1 STATE OF OHIO, SS: 2 COUNTY OF CUYAHOGA. 000---3 IN THE COURT OF COMMON PLEAS 4 ----DOC. 335 5 DEWEY GLEN JONES, et al., 6 Plaintiffs, 7 Case No. 306012 vs. 8 MERIDIA HURON HOSPITAL, Judge Lillian Greene. et al., 9 Defendants. 10 11 \_\_\_\_000\_\_\_\_ 12 Videotaped Deposition of HOWARD S. NEARMAN, M. D. 13 14 Friday, August 8, 1997 15 ---000---The videotaped deposition of HOWARD S. NEARMAN, 16 M. D., a witness herein, called for 17 cross-examination by the plaintiffs under the Ohio 18 Rules of Civil Procedure, taken before me, Priscilla 19 20 A. Hefner, a Notary Public within and for the State 21 of Ohio, at 2533 Lakeside Building, University Hospitals, Cleveland, Ohio, commencing at 4:00 p.m., 22 the day and date above set forth. 23 24 25

## **APPEARANCES:** 1 On behalf of the Plaintiffs: 2 3 CHARLES H. ALLEN, ESQ. Keenan Law Firm 4 148 Nassau Street, N.W. Atlanta, Georgia 30303 -and-5 JACK LANDSKRONER, ESQ. 6 Landskroner Law Firm, Ltd. 55 Public Square, Suite 1040 7 Cleveland, Ohio 44113 On behalf of the Defendant, 8 Meridia Huron Hospital: 9 JAMES CASEY, ESQ. Reminger & Reminger 10 The 113 St. Clair Building 11 Cleveland, Ohio 44114 On behalf of the Defendant, Winston Ho, M. D. 12 and Lakeland Medical Group: 13 STEPHEN WALTERS, ESQ. Reminger & Reminger 14 15 On behalf of the Defendant, Peter Adamek, M. D.: 16 SUSAN REINKER, ESQ. Jacobson, Maynard, Tuschman & Kalur 17 1001 Lakeside Avenue, Suite 1600 Cleveland, Ohio 44114 18 19 On behalf of the Defendant, Rafal Badri, M. D.: 20 MARK JONES, ESQ. Jacobson, Maynard, Tuschman & Kalur 21 22 Also present: 23 MR. KEITH E. MCGREGOR Certified Legal Videographer Legal Video Media 24 -----25

1 THEREUPON, PLAINTIFF'S EXHIBITS 2 NUMBERS 1, 2, 3, AND 4 3 WERE MARKED FOR IDENTIFICATION. 4 ----5 MR. ALLEN: Hi, Doctor 6 Nearman. I'm Charles Allen. I'm one of the 7 plaintiff's attorneys in this case. I am 8 going to try to be as efficient in our time as 9 10 I can. I know you have to be out of here at 6:00. 11 12 If I ask you anything you don't 13 understand, just tell me. I will repeat it. 14 And if you want to take a break, we will take 15 a break. That's absolutely no problem. \_\_\_\_000\_\_\_\_ 16 17 HOWARD S. NEARMAN, M. D., 18 being first duly sworn, was examined and testified as follows: 19 20 \_\_\_000---21 CROSS-EXAMINATION 22 BY MR. ALLEN: 23 Q, I see you've got what appears to **pe** your file in front of you. 24 Yes, sir, 1 do. 25 Α.

1	Q. And so, you've got a couple of depositions in
2	here that you have reviewed?
3	A. These are the rest of my files. I just got
4	them off the table to make room. I basically have a
5	list
6	Q. Is it the same thing that is in this letter?
7	A In the report. Yes. I think I have a
8	couple of extra reports from plaintiffs' experts and
9	some of the defense experts, as well.
10	Q. Okay. Can you just tell me what is not listed
11	in your opinion report.
12	A. Yes; things that I have looked at my
13	opinions really were formed before I got these.
14	${f Q}m{\cdot}$ Your opinions were formed based upon 1 through
15	8
16	A. Based upon 1 through 8; yes.
17	Q. Is that correct? And then you $got$ a new
18	batch of stuff?
19	A. I've got a letter, a report from Doctor
20	Cascorbi. I have a report from a Doctor Mulroney, a
2 1	report from a Doctor Rapkin. Those, I think, are
22	the defense reports. 1 have three or four reports
23	from plaintiffs' experts, too.
24	Q. Just tell me which ones those are.
25	A. I will, as soon as I can find them. They

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1	should be in this. Here they are.
2	I have a Doctor Greendyke, Doctor Bussey,
3	Doctor Semigran, Doctor Greenhouse, and Doctor
4	Orloff, and Doctor Caplan.
5	${}^{\mathbb{Q}}\cdot$ And any new depositions that you did not have
6	in this 1 through 8 category?
7	A. No, sir.
8	${}^{\mathbb{Q}}\cdot$ Did you see any depositions of any of those
9	doctors?
10	A. No, sir.
11	Q. Have you seen any recent depositions?
12	A. No.
13	Q. When was this second package was the second
14	package sent all together?
15	A. March 11, 1997.
16	Q. All right. So, you formed your report, which
17	is dated May 7, before you read this?
18	A. Yes. I generally try when I form reports
19	and opinions, I really don't try not to read the
20	other people's ideas until I form my own ideas and
2 1	then make my judgments.
22	Q. Fair enough. So, when did you first write
23	down your opinions or form y ur opinions before
24	March 11?
25	A* You know, I got most of the I am trying to

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1	figure out when I got some of these things. I
2	obviously got them last year or the year before.
3	Mr. Walters sent me a package. And I honestly don't
4	recall I honestly can't tell you what was in
5	Q. I think it was in <b>1996.</b>
6	A. Probably in <b>1996,</b> with the records. And then
7	the depositions sort of trickled after that as they
8	came in. And I started, obviously, forming opinions
9	from medical records.
10	I like to base things on the facts. And then
11	as I have holes in some of the facts or things I
12	need to fill in in my own mind as to what happened
13	and why and what and I gained some of that or as
14	much as I can from the depositions as they started
15	coming in.
16	So, can I tell you exactly some time before
17	May 7 I formed these? No, I don't know when, but,
18	obviously, sometime after the last of the
19	depositions arrived and before the date of the
20	paper.
21	${\tt Q}$ . So, the basis of your opinions were formed on
22	the records alone. And then you had some holes
23	which you filled in with the depositions; is that
24	correct?
25	A. Yes, sir.

1	Q. What holes did you fill in from the
2	depositions?
3	A. Well, I think you know, I can't recall
4	specifically. There were certain things, such as a
5	lot of what happened in the operating room, as far
6	as what I tried to form opinions or fill the
7	holes in as to what the exact events were that
8	happened around the time of the arrest.
9	I wanted to see what the interactions were
10	with the anesthesia people who were doing the case,
11	both the attending and the resident. I wanted to
12	see a little bit about what Doctor Ho was thinking
13	about in his progress notes when he was doing some
14	of these things.
15	So, some of that type of data were things that
16	obviously weren't, you know, on the record you see
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18	what they were thinking at the time, as well. So,
19	those are the kinds of things that we would be
20	filling in.
2 1	Q. And there were some gaps in the medical record
22	after 12/30, the day of the arrest. And the
23	depositions helped you fill in that blank,
24	meanwhile?
25	A. To some extent.

1	${\tt Q}$ . You spent what total time before you formed
2	your well, just tell me, what total time have you
3	spent reviewing this case?
4	A. I don't know. I keep track of that at home on
5	my computer. I honestly can't tell you what that
6	is.
7	${ m Q}\cdot$ Now, have you had any conversations with any
а	of the defendants?
9	A. No.
10	Q. And you are here on behalf of Doctor Ho,
11	correct?
12	A. Yes. Mr. Walters sent me the chart and asked
13	me to look at this case with respect to the actions
14	of Doctor Ho, as well as to how that may have
15	interacted with what actually happened to Mr. Jones
16	during the anesthetic, during the surgical
17	procedure, and what did happen to him, et cetera.
18	${f Q}$ . So, in other words, what decisions Doctor Ho
19	made pre-operatively, how that affected Mr. Jones
20	once the surgery began, through the procedure?
2 1	A. As well as what did actually happen to
22	Mr. Jones and whether or not Doctor Ho's actions,
23	you know
24	Q. Were a direct cause?
25	A. Were a direct cause of whatever happened to

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1	him in the operating room; correct.
2	${}^{\mathbb{Q}}\cdot$ All right. I've got your opinion letter, and
3	I just marked it as Exhibit 1, before we started
4	here.
5	I guess before I get to that, let me just kind
6	of get a playing field as to who you feel was
7	responsible for what in the care of Mr. Jones.
8	A. Sure.
9	Q. Doctor Ho's responsibility to Mr. Jones was
10	what?
11	A. Doctor Ho was the internist who was seeing
12	Mr. Jones before the operation. It is my
13	understanding that he was asked to help manage his
14	hypertension when that Mr. Jones had when he
15	first came in and then to help make sure that he was
16	ready for the surgical procedure.
17	${\mathbb Q}\cdot$ Is it your opinion that Doctor Ho was brought
18	in to medically clear Mr. Jones for the surgical
19	procedure?
20	A. Well, I don't know what you mean by the term,
2 1	"medically clear." He was asked to give his
22	opinion. You know, and I am not trying to play
23	games with you, but we go through this all the
24	time.
25	We as anesthesiologists are really the people

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who clear patients €or surgery or clear patients for 1 the anesthesia part of the surgery, which is 2 3 essentially the part of keeping them alive during the procedure. We often ask our colleagues for help 4 in doing that or for their opinions. But, when it 5 comes down to it, we are the ones in the operating 6 7 room, not the cardiologists, not the pulmonologists, not the internists. We are the ones who are taking а care of the patients. It is our decision as to when 9 the patient is ready for surgery and to how to make 10 the patient ready for surgery. So, the term, 11 12 "medically clear" is something that people used to use in the past. I don't think that really applies 13 to the practice of anesthesia in peri-operative 14 medicine in modern days, as it were. 15 16 So, yes, again, Doctor Ho was asked to take a 17 look at the patient to help get the patient in as

18 stable a condition as possible and to give his 19 opinion as to whether the patient was, again, in his 20 mind, ready €or surgery. That is not an automatic 21 equator of the patient going to surgery or being 22 ready in the mind of the anesthesiologist, who is 23 actually responsible for the patient 24 interoperatively.

25 Q. What did Doctor Ho say pre-operatively to

1	indicate whether or not Mr. Jones was medically
2	cleared or able to go to surgery?
3	A. Well, Doctor Ho said that his blood pressure
4	was under control and that if I want to quote
5	him, I think in his progress note on the 19th, he
6	said that patient "the echo is pending. He has
7	no clinical sounds of congestive failure; will
8	review with cardiology, review with pulmonary
9	consult; medically clear for surgery."
10	${\mathbb Q}$ . So, when you got your opinion from the record,
11	did that indicate to you that Doctor Ho felt Dewey
12	Jones could withstand the surgical procedure and the
13	anesthesia?
14	A. I assumed that from what he said. Yes.
15	${\tt Q}$ . So, at that point, does he pass the torch on
16	to the anesthesiologist or to the surgeon; or who is
17	responsible after that statement in the medical
18	records and in his deposition?
19	A. Who is responsible for what?
20	$\mathbb{Q}$ . Making sure that Mr. Jones is going to go
21	through the procedure.
22	A. At that point it is the anesthesiologist who
23	is responsible for taking care of Mr. Jones.
24	Q. And Doctor Ho is completely out of the picture
25	at that point?

Α. Well, Doctor Ho has put down his opinions. At 1 that point in time, the way things should work is 2 that the anesthesiologist who is going to be doing 3 that case is going to be taking care of Mr. Jones, 4 who -- in whose hands Mr. Jones is going to be 5 placed is responsible for assessing the patient, for 6 determining whether in the anesthesiologist's 7 training and expertise that Mr. Jones is ready to а tolerate the procedure. 9 10 If there is some other way that Mr. Jones could be made more ready, as it were, €or that or, 11 12 you know, tuned up, as we often say -- put in better shape -- and if there might be a question, then that 13 anesthesiologist may then invoke further personnel, 14 either Doctor Ho or a cardiologist or a 15 pulmonologist or whoever that person feels is best 16 17 suited to answer any questions the anesthesiologist 18 might have. Q. Now, Doctor Ho -- pre-operatively, did he 19 discuss this case with Doctor Adamek? 20 Not that I can see. 21 Α. No. 22 (Brief interruption.) 23 Q, Now, do you believe that that is a breach of the standard of care -- his failure to communicate 24 directly with Doctor Adamek the condition of the 25

1	patient?
2	A. A breach of the standard of care by whom?
3	Q. Doctor Ho.
4	A. No. Doctor Ho has written his opinion in the
5	chart. If Doctor Adamek wants further information,
6	Doctor Adamek has a chart available and should read
7	the chart to gain that information. If Doctor
8	Adamek has further questions or issues that Doctor
9	Ho has not spelled out, then Doctor Adamek gets a
10	chart or gets in touch with Doctor Ho.
11	${\tt Q}$ . So, it is Doctor Adamek's responsibility then
12	if he needs to fill in the blanks of the medical
13	records to contact Doctor Ho?
14	A. Correct.
15	Q. Did Doctor Adamek do that, in your opinion?
16	A. I didn't see any place that he did.
17	Q. Do you believe that is a breach of the
18	standard of care by Doctor Adamek?
19	MS. REINKER: Objection.
20	THE WITNESS: Again, that
21	depends on whether Doctor Adamek had questions
22	concerning that.
23	BY MR. ALLEN:
24	$\mathbb{Q}$ . From reading from his deposition, did he have
25	any questions about it? In your opinion, did he

1	have any questions?
2	A. From his deposition, no. I am not sure that
3	Doctor Adamek I am not sure what Doctor Adamek
4	did in preparation for this.
5	And there was some question in my mind from
6	his deposition about who was in charge of seeing the
7	patient pre-operatively. Doctor Adamek seemed to
8	say he was. And then at some points in time, if I
9	am not mistaken, he seemed to name another one of
10	the anesthesia people there. So, I am not real sure
11	what the answer to your question is.
12	${\mathbb Q}\cdot$ So, assuming that Doctor Adamek had some
13	concern as to whether he understood Doctor Ho's
14	note, would it not be a breach of the standard of
15	care for him then to follow through and contact
16	Doctor Ho?
17	MS. REINKER: Objection,
18	THE WITNESS: If Doctor
19	Adamek was concerned about the patient's
20	condition, if Doctor Adamek had some questions
21	about whether or not the patient could
22	tolerate the anesthesia or is best prepared
23	for the anesthetic and the surgical procedure
24	or if Doctor Adamek needed further questions
25	answered or help in any way, Doctor Ho would

be one of the people that he may wish to 1 2 contact. Yes. BY MR. ALLEN: 3 4 Q. So, it is your opinion, yes, that would be a breach of the standard of care --5 MS. REINKER: Objection. б 7 Q. If he had concerns? If he had concerns, yes. 8 Α. If he had concerns, questions, and he didn't Q. 9 contact Doctor Ho, then that would be a breach of 10 the standard of care, correct? 11 12 Α. Yes. 13 Q. So, Doctor Adamek is then given this patient to render anesthesia care the morning of the 20th. 14 Before that morning, does Doctor Adamek have any 15 16 role in this case to the care of Dewey Jones before 17 the morning of the 20th? Not that I saw; no. 18 Α. Q. So, before the morning of the 20th, Dewey 19 Jones was then basically under the direct care of 20 21 Doctor Ho and Doctor Badri, correct? Yes, sir. 22 Α. We have talked a little bit about Doctor Ho. 23 Q. Is there anything else, in your opinion, that is 24 Doctor Ho's responsibility to Dewey Jones before 25

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1	surgery?
2	A. No; not that I can think of.
3	Q. All right. Now, Doctor Badri's responsibility
4	to Mr. Jones pre-operatively was to do what?
5	A. Well, he is the surgeon of record. So, he is
6	the patient excuse me the physician who
7	admitted Doctor Jones. So Mr. Jones; excuse me.
8	So, it is his responsibility to manage the overall
9	care or coordinate the overall care for Mr. Jones
10	and schedule him for what he feels is the
11	appropriate surgical procedure.
12	${}^{\mathbb{Q}}\cdot$ And managing the overall care means diagnosing
13	the severity of the gall bladder?
14	A. Correct.
15	Q. Determining whether any alternatives to
16	surgery are appropriate, correct?
17	A. Correct.
18	${\mathbb Q},$ Is it true that Doctor Badri has an
19	independent duty to make sure this patient is
20	medically able to withstand surgery and anesthesia?
2 1	A. No. Again, we are going back to who is the
22	captain of the ship here. The captain of the ship
23	is the person who is responsible for putting the
24	patient to sleep. That is the anesthesiologist.
25	If the surgeon feels the patient needs a

surgical procedure, he then schedules it or asks the 1 anesthesiologist or asks for clearance. But, again, 2 the final common denominator is the anesthesiologist 3 If the anesthesiologist says, "Well, this is my best 4 assessment of the patient. This is the risks that I 5 feel the patient may have going into this, and we 6 7 can make the risks better by delaying a week or month -- you know, theoretically, can the patient 8 stand that?" He may ask the surgeon that, et 9 cetera. But, again, it is a collaborative thing. 10 There is not one rubber stamp that goes on and 11 12 everything gets passed. MS. REINKER: Objection. 13 Move to strike any reference to, 14 "captain of the ship." 15 BY MR. ALLEN: 16 Q. Now, as far as -- let's clear Doctor Badri out 17 before we move on. 18 ---000---19 Brief discussion off the record. 20 ---000---21 BY MR. ALLEN: 22 Q, Doctor Badri is then in charge of the overall 23 management of the care of Dewey Jones between the 24 17th and the 20th. Is that your opinion? 25

1	A. Correct.
2	Q. And he is the one that called in Doctor Ho to
3	come
4	A. Correct.
5	Q and give a consult.
6	Once he saw Doctor Ho's consult, if he was
7	unclear as to what Doctor Ho wrote in the record,
8	would it be within the standard of care would it
9	be a breach of the standard of care for him to not
10	follow through and talk with Doctor Ho about his
11	findings?
12	MR. JONES: Objection.
13	THE WITNESS: I am not sure
14	I understand exactly where you are going with
15	that. I mean, if he doesn't understand
16	something in the record, then you call the
17	person who wrote it and say, "What did you
18	write?"
19	BY MR. ALLEN:
20	Q. Would that be a breach of the standard of care
21	to proceed with him being vague as to Doctor Ho's,
22	quote, medical clearance?
23	MR. JONES: Objection.
24	MR. WALTERS: Badri?
25	MR. ALLEN: Doctor

1	Badri.
2	MR. WALTERS: Objection.
3	Go ahead.
4	THE WITNESS: I am not sure
5	we are talking about a standard of care
6	issue. We are talking about a communication
7	issue here.
8	BY MR. ALLEN:
9	Q. Is the failure to communicate properly a
10	standard of care issue?
11	MR. JONES: Objection.
12	THE WITNESS: Yes. You
13	know, if it is I guess I am having trouble
14	trying to have people talk about, "I didn't
15	understand what you wrote here," whether that
16	really is a standard of care issue. We are
17	not talking about caring for a patient. We
18	are talking about words on a piece of paper.
19	Yes. I mean, if there is something
20	that needs to be communicated and the
21	communication is not done and it affects the
22	patient, yes, that is a breach of the standard
23	of care.
24	BY MR. ALLEN:
25	Q. Now, do you have any criticisms as to Doctor

1	
1	Badri's care between the 17th and the 20th that
2	impact the standard of care?
3	MR. JONES: Objection.
4	THE WITNESS: Again, I
5	don't know of any. I am not a surgeon. You
6	know, if we are going to talk about diagnoses
7	and scheduling procedures and alternative
8	types of things, I am going to say that I
9	don't do that surgery, so ${f I}$ am not going to
10	discuss those.
11	BY MR. ALLEN:
12	Q. All right. So, now, <b>I</b> would like to then move
13	you on into the morning of the 20th, if ${\tt I}$ may.
14	That morning of the 20th, is it your
15	understanding that Doctor Adamek and Doctor
16	Senchyshak saw Mr. Jones pre-operatively?
17	A. Correct.
18	${\tt Q}$ . Is it your understanding that there was a
19	pre-op visit the night before by a resident
20	anesthesiologist?
21	A. Correct.
22	${\mathbb Q},$ Do you feel that the resident anesthesiologist
23	the night before properly evaluated this patient?
24	A. I think the resident anesthesiologist looked
25	at the patient and evaluated the patient. I think

