IN THE COURT OF COMMON PLEAS

LORAIN COUNTY, OHIO

Doc. 324

DEANNA MANKO,
etc., et al.,

Plaintiffs,

-vs-

JUDGE McGOUGH
CASE NO. 92CV108560

ELYRIA MEMORIAL HOSPITAL
and MEDICAL CENTER, et al.,

Defendants.

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Deposition of HADLEY MORGANSTERN-CLARREN, M.D., taken as if upon cross-examination before Judith A. Gage, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Hadley Morganstern-Clarren, M.D., 1611 South Green Road, South Euclid, Ohio, at 3:00 p.m. on Monday, November 29, 1993, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants in this cause.

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On behalf of the Defendant
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On behalf of the Defendant McGowan.

HADLEY MORGANSTERN-CLARREN, M.D., of lawful age, called by the Defendant for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF HADLEY MORGANSTERN-CLARREN, M.D.

BY MR. JEFFERS:

Q. Please state your full name.

A. My name is Dr. Hadley Morganstern-Clarren. H-A-D-L-E-Y; last name is Morganstern-Clarren, M-O-R-G-A-N-S-T-E-R-N, C-L-A-R-R-E-N, M.D.

Q. And your professional address is where, please?

A. My address is the University Suburban Health Center, at 1611 South Green Road, in South Euclid, Ohio.

Q. And your specialty is internal medicine?

A. Correct.

Q. Okay. As you are accustomed to, I will say this for the record, I will ask you a number of questions today, and I suppose others will, too, and if any of the questions are confusing or you wish to have them repeated, please do so, so we know we are understanding one another.

A. Fair enough.

Q. Thank you. I see you have a shortened version in front of you of the materials in this case, but you authored a letter of October 8th, 1993, to Mr. Hirshman of three pages, correct?

A. Correct.

Q. And in the first paragraph you describe what you have seen to date, correct?

A. Yes.

Q. Now, has there been anything else added to that?

A. In the meeting I just had with Mr. Hirshman prior to this deposition I was shown the report of a pathologist, I'm sorry, I don't even know the name of the doctor --

MR. HIRSHMAN: Bonnell.

Q. Dr. Bonnell?

A. And I just read that over, I have not reviewed it in any depth, but I saw that prior to this deposition today. Otherwise, all the materials that I have reviewed and from which I base my opinions are the materials that you see outlined in my report.

Q. So that would include Dr. McGowan's office records, Emergency Room visits of April 8th, May 25th, May 26th, '91; hospital records for

admission to Elyria of 5/26 to 5/27 and autopsy report and certain letters by Drs. Efron, Stein and Rosenberg, and the deposition of Dr. McGowan, correct?

A. That is correct.

Q. So you have never seen the deposition of Dr. Starr, or Dr. Brim, correct?

A. Correct.

Q. So you have not obviously the vaguest idea what they had to say unless this was conveyed to you by Mr. Hirshman?

A. It has not been.

Q. How about the report of Nurse Mangan, have you ever seen that?

A. I have not seen that, no.

Q. And the report of Dr. Shane?

A. I have not seen that.

Q. No depositions of Vargo and Toth, nurses?

A. I have not.

Q. Now, since you have now seen Dr. Bonnell's report, referring to your report of October 8th, 1993, do you have anything to add to that report?

A. No. The report by the pathologist simply concurred with mine, that this gentleman had a

markedly reduced life expectancy as I also had argued.

Q. Markedly reduced life expectancy, and you said something --

A. I had also argued in my report.

Q. Okay. By the way, I don't think I on the record introduced myself, I'm John Jeffers, and I represent Elyria Memorial Hospital.

In your report of October 8th, page three, when you talk about Mr. Manko having survived this acute illness, if he had, his prognosis was poor, and then you talk about some of the problems that he had, including his massive obesity, and the cardiac enlargement, correct?

A. Yes.

Q. Amongst other things, and that cardiac enlargement -- is it your opinion in this case that that was a chronic enlargement?

A. Yes.

Q. Okay. Did you look at the autopsy report?

A. Yes.

Q. I think you did, and you will note in the autopsy report that there are comments about the liver and spleen in terms of their pathology --

A. Yes.

Q. -- at autopsy. Those were enlarged, too, correct?
A. Yes.
Q. Okay. And in that sense, I think Dr. Bonnell referred to them as being six times enlarged from the norm. Do you remember that comment of his?
A. I remember the comments about enlargement. I'm sorry, I do not remember that specific statistic.
Q. Does six times sound roughly accurate to you?
A. If you wanted to show me the report I could tell you, but I don't remember off the top of my head.
Q. In the sense of also, not only what Dr. Bonnell says, but in terms of what the autopsy would reveal.
A. I'm sorry, excuse me, here it is. It says, in this report by Dr. Bonnell --
Q. You are referring to August 12th, 1993, a report by Harry J. Bonnell, chief deputy medical examiner?
A. On the first page of his report of that date it states "there was so much passive congestion or back pressure from the failing heart that his

liver is enlarged to more than twice normal size, and his spleen is enlarged to nearly six times normal size."

Q. And you have no reason to disagree with that comment, correct?

A. I have no reason to disagree.

MR. JEFFERS: Okay. In fact, I am going to mark Dr. Bonnell's report, if I might here.

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(Thereupon, Defendant's Exhibit 1, Two-page report of H. Bonnell dated 8/12/93 was marked for purposes of identification.)

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Q. Showing you what's been marked as Defendant's Exhibit 1, which is the report of Dr. Bonnell of August 12, 1993, you have had an opportunity to review it. What I am going to ask you is if you take exception to anything that's said in that particular report.

MR. HIRSHMAN: Which report is that?

MR. JEFFERS: The report of Bonnell of August 12, 1993.

A. The question is whether I disagree with any of

the statements made?
Q. Yes.
A. Some of the statements he makes are inside his own area of expertise as a pathologist. I am not a pathologist; I certainly, however, have no reason to disagree with any of the statements made here.
Q. And in fact, based upon your own knowledge and experience as a Board certified -- correct?
A. Yes.
Q. -- expert in internal medicine, it is your opinion based upon reasonable medical certainty and probability that Mr. Manko would have had a shortened life expectancy because of the, because of his medical, existent medical problems prior to May of 1991, correct?
MR. MISHKIND: Let me show an objection.
A. That is my opinion.
MR. MISHKIND: Let me show an objection to the form of the questions asked by Mr. Jeffers.
Q. Have you had an opportunity to quantify that shortened life expectancy, or are you able to?
A. In my own experience, patients with this severe

degree of obesity, who already are displaying evidence of cardiac enlargement, seldom outlive their 40's.

Q. And taking into account also Mr. Manko's age at the time, 1991?

A. Certainly.

Q. Your report is dated October 8th, 1993. Could you tell us when you first were contacted to review this case?

A. Yes. Mr. Hirshman contacted me in late September of 1993 and asked me to review these records.

MR. JEFFERS: Showing you -- would you please mark that Exhibit 2.

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(Thereupon, Defendant's Exhibit 2, Four-page report of G. Mangan dated 7/9/93 was marked for purposes of identification.)

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Q. Before I get into Exhibit 2, in your discussions with Mr. Hirshman, did you become aware that, in any way about the contents of a report by Gail Mangan, R.N.?

No.

Showing you what has been marked as Exhibit 2,

which is the report of Gail R. Mangan, R.N., B.S.N., of July 9th, 1993, I would appreciate it if you would review that.

A. Thank you.

MR. HIRSHMAN: For the record, I am going to object to a blanket question regarding agreement or disagreement with the report. If you want to ask him specific questions --

MR. JEFFERS: I didn't bring my ear trumpet.

MR. HIRSHMAN: About specific areas of disagreement with the report. You can go ahead and do so but I feel uncomfortable with you saying do you agree or disagree with the report.

MR. JEFFERS: I comprehend that.

MR. HIRSHMAN: Okay.

MR. JEFFERS: But you can make the argument as you wish, and I will go ahead and do what I want, but I understand your point.

MR. HIRSHMAN: All right.

MR. JEFFERS: And I will give you a continuing objection when I lapse into

that, all right? How is that?

MR. HIRSHMAN: Well, let me think about how I want to deal with it, then.

MR. JEFFERS: Okay.

A. I have now read this letter.

Q. Four pages, correct?

A. Correct.

Q. What I would like to do is go through it paragraph by paragraph. Why don't we do that.

In fact, before I do that, is there anything within this report that you take exception with as we sit here right now?

MR. HIRSHMAN: I object to that question.

MR. JEFFERS: I understand that.

MR. HIRSHMAN: For reasons that I have already indicated to Mr. Jeffers, but to elaborate on it, I don't think it's appropriate to simply ask a witness to, in a blanket fashion, to indicate whether he has any disagreement with a four-page report. If you want to get into specific contentions or allegations made by this nurse, I have no objection.

THE WITNESS: 1 think I can answer

this simply, though. For each of the seven points, as far as they go, I would not disagree with these seven points that are specifically made.

Q. Those are contained on pages two, three and four?

A. That's right.

Q. Now, that basically takes up the majority of the letter, except for unnumbered paragraphs one and two on page one and two and three and four on page two.

Any problems with paragraph one on page one? These are the unnumbered paragraphs.

A. I certainly am not familiar with the specific hospital's policies related to arterial blood gases. From my own concerns, I have reviewed this case as to where the information was, so that Dr. McGowan would have it when he came to see the patient on the evening of admission on May 26 of 1991. I think there are some additional nursing issues that are not raised in this report, such as their own responsibility in using the computer system or obtaining additional records and making sure that there has been a flow of information from an Emergency

Room up to the ward.
Q. Now, you mentioned computer transmissions, correct?
A. Yes.
Q. Where did you get that idea?
A. Well, most hospitals currently would have flow of information either by hand or through a computer.
Q. And did you discuss that with Mr. Hirshman, that subject matter?
A. We have discussed it casually, my own thoughts. I was not asked to address that specifically at the time that I reviewed the issues related to Dr. McGowan. As you know, I was asked to address the care that Dr. McGowan rendered --
Q. Correct?
A. -- and I was not asked to give opinions as to nursing care.
Q. Okay. Now, in terms of information availability, is it fair to say that if all the information that Dr. McGowan wanted were at hand or were easily at hand and obtainable, that then it would be your opinion that the nurses had met their duties relative to Dr. McGowan, correct?
A. Correct.

Q. So your only issue, may I take it, or possible issue that you might have with the nurses is whether or not -- and with the hospital is whether or not the information should have been and was available. Is that fair?

A. Absolutely, and I'm stating that not as an expert on nursing care. I'm not trying to establish myself as one, but rather as what one would expect as a doctor works in a hospital ward, what needs to be done for the whole team to get the job accomplished.

Q. Is it your impression in this case that the Emergency Room physician of the 26th, Dr. Starr, did not have available for, or did not give to Dr. McGowan the full information that was derived at the Emergency Room on the 26th and/or the 25th?

MR. HIRSHMAN: If you know.

A. As far as I have been able to read from Dr. McGowan's deposition, that is correct. He did not have the specific information that we are alluding to here related to arterial blood gas results.

Q. Now, you obviously have indicated that you have not read Dr. Starr's deposition so you don't

know what his point of view is on this case --
A. Quite correct.
Q. -- and if I were to tell you that Dr. Starr testified that all that information that you have just alluded to was given to Dr. McGowan, then you could not draw any conclusions because you have a dispute between two physicians as to what information was furnished, correct?
A. That really would be inconsistent with what Dr. McGowan had said had occurred.
Q. That's right. So that that would leave you, if you had all the information that was available in this case, as sort of a judge as to whose credibility you were going to rely on, correct?
MR. MISHKIND: I object to the form of the question.
A. I think I have to ask you to rephrase the question because 1 don't understand it.
Q. Obviously if Dr. McGowan says I didn't get X information and Dr. Starr says I gave him X information, there is a dispute as to what the factual situation is, right? By necessity.
A. There certainly is a dispute between these two parties.
Q. Okay. And therefore, you can't derive any

conclusions as to really whether or not the information was available under that fact pattern, correct?

A. Well, I disagree.

Q. How is that? Would you explain that to me?

A. Because I have been asked to review the care of Dr. McGowan, and I have reviewed his own notes and his behavior in the chart, and I believe him when he states in his deposition that if he had known the results of those blood gases he would have proceeded with the possibility of pulmonary embolism on the 26th.

Q. So by necessity, you would therefore, if I told you Dr. Starr told him he gave him that information, you would by necessity therefore not believe Dr. Starr's version.

A. 1 would have trouble finding a way to explain both parties as telling us the correct information.

Q. And that's because you would have anticipated that if that information were available to Dr. McGowan, that somewhere he might have recorded it?

A. Not only would he have recorded it but that would have in fact implied action, which did not

take place.

Q. And if Dr. McGowan wrote -- did you read his notes, his doctor's notes?

A. As best I could.

Q. And you will note in there on the 27th, where he writes that certain information -- in fact, let's go to them, make life easier, and I will not misquote it.

