is that something subsequent to that article?
A Well, we concluded it. I can't remember if other people -- if it wasn't the first, it was close to the first.
Q Did this talk about anything about the technique?
A I don't remember.
Q Okay. Is it fair to say it talked about the complication -- a specific complication of pneumoperitoneum?
A Correct.
Q Did it talk about bowel perforation?
A I don't remember. Probably it spoke to the fact that this pneumoperitoneum was not

A I don't know what I'm supposed to do with that.
Q You can answer.
MR. HAWAL: You can answer if you can.
A Yes. I mean, he was recognized as one of the first people who did it and he's a well-known surgical endoscopist.
Q And he has a good reputation here in the community as it relates to his insights as to PEG insertion?
MR. HAWAL: Objection.
A As far as I know.
Q Do you know Dr. Ponsky?
A Urn-hum. Peripherally.
Q Have you --
A I don't know him well.
Q Have you read any of his literature as it relates to PEG tube insertion?
A Just the first one.
Q Okay. Do you know that he has published on PEG tube insertion and/or associated issues on numerous occasions?
A I've heard him talk. I don't know -- I assume he's published other articles. I

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don't know that
Q You've heard him talk at seminars or CME's --
A Yeah
Q -- or something on the issue?
A Yeah Maybe just once I can't remember
Q On PEG tube insertion?
A Right
Q Do you know he's the expert in this case?
A I just heard this morning that he was -- I don't know what -- whose expert he was I heard that he was in the case
Q Have you ever reviewed his report?
A No
Q You are Board certified in internal medicine?
A Yes
Q And gastroenterology?
A Yes
Q And it says also medical examiners What is -- is that --
A That's national boards, like when you go through medical school

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Q Okay Thank you
I didn't know if that was like a --
A Nothing special
Q No, I was thinking that was more of like an autopsy, person who does --
A Oh, no
Q Okay Thank you
It says you're licensed in the State of Ohio Any other states?
A No
Q Has your license ever been revoked, suspended or any conditions placed on it?
A No
Q You have maintained the position of division director of gastroenterology for how long7
A I'm not sure I'm -- '91
Q I didn't mean to -- this isn't a quiz, I'm just trying to get an understanding
You are a full professor at Case Western?
A Yes
Q What do you teach, any specific class, or --

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A My responsibilities to the medical school, every year we teach either the first or second year students on gastroenterology, it's almost always first or second year; and then we rotate on the medicine -- we rotate on the general medicine service once a year for a month, two to four weeks, and we have third year medical students then, and I'm usually the teaching attending in that service; and then I perform subspecialty consultations on rounds in the hospital and we usually have a fourth year student -- or often have a fourth year student on service.
Q So you teach classroom to first and second year students on issues of gastroenterology, correct?
A Urn-hum.
Q And do you include in there the insertion of a PEG tube?
A (Shaking head.)
Q No. Okay.
And when you rotate on the service once a year, one month per year, where the third year medical student *is* with you,

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that's a clinical teaching?
A Yes.
Q And do you perform, in the course of that, PEG tube insertions in which the third year medical student will be there?
A It's possible.
Q Okay.
A They're -- if a patient is on the service and needs a PEG, then -- when I'm on the service I don't do procedures, but it's likely that --
Q I see.
A -- if the students -- that patient is the student's patient, the student will go up and observe.
Q When you're on the service you just manage the patients within the -- in-house patients; is that --
A Correct.
Q Okay. So when you're not on service you are doing procedures on a --whenever they're consulted, either outpatient clinic or inpatient?
A Yes. I do procedures once a week on the residents' cases, so they're people

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without their own attendings, and I do cases on my own patients once or two half days a week.
Q Where do those patients come from?
A My own patients?
Q Yes.
A Referrals. Patient referrals.
Q Okay. And performing subspecialty consultations with the fourth year, what does that entail?
A They rotate -- in addition to having to be on the general medicine service two to four weeks a year, each of the attending gastroenterologists here rotate on what's called the consultative GI service, which means that any patient in the hospital who has a GI problem that the primary care physician needs a consult on, we consult, and in that way the students and residents and fellows rotate with the attending, and I'm on this year three months.
Q And when you're on that service for the three months, do you do procedures?
A Yes.
Q Okay. You mentioned that you spend

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approximately 20 percent of your time in an administrative capacity. Do you spend the remaining 80 percent in the clinical setting?
A No, I spend 30 percent of my time doing research and the remaining 50 percent in clinical.
Q And this area of research is in hepatics or liver?
A Predominantly liver diseases.
Q Anything in the area of PEG tube insertion or parenteral nutrition in that manner?
A Well, I -- I'm considered a nutrition expert, my grants are on nutrition and liver disease and I've done research on acid-related diseases, stomach things.
Q But as it relates to a specific --
A PEG?
Q Yes.
A No.
Q As it relates to PEG tube insertions, do you have in your possession any teaching -- any materials that you give to your residents or med students or anybody

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that would help them in learning the particular techniques that are used?
A It's not an important thing for medical students to learn, the fellows need to learn it, and we have a director of endoscopy here and we have videos on most things that the trainees watch before they actually watch one being done.
Q Who is the director of endoscopy?
A His name is Khaled Issa, I-S-S-A.
Q What's his first name?
A K-H-A-L-E-D, Khaled.
Q What does the director of -- how is your position as director of the division of gastroenterology different from the director of endoscopy?
A Well, it's -- it's a lot to do. We have a director of research, a director of endoscopy, director of the outpatients, and I sort of try to make them fit together.
Q So you oversee all the other particular specialty areas?
A Correct.
Q You mentioned that you have five full-time staff, two part-time, and possibly

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hiring two more part-time
A Um-hum
Q Who in your department does most of the PEG tube insertion?
A I think it's pretty even
Q And who is that?
A I'm sorry?
Q And who would that be? You say "even"
A Who are the other people?
Q I mean, you're including yourself, is that --
A Myself, Issa, Cherryan, C-H-E-R-I-Y-A-N, Mullin, and Gacad, G-A-C-A-D Actually, Mullin is not doing them anymore, so it's probably among the four of us
Q And can you give me an approximation of how many PEG tube insertions that you at MetroHealth do over the course of a year?
A Me personally7
Q No, the whole department
A It's a real guess I'm going to say 75 I could be off significantly
Q And are these done mostly in-house or

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in the outpatient clinic?
A They are mostly done in-house --well, all the -- whether a patient is an outpatient or an inpatient, they all come to the endoscopy unit.
Q Okay.
A But we just started doing same day PEG placements, for which I developed the guidelines, and so we've only done maybe two or three of those, but we just developed that, so a patient would come in and then go back out to their home or to a nursing home.
Q Okay. Let me just talk about -- the endoscopy unit is located within the hospital itself?
A It is located on the 11th floor of the twin towers.
Q So in the hospital?
A Correct.
Q And so patients -- I got the impression when you said you're starting to do same day, patients are admitted or are here in-house --
A No, they come directly to the endoscopy unit, we do the procedure, and then they go

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back *to* wherever they were.
Q That's what I meant. I meant they are either in -- in the hospital itself --
A Endoscopy unit.
Q -- and then they go to the endoscopy unit to get done and then they're returned back to the hospital room where they're at. Do you understand what -- I'm trying to make the distinction.
A Correct. But they wouldn't come from another hospital, they would either come from the nursing home or their own home.
Q But they're actually admitted into the hospital?
A No, they come to the endoscopy unit.
Q I'm not talking about now, the same day, I'm talking about --
A Oh, the other ones?
Q Yeah. So prior to the initiation of the same day PEG placement, the procedures that you and your other colleagues were doing were on patients who were either admitted into the hospital itself --
A Correct.
Q Correct?