1	that it depends upon what the level of training
2	was of the resident. It was not a sophisticated,
3	all-inclusive type of evaluation with every single
4	detail. But, was it appropriate for the level of
5	training of the resident? Probably.
6	${}^{\mathbb{Q}}\cdot$ Now, as far as the evaluation of the night
7	before well, as far as the night before
8	evaluation by the anesthesia resident, when did
9	Doctor Adamek become aware of what that resident had
10	written in the record?
11	A. I know that Doctor Adamek first saw the
12	patient the morning before, so I assume that the
13	chart was available for the review of that. So, I
14	assume that that was the point in time that he
15	became aware of any and all of the written things in
16	the record.
17	${}^{\mathbb{Q}}\cdot$ If that was not the first time, and he did not
18	see it until the procedure had started, would that
19	have been a breach of the standard of care by Doctor
20	Adamek, in your opinion?
2 1	MS. REINKER: Objection.
22	THE WITNESS: Doctor Adamek
23	needs to review those things that are in the
24	chart, those things that are pertinent to the
25	patient care, in his judgment. There are many

different workups of patients. 1 I mean, nursing has their input. The pulmonologist 2 has input. And maybe the anesthesia resident 3 4 did. Maybe what Doctor Adamek did was go 5 through the chart and do his own independent 6 assessment, without necessarily looking at the 7 resident's assessment. So, I think failure to а include everything is not necessarily a 9 deviation from the standard of care. I think 10 that Doctor Adamek needs to work up the 11 patient to the extent in his own mind that he 12 has evaluated everything he needs to know 13 14 about the patient. BY MR. ALLEN: 15 Q. So, failure to look at the chart at all before 16 anesthesia began -- that would be a breach of the 17 standard of care by Doctor Adamek if that occurred, 18 19 true? 20 MS. REINRER: Objection. 21 THE WITNESS: Let me 22 rephrase it. I think failure to properly evaluate a patient is a breach of the standard 23 24 of care. There are many ways that people can 25

1	have a proper evaluation of the patient: All,
2	part of the chart, some of the chart is all
3	possible, depending upon the patient and what
4	is written in the chart and what the procedure
5	is planned.
6	BY MR. ALLEN:
7	Q. As far as Doctor Adamek properly evaluating
8	Dewey Jones the morning of before surgery, did he
9	comply with the standard of care by his evaluation
10	and clearance of Dewey Jones for the surgery?
11	MS. REINKER: Objection.
12	I am just going to object and move to
13	strike any testimony which goes beyond the
14	bounds of the doctor's report, which was dated
15	May 7, 1997.
16	THE WITNESS: I think that
17	Doctor Adamek did not do a complete evaluation
18	of Mr. Jones and did not appreciate the
19	severity of Mr. Jones' condition.
20	BY MR. ALLEN:
2 1	Q. By that, Doctor Adamek breached the standard
22	of care, correct?
23	A. Correct.
24	Q. And if Doctor Adamek allowed the procedure to
25	begin without a swan-ganz catheter in place, that

1	was also a breach of the standard of care, true?
2	A. In my opinion, yes.
3	Q. And by failure to put the swan-ganz catheter
4	in place, Doctor Adamek allowed the development of
5	pulmonary edema interoperatively that led to Dewey
6	Jones' demise, true?
7	A. Not necessarily.
8	Q. Within a reasonable degree of medical
9	certainty, is it your opinion that that sequence of
10	events occurred?
11	MS. REINKER: Objection.
12	THE WITNESS: I don't
13	really know what happened to Mr. Jones in the
14	interoperative event there that occurred
15	around 13:00, started occurring somewhere
16	between 12:30, 12:45 and culminated in CPR at
17	13:14.
18	I really there are several things
19	that may have happened. I really can't tell
20	you with 🗝 more likely than not or with a
21	medical probability what did happen.
22	BY MR. ALLEN:
23	Q. I'm sorry. Did you say you have no opinion as
24	to within a reasonable degree of medical probability
25	of what happened, the sequence of events?

1	A. I have several opinions.
2	Q. Within a reasonable degree of medical
3	A. Well, I can't really say. Within a reasonable
4	medical probability means to me more likely than
5	not. And I can't say that.
6	Q. Let me just explore your opinions of what
7	happened. Tell me if you could list those off for
8	me.
9	A. Sure. I think that flash pulmonary edema, as
10	you were implying earlier in your question, is one
11	possibility; that is, for whatever reason, Mr. Jones
12	had acute left ventricular failure. Blood backed
13	up, flooded his lungs, fluid flooded his lungs, and
14	he had what we call flash, meaning acuity, rapidity
15	pulmonary edema.
16	Q. It means what, sir?
17	A. Flash, f-l-a-s-h.
18	Q. It means acute?
19	A. Pulmonary it means acute onset, very rapid
20	pulmonary edema.
21	${f Q}$ . Okay. We have a poor setup here. You are
22	speaking into my bad ear. I really would like to
23	sit on that side. So, I am going to turn to the
24	left. And I'm going to try to listen to you.
25	A. That's quite okay. Sometimes I lapse into my

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1 | West Virginia accent.

2 Q. I'm from Georgia.

3 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; 7 8 that is, the acuity, can be brought upon by acute left ventricular dysfunction. That means the left 9 side of the heart, for whatever reason, just all of 10 a sudden becomes poorly functioning as a pump. 11 This may be due to an arrhythmia. It may be due to 12 ischemia; that is, the heart became ischemic, for 13 whatever reason -- coronary artery disease, which is 14 not uncommon in hypertensive, obese patients. And 15 either one of those things may cause the left 16 ventricle not to pump well and fluid to back up. 17

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 withventilation 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.

8 1 just don't have enough data to figure out9 which is more probable.

10 Q. So, you've got three possibilities?

**11** A. Yes, sir.

12 Q. The flash pulmonary edema caused by the left ventricular dysfunction, two, the fluid overload. 13 Would that also be caused by the left ventricular 14 dysfunction, which would add to pulmonary edema? 15 Left ventricular dysfunction has to play a 16 Α. 17 role in that. It's very difficult to put somebody with a normal heart into pulmonary edema even with a 18 lot of fluid. Usually, it gets put into the toilet 19 instead. But, people who have some sort of 20 compromised heart, as 1 am sure Mr. Jones did --21 with extra fluid, if it is not handled properly, 22 over a period of time that can happen, yes. 23 Ο, Then the third thing was some sort of problem 24 with the tube. For the time frame with the problem 25

1	with the tube, are you talking around the 12:30 time
2	frame, in which there are several modes as to
3	difficulty and
4	A. Correct.
5	Q During extubation. Okay.
6	<b>So,</b> at that point was there a possible pulling
7	of the tube that led to pulmonary
8	A. There could have been.
9	Q Obstruction?
10	A. Are you talking about a frank extubation?
11	Q. Right.
12	A. I am not aware of an extubation. It is
13	certainly not documented. And the depositions don't
14	seem to say clearly that there was an extubation.
15	There is some question about it, I understand. But,
16	there is clearly not documented extubation.
17	Q. So, if there is not documented extubation,
18	then how would the tube get dislodged?
19	A. If the tube is in place but not securely in
20	place and that is, it is sort of riding right at
2 1	the border of right where the opening is to the
22	lungs and the patient moves a bit, starts to
23	cough or bucks, the tip of the tube may flip out and
24	not be in the proper place. The patient may be
25	biting down on the tube and therefore obstructing
25	biting down on the tube and therefore obstructing

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1	the tube itself and then trying to breathe against
2	their own biting down on the tube.
3	The tube may have become kinked through
4	whatever maneuvers. Obviously, I wasn't there. I
5	can't see, can't tell. But, those are all methods
6	by which an airway or airway pseudo-obstruction can
7	occur.
8	$\mathbb{Q}_{*}$ With any one of those ways, doctor, is it true
9	that the anesthesiologist that was 'managing the care
10	should have recognized the problem?
11	A. Correct.
12	${}^{\mathbb{Q}}\cdot$ And, in your opinion, was it a breach of the
13	standard of care by anesthesia in this case the
14	failure to recognize the possible dislodging that
15	led to the pulmonary
16	MR. CASEY: I am going to
17	object and ask you to break it out, Charles,
18	if you can.
19	BY MR. ALLEN:
20	Q. All right. Is it your opinion within a
21	reasonable within scratch that.
22	MR. JONES: Your question
23	assumes dislodgement.
24	BY MR. ALLEN:
25	Q. Is it your opinion that that breached the

standard of care -- that the standard of care was 1 breached by the anesthesiologist, Doctor Adamek, 2 3 and/or the anesthesiologist resident for failing to recognize that there was a problem with the tube? 4 If there was a problem with the tube, it is 5 Α. the anesthesia team's responsibility to recognize 6 and correct that. Yes. 7 Q. And to do that in a timely fashion in which it 8 would cause no damage to Mr. Jones, correct? 9 Correct. Α. 10 Q. So, at about 12:25, 12:30, according to Doctor 11 Senchyshak's deposition and the records, he started 12 13 a reversal process. Is that your understanding? Correct. 14 Α. Q. And when he started a reversal process, it was 15 his testimony that Doctor Adamek was not in the 16 17 room; is that correct? 18 That is my understanding; correct. Α. And is it a breach of the standard of care for 19 Q. Doctor Adamek not to be in the room at the time of 20 reversal? 21 22 I think that is something that Doctor Adamek Α. needs to discuss with Doctor -- I am going to not do 23 well on this name. 24 MR, CASEY: Senchyshak.

1	THE WITNESS: Senchyshak.
2	Thank you.
3	I think that Doctor Senchyshak is a
4	resident who was in, I believe, his fourth
5	month of training at that institution, having
6	done some training previously at another
7	institution if this is a complex case, that
8	it is the attending's responsibility to
9	delineate what the resident can and cannot do
10	by themselves and to make a plan and
11	specifically tell the resident what he or she
12	should or should not do.
13	BY MR. ALLEN:
14	Q. And that should have occurred pre-operatively?
15	A. Correct; or interop, before any other events
16	occurred. I mean, it is a plan that changes or can
17	change, and depending upon the patient. But, he
18	doesn't have to spell out pre-op all the way
19	through, but as they are going should say, "Now,
20	before you do this,'' or, "Before you do that," or,
2 1	"Let me know," or, "You can go ahead and do this,"
22	et cetera.
23	Q. So, either pre-op or interoperatively, Doctor
24	Adamek breached the standard of care by failure to
25	tell Doctor Senchyshak that he needed to be present

for the reversal of anesthesia, true? 1 That is not necessarily true. I think that 2 Α. reversing the patient depends -- is sort of a 3 judgment call at that level. Reversing a patient 4 who apparently was stable throughout the case may or 5 may not have been a judgment call, 6 Doctor Adamek should have made a plan. And 7 8 what that plan included would have been up to Doctor Adamek at that point in time. I really can't say 9 that -- "I think, maybe, before you extubate, call 10 me" -- that would have been a breach of the standard 11 of care. Before reverse, maybe, maybe not. I think 12 that's sort of a judgment call. 13 But, is it your opinion that Doctor Adamek Q. 14 also breached the standard of care by failure to 15 have a proper plan pre-op and interoperatively for 16 the management of Dewey Jones? 17 18 Α. A proper plan as relates to? Care of -- the overall anesthesia care of Q. 19 20 Dewey Jones. Again, 1 think we discussed that Doctor 21 Α, Adamek's pre-operative evaluation was not up to what 22 I consider standard of care, and his failure to use 23 a pulmonary artery catheter was not up to that. 24 So, I agree with that part. 25

1 I can't tell you what the specific anesthetic plan was or discussed or not discussed with the 2 resident, Doctor Senchyshak, because I don't know. 3 Q, Now, if a swan-ganz was in place at the time 4 of a possible flash pulmonary edema, before that, 5 could anesthesia have predicted the flash pulmonary 6 7 edema? Probably not. 8 Α. Q, Why is that? 9 10 Α. Well, again, because of the nature of the -it is a flash pulmonary edema. If this was a result 11 of the dysrhythmia, which compromised the pumping 12 function of the heart, then that will happen. 13 There is no warning. The dysrhythmia happens. And the 14 15 flash pulmonary edema comes literally within seconds to a minute, because the heart then now is not 16 effectively pumping. If this was an acute ischemic 17 episode, just like runners who go running and they 18 have an acute ischemic episode -- that they drop 19 20 dead right there, there is no way to predict it. 21 The pulmonary artery catheter might help one in looking at the slower onset pulmonary edema, 22 i.e., the fluid overload, but not an acute or a 23 flash pulmonary edema, necessarily. 24

25 Q. The ischemic event in the left ventricular

part of the heart -- what evidence is there that 1 that occurred? 2 I don't have evidence that that occurred, Α. 3 necessarily. It may have occurred and then gone 4 away. It is not something that may persist in EKG's 5 for a long period of time. One can get coronary 6 vasospasm so that there is an interruption of 7 adequate blood supply to the heart. The spasm 8 reverses itself, and things are just fine. 9 But, that is the acute nature. There are 10 people who literally drop dead every day of the 11 year, unfortunately, from vasospasm. And when the 12 autopsy is done, their coronary artery vessels are 13 not necessarily severely diseased. They have a 14 15 vasospastic attack, which limits that. So, this may have been one of the things that happened. 16 Q, 17 Staying with the flash pulmonary edema, Dewey Jones had left ventricular dysfunction 18 19 pre-operatively, correct? Correct. 20 Α. 21 Q. So, I assume he was at a higher risk for developing a flash pulmonary edema. 22 23 Α. Correct. Q, What if anything could the anesthesia have 24 done to help prevent flash pulmonary edema in this 25

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1	patient?
2	A. 1 think, as we discussed, putting a pulmonary
3	artery catheter in would help one determine what the
4	pulmonary artery pressures are, what the filling
5	pressure of the heart is, so that if that were
6	trending up throughout the case, one could take some
7	proper steps to correct those. They could also
8	determine what the cardiac output was, how well the
9	heart was pumping.
10	And they may not get into a position where the
11	flash pulmonary edema was more likely to occur.
12	But, then again, they may have had absolutely no
13	control over it if it was one of the events that I
14	just got through discussing.
15	${f Q}$ . But, with the swan-ganz in place, they could
16	have reduced the risk of an acute flash pulmonary
17	edema occurring?
18	A. To some extent.
19	Q. Now, as far as fluid, the intake of fluid in
20	Dewey Jones, do you have an opinion as to whether he
21	got too much fluid interoperatively?
22	A. Yes, I do have an opinion.
23	Q, What is that?
24	A. I don't think he did.
25	Q. Why is that?

1	A. I think the amount of fluid that he got was						
2	certainly within the grounds for a person of his						
3	size and NPR status, et cetera.						
4	Q. What about the output of 25 c.c.'s of urine						
5	and was it 400 c.c.'s of blood loss? Did you						
6	calculate all that together?						
7	A. Yes.						
8	Q. so, 25 c.c.'s of urine output that is						
9	pretty low for a fellow like this?						
10	A. That is a little on the low side. But, again,						
11	it is short it is not the case was an hour and						
12	a half, an hour and 40 minutes for the case itself.						
13	It is something that I would be concerned about, but						
14	it would not flash it would not flash alarms. I						
15	mean, even if we hypothesize that the normal would						
16	have been 50 or 75 c.c.'s for an hour and a half or						
17	100 c.c.'s, that extra 75 c.c.'s or 50 that he had						
18	in his body is not going to send him into pulmonary						
19	edema.						
20	Q. so, do you have an opinion of how much fluid						
21	output he should have had during this procedure?						
22	A. Urine output?						
23	Q. Urine output.						
24	A. We like to see urine output of around 50 to 75						
25	c.c.'s an hour for an adult.						
1	${}^{\mathbb{Q}}\cdot$ Now, real quickly back to Doctor Ho, he was						
----	--	--	--	--	--	--	--
2	supposed to manage the hypertension of Dewey Jones						
3	pre-operatively?						
4	A. That is my understanding. Yes.						
5	Q. Do you feel that he breached the standard of						
6	care by allowing Dewey Jones not to have his						
7	hypertensive medications the night before the						
8	operation?						
9	A. No. I think that he felt that Mr. Jones'						
10	blood pressure was fairly well controlled at that						
11	point in time. And one doesn't want the patient to						
12	get too low. People who are chronic hypertensives						
13	if their blood pressure drifts back towards						
14	normal, that could have severe effects on blood flow						
15	to the brain and blood flow to the kidneys. So, we						
16	like to keep them, especially peri-operative period						
17	we like to keep them on the higher side of						
18	normal than on the lower side.						
19	Q. So, in your opinion, just before surgery, was						
20	Dewey Jones on the higher side of normal blood						
21	pressure?						
22	A. Yes. I think he was in good shape as far as						
23	his blood pressure control in going into the						
24	operating room. His blood pressure in the beginning						
25	of the surgery was approximately 150, <b>160</b> range over						

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1	80 to 90. I think that's exactly what I would have
2	liked to have had.
3	Q. As far as Mr. Jones receiving oxygen,
4	secondary oxygen about 8:00 in the morning,
5	pre-operatively, did that have anything to do with
6	his hypertension? In your opinion, what was the
7	reason for that?
8	A. I don't know what the reason for that was. I
9	don't know whether he was in some pain and it may
10	have been splinting. Again, that's what he
11	presented to the hospital that the gastric pain
12	and that his pain was getting worse. And he
13	didn't take a good breath. Whether he had been
14	laying flat obese patients laying flat it is
15	really pretty difficult for them to maintain higher
16	levels of oxygen saturation. Any one of those
17	things could have been happening.
18	Q. You are aware he had a sleep apnea episode
19	that night?
20	A. Correct; yes.
2 1	Q. 2:00 in the morning, something like that?
22	A. Yes.
23	${\tt Q},$ Do you think that had anything to do with the
24	oxygen being put on him?
25	A. No. The oxygen was put on many hours after

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1	the apneatic episode. So, it's hard to relate the
2	two of them.
3	${\tt Q}$ . So, did the secondary oxygen do anything to
4	increase the oxygenation of Dewey Jones' blood? Did
5	it help him in any way to become more oxygenated?
6	A. One would assume that it would. But, one has
7	no evidence of that, that any measure of blood gases
8	before and after they did have a pre-operative
9	blood gas. But, they did not measure a blood gas
10	after they put him on the oxygen.
11	Q. Was the pre-operative blood gas appropriate?
12	A. Yes.
13	Q. Do you find fault in anybody €or not putting
14	in an arterial line to measure blood gases
15	interoperatively?
16	A. Yes. I mean, that is all part of the
17	hemodynamic monitoring you know, pulmonary artery
18	catheter, for sure. I sort of assumed and made the
19	false assumption that anytime one puts a pulmonary
20	catheter in, one puts an arterial line in, as well.
2 1	That is sort of the first line of hemodynamic
22	monitoring.
23	$\mathbb{Q}$ . So, I'm just going to split it up. Is that a
24	breach of the standard of care for failure to put in
25	that arterial line?