You knew exactly what I was looking for. You are very intuitive.

You will note on May 27, he says "ABG still abnormal"?

A. Yes.

Q. So obviously there is some implication that he had already received certain ABG to make a comparison to know they were still abnormal, correct?

A. Not necessarily. I spent some time looking at that myself.

It seems to me from the record and from the nursing notes and Dr. McGowan's own deposition that the results of the blood gases did not come to him until the 27th itself. He probably received both sets at the same time, they are certainly printed next to each other on the same

sheet of the lab printout, and so he could look at the two in comparison and say it is still abnormal, and that doesn't imply any previous knowledge.

Q. Well, now that we are in the rarefied form of discussion --

MR. HIRSHMAN: What is so rarefied about it, John?

Q. Let's do it this way. I want you to presume that information was in his hands and he was making that comparison that you allude to at 10:00 a.m. on the 27th, all right? I want you to assume that as a fact, sir.

A. All right.

Q. Assuming that as a fact, and if he had acted appropriately on that, on that information, would -- was Mr. Manko salvageable at 10:00 a.m. on the 27th?

A. It is my own belief that at about 10:00 in the morning is when the patient was no longer salvageable. Late morning of the 27th is when I think it was too late to save this gentleman.

Q. Now we are into defining late morning. I don't want to play games with you --

A. I'm not either.

Q. I know you are not. I don't want you to take what I am about to say here -- what I am saying is late morning, I know that rounds are made early sometimes, but are you saying -- let's do a specifically.

Are you saying that by 10:30 this man was not salvageable?

A. The basis for my conclusion, because it is not exactly clear, certainly the nurses on that shift were noting the deterioration of the patient, but I can't tell from the shift notes at exactly what minute or hour they noted that he was taking an abrupt turnoff.

What I do have on the vital signs sheet, this is listed under graphic vital signs, it was at 10:00 that morning that the blood pressure dropped, it had been 173 over 76, 142 over 74, 144 over 78 and then dropped abruptly to 110 over 68, and I believe that correlates clinically with the major hemodynamic event, which is when he probably threw the fatal round of pulmonary emboli.

Q. Repeat the 10:00 blood pressure.

A. 110 over 68, which is a dramatic fall.

Q. And what was the immediately preceding one?

A. 144 over 78.
Q. What time was that?
A. That was listed at 6:00 o'clock a.m.
Q. And what is it listed in the next reading after 10:00?
A. Then at 2:00 o'clock it is 100 over 60 and that is getting pretty close to the arrest.
Q. So is it your opinion that at the time that it went to 110 over 68, that he at that moment in history, he was no longer salvageable, no matter what was done?
A. Yes. What I'm arguing is that that would hemodynamically correlate with an abrupt deterioration of his heart and lung situation. And at that moment we know from the autopsy how much extensive damage was done to the pulmonary vessels, both sides.
Q. Now, let's take it to -- in other words, that moment in history in 10:00 when that recording is made is an important moment in history in time relative to Mr. Manko?
A. Important documentation of the change.
Q. Say 9:30 he is seen, and --

MR. HIRSHMAN: I want to make one thing clear. He is charted as being at 110

over 68 at 10:00; the blood pressure reading before that is at 6:00 o'clock, so what in fact is being stated here, if I understand correctly, is that sometime between 6:00 o'clock and 10:00 this event occurred, not necessarily exactly at 10:00.

MR. JEFFERS: Correct.

MR. MISHKIND: I object to Mr. Hirshman's, what I perceive to be a closing argument.

Let me just finish. I believe that Mr. Jeffers is questioning the doctor and I'm not sure whether that is an objection to what Mr. Jeffers has said, and if it is I object, because I don't think it is an appropriate objection. And 1 move to strike any comments that you have made in that regard.

MR. HIRSHMAN: You are more than capable to make that objection. I want the record to be clear that that's the next preceding blood pressure we have here.

MR. MISHKIND: That was clear in the questions, I believe.

Q. Dr. Morganstern-Clarren and myself understand

salvageable. I can't document exactly at what minute that occurred.

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(Thereupon, a discussion was had off

the record.)

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Q. So what we get down to in terms of your thought process is whether or not certain information was available to Dr. McGowan from the -- between the evening of the 26th to the morning of the 27th, and if it weren't, it should have been, correct?

A. I agree with that.

Q. Okay. And if it were available, then Dr. McGowan should have done something about it, correct?

A. I agree with that.

MR. JEFFERS: Then I have no other questions. Thank you. I told you I would be short.

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EXAMINATION OF HADLEY MORGANSTERN-CLARREN, M.D.

BY MR. MISHKIND:

Q. Doctor, as you know, my name is Howard Mishkind, and before I begin my questioning, I would like to just take a look and see what it is that you have in front of you there.

A. Certainly.

Q. Doctor, you provided me with a copy of your

curriculum vitae, it is a one-page document, in fact, Mr. Hirshman had previously provided it to me, so I'm familiar with it.

A. Good.

Q. My question to you relative to your background is have you done any writing in any articles or texts or any medical publications?

A. No, I have not.

Q. Now, you are an internist, Board certified internist, is that correct?

A. That is correct.

Q. You are not Board certified in pulmonary disease, are you?

A. Correct, I am not.

Q. You are not Board certified as a pathologist either, are you?

A. Correct.

Q. And in fact, when we talked about Dr. Bonnell's report and the analysis of the autopsy, certainly you would defer to a pathologist with regard to the analysis of the pathological findings as it would relate to the issues of morbidity and mortality, is that also correct?

A. Of course.

Q. Now, doctor, as an internist, what books or

journals do you refer to when you want references relative to the clinical features of pulmonary embolism?

A. The most important book I would use is the one that I have right here on my desk, which is my basic internal medicine textbook, Harrison's Principles of Internal Medicine, Twelfth Edition.

Information can be found in all the good basic internal medicine textbooks, however.

Q. Do you believe that the information in Harrison's with regard to clinical features of pulmonary embolism is reliable to you as an internal medicine specialist?

A. Yes.

Q. And you consider it to be authoritative in that regard?

A. Yes.

Q. Is Harrison's also authoritative in your opinion with regard to the significance of diagnostic studies, including the significance of arterial blood gases and chest x-rays and EKGs when it comes to ruling out or confirming the existence of a pulmonary embolism?

Yes.

Q. Now, as I understand it from Mr. Jeffers' question, the pivotal concern that you have with regard to when Mr. Manko was no longer salvageable and when he was salvageable is his hemodynamic status at a particular point in time, is that correct?
A. Yes, you have understood me correctly.
Q. So that you would expect in a hospital, whether it be Elyria Memorial Hospital or University Hospitals or where have you, if a patient is being monitored by the nurses, you would expect that the nurses would note any change in the hemodynamic status of the patient.
A. Yes.
Q. And if the patient has a precipitous drop in his pressure and his heart rate, would you expect a note by a nurse to indicate such things as hypoventilating or change in color, which would be indicative of a change in the hemodynamic status of the patient?
A. Yes, I would expect a notation in the nursing notes of such a change.
Q. Are you aware that in this case the first note by any nurses relative to a change in the patient's status in terms of change in color and

hypoventilating came at or about 2:00 o'clock p.m. on the afternoon of May 27?

A. I'm aware that that blood pressure drop was recorded at 10:00 and I'm aware of a note for the entire shift from the morning through the early afternoon as a summation statement of the change in the patient's condition. So I'm aware of those particular statements that indicate some change earlier than 2:00 o'clock in the afternoon.

Q. Okay. Well, there is a statement , actually, written at 2:20, in the focus notes of the nurses that says change in condition, and I believe it's hypoventilation, it may be hyperventilation, color gray; you want me to show it to you?

A. Let me find a moment to find the appropriate notation. I believe it does say hyperventilation and color gray. Yes.

Q. And it also indicates change in condition at that point.

A. It does.

Q. Okay. Now, and that's -- that, at least from my review of the records and correct me if I'm wrong, would be from the nurses' standpoint the

first time that there was any notation in terms of a clinical change in the patient's status, is that correct, doctor?

A. I'm just going over the notes, so I can answer your question. That is the first notation by a nurse that I can find as well.

Q. And doctor, on the graphic chart, the change in the blood pressure from 10:00 to 2:00 o'clock is, there is some decrease, but there is not a severe change in the patient's blood pressure between those hours, is there?

A. I agree, it drops just ten points more.

Q. Right, exactly. Now, at 2:30, there is a substantial drop in the patient's blood pressure at that time, isn't there?

A. Yes.

Q. And if you could just for the record indicate --

A. That is located in the nursing notes section, where it says transfer assessment, I believe this is just where they are getting the patient over to the intensive care unit and this is listed as time of 2:30 on May 27, and it notes "severe" -- I can't read the next word, "with respiratory distress, hypoxemia," and then under cardiovascular status it says blood pressure

right arm down to 80 over 60.

Q. So certainly at 2:20 to 2:30 timeframe, there is a significant change in his hemodynamic status, would you agree with that?

A. I agree.

Q. Much more profound change than one could describe having taken between, having occurred between 6:00 o'clock a.m. and 10:00 a.m. that we have talked about before, would you agree with that as well?

A. Yes, the patient was going into an arrest situation. He was crashing.

Q. There certainly is a marked change in his hemodynamic status?

A. I agree.

Q. Doctor, I want to back up before we talk about the particulars on your opinions in this case and ask you some general questions.

Do you know Dr. McGowan?

A. No, I do not.

Q. Do you know any of the physicians that were involved in the care of Mr. Manko?

A. No, I do not.

Q. Have you talked to any of the physicians that were involved in Mr. Manko's case since you

learned about the case?
A. No, I have not.
Q. Have you talked to the attorney that represents the Emergency Room doctors?
A. No.
Q. Do you know who that is?
A. No, I don't.
Q. If I told you it was Bill Bonezzi, you didn't know that?
A. I do know Mr. Bonezzi, but I did not know that he was involved in this case and I did not discuss the case with him in any way.
Q. How do you know Mr. Bonezzi?
A. Can we go off the record?
Q. Answer the question on the record, please.
MR. HIRSHMAN: I have a feeling that you may want to go off the record a second.
MR. MISHKIND: On the record.
MR. HIRSHMAN: If he has a privilege problem, he will tell you.
THE WITNESS: Yes, there is.
Q. Has Mr. Bonezzi represented you?
A. No.
Q. Is Mr. Bonezzi a patient of yours?
MR. HIRSHMAN: And if you don't feel

you want to answer that question --
A. I think that is a matter of doctor/patient confidentiality, sir.
Q. The fact that he may be a patient of yours, I'm not entitled to ask you about any relationship of it, but if that's the basis that you know Mr. Bonezzi, from a physician-patient relationship, I won't ask you anything about the particulars of that, but is it a physician-patient relationship that you have with Mr. Bonezzi that you met him like that?
MR. HIRSHMAN: I tell you what, answer yes or no, whether you have a physician-patient relationship.
A. Yes, we do. I also have reviewed some cases for him over the past several years.
Q. Do you know David Rosenberg?
A. I don't know him personally. Our paths have crossed at University Hospitals.
Q. You know him by reputation?
A. No, I know who he is.
Q. What about Dr. Stein, who I believe you read his report from California, one of plaintiff's other experts, do you know him either personally or by reputation?

A. Neither.
Q. And do you know Dr. Efron, the Emergency Room expert in this case for the plaintiff?
A. I do not.
Q. How many cases have you reviewed for Mr. Bonezzi in the past?
A. I suspect I probably have reviewed about five or six cases over the past four or five years.
Q. Beside that number of cases for Mr. Bonezzi, have you ever reviewed any other cases for the Jacobson, Maynard, Tuschman law firm before?
A. Yes, sir.
Q. And how many years are we covering in terms of having reviewed cases for them?
A. I believe since about the mid 1980s.
Q. Have you reviewed any cases for Mr. Hirshman before?
A. Yes, I have.
Q. How many cases have you reviewed for him?
A. I believe I have reviewed two cases for him previous.
Q. Putting aside Mr. Bonezzi and Mr. Hirshman, how many cases have you reviewed for others in that law firm?
A. Probably about 15 others.

Q. 15 or 50?
A. 15.
Have you testified in depositions in any of those cases as an expert witness for any of the lawyers from Jacobson Maynard?
A. Yes.
Q. And on how many occasions?
A. I don't know exactly, but I would assume about a dozen times.
Q. And have you ever testified in court as an expert witness for Mr. Bonezzi, Mr. Hirshman or any of the lawyers at that firm?
A. I believe I have.
Q. Specifically, have you testified for Mr. Hirshman before?
A. Unfortunately, I think the last time we were in a courtroom together we were on opposite sides.
Q. That's the last time, but have you ever testified for Mr. Hirshman before?
A. Not in trial.
Q. Just in deposition?
A. Correct.
Q. What percentage of your work, doctor, in the medical negligence area is for the patient, and what percentage is defending the physician

that's named in the case?
A. In the last several years, most of the cases that I have been asked to review have been in defense of doctors, but over the ten or eleven years that I have reviewed cases, it has now come about 50/50 even for both sides, over time.
Q. You say over the last, is it several years?
A. I have reviewed cases for ten or eleven years now.
Q. But for the last few years, or several years, I want to get the reference in terms of, say, the 1990s, are you reviewing cases for plaintiffs in the 1990s?
A. I am.
Q. What percentage of your work in this area is plaintiff related versus doctor related, or defense related?
A. I guess what I am trying to state is I don't have an ideology. If an attorney asks me to review the material, I will review it fairly and give my opinion. I don't have just one position or the other. I would think that over the last three years, probably about two-thirds of the cases have been on behalf of doctors and

probably about one-third have been on behalf of patients and their families.

