

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

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 4 IN THE COURT OF COMMON PLEAS
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5 DEWEY GLEN JONES, et al.,)
 6 Plaintiffs,)
 7 vs.) Case No. 306012
 8 MERIDIA HURON HOSPITAL,)
 9 et al.,) Judge Lillian Greene.
 10 Defendants.)

Doc. 335

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 13 Videotaped Deposition of HOWARD S. NEARMAN, M. D.
 14 Friday, August 8, 1997

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

24
 25

1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 CHARLES H. ALLEN, ESQ.
4 Keenan Law Firm
5 148 Nassau Street, N.W.
6 Atlanta, Georgia 30303

7 -and-
8 JACK LANDSKRONER, ESQ.
9 Landskroner Law Firm, Ltd.
10 55 Public Square, Suite 1040
11 Cleveland, Ohio 44113

12 On behalf of the Defendant,
13 Meridia Huron Hospital:

14 JAMES CASEY, ESQ.
15 Reminger & Reminger
16 The 113 St. Clair Building
17 Cleveland, Ohio 44114

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

20 STEPHEN WALTERS, ESQ.
21 Reminger & Reminger

22 On behalf of the Defendant,
23 Peter Adamek, M. D.:

24 SUSAN REINKER, ESQ.
25 Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114

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

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

Also present:

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

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

5 ---000---

6 MR. ALLEN: Hi, Doctor
7 Nearman. I'm Charles Allen. I'm one of the
8 plaintiff's attorneys in this case. I am
9 going to try to be as efficient in our time as
10 I can. I know you have to be out of here at
11 6:00.

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.

16 ---000---

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

20 ---000---

21 CROSS-EXAMINATION

22 BY MR. ALLEN:

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

25 A. Yes, sir, I do.

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 Q. 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
21 report from a Doctor Rapkin. Those, I think, are
22 the defense reports. I 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

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

7 A. No, sir.

8 Q. 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
21 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

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 1996.

6 A. Probably in 1996, 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 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
17 -- what the people wrote. You often like to know
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.

21 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 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 Q. Now, have you had any conversations with any
8 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 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?

21 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

1 him in the operating room; correct.

2 Q. 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 Q. 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,
21 "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

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

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 for 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 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 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 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?

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

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

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

21 A. Not that I can see. No.

22 (Brief interruption.)

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

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 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 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 Q. 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

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

3 BY MR. ALLEN:

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

6 MS. REINKER: Objection.

7 Q. -- If he had concerns?

8 A. If he had concerns, yes.

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

12 A. Yes.

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

18 A. Not that I saw; no.

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

22 A. Yes, sir.

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

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 Q. 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 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?

21 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

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

13 MS. REINKER: Objection.

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

16 BY MR. ALLEN:

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

19 ---o0o---

20 Brief discussion off the record.

21 ---o0o---

22 BY MR. ALLEN:

23 Q. Doctor Badri is then in charge of the overall
24 management of the care of Dewey Jones between the
25 17th and the 20th. Is that **your** opinion?

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 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 I am not going to
10 discuss those.

11 **BY MR. ALLEN:**

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

21 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

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

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

15 BY MR. ALLEN:

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

20 MS. REINER: Objection.

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

25 There are many ways that people can

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:

21 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 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

1 West Virginia accent.

2 Q. I'm from Georgia.

3 A. We ought to communicate very well, sir.

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

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

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

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

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

8 1 just don't have enough data to figure out
9 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
13 ventricular dysfunction, two, the fluid overload.
14 Would that also be caused by the left ventricular
15 dysfunction, which would add to pulmonary edema?

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

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

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 So, 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
21 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

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 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 Q. 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

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

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

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

10 A. Correct.

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

14 A. Correct.

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

18 A. That is my understanding; correct.

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

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

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,
21 "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

1 for the reversal of anesthesia, true?

