STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

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IN THE COURT OF COMMON PLEAS

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Doc. 335

DEWEY GLEN JONES, et al.,)
)
Plaintiffs,)
)
vs.) Case No. 306012
)
MERIDIA HURON HOSPITAL, et al.,) Judge Lillian Greene.
)
Defendants.)

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Videotaped Deposition of HOWARD S. NEARMAN, M. D.

Friday, August 8, 1997

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The videotaped deposition of HOWARD S. NEARMAN, M. D., a witness herein, called for cross-examination by the plaintiffs under the Ohio Rules of Civil Procedure, taken before me, Priscilla A. Hefner, a Notary Public within and for the State of Ohio, at 2533 Lakeside Building, University Hospitals, Cleveland, Ohio, commencing at 4:00 p.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiffs:

CHARLES H. ALLEN, ESQ.
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-and-
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On behalf of the Defendant,
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The 113 St. Clair Building
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On behalf of the Defendant, Winston Ho, M. D.
and Lakeland Medical Group:

STEPHEN WALTERS, ESQ.
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On behalf of the Defendant,
Peter Adamek, M. D.:

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On behalf of the Defendant,
Rafal Badri, M. D.:

MARK JONES, ESQ.
Jacobson, Maynard, Tuschman & Kalur

Also present:

MR. KEITH E. MCGREGOR
Certified Legal Videographer
Legal Video Media

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THEREUPON, PLAINTIFF'S EXHIBITS NUMBERS 1, 2, 3, AND 4 WERE MARKED FOR IDENTIFICATION.

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MR. ALLEN: Hi, Doctor Nearman. I'm Charles Allen. I'm one of the plaintiff's attorneys in this case. I am going to try to be as efficient in our time as I can. I know you have to be out of here at 6:00.

If I ask you anything you don't understand, just tell me. I will repeat it. And if you want to take a break, we will take a break. That's absolutely no problem.

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HOWARD S. NEARMAN, M. D., being first duly sworn, was examined and testified as follows:

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CROSS-EXAMINATION

BY MR. ALLEN:

Q. I see you've got what appears to be your file in front of you.

A. Yes, sir, 1 do.

Q. And so, you've got a couple of depositions in here that you have reviewed?
A. These are the rest of my files. I just got them off the table to make room. I basically have a list --
Q. Is it the same thing that is in this letter?
A. -- In the report. Yes. I think I have a couple of extra reports from plaintiffs' experts and some of the defense experts, as well.
Q. Okay. Can you just tell me what is not listed in your opinion report.
A. Yes; things that I have looked at -- my opinions really were formed before I got these.
Q. Your opinions were formed based upon 1 through 8 --
A. Based upon 1 through 8; yes.
Q. -- Is that correct? And then you got a new batch of stuff?
A. I've got a letter, a report from Doctor Cascorbi. I have a report from a Doctor Mulroney, a report from a Doctor Rapkin. Those, I think, are the defense reports. 1 have three or four reports from plaintiffs' experts, too.
Q. Just tell me which ones those are.
A. I will, as soon as I can find them. They

should be in this. Here they are.

I have a Doctor Greendyke, Doctor Bussey, Doctor Semigran, Doctor Greenhouse, and Doctor Orloff, and Doctor Caplan.

Q. And any new depositions that you did not have in this 1 through 8 category?

A. No, sir.

Q. Did you see any depositions of any of those doctors?

A. No, sir.

Q. Have you seen any recent depositions?

A. No.

Q. When was this second package -- was the second package sent all together?

A. March 11, 1997.

Q. All right. So, you formed your report, which is dated May 7, before you read this?

A. Yes. I generally try -- when I form reports and opinions, I really don't -- try not to read the other people's ideas until I form my own ideas and then make my judgments.

Q. Fair enough. So, when did you first write down your opinions or form your opinions before March 11?

A. You know, I got most of the -- I am trying to

figure out when I got some of these things. I obviously got them last year or the year before. Mr. Walters sent me a package. And I honestly don't recall -- I honestly can't tell you what was in --

Q. I think it was in 1996.

A. Probably in 1996, with the records. And then the depositions sort of trickled after that as they came in. And I started, obviously, forming opinions from medical records.

I like to base things on the facts. And then as I have holes in some of the facts or things I need to fill in in my own mind as to what happened and why and what -- and I gained some of that or as much as I can from the depositions as they started coming in.

So, can I tell you exactly some time before May 7 I formed these? No, I don't know when, but, obviously, sometime after the last of the depositions arrived and before the date of the paper.

Q. So, the basis of your opinions were formed on the records alone. And then you had some holes which you filled in with the depositions; is that correct?

A. Yes, sir.

Q. What holes did you fill in from the depositions?

A. Well, I think -- you know, I can't recall specifically. There were certain things, such as a lot of what happened in the operating room, as far as what -- I tried to form opinions or fill the holes in as to what the exact events were that happened around the time of the arrest.

I wanted to see what the interactions were with the anesthesia people who were doing the case, both the attending and the resident. I wanted to see a little bit about what Doctor Ho was thinking about in his progress notes when he was doing some of these things.

So, some of that type of data were things that obviously weren't, you know, on the record you see -- what the people wrote. You often like to know what they were thinking at the time, as well. So, those are the kinds of things that we would be filling in.

Q. And there were some gaps in the medical record after 12/30, the day of the arrest. And the depositions helped you fill in that blank, meanwhile?

A. To some extent.

Q. You spent what total time before you formed your -- well, just tell me, what total time have you spent reviewing this case?
A. I don't know. I keep track of that at home on my computer. I honestly can't tell you what that is.
Q. Now, have you had any conversations with any of the defendants?
A. No.
Q. And you are here on behalf of Doctor Ho, correct?
A. Yes. Mr. Walters sent me the chart and asked me to look at this case with respect to the actions of Doctor Ho, as well as to how that may have interacted with what actually happened to Mr. Jones during the anesthetic, during the surgical procedure, and what did happen to him, et cetera.
Q. So, in other words, what decisions Doctor Ho made pre-operatively, how that affected Mr. Jones once the surgery began, through the procedure?
A. As well as what did actually happen to Mr. Jones and whether or not Doctor Ho's actions, you know --
Q. Were a direct cause?
A. Were a direct cause of whatever happened to

him in the operating room; correct.

Q. All right. I've got your opinion letter, and I just marked it as Exhibit 1, before we started here.

I guess before I get to that, let me just kind of get a playing field as to who you feel was responsible for what in the care of Mr. Jones.

A. Sure.

Q. Doctor Ho's responsibility to Mr. Jones was what?

A. Doctor Ho was the internist who was seeing Mr. Jones before the operation. It is my understanding that he was asked to help manage his hypertension when -- that Mr. Jones had when he first came in and then to help make sure that he was ready for the surgical procedure.

Q. Is it your opinion that Doctor Ho was brought in to medically clear Mr. Jones for the surgical procedure?

A. Well, I don't know what you mean by the term, "medically clear." He was asked to give his opinion. You know, and I am not trying to play games with you, but we go through this all the time.

We as anesthesiologists are really the people

who clear patients €or surgery or clear patients for the anesthesia part of the surgery, which is essentially the part of keeping them alive during the procedure. We often ask our colleagues for help in doing that or for their opinions. But, when it comes down to it, we are the ones in the operating room, not the cardiologists, not the pulmonologists, not the internists. We are the ones who are taking care of the patients. It is our decision as to when the patient is ready for surgery and to how to make the patient ready for surgery. So, the term, "medically clear" is something that people used to use in the past. I don't think that really applies to the practice of anesthesia in peri-operative medicine in modern days, as it were.

So, yes, again, Doctor Ho was asked to take a look at the patient to help get the patient in as stable a condition as possible and to give his opinion as to whether the patient was, again, in his mind, ready €or surgery. That is not an automatic equator of the patient going to surgery or being ready in the mind of the anesthesiologist, who is actually responsible for the patient interoperatively.

Q. What did Doctor Ho say pre-operatively to

indicate whether or not Mr. Jones was medically cleared or able to go to surgery?

A. Well, Doctor Ho said that his blood pressure was under control and that -- if I want to quote him, I think in his progress note on the 19th, he said that patient -- "the echo is pending. He has no clinical sounds of congestive failure; will review with cardiology, review with pulmonary consult; medically clear for surgery."

Q. So, when you got your opinion from the record, did that indicate to you that Doctor Ho felt Dewey Jones could withstand the surgical procedure and the anesthesia?

A. I assumed that from what he said. Yes.

Q. So, at that point, does he pass the torch on to the anesthesiologist or to the surgeon; or who is responsible after that statement in the medical records and in his deposition?

A. Who is responsible for what?

Q. Making sure that Mr. Jones is going to go through the procedure.

A. At that point it is the anesthesiologist who is responsible for taking care of Mr. Jones.

Q. And Doctor Ho is completely out of the picture at that point?

A. Well, Doctor Ho has put down his opinions. At that point in time, the way things should work is that the anesthesiologist who is going to be doing that case is going to be taking care of Mr. Jones, who -- in whose hands Mr. Jones is going to be placed is responsible for assessing the patient, for determining whether in the anesthesiologist's training and expertise that Mr. Jones is ready to tolerate the procedure.

If there is some other way that Mr. Jones could be made more ready, as it were, €or that or, you know, tuned up, as we often say -- put in better shape -- and if there might be a question, then that anesthesiologist may then invoke further personnel, either Doctor Ho or a cardiologist or a pulmonologist or whoever that person feels is best suited to answer any questions the anesthesiologist might have.

Q. Now, Doctor Ho -- pre-operatively, did he discuss this case with Doctor Adamek?

A. Not that I can see. No.

(Brief interruption.)

Q. Now, do you believe that that is a breach of the standard of care -- his failure to communicate directly with Doctor Adamek the condition of the

patient?
A. A breach of the standard of care by whom?
Q. Doctor Ho.
A. No. Doctor Ho has written his opinion in the chart. If Doctor Adamek wants further information, Doctor Adamek has a chart available and should read the chart to gain that information. If Doctor Adamek has further questions or issues that Doctor Ho has not spelled out, then Doctor Adamek gets a chart or gets in touch with Doctor Ho.
Q. So, it is Doctor Adamek's responsibility then if he needs to fill in the blanks of the medical records to contact Doctor Ho?
A. Correct.
Q. Did Doctor Adamek do that, in your opinion?
A. I didn't see any place that he did.
Q. Do you believe that is a breach of the standard of care by Doctor Adamek?
MS. REINKER: Objection.
THE WITNESS: Again, that depends on whether Doctor Adamek had questions concerning that.
BY MR. ALLEN:
Q. From reading from his deposition, did he have any questions about it? In your opinion, did he

have any questions?