Q. How many cases do you review on the average during a month?

A. I get about one new case a month. I average about ten or twelve cases a year.

Q. In fact, you have reviewed cases for the Weston, Hurd law firm, of which Mr. Jeffers is a partner, have you not?

A. Yes, I have.

Q. Have you ever reviewed cases for Mr. Jeffers?

A. No, I have not.

Q. Have you ever testified in any of the cases that you have served as an expert for the Weston, Hurd law firm, either in deposition or in court?

A. I honestly would have to check. I know I have reviewed some cases and I may have had a deposition, I don't believe that I have appeared in court for their law firm.

Q. Do you maintain records of what firms you review cases for?

A. No, I don't.

Q. And you say you would have to check; what would you check to determine that?

A. I really don't have a specific record. I would have to call Mr. Jeffers and ask if I ever worked for you before, appeared in court. I would have to find out.

MR. JEFFERS: Why don't you ask him how many he has done for Weston, Hurd.

MR. MISHKIND: Thank you, John.

Q. What do you charge per hour to review cases?

A. My current fee is $250 per hour.

Q. That's for the review of records?

A. Yes.

Q. What about when you testify by way of deposition, what do you charge per hour?

A. I charge the same, and I have to charge essentially by the amount of time that has been scheduled away from my patients for a day like today. But the rate will still be $250 per hour.

Q. So you will charge for your meeting with Mr. Hirshman on the basis of $250 an hour; you will charge Mr. Jeffers and myself for this deposition on the basis of $250 an hour?

A. That's right, for at least the time between 3:00 and 5:00 that I schedule away from my patients, and if you go beyond 5:00, it would continue to

have that time billed specifically at that rate of $250 per hour.

Q. On the average, how many times a month are you deposed?

A. Less than once per month.

Q. During the course of a year, are we talking six to ten times?

A. I would think five or six times per year.

Q. Now, if you were to testify in person in a courtroom, is your hourly rate any different?

A. No, it is not.

Q. Are you currently serving as an expert witness in any cases that are in litigation for plaintiffs' lawyers?

A. Do you mean have I reviewed some cases that have not yet come to deposition or to trial that are in process?

Q. Cases that lawsuits have been filed, and you have, you are involved serving as the expert. Plaintiff's lawyer contacted you, you have reviewed records. Whether you have been deposed or not, I'm just curious whether you are working with any plaintiff's lawyers at this particular point.

A. Yes.

Q. Okay. What plaintiff's lawyers are you working with currently?
A. I don't have that list right here before me. As I have mentioned, I have reviewed several for the Jacobson, Maynard firm, I believe -- I can't really tell you off the top of my head, sir.
Q. The Jacobson, Maynard firm is not, at least when I last looked, is not a plaintiff's firm. I'm talking about --
A. Excuse me. Forgive me.
Q. I'm talking about on the other side.
A. I currently have reviewed some for Mr. Mike Monteleone's law firm, and I have reviewed some for Mr. Spangenberg's law firm.
Q. Have you testified in any cases involving the treatment of pulmonary embolisms?
A. I don't recall that I have. 1 may have, in all honesty, but it does not immediately come to mind.
Q. Have you issued any reports in prior cases dealing with the proper diagnosis and treatment of a patient with a PE?
A. 1 do not recall having prepared such a report ever before.
Q. How did you first get connected with

Mr. Hirshman?

A. Well, as I mentioned, Mr. Hirshman and I first met when we were on opposite sides of a lawsuit that involved one of my own patients, and I give great credit to Mr. Hirshman that despite the fact that we were on opposite sides, he called me several years later and asked me to review a case for him.

Q. He was representing your patient?

MR. HIRSHMAN: Unlikely.

A. No, he was, I think, representing the surgeon that my patient was suing, and I was there as a subpoenaed witness.

Q. Have you ever been a defendant in a medical negligence case?

A. No.

Q. Have you ever been represented in connection with any claims asserted against you by the Jacobson, Maynard firm?

A. No.

Q. Do you maintain your insurance with PIE?

MR. HIRSHMAN: Objection.

A. I do.

Q. Doctor, I take it you don't participate in any services, make your name available on lists of

expert witnesses or anything of that nature, is that correct?

A. I do not.

Q. Have you ever done so?

A. Never.

Q. Other than the Principles of Internal Medicine that you have in front of you that you reviewed, I believe you told me when we were discussing for reference to the pulmonary function studies that were done in the Emergency Room, did you review Principles of Internal Medicine for any other purpose in connection with this case?

A. 1 read over the section specifically on AA gradients, and I also just reviewed the section on pulmonary embolism. This was again just in preparation for the deposition today. It really did not change any of my opinions, become the basis of any of my opinions, but just to go over it, see that everything that I have been trained in is still current.

Q. And certainly what you read in Harrison's concerning the diagnosis, the treatment, and the prognosis for patients'with PE is consistent with the opinions that you hold as a physician practicing in this area of the state, is that

correct?
A. As I read the material over yesterday, it was quite consistent with my own experience and training, yes.
Q. At any time during the course of your involvement in this case, have you reviewed any other medical literature other than what we have just talked about?
A. Not for the preparation for today or in the preparation of any earlier report.
Q. Which volume of Principles of Internal Medicine is it?
A. This is the twelfth edition, and this is volume two.
Q. Have you been provided with any summaries of any of the deposition testimony in this case in written form by Mr. Hirshman?
A. No.
Q. Have you been provided with any information, doctor, in written form that you subsequently returned to Mr. Hirshman that is not with you today?
A. No.
Q. So what we talked about in terms of the records that you have, the depositions and the reports,

that's the entirety of the information that you are relying on to express the opinions in this case?

A. That's right.

Q. Now, based upon your review in this case, doctor, is there any evidence of Mr. Manko having a history of being short of breath or having difficulty breathing prior to May 25th, 1991?

A. Not that I could find.

Q. Any history of chronic problems with regard to Mr. Manko's heart or lungs prior to May 25th, 1991, that would cause him to be short of breath?

A. Not that I could find in my review of these materials.

Q. Would you agree that the amount of the cardiac enlargement that was seen on the autopsy -- strike that.

With the amount of cardiac enlargement that was seen on the autopsy as described by Mr. Jeffers in terms of six times normal, that you would --

MR. JEFFERS: I didn't say that about the cardiac at all.

MR. HIRSHMAN: It was the spleen he was referring to.

MR. MISHKIND: Okay.

Q. The enlargement of the multi organs, whether it be the liver, the spleen, the heart, all as described in the autopsy to be above what is considered to be normal --

A. I agree.

Q. With regards to heart, would you expect that with the heart being the size that it was as described on autopsy, would you expect for there to have been evidence on chest x-ray of enlargement of the heart or the mediastinum?

MR. JEFFERS: I object unless you are taking into account the size of this fellow, and the morbid obesity that he was suffering from.

Q. Well, you take whatever you need to take into account, doctor. I'm asking you if there is an x-ray taken on the 25th, the 26th, chest x-ray --

MR. JEFFERS: Portable.

MR. MISHKIND: John, please. I was courteous enough to you --

MR. JEFFERS: I'm sorry.

MR. MISHKIND: John, please. I know what you are trying to do, and I resent it. Let me ask the questions the way I want. If you want to follow-up, that is fine.

MR. JEFFERS: Okay.

Q. You know, doctor, do you not, there were x-rays taken on the 25th and 26th?

A. Yes, I do.

Q. And both of the x-rays show no enlargement or certainly within normal limits for the heart, the lungs, and mediastinum, is that correct?

A. I'm looking at the x-ray report dated May 25th, and I agree with you that it is read that way, but it was a portable x-ray and we are specifically trained that you cannot assess cardiac size based on a portable x-ray. You just can't do it.

Q. Doctor, when you have a portable x-ray, doesn't that tend to depict more of an increase in the heart size over a regular x-ray?

A. We are trained to be unable to make any assessment of cardiac size from portable film. There's distortion.

Q. From your training, though, when you have a

portable x-ray versus an x-ray determination that's done in the radiology department, what is your understanding as to whether there is a tendency to have more or less of an increase in the size of a particular organ on the portable film?

A. I'm not trying to be difficult. That's not my understanding. We are taught to simply be unable to make any assessment.

Q. All right. So you don't -- do you have an opinion as to whether or not a portable chest x-ray then is totally unreliable in terms of determining the size of the patient's lungs, heart, and mediastinum?

A. I would go stronger than that. I would say that any physician that tried to assess cardiac size from a portable film is doing an improper means of cardiac assessment.

Q. What about trying to assess a patient with regard to the lungs? Is it appropriate to do assessment of the lungs by way of a portable x-ray?

A. Of course. That's why we do them in a patient who is acutely ill. You would get more information from a better quality film, but you

would at least be able to get some information as to the presence of fluid at the bottom of the lung, an effusion, the presence of infiltrate or tumor or fluid congestion, as in congestive heart failure. It would be under such circumstances that it would become a useful tool.

Q. The x-ray that you referred to, there is the 25th and the 26th film, I don't know if you have noticed --

A. That is correct, I have both.

Q. And both of them suggest that the heart, the mediastinum and the lungs appear within normal limits, do they not?

A. That's what the reports say.

Q. Okay. And your testimony and your opinion in this case is that the reference to the heart and the mediastinum being within normal limits is of no diagnostic significance whatsoever in this case?

A. As far as for the presence of cardiac enlargement, yes, that's exactly what I am saying to you.

Q. Did you see the actual films themselves, doctor?

A. I have not.

Q. Are you saying that all portable x-rays taken of a patient's heart are unreliable in terms of the size of the heart?

A. That has been my training.

Q. But in fairness, you have not seen these particular films to determine whether or not they had diagnostic significance so that one could arrive at certain conclusions based upon the films, have you?

MR, JEFFERS: Relative to the heart or what?

Q. The heart and mediastinum.

A. I have not reviewed the films, but again, if someone showed me the films I would have to state that I would be unable to make an assessment of cardiac size based upon looking at it in person.

Q. Are you critical of the radiologists for their interpretation of the films and the manner that they interpreted?

MR. JEFFERS: Objection.

A. No.

MR. HIRSHMAN: We have all sorts of shifting alliances here. It is like the UN or something.

MR. JEFFERS: I'm trying to balance the equities here.

Q. Doctor, you had indicated in your experience that patients of Mr. Manko's obesity seldom outlive their 40's.

A. Yes.

Q. Are you able to cite me to any studies that would correlate or support an opinion that patients of Mr. Manko's obesity rarely live, outlive their 40's?

A. Not for that specific instance. I'm basing that on my own experience as a house officer and in my own practice. I in fact don't have any patients who have lived into their 50's with this level of obesity and evidence of heart disease already in their early 30's.

Q. Have you ever seen any obesity studies that talk about patients that live with the same degree of obesity into their 60's and 70's? Have you seen any studies that talk about whether that occurs or whether that doesn't occur?

A. I have not seen those specific studies, and again, the issue is not the obesity but also the presence of preexistent heart disease.

Q. I understand that, and we'll talk about that in

a moment. I'm concerned primarily at this point about the obesity issue, and may I conclude that you have not seen any literature talking about obesity studies and the significance of obesity as it relates to mortality?

A. Correct.

Q. If Mr. Manko had survived the acute illness that brought him to the hospital on May 25th and took his life on May 27, 1991, when would Mr. Manko have died?

A. I can't go much beyond the statements that I have already made. I think he certainly would have died before he reached the age of 50. I can't tell you exactly when. He would have had an increased risk of congestive heart failure, an increased risk of cardiac sudden death, an increased risk of pulmonary hypertension, and increased risk he would throw pulmonary emboli in the future, and as you know, many times the first symptom is sudden death rather than any preexistent symptoms at all.

Q. What percentage is there of the likelihood of a repeat PE in a patient that is timely and appropriately treated in a hospital setting?

A. It's a significant percentage, but I do not know

the exact number.

Q. If I told you that the statistics show less than 25 percent of recurrence with patients that are properly treated, would you have any basis to say, Mr. Mishkind, you are way off or --

A. No, in fact my own guess would have been probably about 15 to 20 percent, so it is quite consistent with what you are saying from my own experience.

Q. Would you also agree that a patient that experiences a life-threatening episode such as Mr. Manko was facing and ultimately succumbed to, that that type of patient certainly would be the type of patient that you in your practice would sit down and say Mr. Manko, you have to lose weight, you have to change your lifestyle, otherwise, you are not going to make it to 50 years of age.