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A Yes.
Q When did this same day PEG placement commence?
A Three or four months ago. We were reluctant to start it, actually, because we didn't really think it was terribly safe.
Q And now you believe that it is safe?
A Well, on select patients. I think we've only done two or three.
Q You indicated that you were in charge of starting that up and setting up the --
A No.
Q Okay.
A The nutrition service started it up, but they came and helped me devise the guidelines from a physician's standpoint.
Q Do you have any of these guidelines?
A Um-hum.
Q Can you get me a copy of those, please?
A Sure.
Q And as it relates to these guidelines, what do they talk about? The type of patients that are candidates?
A The type of patients, the consults for nutrition, follow-up, outpatient, home care

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nursing, notification of primary care physician, is the patient appropriate.
Q Do you consider the nutritional -- or the nutritionist's input as it relates to the patient's nutritional status an important factor in your determination of whether a patient is a candidate for this type of a procedure?
A It's a factor. It's more important in the post -- in my opinion, in the post management of the patients, because many patients who get fed by PEG tube get diarrhea and complications.
Q But certainly somebody who is either not taking adequate amount of intake for whatever reason, whether it's swallowing or inability to or just refusal to eat, the insight from a nutritionist as to the status of a patient's nutritional level, albumin, protein levels, okay, that is something that you consider in your evaluation of whether a patient needs a PEG tube, fair enough?
A Yes.
Q These guidelines, do they specifically state a procedure that is followed as far as

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the technique used?
A No.
Q Is that something that you had -- *is* it the same technique that you have used in the other in-house patients?
A Yes.
Q The same day procedure, do you have a pre-op area, the patient then goes to the actual procedure in a procedure room and then goes back to the area where they are recovered and then sent to their --
A Yes, but it's all roughly in the same area.
Q Okay. Do you have specific forms that you use for the purposes of that same day surgery?
A Yes.
Q Okay. Are they different than the ones that are used in-house?
A Not for the procedure itself.
Q Okay. And when you say "the procedure itself," you're talking about the physician's procedure?
A Correct.
Q Okay. I have been provided with a

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number of forms that I believe came from you
A These look like ours
Q Okay Those are forms that have been used in the inpatient MetroHealth --
A Yes
Q -- endoscopy procedure? Okay
A Um-hum
Q The forms that you now utilize in the same day surgery, are those different or similar to that7
A No, this --these are forms that are done in the endoscopy unit around the procedure Itself, the other ones are done to coordinate the different people managing the patient when they go home
Q Okay. I guess I'm not following I'm not understanding
A You're asking me about -- I'm sorry
Q That's okay I'm just not understanding, if you can help me with that Are those forms that are used for patients who undergo PEG tube insertion7
A Yes
Q And those are in-house forms, correct7

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A Yes.
Q Now, as I reviewed those, it appears that they speak more toward pre-op anesthesia, anesthesia checking them, and post-anesthesia evaluation, fair enough?
A Yes.
Q Are those documentations that you as a physician use to document the actual procedure performed, et cetera?
A No, those are computer derived, we type them up.
Q And when you say "computer derived," what does that mean?
A Well, we type in every procedure that we do, we make a note of it, we type in the procedure, what we've done, and print it out.
Q Just so we're talking about the same thing, same procedure that you do in-house versus now in the same day --
A Um-hum.
Q Okay. And when you type it up, is that something that you physically type up?
A Usually the trainee types it up.
Q And that being somebody -- a resident

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or somebody that's assisting in the procedure?
A Right.
Q This is not something that you would actually dictate an operative note?
A No.
Q Okay. And the operative or the procedure note that you would utilize is something that maybe has a heading and then you put in the procedure, then you type it in; is that correct?
A Correct. But there's a large -- there is a large open space that the specifics of each procedure are typed in.
Q Okay. And when you put in there -- do you put in exactly what you did --you know how -- strike that.
This large open space, do you actually type in specifically each step that you have undergone in that procedure?
A We try to.
Q Youtryto?
A (Nodding head.)
Q Is that a requirement?
A Yes.

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Q And who makes that requirement?
A We have -- each person would have specifics written up with -- every attending ;tries to make the fellow describe it as detailed as possible.
Q Is that something that's pre -- I mean, I would assume that you do the procedure pretty much the same way every time, fair enough?
A Urn-hum.
Q And is that something that is preprinted for you underneath "specifics" and then you may alter if there are any ,differences?
A Just the top, and then the procedure itself actually each one is typed in specifically, we don't have a pro forma.
Q Could you also do me a favor and provide me with a copy of the documentation that you use with an example -- and you can take the patient's name off, I'm certainly not interested in that, but show me what you actually type in for the purposes of that procedure? Fair enough?
A All right. So you need two things now,

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right? What's the --
MR. HAWAL: And that you do with me, Doctor, on those things.
Q Yeah. I'm sorry. If you'll give it to him and then he'll provide it *to* me.
The forms that I had shown you earlier that you've identified as inpatient forms, the ones that you used at the hospital, you use different forms for the same day surgery as it relates to the nurse's evaluation post-op?
A Urn-hum.
Q Can you provide me with those, a copy of those as well?
A Yeah.
Q And I think you said it's the responsibility of the resident or the person that you're teaching --
A It's always the attending's responsibility.
Q Okay. But he has the resident -- in reality the resident will do it, you then sign the form after he has completed it?
A Yes.
Q So you as the attending don't actually

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go in and type these?
A Some attendings type. I'm not a great typist.
Q I'm just impressed that you do that, so --okay.
In your practice, are there any texts or publications or journals that in your mind set forth the particular technique for the PEG tube insertion?
A Could you repeat the question again?
Q Sure. Is there any textbook, publication, journals, or any type of guidelines from anywhere that you believe sets forth the technique that should be used for PEG tube insertion?
A There are articles that describe the technique. I can't remember which journals they're from.
Q Is there anything that you rely on or have relied on in forming the same day surgery procedure that you developed about three or four months ago?
A No, it's probably been a compendium of resources. I can't quote a specific --
Q You can't quote a specific journal --

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A -- paper or article that led us to --
Q -- or textbook?
A Correct.
Q So this is something that the technique has evolved over time; is that a fair statement?
A Yes.
Q And the technique has evolved based upon complications or maybe experienced individuals performing it may have found that this way is a little bit better?
A I can't say – I don't think it's because of complications. It's probably just people get more comfortable with doing the procedure.
Q So you don't think techniques have been added to counter any complications that have been experienced?
A I don't know the answer to that.
Q In your practice, have you made any alterations to your technique based upon complications you've experienced?
A The only thing I can remember is we no longer put a button in. A button is something that when you replace a PEG,

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someone's had a PEG in, you remove it, usually when it's been in there longer than six or 12 months, something came out called a button where you didn't have to perform endoscopy, and we were never comfortable with that so we now make it mandatory that we do a repeat endoscopy when we reinsert this.