1	
1	A. Yes.
2	${f Q}$ . And it was a breach of the standard of care to
3	do it pre-operatively, correct?
4	A. No. I would have put it in
5	Q. During?
6	A. Well, I think that's a judgment call, whether
7	one puts it in before induction or after induction.
8	There are people who have different opinions, Some
9	people feel that induction is a dangerous time to
10	put it in, that before induction is the time to put
11	it in, because induction is sort of like the takeoff
12	of the airplane, and you like to have those
13	monitors.
14	Some people say, "Well, in a patient that has
15	tendencies toward ischemia, I don't want to stress
16	them by putting it in. I will wait until I get them
17	off sleep a little bit and then put the A-line in."
18	But, I think not to have it as a monitor
19	during the procedure is a breach.
20	${\mathbb Q}$ . Now, as far as we have concentrated on Doctor
21	Adamek, tell me what you understand the role of
22	Doctor Senchyshak is I think he was a four-month
23	resident in the relationship between him and
24	Doctor Adamek, first, talking to each other
25	pre-operatively with the patient, all the way

through. What relationship did they have? 1 In a teaching institution where residents Α. 2 function and learn anesthesia, the attending 3 anesthesiologist is the person who directs the care 4 of the anesthetic. The way that it usually runs is 5 that they discuss the patient pre-operatively 6 together. They identify what the risk factors are, 7 what the procedure will encompass, how long the 8 procedure will take, and then come to an anesthetic 9 plan, which will include the type of anesthetic, how 10 11 it is administered, the specific names of which agents are you going to give, what are the things 12 that you are going to look out for, et cetera. 13 The attending should be there, is required to be there 14 for all critical parts of the anesthetic phase. 15 Being which phases? Q. 16 Well, I mean, most people consider induction 17 Α. and extubation as the critical parts of any even 18 19 routine case. And there may be critical parts of other cases, depending upon what is being done and 20 how the patient is tolerating things. 21 In this case, was there any other times -- a Q. 22 critical time when Doctor Adamek should have been 23 there? 24 25 Well, I think that that depends upon the Α.

attending anesthesiologist, in particular -- in 1 general, rather -- in particular, Doctor Adamek's 2 assessment of the patient, and how things are 3 going. And, you know, the patient -- it seemed like 4 a fairly smooth interoperative course until, as we 5 talked, about 12:30ish; and, therefore, may not have 6 needed to be there. There didn't appear to be any 7 critical incidences around that time. 8

But, Doctor Adamek should have discussed with 9 Doctor Senchyshak -- I got it that time -- you know, 10 "I want to be called if such and such happens," or, 11 "I am worried about this guy. I will stop back," 12 or, "If nothing happens, don't bother to call me, 13 because you should have a smooth course." 14 I don't know what was said. I don't know. I am just trying 15 to give you the general gestalt of how residents 16 work with attending physicians. 17

18 Q. And I may have taken you off that course. And
19 I apologize. Let me ask you a couple of specific
20 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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1	Q. Or call					
2	A. Okay. We get real upset about those things.					
3	${\tt Q}$ . I apologize for that. You understand my					
4	question?					
5	A. Yes. I understand your question.					
6	I think that he has a duty to Doctor					
7	Senchyshak, again, in particular, and the residents					
8	in general, if they are uncomfortable with any point					
9	in the case where they feel that they need help,					
10	where they are not sure what is going on, or					
11	anything like that, then, yes, they have the					
12	opportunity and duty to call the attending					
13	anesthesiologist.					
14	Q. And do that in a timely manner?					
15	A. Correct; of course.					
16	${\tt Q}$ . Was there anytime that Doctor Senchyshak					
17	failed to timely notify Adamek of any problems?					
18	A. Not that I am aware of. I mean, it looks like					
19	the first problem he has is around the time of					
20	reversal. And according to what I read, that's when					
2 1	Doctor Senchyshak called and said, you know, "We are					
22	having some difficulty here.''					
23	${}^{\mathbb{Q}}{}_{\cdot}$ And going through the records, how long did it					
24	take the resident to call the attending in at that					
25	point when he thought he had problems?					

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

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contract. Is that a breach of the standard of 1 I am not sure how you define it in those 2 care? I think a breach of the standard of care is 3 terms. something that should have been done to a patient 4 and wasn't done. This is not done to a patient. 5 This was an information gathering type of 6 7 thing that, again, was not necessarily an impact upon anybody's care of the patient, because, again, 8 there were certain things that happen, as we discuss 9 down the line. 10 Again, in my own words, he said he would do 11 something. He didn't do it. If that's a breach of 12 the standard of care in legal terms, then, okay. 13 Q, In your opinion, doctor, when a doctor says he 14 is going to do something and he doesn't do it, that 15 is malpractice, isn't it? 16 17 Α. Well, you know, I can say I am going to go play golf this afternoon, and I am not going to get 18 it done. 19 Q. We are talking about the care. I'm sorry. 20 Ι am not trying to get too broad. 21 22 Α. I understand. I understand. And I am not 23 trying to make light of the situation. But, I am saying that I guess if you are going 24 25 to say that, then, yes, I would have to go along

with that Up goid he would de gemething Up						
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						
be, and to gather all the information concerning that.						
that.						
that. Secondly, it is my understanding that the echo						
that. Secondly, it is my understanding that the echo results that were done immediately pre-operatively						

1	really wasn't any real different information Doctor						
2	Ho was going to gather.						
3	Q. You can read echoes, right?						
4	A. Not very well. I am not going to hold myself						
5	out as an expert.						
6	Q. You can read reports?						
7	A. I can read reports.						
8	Q. You can read reports.						
9	A. Yes, I can.						
10	${\mathbb Q}\cdot$ When you read this report, whether it was the						
11	August or the October echo reports, in your opinion,						
12	that echo report was surgery was contraindicated in						
13	a patient like that, true?						
14	A. No; not necessarily correct.						
15	Q. Why is that?						
16	A. That echo shows that the patient has some						
17	global LV left ventricular dysfunction. We						
18	probably have half a dozen patients a day go through						
19	our operating room with that global LV dysfunction.						
20	It is not a contraindication of surgery.						
2 1	It is an indication that the patient is sick,						
22	the patient has an impaired myocardium, an impaired						
23	heart. It is an indication that the patient is at						
24	higher risk, and steps should be taken to try to						
25	minimize that risk. But, it is not a						

contraindication to surgery. 1 Q. Based upon the echocardiogram, he should have 2 been more aggressively monitored interoperatively? 3 That is my opinion; correct. Α. 4 Q. And based upon the echo and the aggressive 5 interoperative monitoring needed, does not Doctor Ho 6 have a responsibility to make sure that that 7 cardiology consult is done and that anesthesia 8 recognizes the need for an aggressive monitoring 9 interoperatively? 10 11 Α. No. Doctor Ho has a responsibility to make sure that the echo is done and that his opinion is 12 in the chart and that his opinion is one more piece 13 of data from which the anesthesiologists will make 14 their decision. He does not have responsibility to 15 16 call in the cardiologist. Anesthesiologists can read reports of echoes 17 and make their decision independently. 18 So, in your opinion, cardiology was not 19 Q, needed, based upon the fact that anesthesia should 20 21 have been able to recognize this? They should have been able to read the report; Α. 22 correct. And if anesthesia wanted further 23 information concerning the report or concerning the 24 implications of the report, then they may want to 25

choose to call cardiology. But, they may not, also. ---000---Recess off the record. ---000---Thereupon, the deposition was recessed at 5:25 p.m. \_\_\_000---

1	CERTIFICATE
2	STATE OF OHIO, ) SS:
3	COUNTY OF CUYAHOGA.
4	
5	I, Priscilla A. Hefner, a Notary Public within
6	and for the State of Ohio, duly commissioned and
7	qualified, do hereby certify that the foregoing
8	witness was first duly sworn to testify the truth,
9	the whole truth, and nothing but the truth; that the
10	testimony then given by him was reduced to writing b
11	means of Stenotype; that said Stenotype notes were
12	subsequently transcribed in the absence of said
13	witness; that the foregoing is a true and correct
14	transcript of the testimony then given by the witnes
15	as aforesaid; that ${\tt I}$ am not ${\tt a}$ relative, attorney, or
16	counsel <b>of</b> any party or otherwise interested in the
17	events of this action.
18	IN WITNESS WHEREOF, I have hereunto set my
19	hand and affixed my Seal of Office in Cleveland,
20	Ohio, this $18^{4/2}$ day of $1997$ .
2 1	Princilla a Helmon
22	Priscilla A. Hefrer
23	Registered Professional Reporter. Notary Public in and for
24	the State of Ohio. My commission expires:
25	February 11, 2002

Dr.	Howard S. Nearman	Conden	ise	It <sup>™</sup> Jones v. Meridia Hospital
		Page 1		Page 3
1	STATE OF OHIO, ) SS:		1	000
2	COUNTY OF CUYAHOGA. )		2	THEREUPON, PLAINTIFF'S EXHIBITS
3	00 IN THE COURT OF COMMON PLEAS		3	NUMBERS 1, 2, 3, AND 4
4			4	WERE MARKED FOR IDENTIFICATION.
5	DEWEY GLEN JONES, et al., )		5	000
6	Plaintiffs, )		6	MR. ALLEN. Hi, Doctor
7	vs. ) Case No. 306012		7	Nearman. I'm Charles Allen. I'm one of the
8	MERIDIA HURON HOSPITAL, ) et al., ) Judge Lillian Greene.		8	plaintiff's attorneys in this case. I am
9	) Defendants.		9	going to try to be as efficient in our time as
:10			10	I can. I know you have to be out of here at
311			11	6:00.
12	000	1	12	If I ask you anything you don't
:13	Videotaped Deposition of HOWARD S. NEARMAN, M. D.		12	understand, just tell me. I will repeat it.
:14	Friday, August 8, 1997		13 14	And if you want to take a break, we will take
:15		1	14 15	a break. That's absolutely no problem.
:16	The videotaped deposition of HOWARD S. NEARMAN,	1		
:17	M. D., a witness herein, called for	1	16	
:18	cross-examination by the plaintiffs under the Ohio		17	HOWARD S. NEARMAN, M. D.,
:19	Rules of civil Procedure, taken before me, Priscilla	1	18 10	being first duly sworn, was examined
:20	A. Hefner, a Notary Public within and for the State	1	19 20	and testified as follows:
21	of Ohio, at 2533 Lakeside Building, University	1	20	
:22	Hospitals, Cleveland, Ohio, commencing at 4:00 p.m.,		21	CROSS-EXAMINATION
23	the day and date above set forth.	12		BY MR. ALLEN:
:24		2		Q. I see you've got what appears to be your file
:25		2		in front of you.
			25	A. Yes, sir, I do.
		Page 2		Page 4
1	APPEARANCES:		1	Q. And so, you've got a couple of depositions in
2	On behalf of the Plaintiffs:		2	here that you have reviewed?
3	CHARLES A. ALLEN, ESQ. Keenan Law Firm		3	A. These are the rest of my files. I just got
4	148 Nassau Street, N.W. Atlanta, Georgia 30303		4	them off the table to make room. I basically have a
5	-and- JACK LANDSKRONER, ESQ.		5	list
6	Iandskroner Law Firm, Ltd. 55 Public Square, Suite 1040		6	Q. Is it the same thing that is in this letter?
7	Cleveland, Ohio 44113		7	A In the report. Yes. I thirk I have a
8	On behalf of the Defendant, Meridia Huron Hospital:			couple of extra reports from plaintiffs' experts and
9	JAMES CASEY, ESQ.			some of the defense experts, <b>as</b> well.
10	Reminqer & Reminqer The 113 St. Clair Building	1		Q. Okay. Can you just tell me what is not listed
111	Cleveland, Ohio 44114			in your opinion report.
:12	On behalf of the Defendant, Winston Ho, M. D. and Lakeland Medical Group:			A. Yes; things that I have looked at my
113	STEPHEN WALTERS, ESQ.			opinions really were formed before I got these.
114	Reminger & Reminger			Q. Your opinions were formed based upon 1 through
15	On behalf of the Defendant, Peter Adamek, M. D.:	1		8
16	SUSAN REINKER, ESQ.			
17	Jacobson, Maynard, Tuschman <b>4</b> Kalur 1001 Lakeside Avenue, Suite 1600			A. Based upon 1 through 8; yes.
18	Cleveland, Ohio 44114			Q Is that correct? And then you got a new
119	0n behalf of the Defendant, Rafal Badri, M. D.:			batch of stuff?
210	MARK JONES, ESQ.			A. I've got a letter, a report from Doctor
:11	Jacobson, Maynard, Tuschman & Kalur	1		Cascorbi, I have a report from a Doctor Mulroney, a
;12	Also present:			report from a Doctor Rapkin. Those, I think, are
23	, MR. KEITH E. MCGREGOR certified Legal Videographer			the defense reports. I have three or four reports
24	Legal video Media 			from plaintiffs' experts, too.
25		:2		Q. Just tell me which ones those are.
1		:2	25	A. I will, as soon as I can find them. They

Dr.	Howard S. Nearman Con	idens	eIt <sup>™</sup> Jones v. Meridia Hospital
	Pag	e 5	Page 7
I	should be in this. Here they are.	1	Q. What holes did you fill in from the
2	I have a Doctor Greendyke, Doctor Bussey,	2	depositions?
3	Doctor Semigran, Doctor Greenhouse, and Doctor	3	A. Well, I <i>think</i> you know, I can't recall
4	Orloff, and Doctor Caplan.	4	specifically. There were certain things, such as a
5	Q. And any new depositions that you did not have	5	lot of what happened in the operating room, as far
6	in this 1 through 8 category?	6	
7	A. No, sir.	7	holes in as to what the exact events were that
8	Q. Did you see any depositions of any of those	8	TT
9	doctors?	9	
10	A. No, sir.	10	
11	Q. Have you seen any recent depositions?	11	e
12	A. No.	12	see a little bit about what Doctor Ho was thinking
13	Q. When was this second package was the second	13	
14	package sent all together?		of these things.
15	A. March 11,1997.	15	
16	Q. All right. So, you formed your report, which	16	
17	is dated May 7, before you read this?	17	1 1
18	A. Yes. I generally try when I form reports	18	<b>5 6 7</b>
19	and opinions, I really don't try not to read the	19	e
20	other people's ideas until I form my own ideas and	20	e
21	then make my judgments.	21	- C 1
22	Q. <b>Fair</b> enough. So, when did you first write	22	3
23 24	down your opinions or form your opinions before March 11?	23 24	
24	A. You know, I got most of the I am trying to		A. Tosomeextent.
	Pag	,	Page 8 Q. You spent what total time before you formed
	figure out when I got some of these things. I	1	your – well, just tell me, what total time have you
2	obviously got them last year or the year before. Mr. Walters sent me a package. And I honestly don't	1	spent reviewing this case?
	recall – I honestly can't tell you what was in	1	A. I don't know. I keep track of that at home on
5	Q. I think it was in 1996.		my computer. I honestly can't tell you what that
6	A. Probably in 1996, with the records. And then		is.
7	the depositions sort of trickled after that as they	7	
8	came in. And I started, obviously, forming opinions	8	of the defendants?
9	from medical records.	9	A. No.
10	I like to base things on the facts. And then	10	Q. And you are here on behalf of Doctor Ho,
11	as I have holes in some of the facts or things I	11	
12	need to fill in in my own mind as to what happened	12	A. Yes. Mr. Walters sent me the chart and asked
13	and why and what and I gained some of that or as	13	me to look at this case with respect to the actions
14	much as I can from the depositions as they started	14	
15	coming in.	15	interacted with what actually happened to Mr. Jones
16	So, can I tell you exactly some time before	16	during the anesthetic, during the surgical
17	May 7 I formed these? No, I don't know when, but,	17	
18	obviously, sometime after the last of the	18	
19	depositions arrived and before the date of the	19	
20	paper.	20	
21	Q. So, the basis of your opinions were formed on	21	¥ 11
22	the records alone. And then you had some holes	22	· · · · · · · · · · · · · · · · · · ·
23	which you filled in with the depositions; is that	23	•
24	correct?	24	-
25	A. Yes, sir.	25	A. Were a direct cause of whatever happened to

Dr.	Howard S. Nearman Co	onden	ise	It <sup>™</sup> Jones v. Meridia Hospital
	Pa	ge 9		Page 11
1	him in the operating room; correct.		1	indicate whether or not Mr. Jones was medically
2	Q. All right. I've got your opinion letter, and		2	cleared or able to go to surgery?
3	I just marked it as Exhibit 1, before we started		3	A. Well, Doctor Ho said that his blood pressure
4	here.		4	was under control and that if I want to quote
5	I guess before I get to that, let me just kind		5	him, I think in his progress note on the 19th, he
6	of get a playing field as to who you feel was		6	said that patient "the echo is pending. He has
7	responsible for what in the care of Mr. Jones.		7	no clinical sounds of congestive failure; will
	A. sure.		8	review with cardiology, review with pulmonary
9	Q. Doctor Ho's responsibility to Mr. Jones was		9	consult; medically clear for surgery."
0	what?		0	Q. So, when you got your opinion from the record,
1	A. Doctor Ho was the internist who was seeing		Ι	did that indicate to you that Doctor Ho felt Dewey
2	Mr. Jones before the operation. It is my		2	Jones could withstand the surgical procedure and the
3	understanding that he was asked to help manage his			anesthesia?
4	hypertension when that Mr. Jones had when he		4	A. I assumed that from what he said. Yes.
5	first came in and then to help make sure that he was		5	Q. So, at that point, does he pass the torch on
6	ready for the surgical procedure.		6	to the anesthesiologistor to the surgeon; or who is
7	Q. Is it your opinion that Doctor Ho was brought		7	responsible after that statement in the medical
8	in to medically clear Mr. Jones for the surgical		8	records and in his deposition?
9	procedure?		9	A. Who is responsible for what?
:0	<b>A.</b> Well, I don't know what you mean by the term,	2	20	Q. Making sure that Mr. Jones is going to go
1:1	"medically clear." He was asked to give his	2	21	through the procedure.
:2	opinion. You know, and I am not trying to play	!	22	A. At that point it is the anesthesiologist who
B	games with you, but we go through this all the	!	23	is responsible for taking care of Mr. Jones.
14	time.	2	24	Q. And Doctor Ho is completely out of the picture
:5	We as anesthesiologists are really the people	2	25	at that point?
	Pag	e 10		Page 12
1	who clear patients for surgery or clear patients for		1	A. Well, Doctor Ho has put down his opinions. At
2	the anesthesia part of the surgery, which is		2	that point in time, the way things should work is
3	essentially the part of keeping them alive during		3	that the anesthesiologist who is going to be doing
	the procedure. We often ask our colleagues for help		4	that case is going to be taking care of Mr. Jones,
5	in doing that or for their opinions. But, when it		5	who in whose hands Mr. Jones is going to be
6	comes down to it, we are the ones in the operating		6	placed is responsible for assessing the patient, for
7	room, not the cardiologists, not the pulmonologists,		7	determining whether in the anesthesiologist's
8	not the internists. We are the ones who are taking		8	training and expertise that Mr. Jones is ready to
9	care of the patients. It is our decision as to when			tolerate the procedure.
10	the patient is ready for surgery and to how to make	1	10	If there is some other way that Mr. Jones
11	the patient ready for surgery. So, the term,	1	11	could be made more ready, as it were, for that or,
12	"medically clear" is something that people used to	1	12	you know, tuned up, as we often say put in better
13	use in the past. I don't <i>think</i> that really applies	1	13	shape – and if there might be a question, then that
14	to the practice of anesthesia in peri-operative	1	14	anesthesiologistmay then invoke further personnel,
15	medicine in modern days, as it were.	1	15	either Doctor Ho or a cardiologist or a
16	So, yes, again, Doctor Ho was asked to take a	1	16	pulmonologist or whoever that person feels is best
17	look at the patient to help get the patient in as	1		suited to answer any questions the anesthesiologist
18	stable a condition as possible and to give his	1		might have.
19	opinion as to whether the patient was, again, in his	1	19	Q. Now, Doctor Ho pre-operatively, did he
zio	mind, ready for surgery. That is not an automatic	2		discuss this case with Doctor Adamek?
21	equator of the patient going to surgery or being	2	21	A. Not that I can see. No.
22	ready in the mind of the anesthesiologist, who is	2	22	(Brief interruption.)
23	actually responsible for the patient	2	23	Q. Now, do you believe that that is a breach of
24	interoperatively.		24	the standard of care - his failure to communicate
25	Q. What did Doctor Ho say pre-operatively to	2	25	directly with Doctor Adamek the condition of the
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Dr.	Howard S. Nearman Con	lens	eIt <sup>™</sup> Jones v. Meridia Hospital
	Page	3	Page 15
1	patient?	Ι	be one of the people that he may wish to
	A. A breach of the standard of care by whom?	2	contact. Yes.
3	Q. Doctor Ho.	3	BY MR. ALLEN:
4	A. No. Doctor Ho has written his opinion in the	4	Q. So, it is your opinion, yes, that would be a
5	chart. If Doctor Adamek wants further information,	5	breach of the standard of care
6	Doctor Adamek has a chart available and should read	6	MS. <b>REINKER</b> objection.
7	the chart to gain that infomation. If Doctor	7	Q If he had concerns?
8	Adamek has further questions or issues that Doctor	8	A. If he had concerns, yes.
9	Ho has not spelled out, then Doctor Adamek gets a	9	Q. If he had concerns, questions, and he didn't
0	chart or gets in touch with Doctor Ho.	0	contact Doctor Ho, then that would be a breach of
1	Q. So, it is Doctor Adamek's responsibility then	Ι	the standard of care, correct?
2	if he needs to fii in the blanks of the medical	2	A. Yes.
3	records to contact Doctor Ho?	3	Q. So, Doctor Adamek is then given this patient
4	A. Correct.	4	to render anesthesia care the morning of the 20th.
5	Q. Did Doctor Adamek do that, in your opinion?	5	8,
6	<b>A.</b> I didn't see any place that he did.	6	role in this case to the care of Dewey Jones before
7	Q. Do you believe that is a breach of the	7	6
8	standard of care by Doctor Adamek?	8	· · · · · · · · · · · · · · · · · · ·
9	MS. REINKER: objection.	9	
0:	THE WITNESS: Again, that	0!	5
1:1	depends on whether Doctor Adamek had questions		Doctor Ho and Doctor Badri, correct?
12	concerning that.		A. Yes, sir.
B	BY MR. ALLEN:	B	
14	Q. From reading from his deposition, did he have		Is there anything else, in your opinion, that is
:5	any questions about it? In your opinion, did he		Doctor Ho's responsibility to Dewey Jones before
	Page 1	1	Page 16
•	have any questions?		surgery?
•	A. From his deposition, no. I am not sure that		A. No; not that I can think of.
	Doctor Adamek I am not sure what Doctor Adamek	1	Q. All right. Now, Doctor Badri's responsibility
	did in preparation for this.		to Mr. Jones pre-operatively was to do what?
5	And there was some question in my mind from	1	A. Well, he is the surgeon of record. So, he is
6	his deposition about who was in charge of seeing the		the patient excuse me the physician who
7	patient pre-operatively. Doctor Adamek seemed to	7	
8	say he was. And then at some points in time, if I	8	
9	am not mistaken, he seemed to name another one of	9	
	the anesthesia people there. So, I am not real sure	10	appropriate surgical procedure.
$\begin{vmatrix} 11 \\ 12 \end{vmatrix}$	<ul><li>what the answer to your question is.</li><li>Q. So, assuming that Doctor Adamek had some</li></ul>	11 12	
	concern as to whether he understood Doctor Ho's	12	
13	note, would it not be a breach of the standard of		A. correct.
	care for him then to follow through and contact	15	
15 16	Doctor Ho?	15	
17	MS. WINKER: objection.	17	A. correct.
18	THE WITNESS: If Doctor	18	
19	Adamek was concerned about the patient's	19	
20	condition, if Doctor Adamek had some questions	20	
20	about whether or not the patient could	21	A. No. Again, we are going back to who is the
22	tolerate the anesthesia or is best prepared	22	
213	for the anesthetic and the surgical procedure	23	is the person who is responsible for putting the
214		24	
25	answered or help in any way, Doctor Ho would	25	
L			