A. I don't know if I would phrase it quite that way. I would certainly state he has got to lose weight. This is the beginning of what would be a series of catastrophic events, and our only hope would be for him to succeed in losing weight.

Unfortunately, I think, as you know, the

long-term success in control of morbid obesity is very poor.

Q. Doctor, I'm sure you have had patients that have had heart attacks, have had other situations that when they experience such an event, that they have a change of lifestyle and that they realize that they were on death's doorstep and they changed their lifestyle to make sure that their longevity is increased, isn't that a fact?

MR. JEFFERS: I object.

A. Of course it is true, and I have seen people stop smoking, get on a better diet and start exercise programs, but I have not seen patients with this severe degree of morbid obesity, which is a very difficult problem for patients, achieve success by being read the riot act.

Q. Do you have any idea what the quality of Telley Manko's life was prior to May of 1991?

A. I don't have specific information about the quality of his life.

Q. Do you have any idea as to his ability to function at work and at play without becoming short of breath, and without being disabled from normal activities of running and playing and

working?
A. I don't believe that I have been shown specific information that addresses that.
Q. In your experience, doctor, with patients that are obese -- have you ever had patients that have -- what's your understanding as to Telley Manko's weight prior to his death during the hospitalization?
A. I have seen some weights listed of 340 and 357 pounds.
Q. Do you have any patients in your practice or have you treated patients in your practice in that weight range?
A. Yes, I have.
Q. And have those patients been disabled with regard to shortness of breath and things of that nature?
A. As I recall, not having specific charts in front of me, several of them have had problems with shortness of breath, several of them did have problems with their legs with walking and with chronic swelling.
Q. Now, with regard to Mr. Manko, are you aware of any problems that he had with regard to chronic swelling and difficulty with walking over the

years?

A. I have not read of any history of having a previous chronic swelling.

Q. So if there is no history of chronic swelling, chronic difficulty with walking and chronic pulmonary problems, would Mr. Manko from a symptom complex standpoint be an atypical obese patient?

A. I don't think so. He was only 30 years old. I would think that this would definitely be something that you would expect to occur eventually.

Q. So you are not surprised that at 30 years of age with his weight that he was able to function normally?

A. I'm not surprised.

Q. And you just can't tell me if he had survived and had gone on a diet, whether it was a religious one or semi-religious in terms of following your advice, you are not able to tell me how much longer that would have extended his life?

A. I would certainly agree with you that it would have extended his life, but I cannot tell you exactly how long that extension would be.

Q. Can you say that it was out of the question for him to have lived into his 60s if he had followed your advice with regard to weight loss and diet?

MR. JEFFERS: I object because that's the argument about anything is possible. Chicken Little and et cetera.

A. I will use the argument of medical probability. It certainly is possible that he could have gone on longer or that the next day something else catastrophic would happen in term of an arrhythmia. All I can say is that in general probability, as I have already stated, I do not believe he would have gone beyond his 40s.

Q. But that's regardless of whether he did anything to alter his diet and his weight, correct?

A. Again, based on medical probability, I don't think you can make that projection, that he suddenly would change from this 300 plus pounds to a normal body habitus. I have never seen anybody succeed to that degree. I would certainly agree with you that if he was able to do that, that would extend his life expectancy.

Q. And you would not be able to say to any degree of probability exactly when he would have died

under those circumstances, correct?

MR. JEFFERS: Object.

A. I would have to tell you that because he already had cardiac enlargement, I would still assume even with an ideal weight, he would still have a shortened life expectancy, but now we really are speculating.

Q. Doctor, are you able to tell me what degree of cardiac enlargement is post pulmonary embolic event that took his life, and what degree of enlargement he had prior to coming into the hospital on May 25th, 1991?

A. That would be very hard to do, of course, without having open heart surgery or some kind of more precise cardiac testing in advance, but I will tell you that what was found at autopsy to be enlargement of the left side of his heart certainly would represent preexistent heart disease.

Pulmonary embolization causes increased pressures within the lungs, and that causes a backup pressure on the right side of the heart. You can go into acute right heart overload. So if simply right heart findings were found at the time of autopsy, I would actually be quite

satisfied to attribute all of it or most of it to the acute illness with pulmonary embolization, but the fact that there was significant left-sided enlargement, which I cannot attribute to the embolization process at all, is what leads me to the conclusion that there was true cardiac damage before this patient had this pulmonary illness.

Q. Well, you would agree, at least, that massive pulmonary emboli, as you just said, can cause cardiac congestion?

A. To the right side of the heart, but at autopsy, they found enlargement of the entire heart, and I cannot explain the enlargement of the left side of the heart based on this illness.

Q. Are you aware of how rapidly the spleen and the liver increase in size, or splenomegaly and hepatomegaly, how rapidly they occur in acute congestive heart failure secondary to a pulmonary embolism?

A. It can be quite rapid.

Q. With regard to the degree of increase in the spleen and the increase of the liver in response to acute congestive heart failure secondary to the pulmonary embolism, would you defer to the

pathologist in terms of talking about how much damage was caused by the pulmonary embolism versus how much predated Mr. Manko's acute illness?

A. Well, there are actually three variables. There is the underlying heart disease, then there is the pulmonary embolism, and then there is the cardiac arrest with the acute failure of the heart leading to backup of fluid into these organs.

I don't know of even any pathologist who could tell you in a percentage breakdown which components of the fluid came from which of the three pathological processes.

Q. Well, the cardiac arrest was the end stage event after his hemodynamic status, after he went into shock, correct?

A. Correct, and that could have caused a great deal of fluid backup in several minutes.

Q. Right, okay, and all of that was precipitated, as we ultimately know, by the pulmonary embolism, correct?

A. I agree.

Q. So that had he been treated at a point in time where you believe him to be salvageable, there

is a high likelihood that this patient would not have suffered an arrest of any sort in the hospital in May of 1991, correct?

A. I agree with you.

Q. And whatever degree of damage to the heart that was caused by the passive congestion and the arrest that was precipitated by the PE, that would have been avoided, correct?

MR. HIRSHMAN: I object. You were talking about the spleen and the liver, and all of a sudden you have jumped back to the heart.

MR. MISHKIND: He is with me.

THE WITNESS: I am following. I actually agree with your statement.

Q. Do you have an opinion, doctor, as to how much of the increase in Mr. Manko's liver was secondary to fatty infiltration versus the congestive heart failure?

A. I would have to leave that to the pathologist.

Q. Are you aware of whether or not fatty infiltration of the liver is reversible?

a. It is reversible.

Q. Is there evidence in your review of the autopsy of right or left ventricular hypertrophy?

A. No, what is indicated is global enlargement of all chambers.
Q. So you interpret that to mean that both the right and left ventricles were enlarged?
A. That is exactly what it means.
Q. In your opinion, doctor, does obesity predispose a patient to forming blood clots?
A. It does.
Q. Do you hold an opinion in this case as to the cause of the PE?
A. My conclusion, although it is not confirmed by the autopsy because the autopsy doesn't address this specific issue, is that the PE, pulmonary embolism, was a result of deep vein thrombophlebitis. The autopsy, however, did not prove the location of the deep vein thrombophlebitis.
Q. Why didn't the autopsy prove the source or location?
A. I don't know.
Q. Would you agree that that's a shortcoming of the autopsy? Without criticizing anyone, it just didn't go far enough to --
A. Well, they certainly did establish the cause of death, which is the ultimate purpose of an

autopsy, but certainly in terms of our own discussion as to trying to understand the sequence of events for Mr. Manko, it would have been very helpful.

Q. What is your understanding -- strike that.

Do you have an opinion, then, as to what caused the thrombophlebitic event in Mr. Manko?

A. Well, the one risk factor that we have identified is obviously the morbid obesity. There may also have been some kind of problem with the coagulation state of his blood, but this was not tested in the hospital, and I have no specific information.

Q. Based upon all of the information that you have, and I see you have the April, '91 Emergency Room record when -- I'm sorry, April 9th, '91 Emergency Room record, when he was treated at Elyria Memorial Hospital for a work injury --

MR. JEFFERS: That is April 8th?

THE WITNESS: That's correct. April 8th.

MR. MISHKIND: I believe the injury is April 8th, the treatment is April 9th, but in any event it is early April, '91, do you hold an opinion as to whether that

event was a factor that influenced the formation of the thrombi?

A. I do not have an opinion on that particular subject. I have no evidence that links that Emergency Room visit and that episode with the subsequent events in May.

Q. Is it your opinion, then, that that is unrelated?

MR. HIRSHMAN: He just told you he has no opinion.

Q. But the finishing of your sentence confused me. You do not hold -- correct me if I'm wrong. Is what you just told me that you don't know one way or another whether the injury that's described in April, 1991 was a cause that contributed to the formation of the thrombi, or is it your opinion that we can exclude the Emergency Room, the injury that caused that Emergency Room visit from consideration?

A. What I am stating is that I cannot find any evidence that links the two. There may have been a relationship, but I don't find any evidence that does link them.

Q. In terms of treating a patient that has a PE, I'm sure that in your practice you have seen

patients that have been in the hospital with suspicion of a pulmonary embolism?

A. Many.

Q. And I am sure you have been contacted by Emergency Room doctors that have seen your patients and have described certain symptoms, and you have caused those patients to be admitted for a workup to determine or to rule out the existence of a PE.

A. I haven't had them admitted to rule out the presence. It doesn't require hospitalization. Certainly the question has arisen and we have addressed it. Often the presence of embolization can be established right from the Emergency Room with a scan or studies of the legs, and then the patient can be managed as an outpatient or brought into the hospital, depending on whether or not embolization is present.

Q. And the determination as to whether that patient can be treated on an outpatient basis or in the hospital also depends upon just how significant the oxygen deprivation of the patient is associated with that PE, correct?

A. No matter how severe the hypoxemia associated

with the pulmonary embolization, the presence of pulmonary embolization requires hospitalization and intravenous Heparin; however, even if there is no pulmonary embolization, you are absolutely right, you would use how sick the patient is in terms of clinical examination and other supporting testing to determine if they were so sick with PE or not that they needed to be in the hospital.

Q. Is it a fair statement to say, then, that what caused the PE, whether it is the Emergency Room visit, whether it is some coagulation problem, isn't really relevant, that what is relevant is when was there sufficient clinical and diagnostic evidence available so that a diagnosis of PE could be made and timely treatment begun?

A. From a doctor's point of view, that would be correct.

Q. You wouldn't be as concerned once having been told about the clinical status of the patient in terms of whether he is tachycardic, what his respirations are, what his blood gases are, as to what caused his clot formation; you are more concerned at that point about confirming it

being a pulmonary embolism and starting the patient on appropriate treatment, correct?

MR. HIRSHMAN: Objection.

MR. JEFFERS: Object.

A. That is exactly right.

Q. Would you agree that it is highly unlikely to have a 30 year old patient who has a history of very minimal smoking and no history of chronic respiratory problems to have a diagnosis of chronic obstructive pulmonary disease?

MR. JEFFERS: Those factors alone, objection.

A. It depends on what you mean. Certainly I would be surprised to have such a patient have COPD as defined by emphysema or chronic bronchitis. It would be very common for such a patient to have asthma, which is also part of the COPD category, so it gets somewhat into semantics and it is very common even in a patient who never had asthma to come in with a first attack brought on by infection, or some other toxic exposure.

Q. If you had COPD would you expect, doctor, if the patient has asthma, to have as significantly abnormal PO2 and PCO_2 values as this patient had during the first Emergency Room visit on May

25th, 1991?

MR. JEFFERS: Object.

A. Yes, 1 have seen patients come in with levels quite consistent with asthma in this range.

Q. You have?

A. I have.

Q. If you had been contacted by a physician -- strike that.

I understand from looking at your report at the bottom of the first page, you indicate that Dr. McGowan cannot be held responsible that Mr. Manko was not hospitalized on May 25th, 1991. Am I correct in that that statement is based upon the fact that we know Dr. McGowan was not contacted with regard to the patient's condition while he was in the Emergency Room on May 25th, 1991?

A. Exactly. He was not involved in the assessment of the patient, or the decision made.

Q. That decision making was one made by the Emergency Room doctor?

A. Yes.

Q. Now, if you had been contacted, doctor, by the ER physician about Mr. Manko on May 25th and told the patient had a history, complained of

shortness of breath, rapid heart rate, rapid respirations, chest tightness with ambulation, weight of 357, history of blood in the urine, and EKG showing a right axis deviation, sinus tachycardia, normal portable chest x-ray, PO2 of 59 and a PCO_2 of 29, and this is your patient, would **you** have admitted the patient to the hospital?

MR. HIRSHMAN: Hold on a minute. I am making an objection and I am going to tell you this is outside the scope of the opinions that he is going to give, and pursuant to Rule 26 it will not be an opinion that he will render in a courtroom and he will not render it here.