A. From his deposition, no. I am not sure that Doctor Adamek -- I am not sure what Doctor Adamek did in preparation for this.

And there was some question in my mind from his deposition about who was in charge of seeing the patient pre-operatively. Doctor Adamek seemed to say he was. And then at some points in time, if I am not mistaken, he seemed to name another one of the anesthesia people there. So, I am not real sure what the answer to your question is.

Q. So, assuming that Doctor Adamek had some concern as to whether he understood Doctor Ho's note, would it not be a breach of the standard of care for him then to follow through and contact Doctor Ho?

MS. REINKER: Objection,

THE WITNESS: If Doctor Adamek was concerned about the patient's condition, if Doctor Adamek had some questions about whether or not the patient could tolerate the anesthesia or is best prepared for the anesthetic and the surgical procedure or if Doctor Adamek needed further questions answered or help in any way, Doctor Ho would

be one of the people that he may wish to contact. Yes.

BY MR. ALLEN:

Q. So, it is your opinion, yes, that would be a breach of the standard of care --

MS. REINKER: Objection.

Q. -- If he had concerns?

A. If he had concerns, yes.

Q. If he had concerns, questions, and he didn't contact Doctor Ho, then that would be a breach of the standard of care, correct?

A. Yes.

Q. So, Doctor Adamek is then given this patient to render anesthesia care the morning of the 20th. Before that morning, does Doctor Adamek have any role in this case to the care of Dewey Jones before the morning of the 20th?

A. Not that I saw; no.

Q. So, before the morning of the 20th, Dewey Jones was then basically under the direct care of Doctor Ho and Doctor Badri, correct?

A. Yes, sir.

Q. We have talked a little bit about Doctor Ho. Is there anything else, in your opinion, that is Doctor Ho's responsibility to Dewey Jones before

surgery?
A. No; not that I can think of.
Q. All right. Now, Doctor Badri's responsibility to Mr. Jones pre-operatively was to do what?
A. Well, he is the surgeon of record. So, he is the patient -- excuse me -- the physician who admitted Doctor Jones. So -- Mr. Jones; excuse me. So, it is his responsibility to manage the overall care or coordinate the overall care for Mr. Jones and schedule him for what he feels is the appropriate surgical procedure.
Q. And managing the overall care means diagnosing the severity of the gall bladder?
A. Correct.
Q. Determining whether any alternatives to surgery are appropriate, correct?
A. Correct.
Q. Is it true that Doctor Badri has an independent duty to make sure this patient is medically able to withstand surgery and anesthesia?
A. No. Again, we are going back to who is the captain of the ship here. The captain of the ship is the person who is responsible for putting the patient to sleep. That is the anesthesiologist.
If the surgeon feels the patient needs a

surgical procedure, he then schedules it or asks the anesthesiologist or asks for clearance. But, again, the final common denominator is the anesthesiologist If the anesthesiologist says, "Well, this is my best assessment of the patient. This is the risks that I feel the patient may have going into this, and we can make the risks better by delaying a week or month -- you know, theoretically, can the patient stand that?" He may ask the surgeon that, et cetera. But, again, it is a collaborative thing. There is not one rubber stamp that goes on and everything gets passed.

MS. REINKER: Objection. Move to strike any reference to, "captain of the ship."

BY MR. ALLEN:

Q. Now, as far as -- let's clear Doctor Badri out before we move on.

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Brief discussion off the record.

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BY MR. ALLEN:

Q. Doctor Badri is then in charge of the overall management of the care of Dewey Jones between the 17th and the 20th. Is that **your** opinion?

A. Correct.

Q. And he is the one that called in Doctor Ho to come --

A. Correct.

Q. -- and give a consult.

Once he saw Doctor Ho's consult, if he was unclear as to what Doctor Ho wrote in the record, would it be within the standard of care -- would it be a breach of the standard of care for him to not follow through and talk with Doctor Ho about his findings?

MR. JONES: Objection.

THE WITNESS: I am not sure I understand exactly where you are going with that. I mean, if he doesn't understand something in the record, then you call the person who wrote it and say, "What did you write?"

BY MR. ALLEN:

Q. Would that be a breach of the standard of care to proceed with him being vague as to Doctor Ho's, quote, medical clearance?

MR. JONES: Objection.

MR. WALTERS: Badri?

MR. ALLEN: Doctor

Badri.

MR. WALTERS: Objection.

Go ahead.

THE WITNESS: I am not sure we are talking about a standard of care issue. We are talking about a communication issue here.

BY MR. ALLEN:

Q. Is the failure to communicate properly a standard of care issue?

MR. JONES: Objection.

THE WITNESS: Yes. You know, if it is -- I guess I am having trouble trying to have people talk about, "I didn't understand what you wrote here," whether that really is a standard of care issue. We are not talking about caring for a patient. We are talking about words on a piece of paper.

Yes. I mean, if there is something that needs to be communicated and the communication is not done and it affects the patient, yes, that is a breach of the standard of care.

BY MR. ALLEN:

Q. Now, do you have any criticisms as to Doctor

Badri's care between the 17th and the 20th that impact the standard of care?

MR. JONES: Objection.

THE WITNESS: Again, I don't know of any. I am not a surgeon. You know, if we are going to talk about diagnoses and scheduling procedures and alternative types of things, I am going to say that I don't do that surgery, so I am not going to discuss those.

BY MR. **ALLEN:**

Q. All right. So, now, I would like to then move you on into the morning of the 20th, if I may.

That morning of the 20th, is it your understanding that Doctor Adamek and Doctor Senchyshak saw Mr. Jones pre-operatively?

A. Correct.

Q. Is it your understanding that there was a pre-op visit the night before by a resident anesthesiologist?

A. Correct.

Q. Do you feel that the resident anesthesiologist the night before properly evaluated this patient?

A. I think the resident anesthesiologist looked at the patient and evaluated the patient. I think

that -- it depends upon what the level of training was of the resident. It was not a sophisticated, all-inclusive type of evaluation with every single detail. But, was it appropriate for the level of training of the resident? Probably.

Q. Now, as far as the evaluation of the night before -- well, as far as the night before evaluation by the anesthesia resident, when did Doctor Adamek become aware of what that resident had written in the record?

A. I know that Doctor Adamek first saw the patient the morning before, so I assume that the chart was available for the review of that. So, I assume that that was the point in time that he became aware of any and all of the written things in the record.

Q. If that was not the first time, and he did not see it until the procedure had started, would that have been a breach of the standard of care by Doctor Adamek, in your opinion?

MS. REINKER: Objection.

THE WITNESS: Doctor Adamek needs to review those things that are in the chart, those things that are pertinent to the patient care, in his judgment. There are many

different workups of patients. I mean, nursing has their input. The pulmonologist has input. And maybe the anesthesia resident did.

Maybe what Doctor Adamek did was go through the chart and do his own independent assessment, without necessarily looking at the resident's assessment. So, I think failure to include everything is not necessarily a deviation from the standard of care. I think that Doctor Adamek needs to work up the patient to the extent in his own mind that he has evaluated everything he needs to know about the patient.

BY MR. ALLEN:

Q. So, failure to look at the chart at all before anesthesia began -- that would be a breach of the standard of care by Doctor Adamek if that occurred, true?

MS. REINRER: Objection.

THE WITNESS: Let me rephrase it. I think failure to properly evaluate a patient is a breach of the standard of care.

There are many ways that people can

have a proper evaluation of the patient: All, part of the chart, some of the chart is all possible, depending upon the patient and what is written in the chart and what the procedure is planned.

BY MR. ALLEN:

Q. As far as Doctor Adamek properly evaluating Dewey Jones the morning of before surgery, did he comply with the standard of care by his evaluation and clearance of Dewey Jones for the surgery?

MS. REINKER: Objection. I am just going to object and move to strike any testimony which goes beyond the bounds of the doctor's report, which was dated May 7, 1997.

THE WITNESS: I think that Doctor Adamek did not do a complete evaluation of Mr. Jones and did not appreciate the severity of Mr. Jones' condition.

BY MR. ALLEN:

Q. By that, Doctor Adamek breached the standard of care, correct?

A. Correct.

Q. And if Doctor Adamek allowed the procedure to begin without a swan-ganz catheter in place, that

was also a breach of the standard of care, true?
A. In my opinion, yes.
Q. And by failure to put the swan-ganz catheter in place, Doctor Adamek allowed the development of pulmonary edema interoperatively that led to Dewey Jones' demise, true?
A. Not necessarily.
Q. Within a reasonable degree of medical certainty, is it your opinion that that sequence of events occurred?
MS. REINKER: Objection.
THE WITNESS: I don't really know what happened to Mr. Jones in the interoperative event there that occurred around 13:00, started occurring somewhere between 12:30, 12:45 and culminated in CPR at 13:14.
I really -- there are several things that may have happened. I really can't tell you with -- more likely than not or with a medical probability what did happen.
BY MR. ALLEN:
Q. I'm sorry. Did you say you have no opinion as to within a reasonable degree of medical probability of what happened, the sequence of events?

A. I have several opinions.
Q. Within a reasonable degree of medical --
A. Well, I can't really say. Within a reasonable medical probability means to me more likely than not. And I can't say that.
Q. Let me just explore your opinions of what happened. Tell me if you could list those off for me.
A. Sure. I think that flash pulmonary edema, as you were implying earlier in your question, is one possibility; that is, for whatever reason, Mr. Jones had acute left ventricular failure. Blood backed up, flooded his lungs, fluid flooded his lungs, and he had what we call flash, meaning acuity, rapidity -- pulmonary edema.
Q. It means what, sir?
A. Flash, f-l-a-s-h.
Q. It means acute?
A. Pulmonary -- it means acute onset, very rapid pulmonary edema.
Q. Okay. We have a poor setup here. You are speaking into my bad ear. I really would like to sit on that side. So, I am going to turn to the left. And I'm going to try to listen to you.
A. That's quite okay. Sometimes I lapse into my

West Virginia accent.