Dr.	. Howard S. Nearman Cond	dens	Jones v. Meridia Hospital
	Page 1	17	Page 19
Ι	surgical procedure, he then schedules it or asks the	1	Badri,
2	anesthesiologist or asks for clearance. But, again,	2	MR. WALTERS: objection.
3	the final common denominator is the anesthesiologist	3	Go ahead.
4	If the anesthesiologist says, "Well, this is my best	4	THE WITNESS: I am not sure
5	assessment of the patient. This is the risks that I	5	we are talking about a standard of care
6	feel the patient may have going into this, and we	6	issue. We are talking about a communication
7	can make the risks better by delaying a week or	7	issue here.
8	month you know, theoretically, can the patient	8	BY MR. ALLEN:
9	stand that?" He may ask the surgeon that, et	9	Q. Is the failure to communicate properly a
10	cetera. But, again, it is a collaborative thing.	IC	
11	There is not one rubber stamp that goes on and	11	MR. JONES: objection.
12	everything gets passed.		5
13	MS. REINKER: objection.	113	know, if it is – I guess I am having trouble
14	Move to strike any reference to,	.14	
15	"captain of the ship."	11	
16	BY MR. ALLEN:	16	
17	Q. Now, <b>as</b> far <b>as</b> let's clear Doctor Badri out	.17	· · · · · · · · · · · · · · · · · · ·
18	before we move on.	.18	
19		19	
20	Brief discussion off the record.	20	Ũ
21		21	
22	BY MR. ALLEN:	22	
23	Q. Doctor Badri is then in charge of the overall	:23	1 , 5 ,
214	management of the care of Dewey Jones between the	:24	
25	17th and the 20th. Is that your opinion?	:25	
	Page 1		Page 20
1	A. Correct.	1	Badri's care between the 17th and the 20th that
2	Q. And he is the one that called in Doctor Ho to		impact the standard of care?
3	come	3	-
4	A. Correct.	4	
4	Q and give a consult.	5	e v
6	Once he saw Doctor Ho's consult, if he was	6	
7	unclear as to what Doctor Ho wrote in the record,	7	
	would it be within the standard of care would it		
8	be a breach of the standard of care for him to not	8	
9	follow through and talk with Doctor Ho about his		
10		1:10	
11 12	findings?		
12	MR. JONES: objection.	1.12	
13	THE WITNESS: I am not sure	1	you on into the morning of the 20th, if I may.
14	I understand exactly where you are going with	.14	8
15	that. I mean, if he doesn't understand	1.15	e
16	something in the record, then you call the	.16	
17	person who wrote it and say, "What did you	17	
18	write?"	1:18	
19	BY MR. ALLEN:	1:19	
20	Q. Would that be a breach of the standard of care	20	e
21	to proceed with him being vague <b>as</b> to Doctor Ho's,	21	A. Correct.
22	quote, medical clearance?	122	
23	MR. JONES: objection.	123	
24	MR. WALTERS: Badri?	24	e
25	MR. ALLEN. Doctor	25	at the patient and evaluated the patient. I think

Dr	. Howard S. Nearman Con	dens	eIt <sup>™</sup> Jones v. Meridia Hospital
	Page 2	21	Page 23
1	that it depends upon what the level of training	1	have a proper evaluation of the patient: All,
2	was of the resident. It was not a sophisticated,	2	part of the chart, some of the chart is all
3	all-inclusive type of evaluation with every single	3	possible, depending upon the patient and what
4	detail. But, was it appropriate for the level of	4	is written in the chart and what the procedure
5	training of the resident? Probably.	5	is planned.
6	Q. Now, as far as the evaluation of the night	6	BY MR. ALLEN:
7	before well, as far as the night before	7	Q. As far as Doctor Adamek properly evaluating
8	evaluation by the anesthesia resident, when did	8	Dewey Jones the morning of before surgery, did he
9	Doctor Adamek become aware of what that resident ha	K 9	1 5
0	written in the record?	10	
1	A. I know that Doctor Adamek first saw the	11	MS. REINKER: objection.
2	patient the morning before, so I assume that the	12	5 6 6 5
3	chart was available for the review of that. So, I	13	
4	assume that that was the point in time that he	14	1 /
5	became aware of any and all of the written things in	15	May <b>7</b> , 1997.
6	the record.	16	
7	Q. If that was not the first time, and he did not	17	1
8	see it until the procedure had started, would that	18	11
9	have been a breach of the standard of care by Doctor	19	5
:0	Adamek, in your opinion?	20	
!1	MS. REINKER: objection.	21	Q. By that, Doctor Adamek breached the standard
12	THE WITNESS: Doctor Adamek	22	~
13	needs to review those things that are in the	23	
!4 !5	chart, those things that are pertinent to the patient care, in his judgment. There are many	24 25	Q. And if Doctor Adamek allowed the procedure to begin without a swan-ganz catheter in place, that
	Page 2	1	Page 24
1	different workups of patients. I mean,		was also a breach of the standard of care, true?
2	nursing has their input. The pulmonologist has input. And maybe the anesthesia resident	2	A. In my opinion, yes.
3	did.	2	Q. And by failure to put the swan-ganz catheter in place, Doctor Adamek allowed the development of
	Maybe what Doctor Adamek did was go	1	pulmonary edema interoperatively that led to Dewey
<b>5</b> 6	through the chart and do his own independent	6	
7	assessment, without necessarily looking at the	7	A. Not necessarily.
8	resident's assessment. So, I think failure to	8	Q. Within a reasonable degree of medical
9	include everything is not necessarily a	9	certainty, is it your opinion that that sequence of
10	deviation from the standard of care. I <i>think</i>	10	events occurred?
11	that Doctor Adamek needs to work up the	10	MS. REINKER: objection.
12	patient to the extent in his own mind that he	112	
13	has evaluated everything he needs to know	112	
14	about the patient.	14	interoperative event there that occurred
15	BY MR. ALLEN	15	around 13:00, started occurring somewhere
16	Q. So, failure to look at the chart at all before	16	between 12:30, 12:45 and culminated in CPR at
17	anesthesia began that would be a breach of the	17	13:14.
18	standard of care by Doctor Adamek if that occurred,	118	
19	true?	19	that may have happened. I really can't tell
20	MS. REINKER: objection.	20	you with – more likely than not or with a
21	THE WITNESS: Let me	21	medical probability what did happen.
22	rephrase it. I thirk failure to properly	22	BY MR. ALLEN:
23	evaluate a patient is a breach of the standard	23	Q. I'm sorry. Did you say you have no opinion as
24	of care.	24	to within a reasonable degree of medical probability
25	There are many ways that people can	25	of what happened, the sequence of events?
h			$\mathbf{D}_{\text{agg}} 21 = \mathbf{D}_{\text{agg}} 24$

Dr	Howard S. Nearman Cond	ense	-It <sup>™</sup> Jones v. Meridia Hospital
	Page 25		Page 27
1	A. I have several opinions.	1	dislodgement of the tube that caused him to have
2	Q. Within a reasonable degree of medical	2	some upper airway obstruction, which will also give
3	A. Well, I can't really say. Within a reasonable	3	you an upper airway pulmonary edema type of picture,
4	medical probability means to me more likely than	4	not caused by the heart, per se, but caused by
5	not. And I can't say that.	5	obstruction to breathing in and out and generating
6	Q. Let me just explore your opinions of what	6	negative pressures in the chest, which sort of sucks
7	happened. Tell me if you could list those off for	7	water into the lungs.
8	me.	8	I just don't have enough data to figure out
9	A. Sure. I think that flash pulmonary edema, as	9	which is more probable.
10	you were implying earlier in your question, is one	10	Q. So, you've got <b>three</b> possibilities?
11	possibility; that is, for whatever reason, Mr. Jones	111	A. Yes, sir.
12	had acute left ventricular failure. Blood backed	12	Q. The flash pulmonary edema caused by the left
13	up, flooded his lungs, fluid flooded his lungs, and	13	ventricular dysfunction, two, the fluid overload.
14	he had what we call flash, meaning acuity, rapidity	14	, , , , , , , , , , , , , , , , , , ,
15	pulmonary edema.	15	
16	Q. It means what, sir?	1	<b>A</b> . Left ventricular dysfunction has to play a
17	A. Flash, f-1-a-s-h.	1	role in that. It's very difficult to put somebody
18	Q. It means acute?		with a normal heart into pulmonary edema even with a
19	A. Pulmonary it means acute onset, very rapid		lot of fluid. Usually, it gets put into the toilet
20	pulmonary edema.	1	instead. But, people who have some sort of
21	Q. Okay. We have a poor setup here. You are	21	compromised heart, as I am sure Mr. Jones did
22	speaking into my bad ear. I really would like to	22	with extra fluid, if it is not handled properly,
23	sit on that side. So, I am going to turn to the	23	over a period of time that can happen, yes.
24	left. And I'm going to try to listen to you.	24	Q. Then the third thing was some sort of problem
25	A. That's quite okay. Sometimes I lapse into my	25	with the tube. For the time frame with the problem
	Page 26	1	Page 28
1	West Virginia accent.	1	with the tube, are you talking around the 12:30 time
2	Q. I'm from Georgia.	2	frame, in which there are several modes as to
	A. We ought to communicate very well, sir.	3	difficulty and
4	I think that that's one possibility. He may	1	A. correct.
5	have been and that could be very acute. That may	5	
6	be brought on by an arrhythmia.	6	So, at that point was there a possible pulling
7	Again, the flash part of the pulmonary edema;	7	of the tube that led to pulmonary
8	that is, the acuity, can be brought upon by acute		A. There could have been.
9	left ventricular dysfunction. That means the left	9	
10	side of the heart, for whatever reason, just all of	10	A. Are you talking about a frank extubation?
	a sudden becomes poorly functioning as a pump. This may be due to an arrhythmia. It may be due to	111	<ul><li>Q. Right.</li><li>A. I am not aware of an extubation. It is</li></ul>
12	ischemia; that is, the heart became ischemic, for	112	
13	whatever reason coronary artery disease, which is	13	certainly not documented. And the depositions don't
14 15	not uncommon in hypertensive, obese patients. And	14	seem to say clearly that there was <b>an</b> extubation. There is some question about it, I understand. But,
1	either one of those things may cause the left	15	
16	ventricle not to pump well and fluid to back up.	116	Q. So, if there is not documented extubation,
17 18	He may have had pulmonary edema that developed	17	then how would the tube get dislodged?
10	a little bit more slowly, due to fluid overload,	18 19	A. If the tube is in place but not securely in
20	although I think that's a little less likely than	20	place and that is, it is sort of riding right at
20	the flash pulmonary edema, just by looking at his	20	the border of right where the opening is to the
21	fluid balances in eyes and nose. But, it is a	21	lungs and the patient moves a bit, starts to
22	possibility.	22	cough or bucks, the tip of the tube may flip out and
23 24	Finally, there may have been some problem with	23 24	not be in the proper place. The patient may be
	ventilation or with the placement of the tube or	25	biting down on the tube and therefore obstructing
2.5	vention of with the placement of the tube of	<u>[</u>	

Dr.	. Howard S. Nearman Conde	nse	eIt <sup>™</sup> Jones v. Meridia Hospital
	Page 29		Page 31
1	the <b>tube</b> itself and then trying to breathe against	1	THE WITNESS: senchyshak.
2	their own biting down on the tube.	2	Thankyou.
3	The tube may have become kinked through	3	I think that Doctor Senchyshak is a
4	whatever maneuvers. Obviously, I wasn't there. I	4	resident who was in, I believe, his fourth
5	can't see, can't tell. But, those are all methods	5	month of training at that institution, having
6	by which an airway or airway pseudo-obstruction can	6	done some training previously at another
7	occur.	7	institution – if this is a complex case, that
8	Q. With any one of those ways, doctor, is it true	8	it is the attending's responsibility to
9	that the anesthesiologist that was managing the care	9	delineate what the resident can and cannot do
0	should have recognized the problem?	10	by themselves and to make a plan and
1	A. Correct.	1	specifically tell the resident what he or she
2	Q. And, in your opinion, was it a breach of the	2	should or should not do.
3	standard of care by anesthesia in this case the	3	BY MR. ALLEN:
4	failure to recognize the possible dislodging that	4	Q. And that should have occurred pre-operatively?
5	led to the pulmonary	5	A. Correct; or interop, before any other events
6	MR. CASEY: I am going to	6	occurred. I mean, it is a plan that changes or can
7	object and ask you to break it out, Charles,	7	change, and depending upon the patient. But, he
8	ifyoucan.	8	doesn't have to spell out pre-op all the way
9	BY MR. ALLEN:	9	through, but as they are going should say, "Now,
0	Q. All right. Is it your opinion within a	20	before you do this," or, "Before you do that," or,
1	reasonable within scratch that.	21	"Let me know," or, "You can go ahead and do this,"
2	MR. JONES: Your question	!2	et cetera.
3	assumes dislodgement.	23	Q. So, either pre-op or interoperatively, Doctor
4	BY MR. ALLEN:	24	Adamek breached the standard of care by failure to
5	Q. Is it your opinion that that breached the	25	tell Doctor Senchyshak that he needed to be present
	Page 30		Page 32
1	standard of care that the standard of care was		for the reversal of anesthesia, true?
2	breached by the anesthesiologist, Doctor Adamek,		A. That is not necessarily true. I think that
3	and/or the anesthesiologist resident for failing to		reversing the patient depends is sort of a
	recognize that there was a problem with the tube?		judgment call at that level. Reversing a patient
	A. If there was a problem with the tube, it is	5	who apparently was stable throughout the case may or
6	the anesthesia team's responsibility to recognize	6	may not have been a judgment call.
7	and correct that. Yes.	7	Doctor Adamek should have made a plan. And
8	Q. And to do that in a timely fashion in which it	8	what that plan included would have been up to Doctor
9	would cause no damage to Mr. Jones, correct?	9	Adamek at that point in time. I really can't say
0	A. Correct.	0	that "I thirk, maybe, before you extubate, call
1	Q. So, at about 12:25, 12:30, according to Doctor	1	me" - that would have been a breach of the standard
2	Senchyshak's deposition and the records, he started	2	of care. Before reverse, maybe, maybe not. I think
3	a reversal process. Is that your understanding?	3	that's sort of a judgment call.
4	A. Correct.	4	Q. But, is it your opinion that Doctor Adamek
5	Q. And when he started a reversal process, it was	5	also breached the standard of care by failure to
6	his testimony that Doctor Adamek was not in the	6	have a proper plan pre-op and interoperatively for
7	room; is that correct?	7	the management of Dewey Jones?
8	A. That is my understanding; correct.	8	A. A proper plan as relates to?
9	Q. And is it a breach of the standard of care for	9	Q. Care of the overall anesthesia care of
0	Doctor Adamek not to be in the room at the time of	:0	Dewey Jones.
1	reversal?	1:1	A. Again, I think we discussed that Doctor
2	A. I think that is something that Doctor Adamek	:2	Adamek's pre-operative evaluation was not up to what
	needs to discuss with Doctor I am going to not do	:3	I consider standard of care, and his failure to use
4	well on this name.	:4	a pulmonary artery catheter was not up to that. So,
5	MR. CASEY senchyshak.	:5	I agree with that part.
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Dr.	r. Howard S. Nearman Conden		Elt <sup>™</sup> Jones v. Meridia Hospit
	Page 33		Page 3
1	I can't tell you what the specific anesthetic	1	patient?
2	plan was or discussed or not discussed with the	2	A. I <i>think</i> , as we discussed, putting a pulmonary
3	resident, Doctor Senchyshak, because I don't know.	3	artery catheter in would help one determine what the
4	Q. Now, if a swan-ganz was in place at the time	4	pulmonary artery pressures are, what the filling
5	of a possible flash pulmonary edema, before that,	5	pressure of the heart is, so that if that were
6	could anesthesia have predicted the flash pulmonary	6	trending up throughout the case, one could take some
7	edema?	7	proper steps to correct those. They could also
8	A. Probably not.	8	determine what the cardiac output was, how well the
9	Q. Why is that?	9	heart was pumping.
10	A. Well, again, because of the nature of the	10	And they may not get into a position where the
	it is a flash pulmonary edema. If this was a result	11	flash pulmonary edema was more likely to occur.
12	of the dysrhythmia, which compromised the pumping	12	But, then again, they may have had absolutely no
13	function of the heart, then that will happen. There	13	control over it if it was one of the events that I
	is no warning. The dysrhythmia happens. And the		just got through discussing.
15	flash pulmonary edema comes literally within seconds	15	Q. But, with the swan-ganzin place, they could
	to a minute, because the heart then now is not	16	
16		17	edema occurring?
17	effectively pumping. If this was an acute ischemic		
18	episode, just like runners who go running and they	18	
19	have an acute ischemic episode that they drop	19	Q. Now, as far as fluid, the intake of fluid in
20	dead right there, there is no way to predict it.	20	Dewey Jones, do you have an opinion as to whether he
21	The pulmonary artery catheter might help one	21	got too much fluid interoperatively?
22	in looking at the slower onset pulmonary edema,	22	A. Yes, I do have an opinion.
23	i.e., the fluid overload, but not an acute or a	23	Q. What is that?
24	flash pulmonary edema, necessarily.	1	A. I don't think he did.
25	Q. The ischemic event in the left ventricular		Q. Why is that?
	Page 34	1	Page 3
1	part of the heart what evidence is there that		A. I <i>think</i> the amount of fluid that he got was
2	that occurred?		certainly within the grounds for a person of his
	A. I don't have evidence that that occurred,	(	size and NPR status, et cetera.
4	necessarily. It may have occurred and then gone	4	Q. What about the output of 25 c.c.'s of urine
5	away. It is not something that may persist in EKG's	5	and was it 400 c.c.'s of blood loss? Did you
6	for a long period of time. One can get coronary	6	calculate all that together?
7	vasospasm so that there is an interruption of	7	A. Yes.
8	adequate blood supply to the heart. The spasm	8	Q. So, 25 c.c.'s of urine output that is
9	reverses itself, and things are just fine.	9	pretty low for a fellow like this?
10	But, that is the acute nature. There are	10	A. That is a Little on the low side. But, again,
1	people who literally drop dead every day of the	11	it is short it is not the case was an hour and
12	year, unfortunately, from vasospasm. And when the	12	a half, an hour and 40 minutes for the case itself.
13	autopsy is done, their coronary artery vessels are	13	It is something that I would be concerned about, but
14	not necessarily severely diseased. They have a	1	it would not flash it would not flash alarms. I
15	vasospastic attack, which limits that. So, this may	15	mean, even if we hypothesize that the normal would
16	have been one of the things that happened.	16	
17	Q. Staying with the flash pulmonary edema, Dewey	17	100 c.c.'s, that extra 75 c.c.'s or 50 that he had
18	Jones had left ventricular dysfunction		in his body is not going to send him into pulmonary
19	pre-operatively, correct?	19	edema.
2.0	A. Correct.	20	Q. So, do you have an opinion of how much fluid
			• •
21	Q. So, I assume he was at a higher <b>risk</b> for	21	output he should have had during this procedure?
22	developing a flash pulmonary edema.	212	1
B	A. Correct.	23	Q. Urine output.
14	Q. What if anything could the anesthesia have		A. We like to see urine output of around 50 to 75
2:5	done to help prevent flash pulmonary edema in this	25	c.c.'s an hour for an adult.