MR. MISHKIND: He'll render it here. You don't have the right to instruct him not to,

MR. HIRSHMAN: He will not render it here -- he will render it here provided you get a court order that says he has an obligation to render it here.

MR. MISHKIND: Mr. Hirshman, I sat through your depositions where you have doubled up and asked questions on behalf of

Mr. Bonezzi with regard to the Emergency Room doctors, and I know very well what's going on in this particular case. I'm entitled to ask this doctor questions so I know exactly what is going to be coming, whether it is asked by you or asked by Mr. Bonezzi, and when he says he cannot be held responsible that he was not hospitalized, I'm entitled to ask him on what does he base that.

MR. HIRSHMAN: And he is telling you that there is absolutely no opinion that he is going to be rendering one way or the other as it pertains to the Emergency Room physician from the Emergency Room visit of May 25th, 1991, and your question is directed towards the Emergency Room physician's care and treatment, and as a result, he is not answering the question.

MR. MISHKIND: You have no right to instruct -- is this your client?

MR. HIRSHMAN: He is not my client.

MR. MISHKIND: You have no right to instruct --

MR. HIRSHMAN: He will not answer.

MR. MISHKIND: Will you please instruct the witness to answer the question?

THE NOTARY: You are so instructed.

MR. HIRSHMAN: You don't have to go through that. You know that.

MR. MISHKIND: I am going to.

MR. HIRSHMAN: There is absolutely no basis for you asking anybody to instruct anybody to answer the question.

The thing you do is simply go file a motion with the court.

MR. MISHKIND: I am going to.

MR. HIRSHMAN: And you don't have to make a record of it. This is 1993.

MR. MISHKIND: I know. Almost 1994. And I am absolutely, I want to finish the record, I am absolutely entitled to ask him opinions in this case, especially when he has said that he cannot be held responsible for being hospitalized.

MR. HIRSHMAN: If you want to ask a question about McGowan, you go ahead. You want to ask a question about Starr or Brim, you will not, because he has not offered

opinions in regard to those physicians.

MR. MISHKIND: I understand the game you are playing, Toby, and I hear you loud and clear, and we'll take it up with the court.

MR. JEFFERS: You have not gotten him to answer yet.

Q. Doctor, will you answer the question?

A. I have been instructed by counsel not to.

Q. You know he is not your lawyer.

A. I understand.

Q. You realize that we are going to come back if the court orders that?

A. I will do whatever the court tells me to do.

Q. Doctor, in your practice, if you have a patient that has shortness of breath, that has rapid heart rate, that has rapid respirations, that is complaining of chest tightness on ambulation, that has EKG findings showing right axis deviation and sinus tachycardia, and has blood gases with a PO2 of 59 and a PCO_2 of 29, are those blood gas findings and the clinical presentation consistent with a patient that has a pulmonary embolism?

MR. HIRSHMAN: Is that a different

question than the one you just asked?

MR. MISHKIND: It certainly is.

THE WITNESS: Yes.

MR. HIRSHMAN: I don't think it is.

MR. MISHKIND: It most certainly is. I am asking a medical question, hypothetical, based upon -- I'm not asking him in his clinical -- look, this man is a doctor, and if he can't tell me whether or not those clinical symptoms are consistent with a PE then I would submit that he is not qualified to answer any of the questions in this case.

MR. HIRSHMAN: Answer the question for me, Howie, where do you get the particular hypotheticals?

MR. MISHKIND: Toby, come on. Stop it.

MR. HIRSHMAN: Where did you get the hypothetical facts that you just put to the doctor?

MR. MISHKIND: I'm entitled to ask him in his clinical setting, in his clinical practice, if he is presented with those symptoms.

MR. HIRSHMAN: Did you or did you not get those clinical facts from the Emergency Room record of May 25th, 1991?

MR. MISHKIND: In a moment we will wind up suspending the deposition and Judge McGough will have to --

MR. HIRSHMAN: You do what you want.

MR. MISHKIND: I think you are absolutely out of line, and you know darn well I am entitled to ask him a hypothetical.

I'm not going to ask him opinion questions relative to whether the Emergency Room doctors did or did not do what they should have done, because you have already instructed him not to answer those questions.

I'm asking him in a clinical setting, I want to understand this doctor's understanding and knowledge of a PE and if he has a patient with those symptoms, notwithstanding the fact that they have happened to me or what Telley Manko had, and I will agree with you, I want to know whether or not this doctor would raise an

index of suspicion in his mind of, that the patient has a PE. It's a simple question, I'm entitled to an answer.

Q. Doctor, please answer the question.

MR. HIRSHMAN: Tell you what. You can answer that question, but I'll take it question by question.

A. I would have an index of suspicion. There could be alternative explanations. It could not necessarily be a pulmonary embolism, but it is certainly one of the conditions to consider.

Q. And if you raised the question of a pulmonary embolism in your mind with this particular patient, would you agree that a pulmonary embolism is a potentially life threatening condition?

A. Of course.

Q. And a pulmonary embolism, if there is a suspicion of that and other things, needs to be evaluated?

A. Yes.

Q. I take it, doctor, as you sit here right now, even though you may or may not have opinions about what the Emergency Room doctor on May 25th should have done, you are not intending to come

into the courtroom when this case goes to trial and indicate that you believe that this Emergency Room doctor complied with accepted standards of practice in terms of what he did, are you?

A. I was not intending to make any opinions about the management on May 25th at all.

Q. And I presume that that is because you have not been asked to address issues on behalf of the Emergency Room doctors, is that correct?

A. Correct.

Q. So you are also then not going to be offering opinion questions with regard to the management by the Emergency Room doctor on May 26 either, is that also correct?

A. That's correct.

Q. In a patient where you have the blood gases that we have described in terms of the PO2 of 59, and the PCO_2 of 29, EKG findings that we have discussed, the sinus tachycardia, the shortness of breath, normal portable chest film, are you from your training and experience qualified to provide the pulmonary consult that's necessary to rule out or confirm a PE, or would you refer the patient to a pulmonary specialist?

A. That depends on the circumstances. We certainly do not need a pulmonary specialist to order a VQ lung scan to consider the possibility of pulmonary embolism.

There are many circumstances of confusing pictures of unexplained shortness of breath where a pulmonary specialist is very helpful, and that might be one of the tests, among others, that would be ordered or recommended by the pulmonary specialist, but no, we can order the appropriate studies for PE ourselves.

Q. And you are familiar with VQ scans and other diagnostic studies that can rule out or confirm the existence of PE?

A. I am.

Q. And you do that in your clinical practice?

A. Yes, both as outpatient and inpatient care.

Q. With the type of blood gases that we have talked about in the clinical picture, if that was your patient, would you have ordered a stat VQ scan?

MR. JEFFERS: Could I have the question read, please?

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(Thereupon, the requested portion of the record was read by the Notary.)

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MR. JEFFERS: What date?

THE WITNESS: What date?

Q. And the shortness of breath, the sinus tachycardia. On May 25th.

A. If as a theoretical I had seen a patient with these findings --

Q. Yes.

A. Yes, I would have.

Q. And if the VQ scan had confirmed the existence of pulmonary embolism, would the standard of care then have been to start the patient on Heparin?

A. Yes, the standard of care would have been to admit the patient to the hospital and start the patient on Heparin.

Q. What is your opinion as to starting a patient prophylactically on Heparin pending the results of the VQ scan?

A. That again gets to your index of suspicion. If you truly think the patient has had a pulmonary embolism, you are not just checking one of many possibilities and we might not be able to get the scan for some delay of time, you might want to start the Heparin immediately.

Q. Now, is a blood gas of PO2 of 52 and a PCO_2 of 22, is that a worse status in terms of the patient's oxygenation or is that an improving -- is that less of a degree of hypoxia, or more of a degree of hypoxia?

MR. JEFFERS: Did you say PCO_2 --

MR. MISHKIND: PCO_2 of 22, and PO2 of 52.

MR. HIRSHMAN: As compared to --

MR. MISHKIND: As compared to the PO2 of 59 and the PCO_2 of 29.

Q. Is that more or less hypoxic?

A. It would indicate that the patient is more hypoxic, in other words, the patient is in worse condition as the PO2 drops to 52.

Q. Now, we talked about the issue of communication between Dr. Starr and Dr. McGowan, and Mr. Jeffers asked you about whether you can or cannot draw any conclusions based upon what Dr. McGowan said in his testimony and what Mr. Jeffers tells you Dr. Starr said in his testimony. You recall that, don't you?

A. Yes.

Q. If in fact Dr. Starr did tell Dr. McGowan that he had a patient in the Emergency Room who had

thrown up four times, who had expectorated white mucus, who had sharp anterior chest pain, who was short of breath, tachycardic, respirations of 28, sinus tachycardia on the EKG, and the blood gases which were taken in the second Emergency Room were reported and communicated to this Emergency Room doctor to be a PO_2 of 52 and a PCO_2 of 22, and if that information was conveyed to Dr. McGowan even before he arrived at the hospital, would you agree that Dr. McGowan had an obligation to, number one, to raise an index of suspicion of a pulmonary embolism?

A. Yes.

Q. And if that information had been conveyed to him, do you agree that when Dr. McGowan got to the hospital, that rather than indicating repeat blood gases in the morning and pulmonary function studies in the morning, that what he should have done that evening were studies directed toward ruling out or confirming a PE, such as the VQ scan?

A. I agree.

Q. And if that information was conveyed by Dr. Starr to Dr. McGowan, and he failed to raise

an index of suspicion of a PE and he failed to do the type of studies that are available to confirm the existence of a PE, Dr. McGowan's care fell below accepted standards of care in Ohio and the United States of America, correct?

MR. HIRSHMAN: Objection.

A. Under those circumstances, I would agree.

MR. HIRSHMAN: We are dealing with Ohio here. The United States of America has nothing to do --

MR. MISHKIND: I know that. Ohio is part of the United States of America.

MR. HIRSHMAN: I gather that. We are dealing with acceptable standards of care in the State of Ohio.

Q. I understand that, and you would agree that that would not be within accepted standards of practice in the State of Ohio if Dr. McGowan, having been given that information, failed to raise the index of suspicion and then further to do appropriate studies to determine whether he had a PE?

A. I agree with that, and that in fact is based on the fact that my understanding of the records that I have reviewed indicate that Dr. McGowan

did not have those blood gas results is the reason why I do not feel that he is in fact responsible for falling below any acceptable standard of care, because the other findings that you listed and the exam findings that Dr. McGowan found on his own examination on May 26 in themselves would not lead to that same indiction of suspicion, it truly is the blood gas result that would raise the index of suspicion and lead a doctor to be able to make this diagnosis in time.

Q. So that the rock solid evidence that you would rely on to criticize Dr. McGowan would be if in fact Dr. McGowan had that information on the blood gases, and all of the other clinical information which we know you to describe to be sort of nonspecific, had he had that information on the blood gases, there would be no question in your mind and you would look over to the jury at the time of trial and indicate that Dr. McGowan fell below accepted standards if in fact he had that information on the blood gases. Correct?

A. I would agree.

Q. Now, being a physician in this state that has

admitted patients to a hospital from an Emergency Room, is it customary for the Emergency Room record to go with the patient when they are admitted to a medical floor?

A. In my own experience, yes.

Q. Do you know of any experiences where that's not standard practice, to send at least the cover page that has the complaints, the history and the treatment from the ER?

A. There are obviously hundreds of hospitals in the state where I have no knowledge of their working procedures.

I can only tell you that from the hospitals that I have worked in, one would expect that the Emergency Room records would come up to the floor with the patient.

Q. And would you agree that Dr. McGowan -- strike that. Is it your understanding from reviewing this case that Dr. McGowan had no knowledge of blood gases having been taken in the Emergency Room on May 26?

A. I only know for sure that he had not received the results, and it's not altogether clear from the records that I have reviewed that he even knew that they had been obtained. You know, he

makes a request for lab and for x-ray in the notes that I read.

Q. But you would agree that it's incumbent upon Dr. McGowan to look at the Emergency Room record that is on the floor when the patient is transported, and 1 want you to assume for this question that the Emergency Room record that has the patient's presenting symptoms and what was done on the 26th of May, that at least the page with the nurses' notes and the doctor's notes, that page is on the floor, on the medical floor when Telley Manko was admitted to his room.

A. I cannot tell you that.

Q. I want you to assume that to be the case, just for purposes of my question, okay?

A. As a theoretical, if it had gone up to the floor with the patient, and then Dr. McGowan came to examine the patient on the hospital ward, yes, I certainly would agree that it would be his responsibility to review the Emergency Room record.

Q. And then the question would be whether or not that Emergency Room record gave him any indication that blood gases had been drawn at all. Right?