Q. I'm from Georgia.

A. We ought to communicate very well, sir.

I think that that's one possibility. He may have been -- and that could be very acute. That may be brought on by an arrhythmia.

Again, the flash part of the pulmonary edema; that is, the acuity, can be brought upon by acute left ventricular dysfunction. That means the left side of the heart, for whatever reason, just all of a sudden becomes poorly functioning as a pump. This may be due to an arrhythmia. It may be due to ischemia; that is, the heart became ischemic, for whatever reason -- coronary artery disease, which is not uncommon in hypertensive, obese patients. And either one of those things may cause the left ventricle not to pump well and fluid to back up.

He may have had pulmonary edema that developed a little bit more slowly, due to fluid overload, although I think that's a little less likely than the flash pulmonary edema, just by looking at his fluid balances in eyes and nose. But, it is a possibility.

Finally, there may have been some problem with ventilation or with the placement of the tube or

dislodgement of the tube that caused him to have some upper airway obstruction, which will also give you an upper airway pulmonary edema type of picture, not caused by the heart, per se, but caused by obstruction to breathing in and out and generating negative pressures in the chest, which sort of sucks water into the lungs.

1 just don't have enough data to figure out which is more probable.

Q. So, you've got three possibilities?

A. Yes, sir.

Q. The flash pulmonary edema caused by the left ventricular dysfunction, two, the fluid overload. Would that also be caused by the left ventricular dysfunction, which would add to pulmonary edema?

A. Left ventricular dysfunction has to play a role in that. It's very difficult to put somebody with a normal heart into pulmonary edema even with a lot of fluid. Usually, it gets put into the toilet instead. But, people who have some sort of compromised heart, as 1 am sure Mr. Jones did -- with extra fluid, if it is not handled properly, over a period of time that can happen, yes.

Q. Then the third thing was some sort of problem with the tube. For the time frame with the problem

with the tube, are you talking around the 12:30 time frame, in which there are several modes as to difficulty and --

A. Correct.

Q. -- During extubation. Okay.

So, at that point was there a possible pulling of the tube that led to pulmonary --

A. There could have been.

Q. -- Obstruction?

A. Are you talking about a frank extubation?

Q. Right.

A. I am not aware of an extubation. It is certainly not documented. And the depositions don't seem to say clearly that there was an extubation. There is some question about it, I understand. But, there is clearly not documented extubation.

Q. So, if there is not documented extubation, then how would the tube get dislodged?

A. If the tube is in place but not securely in place -- and that is, it is sort of riding right at the border of right where the opening is to the lungs -- and the patient moves a bit, starts to cough or bucks, the tip of the tube may flip out and not be in the proper place. The patient may be biting down on the tube and therefore obstructing

the tube itself and then trying to breathe against their own biting down on the tube.

The tube may have become kinked through whatever maneuvers. Obviously, I wasn't there. I can't see, can't tell. But, those are all methods by which an airway or airway pseudo-obstruction can occur.

Q. With any one of those ways, doctor, is it true that the anesthesiologist that was 'managing the care should have recognized the problem?

A. Correct.

Q. And, in your opinion, was it a breach of the standard of care by anesthesia in this case the failure to recognize the possible dislodging that led to the pulmonary --

MR. CASEY: I am going to object and ask you to break it out, Charles, if you can.

BY MR. ALLEN:

Q. All right. Is it your opinion within a reasonable -- within -- scratch that.

MR. JONES: Your question assumes dislodgement.

BY MR. ALLEN:

Q. Is it your opinion that that breached the

standard of care -- that the standard of care was breached by the anesthesiologist, Doctor Adamek, and/or the anesthesiologist resident for failing to recognize that there was a problem with the tube?

A. If there was a problem with the tube, it is the anesthesia team's responsibility to recognize and correct that. Yes.

Q. And to do that in a timely fashion in which it would cause no damage to Mr. Jones, correct?

A. Correct.

Q. So, at about 12:25, 12:30, according to Doctor Senchyshak's deposition and the records, he started a reversal process. Is that your understanding?

A. Correct.

Q. And when he started a reversal process, it was his testimony that Doctor Adamek was not in the room; is that correct?

A. That is my understanding; correct.

Q. And is it a breach of the standard of care for Doctor Adamek not to be in the room at the time of reversal?

A. I think that is something that Doctor Adamek needs to discuss with Doctor -- I am going to not do well on this name.

MR. CASEY: Senchyshak.

THE WITNESS: Senchyshak. Thank you.

I think that Doctor Senchyshak is a resident who was in, I believe, his fourth month of training at that institution, having done some training previously at another institution -- if this is a complex case, that it is the attending's responsibility to delineate what the resident can and cannot do by themselves and to make a plan and specifically tell the resident what he or she should or should not do.

BY MR. ALLEN:

Q. And that should have occurred pre-operatively?

A. Correct; or interop, before any other events occurred. I mean, it is a plan that changes or can change, and depending upon the patient. But, he doesn't have to spell out pre-op all the way through, but as they are going should say, "Now, before you do this,'' or, "Before you do that," or, "Let me know," or, "You can go ahead and do this," et cetera.

Q. So, either pre-op or interoperatively, Doctor Adamek breached the standard of care by failure to tell Doctor Senchyshak that he needed to be present

for the reversal of anesthesia, true?

A. That is not necessarily true. I think that reversing the patient depends -- is sort of a judgment call at that level. Reversing a patient who apparently was stable throughout the case may or may not have been a judgment call,

Doctor Adamek should have made a plan. And what that plan included would have been up to Doctor Adamek at that point in time. I really can't say that -- "I think, maybe, before you extubate, call me" -- that would have been a breach of the standard of care. Before reverse, maybe, maybe not. I think that's sort of a judgment call.

Q. But, is it your opinion that Doctor Adamek also breached the standard of care by failure to have a proper plan pre-op and interoperatively for the management of Dewey Jones?

A. A proper plan as relates to?

Q. Care of -- the overall anesthesia care of Dewey Jones.

A, Again, 1 think we discussed that Doctor Adamek's pre-operative evaluation was not up to what I consider standard of care, and his failure to use a pulmonary artery catheter was not up to that. So, I agree with that part.

I can't tell you what the specific anesthetic plan was or discussed or not discussed with the resident, Doctor Senchyshak, because I don't know.

Q. Now, if a swan-ganz was in place at the time of a possible flash pulmonary edema, before that, could anesthesia have predicted the flash pulmonary edema?

A. Probably not.

Q. Why is that?

A. Well, again, because of the nature of the -- it is a flash pulmonary edema. If this was a result of the dysrhythmia, which compromised the pumping function of the heart, then that will happen. There is no warning. The dysrhythmia happens. And the flash pulmonary edema comes literally within seconds to a minute, because the heart then now is not effectively pumping. If this was an acute ischemic episode, just like runners who go running and they have an acute ischemic episode -- that they drop dead right there, there is no way to predict it.

The pulmonary artery catheter might help one in looking at the slower onset pulmonary edema, i.e., the fluid overload, but not an acute or a flash pulmonary edema, necessarily.

Q. The ischemic event in the left ventricular

part of the heart -- what evidence is there that that occurred?

A. I don't have evidence that that occurred, necessarily. It may have occurred and then gone away. It is not something that may persist in EKG's for a long period of time. One can get coronary vasospasm so that there is an interruption of adequate blood supply to the heart. The spasm reverses itself, and things are just fine.

But, that is the acute nature. There are people who literally drop dead every day of the year, unfortunately, from vasospasm. And when the autopsy is done, their coronary artery vessels are not necessarily severely diseased. They have a vasospastic attack, which limits that. So, this may have been one of the things that happened.

Q. Staying with the flash pulmonary edema, Dewey Jones had left ventricular dysfunction pre-operatively, correct?

A. Correct.

Q. So, I assume he was at a higher risk for developing a flash pulmonary edema.

A. Correct.

Q. What if anything could the anesthesia have done to help prevent flash pulmonary edema in this

patient?

A. 1 think, as we discussed, putting a pulmonary artery catheter in would help one determine what the pulmonary artery pressures are, what the filling pressure of the heart is, so that if that were trending up throughout the case, one could take some proper steps to correct those. They could also determine what the cardiac output was, how well the heart was pumping.

And they may not get into a position where the flash pulmonary edema was more likely to occur. But, then again, they may have had absolutely no control over it if it was one of the events that I just got through discussing.

Q. But, with the swan-ganz in place, they could have reduced the risk of an acute flash pulmonary edema occurring?

A. To some extent.

Q. Now, as far as fluid, the intake of fluid in Dewey Jones, do you have an opinion as to whether he got too much fluid interoperatively?

A. Yes, I do have an opinion.

Q. What is that?

A. I don't think he did.

Q. Why is that?

A. I think the amount of fluid that he got was certainly within the grounds for a person of his size and NPR status, et cetera.

Q. What about the output of 25 c.c.'s of urine and -- was it 400 c.c.'s of blood loss? Did you calculate all that together?

A. Yes.

Q. So, 25 c.c.'s of urine output -- that is pretty low for a fellow like this?

A. That is a little on the low side. But, again, it is short -- it is not -- the case was an hour and a half, an hour and 40 minutes for the case itself. It is something that I would be concerned about, but it would not flash -- it would not flash alarms. I mean, even if we hypothesize that the normal would have been 50 or 75 c.c.'s for an hour and a half or 100 c.c.'s, that extra 75 c.c.'s or 50 that he had in his body is not going to send him into pulmonary edema.

Q. So, do you have an opinion of how much fluid output he should have had during this procedure?

A. Urine output?

Q. Urine output.

A. We like to see urine output of around 50 to 75 c.c.'s an hour for an adult.

Q. Now, real quickly back to Doctor Ho, he was supposed to manage the hypertension of Dewey Jones pre-operatively?
A. That is my understanding. Yes.
Q. Do you feel that he breached the standard of care by allowing Dewey Jones not to have his hypertensive medications the night before the operation?
A. No. I think that he felt that Mr. Jones' blood pressure was fairly well controlled at that point in time. And one doesn't want the patient to get too low. People who are chronic hypertensives -- if their blood pressure drifts back towards normal, that could have severe effects on blood flow to the brain and blood flow to the kidneys. So, we like to keep them, especially peri-operative period -- we like to keep them on the higher side of normal than on the lower side.
Q. So, in your opinion, just before surgery, was Dewey Jones on the higher side of normal blood pressure?
A. Yes. I think he was in good shape as far as his blood pressure control in going into the operating room. His blood pressure in the beginning of the surgery was approximately 150, 160 range over

80 to 90. I think that's exactly what I would have liked to have had.