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1       0. Now, real quickly back to Doctor Ho, he was         2       1       the appeadicepisode. So, it's hard to relate the         2       spre-operatively?       3       0. So, oid the secondary oxygen do mything to         4       A. That is my understanding. Yes.       5       0. Do yon the that he breached the standard of         6       care by allowing Dewey Jones ton to have his       7       hypertensive medications the night before the         9       operation?       8       A. One would assume that it would. But, one has         9       A. No. I think that he felt that Mr. Jones'       9       before and after " they di that a pre-operative         9       Dovey Jones' More' Mo	Dr.	Howard S. Nearman Cond	ense	It <sup>™</sup> Jones v. Meridia Hospital
2         supposed to manage the hypertension of Dewey Jones         2         twoofthem.           3         Q. So, did the secondary oxygen do anything to           4         A. That is my understanding. Yes.         3         Q. So, did the secondary oxygen do anything to           5         Q. Do you feel that he breached the standard of care by allowing Dewey Jones not to have his         increase the oxygenation of Dewey Jones' blood? Did           6         care by allowing Dewey Jones not to have his         normal, that ould have sense the respective or sygenate?           1         point in time. And on deosn't want the patient to         a core by allow a gene-operative           10         point in time. And on edosn't want the patient to         a core by allow a gene-operative?           13         a core by allow of blood pressure drifts back towards         in and blood flow to the kidneys. So, we           14         normal, that could have severe effects on blood flow         in an arterial Line to measure blood gase           15         intraverselly perioperative period         intraverselly?           16         like to keep them, especially perioperative period         fits and this patient the bight side of normal blood           17         pressure?         A. Yes. I think he was in good shape as far as         fits blood pressure in the beginning           20         bis blood pressure onormal blood         fit		Page 37		Page 39
2         supposed to minage the hypertension of Dewey Jones         2         twoorthem.           3         pre-operatively?         Q. So, did the scendary oxygen do anything to           4         A. That is my understanding. Yes.         Q. So, did the scendary oxygen do anything to           5         Q. Do you feel that he breached the standard of care by allowing Dewey Jones not to have his         the prime in any way to become more oxygenate?           6         A. No. I think that he felt that Mr. Jones'         A. No. I think that he felt that Mr. Jones'           10         blood pressure was fairly well controlled at that         normal, that could have a per-operative           12         point in time. And one doesn't want the pratient to         poor of the doesn't want the pratine to           12         poor stain and blood flow to the kidneys. So, wet         in an arterial lare to measure blood gases           13         normal, that could have severe effects on blood flow         in an arterial lare to measure blood gases           14         normal, that could have side         10         O. No you find fault in anybody for not puting           14         normal, that could have side         10         Newey Jones on the higher side of normal blood           15         increase admit of the standard of care to depressure courts in going into the         10         Newey Jones an attreiil line of the standard of care to depressure courts i	1	-	1	the apneatic episode. So, it's hard to relate the
4       A. That is my understanding. Yes.       4       increase the oxygenation of Dewy Jones hot of have his         5       Q. Do you feel that he breached the standard of       6       Care by allowing Dewy Jones not to have his         7       hypertensive medications the night before the       5       it help him in any way to become more oxygenated?         8       operation?       6       A. No. I think that he felt that Mr. Jones'       9         10       blood pressure was fairly well controlled at that       10       10       Was the pre-operative blood gase         11       point in time. And on decosn't want the patient to       10       Q. So, in thist four operative blood gase         12       operating pressure drifts back towards       10       10       Was the pre-operative blood gases         13       op the brood pressure in the kidneys. So, we       15       interoperatively?         14       in an atterfal Line to measure blood gases       15       interoperatively?         16       hits to keep them, operating by en-operative period       16       A. Yes.         13       Q. Do you find fault in anybody for not puting       14       in an atterfal Line to measure blood gases         15       interoperatively?       16       A. Yes.       15       interoperatively?         16	2		2	twoofthem.
<ul> <li>5 Q. Do you feel that he breached the standard of 6 care by allowing Dewey Jones not to have his 7 hypertensive medications the night before the 8 operation?</li> <li>A. No. I think that he felt that Mr. Jones?</li> <li>A. No. I think that he felt that Mr. Jones?</li> <li>Bolod pressure was fairly well controlled at that 11 point in time. And one doesn't want the patient to 2 get too low. People who are chronic hypertensives?</li> <li>I due to any any other of the standard of 2 due to low pressure diffs back towards</li> <li>I due to any any other of the standard of 9 us to the brain and blood flow to the kidneys. So, we 16 like to keep them on the higher side of 19 or you roimion, just before surgery, was 20 Dewey Jones on the higher side of 19 or you roimion, just before surgery, was 20 Dewey Jones on the higher side of 19 or you roimion, just before surgery, was 20 Dewey Jones on the higher side of 19 pre-torentively, did that have anything to do with 5 really pre-torentively, did that have anything to do with 6 his hypertension? In your opinion, what was the 2 operatively, did that have anything to do with 6 his hypertension? In your opinion, what was the 2 evels of oxygen saturation. Any one of those 3 realisting flat - obese patients laying flat - it is 5 really prety difficul from the morning. 5 really relatively difficul from the morning. 5 really relatively difficul from the morning. 6 levels of oxygen saturation. Any one of those 7 things could have been happening. 8 Q. You are aware be had a sleep apnea episode 9 that high in any as guting worse. 10 Q. 2:00 in the morning, something like that? 2 Q. Do you think that had anything to do with the 3 roid that have anything to do with the 3 roid thave been happening. 3 Q. You are aware be had a sleep a</li></ul>	3		3	Q. So, did the <i>secondary</i> oxygen do anything to
5       0. Do you feel that he breached the standard of 6 care by allowing Dewey Jones not to have his 7 hypertensive medications the night before the 8 operation?       5 it help finin in any way to become more sygenated?         6       A. One would assume that it would. But, one has 7 hopertensive medications the night before the 8 operation?       5 it help finin in any way to become more sygenated?         7       A. No. 1 think that he felt that Mr. Jones' 10 blood pressure was fairly well controlled at that 11 point in time. And one doesn't want the patient to 2 get to low. People who are chronic hypertensives 13 or if their blood pressure drifts back towards 14 normal, that could have server effects to blood flow 15 to the brain and blood flow to the kidneys. So, we 16 like to keep them on the higher side of 17 - we like to keep them on the higher side of 18 normal than on the lower side. 19 Q. So, in your opinion, just before surgery, was 20 Dewey Jones on the higher side of 19 ressure?       3 Q. Do you find fault in anybody for not putting 14 in an attrial Line Domeasure blood gases 15 interoperatively?         14 Nex.       1 or mail, that could have server effects on blood flow 15 or the surgery was approximately 150, 160 rmg over 16 ket surgery was approximately 150, 160 rmg over 17 eraot that?       3 Q. No, I'n just going to splitit up. Is that a 2 or solar or fault in anybody for no put in 2 road that 800 in the morning, 3 pre-operatively, diffult for them to maind it may 14 line anterial line is a dangerous time to put 14 presented to the hospital - that was in some pain and it may 15 really prety difficult for them to maind it may 16 ket startiger was a good breath. Whether he had been 14 laying flat - obese patients laying flat - it is 3 really repredure y sit in. Jor sa that artifiane to put 13 rig. Do you think	4		4	increase the oxygenation of Dewey Jones' blood? Did
6       care by allowing Dewey Jones not to have his       7         7       hypertensive medications the night before the         9       operation?         9       A. No. T think that he felt that Mr. Jones'         9       A. No. T think that he felt that Mr. Jones'         9       A. No. T think that he felt that Mr. Jones'         9       A. No. T think that he felt that Mr. Jones'         9       A. No. T think that he felt that Mr. Jones'         10       blood pressure was fairly well controlled at that         11       point in time. And one doesn't want the patient to         12       get too low. People who are chronic hypertensives         13       - Do you find fault in anybody for not putting         14       normal than on the lower side.         15       to the brain and blood How to the kidneys. So, we         16       Ike to keep them, one the higher side of         17       - we like to keep them, one the ligher side of         18       normal than on the lower side.         19       Q. So, in your opinion, just before surgery, was         20       Dewey Jones on the higher side of normal blood         21       resting room. His blood pressure in the beginning         23       his blood pressure control in going into the         24<	5		5	it help him in any way to become more oxygenated?
7       hypertensive medications the night before the 8       7       no evidence of that, that any measure of blood gases         8       before and after - they did have a pre-operative         9       A. No. I think that he felt that Mr. Jones'       blood pressure was fairly well controlled at that         10       point in time. And one doesn't want the patient to 2 get too low. People who are chronic hypertensives       10         13	6	care by allowing Dewey Jones not to have his	6	A. One would assume that it would. But, one has
<ul> <li>8 operation?</li> <li>9 A. No. 1 think that he felt that Mr. Jones'</li> <li>10 blood pressure was fairly well controlled at that</li> <li>11 point in time. And one doesn't want the patern to</li> <li>12 get too low. People who are chronic hypertensives</li> <li>13 — if their blood pressure drifts back towards</li> <li>14 normal, that could have severe effects on blood flow</li> <li>15 to the brain and blood flow to the kidneys. So, we</li> <li>16 like to keep them, ospecially peri-operative period</li> <li>17 — we like to keep them, ospecially peri-operative period</li> <li>18 on the lower side.</li> <li>19 Q. So, in your opinion, just before surgery, was</li> <li>20 Devey Jones on the higher side of normal blood</li> <li>21 pressure?</li> <li>22 A. Yes. I think he was in good shape as far as</li> <li>23 fits blood pressure control in going into the</li> <li>24 operating room. His blood pressure in the beginning</li> <li>25 of the surgery was approximately 150, 160 range over</li> <li>26 No 90. I think that's exactly what I would have</li> <li>21 Ro to 90. I think that's exactly what I would have</li> <li>21 Ro to 90. I think that's exactly what I would have</li> <li>23 A far as Mr. Jones receiving oxygen,</li> <li>34 A loon't know what the reason for that was. 1</li> <li>35 of the surgery was approximately 150, 160 range over</li> <li>36 A I don't know what the reason for that was. 1</li> <li>37 A baw been splinting. Again, that's what he</li> <li>39 con't now whether he was in some pain and it may</li> <li>31 have been splinting. Again, that's what he</li> <li>33 have been splinting. Again, that's what he</li> <li>34 operating flat - obese patients laying flat - it is</li> <li>35 realy pretty difficult for them to maintain higher</li> <li>30 e No ware he had a sleep apne episode</li> <li>31 have been splinting. 200 Now, se far as we have concentrated on Doctor</li> <li>34 A Yes.</li> <li>35 or 0 bo you think that had anything to do with the</li> </ul>	7		7	no evidence of that, that any measure of blood gases
9       A. No. 1 think that he felt that Mr, Jones'       9       blood pressure was fairly well controlled at that         10       point in time. And one doesn't want the patient to       after they put blin on the oxygen.         11       Q. Was the pre-operative blood gas appropriate?         12       get too low. People who are chronic hypertensives         13       - if their blood pressure drifts back towards         14       normal, that could have severe effects on blood flow         16       like to keep them on the higher side of         17       - we like to keep them on the higher side of         18       normal than on the lower side.         19       Q. So, in your opinion just before surgery, was         18       blood pressure control in going into the         21       A. Yes.         23       No to 90. I think that's exactly what I would have         2       liked to have had.         30       O. A far as Mr. Jones receiving oxygen,         34       secondary oxygen about 8:00 in the morning,         5       pre-operatively, did that was aptiend to the was in some pain and it may         10       have bene splinting. Again, that's what he         13       O. A far as Mr. Jones receiving oxygen,         34       a for thawy get ony openion, what was in some pain and it may <td>8</td> <td>••</td> <td>8</td> <td>before and after they did have <b>a</b> pre-operative</td>	8	••	8	before and after they did have <b>a</b> pre-operative
<ul> <li>point in time. And one doesn't want the patient to 12 get too low. People who are chronic hypertensives 13 q. Despite tholod gess appropriate?</li> <li>12 A. Yes. 11 Q. Was the pre-operative blood gas appropriate?</li> <li>12 A. Yes. 12 A. Yes. 13 q. Do you find fault in anybody for not putting 14 in an arterial Line to measure blood gases 15 interoperatively?</li> <li>16 A. Yes. 1 mean, that is all part of the 17 - we like to keep them, especially peri-operative yero of 16 k. Yes. 1 mean, that is all part of the 17 - we like to keep them on the higher side of 17 - we like to keep them on the higher side of normal blood 17 - we like to keep them on the higher side of normal blood 29 sessure?</li> <li>18 O. So, in your opinion, just before surgery, was 20 Devey Jones on the higher side of normal blood 21 pressure?</li> <li>19 A. Yes. 1 think he was in good shape as far as 23 his blood pressure control in going into the 24 operating room. His blood pressure in the beginning 25 of the surgery was approximately 150, 160 range over 28 liked to have had.</li> <li>10 Q. As far as Mr. Jones receiving oxygen, 4 secondary oxygen about 8:00 in the morning, 5 pre-operatively, did that have anything to do with.</li> <li>11 presented to the hospital that the gastric pain and it may 5 hav been splinting. Again, that's what he 11 presented to the hospital that the gastric pain 29 don't know whether he was in some pain and it may 51 redy party difficult for them to maintain higher 16 levels of oxygen satureton. Any one of those 13 monitors.</li> <li>14 laying flat obese patients laying flat it is 15 really prety difficult for them to maintain higher 16 levels of oxygen satureton. Any one of those 13 monitors.</li> <li>14 laying flat obese patients laying flat it is 15 really prety difficult for them to maintain higher 16 levels of oxygen satureton. Any one of those 13 monitors.</li> <li>14 A. Yes. 14 having the 20 you think that had anything to do with the 13 presented to the hospital it is 16 poly</li></ul>		*	9	blood gas. But, they did not measure a blood gas
<ul> <li>point in time. And one doesn't want the patient to is get too low. People who are chronic hypertensives is get too low. People who are chronic hypertensives is a point in time to proper drifts back towards in an arterial Line to measure blood gas appropriate?</li> <li>i. A. Yes. 1</li> <li>i. Do you find fault in anybody for not putting in an arterial Line to measure blood gases is interoperatively?</li> <li>i. A. Yes. 1. Then, that is all part of the isoner and made the isoner and made the isoner and made the isoner and made the isoner and mode the isoner and mode the isoner and mode the isoner and made the isoner and mode the isoner and mode the isoner and made the isoner and mode the isoner and made the isoner and made the isoner and mode the isoner and made the isoner and mode the isoner and made the isoner and mode the isoner and made the i</li></ul>	10	blood pressure was fairly well controlled at that	10	after they put him on the oxygen.
12       get too low. People who are chronic hypertensives       12       A. Yes.         13	11		11	Q. Was the pre-operative blood gas appropriate?
14       normal, that could have severe effects on blood flow       14       in an arterial Line to measure blood gases         15       to the brain and blood flow to the kidneys. So, we       16       interoperatively?         16       like to keep them, especially peri-operative period       16       A. Yes. I mean, that is all part of the         17       - we like to keep them on the higher side of       17       hemodynamic monitoring you know, pulmonary artery         18       normal than on the lower side.       17       hemodynamic monitoring you know, pulmonary artery         18       normal than on the ligher side of normal blood       20       catheter i, one puts an arterial line in, as well.         21       pressure?       21       That is sort of the first line of hemodynamic       22         20       sort of the surgery was approximately 150, 160 range over       25       that arterial line?       20         15       ore ating room. His blood pressure control in going into the       20       Sort of the standard of care to failure to put in         21       Nat a Mr. Jones receiving oxygen,       4       4       4       4       4         20       As far as Mr. Jones receiving oxygen,       4       A. No. I wouldhave put it in -       5       0       0       1       A. Yes.         2	12		12	<b>A.</b> <i>Yes.</i>
14 normal, that could have severe effects on blood flow       14 in an arterial Line to measure blood gases         15 to the brain and blood flow to the kidneys. So, we       15 interoperatively?         16 like to keep them, especially peri-operative period       16 A. Yes. I mean, that is all part of the         17 we like to keep them on the higher side of       17 hemodynamic monitoring you know, pulmonary artery         18 normal than on the lower side.       19 Gase assumption that anytime one puts a pulmonary         20 Devey Jones on the higher side of normal blood       20 catheter i, one puts an arterial line in, as well.         21 pressure?       21 That is sort of the first line of hemodynamic         22 A. Yes. I think he was in good shape as far as       23 bis blood pressure control in going into the       22 O. So, [T] uist going to splitit up. Is that a         24 operating room. His blood pressure in the beginning.       25 of the surgery was approximately 150, 160 range over       25         18 0 to 90. I think that's exactly what I would have       1 A. Yes.       2 Q. And it was a breach of the standard of care to         3 Q. As far as Mr. Jones receiving oxygen.       4 A. No. I wouldhave put it in       5 O. During?         5 pre-operatively, (did that have anything to do with       5 O. During?       6 A. Well, I think that's ajudgment call, whether         7 reason for that?       8. I don't know whether he was in some pain andi tray       6 of the airplane, and you like	13		13	Q. Do you find fault in anybody for not putting
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23 resident in the relationship between him and	21		21	-
	22	A. Yes.	22	-
14 oxygen being put on him?	1	· · ·	23	1
	1	oxygen being put on him?	24	Doctor Adamek, first, talking to each other
25 A. No. The oxygen was put on many hours after25 pre-operatively with the patient, all the way	25	A. No. The oxygen was put on many hours after	25	pre-operatively with the patient, all the way