A. Certainly.
Q. If it indicated that blood gases had been drawn, then would you agree that it was his obligation to determine what the results of those Emergency Room blood gases were?
A. I think that's where you get into the issue of a judgment by what you mean by his obligation. Certainly if the results are there, you would expect that he had a responsibility to look at that data and take it into his assessment and plan. If it was not on the floor, and often times, various pieces of that are not up on the floor, you have to use your own judgment as to whether or not it is something that can wait until morning or something that needs to be chased down in the evening, when everything is sort of shut down and inconvenient, and that's always a matter of judgment based on how acutely you think you need that information.
Q. What about a situation where Dr. McGowan knows that this patient had been admitted to the Emergency Room on the 25th, and now is returning on the 26th? Would you expect that the doctor would look at just the Emergency Room record of the 26th, and not the Emergency Room record of

the night before or would you expect that the Emergency Room -- I'm sorry -- that the admitting doctor would look at the Emergency Room record from the 26th and the 25th, or would you expect him just to look at the Emergency Room record of the 26th?

MR. HIRSHMAN: Let me make an objection before you answer, and that is that are you suggesting in your question that the Emergency Room record of the 25th was in the chart on the floor?

MR. MISHKIND: I'm not suggesting anything. I'm asking him.

MR. HIRSHMAN: Whether he should have run it down?

MR. MISHKIND: I didn't say run it down. I'm asking whether or not knowing that the patient had been in the 25th and had returned the 26th and was being admitted to the floor, the attending, do you feel that he had an obligation to determine what had been done for him not only in that Emergency Room visit of several hours before, but of the Emergency Room visit the night before.

A. Let me answer your question. Certainly if it was on the floor before him, he would have the same responsibility to review it as all the other materials that were there before him. Again, there would be a matter of judgment in terms of trying to obtain previous records that evening. The patient could have come from another hospital and the same issue would come up to his getting records from the other hospital. It depends on your own judgment that night on whether you need them that evening or whether you wait until it comes in normal channels in the morning, and you make that judgment based on how acutely you feel you need that information based on the patient's bedside presentation at that moment.

Q. Well, we know that Mr. Manko did not come from any other hospital so we can exclude every other hospital in the world other than Elyria Memorial Hospital, correct?

A. Yes. I'm just trying to state that this is a situation that comes up with some regularity.

Q. Now, if the doctor instructed the nurses to have available for him on the floor all of the results from the Emergency Room -- strike that.

If he had requested the nurse on the floor that Mr. Manko was being admitted to to have available for him on the floor all of the results of the tests that were run in that Emergency Room, and he got to the floor and he didn't have available the results from the arterial blood gases, first, would you agree that nurses have certain obligations to comply with orders given by physicians?

MR. JEFFERS: Is that rhetorical?

A. With appropriate orders, of course.

Q. And if you instruct a nurse "I am coming to the floor, my patient has been admitted, make arrangements to have the results from the tests that were performed in the Emergency Room available for me," would you agree that it is the responsibility of that nurse to get the information and have it available for you?

A. Not necessarily. I don't think the nurses at my own hospital would necessarily do that. They might consider that an inappropriate order if part of that is the responsibility as defined in the procedures of that particular hospital for a floor secretary or the lab itself or the Emergency Room to handle that kind of flow of

information. It may not be the nurse's job at all.

Q. Okay. Well, if it in fact is the hospital policy to have available all information, not only the Emergency Room record but all vital information from labs that were done in the Emergency Room available on the floor when the patient is admitted to the hospital, and that information is not available, would you agree that that is a failure on the part of the nurses to do that which they are required to do at the given hospital?

MR. JEFFERS: Objection, that is rhetorical, number one; but number two, what you are saying isn't necessarily the policy at this particular hospital.

MR. MISHKIND: Your objection is noted.

MR. JEFFERS: Okay. This is I'm sure hypothetical, I guess.

A. If what you are asking is if the procedure of the hospital is it is the nurse's responsibility to collect and prepare the materials, then logic would follow that then it would be the nurses' error if they were not provided to the

physician.

MR. JEFFERS: If it were available?

A. But I only know this based on how you are asking the question. I have no basis of knowledge of the actual procedures of this hospital and in the hospitals that I have worked at that has not been a nursing duty.

Q. If a test is done in an Emergency Room on an arterial blood gas, isn't that done on a stat basis?

MR. JEFFERS: What is done?

MR. MISHKIND: Arterial blood gas.

Q. Aren't they done on a stat basis?

A. In my own hospital all arterial blood gases are done as soon as possible, so in that sense, yes, it would be a stat test.

Q. And if the Emergency Room record indicates, and it is checked off on the sheet that shows arterial blood gases having been drawn, do you know of any reason that the results would not be available to the admitting physician the same day that that patient is admitted from the Emergency Room?

A. I don't know of any reasons why that would be so.

Q. Would you agree that if blood gases are drawn they should be available to the physician that is about to undertake to care for that physician that is being admitted to the hospital?
A. I agree.
Q. And if in fact, number one, that information had been conveyed that arterial blood gases were drawn and Dr. McGowan didn't know what the results were when he got to the floor, it was incumbent upon him to obtain that information to know exactly how hypoxic this patient was?
A. Again, that depends on how acutely ill the patient is, as Dr. McGowan is assessing the patient, if that information becomes critical any more than urinalysis or blood test or any other tests that may or may not be relevant to the immediate necessity to make a correct diagnosis. That has to be part of the bedside diagnosis, whether or not you would need that piece of data at that moment or whether or not people can hunt it down in the morning.
Q. So your testimony is that very possibly, the blood gases could have been overlooked until the following morning without jeopardizing the patient's well being?

MR. JEFFERS: Object.

MR. HIRSHMAN: Object to the term "overlooked." It seems to suggest an inadvertence. I don't think that is what he is saying.

A. I didn't say that.

Q. You can say whatever you want in terms of what it suggests. The statement is, doctor, you are saying that it is conceivable in this scenario that if the doctor saw the patient and felt that he was hemodynamically stable, that the results of the blood gases would not necessarily have been needed that evening, but it would be acceptable to wait until the following morning?

A. No, that's not what I am saying. I am stating that it could easily be true that the degree of hypoxemia would not be suspected at bedside, that only with the blood gas result before you you would say, my goodness, that is much worse than I would have guessed by looking at this gentleman, he is breathing somewhat rapidly, his lungs are clear, he is on oxygen and you have no reason to guess the oxygen levels would be that low.

If you had them in front of you you would

act, but if you don't have that level before you you would not even realize that it is such a critical piece of information.

Q. So that if we go back again to the Emergency Room setting, the Emergency Room doctor conveyed chat information to Dr. McGowan during their conversation on the phone as Dr. McGowan is on his way from another hospital to Elyria Memorial as to the blood gases, it would be inexcusable on the part of Dr. McGowan when he arrived at the hospital not to act on those blood gases, would you agree?

A. I don't know if I would use the word "inexcusable."

Q. It would be substandard care not to act upon the blood gas?

A. I agree.

Q. Would you also agree that it would be substandard for anyone not to communicate to an attending those blood gases if the information was known to them?

A. I would agree.

Q. From your review of this case, doctor, is there any evidence that the blood gases drawn in the Emergency Room on May 26, 1991, were reported to

anyone on that day?

A. I don't find any evidence that it was reported to anyone on the 26th.

Q. Would you agree that the standard of practice that you are familiar with in hospitals, where a patient is admitted through an Emergency Room, is that there should be a recording of not only when the blood gases are drawn, but who they are reported to, when they are reported out, so that there is a record of the drawing and the reporting of the results?

MR. HIRSHMAN: Are you asking him a question regarding the standard of care for Emergency Room physicians?

MR. MISHKIND: I'm talking about the hospital. In the hospital setting if there is an arterial blood gas drawn, should there be a record as to not only when it was drawn, but when it was reported and to whom it was reported, so that the record shows that that information was acted upon.

MR. JEFFERS: Objection, does this include reporting directly to the Emergency Room because you are talking about the 26th

and --

MR. MISHKIND: I'm talking about documentation of the results being reported and recorded somewhere in the hospital record.

A. I have seen in hospitals in which I have worked where the time of the drawing of the arterial blood gases is documented, the time that it is received by the lab is reported and often the time that it is reported to the floor, but I have not necessarily seen it documented, you know, each person, the exact time they got the news and then acted upon it, so I'm sure there is some variability at some point after the information is recorded.

Q. But certainly in your experience, you have seen at least documentation as to the drawing of the blood gases and documentation as to the reporting out of the results, not necessarily to whom it was reported, but that there was a reporting out from the lab to someone of the results?

A. Not necessarily. I have seen the lab printouts say the exact time that the result was made, and then I have seen some variability as far as, you

know, what happens with the flow of information. I don't know if that's set in stone. I think every hospital probably does it its own way.

Q. Do you know what time the lab arterial blood gases on May 26, 1991, were available, having obviously been drawn and having been tested?

A. Which date, now?

Q. 5/26.

A. 5/26?

Q. Yes.

A. It states that it was performed at 1726 hours. That's documented. Beyond that --

Q. That's 5:26 p.m.?

A. Correct.

Q. And that certainly would correlate with the time when the patient was still in the Emergency Room, would you agree with that?

A. Yes, I would.

Q. And if this was a lab finding or lab test that had been ordered by the Emergency Room, would you expect that the results from the lab would be reported to someone in the Emergency Room?

A. I would expect that.

Q. Is there any evidence that that took place in

this case?
A. I did not find any evidence.
MR. JEFFERS: You mean in the record?
A. In the records that I reviewed I did not find any evidence that that took place.
Q. You found no evidence that someone in the lab reported it to the Emergency Room, or that someone in the Emergency Room actually received it, correct?
A. Correct.
Q. Now, from your review of the records, doctor, tell me what time it was that Dr. McGowan saw Mr. Manko for the first time on May 27.
A. On May 27 now?
Q. May 27, right.
MR. JEFFERS: From the record?
MR. MISHKIND: Yes.
A. The progress note of Dr. McGowan on the 27th doesn't give a time. I believe from his deposition he stated he was there about 10:00 in the morning.
Q. And is it your understanding that whether it is 10:00 a.m., as Dr. McGowan claims in his testimony, or some other time, that when he came

to the hospital he had now available to him, perhaps for the first time, perhaps not, the blood gases from May 27 as well as the blood gases from May 26?

MR. HIRSHMAN: So the question is whether he had available to him at 10:00 the blood gases from the 27th and the 26th?

MR. MISHKIND: Or whatever time it was that he first saw the patient.

A. I would certainly agree based on his note of May 27, his first statement is ABGs still abnormal, so presumably he is basing that statement on having the results before him on that date.

Q. Now, do you know the mechanism by which he learned of the abnormal blood gases from May 26 when he arrived at the hospital on May 27?

MR. JEFFERS: Read that one again, please.

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(Thereupon, the requested portion of the record was read by the Notary.)

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A. I don't know the entire mechanism. There is a notation in the nursing care record of May 27 at

1:45 p.m. that says Dr. McGowan here, ABGs received.

Q. And that 1:45 p.m., that's inconsistent with what you read Dr. McGowan to have opined as the time that he saw the blood gases, correct?

MR. JEFFERS: I object because you are taking something out of context. You already know what the testimony has been on this particular subject --

MR. MISHKIND: John, is that an objection or one of your normal speeches?

MR. JEFFERS: You are misleading him.

MR. HIRSHMAN: Don't testify. Make the objection.

MR. JEFFERS: I make the objection.

MR. MISHKIND: Don't say I am misleading. I resent that.

MR. JEFFERS: You know the testimony has already been that was a takeoff time, I believe.

MR. MISHKIND: No one said that was a takeoff time. Now you are misleading people. Keep the record accurate.

Q. Doctor, I'm not going to -- let's move on.

Would you agree, put it simple, that once having obtained the blood gases, that delaying either ordering on one's own, or requesting an immediate consultation by a pulmonary physician, delaying of any time once having the 5/26 and the 5/27 blood gases would not be within accepted standards of practice?

A. I'm not sure I understand the question. Would you just rephrase it so I can answer it.

Q. If you assume for my question that May 27, 1991, at some time in the daylight hours, when Dr. McGowan arrived at the hospital, that he for the first time saw the May 26, 1991 blood gases and the blood gases drawn early a.m. on May 27, 1991, and had that information and obviously whatever clinical information was available concerning the patient's status during the early morning of May 27, would you agree that the patient at that point required immediate investigation by way of either pulmonary consultation or diagnostic studies being ordered by that physician?

A. Of course, and in fact that's my understanding of what Dr. McGowan did when he got that information. I would state that this 1:45 p.m.

time does not necessarily mean that that's the first time that Dr. McGowan saw the previous results. It simply states ABGs received. I don't think we can state that to mean that the previous blood gases of the previous days could not have been seen by Dr. McGowan earlier that day.

Q. Is there anything in the hospital record, doctor, that you have come across that would show that Dr. McGowan was at the hospital, seeing Telley Manko, any earlier than 1:00 p.m. or thereabouts and saw those blood gases for the first time at 1:00 or 1:45?

MR. HIRSHMAN: Before you answer the question, let me have it read back.

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(Thereupon, the requested portion of the record was read by the Notary.)

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A. I have not seen any records in the chart that show an earlier time, but again, his deposition testimony is that he was at the hospital in the morning.