Q Mr. Hawal has indicated to me this is your first deposition that you have given.

A Yes.

Q Have you ever served as an expert in any other cases before?

A Yes.

Q Tell me what those cases involved, or let me -- let's start with this. How many times have you served as an expert?

A Probably three.

Q Three or--

A Less than five for sure.

Q Over the course *of* how long?

A Since 1980. 19 years.

Q Any of those times when you served as an expert, either three or less than five, did you address the issue of PEG tube

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insertion?

A No.

Q So this *is* the first time in your experience as an expert this issue has come up where you've been asked to --

A Yes.

Q -- render an opinion?

I take it with those three or less than five times you have not -- it's not gone beyond writing a report?

A Correct.

Q Have you ever done any work for Mr. John Martin before?

A On this case.

Q Excuse me. Other than this case.

A No.

Q How about **Mr.** Hawal?

A No.

Q I know he kind of came in afterwards, The cases that you reviewed, were those in Ohio?

A Yes.

Q And do you know the lawyers that asked you to review stuff for them?

A I could probably -- I keep files.

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There was one in Akron, Roetzel maybe.

Q Roetzel & Andress?

A There was someone named Crist who was the lawyer, but -- I can't remember.

Q When you've reviewed those cases, how many times did you do it for plaintiffs?

A None.

Q The three reviews or less than five have been for defendants?

A Um-hum.

Q Local defendants?

A Ohio. I mean, in Akron.

Q Okay. Northeast Ohio?

A Um-hum,

Q Do you have any idea what you're going to charge for this deposition?

A No. I charge 250 an hour. I don't know if depositions get more or less.

Q Okay. You charge 250 an hour to review medical records?

A Um-hum.

Q How long did it take you to review the medical records before you rendered your opinion in your report -- opinions, excuse me, in the report dated July 19th, 1998?

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A Probably two or three hours with Martin and another four or five hours subsequent to Martin.

Q How is *it* that Mr. Martin called you or you were initially contacted?

A I have no idea.

Q Did he give you any type of summary or tell you what the case was about or what happened, or --

A I think -- all I have in my file is what I gave you.

Q Okay. Right there?

A So I suspect he'must have given me some of that I don't remember the specifics of our phone conversation.

Q Was there ever any letters that accompanied any of the materials that you have in your file?

A Not that I remember.

Q So you would just get an envelope with materials in it and there would be nothing else?

A I got a letter from Bill about this meeting and did I want to get involved. I can't remember any -- I don't have any

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letter from Martin that I -- no, that's not true I may have some letters I do have letters

Q If you can just give me some idea of what those letters say Do they say enclosures, please find, or --

A I don't remember I can get them for you

Q Okay

A This was a while ago

Q I understand Why don't you -- can you get them for me7

MR HAWAL Also, just make sure that you are aware, the doctor has to be at ten o'clock with patients, so --

A I can get the letters though if you want

Q Yeah, if you could

MR HAWAL And I'll see them first Doctor

- - - -

(Recess had)

- - - - -

BY MS SANDACZ

Q While Mr Hawal is looking at those

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letters, I want to go through -- this is your entire file that is before you here that you have received and reviewed?

A Um-hum.

Q First of all, you have the deposition of James Brown, Dr. James Brown, correct?

A Um-hum.

Q Deposition of Arnold Vogten?

A (Nodding head.)

Q You have what appears to be progress sheets dated March 27th, 1997 and enclosures of the endoscopy procedure and the nurse's notes, et cetera, correct?

A Urn-hum.

Q You also have what appears to be a front page of the Cleveland Clinic Foundation patient data sheet with maybe some more demographic information regarding the admission of Mr. Darrell up until the point of discharge on 4-21-97, correct?

A Um-hum. Yes. I'm sorry. Yes.

Q That's okay. Discharge summary, dining services form, Cleveland Clinic Hospital, dated March 28th, 1997, operative note of Dr. Harry Reynolds for Mr. Delmar Darrell.

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We have the Cleveland Clinic Foundation Department of General Internal Medicine hospital exploration summary dated 4-21-97. Chart and physician record of Kaiser Permanente, looks like an emergency room presentation dated 3-28-97. Admission assessment, I guess it's nursing admission assessment for Cleveland Clinic Foundation. Preoperative assessment inclusive of general anesthesia, anesthesia record. Post anesthesia care record of Cleveland Clinic dated 3-28-97. Cleveland Clinic Hospital exploratory laparotomy operative report of Harry Reynolds and Roland Phipps, 4-20-97. Cleveland Clinic Hospital, Harry Reynolds, tracheostomy and preoperative assessment. Cleveland Clinic general anesthesia sheet and anesthesia record, 4-18-97. Is that the -- is that all-inclusive of the file that you have reviewed in this matter?

A To the best of my knowledge.

Q Okay. Obviously your report was generated prior to the depositions of both Dr. Brown and Dr. Vogten, correct?

A I believe everything I got except the

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two depositions I received from Martin.

Q Okay. Did you ever receive any of the Judson Park records that – and I don't know if you're familiar with -- Judson Park is the nursing home where Mr. --

A Yeah, I must have, because I --there was that weight loss, because he lost a lot of weight before this procedure.

Q Okay. What is your recollection of how much weight he lost?

A A lot. Over 30 percent of his body weight, I remember that, which is where the rate of death increases.

Q Okay. And when you say "before this procedure," at what point in time? From what point in time did he lose that weight?

A I don't remember.

Q Okay. Was it at the point in time after his obvious intracranial bleed and then he was discharged to the nursing home, from that point until his – to the procedure that you believe he suffered that 30 percent drop in body weight --

A It was while he was in the nursing home, but then I believe there was an

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inaccurate weight in the nursing home, so he really hadn't lost all that much weight, as I remember.

Q So when you say he lost 30 percent of his body weight, that in fact did not happen?

A Right.

Q So when you say that increases his risk of mortality or morbidity, that is not in fact a fact; is that correct?

A Weight loss?

Q No, I'm talking about the 30 percent loss of body weight that you described.

A I don't want to comment too specifically because I don't remember -- I don't remember actually what that is. I do remember looking at the nursing home reports, and I do remember the weights that I saw was a 30 percent weight loss, and then I was told that one of the weights was incorrect and that he had actually not lost 30 percent. I don't remember how much weight he lost, so I'm uncomfortable saying whether that was a risk factor or not.

Q Okay. So for the basis of your

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opinions that you're going to tell me today, you just don't know what the amount of weight loss was that Mr Darrell suffered at the nursing home?

A Correct But I do know that the state of malnutrition influences the outcome of the procedure

Q Sure, and a lot of times patients who need PEG tube insertions, it's because of a nutritional state?

A Absolutely

Q Before we get too far as to the letters, there are several notations on the deposition of Dr Brown, specific page numbers Did you make those?

A Yeah Yes

Q And what reason did you make those notations?