Q. As far as Mr. Jones receiving oxygen, secondary oxygen about 8:00 in the morning, pre-operatively, did that have anything to do with his hypertension? In your opinion, what was the reason for that?

A. I don't know what the reason for that was. I don't know whether he was in some pain and it may have been splinting. Again, that's what he presented to the hospital -- that the gastric pain -- and that his pain was getting worse. And he didn't take a good breath. Whether he had been laying flat -- obese patients laying flat -- it is really pretty difficult for them to maintain higher levels of oxygen saturation. Any one of those things could have been happening.

Q. You are aware he had a sleep apnea episode that night?

A. Correct; yes.

Q. 2:00 in the morning, something like that?

A. Yes.

Q. Do you think that had anything to do with the oxygen being put on him?

A. No. The oxygen was put on many hours after

the apneatic episode. So, it's hard to relate the two of them.

Q. So, did the secondary oxygen do anything to increase the oxygenation of Dewey Jones' blood? Did it help him in any way to become more oxygenated?

A. One would assume that it would. But, one has no evidence of that, that any measure of blood gases before and after -- they did have a pre-operative blood gas. But, they did not measure a blood gas after they put him on the oxygen.

Q. Was the pre-operative blood gas appropriate?

A. Yes.

Q. Do you find fault in anybody €or not putting in an arterial line to measure blood gases interoperatively?

A. Yes. I mean, that is all part of the hemodynamic monitoring -- you know, pulmonary artery catheter, for sure. I sort of assumed and made the false assumption that anytime one puts a pulmonary catheter in, one puts an arterial line in, as well. That is sort of the first line of hemodynamic monitoring.

Q. So, I'm just going to split it up. Is that a breach of the standard of care for failure to put in that arterial line?

A. Yes.

Q. And it was a breach of the standard of care to do it pre-operatively, correct?

A. No. I would have put it in --

Q. During?

A. Well, I think that's a judgment call, whether one puts it in before induction or after induction. There are people who have different opinions, Some people feel that induction is a dangerous time to put it in, that before induction is the time to put it in, because induction is sort of like the takeoff of the airplane, and you like to have those monitors.

Some people say, "Well, in a patient that has tendencies toward ischemia, I don't want to stress them by putting it in. I will wait until I get them off sleep a little bit and then put the A-line in."

But, I think not to have it as a monitor during the procedure is a breach.

Q. Now, as far as we have concentrated on Doctor Adamek, tell me what you understand the role of Doctor Senchyshak is -- I think he was a four-month resident -- in the relationship between him and Doctor Adamek, first, talking to each other pre-operatively with the patient, all the way

through. What relationship did they have?
A. In a teaching institution where residents function and learn anesthesia, the attending anesthesiologist is the person who directs the care of the anesthetic. The way that it usually runs is that they discuss the patient pre-operatively together. They identify what the risk factors are, what the procedure will encompass, how long the procedure will take, and then come to an anesthetic plan, which will include the type of anesthetic, how it is administered, the specific names of which agents are you going to give, what are the things that you are going to look out for, et cetera. The attending should be there, is required to be there for all critical parts of the anesthetic phase.
Q. Being which phases?
A. Well, I mean, most people consider induction and extubation as the critical parts of any even routine case. And there may be critical parts of other cases, depending upon what is being done and how the patient is tolerating things.
Q. In this case, was there any other times -- a critical time when Doctor Adamek should have been there?
A. Well, I think that that depends upon the

attending anesthesiologist, in particular -- in general, rather -- in particular, Doctor Adamek's assessment of the patient, and how things are going. And, you know, the patient -- it seemed like a fairly smooth interoperative course until, as we talked, about 12:30ish; and, therefore, may not have needed to be there. There didn't appear to be any critical incidences around that time.

But, Doctor Adamek should have discussed with Doctor Senchyshak -- I got it that time -- you know, "I want to be called if such and such happens," or, "I am worried about this guy. I will stop back," or, "If nothing happens, don't bother to call me, because you should have a smooth course." I don't know what was said. I don't know. I am just trying to give you the general gestalt of how residents work with attending physicians.

Q. And I may have taken you off that course. And I apologize. Let me ask you a couple of specific questions.

Is it Doctor Senchyshak's, the resident's, duty to communicate to Doctor Adamek at any stages along the operation -- he had an independent duty to go out and talk to Doctor Adamek about anything?

A. We are not going to use the term, "go out."

Q. Or call --
A. Okay. We get real upset about those things.
Q. I apologize for that. You understand my question?
A. Yes. I understand your question.
I think that he has a duty to -- Doctor Senchyshak, again, in particular, and the residents in general, if they are uncomfortable with any point in the case where they feel that they need help, where they are not sure what is going on, or anything like that, then, yes, they have the opportunity and duty to call the attending anesthesiologist.
Q. And do that in a timely manner?
A. Correct; of course.
Q. Was there anytime that Doctor Senchyshak failed to timely notify Adamek of any problems?
A. Not that I am aware of. I mean, it looks like the first problem he has is around the time of reversal. And according to what I read, that's when Doctor Senchyshak called and said, you know, "We are having some difficulty here.''
Q. And going through the records, how long did it take the resident to call the attending in at that point when he thought he had problems?

A. A matter of a couple of minutes, from what I understand, reading the deposition. I don't have -- there is no documentation.
Q. Is there a specific standard of care, protocol: He should have been there within five; he should have notified him within ten?
A. No. He should notify him whenever he is uncomfortable, whenever he is having a problem.
Q. Now, back to Doctor Ho, did Doctor Ho, in your opinion, do anything incorrectly that just did not impact on Dewey Jones' outcome?
A. I think that Doctor Ho wrote in his note that he was going to look at the echo and review it with cardiology, if need be. And he did not follow up on that.
Q. And do you understand that you can breach the standard of care, but not cause damage to a patient? Do you understand that concept, doctor?
A. Yes.
Q. Was that a breach of the standard of care -- his failure to get with cardiology on that echocardiogram?
A. I think that any time that you state in a chart that, "I am going to do something," and you don't do it, then you are not honoring the

contract. Is that a breach of the standard of care? I am not sure how you define it in those terms. I think a breach of the standard of care is something that should have been done to a patient and wasn't done. This is not done to a patient.

This was an information gathering type of thing that, again, was not necessarily an impact upon anybody's care of the patient, because, again, there were certain things that happen, as we discuss down the line.

Again, in my own words, he said he would do something. He didn't do it. If that's a breach of the standard of care in legal terms, then, okay.

Q. In your opinion, doctor, when a doctor says he is going to do something and he doesn't do it, that is malpractice, isn't it?

A. Well, you know, I can say I am going to go play golf this afternoon, and I am not going to get it done.

Q. We are talking about the care. I'm sorry. I am not trying to get too broad.

A. I understand. I understand. And I am not trying to make light of the situation.

But, I am saying that I guess if you are going to say that, then, yes, I would have to go along

with that. He said he would do something, He didn't follow up on it. To me, that's a breach of the standard of care, I guess.

Q. Mow let's take it one step further. That didn't matter, in your opinion. Is that your testimony?

A. No. Again, my testimony was that I don't think that that impacted upon the subsequent events that happened here.

Q. And that's because the anesthesiologist, in your opinion, has the ultimate responsibility for evaluating the patient before surgery --

A. Well, yes.

Q. -- Is that true?

A. I think that's primarily -- that is one of the reasons. And that is, the anesthesiologist has the duty to quote, clear, unquote, the patient, to be sure that the patient is in as good a shape as need be, and to gather all the information concerning that.

Secondly, it is my understanding that the echo results that were done immediately pre-operatively were not different significantly from the echo results that Doctor Ho knew about that were done several months prior to that. And therefore, there

really wasn't any real different information Doctor Ho was going to gather.

Q. You can read echoes, right?

A. Not very well. I am not going to hold myself out as an expert.

Q. You can read reports?

A. I can read reports.

Q. You can read reports.

A. Yes, I can.

Q. When you read this report, whether it was the August or the October echo reports, in your opinion, that echo report was surgery was contraindicated in a patient like that, true?

A. No; not necessarily correct.

Q. Why is that?

A. That echo shows that the patient has some global LV -- left ventricular dysfunction. We probably have half a dozen patients a day go through our operating room with that global LV dysfunction. It is not a contraindication of surgery.

It is an indication that the patient is sick, the patient has an impaired myocardium, an impaired heart. It is an indication that the patient is at higher risk, and steps should be taken to try to minimize that risk. But, it is not a

contraindication to surgery.

Q. Based upon the echocardiogram, he should have been more aggressively monitored interoperatively?

A. That is my opinion; correct.

Q. And based upon the echo and the aggressive interoperative monitoring needed, does not Doctor Ho have a responsibility to make sure that that cardiology consult is done and that anesthesia recognizes the need for an aggressive monitoring interoperatively?

A. No. Doctor Ho has a responsibility to make sure that the echo is done and that his opinion is in the chart and that his opinion is one more piece of data from which the anesthesiologists will make their decision. He does not have responsibility to call in the cardiologist.

Anesthesiologists can read reports of echoes and make their decision independently.

Q. So, in your opinion, cardiology was not needed, based upon the fact that anesthesia should have been able to recognize this?

A. They should have been able to read the report; correct. And if anesthesia wanted further information concerning the report or concerning the implications of the report, then they may want to

choose to call cardiology. But, they may not, also.

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Recess off the record.

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Thereupon, the deposition was recessed at 5:25 p.m.

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CERTIFICATE

STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

I, Priscilla A. Hefner, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the foregoing witness was first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the testimony then given by him was reduced to writing b means of Stenotype; that said Stenotype notes were subsequently transcribed in the absence of said witness; that the foregoing is a true and correct transcript of the testimony then given by the witnes as aforesaid; that I am not a relative, attorney, or counsel of any party or otherwise interested in the events of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Seal of Office in Cleveland, Ohio, this 18th day of August 1997.