Q. Okay, and you are, for purposes of the opinions that you hold in this case, you are accepting

the testimony of Dr. McGowan as being reliable, and are basing it on that he saw the blood gases in the morning as opposed to 1:00 or 1:15 p.m. for the first time.

A. Yes, I am basing it on his sworn testimony.

Q. Okay. Would you agree that a patient of Mr. Manko's condition, after having been seen in two emergency rooms and then having been admitted to the hospital, needed to be seen by the attending sometime the morning of May 27 as opposed to for the first time on that day at 1:15 or 1:30 in the afternoon?

A. That depends totally on the clinical situation. It was appropriate that Dr. McGowan had come in on the evening of admission, which he did, and then the hospital rules would normally be that the patient needs to be seen the next day, and then your judgment as to again what time that has to be is based on your own availability to come in and how sick the patient is.

Q. Hemodynamically, when we talk about the blood pressure and the heart rate, was the patient stable enough during the morning at 10:00 such that he didn't need to be seen by Dr. McGowan?

A. Well, he certainly did need to be seen by

Dr. McGowan, and my understanding is that he was seen by Dr. McGowan.

Q. And is it your understanding at 10:00, then, that's when Dr. McGowan requested that there be a pulmonary consultation?

A. According to, again, Dr. McGowan's testimony at deposition, he states that he made the telephone consultation in the morning, although he wrote the order for it in the chart in the afternoon.

Q. You would agree, would you not, in fact you would agree with Dr. McGowan's own admission that it would be unacceptable to wait three hours after seeing the blood gases to request a pulmonary consultation on this patient?

A. Based on the clinical condition of the patient on that day, I would consider three hours an unnecessary delay.

Q. Substandard delay, below the accepted standard of practice?

A. Again, that's a matter of judgment. I don't think I would use the word substandard. I would not understand why you would delay, since obviously time would be of the essence.

Q. So you disagree with Dr. McGowan, then, is that what you are saying?

A. No, I don't disagree with Dr. McGowan. I am making my own opinion as to what you have given me as a theoretical.

Q. And what I am telling you is that Dr. McGowan has admitted that it would not be in keeping with accepted standards to wait three hours to request a pulmonary consult if at 10:00 a.m. on May 27 he had the results of the arterial blood gases, and my question to you is do you agree with Dr. McGowan's statement.

A. I would disagree with Dr. McGowan being asked to be an expert on medical standards in his own case.

Q. I don't want you to judge the legal significance or whether or not he can do that.

Do you agree or disagree with Dr. McGowan's statement that it would not be in keeping with accepted standards to wait three hours if at 10:00 a.m. he had the results of the arterial blood gases?

A. I will give the same answer **I** did before. I really have no comment on Dr. McGowan's opinion about that, since I do not consider him to be an expert on standards of care. I truly believe that it would be wrong to have any delay in the

attaining of appropriate care for this patient.
Q. Doctor, would you agree that mortality from pulmonary embolism is decreased the earlier the diagnosis is made?
A. Yes.
Q. Would you agree that mortality from pulmonary embolism is decreased the earlier treatment is started?
A. Yes.
Q. And we have already talked about in your opinion that Heparin is the standard of care in terms of anti-coagulating a patient with a diagnosis of pulmonary embolism?
A. I agree.
Q. And in a patient with a high level of suspicion of pulmonary embolism, starting the patient on Heparin even before the diagnostic studies have come back also is an accepted practice?
A. Correct.
Q. And we know that in the face of ABGs that indicated significant hypoxia, clinical findings, from the Emergency Room of the 26th, clinical findings on the 27th, we know throughout the entire treatment that Heparin was never started on this patient, correct?

A. Let me just check something.
Q. Okay.
A. Correct.
Q. With the blood gases of the 26th in hand, in conjunction with the blood gases from the 27th in hand, so both now available to you, what would you have ordered by way of treatment?
A. As a theoretical, if I had this patient and I had the blood gas results in my hands --
Q. Yes.
A. I would order a stat VQ lung scan to see if I could detect the presence of pulmonary embolism.
Q. Would you have initiated any treatment at that point?
A. It depends on how acutely ill the patient was. If, for example, you are talking about the time, maybe the evening of admission on the 26th, early in the morning on the 27th, when the patient looked quite good, I probably would not have started Heparin before I got documentation of the presence of pulmonary embolization, but if I got this information just as the patient was starting to deteriorate acutely, I might just start the Heparin.
Q. Now, the deterioration, the acute deterioration,

I want to be clear on that, I showed you that focus reference before in terms of the nurses' note that showed the focus in terms of change in condition and the patient hyperventilating --

A. Yes.

Q. And I think it was at 2:00 o'clock. Is that when you would have started the patient on Heparin, even pending the outcome of the VQ scan?

MR. JEFFERS: What time?

A. I think it was 2:00 o'clock or 2:15, as I recall. I would have done it sooner. I would have done it when the blood pressure started to fall earlier, because that would have been a sign to me of hemodynamic deterioration, and a serious change for the worse.

Q. But certainly he was not in shock at that point, was he?

A. He was going into shock, and if you are going to correct shock, you have to intercept it early. Once a patient is in advanced shock you are too late.

Q. But he was not in shock, though?

A. When you drop from 144 systolic to 110 you are going into shock. That's a very abrupt drop.

Q. So it's your testimony that the drop from 6:00 o'clock and then what is recorded at 10:00 is evidence that the patient is in shock?
A. Going into shock.
Q. That is different than being in shock?
A. It is all a matter of gradations, as I'm sure you would agree. But I'm stating that for us to be successful in the management of patients who are going into shock, we have to get them as they are crashing, not after they already hit bottom.
Q. The fact is, he had no treatment for his hypoxia between 10:00 a.m. and when he started to hyperventilate at 2:15, 2:20, correct?
A. If you mean no treatment in terms of the fact that the patient was not receiving Heparin over that time, I would agree with you.
Q. Are you familiar with any of the studies in the medical literature that talk about the likelihood of patients surviving a PE when they are fortunate enough to arrive at a hospital prior to going into hemodynamic shock?
A. Yes.
Q. And what is your understanding as to the likelihood of surviving, given a proper

diagnosis of the PE and initiation of anti-coagulation therapy prior to hemo -- going into hemodynamic shock?

A. Of course, this depends to a certain extent on how massive the pulmonary embolization would be, but in general for all pulmonary emboli, the current survivability is considered about ninety percent.

Q. And we talked about the recurrence of pulmonary embolism in properly treated patients; you are not familiar with the statistics but you would not quarrel with 15, 20 percent?

A. I would not quarrel with that.

MR. HIRSHMAN: He didn't quarrel with it last time you asked, either.

MR. MISHKIND: I know that, and I'm sure he won't quarrel if I happen to ask him again.

Q. Are you familiar with the body's fibromyelinic system, the ability of the body to dissolve clots?

A. Yes.

Q. The body has, is it an enzyme, urokinase?

A. There are long cascades of chemicals involved. I always have to pull the book out with the

chart because it is very complicated, and frequently updated.

Q. Is the body's availability of urokinase one of the mechanisms by which patients dissolve clots that are formed from a pulmonary embolism?

A. I would have to look in a source book for that answer.

Q. At this point, you're not able without making some reference to the medical literature to tell me how that mechanism goes about?

A. That's correct.

Q. And I presume you are also then not in a position to tell me to what extent the body's urokinase mechanism or the thrombolytic system can lyse significant clot formation over a period of time?

A. I would have to look that up for you.

Q. Do you know what percentage of patients that die of massive pulmonary embolism have cardiomegaly?

A. No, I do not.

Q. Do you know what percentage of the cardiomegaly that Mr. Manko had on autopsy was caused by the massive pulmonary embolism?

A. As I have stated, I believe that the left-sided

enlargement was 100 percent not related to the pulmonary embolism.

Q. Can you, putting aside the left-sided heart failure, which we talked about, can you tell me to what extent the remainder of the cardiomegaly was due to massive pulmonary embolism?

A. I can't give you a percentage.

Q. You have no opinion, then?

A. I have no opinion.

Q. In your report, doctor, in the last page, you indicate in the second full paragraph that when the arterial blood gases were given to Dr. McGowan on May 27, and parenthetically, that implies that he didn't have any blood gas results prior to May 27 --

A. Yes.

Q. -- he then, continuing on with your statement, he appropriately requested consultation by pulmonary and cardiology specialists, we can agree, can we not, that if he did not request a stat pulmonary or cardiac consultation, once having received the arterial blood gases, that that would not be in keeping with accepted standards of practice?

A. I would agree.

Q. If appropriate pulmonary consultation had been requested on a stat basis at or about 10:00 a.m., what is your opinion as to the probability of the patient surviving?
A. I still think that Mr. Manko probably would have died.
Q. And can you give me what percentage likelihood there is that he would have died at 10:00?
A. Well, not at 10:00, but as I have already testified, I think that the processes of cardiovascular collapse and massive bilateral embolization had already occurred and it had already become irreversible.
Q. You are saying that it is a virtual certainty at 10:00 a.m., but are you saying it is more likely than not that even with appropriate treatment --
A. Definitely more likely than not.
Q. Can you tell me what the likelihood is percentage-wise that he would have died even with appropriate consultation even at or about 10:00 a.m.?
A. I cannot give you exact percentage, but I can state that it is a medical probability that he would have died.
Q. You cannot be any more specific. Obviously you

know since you testified medical probability is more than 50 percent --
A. Right.
Q. That's the best you can do?
A. Yes, and that's what I am asked to do in this circumstance.
Q. But you are not giving me a ninety percent or ninety-five percent likelihood, or eighty percent likelihood, are you?
A. No.
Q. But the best you can say in your opinion is more than likely?
A. Correct.
Q. Which is --
MR. HIRSHMAN: Which is what the legal standard is.
Q. Which is slightly above 50 percent?
A. Anywhere from 50 to a hundred.
Q. Are you telling me that -- what is your opinion?
A. I think he would have died.
Q. What about at 6:00 o'clock a.m., if appropriate treatment had been commenced?
A. I think he probably would have lived.
MR. HIRSHMAN: At 6:00 o'clock a.m.?

THE WITNESS: Yes.
Q. And at 8:00 a.m., absent evidence of change in his hemodynamic status, is your opinion the same?
A. That he probably would have lived at that point?
Q. Yes.
A. Yes.
Q. At 9:00 a.m., absent evidence of change in his hemodynamic status?
A. Yes.
Q. And we don't have any evidence of change in his hemodynamic status at 9:00 o'clock a.m., do we?
A. We have already discussed that, correct.
Q. But that's -- my question is accurate, correct?
A. Yes.
MR. HIRSHMAN: It's you who has the burden of proof, though.
MR. MISHKIND: Excuse me?
MR. HIRSHMAN: It's you who has the burden of proof.
MR. MISHKIND: That's precisely why I am asking these questions, Mr. Hirshman. I appreciate you reminding me of that.
Q. Have you reviewed Dr. McGowan's pulmonary

consult request?
A. I saw the order written in the chart.
Q. Was it requested stat?
MR. JEFFERS: Why don't we just stipulate it was.
A. It does not state stat.
Q. In fact it says within 24 hours, correct?
A. There is a separate sheet, doctor.
MR. HIRSHMAN: It is under consultation.
THE WITNESS: He has it ticked off as within 24 hours.
Q. Can we agree that that is not in keeping with accepted standards of practice, given the information on the 27th that the doctor had at this time of the arterial blood gases to request the pulmonary consultation take place within --
A. I believe, doctor --
Q. Let me finish. Within 24 hours, based upon the hospital record?
A. Based upon that tick, I would agree with you, although I believe Dr. McGowan in his deposition stated he in fact called the pulmonary consultant to get him to come over.
Q. And other than what Dr. McGowan said in his

testimony, is there any evidence whatsoever that permits you to indicate that Dr. McGowan's statement is accurate? I mean, is there anything in the record that would suggest that he did request pulmonary, or did talk to Dr. McGowan, Dr. Dacha, the pulmonary specialist, earlier than -- strike that. Is there any indication in the record that Dr. McGowan spoke to Dr. Dacha before writing this consultation that is signed 1:15 a.m. on May 27, 1991?

MR. HIRSHMAN: In the medical record?

MR. MISHKIND: In the medical record.

A. I have not seen any other documentation in the record. My opinion is really based on what Dr. McGowan said in his deposition.

Q. Would you agree that at the time that we get to 1:15 or 1:30 p.m., that the impression that a physician should have had of Mr. Manko's condition should have included a suspicion of pulmonary embolism?

A. Yes.

Q. Doctor, do you hold any additional opinions

beyond those which we have discussed during this deposition and beyond those which are expressed in your report?

A. If anyone asks me some specific questions on other issues, I would answer, but these are the opinions that I am intending to present in testimony.

Q. What we have talked about during this deposition --

A. Yes.

Q. -- and what you have expressed in the report?

A. That would be my intention and my understanding.

MR. MISHKIND: Give me a second, doctor. I think I may be done.