A I usually make those things when I -- when I'm reading through something and it doesn't make sense and I want to read back over it or something didn't gel or I thought something was not right

Q I see several notations or at least brackets around testimony There is one

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section, and I'll show it to you, it's got a little bracket and it says "No" next to it, and it says -- it's right around the area, it says, "He would then start pressing against the anterior abdominal wall while we're both watching the monitor to see if he can indent the stomach with his finger. That tells us whether or not there's something intervening between the wall of the stomach and the abdominal wall." Can you tell me why you put a bracket around there and it says "No"?

A Because it doesn't tell you if there's something between the stomach or not, it just tells you you can see light – I mean, you can see the finger.

Q Okay. So you were objectingto what he was concluding based upon the indentation or --

A I think it's an incomplete statement.

Q Okay. And what would be needed to complete that statement?

A What would be needed would be to -- and Dr. Vogten mentioned this, transillumination, indentation and

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aspiration.

Q Those are three things that Dr. Vogten used or described –

A In his deposition, I noticed.

Q Okay. He described that they use those particular things?

A Correct. Which was not done here, stated here.

Q Okay. Was there anywhere in that deposition of Dr. Brown that you saw him indicate that transillumination was in fact utilized in his –

A I would have to --transillumination -- I don't remember. I'd have to look through this.

Q Okay. So you don't remember whether or not Dr. Brown indicated in his deposition that transillumination was used?

A Correct. But I did not reread this prior to today.

Q If in fact he did use transillumination, that *is* one of the techniques used to identify the location for the PEG tube placement?

A Correct,

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Q When you put the endoscopy scope down, does that necessarily have a light on it?
A It better have, yes.
Q So you use this light that's on the endoscope to, number one, get your way down to the area that you're looking in, and then also it can be utilized to shine against the wall *of* the stomach and transilluminate the light out to the skin area?
A Yes.
Q Okay. Just let me look at these letters real quick.
Any other letters than these ones that appear to be written to and from yourself regarding the payment or fee structure for your review?
A No, I don't think so.
Q Has anything been removed out of your file?
A Not that I know of.
Q Okay.
A And I do notice here that right under here transillumination is stated.
Q So your notation about "No" was for the purpose of --

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A The top portion
Q Okay As it relates to the remainder of your notations I see some similar kinds of brackets Is that just to -- tell me what those are made for
A As I mentioned, they're things that either don't make sense to me or I need more information on
Q Okay Do you know Jack Conomy?
A Yes
Q Did you --
A I know Jack Conomy very peripherally
Q Okay
A I was an intern at the Cleveland Clinic and he was I believe, the chairman of neurology at the time
Q Have you seen any type of report from Dr Conomy?
A No
Q Are you going to be rendering any opinions as it relates to Mr Darrell's potential recovery from his CVA?
A I've not been asked to do that
Q Okay Are you going to render any opinions as it relates to his life

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expectancy had he survived this procedure?
A I've not been asked that.
Q And you indicated to me you have not seen the report of Dr. Ponsky; is that right?
A Correct.
Q Do you know any of the physicians in this case, either Dr. Brown or Dr. Vogten?
A No, I don't know Dr. Brown. That was the first time I had ever seen the name, which surprised me, because he's a gastroenterologist and Cleveland is not that big. Dr. Vogten I know peripherally.
Q And how do you know him peripherally?
A I know him from when he came to Cleveland, he would come to some of the city-wide conferences, and I had heard his name as a former trainee up at the Mayo Clinic.
Q Do you have any understanding as to his reputation here in the community?
A No.
Q Do you know anything about his background as it relates to internal medicine or endoscopy issues?

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A No I mean, just that he came from the Netherlands and he did some training at the Mayo Clinic, and I was surprised when he -- I saw him in Cleveland I had not seen him or heard anything from him in many years
Q I asked you earlier about the number of PEG tubes that are done in a year by your group and you indicated about 75 or gave me an estimate
A That's a --that's a guess
Q And I'm not asking -- I just want to get an understanding
Of those 75, how many do you do per year?
A Probably 15 to 20
Q Are you involved at all in the decision as it relates to allowing – or decision as it relates to the need for the PEG tube?
A Yes
Q Okay And is that something that's shared with the patient's attending physician?
A His primary care physician?
Q Thank you That's what I mean
A There's two layers that happen The

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in-house patients, which until just the last few months would be all the patients, would be seen by the consulting gastroenterologist on the team and a decision regarding the appropriateness of it, the anatomy of -- there are certain questions you need to know, is there reflux, are there scars, is there gastromotility problems, certain decisions that go into that, how recent, what's the cause, is there weight loss, is he expected to recover from his stroke within a reasonable amount of time so we could feed him with, you know, nasogastric tubes and things, that decision is made independent of the endoscopist, okay? That patient then would be referred to the endoscopy center, at which time a second evaluation is performed, albeit more briefly at that time by the attending physician.

Q And the same day surgery that you now utilize, tell me how that procedure is done.

A That is done in an ideal situation as a primary care physician identifies the problem, the patient's problem, they contact one of the gastroenterology attendings,

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discussions are had with the nutrition department that handles almost all of the logistics of post-procedure, and then the patient is brought to the endoscopy unit

Q You talked a little bit about indications You mentioned whether or not the patient has had weight loss, that is obviously an indication for consideration for a PEG tube insertion7

A It's one factor, yes

Q Okay And inability to eat or maintain nutritional status, correct7

A Yes

Q Difficulty swallowing?

A Yes

Q Stroke type event that interferes with the ability of a patient to swallow --

A Yes

Q -- or to take in adequate nutrition7

A Yes

Q Dehydration may be one? Not in and of itself, but along --

A Not in and *of* itself, yes

Q Do you have any reason *to* believe that Mr Darrell was not a candidate or did not have indications for PEG tube insertion?

A I have no reason to believe that he was not a candidate.

Q So in fact in this type -- this would be the type of patient that you would follow through with a primary care's request to have a PEG tube inserted: is that fair?

A From the information I have, yes.

Q Okay. So you're not critical of any decision for the PEG tube insertion?

A No, other than it may have been delayed too long.

Q Okay. We'll talk about that. You would agree that a PEG tube is generally accepted as a safe procedure?

A Yes.

Q Okay. And I think you even now use the same day surgery, you beiieve that route or method of procedure is also an effective and safe --

A For a very specific type patient..

Q What specific type patient?

A Basically someone who has no other medical conditions other than perhaps inability to swallow, for example, someone

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with Lou Gehrig's disease who is functioning at home and just can't swallow.

Q So you're talking nursing home patients in that same day surgery setting?

A I think we've only done *two* or three.

Q So you haven't made any conclusions --

A No.

Q -- as it relates to whether a nursing home patient may be a candidate for your same day surgery?

A No, I don't think that number *of* patients is enough to make any conclusions.

Q You would agree with me that the -- strike that

Contraindications for the procedure, any, just on a general basis?

A Anatomy, gastroesophageal reflux disease, poor life expectancy, ascites, morbid obesity.

Q Any reason to believe that Mr. Darrell suffered from any of those contraindications?

A No.

Q What is a pull-through technique?

A A pull-through technique is the one

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that was developed by Gauderer and Ponsky where -- do you want me to describe it in detail?

Q Absolutely.