Priscilla A. Hefner

Priscilla A. Hefner
Registered Professional Reporter.
Notary Public in and for
the State of Ohio.
My commission expires:
February 11, 2002

STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

---oOo---
IN THE COURT OF COMMON PLEAS
---oOo---

DEWEY GLEN JONES, et al.,)
)
Plaintiffs,)
)
vs.) Case No. 306012
)
MERIDIA HURON HOSPITAL, et al.,) Judge Lillian Greene.
)
Defendants.)

---oOo---

Videotaped Deposition of HOWARD S. NEARMAN, M. D.

Friday, August 8, 1997

The videotaped deposition of HOWARD S. NEARMAN, M. D., a witness herein, called for cross-examination by the plaintiffs under the Ohio Rules of civil Procedure, taken before me, Priscilla A. Hefner, a Notary Public within and for the State of Ohio, at 2533 Lakeside Building, University Hospitals, Cleveland, Ohio, commencing at 4:00 p.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiffs:

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-and-
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On behalf of the Defendant, Winston Ho, M. D. and Lakeland Medical Group:

STEPHEN WALTERS, ESQ.
Reminger & Reminger

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On behalf of the Defendant, Rafal Badri, M. D.:

MARK JONES, ESQ.
Jacobson, Maynard, Tuschman & Kalur

Also present:

MR. KEITH E. MCGREGOR
certified Legal Videoqrapher
Legal video Media
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THEREUPON, PLAINTIFF'S EXHIBITS NUMBERS 1, 2, 3, AND 4 WERE MARKED FOR IDENTIFICATION.
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MR. ALLEN. Hi, Doctor Nearman. I'm Charles *Allen*. I'm one of the plaintiff's attorneys in this case. I am going to try to be as efficient in our time as I can. I know you have to be out of here at 6:00.

If I ask you anything you don't understand, just tell me. I will repeat it. And if you want to take a break, we will take a break. That's absolutely no problem.

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HOWARD S. NEARMAN, M. D., being first duly sworn, was examined and testified as follows:

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CROSS-EXAMINATION

BY MR. ALLEN:

Q. I see you've got what appears to be your file in front of you.

A. Yes, sir, I do.

Q. And so, you've got a couple of depositions in here that you have reviewed?

A. These are the rest of my files. I just got them off the table to make room. I basically have a list --

Q. Is it the same thing that is in this letter?

A. -- In the report. *Yes*. I think I have a couple of extra reports from plaintiffs' experts and some of the defense experts, as well.

Q. Okay. Can you just tell me what is not listed in your opinion report.

A. Yes; things that I have looked at -- my opinions really were formed before I got these.

Q. Your opinions were formed based upon 1 through 8 --

A. Based upon 1 through 8; yes.

Q. -- Is that correct? And then you got a new batch of stuff?

A. I've got a letter, a report from Doctor Cascorbi, I have a report from a Doctor Mulroney, a report from a Doctor Rapkin. Those, I think, are the defense reports. I have three or four reports from plaintiffs' experts, too.

Q. Just tell me which ones those are.

A. I will, as soon as I can find them. They

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should be in this. Here they are.
I have a Doctor Greendyke, Doctor Bussey, Doctor Semigran, Doctor Greenhouse, and Doctor Orloff, and Doctor Caplan.
Q. And any new depositions that you did not have in this 1 through 8 category?
A. No, sir.
Q. Did you see any depositions of any of those doctors?
A. No, sir.
Q. Have you seen any recent depositions?
A. No.
Q. When was this second package -- was the second package sent all together?
A. March 11,1997.
Q. All right. So, you formed your report, which is dated May 7, before you read this?
A. Yes. I generally try -- when I form reports and opinions, I really don't -- try not to read the other people's ideas until I form my own ideas and then make my judgments.
Q. Fair enough. So, when did you first write down your opinions or form your opinions before March 11?
A. You know, I got most of the -- I am trying to

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figure out when I got some of these things. I obviously got them last year or the year before. Mr. Walters sent me a package. And I honestly don't recall – I honestly can't tell you what was in --
Q. I think it was in 1996.
A. Probably in 1996, with the records. And then the depositions sort of trickled after that as they came in. And I started, obviously, forming opinions from medical records.
I like to base things on the facts. And then as I have holes in some of the facts or things I need to fill in in my own mind as to what happened and why and what -- and I gained some of that or as much as I can from the depositions as they started coming in.
So, can I tell you exactly some time before May 7 I formed these? No, I don't know when, but, obviously, sometime after the last of the depositions arrived and before the date of the paper.
Q. So, the basis of your opinions were formed on the records alone. And then you had some holes which you filled in with the depositions; is that correct?
A. Yes, sir.

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Q. What holes did you fill in from the depositions?
A. Well, I *think* -- you know, I can't recall specifically. There were certain things, such as a lot of what happened in the operating room, as far as what – I tried to form opinions or fill the holes in as to what the exact events were that happened around the time of the arrest.
I wanted to see what the interactions were with the anesthesia people who were doing the case, both *the* attending and the resident. I wanted to see a little bit about what Doctor Ho was thinking about in his progress notes when he was doing some of these things.
So, some of that type of data were things that obviously weren't, you know, on the record you see -- what the people wrote. You often like to know what they were thinking at the time, as well. So, those are *the* kinds of things that we would be filling in.
Q. And there were some gaps in the medical record after 12/30, the day of the arrest. And the depositions helped you fill in that blank, meanwhile?
A. Tosomeextent.

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Q. You spent what total time before you formed your – well, just tell me, what total time have you spent reviewing this case?
A. I don't know. I keep track of that at home on my computer. I honestly can't tell you what that is.
Q. Now, have you had any conversations with any of the defendants?
A. No.
Q. And you are here on behalf of Doctor Ho, correct?
A. Yes. Mr. Walters sent me the chart and asked me to look at this case with respect to the actions of Doctor Ho, as well as to how that may have interacted with what actually happened to Mr. Jones during the anesthetic, during the surgical procedure, and what did happen to him, et cetera.
Q. So, in other words, what decisions Doctor Ho made pre-operatively, how that affected Mr. Jones once the surgery began, through the procedure?
A. As well as what did actually happen to Mr. Jones and whether or not Doctor Ho's actions, you know --
Q. Were a direct cause?
A. Were a direct cause of whatever happened to

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him in the operating room; correct.
Q. All right. I've got your opinion letter, and I just marked it as Exhibit 1, before we started here.
I guess before I get to that, let me just kind of get a playing field as to who you feel was responsible for what in the care of Mr. Jones.
A. sure.
Q. Doctor Ho's responsibility to Mr. Jones was what?
A. Doctor Ho was the internist who was seeing Mr. Jones before the operation. It is my understanding that he was asked to help manage his hypertension when -- that Mr. Jones had when he first came in and then to help make sure that he was ready for the surgical procedure.
Q. Is it your opinion that Doctor Ho was brought in to medically clear Mr. Jones for the surgical procedure?
A. Well, I don't know what you mean by the term, "medically clear." He was asked to give his opinion. You know, and I am not trying to play games with you, but we go through this all the time.
We as anesthesiologists are really the people

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who clear patients for surgery or clear patients for the anesthesia part of the surgery, which is essentially the part of keeping them alive during the procedure. We often ask our colleagues for help in doing that or for their opinions. But, when it comes down to it, we are the ones in the operating room, not the cardiologists, not the pulmonologists, not the internists. We are the ones who are taking care of the patients. It is our decision as to when the patient is ready for surgery and to how to make the patient ready for surgery. So, the term, "medically clear" is something that people used to use in the past. I don't *think* that really applies to the practice of anesthesia in peri-operative medicine in modern days, as it were.
So, yes, again, Doctor Ho was asked to take a look at the patient to help get the patient in as stable a condition as possible and to give his opinion as to whether the patient was, again, in his mind, ready for surgery. That is not an automatic equator of the patient going to surgery or being ready in the mind of the anesthesiologist, who is actually responsible for the patient interoperatively.
Q. What did Doctor Ho say pre-operatively to

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indicate whether or not Mr. Jones was medically cleared or able to go to surgery?
A. Well, Doctor Ho said that his blood pressure was under control and that -- if I want to quote him, I *think* in his progress note on the 19th, he said that patient -- "the echo is pending. He has no clinical sounds of congestive failure; will review with cardiology, review with pulmonary consult; medically clear for surgery."
Q. So, when you got your opinion from the record, did that indicate to you that Doctor Ho felt Dewey Jones could withstand the surgical procedure and the anesthesia?
A. I assumed that from what he said. Yes.
Q. So, at that point, does he pass the torch on to the anesthesiologist or to the surgeon; or who is responsible after that statement in the medical records and in his deposition?
A. Who is responsible for what?
Q. Making sure that Mr. Jones is going to go through the procedure.
A. At that point it is the anesthesiologist who is responsible for taking care of Mr. Jones.
Q. And Doctor Ho is completely out of the picture at that point?

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A. Well, Doctor Ho has put down his opinions. At that point in time, the way things should work is that the anesthesiologist who is going to be doing that case is going to be taking care of Mr. Jones, who -- in whose hands Mr. Jones is going to be placed is responsible for assessing the patient, for determining whether in the anesthesiologist's training and expertise that Mr. Jones is ready to tolerate the procedure.
If there is some other way that Mr. Jones could be made more ready, as it were, for that or, you know, tuned up, as we often say -- put in better shape – and if there might be a question, then that anesthesiologist may then invoke further personnel, either Doctor Ho or a cardiologist or a pulmonologist or whoever that person feels is best suited to answer any questions the anesthesiologist might have.
Q. Now, Doctor Ho -- pre-operatively, did he discuss this case with Doctor Adamek?
A. Not that I can see. No.
(Brief interruption.)
Q. Now, do you believe that that is a breach of the standard of care – his failure to communicate directly with Doctor Adamek the condition of the

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patient?
A. A breach of the standard of care by whom?
Q. Doctor Ho.
A. No. Doctor Ho has written his opinion in the chart. If Doctor Adamek wants further information, Doctor Adamek has a chart available and should read the chart to gain that infomation. If Doctor Adamek has further questions or issues that Doctor Ho has not spelled out, then Doctor Adamek gets a chart or gets in touch with Doctor Ho.
Q. So, it is Doctor Adamek's responsibility then if he needs to fill in the blanks of the medical records to contact Doctor Ho?
A. Correct.
Q. Did Doctor Adamek do that, in your opinion?
A. I didn't see any place that he did.
Q. Do you believe that is a breach of the standard of care by Doctor Adamek?
MS. REINKER: objection.
THE WITNESS: Again, that depends on whether Doctor Adamek had questions concerning that.
BY MR. ALLEN:
Q. From reading from his deposition, did he have any questions about it? In your opinion, did he