MR. MISHKIND: Doctor, thank you for your time.

MR. JEFFERS: I have a fast question.

- - - -

EXAMINATION OF HADLEY MORGANSTERN-CLARREN, M.D.

BY MR. JEFFERS:

Q. Do you have any other criticisms relative to the nurses or hospitals other than what you have discussed today?

A. I do not.
Q. Next question, let's say that hypothetically, on or about May 15th, **1991**, a 400 to 500 pound object struck the leg of Mr. Manko.

Assuming that to be true, would that be information that would have been important to be given to the Emergency Room physicians on May 25th or May 26 or to the attending physician, Dr. McGowan?
A. Yes.
Q. And why is that?
A. Because the history of trauma raises the additional possibility of internal injury, and whether that would be internal bleeding, fracture, thrombosis, it would all have some possibility of leading subsequently to shortness of breath.
Q. Now, if that information had been given by Mr. Manko or by a member of his family or anybody else with him to Dr. McGowan, for example, with the information that Dr. McGowan had on May 26 and/or May 27, up to 10:00 a.m., would that have raised the suspicion relative to a PE?

MR. MISHKIND: I object, because in

the question you are implying that there wasn't enough information already without that to raise it, which he has already testified to.

Q. The information that was available to Dr. McGowan. Let's tack on a 400 or 500 pound object striking Mr. McGowan's leg, which he tells no one of. Mr. Manko, if that information had been given to Dr. McGowan, would that information have raised a suspicion in his mind to test for a PE?

MR. MISHKIND: Objection.

A. It should have, yes.

Q. Or should it have?

A. It should have, yes.

Q. Have you testified -- nave you reviewed any more than one file for my law firm?

A. I believe I have.

Q. Two?

A. Maybe two.

Q. About two? How about for Mr. Weisman's law firm, or for anybody else over at Mr. Weisman's law firm?

A. I don't believe I have ever been asked to review a case for Mr. Mishkind's firm.

Q. Did you receive any letters from Mr. Hirshman or from anybody else at Mr. Hirshman's office?
A. There was a brief cover letter.
Q. Said enclosed please find --
A. Right, a list of the materials, and I did not keep it and I did not use it as the basis of any opinions.
Q. Any other information that you received from Mr. Hirshman?
A. No.

MR. JEFFERS: Thank you.

- - - -

EXAMINATION OF HADLEY MORGANSTERN-CLARREN, M.D.

BY MR. MISHKIND:

Q. Doctor, I just have one or two questions, I'm not going to say one because I don't want to be called a liar.

We have already talked about the information that you as a clinician would have felt sufficient enough to raise an index of suspicion of a PE, and you just had the variable of an injury with a 400 pound bar striking the patient.

The fact remains that even with that removed, with the blood gases that we know to

have existed on May 25th and then May 26th and the clinical history with the shortness of breath, the chest pain, the sinus tachycardia, the right axis deviation, all of those were sufficient in and of themselves to raise an index of suspicion of PE, correct?

A. I have already stated that, yes.

Q. And all of those were sufficient regardless of an additional history of a leg injury to cause there to be a need for diagnostic studies to rule out or confirm a pulmonary embolism, correct?

A. Certainly. The issue as it was just raised to me is that it would give an additional index of suspicion.

Q. But that would not excuse someone if they were not aware of that from raising an index of suspicion with regard to the available information on blood gases, clinical presentation, EKG findings, correct?

A. I agree.

MR. MISHKIND: No further questions.

- - - -

EXAMINATION OF HADLEY MORGANSTERN-CLARREN, M.D.

BY MR. JEFFERS:

Q. Notwithstanding what was done or what was not done in this particular case, if Mr. Manko or a representative of Mr. Manko had advised any physician of this, or any nurse of this 400 or 500 pound object striking his leg, that should have changed the course of his treatment, correct?

MR. MISHKIND: Objection.

A. I would agree with that.

MR. JEFFERS: Thank you.

MR. HIRSHMAN: Howard, I just wrote you a letter.

MR. JEFFERS: Do you want to waive signature? Say no.

THE WITNESS: If you want me to read it, I will be happy to.

MR. HIRSHMAN: A up to you.

THE WITNESS: I don't think we used a lot of complicated technical language.

MR. HIRSHMAN: I would say it is your decision but I have no reason to request that you read it.

(Signature waived.)

C E R T I F I C A T E

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

I, Judith A. Gage, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named HADLEY MORGANSTERN-CLARREN was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and the reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 18th day of December A.D. 19 93.

Judith Gage

Judith A. Gage, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires March 24, 1995

WITNESS INDEX

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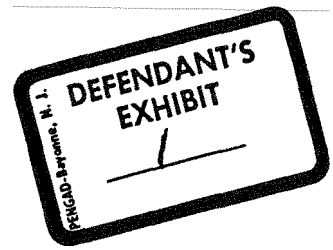
EXHIBIT INDEX

EXHIBIT	MARKED
Defendant's Exhibit 1, Two-page report of H. Bonnell dated 8/12/93	8
Defendant's Exhibit 2, Four-page report of G. Mangan dated 7/9/93	10

HARRY J. BONNELL, M.D.
Chief Deputy Medical Examiner
5555 Overland Avenue, Building 14
San Diego, California 92123



12 August 1993

William D. Bonezzi, Esquire
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114-1192

RE: Manko v. Acute Care et al.

Dear Mr. Bonezzi:

You have asked for my opinion regarding the longevity of Telly J. Manko, Jr. had he not succumbed when he did. My opinion is rendered after reviewing the Emergency Room Record of 5/25/91 and the admission records of Elyria Memorial Hospital and Medical Center for 5/26 - 5/27/91, as well as the 33 glass slides prepared as part of the autopsy, and the autopsy report itself.

Mr. Manko was terribly obese and carried the diagnosis of morbid obesity, morbid meaning diseased, His obesity was so severe as to be pathological. His heart was more than 60% larger than normal and because of the increased workload as manifested by the enlargement, had actually begun to fail. There was so much passive congestion, or back-pressure, from the failing heart that his liver is enlarged to more than twice normal size and his spleen is enlarged to nearly six times normal size. In addition, baok pressure into hie lungs has resulted in the destruction of red blood cells which have been forced out of the blood vessels and into the air spaces of the lung. They have then been phagocytized by macrophages, ie. eaten by cells whose purpose is to get rid of dead material in the body.

In addition, his liver shows severe fatty degeneration as well as focal areas of hepatitis where the liver cells are dying. There is change in the central veins of the liver reacting to the back pressure from the heart. The pancreas also shows evidence of scarring as a result of damage to it and the number of Islets of Langerhans are decreased suggesting a pre-diabetic condition.

Last, but certainly not least, there were severe respiratory problems. As you know, obese people have great difficulty breathing deeply enough to get enough oxygen into their lungs, especially when seated or laying down. The massive fat deposits push up the diaphragms between the belly and the chest so that the lungs cannot fully expand, This is manifested by the elevated hematocrit and hemeglobin as the body responds to a low level of

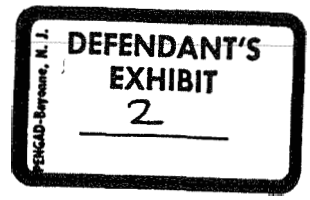
oxygen and tries to compensate by making more red blood cells tc carry more oxygen.

In short, in my opinion, Telly Manko had less than 10 years of life left to live and approximately half of that would have been as a respiratory or obesity-caused cripple. These types of patients typically come into a medical examiner/coroner office because they no longer have a regular doctor to sign a death certificate or because they are suddenly found dead and other causes such as drugs, etc. need to be ruled out. In my experience, these massively obese individuals rarely survive *to see* their 40's and personally, none of *my* cases lived that long. The damage Lo his heart has already been done and is not reversible. Lastly, it was his obesity that pre-disposed him to forming blood clots in hi8 legs and even had he survived this episode, his risk would be as high as it could possibly be to to have repeated episode8 *of* blood clots forming and then passing into his lungs.

Please feel free to contact me if you have any questions.

Sincerely,

Harry J. Bonnell, M.D.



Gail R. Mangan, R.N., B.S.N.
4300 Weymouth Road
Medina, Ohio 44256

July 9, 1993

Mr. John Jeffers, Attorney at Law
Weston Hurd Fallon Paisley & Howley
Counsellors at Law
2500 Terminal Tower
Cleveland, Ohio 44113-4952

RE: Deanna Manko, etc.
vs. Elyria Memorial
Hospital Medical
Center, et al.

Dear Mr. Jeffers,

I have reviewed the emergency room records from Elyria Memorial Hospital from 5/25/91, the hospital records from Elyria Memorial Hospital from 5/26/91 to 5/27/91, copies Of the Hospital's policies relating to arterial blood gasses, medical responsibility for treatment, standing orders and patient admission, as well as the deposition transcripts for Marjorie A. Vargo and Janet Toth.

It is my understanding that on May 25, 1991 at approximately 8:30 p.m. Mr. Telly J. Manko, Jr. presented to Elyria Memorial Hospital's Emergency Department with complaints of chest tightness, shortness of breath upon ambulation and blood in his urine. Mr. Manko's vital signs were as follows: Blood Pressure 146/84, Temperature 37.4 degrees celsius, Pulse 137 and Respirations 26. Mr. Manko received a portable chest xray, an EKG, blood chemistries, an arterial blood gas and a breathing treatment and was discharged to home with a prescription for ventolin inhaler every six hours, activity restrictions and a follow up appointment with his physician on the following Tuesday.

July 9, 1993

Mr. John Jeffers
RE: Manko

On May 26, 1991 Mr. Manko returned to the Emergency Room at 4:30 p.m. for complaints of shortness of breath with exertion, vomiting 4 times that day, sternal chest pain and a productive cough of white sputum. Subsequently, Mr. Manko was admitted to 5 Smythe for further evaluation. On May 27, 1991 at approximately 2:30 p.m. Mr. Manko's condition worsened and he was transferred to the Cardiac Intensive Unit. While in the CCU, Mr. Manko suffered a cardiopulmonary arrest and was pronounced at 3:30 p.m. on May 27, 1991.

It is my opinion that the nurses that were involved in the care of Mr. Telly Manko delivered care in an acceptable and professional manner utilizing ANA and JCAH standards of clinical practice in nursing as well as following the policies and procedures of Elyria Memorial Hospital Medical Center as evidenced below.

1) The nursing admission and data base form was properly completed by the E.R. nurse M. Turton, R.N. and the receiving nurse on 5S J. Toth, R.N. according the policies of Elyria Memorial Hospital.

2) It is documented in the patient chart that Dr. McGowan had written an order on 5/26/91 at 10 p.m. for the nurse to "obtain x-ray report of chest taken in E.R." However, it is not noted in the orders written by Dr. McGowan between 5/26/91 to 5/27/91 requesting the nurse to obtain any other information with regard to the patient's previous visit to the E.R. on 5/25/91 or on 5/26/91,

July 9, 1993

Mr. John Jeffers
RE: Manko

3) It is further noted that on 5/25/91 E.R. record the ABG results drawn on Mr, Manko were recorded and that the results were abnormal. The E.R. physician was aware of these results, but still discharged the patient. It is not a nursing responsibility to determine the discharge of a patient, but the responsibility of the nurse to do discharge teaching, which was completed prior to Mr. Manko leaving the hospital.

4) On 5/26/91 at 10:00 P.M. an order was written to obtain an "ABG in am". Said order was entered as order 0018, it was obtained from the patient 8:15 a.m. by the respiratory therapist. The results of the ABG were telephoned to the floor by 8:32 a.m., It was noted in the progress note on 5/27/91 written by Dr. McGowan that the "ABG's still abnormal still having difficulty breathing". It is further stated in the deposition of Marjorie A. Vargo,R.N., that the results were called to the floor and that a record is kept in the unit's communication book.

5) During Mr. Manko's hospital stay, he continued to have labored breathing and shortness of breath with exertion, as indicated by the nursing care plans instituted on 5/26/91, as well as the documentation of the Nursing Care Records of 5/26/91 to 5/27/91, On 5/27/91 at 2:20 p.m. the nurse noted a change in Mr. Manko's condition and took action to seek the assistance of the pulmonary physician Dr. Dacha. It is also indicated in the graphic flowsheet that the vitals signs were taken more frequently than required by policy, in order to closely monitor Mr. Manko's condition.

6) During the arrest on 5/27/91, the nurses followed the ACLS protocols.

July 9, 1993

Mr. John Jeffers
RE: Manko

7) On 5/27/91 at 1:15 p.m. Dr. McGowan wrote an order and a consult for Dr. Dacha, pulmonary physician to see Mr. Manko. This consult was called to 2S to notify Dr. Dacha, and the consult was written to be done within **24** hours. This order and consult was not written as a "STAT". Thereby the nurse was correctly following Dr. McGowan's order.

Thank you for the opportunity to review this matter, should you have any questions, please feel free to contact me.

Sincerely,

Gail R. Mangan

Gail R. Mangan, R.N., B.S.N.