Dr	. Howard S. Nearman C	ondense	eIt <sup>™</sup> Jones v. Meridia Hospital
	Pag	ge 41	Page 43
1	through. What relationship did they have?	1	Q. Or call
2	A. In a teaching institution where residents	2	A. Okay. We get real upset about those things.
3	function and learn anesthesia, the attending	3	Q. I apologize for that. You understand my
4	anesthesiologist is the person who directs the care	4	question?
5	of the anesthetic. The way that it usually runs is	5	A. Yes. I understand your question.
6	that they discuss the patient pre-operatively	6	I <i>think</i> that he has a duty to Doctor
7	together. They identify what the risk factors are,	7	Senchyshak, again, in particular, and the residents
8	what the procedure will encompass, how long the	8	in general, if they are uncomfortable with any point
9	procedure will take, and then come to an anesthetic	9	in the case where they feel that they need help,
0	plan, which will include the type of anesthetic, how	0	where they are not sure what is going on, or
1	it is administered, the specific names of which	1	anything like that, then, yes, they have the
2	agents are you going to give, what are the things	2	opportunity and duty to call the attending
3	that you are going to look out for, et cetera. The	3	anesthesiologist.
4	attending should be there, is required to be there	4	Q. And do that in a timely manner?
5	for all critical parts of the anesthetic phase.	5	A. Correct; of course.
6	Q. Being which phases?	6	Q. Was there anytime that Doctor Senchyshak
7	A. Well, I mean, most people consider induction	7	failed to timely notify Adamek of any problems?
8	and extubation <b>as</b> the critical parts of any even	8	A. Not that I am aware of. I mean, it looks like
9	routine case. And there may be critical parts of	9	the first problem he has is around the time of
0	other cases, depending upon what is being done and	0	reversal. And according to what I read, that's when
1	how the patient is tolerating things.	1	Doctor Senchyshak called and said, you know, "We are
2	Q. In this case, was there any other times a	2	
3	critical time when Doctor Adamek should have been	n 3	Q. And going through the records, how long did it
4	there?	4	
5	A. Well, I <i>think</i> that that depends upon the	5	point when he thought he had problems?
	Pag	ge 42	Page 44
1	attending anesthesiologist, in particular in		A. A matter of a couple of minutes, from what I
2	general, rather in particular, Doctor Adamek's	2	understand, reading the deposition. I don't have
3	assessment of the patient, and how things are	3	there is no documentation.
4	going. And, you know, the patient it seemed like	. 4	Q. Is there a specific standard of care,
5	a fairly smooth interoperative course until, as we	5	protocol: He should have been there within five; he
6	talked, about 12:30ish; and, therefore, may not have	e 6	should have notified him within ten?
7	needed to be there. There didn't appear to be any		A. No. He should notify him whenever he is
8	critical incidences around that time.	8	uncomfortable, whenever he is having a problem.
9	But, Doctor Adamek should have discussed with	h 9	Q. Now, back to Doctor Ho, did Doctor Ho, in your
0	Doctor Senchyshak I got it that time you know	, 0	opinion, do anything incorrectly that just did not
1	"I want to be called if such and such happens," or,	1	impact on Dewey Jones' outcome?
2	"I am worried about this guy. I will stop back,"	2	A. I think that Doctor Ho wrote in his note that
3	or, "If nothing happens, don't bother to call me,	3	he was going to look at the echo and review it with
4	because you should have a smooth course." I don't	4	cardiology, if need be. And he did not follow up on
5	know what was said. I don't know. I am just tryin		
6	to give you the general gestalt of how residents	6	Q. And do you understand that you can breach the
7	work with attending physicians.	7	standard of care, but not cause damage to a
8	Q. And I may have taken you off that course. And	8	patient? Do you understand that concept, doctor?
9	I apologize. Let me ask you a couple of specific	9	
0	questions.	0	Q. Was that a breach of the standard of care $-$
1	Is it Doctor Senchyshak's, the resident's,	1	
2	duty to communicate to Doctor Adamek at any stag	ges 2	
:3	along the operation he had an independent duty to		A. I think that any time that you state in a
4	go out and talk to Doctor Adamek about anything?	4	
5	A. We are not going to use the term, "go out."	:5	

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Dr.	Howard S. Nearman Conde	ense	elt <sup>™</sup> Jones v. Meridia Hospital
	Page <b>45</b>		Page <b>47</b>
1	contract. Is that a breach of the standard of		really wasn't any real different infomation Doctor
2	care? I am not sure how you define it in those	2	Ho was going to gather.
3	terms. I thirk a breach of the standard of care is	3	Q. You can read echoes, right?
4	something that should have been done to a patient	4	A. Not very well. I am not going to hold myself
5	and wasn't done. This is not done to a patient.	5	out <b>as</b> an expert.
6	This was an information gathering type of	6	Q. You can read reports?
7	thing that, again, was not necessarily an impact	7	A. Icanreadreports.
8	upon anybody's care of the patient, because, again,	8	Q. You can read reports.
9	there were certain things that happen, as we discuss	9	A. Yes, I can.
10	down the line.	10	Q. When you read this report, whether it was the
11	Again, in my own words, he said he would do	111	August or the October echo reports, in your opinion,
12	something. He didn't do it. If that's a breach of	12	that echo report was surgery was contraindicated in
13	the standard of care in legal terms, then, okay.	13	a patient like that, true?
14	Q. In your opinion, doctor, when a doctor says he	14	A. No; not necessarily correct.
15	is going to do something and he doesn't do it, that	15	Q. Why is that?
16	is malpractice, isn't it?	16	A. That echo shows that the patient has some
17	A. Well, you know, I can say I am going to go	117	global LV left ventricular dysfunction. We
18	play golf this afternoon, and I am not going to get	18	probably have half a dozen patients a day go through
19	it done.	19	our operating room with that global LV dysfunction.
20	Q. We are talking about the care. I'm sorry. I	20	It is not a contraindication of surgery.
21	am not trying to get too broad.	21	It is an indication that the patient is sick,
22	A. I understand. I understand. And I am not	22	the patient has an impaired myocardium, an impaired
23	trying to make light of the situation.	23	heart. It is an indication that the patient is at
24	But, I am saying that I guess if you are going	24	higher risk, and steps should be taken to try to
25	to say that., then, yes, I would have to go along	25	minimize that risk. But, it is not a
	Page 46		Page 48
1	with that. He said he would do something. He	1	contraindication to surgery.
2	didn't follow up on it. To me, that's a breach of	2	Q. Based upon the echocardiogram, he should have
	the standard of care, I guess.		been more aggressively monitored interoperatively?
4	Q. Now let's take it one step further. That	4	A. That is my opinion; correct.
5	didn't matter, in your opinion. Is that your	5	Q. And based upon the echo and the aggressive
6	testimony?	6	I B /
7	A. No. Again, my testimony was that I don't	7	have a responsibility to make sure that that
8	thirk that that impacted upon the subsequent events	8	cardiology consult is done and that anesthesia
9	that happened here.	9	recognizes the need for an aggressive monitoring
10	Q. And that's because the anesthesiologist, in	10	interoperatively?
11	your opinion, has the ultimate responsibility for	111	A. No. Doctor Ho has a responsibility to make
12	evaluating the patient before surgery	12	sure that the echo is done and that his opinion is
13	A. Well, yes.	1	in the chart and that his opinion is one more piece
14	Q Is that true?	114	e
15	A. I <i>think</i> that's primarily – that is one of the	15	their decision. He does not have responsibility to
16	reasons. And that is, the anesthesiologist has the		call in the cardiologist.
17	duty to quote, clear, unquote, the patient, to be	17	Anesthesiologists can read reports of echoes
18	sure that the patient is in <b>as</b> good a shape as need	18	and make their decision independently.
19	be, and to gather all the information concerning	19	Q. So, in your opinion, cardiology was not
20	that.	20	needed, based upon the fact that anesthesia should
21	Secondly, it is my understanding that the echo	21	have been able to recognize this?
22	results that were done immediately pre-operatively	22	A. They should have been able to read the report;
23	were not different significantly from the echo	23	correct. And if anesthesia wanted further
24	results that Doctor Ho knew about that were done		information concerning the report or concerning the
25	several months prior to that. And therefore, there	25	implications of the report, then they may want to $Page 45 - Page 48$

Dr.	Howard S. Nearman	Conde	nselt <sup>TM</sup>	Jones v. Meridia Hospital
		Page 49		
1	choose to call cardiology. But, they may not,			
2	also.			
3				
4	Recess off the record.			
5	000			
6	Thereupon, the deposition was			
7	recessed at 5:25 p.m.			
8	000			
9				
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22				
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24				
25				
		Page 50		
1	CERTIFICATE			
2	STATE OF OHIO, SS:			
3	COUNTY OF CUYAHOGA. )			
4				
5	I, Priscilla A. Hefner, a Notary Public within			
6	and for the State of Chio, duly commissioned and			
7	qualified, do hereby certify that the foregoing			
	witness was first duly sworn to testify the truth,			
9	the whole truth, and nothing but the truth; that the			
10	testimony then given by him was reduced to writing by			
	means of Stenotype; that said Stenotype notes were			
12	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			
18				
	hand and affixed my Seal of office in Cleveland,			
20				
21				
22	Priscilla A. Hefner Registered Professional Reporter.			
23	Notary Public in and for the state of <b>Chio.</b>			
24	My commission expires: February 11,2002			
25				

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Dr. Hov	ward	S. Near	man		Con	dense	eIt™			's - card	iologists
's[7] 36:8	36:4 36:16	36:5 36:17	A-line [1] able [4] 11:2	40:17 16:20	airway [4 27:3	<b>1]</b> 29:6	27:2 29:6	arrhythmia [2] 26:12	26:6	best [3] 12:16 17:4	14:22
36:17	36:25		48:21 48:22		al [2]	1:5	1:8	arrived [1]	6:19	better [2] 17:7	12:12
-and [1] 00 [5]	2:5 1:22	3:11	above [1]	1:23	alarms		36:14	arterial[3] 39:20 39:25	39:14	between [4]	17:24
24:15	38:4	38:21	absence [1] absolutely [2]	50:12 3:15	alive [1] 1 all-inclu		1	artery [7]	26:14	20:1 24:16	40:23
1 [5]	3:3	4:14	35:12	5.15	21:3	-	·1	32:24 33:21	34:13	beyond [1]	23:13
4:16 <b>100</b> [1]	5:6	9:3	accent[1]	26:1	Allen [20]		2:3	35:3 35:4 asks [2] 17:1	39:17 17:2	bit [5] 7:12 26:19 28:22	15:23 40:17
1001[1]			according [2] 43:20	30:11	3:6 3 13:23 1	3:7 5:3	3:22 17:16	assessing[1]	17:2	biting [2]	28:25
1040[1]			action [1]	50:17	17:22 1	8:19	18:25	assessment[4]		29:2	-0120
11[3]	5:15	5:24	actions [2]	8:13		.9:24 23:6	20:11 23:20	22:7 22:8	42:3	bladder [1]	16:13
50:24	0.10		8:22		24:22 2	29:19	29:24	<b>assume [4]</b> 21:14 34:21	21:12 39:6	blank [1] blanks [1]	7:23
	2:10 24:16	24:16	<b>acuity</b> [2] 26:8	25:14	31:13		02.04	assumed [2]	11:14	blood [17]	13:12 11:3
28:1	30:11	30:11	acute [10]	25:12	allowed	[2]	23:24	39:18		25:12 34:8	36:5
42:6		7 00	25:18 25:19	26:5	allowing	g <b>[1]</b>	37:6	assumes [1]	29:23	37:10         37:13           37:15         37:20	37:14 37:23
[12/30[1] [13[2]	] 24:15	7:22 24:17	26:8 33:17 33:23 34:10	33:19 35:16	alone		6:22	assuming [1] assumption [1]	14:12 30:10	37:24 39:4	39:7
	24:17	27.17	Adamek [47]	2:15	<b>along</b> [2] 45:25		42:23	Atlanta [1]	2:4	39:9 39:9 39:14	39:11
	2:4		12:20 12:25 13:6 13:8	13:5 13:9	alternati	vern	20:7	attack[1]	34:15	body [1] 36:18	
150[1]			13:15 13:18	13:9	alternati			attending[7]	7:11	border [1]	28:21
160 [1]			14:3 14:3	14:7	amount		36:1	41:3 41:14 42:17 43:12	42:1 43:24	bother [1]	42:13
1600[1]		20.1	14:12 14:19 14:24 15:13	14:20 15:15	anesthes			attending's [1]		bounds [1]	23:14
17th [2]		20:1 6:6	20:15 21:9	21:11		.0:14 .4:22	11:13 15:14	attorney[1]	50:15	brain [1]37:15	
1990[2]		5:15	21:20 21:22 22:11 22:18	22:5 23:7	16:20 2	21:8	22:3	attorneys[1]	3:8	breach [25] 13:2 13:17	12:23 14:14
23:15	50:20	0.10	23:17 23:21	23:24		9:13 2:19	30:6 33:6	August [2]	1:14	15:5 15:10	18:9
19th [1]			24:4 30:2 30:20 30:22	30:16 31:24	34:24 4	1:3	48:8	47:11 automatic[1]	10:20	18:20 19:22 22:17 22:23	21:19 24:1
	3:3	38:21	32:7 32:9	32:14		8:23	-4	autopsy[1]	34:13	29:12 30:19	32:11
2002 [1] 20th [7]		15:17	40:21 40:24 42:9 42:22	41:23 42:24	anesthes		St [21] 11:22	available [2]	13:6	39:24 40:2 44:16 44:20	40:19
	17:25	20:1	42:9 42:22	42:24	12:3 1	2:14	12:17	21:13		44:16 44:20 45:3 45:12	45:1 46:2
1	20:14		Adamek's [3]	13:11		7:2 20:20	17:3 20:22	Avenue [1]	2:17	breached [6]	23:21
	30:11 49:7	36:4	32:22 42:2		20:24 2	9:9	30:2	aware [5] 21:15 28:12	21:9 38:18	29:25 30:2 32:15 37:5	31:24
2533 [I]			add [1] 27:15 atdequate [1]	34:8		1:4 6:10	42:1 46:16	43:18		break [3]	3:14
	3:3		administered		anesthes			away [1] 34:5		3:15 29:17	
30 [3]	24:16	28:1	41:11	-	12:7	U		backed [1] bad [1] 25:22	25:12	breath [1]	38:13
30:11 30303 [1	11	2:4	admitted [1]	16:7	anesthes 9:25 4		ists[3] 48:17	Badri [7]	2:19	breathe [1] breathing [1]	29:1 27:5
:306012		2. <del>4</del> 1:7	adult [1] 36:25 affected [1]	8:19	anesthet		8:16	15:21 16:18	17:17	Brief [2] 12:22	17:20
30ish[1]		42:6	affects [1]	19:21	14:23 3	3:1	41:5	17:23 18:24	19:1 16:3	broad [1]	45:21
<b>1</b> [2]	1:22	3:3	affixed[1]	50:19	1		41:15 12:17	Badri's [2] 20:1	10.3	brought [3]	9:17
	36:12		aiforesaid [1]	50:15	answer[2	·1	14.11	balances [1]	26:22	26:6 26:8	20.02
400[1]		2.7	afternoon[1]	45:18	answered		14:25	base [1] 6:10		bucks [1] Building [2]	28:23 1:21
44113[1 44114[2		2:7 2:11	<b>again</b> [18] 10:19 13:20	10:16 16:21	anybody		45:8	based [5] 4:16 48:2	4:14 48:5	2:10	1,441
2:18	-1	ا د به	17:2 17:10	20:4	anytime 43:16	[2]	39:19	48:20	J.J	Bussey [1]	5:2
	24:16		26:7 32:21 35:12 36:10	33:10 38:10	43:10 apnea[1]		38:18	basis [1] 6:21		C [2] 50:1	50:1
1	49:7		43:7 45:7	45:8	apneatic	[1]	39:1	batch [1]	4:18	<b>C.C</b> [7] 36:4 36:8 36:16	36:5 36:17
<b>50</b> [3] 36:24	36:16	36:17	45:11 46:7		apologiz		42:19	became [2] 26:13	21:15	36:17 36:25	50.17
1	2:6		against	29:1	43:3	_		become [3]	21:9	calculate [1]	36:6
	3:11		agents[1] aggressive[2]	41:12 48:5	appear [1]		42:7	29:3 39:5		cannot[1]	31:9
7 [3]	5:17	6:17	48:9	40:0	<b>APPEAF</b> 2:1	VAINU	LO[1]	becomes [1]	26:11	Caplan <sub>[1]</sub>	5:4
23:15	00.50	06.17	aggressively	]	applies [	l)	10:13	began [2] 22:17	8:20	captain [3] 16:22 17:15	16:22
<b>75</b> [3] 36:24	36:16	36:17	48:3		apprecia	te [1]	23:18	begin 111	23:25	cardiac[1]	35:8
8 [5]	1:14	4:15	agree [1] 32:25 ahead [2]	10.2	appropri			beginning [1]	37:24	cardiologist [2	
4:16	5:6	38:4	anead [2]	19:3	[ 16:16 2 [arrest[2]]		39:11 7:8	behalf [6]	2:2	48:16	
	38:1		airplane[1]	40:12	7:22		,.0	2:8 2:12 2:19 8:10	2:15	cardiologists	[1]
90 [1]	38:1		l		L			4.17 0.10			