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have any questions?
A. From his deposition, no. I am not sure that Doctor Adamek -- I am not sure what Doctor Adamek did in preparation for this.
And there was some question in my mind from his deposition about who was in charge of seeing the patient pre-operatively. Doctor Adamek seemed to say he was. And then at some points in time, if I am not mistaken, he seemed to name another one of the anesthesia people there. So, I am not real sure what the answer to your question is.
Q. So, assuming that Doctor Adamek had some concern as to whether he understood Doctor Ho's note, would it not be a breach of the standard of care for him then to follow through and contact Doctor Ho?
MS. WINKER: objection.
THE WITNESS: If Doctor Adamek was concerned about the patient's condition, if Doctor Adamek had some questions about whether or not the patient could tolerate the anesthesia or is best prepared for the anesthetic and the surgical procedure or if Doctor Adamek needed further questions answered or help in any way, Doctor Ho would

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be one of the people that he may wish to contact. Yes.
BY MR. ALLEN:
Q. So, it is your opinion, yes, that would be a breach of the standard of care --
MS. REINKER objection.
Q. -- If he had concerns?
A. If he had concerns, yes.
Q. If he had concerns, questions, and he didn't contact Doctor Ho, then that would be a breach of the standard of care, correct?
A. Yes.
Q. So, Doctor Adamek is then given this patient to render anesthesia care the morning of the 20th. Before that morning, does Doctor Adamek have any role in this case to the care of Dewey Jones before the morning of the 20th?
A. Not that I saw; no.
Q. So, before the morning of the 20th, Dewey Jones was then basically under the direct care of Doctor Ho and Doctor Badri, correct?
A. Yes, sir.
Q. We have talked a little bit about Doctor Bo. Is there anything else, in your opinion, that is Doctor Ho's responsibility to Dewey Jones before

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surgery?
A. No; not that I can think of.
Q. All right. Now, Doctor Badri's responsibility to Mr. Jones pre-operatively was to do what?
A. Well, he is the surgeon of record. So, he is the patient -- excuse me -- the physician who admitted Doctor Jones. So -- Mr. Jones; excuse me. So, it is his responsibility to manage the overall care or coordinate the overall care for Mr. Jones and schedule him for what he feels is the appropriate surgical procedure.
Q. And managing the overall care means diagnosing the severity of the gall bladder?
A. correct.
Q. Determining whether any alternatives to surgery are appropriate, correct?
A. correct.
Q. Is it true that Doctor Badri has an independent duty to make sure this patient is medically able to withstand surgery and anesthesia?
A. No. Again, we are going back to who is the captain of the ship here. The captain of the ship is the person who is responsible for putting the patient to sleep. That is the anesthesiologist.
If the surgeon feels the patient needs a

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surgical procedure, he then schedules it or asks the anesthesiologist or asks for clearance. But, again, the final common denominator is the anesthesiologist If the anesthesiologist says, "Well, this is my best assessment of the patient. This is the risks that I feel the patient may have going into this, and we can make the risks better by delaying a week or month -- you know, theoretically, can the patient stand that?" He may ask the surgeon that, et cetera. But, again, it is a collaborative thing. There is not one rubber stamp that goes on and everything gets passed.

MS. REINKER: objection.

Move to strike any reference to, "captain of the ship."

BY MR. ALLEN:

Q. Now, as far as -- let's clear Doctor Badri out before we move on.

---o0o---

Brief discussion off the record.

---o0o---

BY MR. ALLEN:

Q. Doctor Badri is then in charge of the overall management of the care of Dewey Jones between the 17th and the 20th. Is that your opinion?

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A. Correct.

Q. And he is the one that called in Doctor Ho to come --

A. Correct.

Q. -- and give a consult.

Once he saw Doctor Ho's consult, if he was unclear as to what Doctor Ho wrote in the record, would it be within the standard of care -- would it be a breach of the standard of care for him to not follow through and talk with Doctor Ho about his findings?

MR. JONES: objection.

THE WITNESS: I am not sure I understand exactly where you are going with that. I mean, if he doesn't understand something in the record, then you call the person who wrote it and say, "What did you write?"

BY MR. ALLEN:

Q. Would that be a breach of the standard of care to proceed with him being vague as to Doctor Ho's, quote, medical clearance?

MR. JONES: objection.

MR. WALTERS: Badri?

MR. ALLEN. Doctor Badri,

MR. WALTERS: objection.

Go ahead.

THE WITNESS: I am not sure we are talking about a standard of care issue. We are talking about a communication issue here.

BY MR. ALLEN:

Q. Is the failure to communicate properly a standard of care issue?

MR. JONES: objection.

THE WITNESS: Yes. You know, if it is – I guess I am having trouble trying to have people talk about, "I didn't understand what you wrote here," whether that really is a standard of care issue. We are not talking about caring for a patient. We are talking about words on a piece of paper.

Yes. I mean, if there is something that needs to be communicated and the communication is not done and it affects the patient, yes, that is a breach of the standard of care.

BY MR. ALLEN:

Q. Now, do you have any criticisms as to Doctor Badri's care between the 17th and the 20th that impact the standard of care?

MR. JONES: objection.

THE WITNESS: Again, I don't know of any. I am not a surgeon. You know, if we are going to talk about diagnoses and scheduling procedures and alternative types of things, I am going to say that I don't do that surgery, so I am not going to discuss those.

BY MR. ALLEN

Q. All right. So, now, I would like to then move you on into the morning of the 20th, if I may.

That morning of the 20th, is it your understanding that Doctor Adamek and Doctor Senchyshak saw Mr. Jones pre-operatively?

A. Correct.

Q. Is it your understanding that there was a pre-op visit the night before by a resident anesthesiologist?

A. Correct.

Q. Do you feel that the resident anesthesiologist the night before properly evaluated this patient?

A. I think the resident anesthesiologist looked at the patient and evaluated the patient. I think

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that -- it depends upon what the level of training was of the resident. It was not a sophisticated, all-inclusive type of evaluation with every single detail. But, was it appropriate for the level of training of the resident? Probably.

Q. Now, as far as the evaluation of the night before -- well, as far as the night before evaluation by the anesthesia resident, when did Doctor Adamek become aware of what that resident hac written in the record?

A. I know that Doctor Adamek first saw the patient the morning before, so I assume that the chart was available for the review of that. So, I assume that that was the point in time that he became aware of any and all of the written things in the record.

Q. If that was not the first time, and he did not see it until the procedure had started, would that have been a breach of the standard of care by Doctor Adamek, in your opinion?

MS. REINKER: objection.

THE WITNESS: Doctor Adamek needs to review those things that are in the chart, those things that are pertinent to the patient care, in his judgment. There are many

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different workups of patients. I mean, nursing has their input. The pulmonologist has input. And maybe the anesthesia resident did.

Maybe what Doctor Adamek did was go through the chart and do his own independent assessment, without necessarily looking at the resident's assessment. So, I think failure to include everything is not necessarily a deviation from the standard of care. I *think* that Doctor Adamek needs to work up the patient to the extent in his own mind that he has evaluated everything he needs to know about the patient.

BY MR. ALLEN

Q. So, failure to look at the chart at all before anesthesia began -- that would be a breach of the standard of care by Doctor Adamek if that occurred, true?

MS. REINKER: objection.

THE WITNESS: Let me rephrase it. I think failure to properly evaluate a patient is a breach of the standard of care.

There are many ways that people can

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have a proper evaluation of the patient: All, part of the chart, some of the chart is all possible, depending upon the patient and what is written in the chart and what the procedure is planned.

BY MR. ALLEN:

Q. As far as Doctor Adamek properly evaluating Dewey Jones the morning of before surgery, did he comply with the standard of care by his evaluation and clearance of Dewey Jones for the surgery?

MS. REINKER: objection.

I am just going to object and move to strike any testimony which goes beyond the bounds of the doctor's report, which was dated May 7, 1997.

THE WITNESS: I think that Doctor Adamek did not do a complete evaluation of Mr. Jones and did not appreciate the severity of Mr. Jones' condition.

BY MR. ALLEN:

Q. By that, Doctor Adamek breached the standard of care, correct?

A. Correct.

Q. And if Doctor Adamek allowed the procedure to begin without a swan-ganz catheter in place, that

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was also a breach of the standard of care, true?

A. In my opinion, yes.

Q. And by failure to put the swan-ganz catheter in place, Doctor Adamek allowed the development of pulmonary edema interoperatively that led to Dewey Jones' demise, true?

A. Not necessarily.

Q. Within a reasonable degree of medical certainty, is it your opinion that that sequence of events occurred?

MS. REINKER: objection.

THE WITNESS: I don't really know what happened to Mr. Jones in the interoperative event there that occurred around 13:00, started occurring somewhere between 12:30, 12:45 and culminated in CPR at 13:14.

I really -- there are several things that may have happened. I really can't tell you with -- more likely than not or with a medical probability what did happen.

BY MR. ALLEN:

Q. I'm sorry. Did you say you have no opinion as to within a reasonable degree of medical probability of what happened, the sequence of events?