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

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

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

18 A. A proper plan as relates to?

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

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

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

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

8 A. Probably not.

9 Q. Why is that?

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

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

25 Q. The ischemic event in the left ventricular

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

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

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

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

20 A. Correct.

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

23 A. Correct.

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

1 patient?

2 A. I 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 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 Q. 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, 160 range over

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.

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

22 A. Yes.

23 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

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

3 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 for 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.
21 That is sort of the first line of hemodynamic
22 monitoring.

23 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 A. Yes.

2 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 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

1 through. What relationship did they have?

2 A. In a teaching institution where residents
3 function and learn anesthesia, the attending
4 anesthesiologist is the person who directs the care
5 of the anesthetic. The way that it usually runs is
6 that they discuss the patient pre-operatively
7 together. They identify what the risk factors are,
8 what the procedure will encompass, how long the
9 procedure will take, and then come to an anesthetic
10 plan, which will include the type of anesthetic, how
11 it is administered, the specific names of which
12 agents are you going to give, what are the things
13 that you are going to look out for, et cetera. The
14 attending should be there, is required to be there
15 for all critical parts of the anesthetic phase.

16 Q. Being which phases?

17 A. Well, I mean, most people consider induction
18 and extubation as the critical parts of any even
19 routine case. And there may be critical parts of
20 other cases, depending upon what is being done and
21 how the patient is tolerating things.

22 Q. In this case, was there any other times -- a
23 critical time when Doctor Adamek should have been
24 there?

25 A. Well, I think that that depends upon the

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

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

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.

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

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

1 Q. Or call --

2 A. Okay. We get real upset about those things.

3 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 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
21 Doctor Senchyshak called and said, you know, "We are
22 having some difficulty here."

23 Q. 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?

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

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

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

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

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

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

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

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

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

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

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

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

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

13 A. Well, yes.

14 Q. -- Is that true?

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

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

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 Q. 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.

21 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

1 contraindication to surgery.

2 Q. Based upon the echocardiogram, he should have
3 been more aggressively monitored intraoperatively?

4 A. That is my opinion; correct.

5 Q. And based upon the echo and the aggressive
6 intraoperative monitoring needed, does not Doctor Ho
7 have a responsibility to make sure that that
8 cardiology consult is done and that anesthesia
9 recognizes the need for an aggressive monitoring
10 intraoperatively?

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

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

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

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

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

3 ---o0o---

4 Recess off the record.

5 ---o0o---

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

8 ---o0o---

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

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

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

Page 1

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

Page 2

1 APPEARANCES:
 2 On behalf of the Plaintiffs:
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 19 and Lakeland Medical Group:
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 21 Reminger & Reminger
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 MARK JONES, ESQ.
 Jacobson, Maynard, Tuschman & Kalur
 Also present:
 MR. KEITH E. MCGREGOR
 certified Legal Videographer
 Legal video Media
 ---o0o---

Page 3

1 ---o0o---
 2 THEREUPON, PLAINTIFF'S EXHIBITS
 3 NUMBERS 1, 2, 3, AND 4
 4 WERE MARKED FOR IDENTIFICATION.
 5 ---o0o---
 6 MR. ALLEN. Hi, Doctor
 7 Nearman. I'm Charles Allen. I'm one of the
 8 plaintiff's attorneys in this case. I am
 9 going to try to be as efficient in our time as
 10 I can. I know you have to be out of here at
 11 6:00.
 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.
 16 ---o0o---
 17 HOWARD S. NEARMAN, M. D.,
 18 being first duly sworn, was examined
 19 and testified as follows:
 20 ---o0o---
 21 CROSS-EXAMINATION
 22 BY MR. ALLEN:
 23 Q. I see you've got what appears to be your file
 24 in front of you.
 25 A. Yes, sir, I do.