A Okay. The patient -- once the decision to do the procedure is made, the patient is brought to the endoscopy unit, the abdominal wall is sterilized, the patient is given sedation. The back of the mouth is sprayed with topical Novocaine. An endoscope is then advanced under direct vision into the stomach. The standard endoscopic procedure is performed, that is, to evaluate all the areas, the postbulbar and bulbar duodenum, the anterior, the proximal and distal stomach with retrograde views and the esophagus.

After that is performed and there is no reason not to perform the PEG, such as an ulcer or a pyloric narrowing or free reflux of material in which a PEJ would be performed instead of a PEG, the stomach is blown up, insufflated, and the endoscopy operator then starts to move the tip towards the anterior abdominal wall.

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At that time the other person -- it's a two person procedure. After he has anest -- cleaned the area, he puts a drape on and you look for a light, and once you see the light -- and it's very important, you have to make sure there's no scar area around it, you palpate with the finger against the abdominal wall. The endoscopist -- and now with the video cameras both the endoscopist and the other)operator look for where you have an optimal point of indentation. Once that is obtained you then start to anesthetize with Xylocaine and you do -- you start to inject and you inject and aspirate all the time.

Q Injecting what?

A Initially Xylocaine.

Q Okay.

A And then once you're comfortable, the idea with the aspiration is to make sure that you don't get anything back, air, you know, black material, intestinal material, discolored material before – or air before the needle is into the – in the stomach.

Once that's done a small three or

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five millimeter nick is made in the skin where you want to go. You then introduce the trocar with the intracath over it, and once again, usually with a little saline, you advance and aspirate, advance and aspirate, once again to make sure that the only time you get air is when the needle is in the stomach.

Once you're comfortable with that you then advance a thread.

Q Guide wire?

A Guide wire.

Q What do you guys use? I'm sorry.

A Athread.

Q An actual piece of --

A Yeah, it's surgical suture.

Q Okay.

A Through the trocar. The endoscopist grabs it with a biopsy forceps through it, takes it out. Then the PEG tube is tied to this and then the person on the outside pulls it back through the abdominal wall so that the bumper is inside the stomach. Then we put an outer sheath to maintain it in place. The endoscopist then goes back in to

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make sure that it's in place, that it's not too tight, we inject some fluid to make sure there's free flow and no resistance, and if all those things happen we put, you know, Betadine and things locally, we tie it up, we give the patient antibiotics, and we make them NPO for **24** hours, and that's the procedure.

Q So when I said to you a pull-through, you were able to give me all of those techniques?

A Um-hum.

Q So you knew what I was talking about when I said a pull-through?

A Yes.

Q Okay. In your review of both Dr. Vogten and Dr. Brown's deposition testimony, did they describe the procedure in a manner in which you did right there?

A Brown did not.

Q Okay.

A Brown did not discuss aspiration, Vogten did.

Q Who was in charge of doing the aspiration?

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A The non-endoscopist.
Q So if Dr. Brown is up at the head of the bed, that's not his role --
A Correct.
Q --to do the aspiration?
So when Dr. Vogten says, I was aspirating, that would be his role?
A Yes.
Q So your review of Dr. Vogten's testimony is that he followed the technique that you've just described?
A Regarding those three things about the transillumination thing and --
Q Aspiration?
A And then palpation.
Q How about insufflation?
A Insufflation, yes.
Q Do you elevate the head to displace the colon?
A We elevate the head of the bed for two reasons, to displace the colon and to minimize aspiration.
Q So if Dr. Brown and Dr. Vogten used those five things that we've just talked about, elevate the head of the bed,

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insufflation, transillumination, palpation and aspiration, you would agree with me that they met the standard of care in performing this procedure7
A Probably
Q As the endoscopist doing the procedure, do you have any contact with the family about obtaining consent7
A Yes
Q And tell me how that comes about
A If the patient can't give consent, which is often the case, you get the nearest relative or someone who has power and you go over the necessity for the procedure, you go over the stated risks and hopefully the expected outcomes
Q Necessity of procedure we've talked about, the indications, is that fair?
A Um-hum
Q Okay As it relates to risks, what do you tell them7
A We tell them that people can hemorrhage, you can have leaks, you can have perforation, and you can have infection
Q When you have given that discussion or

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had that discussion with the family where you have said hemorrhage, leaks, perforation, infection, have you ever had anyone say, I don't want the procedure?
A Yes, probably.
Q You have? On how many occasions?
A Not many.
Q Okay. And did they give you a reason why they didn't want the procedure?
A Usually it's because they think the quality of life is so bad that they don't want to prolong life.
Q So this is a patient who obviously has multiple other medical problems that this is just not going to correct those problems?
A Urn-hum.
Q Yes?
A Yes.
Q Okay. So the majority of your contact with and discussions with families, other than the times when the patient has very poor quality of life, you have never had anyone refuse the procedure?
A Not to my --the best of my knowledge.
Q Do you ever tell them that death could

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be a complication as well?
A Yes.
Q And even with that, they still agree to the procedure?
A Yes.
Q Would you agree with me -- strike that. I'm getting ahead of myself.
Sorry.
What is the percentage of complications for perforation, do you know?
A When I reviewed it, it's estimated somewhere around one percent.
Q And I didn't ask you this, and I apologize: What did you do in preparation for your depo today other than talk to Mr. Hawal?
A Well, actually, I didn't talk to Mr. Hawal very much about this deposition.
Q I apologize. I just assumed.
A I did not review Brown's. I reviewed Vogten's because I just received that not that long ago.
Q Okay.
A I re-reviewed my articles.
Q What articles?

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A I -- I have a file of articles on PEG.
Q Are any of those articles written by Dr. Ponsky?
A The original one.
Q That's the one in 1980 or 19 –
A '80, '81. The first author was Gauderer.
Q Right. What else did you do?
A That was pretty much it.
Q Did you do any MEDLINE search or look in any textbooks?
A Yeah, I looked in some textbooks. I have a pretty big file though on PEGs.
Q Did you rely on anything to render your opinions that you have articulated in your July, 1998 report?
A I probably talked to some gastroenterologists for their opinion, if they had ever seen this particular complication.
Q And those are gastroenterologists that you deal with here at Metro?
A Yeah.
Q Have you ever in your practice had a complication of a perforation?

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A No.
Q Have any of your colleagues had one?
A Yes.
Q Have you ever heard of it happening?
A Yes.
Q Would you agree with me that that complication can occur even with the best technique?
A What complication?
Q Perforation.
A Of what?
Q Perforation of the colon.
A No.
Q Why not?
A When people talk about perforations, the one percent is talking --they're almost always from the stomach, they're gastric perforations almost always, and then when I reviewed the literature about gastrocolic fistulas, that happens rarely, two or three per thousand, but gastrocolic fistula is not what this gentleman had.
Q What did he have?
A This person had a transsection of the colon with peritonitis from that.

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Q Transsection of the colon --
A Transverse colon.
Q Transverse colon.
A According to the Cleveland Clinic's note.
Q And you are of the opinion that that could not occur even with the best technique?
A It's probable that it would not occur.
Q And that's based upon the percentage of --
A The literature.
Q Okay. And why is it that that transverse colon is not in a position to cause -- to be perforated with this type of procedure?
A Because with the techniques -- if you avoid scars -- and I don't know if this gentleman had an abdominal scar, from review of the records I was not able to ascertain that.
Q Would that be something that would be important for you to know?
A It would be something important for the endoscopist to know.