Index Page 1

Dr. Howard	S. Near	man	<b>CondenseIt</b> <sup>™</sup>		cardiology - echo
cardiology [6]	11:8	clear [8] 9:18 9:21	conversations [1]	denominator[1]	13:6 13:7 13:8
44:14 44:21 48:19 49:1	48:8	10:1         10:1         10:12           11:9         17:17         46:17	8:7	17:3	13:9         13:10         13:11           13:13         13:15         13:18
Cafe [58] 9:7	10:9	clearance[3] 17:2	<b>coordinate</b> [1] 16:9 <b>coronary</b> [3] 26:14	<b>depending PI</b> 23:3 31:17 41:20	13:21 14:3 14:3
11:23 12:4	12:24	18:22 23:10	34:6 34:13	deposition[9] 1:13	14:7 14:12 14:13
13:2 13:18	14:15	<b>cleared</b> [1] 11:2	correct [36] 4:17	1:16 11:18 13:24	14:16 14:18 14:20 14:24 14:25 15:10
<b>15:5</b> 15:11 15:16 15:20	15:14 16:9	<b>clearly</b> [2] 28:14	6:24 8:11 9:1	14:2 14:6 30:12 44:2 49:6	15:13 15:15 15:21
16:9 16:12	17:24	28:16 Classification 1.00	13:14         15:11         15:21           16:14         16:16         16:17	depositions[11]	15:21 15:23 15:25
18:8 18:9	18:20	<b>Cleveland</b> [5] 1:22 2:7 2:11 2:18	18:1 18:4 20:17	4:1 5:5 5:8	16:3 16:7 16:18 17:17 17:23 18:2
19:5 19:10 19:23 20:1	19:16 20:2	50:19	20:21 23:22 23:23	5:11 67 6:14	18:6 18:7 18:10
21:19 21:25	22:10	clinical [1] 11:7	28:4 29:11 30:7 30:9 30:10 30:14	6:19 6:23 7:2 7:23 28:13	18:21 18:25 19:25
22:18 22:24	23:9	collaborative [1]	30:17 30:18 31:15	detail[1] 21:4	20:15         20:15         21:9           21:11         21:19         21:22
23:22 24:1 29:13 30:1	29:9 30:1	17:10	34:19 34:20 34:23	determine [2] 35:3	21:11 21:19 21:22 22:5 22:11 22:18
3019 31:24	32:12	colleagues[1] 10:4	35:7         38:20         403           43:15         47:14         48:4	35:8	23:7 23:17 23:21
32:15 32:19	32:19	<b>corning</b> [1] 6:15	48:23 50:13	determining[2] 12:7	23:24 24:4 29:8 30:2 30:11 30:16
32:23 37:6 40:2 41:4	39:24 444	commencing [1]	cough[1] 28:23	16:15	30:20 30:22 30:23
44:17 44:20	45:2	commission [1] 50:24	counsel[1] 5 016	developed[1] 26:18	31:3 31:23 31:25
45:3 45:8	45:13	commissioned [1]	COUNTY [2] 1:2	developing[1] 34:22	32:7 32:8 32:14 32:21 33:3 37:1
45:20 46:3	10.17	50:6	50:3	development[1] 24:4	40:20 40:22 40:24
caring[1] Cascorbi [1]	19:17 4:20	<b>common</b> [2] 1:3	<b>couple</b> [4] 4:1 4:8 42:19 44:1	deviation [1] 22:10	41:23 42:2 42:9
<b>Cascorbi</b> [1] <b>case</b> [17] 1:7	4:20 3:8	17:3	<b>4:8</b> 42:19 44:1 <b>course [4]</b> 42:5	<b>Dewey</b> [18] 1:5	42:10 42:21 42:22 42:24 43:6 43:16
7:10 8:3	8:13	<b>communicate[4]</b> 12:24 19:9 26:3	42:14 42:18 43:15	11:11 15:16 15:19	43:21 44:9 44:9
12:4 12:20	15:16	42:22	COURT [1] 1:3	15:25 17:24 23:8	44:12 44:18 45:14
29:13 31:7 35:6 36:11	32:5 36:12	communicated [1]	CPR [1] 24:16	23:10 24:5 32:17 32:20 34:17 35:20	45:14 46:24 47:1 48:6 48:11
41:19 41:22	43:9	19:20	<b>critical</b> [5] 41:15	37:2 37:6 37:20	doctor's[1] 23:14
cases[1]41:20		<b>communication</b> [2] 19:6 19:21	41:18 41:19 41:23 42:8	39:4 44:11	ioctors[1] 5:9
CASEY [3]	2:9	complete[1] 23:17	42:8 criticisms [1] 19:25	diagnoses[1] 20:6	documentation [1]
29:16 30:25		completely[1] 11:24	cross-examination [2	diagnosing[1] 16:12	44:3
category [1]	5:6	complex[1] 31:7	1:18 3:21	<b>different[4]</b> 22:1 40:8 46:23 47:1	documented [3] 28:13
<b>catheter</b> [7] 24:3 32:24	23:25 33:21	comply[1] 23:9	culminated [1] 24:16	difficult[2] 27:17	28:16 28:17
35:3 39:18	39:20	compromised[2]	CUYAHOGA [2]	38:15	<b>doesn't [4]</b> 18:15 31:18 37:11 45:15
caused [5]	27:1	27:21 33:12	1:2 50:3	difficulty [2] 28:3	done[13] 19:21
27:4 27:4	27:12	computer[1] 8:5	<b>D</b> [4] 1:13 1:17 2:12 3:17	43:22	31:6 34:13 34:25
27:14	7.4	concentrated[1]	D.[2] 2:15 2:19	<b>direct [3]</b> 8:24 8:25 15:20	41:20 45:4 45:5
certain[2] 45:9	7:4	40:20 concept[1] 44:18	damage[2] 30:9	directly[1] 12:25	45:5 45:19 46:22 46:24 48:8 48:12
certainly [2]	28:13	<b>concept</b> [1] 44:18 <b>concern</b> [1] 14:13	44:17	directs[1] 41:4	down [6] 5:23
36:2		concerned[2] 14:19	dangerous [1] 40:9	discuss[5] 12:20	10:6 12:1 28:25
certainty[1]	24:9	36:13	data [3] 7:15 27:8	20:10 30:23 41:6	29:2 45:10
Certified [1]	2:23	concerning[4] 13:22	48:14	45:9	dozen [1] 47:18
certify [1]	50:7	46:19 48:24 48:24	date [2] 1:23 6:19	discussed[5] 32:21 33:2 33:2 35:2	drifts[1] 37:13
<b>cetera</b> [5] 17:10 31:22	8:17	<b>concerns</b> [3] 15:7 15:8 15:9	dated [2] 5:17 23:14	42:9	drop [2] 33:19 34:11
41:13	36:3	15:8 15:9 condition[4] 10:18	days [1] 10:15	discussing[1] 35:14	<b>due</b> [3] 26:12 26:12 26:19
change <sub>[1]</sub>	31:17	12:25 14:20 23:19	dead [2] 33:20 34:11	discussion[1] 17:20	duly [3] 3:18 50:6
changes[1]	31:16	congestive[1] 11:7	decision [3] 10:9	disease[1] 26:14	50:8
charge [2]	14:6	consider[2] 32:23	48:15 48:18	diseased[1] 34:14	during [7] 8:16
17:23		41:17	decisions [1] 8:18	<b>dislodged</b> [1] 28:18	8:16 10:3 28:5 36:21 40:5 40:19
<b>Charles</b> [3] 3:7 29:17	2:3	consult <sub>[4]</sub> 11:9	Defendant [4] 2:8	dislodgement[2]	duty [6] 16:19 42:22
3:7 29:17 chart[14]	8:12	18:5 18:6 48:8 contact[4] 13:13	2:12 2:15 2:19 defendants [2] 1:9	27:1 29:23 dialodainaru 20:14	42:23 43:6 43:12
13:5 13:6	13:7	14:15 15:2 15:10	8:8	<b>dislodging[1]</b> 29:14 <b>doctor[123]</b> 3:6	46:17
13:10 21:13	21:24	<b>contract</b> [1] 45:1	defense <sup>[2]</sup> 4:9	4:19 4:20 4:21	dysfunction [7] 26:9
22:6 22:16 23:2 23:4	23:2 44:24	contraindicated <sup>[1]</sup>	4:22	5:2 5:2 5:3	27:13         27:15         27:16           34:18         47:17         47:19
48:13	44:24	47:12	define[1] 45:2	5:3 5:3 5:4	dysrhythmia[2]
<b>chest</b> [1]27:6		contraindication[2]	degree [3] 24:8	7:12 8:10 8:14 8:18 8:22 9:9	33:12 33:14
choose[1]	49:1	47:20 48:1	24:24 25:2	9:11 9:17 10:16	E[3] 2:23 50:1
chronic <sup>[1]</sup>	37:12	<b>control</b> [3] 11:4 35:13 37:23	delaying [1] 17:7	10:25 11:3 11:11	50:1
<b>Civil</b> [1]1:19		<b>controlled</b> [1] 37:10	<b>delineate</b> [1] 31:9 <b>demise</b> [1] 24:6	11:24 12:1 12:15 12:19 12:20 12:25	ear [1] 25:22
Clair [1] 2:10			<b>demise</b> [1] 24:6	13:3 13:4 13:5	echo [9] 11:6 44:13
L		1			

Dr. Howard	S. Near	man		Condens	eIt™		ech	ocardiogram ·	• invoke
46:21 46:23	47:11	extra [3] 4:8	27:22	flooded [2]	25:13	Greenhouse	5:3	Huron [2]	1:8
47:12 47:16 48:12	48:5	36:17	<b>20</b> 10	25:13		grounds [1]	36:2	2:8	
echocardiogra	am[2]	extubate [1] extubation [7]	32:10 28:5	flow [2] 37:14 fluid [13]	37:15 25:13	Group [1]	2:12	hypertension [ 9:14 37:2	3] 38:6
44:22 48:2	4111[~'J	28:10 28:12	28:14	26:17 26:19	26:22	guess [4] 19:13 45:24	9:5 46:3	hypertensive	
echoes[2]	47:3	28:16 28:17	41:18	27:13 27:19	27:22	guy [1] 42:12	10.0	26:15 37:7	
48:17	04.5	eyes [1] 26:22		33:23 35:19 35:21 36:1	35:19 36:20	H[1] 2:3		hypertensives	[1]
edema [23] 25:9 25:15	24:5 25:20	<b>F</b> <sub>[1]</sub> 50:1		follow [4]	14:15	half [3] 36:12	36:16	37:12 hypothesize	26.15
26:7 26:18	26:21	f-l-a-s-h[1]	25:17	18:10 44:14	46:2	47:18		<b>i.e</b> [1] 33:23	50.15
27:3 27:12 27:18 33:5	27:15 33:7	<b>fact</b> [1] 48:20 factors [1]	41:7	follows[1]	3:19	hand [1] 50:19	07 00	ideas [2] 5:20	5:20
33:11 33:15	33:22	facts [2] 6:10	6:11	foregoing 121	50:7	handled [1] hands [1]	27:22 12:5	IDENTIFICA	
33:24 34:17	34:22	failed[1]	43:17	50:13 form [4] 5:18	5:20	happening [1]	38:17	[I] 3:4	
34:25 35:11 36:19	35:17	failing[1]	30:3	5:23 7:6	0.20	hard [1] 39:1	00.17	identify[1]	41:7
effectively	33:17	failure [14]	11:7	formed [6]	4:13	heart [12]	26:10	immediately [1 46:22	]
effects[1]	37:14	12:24 19:9 22:16 22:22	22:8 24:3	4:14 5:16 6:21 8:1	6:17	26:13 27:4	27:18	impact [3]	20:2
efficient [1]	3:9	25:12 29:14	31:24	forming [1]	6:8	27:21 33:13 34:1 34:8	33:16 35:5	44:11 45:7	
either [3]	12:15	32:15 32:23	39:24	forth [1] 1:23	0.0	35:9 47:23		impacted [1]	46:8
26:16 31:23 EKG's [1]	34:5	44:21 Fair [1] 5:22		four [1] 4:22		Hefner	1:20	impaired [2] 47:22	47:22
encompass[1]	34:5 41:8	fairly [2]	37:10	four-month[1]		50:5 50:22 help [10] 9:13	9:15	implications	11
episoder4	33:18	42:5	07.10	fourth[1]	31:4	10:4 10:17	9.13	48:25	•1
33:19 38:18	39:1	false [1] 39:19		frame [2] 28:2	27:25	33:21 34:25	35:3	implying [1]	25:10
equator[1]	10:21	far [9] 7:5	17:17	frank[1]	28:10	39:5 43:9	7:23	incidences [1]	42:8
especially [1]	3716	21:6 21:7 35:19 37:22	23:7 38:3	Friday [1]	1:14	helped [1] hemodynamic		include [2] 41:10	22:9
ESQ [6] 2:3 2:9 2:13	2:5 2:16	40:20		front [1] 3:24		39:17 39:21	[4]	included[1]	32:8
2:20	<i></i>	fashion[1]	30:8	function[2]	33:13	hereby [1]	50:7	incorrectly[1]	44:10
essentially [1]	10:3	fault [1] 39:13		41:3		herein [1]	1:17	increase [1]	39:4
et [7] 1:5	1:8	February [1]	50:24	functioning	26:11	hereunto [1]	50:18	independent [3	
8:17 17:9 36:3 41:13	31:22	<b>feels</b> [3] 12:16 16:25	16:10	<b>gain</b> [1] 13:7 gained [1]	6.12	<b>Hi</b> [1] 3:6		16:19 22:6	42:23
evaluate[1]	22:23	fellow[1]	36:9	gall[1] 16:13	6:13	higher[5] 37:17 37:20	34:21 38:15	independently 48:18	[1]
evaluated [3]	20:23	felt [2] 11:11	37:9	games [1]	9:23	47:24	50.10	indicate [2]	11:1
20:25 22:13		field [1] 9:6		gaps [1] 7:21		Ho [36] 2:12	7:12	11:11	_
evaluating[2] 46:12	23:7	figure [2]	6:1	gas [3] 39:9	39:9	8:10 8:14 9:11 9:17	8:18 10:16	indication [2]	47:21
evaluation [7]	21:3	27:8 file [1] 3:23		39:11	20-7	10:25 11:3	11:11	47:23 induction [6]	40:7
21:6 21:8	23:1	files [1] 4:3		gases [2] 39:14	39:7	11:24 12:1 12:19 13:3	12:15 13:4	40:7 40:9	40:10
23:9 23:17	32:22	fill[5] 6:12	7:1	gastric [1]	38:11	13:9 13:10	13:13	40:11 41:17	
event[2] 33:25	24:14	7:6 7:23	13:12	gather [2]	46:19	14:16 14:25	15:10	information [6] 13:7 45:6	13:5 46:19
events[7]	7:7	filled [1]	6:23	47:2		15:21 15:23 18:7 18:10	18:2 37:1	47:1 48:24	40.19
24:10 24:25	31:15	filling [2] 35:4	7:20	gathering [1]	45:6	44:9 44:9	44:12	input [2]22:2	22:3
35:13 46:8 evidence[3]	50:17 34:1	final [1] 17:3		general [3] 42:16 43:8	42:2	46:24 47:2 48:11	48:6	instead [1]	27:20
34:3 39:7	J77.1	Finally [1]	26:24	generally[1]	5:18	Ho's [6] 8:22	9:9	institution[3] 31:7 41:2	31:5
exact[1]7:7		findings [1]	18:11	generating [1]	27:5	14:13 15:25	18:6	intake [1]	35:19
exactly[3]	6:16	fine [1] 34:9		Georgia [2]	2:4	18:21		interacted[1]	8:15
18:14 38:1	0.10	Firm [2] 2:3	2:6	26:2	10.10	hold [1] 47:4	6.00	interactions [1]	
examined [1]	3:18	first [9] 3:18	5:22 21:17	gestalt[1] given [3]	42:16 15:13	holes [4] 6: 11 7:1 7:7	6:22	interested [1]	50:16
excuse[2] 16:7	16:6	9:15 21:11 39:21 40:24	43:19	50:10 50:14	10:15	home [1]	8:4	internist[1]	9:11
Exhibit [1]	9:3	50:8		GLEN[1]	1:5	honestly [3]	6:3	internists[1]	10:8
EXHIBITS [1]	3:2	five[1] 44:5		global [2]	47:17	6:4 8:5		interop [1]	31:15
expert[1]	47:5	flash[18] 25:14 25:17	25:9 26:7	47:19	00.1 <i>0</i>	honoring [1]	44:25	interoperative 24:14 42:5	48:6
expertise[1]	12:8	26:21 27:12	33:5	goes [2] 17:11	23:13	hospital [3] 2:8 38:11	1:8	interoperative	
experts [3] 4:9 4:23	4:8	33:6 33:11	33:15	golf [1] 45:18 gone [1] 34:4		Hospitals [1]	1:22	10:24 24:5	31:23
4:9 4:25 expires [1]	50:24	33:24         3417           34:25         35:11	34:22 35:16	good [3] 37:22	38:13	hour [4] 36:11	36:12	32:16 35:21	39:15
explore[1]	25:6	36:14 36:14	20110	46:18	U () () ()	36:16 36:25		48:3 48:10 interruption [2	112.22
extent [3]	7:25	flat [2] 38:14	38:14	Greendyke[1]	5:2	hours[1]	38:25	34:7	12.22
22:12 35:18		flip[1] 28:23		Greene [1]	1:8	HOWARD [3] 1:16 3:17	1:13	invoke [1]	12:14
		<u>L</u>		1		1.10 2.17		1	

Index Page 3

Dr. Howard	S. Near	man		Condens	eIt			ischemia -	overload
ischemia <sub>[2]</sub>	26:13	33:25 34:18	47:17	32:5 32:6	34:4	myocardium	1]	35:11	
40:15		legal [3] 2:23	2:24	34:5 34:15	35:10	47:22		occurred [8]	22:18
ischemic[4]	26:13	45:13		35:12 38:9 42:6 42:18	41:19 48:25	<b>N.W</b> [1] 2:4		24:10 24:14	31:14
33:17 33:19	33:25	less [1] 26:20		49:1	70.40	name[2]14:9	30:24	31:16 34:2 34:4	34:3
<b>issue [4]</b> 19:6 19:10 19:16	19:7	<b>letter</b> [3] 4:6 9:2	4:19	Maynard <sup>[2]</sup>	2:17	names[1] Nassau [1]	41:11 2:4	occurring[2]	24:15
issues [1]	13:8	level [3] 21:1	21:4	2:21	1	nature [2]	33:10	35:17	
itself [3] 29:1	34:9	32:4		MCGREGOR	-[1]	34:10	55.10	October [1]	47:11
36:12		levels <sup>[1]</sup>	38:16	mean [9] 9:20	18:15	Nearman [4]	1:13	Off[6] 4:4	17:20
JACK [1]	2:5	light [1] 45:23		19:19 22:1	31:16	1:16 3:7	3:17	25:7 40:17 49:4	42:18
<b>Jacobson</b> [2] 2:21	2:17	liked [1] 38:2		36:15 39:16	41:17	necessarily[9]	22:7	Office[1]	50:19
	2.0	Likely [4]	24:20	43:18		22:9 24:7	32:2	often[3] 7:17	10:4
JAMES [1]	2:9	25:4 26:20	35:11	meaning [1]	25:14	33:24 34:4 45:7 47:14	34:14	12:12	10.4
<b>Jones [47]</b> 2:20 8:15	1:5 8:19	Lillian	1:8	means [7]	16:12	need [5] 6:12	43:9	Ohio[11]	1:1
8:22 9:7	9:9	limits [1]	34:15	<b>25:4 25:16 25:19 26:9</b>	25:18 50:11	44:14 46:18	48:9	1:18 1:21	1:22
9:12 9:14	9:18	line [5] 39:14	39:20	meanwhile [1]		needed[5]	14:24	2:7 2:11	2:18
11:1 11:12	11:20	39:21 39:25	45:10	measure [3]	7:24 39:7	31:25 42:7	48:6	50:2 50:6 50:23	50:20
11:23 12:4 12:8 12:10	12:5 15:16	list [2] 4:5	25:7	39:9 39:14	57.1	48:20			10.2
15:20 15:25	15:10	listed[1]	4:10	Media[1]	2:24	needs [7]	13:12	once [2] 8:20 one [25] 3:7	18:6
16:7 16:7	16:9	listen [1]	25:24	medical [11]	2:12	16:25 19:20 22:11 22:13	21:23 30:23	<b>One [25]</b> 3:7 15:1 17:11	14:9 18:2
17:24 18:12	18:23	literally[2]	33: <b>15</b>	6.9 7:21	11:17	1		25:10 26:4	26:16
19:11 20:3	20:16	34:11 look [5] 8:13	10.17	13:12 18:22	24:8	negative[1]	27:6	29:8 33:21	34:6
23:8 23:10 24:13 25:11	23:18 27:21	22:16 41:13	10:17 44:13	24:21 24:24	25:2	new [2] 4:17	5:5	34:16 35:3	35:6
29:22 30:9	32:17	Looked [2]	44:13	254	0.10	night [6] 20:19 21:6 21:7	20:23 37:7	35:13 37:11 39:6 <b>39:6</b>	38:16 39:19
32:20 34:18	35:20	20:24	7.14	medically [6] 9:21 10:12	9:18 11:1	38:19	57:7	39:20 40:7	39:19 46:4
37:2 37:6	37:20	looking [3]	22:7	11:9 16:20	11.1	normal [5]	27:18	46:15 48:13	10.1
38:3		26:21 33:22		medications	137:7	36:15 37:14	37:18	ones[3] 4:24	10:6
<b>Jones' [5]</b> 24:6 37:9	23:19 39:4	looks[1]	43:18	medicine	10:15	37:20		10:8	
44:11	39.4	loss [1] 36:5		Meridia [2]	1:8	nose[1] 26:22		onset[2]25:19	33:22
Judge [1]	1:8	low [3] 36:9	36:10	2:8		Notary [3]	1:20	<b>0O0 [1]</b> 2:24	
judgment	21:25	37:12		:methods[1]	29:5	50:5 50:23		opening[1]	28:21
32:4 32:6	32:13	lower[1]	37:18	might [3]	12:13	<b>note</b> [3] 11:5 44:12	14:14	operating[5]	7:5
40:6		Ltd [1] 2:6		12:18 33:21			<b>FO.11</b>	9:1 10:6	37:24
judgments[1]	5:21	lungs [4]	25:13	mind [5] 6:12	10:20	notes[2]7:13	50:11	47:19	0.10
Kalur [2]	2:17	25:13 27:7	28:22	10:22 14:5	22:12	nothing[2] 50:9	42:13	<b>operation[3]</b> 37:8 42:23	9:12
2:21		LV [2] 47:17	47:19	minimize [1]	47:25	notified[1]	44:6	opinion[34]	4:11
Keenan [1]	2:3	M [6] 1:13	1:17	minute[1]	33:16	notify [2]	43:17	9:2 9:17	9:22
keep [3] 8:4	37:16	2:12 2:15 3f 7	2:19	minutes [2]	36:12	44:7	73.17	10:19 11:10	13:4
37:17	10.2	maintain[1]	38:15	44:1	14.0	now [16] 8:7	12:19	13:15 13:25	15:4
keeping <sub>[1]</sub> KEITH <sub>[1]</sub>	10:3	malpractice[1]		mistaken [1]	14:9	12:23 16:3	17:17	15:24 17:25 24:2 24:9	21:20 24:23
kidneys[1]	2:23	manage[3]	<b>9:</b> 13	modern[1]	10:15	19:25 20:12	21:6	29:12 29:20	29:25
kind [1] 9:5	37:15	16:8 37:2	ו15	modes[1]	28:2	31:19 33:4 35:19 37:1	33:16 40:20	32:14 35:20	35:22
<b>kinds</b> [1] 9:5	7.10	management	2]	monitor[1]	40:18	44:9 46:4	10.40	36:20 37:19	38:6
	7:19	17:24 32:17		monitored[1]	48:3	NPR [1] 36:3		44:10 45:14 46:11 47:11	<b>46:5</b> 48:4
kinked [1]	29:3	managing[2]	16:12	monitoring [4] 39:22 48:6	39:17 48:9	NUMBERS	3:3	48:12 48:13	48:4 48:19
knew[1]	46:24	29:9		<b>imonitors</b> [1]	40:13	nursing [1]	22:2	opinions [13]	4:13
Lakeland [1]	2:12	maneuvers[1]	29:4	month [2]	40:13	obese[2]	26:15	4:14 5:19	5:23
Lakeside [2] 2:17	1:21	manner[1]	43:14	31:5	11:0	38:14	20.15	5:23 6:8	6:21
Landskroner[	21	March [2]	5:15	months [1]	46:25	object [2]	23:12	7:6 10:5	12:1
2:5 2:6	~1	5:24	0.00	morning [10]	15:14	29:17		25:1 25:6	40:8
lapse [1]25:25		MARK <sup>[1]</sup>	2:20	15:15 15:17	15:19		13:19	opportunity[1	-
last [2] 6:2	6:18	<b>marked</b> [2] 9:3	3:4	20:13 20:14	21:12	14:17 15:6	17:13	Orloff <sup>[1]</sup>	5:4
Law [2] 2:3	2:6	9:3 matter[2]	11.1	23:8 38:4	38:21	18:12 18:23 19:11 20:3	19:2 21:21	otherwise[1]	50:16
laying [2]	38:14	46:5	44:1	most [2] 5:25	41:17	22:20 23:11	24:11	ought [1]	26:3
38:14	20.14	<b>may</b> [33] 5:17	6:17	move [4]	17:14	obstructing [1]		outcome [1]	44:11
learn [1] 41:3		8:14 12:14	15:1	17:18 20:12	23:12	obstruction [3]		<b>output</b> [7] 36:4 36:8	35:8
led [3] 24:5	28:7	17:6 17:9	20:13	moves[1]	28:22	27:5 28:9		36:4 36:8 36:22 36:23	36:21 36:24
29:15		23:15 24:19	26:4	MS [8] 13:19	14:17	obviously [5]	6:2	overall [5]	16:8
left[11] 25:12	25:24	26:5         26:12           26:16         26:18	26:12	<b>15:6</b> 17:13 22:20 23:11	21:21 24:11	6:8 6:18	7:16	16:9 16:12	17:23
26:9 26:9	26:16	28:23 28:24	26:24 29:3	1 <b>Mulroney</b> [1]	4:20	29:4		32:19	
27:12 27:14	27:16		ل , تربيد		т.4U	0 <b>CCUT</b> [2]	29:7	overload [3]	26:19
		J	******			1	··	L	