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A. I have several opinions.
Q. Within a reasonable degree of medical --
A. Well, I can't really say. Within a reasonable medical probability means to me more likely than not. And I can't say that.
Q. Let me just explore your opinions of what happened. Tell me if you could list those off for me.
A. Sure. I think that flash pulmonary edema, as you were implying earlier in your question, is one possibility; that is, for whatever reason, Mr. Jones had acute left ventricular failure. Blood backed up, flooded his lungs, fluid flooded his lungs, and he had what we call flash, meaning acuity, rapidity -- pulmonary edema.
Q. It means what, sir?
A. Flash, f-l-a-s-h.
Q. It means acute?
A. Pulmonary -- it means acute onset, very rapid pulmonary edema.
Q. Okay. We have a poor setup here. You are speaking into my bad ear. I really would like to sit on that side. So, I am going to turn to the left. And I'm going to try to listen to you.
A. That's quite okay. Sometimes I lapse into my

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West Virginia accent.
Q. I'm from Georgia.
A. We ought to communicate very well, sir.
I think that that's one possibility. He may have been -- and that could be very acute. That may be brought on by an arrhythmia.
Again, the flash part of the pulmonary edema; that is, the acuity, can be brought upon by acute left ventricular dysfunction. That means the left side of the heart, for whatever reason, just all of a sudden becomes poorly functioning as a pump. This may be due to an arrhythmia. It may be due to ischemia; that is, the heart became ischemic, for whatever reason -- coronary artery disease, which is not uncommon in hypertensive, obese patients. And either one of those things may cause the left ventricle not to pump well and fluid to back up.
He may have had pulmonary edema that developed a little bit more slowly, due to fluid overload, although I think that's a little less likely than the flash pulmonary edema, just by looking at his fluid balances in eyes and nose. But, it is a possibility.
Finally, there may have been some problem with ventilation or with the placement of the tube or

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dislodgement of the tube that caused him to have some upper airway obstruction, which will also give you an upper airway pulmonary edema type of picture, not caused by the heart, per se, but caused by obstruction to breathing in and out and generating negative pressures in the chest, which sort of sucks water into the lungs.
I just don't have enough data to figure out which is more probable.
Q. So, you've got three possibilities?
A. Yes, sir.
Q. The flash pulmonary edema caused by the left ventricular dysfunction, two, the fluid overload. Would that also be caused by the left ventricular dysfunction, which would add to pulmonary edema?
A. Left ventricular dysfunction has to play a role in that. It's very difficult to put somebody with a normal heart into pulmonary edema even with a lot of fluid. Usually, it gets put into the toilet instead. But, people who have some sort of compromised heart, as I am sure Mr. Jones did -- with extra fluid, if it is not handled properly, over a period of time that can happen, yes.
Q. Then the third thing was some sort of problem with the tube. For the time frame with the problem

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with the tube, are you talking around the 12:30 time frame, in which there are several modes as to difficulty and --
A. correct.
Q. -- During extubation. Okay.
So, at that point was there a possible pulling of the tube that led to pulmonary --
A. There could have been.
Q. -- Obstruction?
A. Are you talking about a frank extubation?
Q. Right.
A. I am not aware of an extubation. It is certainly not documented. And the depositions don't seem to say clearly that there was an extubation. There is some question about it, I understand. But, there is clearly not documented extubation.
Q. So, if there is not documented extubation, then how would the tube get dislodged?
A. If the tube is in place but not securely in place -- and that is, it is sort of riding right at the border of right where the opening is to the lungs -- and the patient moves a bit, starts to cough or bucks, the tip of the tube may flip out and not be in the proper place. The patient may be biting down on the tube and therefore obstructing

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the tube itself and then trying to breathe against their own biting down on the tube.

The tube may have become kinked through whatever maneuvers. Obviously, I wasn't there. I can't see, can't tell. But, those are all methods by which an airway or airway pseudo-obstruction can occur.

Q. With any one of those ways, doctor, is it true that the anesthesiologist that was managing the care should have recognized the problem?

A. Correct.

Q. And, in your opinion, was it a breach of the standard of care by anesthesia in this case the failure to recognize the possible dislodging that led to the pulmonary --

MR. CASEY: I am going to object and ask you to break it out, Charles, if you can.

BY MR. ALLEN:

Q. *All* right. Is it your opinion within a reasonable -- within -- scratch that.

MR. JONES: Your question assumes dislodgement.

BY MR. ALLEN:

Q. Is it your opinion that that breached the

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standard of care -- that the standard of care was breached by the anesthesiologist, Doctor Adamek, and/or the anesthesiologist resident for failing to recognize that there was a problem with the tube?

A. If there was a problem with the tube, it is the anesthesia team's responsibility to recognize and correct that. Yes.

Q. And to do that in a timely fashion in which it would cause no damage to Mr. Jones, correct?

A. Correct.

Q. So, at about 12:25, 12:30, according to Doctor Senchyshak's deposition and the records, he started a reversal process. Is that your understanding?

A. Correct.

Q. And when he started a reversal process, it was his testimony that Doctor Adamek was not in the room; is that correct?

A. That is my understanding; correct.

Q. And is it a breach of the standard of care for Doctor Adamek not to be in the room at the time of reversal?

A. I think that is something that Doctor Adamek needs to discuss with Doctor -- I am going to not do well on this name.

MR. CASEY senchyshak.

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THE WITNESS: senchyshak. Thankyou.

I think that Doctor Senchyshak is a resident who was in, I believe, his fourth month of training at that institution, having done some training previously at another institution – if this is a complex case, that it is the attending's responsibility to delineate what the resident can and cannot do by themselves and to make a plan and specifically tell the resident what he or she should or should not do.

BY MR. ALLEN:

Q. And that should have occurred pre-operatively?

A. Correct; or interop, before any other events occurred. I mean, it is a plan that changes or can change, and depending upon the patient. But, he doesn't have to spell out pre-op all the way through, but as they are going should say, "Now, before you do this," or, "Before you do that," or, "Let me know," or, "You can go ahead and do this," et cetera.

Q. So, either pre-op or interoperatively, Doctor Adamek breached the standard of care by failure to tell Doctor Senchyshak that he needed to be present

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for the reversal of anesthesia, true?

A. That is not necessarily true. I think that reversing the patient depends -- is sort of a judgment call at that level. Reversing a patient who apparently was stable throughout the case may or may not have been a judgment call.

Doctor Adamek should have made a plan. And what that plan included would have been up to Doctor Adamek at that point in time. I really can't say that -- "I think, maybe, before you extubate, call me" – that would have been a breach of the standard of care. Before reverse, maybe, maybe not. I think that's sort of a judgment call.

Q. But, is it your opinion that Doctor Adamek also breached the standard of care by failure to have a proper plan pre-op and interoperatively for the management of Dewey Jones?

A. A proper plan as relates to?

Q. Care of -- the overall anesthesia care of Dewey Jones.

A. Again, I think we discussed that Doctor Adamek's pre-operative evaluation was not up to what I consider standard of care, and his failure to use a pulmonary artery catheter was not up to that. So, I agree with that part.

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I can't tell you what the specific anesthetic plan was or discussed or not discussed with the resident, Doctor Senchyshak, because I don't know.
Q. Now, if a swan-ganz was in place at the time of a possible flash pulmonary edema, before that, could anesthesia have predicted the flash pulmonary edema?
A. Probably not.
Q. Why is that?
A. Well, again, because of the nature of the -- it is a flash pulmonary edema. If this was a result of the dysrhythmia, which compromised the pumping function of the heart, then that will happen. There is no warning. The dysrhythmia happens. And the flash pulmonary edema comes literally within seconds to a minute, because the heart then now is not effectively pumping. If this was an acute ischemic episode, just like runners who go running and they have an acute ischemic episode -- that they drop dead right there, there is no way to predict it.
The pulmonary artery catheter might help one in looking at the slower onset pulmonary edema, i.e., the fluid overload, but not an acute or a flash pulmonary edema, necessarily.
Q. The ischemic event in the left ventricular

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part of the heart -- what evidence is there that that occurred?
A. I don't have evidence that that occurred, necessarily. It may have occurred and then gone away. It is not something that may persist in EKG's for a long period of time. One can get coronary vasospasm so that there is an interruption of adequate blood supply to the heart. The spasm reverses itself, and things are just fine.
But, that is the acute nature. There are people who literally drop dead every day of the year, unfortunately, from vasospasm. And when the autopsy is done, their coronary artery vessels are not necessarily severely diseased. They have a vasospastic attack, which limits that. So, this may have been one of the things that happened.
Q. Staying with the flash pulmonary edema, Dewey Jones had left ventricular dysfunction pre-operatively, correct?
A. Correct.
Q. So, I assume he was at a higher risk for developing a flash pulmonary edema.
A. Correct.
Q. What if anything could the anesthesia have done to help prevent flash pulmonary edema in this

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patient?
A. I *think,* as we discussed, putting a pulmonary artery catheter in would help one determine what the pulmonary artery pressures are, what the filling pressure of the heart is, so that if that were trending up throughout the case, one could take some proper steps to correct those. They could also determine what the cardiac output was, how well the heart was pumping.
And they may not get into a position where the flash pulmonary edema was more likely to occur. But, then again, they may have had absolutely no control over it if it was one of the events that I just got through discussing.
Q. But, with the swan-ganz in place, they could have reduced the risk of an acute flash pulmonary edema occurring?
A. To some extent.
Q. Now, as far as fluid, the intake of fluid in Dewey Jones, do you have an opinion as to whether he got too much fluid interoperatively?
A. Yes, I do have an opinion.
Q. What is that?
A. I don't think he did.
Q. Why is that?

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A. I *think* the amount of fluid that he got was certainly within the grounds for a person of his size and NPR status, et cetera.
Q. What about the output of 25 c.c.'s of urine and -- was it 400 c.c.'s of blood loss? Did you calculate all that together?
A. Yes.
Q. So, 25 c.c.'s of urine output -- that is pretty low for a fellow like this?
A. That is a Little on the low side. But, again, it is short -- it is not -- the case was an hour and a half, an hour and 40 minutes for the case itself. It is something that I would be concerned about, but it would not flash -- it would not flash alarms. I mean, even if we hypothesize that the normal would have been 50 or 75 c.c.'s for an hour and a half or 100 c.c.'s, that extra 75 c.c.'s or 50 that he had in his body is not going to send him into pulmonary edema.
Q. So, do you have an opinion of how much fluid output he should have had during this procedure?
A. Urine output?
Q. Urine output.
A. We like to see urine output of around 50 to *75* c.c.'s an hour for an adult.