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Q Well, if you're rendering opinions --
A Yes, it would be
Q Okay.
A But then it's not stated in the endoscopy report about a scar, and I don't know -- there's no report that they avoided a scar or didn't avoid a scar I don't know
Q Let me ask you this You're talking about an actual surgical scar7
A Previous surgical scar
Q Can a patient have scar tissue or adhesions for whatever reason either from alcohol abuse –
A Rarely.
Q Okay Any other -- pancreatitis, anything that they can develop --
A Endometriosis, and very rare, very rare diseases of fibrosis
Q If the transverse colon is transected, as in this case, how does that occur7
A The transverse colon was between the abdominal wall and the stomach where the tube was placed
Q Is there any explanation of why if

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you've done the insufflation, transillumination, palpation and the aspiration, that this can still occur?
A Not that I know of.
Q What about the colon being so empty that it collapses on itself and gives you the impression that it is - there is nothing in between the stomach and the abdominal wall?
A That would be very rare. The colon almost always has air, and when the patient's in the supine position the transverse colon is where the air goes to, the air floats, it's the highest portion, so if there's going to be air anywhere in the colon, and there is always air in the colon, it's going to be in the transverse colon,
Q Is there any explanation of why the transverse colon may not drop when you do the head of the bed elevated, the insufflation, all of those techniques?
A Any reason why it would not drop?
Q Yeah, why it wouldn't displace.
A No, other than scar tissue.
Q Okay. Am I correct in stating that

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your opinion is based upon the fact that this -- your opinion that the technique completed by Dr. Vogten and Dr. Brown in performing this PEG tube insertion on Mr. Darrell was below the standard of care is based upon the mere fact that the perforation of the transverse colon occurred?
A No, that's not correct.
Q Okay. What is --
A That's one factor.
Q Okay. What else?
A The other factor is that there's the note, there's no documentation on the note, it's just stated "pull-through.":
Q Well, Doctor, you just gave me a whole technique of what the pull-through meant, and if in fact they followed that, your conclusion is based merely upon the fact that the perforation occurred?
A No, because not everyone has the same opinion of a pull-through. I mean, if you look -- I look to see the different techniques. Pull-through techniques are not described the same way in the literature.

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Gauderer and Ponsky's original technique did not even talk about transillumination, finger palpation and aspiration, even the Mayo Clinic description doesn't, so I don't know what a standard pull-through is. I told you what my opinion is -
Q Sure.
A -- and I didn't know from their report, their endoscopy report, what that was.
Q Well, certainly a pull-through means -- the pull-through means basically instead *of* inserting it from outside the stomach you're pulling it through from the inside out.
A Um-hum.
Q And I think what you said is that Dr. Ponsky and this other author did not include transillumination initially but have subsequently added that, that's something that's in the literature?
A Not -- it's not described all the same in different parts of the literature.
Q Okay. But you indicated to me that if those -- strike that.
You talked about five things, head of the bed elevated, insufflation,

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transillumination, palpation and aspiration.
A Um-hum.
Q If any one of those were not completed, in your opinion does that mean that they breached the standard of care in the performance of a pull-through technique?
A It's probable that they did or this complication would not have happened. This is an extremely rare -- in my opinion, an extremely rare --
Q But you have heard it happening, correct?
A I'm not sure.
Q Not personally, but through the literature?
A No, I'm not sure.
Q Okay.
A Because these review articles, when I -- I reviewed them, they talk about peritonitis and then they say almost all are from the stomach, okay? Well, "almost all," I'm not sure where the others are, okay? And the gastrocolic fistula happens, but that's not - gastrocolic fistula is when a

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tract develops from the stomach *to* the colon, there's no peritonitis, and the problem the patient has there is when you put the food in the stomach or the enteral feeding, it goes right out his rear end.
Q So your review of the literature is you're not convinced by your review of the literature that transverse colon perforation was included as part of the perforation that they speak about?
A Correct.
Q Anything else on which you base your opinion that Dr. Vogten and Dr. Brown breached the standard of care in performance of this procedure other than lack of documentation as to what they did and perforation of the bowel?
A Yes.
Q Okay:
A And there seemed to be poor documentation of post-procedure, which seemed to be more nursing than physician.
Q That didn't cause any injury to Mr. Brown -- or Mr. Darrell, correct?
A I don't know that. I mean, it's --

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perhaps he may have been able to -- may have been able to diagnose the peritonitis earlier. I don't know.
Q When in your mind can a peritonitis be --when would you anticipate the signs and symptoms of a peritonitis to demonstrate themselves when a patient has a perforation of his bowel?
A When I read the post-procedure note, this guy's blood pressure dropped a lot, okay? Now, blood pressure drops, but this was a lot. I don't remember the specifics, but it would make me very concerned.
Q Do you have any recollection or understanding of what the explanation is for the blood pressure dropping?
A I -- Narcan was given, so I presume the thought was because of the sedation that he received.
Q And, Doctor, that can happen in a patient who is nutritionally depleted or has less reserves, they --
A Yes.
Q -- can be more sensitive to sedative medications, correct?

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A Yes.
Q And so in your practice you have experienced patients decreasing their blood pressure as a result of anesthetic or sedating medications, correct?
A Yes, but not to this extent.
Q Okay. Do you have an understanding as to any other explanation of why the blood pressure was noted to be low?
A No.
Q Okay. Other than that reporting of that one blood pressure, do you have any opinions whether or not he showed any other signs or symptoms that this gentleman -- (~~) that his bowel was perforated?
A Well, he was agitated, which is often a sign of infection or hypoxia, but it's not clearly stated what his mental status was before, so I'm not sure if that was different or not.
Q Well, let me represent to you that Mr. Darrell pulled out his NG tube a number of times. That would be consistent with somebody who was somewhat agitated, fair enough?

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A Yes.
Q All right. Other than the blood pressure, did you see an elevation in his pulse rate?
A I don't remember that.
Q Okay. You can look if you'd like.
A I'm sorry. Here it is.
No, his heart rate was 86.
Q Would you expect if there is an actual decrease in blood pressure that you would see an inverse increase in someone's pulse rate?
A In someone who is healthy, not in someone who is sick. Not in someone who is -- people with -- old people can have florid peritonitis and have -- really not look very bad.
Q Okay. What was his blood pressure upon discharge?
Let me help you if I can. Do you see it on the top there? It's right there.
A Oh. Discharge. 129 over 89. 159.
Q And in your opinion that would be --
A That's acceptable blood pressure.
Q And so if those vital signs are

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accurate, 129 over 39, pulse 88, respirations 18, you would agree with me that that patient is stable regarding his vital signs?
A Regarding his vital signs, yes.
Q There was also noted decrease in his oxygen saturation; that can occur as well *as* a result of his sedation?
A Correct.
Q Any indication that his oxygen saturation decreased as a result of anything other than the sedation medications?
A No.
Q Do you have any opinion as to whether or not it was a breach of the standard of care to release him back to the nursing home with those vital signs as we've stated?
A I'm uncomfortable answering that.
Q Okay.
A I don't know. This is exactly why we don't do many patients same day. I don't -- I don't -- I can't sit and look at what their decision process is at that time. It's highly likely that we would have admitted this patient to the hospital simply