Dr. How	vard S	S. Near	man		Cond	lenseIt™			OW	m - right
27:13	33:23		16:23 18:17	36:2	pressure		33:17 35:9	**************************************	reference [1]	17:14
Own [6] 5	5:20	6:12	41:4			:10 37:13	put [13] 12:1	12:12	Registered	
	22:12	29:2	personnel [1]	12:14	1	:23 37:24	24:3 27:17	27:19	REINKER [9]	2:16
45:11			pertinent [1]	21:24	pressures	[2] 27:6	38:24 38:25	39:10	13:19 14:17	15:6
oxygen	<b>7</b> ]	38:3	Peter [1] 2:15		35:4	• • •	39:24 40:4 40:10 40:17	40:10	17:13 21:21	22:20
	38:16 39:3	38:24 39:10	phase [1]	41:15	pretty [2] 38:15	36:9		10.00	23:11 24:11	
oxygena			phases [1]	41:16		24.05	<b>puts</b> [3] 39:19 40:7	39:20	relate[1]	39:1
oxygena			physician <sup>[1]</sup>	16:6	prevent[1]		putting [4]	16:23	relates [1]	32:18
39:4	nonfi	1	physicians [1]		previousl		35:2 39:13	40:16	relationship	2] 40:23
<b>p.m</b> [2] 1	1.22	49:7	picture <sup>[2]</sup>	11:24	primarily		qualified[1]	50:7	41:1	
package		5:13	27:3	A A 144 (	Priscilla		questions[9]	12:17	relative[1]	50:15
	<b>5:3</b>	5:15	piece[2] 19:18	48:13		:22	13:8 13:21	13:25	Reminger [4]	2:10
<b>jpain</b> [3] 3		38:11	place[8]13:16	23:25	<b>probabili</b> 24:24 25		14:1 14:20	14:24	2:10 2:14	2:14
38:12	0.9	50.11	24:4 28:19	28:20			15:9 42:20		render[1]	15:14
paper [2]		6:20	28:24 33:4	35:15	probable	-	quickly[1]	37:1	repeat [1]	3:13
19:18		0.20	placed[1]	12:6	problem [9	<b>3:15</b> (24) 27:25	quite [1] 25:25		rephrase [1]	22:22
part [7] 1	0:2	10:3	placement <sub>[1]</sub>	26:25	26:24 27		quote [3]	11:4	report [12]	4:7
23:2 2	26:7	32:25	plaintiff's [2]	3:2	43:19 44		18:22 46:17		4:11 419	4:20
34:1 3	9:16		3:8		problem		R[1] 50:1		4:21 5:16	23:14
particula	LT [3]	42:1	plaintiffs[3]	1:6	43:25		Rafal	2:19	47:10 47:12 48:24 48:25	48:22
	3:7		1:18 2:2		procedure	[19] 1:19	range [1]	37:25	<b>Reporter</b> [1]	50:22
parts [3] 4	1:15	41:18	plaintiffs' [2]	4:8	8:17 8:2	20 9:16	rapid[1]25:19			
41:19			4:23		9:19 10:		rapidity [1]	25:14	<b>reports</b> [9] 4:22 4:22	4:8 5:18
party [1]5			plan [8] 31:10	31:16	11:21 12:		Rapkin [1]	4:21	47:6 47:7	47:8
pass [1] 1			32:7 32:8	32:16	16:11 17: 23:4 23:		rather [1]	42:2	47:11 48:17	.,,,,,
passed [1]	]	17:12	32:18 33:2	41:10	40:19 41:		read [11] 5:17	42:2 5:19	required [1]	41:14
past[1] 1	0:13		planned [1]	23:5	procedure		13:6 43:20	47:3	resident[16]	7:11
patient [5		10:10	<b>play [3]</b> 9:22 45:18	27:16	proceed[1]		47:6 47:7	47:8	20:19 20:22	20:24
		10:17		0.6	[process [2]		47:10 48:17	48:22	21:2 21:5	21:8
		10:23	playing [1]	9:6	30:15	50.15	reading [2]	13:24	21:9 22:3	30:3
		13:1 15:13	PLEAS <sub>[1]</sub>	1:3	Profession	าลโกา	44:2		31:4 31:9 33:3 40:23	31:11 43:24
		16:24	point [10]	11:15	50:22		ready [7]	9:16	resident's [2]	43.24 22:8
		17:6	11:22 11:25 21:14 28:6	12:2 32:9	progress [2	7:13	10:10 10:11	10:20	42:21	22:0
17:8 1	9:17	19:22	37:11 43:8	43:25	11:5		10:22 12:8	12:11	residents [3]	41:2
		20:25	points[1]	14:8	proper [5]	23:1	real [4] 14:10	37:1	42:16 43:7	T1,2
		22:12 23:1	poor[1] 25:21		28:24 32:	16 32:18	43:2 47:1	6.10	respect[1]	8:13
		28:24	poorly [1]	26:11	35:7		<b>really [13]</b> 5:19 9:25	4:13 10:13	responsibility	
31:17 3:	2:3	32:4	position <sub>[1]</sub>	35:10	properly [s	1 19:9	19:16 24:13	24:18	9:9 13:11	15:25
35:1 3		40:14	possibilities		20:23 22:	22 23:7	24:19 25:3	25:22	16:3 16:8	30:6
		41:21	27:10	•1	protocol	44:5	32:9 38:15	47:1	31:8 46:11	48:7
		44:18 45:8	possibility[3]	25:11	protocor[1]	-	reason [5]	25:11	48:11 48:15	
		46:18	26:4 26:23		[1] 29:		26:10 26:14	38:7	<b>responsible</b> [7] 10:23 11:17	9:7 11:19
47:13 4	7:16	47:21	possible [5]	10:18	Public [4]	1:20	38:8		11:23 12:6	16:23
1	7:23		23:3 28:6	29:14	2:6 50:		<b>reasonable</b> [5] 24:24 25:2	24:8	<b>irest</b> [1] 4:3	10.200
patient's		14:19	33:5		flulling [1]	28:6	29:21	25:3	result[1]	33:11
patients [		10:1	practice[1]	10:14	pulmonary		reasons [1]	46:16	results [2]	46:22
	0:9		pre-op [4]	20:19	24:5 25:	9 25:15	receiving [1]	38:3	46:24	40.22
26:15 38		47:18	31:18 31:23	32:16	25:19 25:	20 26:7	recent[1]	58.5 5:11	reversal	30:13
pending		11:6	pre-operative		26:18 26:2		,		30:15 30:21	32:1
people [15		7:10	32:22 39:8	39:11	27:12 27: 28:7 29:		Recess [1]	49:4	43:20	
		10:12 19:14	pre-operative 8:19 10:25	<b>ly[14]</b> 12:19	28:7 29: 33:5 33:6		recessed[1]	49:7	reverse [1]	32:12
		34:11	8:19 10:25 14:7 16:4	20:16	33:15 33:2		recognize [4] 30:4 30:6	29:14	reverses [1]	34:9
		40:9	31:14 34:19	37:3	33:24 34:1			48:21	reversing [2]	32:3
	1:17		38:5 40:3	40:25	34:25 35:2		recognized [1]		32:4	
people's	[1]	5:20	41:6 46:22		35:11 35:1		recognizes [1]	48:9	review [5]	11:8
per [1] 27		1	predict[1]	33:20	39:17 39:1		record [10] 7:21 11:10	7:16	11:8 21:13	21:23
peri-oper		2]	predicted[1]	33:6	pulmonolo		17:20 18:7	16:5 18:16	44:13	
10:14 37			preparation[1]	14:4	12:16 22:2		21:10 21:16	49:4	reviewed [1]	4:2
period [3]			prepared [1]	14:22	pulmonolo	g1StS [1]	records [7]	6:6	reviewing [1]	8:3
	7:16	1	present[2]	2:22	10:7	<b>~</b> • • •	6:9 6:22	11:18	riding [1]	28:20
persist[1]		34:5	31:25	44 , 44 A	<b>pump</b> [2] 26:17	26: <b>1</b> I	13:13 30:12	43:23	right [10]	5:16
person[5]		4	presented [1]	38:11		30.10	reduced [2]	35:16	9:2 16:3	20:12
r[9]			T	~~	pumping [3]	33:12	50:10		28:11 28:20	28:21
L					L		1		1	

Dr. Howard	S. Near	man		Condens	eIt™			ris	k - wait
29:20 33:20	47:3	Ship[3] 16:22	16:22	44:20 45:1	45:3	terms [2]	45:3	9:22 19:14	29:1
risk [5] 34:21	35:16	17:15		45:13 46:3		45:13		42:15 45:21	45:23
41.7 47:24	47:25	short [1] 36:11	(m) 4 m	started [7] 6:14 9:3	6:8	testified[1]	3:19	tube [14] 26:25	27:1
risks [2] 17:5	17:7	shows[1]	47:16	6:14 9:3 24:15 30:12	21:18 30:15	testify[1]	50:8	27:25 28:1 28:18 28:19	28:7 28:23
role[3] 15:16 40:21	27:17	sick[1] 47:21	0(10	starts[1]	28:22	testimony[6] 30:16 46:6	23:13 46:7	28:25 29:1	29:2
room[8] 4:4	7:5	<b>side</b> [6] 25:23 36:10 37:17	26:10 37:18	state [6] 1:1	1:20	50:10 50:14	40.7	29:3 30:4	30:5
9:1 10:7	30:17	37:20	57.10	44:23 50:2	50:6	Thank [1]	31:2	tuned [1]	12:12
30:20 37:24	47:19	significantly	[1]	50:23		themselves		<b>turn</b> [1] 25:23	
routine[1]	41:19	46:23		statement[1]	11:17	theoretically		Tuschman [2]	2:17
rubber[1]	17:11	single[1]	21:3	status [1]	36:3	17:8	-	2:21	00.0
Rules [1]	1:19	sit[1] 25:23		Staying[1]	34:17	therefore[3]	28:25	two [2] 27:13	39:2
runners[1]	33:18	situation [1]	45:23	Stenotype[2] 50:11	50:11	42:6 46:25		<b>type</b> [5] 7:15 27:3 41:10	21:3 45:6
running[1]	33:18	size [1] 36:3		step[1] 46:4		Thereupon [2] 49:6	3:2	types [1]	20:8
runs [1] 41:5		Sleep[3] 16:24	38:18	STEPHEN[1]	213	thinking [2]	7:12	ultimate	46:11
<b>S</b> [3] 1:13 3:17	1:16	40: 17 slower[1]	22.00	steps [2] 35:7	47:24	7:18	1.12	unclear [1]	18:7
saturation[1]	38:16	slowly [1]	33:22 26:19	stop[1] 42:12	77.207	third [1] 27:24		uncomfortabl	
saw [4] 15:18	18:6	smooth <sub>[2]</sub>	42:5	street[1]	2:4	thought[1]	43:25	43:8 44:8	C[2]
20:16 21:11	10.0	42:14	42:5	stress[1]	40:15	three [2] 4:22	27:10	uncommon [1]	26:15
says[2] 17:4	45:14	sometime [1]	6:18	strike [2]	17:14	through[15]	4:14	under [3]	1:18
schedule [1]	16:10	Sometimes [1]		23:13	1111-1	4:16 5:6	8:20	11:4 15:20	
schedules[1]	17:1	somewhere [1]		stuff [1] 4:18		9:23 11:21	14:15	understand[13]	3:13
scheduling[1]		<b>soon</b> [1] 4:25	2	subsequent[1]	46:8	18:10 22:6 31:19 35:14	29:3 41:1	18:14 18:15 28:15 40:21	19:15 43:3
scratch	29:21	sophisticated	r11	subsequently		43:23 47:18	41.1	43:5 44:2	44:16
se [1] 27:4		21:2	[~]	50:12		throughout[2]	32:5	44:18 45:22	45:22
Seal[1] 50:19		<b>SOTTY</b> [2] 24:23	45:20	such [3] 7:4	42:11	35:6		understood[1]	14:13
second [2]	5:13	SOFT [10] 6:7	27:6	42:11		timely [3]	30:8	unfortunately	[1]
5:13		27:20 27:24	28:20	sucks[1]	27:6	43:14 43:17		34:12	
secondary[2]	38:4	32:3 32:13 39:21 40:11	39:18	sudden[1]	26:11	times [1]	41:22	University[1]	
39:3		sounds[1]	11:7	Suite [z] 2:6	2:17	tip[1] 28:23	<i></i>	unquote[1]	46:17
Secondly[1]	46:21	spasm[1]	34:8	suited[1]	12:17	together[3] 36:6 41:7	5:14	up [11] 12:12 25:13 2617	22:11 32:8
seconds[1]	33:15	speaking[1]	25:22	supply [1]	34:8	toilet[1]27:19		32:22 32:24	35:6
securely [1]	28:19	specific [4]	33:1	supposed[1]	37:2	tolerate <sup>[2]</sup>	12:9	39:23 44:14	46:2
<b>See [10]</b> 3:23 7:9 7:12	5:8 7:16	41:11 42:19	44:4	surgeon[5] 16:5 16:25	11:16 17:9	14:22	14.1	upper [2]	27:2
12:21 13:16	21:18	specifically <sub>[2]</sub>	7:4	20:5	11.2	tolerating [1]	41:21	27:3	
29:5 36:24		31:11		surgery [21]	8:20	too [4] 4:23	35:21	upset[1]	43:2
seeing[2]	9:11	spell[1] 31:18		10:1 10:2	10:10	37:12 45:21		urine [5] 36:4	36:8
14:6		spelled[1]	13:9	10:11 10:20 11:2 11:9	10:21 16:1	torch [1] 11:15		36:22 36:23	36:24
seem [1] 28:14	<i>.</i> .	spent <sub>[2]</sub>	8:1	16:16 16:20	20:9	total [2] 8:1	8:2	used [1] 10:12	07.10
Semigran [1]	5:3	8:3	20.10	23:8 23:10	37:19	touch[1]	13:10	usually [2] 41:5	27:19
Senchyshak[1 20:16 30:25	1] 31:1	splinting[1] split[1] 39:23	38:10	37:25 46:12	47:12	toward[1]	40:15	vague [1]	18:21
31:3 31:25	33:3	Square [1]	2:6	47:20 48:1 surgical [7]	9.16	towards [1]	37:13	-	34:7
40:22 42:10	43:7		2.0 50:2	9:16 9:18	8:16 11:12	track [1] 8:4		34:12	
43:16 43:21		<b>St</b> [1] 2:10	50.2	14:23 16:11	17:1	training[5] 21:1 21:5	12:8	vasospastic[1]	
Senchyshak's 30:12 42:21	[2]	stable <sub>[2]</sub>	10:18	SUSAN[1]	2:16	21:1 21:5 31:6	31:5	ventilation[1]	26:25
send [1] 36:18		32:5	10.10		23:25	transcribed[1]	50:12	ventricle[1]	26:17
sent [3] 5:14	6:3	stages[1]	42:22		35:15		50:12	ventricular [8]	25:12
8:12	0.5	stamp[1]	17:11	Sworn [2]	3:18	A	35:6		27:14
sequence [2]	24:9	stand[1]	17:9	50:8 [ <b>T</b> [2] 50:1	<b>50</b> 1	trickled [1]	6:7	27:16 33:25 47:17	34:18
24:25		standard[39]	12:24	'Γ[2] 50:1 table[1] 4:4	50:1	tried [1] 7:6		vessels [1]	34:13
set [2] 1:23	50:18	13:2 13:18	14:14		10.11		19:13		2:24
;etup [1]	25:21	15:5 15:11 18:9 18:20	18:8	· · ·	40:11		22:19	Videographer	
everal [4]	24:18		19:5 19:22	11:23 12:4	10:8	24:1 24:6	29:8	2:23	
25:1 28:2	46:25	20:2 21:19	22:10		41:2		46:14	videotaped [2]	1:13
severe [1]	37:14	22:18 22:23	23:9		30:6	47:13 50:13	<b>7</b> 0 0	1:16	
severely[1]	34:14	23:21 24:1	29:13	ten [1] 44:6	20.0		50:9		26:1
everity [2]	16:13		30:19 32:15	1 4 4	10.15	50:9	5.10	visit[1] 20:19	1
23:19			39:24	1	40:15		5:18 47:24	<b>VS</b> [1] 1:7	
shape [3] 37:22 46:18	12:13		44:17	42:25	10:11		5:25	wait[1] 40:16	
37:22 46:18						, i Gri			

Dr. Howard		an	<b>CondenseIt</b> <sup>™</sup>		Walters - ye
<b>Walters</b> [5] 6:3 8:12	2:13 18:24				
6:3 8:12	18:24				
19:2					
vants[1]	13:5				
warning[1]	33:14				
vater [1]	27:7				
ways [2] 22:25	29:8				
veek [1] 17:7					
West [1] 26:1					
WHEREOF [1	150.18				
whole[1]	50:9				
Winston [1]	2:12				
	2.12				
wish [1] 15:1					
within [13] 18:8 24:8 25:2 25:3	1:20				
18:8 24:8 25:2 25:3	24:24 29:20				
29:21 33:15	36:2				
44:5 44:6	50:5				
without [2]	22:7				
23:25					1
withstand [2]	11:12				, ,
16:20					
	1:17				
vitness [16] 13:20 14:18	18:13				
19:4 19:12	20:4				
21:22 22:21	23:16				
24:12 31:1	50:8				
50:13 50:14	50:18				
vords [3]	8:18				
19:18 45:11					
workups [1]	22:1				
vorried [1]	42:12				
worse [1]	38:12				
mite [2] 5:22	18:18				
writing [1]	50:10				
mitten[4]					
21:10 21:15	13:4 23:4				
	1				
wrote[5] 18:7 18:17	7:17				
44:12	19.10				
/ear [3] 6:2	6:2				
34:12	0.2				
J-f. 1 44					
	1			· · · · · · · · · · · · · · · · · · ·	
	1				
	1				
	}				

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