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Q. Now, real quickly back to Doctor Ho, he was supposed to manage the hypertension of Dewey Jones pre-operatively?
A. That is my understanding. Yes.
Q. Do you feel that he breached the standard of care by allowing Dewey Jones not to have his hypertensive medications the night before the operation?
A. No. I think that he felt that Mr. Jones' blood pressure was fairly well controlled at that point in time. And one doesn't want the patient to get too low. People who are chronic hypertensives -- if their blood pressure drifts back towards normal, that could have severe effects on blood flow to the brain and blood flow to the kidneys. So, we like to keep them, especially peri-operative period -- we like to keep them on the higher side of normal than on the lower side.
Q. So, in your opinion, just before surgery, was Dewey Jones on the higher side of normal blood pressure?
A. Yes. I think he was in good shape as far as his blood pressure control in going into the operating room. His blood pressure in the beginning of the surgery was approximately 150, 160 range over

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80 to 90. I think that's exactly what I would have liked to have had.
Q. As far as Mr. Jones receiving oxygen, secondary oxygen about 8:00 in the morning, pre-operatively, did that have anything to do with his hypertension? In your opinion, what was the reason for that?
A. I don't know what the reason for that was. I don't know whether he was in some pain and it may have been splinting. Again, that's what he presented to the hospital -- that the gastric pain -- and that his pain was getting worse. And he didn't take a good breath. Whether he had been laying flat -- obese patients laying flat -- it is really pretty difficult for them to maintain higher levels of oxygen saturation. Any one of those things could have been happening.
Q. You are aware he had a sleep apnea episode that night?
A. Correct; yes.
Q. 2:00 in the morning, something like that?
A. Yes.
Q. Do you think that had anything to do with the oxygen being put on him?
A. No. The oxygen was put on many hours after

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the apneatic episode. So, it's hard to relate the twoofthem.
Q. So, did the *secondary* oxygen do anything to increase the oxygenation of Dewey Jones' blood? Did it help him in any way to become more oxygenated?
A. One would assume that it would. But, one has no evidence of that, that any measure of blood gases before and after -- they did have a pre-operative blood gas. But, they did not measure a blood gas after they put him on the oxygen.
Q. Was the pre-operative blood gas appropriate?
A. *Yes.*
Q. Do you find fault in anybody for not putting in an arterial Line to measure blood *gases* interoperatively?
A. *Yes.* I mean, that is all part of the hemodynamic monitoring -- you know, pulmonary artery catheter, for sure. I sort of assumed and made the false assumption that anytime one puts a pulmonary catheter in, one puts an arterial line in, as well. That is sort of the first line of hemodynamic monitoring.
Q. So, I'm just going to split it up. Is that a breach of the standard of care for failure to put in that arterialline?

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A. Yes.
Q. And it was a breach of the standard of care to do it pre-operatively, correct?
A. No. I wouldhave put it in --
Q. During?
A. Well, I think that's a judgment call, whether one puts it in before induction or after induction. There are people who have different opinions. Some people feel that induction is a dangerous time to put it in, that before induction is the time to put it in, because induction is sort of like the takeoff of the airplane, and you like to have those monitors.
Some people say, "Well, in a patient that has tendencies toward ischemia, I don't want to stress them by putting it in. I will wait until I get them off sleep a little bit and then put the A-line in."
But, I think not to have it as a monitor during the procedure is a breach.
Q. Now, as far as we have concentrated on Doctor Adamek, tell me what you understand the role of Doctor Senchyshak is -- I think he was a four-month resident -- in the relationship between him and Doctor Adamek, first, talking to each other pre-operatively with the patient, all the way

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through. What relationship did they have?
A. In a teaching institution where residents function and learn anesthesia, the attending anesthesiologist is the person who directs the care of the anesthetic. The way that it usually runs is that they discuss the patient pre-operatively together. They identify what the risk factors are, what the procedure will encompass, how long the procedure will take, and then come to an anesthetic plan, which will include the type of anesthetic, how it is administered, the specific names of which agents are you going to give, what are the things that you are going to look out for, et cetera. The attending should be there, is required to be there for all critical parts of the anesthetic phase.
Q. Being which phases?
A. Well, I mean, most people consider induction and extubation as the critical parts of any even routine case. And there may be critical parts of other cases, depending upon what is being done and how the patient is tolerating things.
Q. In this case, was there any other times -- a critical time when Doctor Adamek should have been there?
A. Well, I *think* that that depends upon the

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attending anesthesiologist, in particular -- in general, rather -- in particular, Doctor Adamek's assessment of the patient, and how things are going. And, you know, the patient -- it seemed like a fairly smooth interoperative course until, as we talked, about 12:30ish; and, therefore, may not have needed to be there. There didn't appear to be any critical incidences around that time.
But, Doctor Adamek should have discussed with Doctor Senchyshak -- I got it that time -- you know, "I want to be called if such and such happens," or, "I am worried about this guy. I will stop back," or, "If nothing happens, don't bother to call me, because you should have a smooth course." I don't know what was said. I don't know. I am just trying to give you the general gestalt of how residents work with attending physicians.
Q. And I may have taken you off that course. And I apologize. Let me ask you a couple of specific questions.
Is it Doctor Senchyshak's, the resident's, duty to communicate to Doctor Adamek at any stages along the operation -- he had an independent duty to go out and talk to Doctor Adamek about anything?
A. We are not going to use the term, "go out."

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Q. Or call --
A. Okay. We get real upset about those things.
Q. I apologize for that. You understand my question?
A. Yes. I understand your question.
I *think* that he has a duty to -- Doctor Senchyshak, again, in particular, and the residents in general, if they are uncomfortable with any point in the case where they feel that they need help, where they are not sure what is going on, or anything like that, then, yes, they have the opportunity and duty to call the attending anesthesiologist.
Q. And do that in a timely manner?
A. Correct; of course.
Q. Was there anytime that Doctor Senchyshak failed to timely notify Adamek of any problems?
A. Not that I am aware of. I mean, it looks like the first problem he has is around the time of reversal. And according to what I read, that's when Doctor Senchyshak called and said, you know, "We are having some difficulty here."
Q. And going through the records, how long did it take the resident to call the attending in at that point when he thought he had problems?

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A. A matter of a couple of minutes, from what I understand, reading the deposition. I don't have -- there is no documentation.
Q. Is there a specific standard of care, protocol: He should have been there within five; he should have notified him within ten?
A. No. He should notify him whenever he is uncomfortable, whenever he is having a problem.
Q. Now, back to Doctor Ho, did Doctor Ho, in your opinion, do anything incorrectly that just did not impact on Dewey Jones' outcome?
A. I think that Doctor Ho wrote in his note that he was going to look at the echo and review it with cardiology, if need be. And he did not follow up on that.
Q. And do you understand that you can breach the standard of care, but not cause damage to a patient? Do you understand that concept, doctor?
A. Yes.
Q. Was that a breach of the standard of care – his failure to get with cardiology on that echocardiogram?
A. I think that any time that you state in a chart that, "I am going to do something," and you don't do it, then you are not honoring the

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contract. Is that a breach of the standard of care? I am not sure how you define it in those terms. I think a breach of the standard of care is something that should have been done to a patient and wasn't done. This is not done to a patient.

This was an information gathering type of thing that, again, was not necessarily an impact upon anybody's care of the patient, because, again, there were certain things that happen, as we discuss down the line.

Again, in my own words, he said he would do something. He didn't do it. If that's a breach of the standard of care in legal terms, then, okay.

Q. In your opinion, doctor, when a doctor says he is going to do something and he doesn't do it, that is malpractice, isn't it?

A. Well, you know, I can say I am going to go play golf this afternoon, and I am not going to get it done.

Q. We are talking about the care. I'm sorry. I am not trying to get too broad.

A. I understand. I understand. And I am not trying to make light of the situation.

But, I am saying that I guess if you are going to say that., then, yes, I would have to go along

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with that. He said he would do something. He didn't follow up on it. To me, that's a breach of the standard of care, I guess.

Q. Now let's take it one step further. That didn't matter, in your opinion. Is that your testimony?

A. No. Again, my testimony was that I don't think that that impacted upon the subsequent events that happened here.

Q. And that's because the anesthesiologist, in your opinion, has the ultimate responsibility for evaluating the patient before surgery --

A. Well, yes.

Q. -- Is that true?

A. I *think* that's primarily – that is one of the reasons. And that is, the anesthesiologist has the duty to quote, clear, unquote, the patient, to be sure that the patient is in as good a shape as need be, and to gather all the information concerning that.

Secondly, it is my understanding that the echo results that were done immediately pre-operatively were not different significantly from the echo results that Doctor Ho knew about that were done several months prior to that. And therefore, there

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really wasn't any real different infomation Doctor Ho was going to gather.

Q. You can read echoes, right?

A. Not very well. I am not going to hold myself out as an expert.

Q. You can read reports?

A. Icanreadreports.

Q. You can read reports.

A. Yes, I can.

Q. When you read this report, whether it was the August or the October echo reports, in your opinion, that echo report was surgery was contraindicated in a patient like that, true?

A. No; not necessarily correct.

Q. Why is that?

A. That echo shows that the patient has some global LV -- left ventricular dysfunction. We probably have half a dozen patients a day go through our operating room with that global LV dysfunction. It is not a contraindication of surgery.

It is an indication that the patient is sick, the patient has an impaired myocardium, an impaired heart. It is an indication that the patient is at higher risk, and steps should be taken to try to minimize that risk. But, it is not a

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contraindication to surgery.

Q. Based upon the echocardiogram, he should have been more aggressively monitored interoperatively?

A. That is my opinion; correct.

Q. And based upon the echo and the aggressive interoperative monitoring needed, does not Doctor Ho have a responsibility to make sure that that cardiology consult is done and that anesthesia recognizes the need for an aggressive monitoring interoperatively?

A. No. Doctor Ho has a responsibility to make sure that the echo is done and that his opinion is in the chart and that his opinion is one more piece of data from which the anesthesiologists will make their decision. He does not have responsibility to call in the cardiologist.

Anesthesiologists can read reports of echoes and make their decision independently.

Q. So, in your opinion, cardiology was not needed, based upon the fact that anesthesia should have been able to recognize this?

A. They should have been able to read the report; correct. And if anesthesia wanted further information concerning the report or concerning the implications of the report, then they may want to

choose to call cardiology. But, they may not, also.

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Recess off the record.

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Thereupon, the deposition was recessed at 5:25 p.m.

---o0o---

CERTIFICATE

STATE OF OHIO, } SS:

COUNTY OF CUYAHOGA.)

I, Priscilla A. Hefner, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the foregoing witness was first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the testimony then given by him was reduced to writing by means of Stenotype; that said Stenotype notes were subsequently transcribed in the absence of said witness; that the foregoing is a true and correct transcript of the testimony then given by the witness as aforesaid; that I am not a relative, attorney, or counsel of any party or otherwise interested in the events of this action

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Seal of office in Cleveland, Ohio, this _____ day of _____ 1997.

Priscilla A. Hefner
Registered Professional Reporter.
Notary Public in and for
the state of Ohio.
My commission expires:
February 11,2002