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because of -- for observation simply because of his deteriorated state and that degree of hypotension. That's – that's an unusual degree of hypotension.
Q You mean the hypotension that's recorded this one time here?
A Correct. Well, it drops further. It's not just the one time. There's blood pressure Of 53 over 26 and then 26 over 8, this is an unobtainable number. Also, I mean, you can't – that blood pressure of 26 over 8, I mean, I don't know how they got that. I mean, I don't know how they measured that.
Q Okay. So probably these – these values are probably incorrect, correct?
MR. HAWAL: Objection.
A All I know is that I don't know how they got that degree of --
Q Okay. If you were a physician and you saw those and you walked over to the patient, what would you look for?
A I would look for his mental status, I would examine his abdomen, but sometimes those things don't -- they can't come up

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because they're older people.
Q Assuming this to be the case where his blood pressure was 26 over 8, would in this case you see the change in his pulse rate?
A Not necessarily.
Q Okay. Now, when a nurse comes to you and says --
A I want to say –
Q Sure.
A I want to step back. I am uncomfortable at this point because I don't want to project -- I wasn't there, okay? All I'm saying is that you asked me if it would be standard of care, and I'm uncomfortable saying that it is standard of care. That's all I'm saying.
Q When you say you're uncomfortable, you're uncomfortable --
A That would be not -- I'm sorry.
Q You would be uncomfortable rendering an opinion either way, whether it breached or met the standard of care?
A I would be comfortable saying that would not be my standard of care.
Q Okay. Just so I understand what

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opinion you're putting here, you're saying that this is the type of patient that should have been admitted to the hospital based upon his blood pressures?
A I don't -- I don't know how to answer that question.
Q I guess I'm --
A I don't want to criticize them too much or not because I don't know. 1 don't want to --you asked me if this was standard of care to discharge him based on his vital signs, and all I'm saying is I'm uncomfortable saying yes or no to that question.
Q That's fine. As long as you're not going to render an opinion, that's all I need to know. You don't have enough information and you weren't there to render an opinion --
A Correct.
Q Okay. That's fine.
MR. HAWAL: However, he did say that he would have evaluated -- a physician should have seen him based on that kind of information.

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A Yes, I agree with that
Q If a -- let me give you a hypothetical situation
A patient comes -- or a nurse comes up to you and says patient X has a blood pressure of 53 over *28* and *26* over *8,* your practice would be to go over and evaluate that patient, correct?
A Yes
Q And if in your evaluation this person appears to be normal mentation for him, normal status in other manners, you would suspect or think that these blood pressure readings were inaccurate, is that a fair statement?
A I would be concerned that his blood pressure -- I would be -- I would be concerned that the latter blood pressure measurements were actually made up
Q Or maybe not -- maybe there's something wrong with the machinery --
A Correct
Q -- or something?
A That's possible
Q And that has happened?

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A Yes, absolutely.
Q And if that happens, that would indicate that maybe perhaps these blood pressure readings are not the true and accurate blood pressures for Mr. Darrell?
MR. HAWAL: Objection.
A Yes, assuming that you're not -- assuming you're using machinery that works.
Q Let's talk a little bit about the documentation, because that seemed to be part of your opinion as it relates to standard of care.
You indicate that the documentation of this operative procedure or the PEG tube insertion procedure performed by Dr. Vogten and Dr. Brown is insufficient to give you an understanding of what in fact transpired.
A Correct.
Q But I've asked you to assume that they did what they said they did in their deposition; you would agree with me that they met the standard of care as it relates to the pull-through technique?
A Probably. Dr. Vogten's.

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Q Well, we talked about that. Dr. Brown doesn't do the aspiration.
A Correct. I agreed with Dr. Vogten's --
Q And if in fact the procedure was done in the manner in which Dr. Vogten said it was done, you would agree he met the standard of care?
MR. HAWAL: Objection, because you're -- I want to object to the foundation of your hypothetical because both doctors testified that they didn't remember this procedure, so --
Q Okay. If they did the procedure in the normal course that they described in their depositions, you would agree with me that they met the acceptable standards of care?
A Yes.
Q What is it about the documentation that you are critical of?
A They don't describe it, and everyone's pull-through is not the same.
Q And what is it that you need to --
A There *is* no description of the abdominal wall.
Q As it relates to the endoscopy

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findings?
A As it relates to whether the scar is done, the way they chose the spot.
Q There has been some reference that JCHO has requirements as it relates to operative notes procedures
A Um-hum
Q Are you aware of what those requirements are?
A When they came by -- not the specifics, but when they came by the last time they -- we had to have all -- the last time being probably a year ago, all the operative procedures, whether they were done in endoscopy or in the OR, had to have the same material and they had to have basically -- I think I gave you the one --
Q Oh, those forms?
A Right They had to have a lot of these things Each specific detail, I don't remember --
Q Okay
A -- which --
Q And we already talked about -- the forms that you're referencing are anesthesia

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records, correct?
A No.
Q Preanesthesia evaluation --
A And post, and nursing.
Q Right.
A And physician. Physician evaluation, anesthesia, which is conscious sedation.
Q Where in here is anything about what you, Doctor, do?
A The -- all this is done, first two pages.
Q That's not anesthesia doing that?
A No. This is not – the reason is because this is conscious sedation.
Q Okay.
A So --
Q There's no anesthesiologist.
A Right.
Q You are them. Got you.
Do you know whether JCHO governs freestanding endoscopy --
A I don't know that.
Q Do you have any understanding of whether there is another governing body that operates over freestanding --

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A I don't know
Q You're not in a position to render any opinions as to what JCHO requires as it relates to operative procedures in the procedure that was performed by Dr Brown and Dr Vogten?
A Correct
Q So your criticism as to documentation is based upon what you at MetroHealth use --
A What we're required -- yes
Q -- and what you're required –
A Yes
Q --based upon your understanding of what JCHO requires?
A Yes
Q Other than the fact that they don't describe the technique, is there anything else that should be included in this report that is not?
A As I remember, I thought there might have been a little bit more description of the patient before the surgery, but my major concern was the lack of documentation of the procedure itself
Q Okay

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A I think as well that there wasn't enough about the patient evaluation before.
Q Okay. Do you have any understanding of any conversations that Dr. Vogten had with any of the primary care physicians for Mr. Darrell?
A No.
Q So you don't know whether or not they did anything preoperatively to assess his need for -- indication for the PEG tube placement, his ability to undergo that and evaluating any additional data?
A Correct. I don't know.
Q Anything else about this reporting or documentation that you are critical of?
A No.
Q So you are assuming based upon the absence of documentation and the existence of the perforation that the procedure was done incorrectly; is that fair?
A Yes.
Q I want to turn to your July 9th, 1998 report. Is that the only report that you have rendered in this case?
A That one?

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Q Yes.
A Yes. Is that to Mr. Martin?
Q That is correct.
A Yes.
Q Any drafts of this report?
A No, I don't think so.
Q And what I mean by that, *is* there something that you may have given to Mr. Martin or anyone else, what do you think about this?
A Oh, no.
Q Take this out -- okay.
Anything taken out at the request of anybody?
A No.
Q Do you keep any notes or anything that helps you prepare this report?
A If I did, I threw them out. You know, I write it in draft first.
Q There are three opinions set forth in this particular report. Are these all the opinions that you are going to espouse in the event that a trial goes forward in this case?
A Yes.

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MR. HAWAL: Well, he's already corrected you, Bev, that he's not giving the third one about the weight loss.
Q Well, that's -- I'll explore that, because I think we did talk a little bit about that but I think you seemed to indicate that there was a delay in getting the procedure done and I don't know if it's related to that -- yeah, there is reference to the delay in that third one.
A Um-hum.
Q So let's talk about the first one. Again, you talk about extremely poor documentation of the patient's status and ability to undergo the PEG placement prior to the procedure. Now, I think we just talked about you don't know what transpired prior to the procedure actually being done.
A Correct.
Q If I'm correct, you don't have any understanding as to the consent or the discussions had with the daughter or Mr. Darrell as it relates to the need for the procedure?

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A Correct.
Q All right. You're not going to offer any opinions as to whether or not Mr. Darreii or his family members obtained informed consent as it --
A No.
Q -- relates to the procedure?
There is also an inadequate description of the actual procedure itself regarding, most importantly, the basis of the site selection and confirmation of placement of the PEG tube in the appropriate place. There is also poor documentation and description of the post-procedure monitoring and predischarge evaluation of the patient by the nursing and physician staff. Let's take the first part first.
Site selection and Confirmation of placement all relate to the -- what you believe should be a little bit more descriptive or -- descriptive technique?
A Correct.
Q As it relates to the post-procedure monitoring and predischarge evaluation, I think you indicated you don't have an

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opinion whether this patient should have been discharged back to the nursing home; is that fair?
A Yes.
Q We talked at length about the blood pressure monitoring, and I think you indicated you don't know anything else other than those two values?
A Correct.
Q Okay. You made a statement, I have included copies of standard pre and post patient evaluation sheets for your review and comparison to those provided in Mr. Darrell's case. Those are the forms that we looked at?
A Yes.
Q Anything else as it relates to this opinion you've espoused?
A No.
Q We've exhausted it. Okay. I'll keep it on time.
A That'sokay.
Q Second opinion, the complication which occurred is extremely rare. My review of the literature and nonspecific survey of

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physicians in this field indicate that it would have been a preventable complication. Survey of physicians, these are the colleagues you talked about?
A Yes.
Q Talked to.
And who were they specifically?
A Issa, Cheriyan, I think that was it.
Q Did you have an opinion prior to talking to those individuals or is that something that you formed with them?
A Oh, no, I had an opinion. Oh, no, I had an opinion.
Q In light of this and the very poor documentation before, during and after, lends credence to the probability of errors; and I think we talked about those two factors being in your opinion.
A Yes.
Q Forming the basis.
Now, let's talk about the third opinion. We talked about that you've indicated 30 percent -- 37 percent of his body weight was lost during a one monfh stay.

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A Is that what I wrote, 37?
Q I think you've already indicated that there was a -- it was an incorrect weight preadmission.
A Someone told me that the weight was incorrect and so that it was not that much of a weight loss.
Q So you are no longer of that opinion, that he suffered this extensive 30 percent loss of his body weight?
A Yes.
Q All right. Now, you do talk about the delay in getting a consultation. Tell me what -- are you critical of the time frame?
A It must have been -- and I don't remember -- because I don't actually know where my -- I must have -- must have had them, but I don't remember where they are and I don't remember how long ago. I don't remember the time frame, I don't remember the specifics of it, so I don't know.
Q Okay.
A I'd have to look that over again.
Q Okay. So as we sit here today, you don't have an understanding of what delay

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took place?
A I don't remember the basis upon which I wrote that
Q Okay And as I look at your file materials, it doesn't appear that you have any of the nursing home notes, certainly in the file that you've presented to me
A Correct
Q Do you think that you have some of the Judson?
A I don't know where they are I mean, I know I read them
Q Okay Are you going to be rendering an opinion that there was a delay here that caused --
MR HAWAL No
Q Okay.
MR. HAWAL I mean, the --
A Especially because I think one of the factors that made me concerned is the weight loss, and so if that's not --
Q That's fair enough
MR HAWAL Not an issue
Q So this whole third opinion you have in your report is a non-issue?

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A Correct.
Q And it was based upon misinformation that you reviewed in the records?
A Correct.
Q Doctor, you would agree with me that there was an indication for a PEG tube insertion in Mr. Darrell?
A Yes.
MR. HAWAL: Objection. Asked and answered.
Q Doctor, you would agree with me that there was no contraindications that you're aware of for the insertion of a PEG tube in Mr. Darrell?
MR. HAWAL: Asked and answered.
Q You can answer.
A Yes.
Q Okay. Would you agree with me, Doctor, that even if those steps are taken during the procedure, insufflation, transillumination, palpation, aspiration, head of the bed elevated, that it is not 100 percent unavoidable for a bowel perforation?

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MR. HAWAL: Objection, Asked and answered.
A What? Could you repeat the question'?
THE WITNESS: And do I have to answer that? Should I answer this?
MR. HAWAL: You can answer it. I'm objecting because it's already been something gone over in the deposition, you've answered it before.
Q Mr. Hawal doesn't like when I ask questions twice.
MR. HAWAL: I don't like repetitive questions.
A If you can just repeat the question
Q That's all right.
Doctor, would you agree with me that even if the safety maneuvers that we talked about, the five, were performed, that the bowel perforation is not 100 percent unavoidable?
A No, I don't agree that nothing's -- I don't believe that everything is possible, I don't believe that, if you do standard of care.
Q Okay.

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A I mean, I hear that all the time. I don't believe it.
Q Do you ever read the Gastrointestinal Endoscopy Clinics of North America?
A Occasionally, yeah.
Q Is that the same journal that you printed your article in in 1994? 1984, excuse me.
A What was the journal again?
Q Gastrointestinal Endoscopy Clinics of North America.
A You know, I don't remember. There's a couple endoscopy journals. I'm not sure.
Q Is that a book maybe?
A It's a --there's Gastroenterology Clinics of North America, which is a book that comes out every other month, and then there's journals, endoscopy journals, and I published mine in a journal. The difference is that the journal articles are peer reviewed, those articles are reviews that are opinions of the author.
MS. SANDACZ: Okay. I'm done. Thank you very much.
(Deposition concluded at 9:39 a.m.)

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CERTIFICATE

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

I, David J. Collier, Registered Professional Reporter, Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, ARTHUR J. McCULLOUGH, JR., M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 23rd day of September, 1999.

_____
David J. Collier, RPR,
Notary Public/State of Ohio.
Commission expiration: April 26, 2001

Concordance Report

Unique Words: **1,473**
Total Occurrences: **4,505**
Noise Words: **384**
Total Words In File: **13,745**

Single File Concordance
Case Sensitive
Noise Word List(s): **NOISE.NOI**
Cover Pages = **0**
Includes **ALL** Text Occurrences
Dates **ON**
Includes Pure Numbers
Possesive Forms **ON**

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