Page 4

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 Q. 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
 21 report from a Doctor Rapkin. Those, I think, are
 22 the defense reports. I 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 Q. And any new depositions that you did not have
 6 in this 1 through 8 category?
 7 A. No, sir.
 8 Q. 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
 21 then make my judgments.
 22 Q. ~~Fair~~ enough. So, when did you first write
 23 down your opinions or form your 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 1996.
 6 A. Probably in 1996, 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 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.

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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
 17 -- what the people wrote. You often like to know
 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.
 21 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.

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1 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 Q. Now, have you had any conversations with any
 8 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 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?
 21 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 Q. 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 Q. 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,
 21 "medically clear." He was asked to give his
 22 opinion. You know, and I **am** not trying to play
 23 B games with you, but we go through this all the
 24 time.
 25 We as anesthesiologists are really the people

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 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 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 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?

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1 who clear patients for surgery or clear patients for
 2 the anesthesia part of the surgery, which is
 3 essentially the part of keeping them alive during
 4 the procedure. We often ask our colleagues for help
 5 in doing that or for their opinions. But, when it
 6 comes down to it, we **are** the ones in the operating
 7 room, not the cardiologists, not the pulmonologists,
 8 not the internists. We **are** the ones who are taking
 9 care of the patients. It is our decision as to when
 10 the patient is ready for surgery and to how to make
 11 the patient ready for surgery. So, the term,
 12 "medically clear" is something that people used to
 13 use in the past. I don't **think** that really applies
 14 to the practice of anesthesia in peri-operative
 15 medicine in modern days, as it were.
 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 for 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 A. Well, Doctor Ho has put down his opinions. At
 2 that point in time, the way things should work is
 3 that the anesthesiologist who is going to be doing
 4 that case is going to be taking care of Mr. Jones,
 5 who -- in whose hands Mr. Jones is going to be
 6 placed is responsible for assessing the patient, for
 7 determining whether in the anesthesiologist's
 8 training and expertise that Mr. Jones is ready to
 9 tolerate the procedure.
 10 If there is some other way that Mr. Jones
 11 could be made more ready, as it were, for that or,
 12 you know, tuned up, as we often say -- put in better
 13 shape -- and if there might be a question, then that
 14 anesthesiologist may then invoke further personnel,
 15 either Doctor Ho or a cardiologist or a
 16 pulmonologist or whoever that person feels is best
 17 suited to answer any questions the anesthesiologist
 18 might have.
 19 Q. Now, Doctor Ho -- pre-operatively, did he
 20 discuss this case with Doctor Adamek?
 21 A. Not that I can see. No.
 22 (Brief interruption.)
 23 Q. Now, do you believe that that is a breach of
 24 the standard of care -- his failure to communicate
 25 directly with Doctor Adamek the condition of the

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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
 0 chart or gets in touch with Doctor Ho.
 1 Q. So, it is Doctor Adamek's responsibility then
 2 if he needs to fill in the blanks of the medical
 3 records to contact Doctor Ho?
 4 A. Correct.
 5 Q. Did Doctor Adamek do that, in your opinion?
 6 A. I didn't see any place that he did.
 7 Q. Do you believe that is a breach of the
 8 standard of care by Doctor Adamek?
 9 MS. REINKER: objection.
 10 THE WITNESS: Again, that
 11 depends on whether Doctor Adamek had questions
 12 concerning that.
 13 BY MR. ALLEN:
 14 Q. From reading from his deposition, did he have
 15 any questions about it? In your opinion, did he

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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 Q. 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. WINKER: 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

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

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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 Q. 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 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?
 21 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

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

13 MS. REINKER: objection.

14 Move to strike any reference to,

15 "captain of the ship."

16 BY MR. ALLEN:

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

19 ---o0o---

20 Brief discussion off the record.

21 ---o0o---

22 BY MR. ALLEN:

23 Q. Doctor Badri is then in charge of the overall
24 management of the care of Dewey Jones between the
25 17th and the 20th. Is that your opinion?

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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 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 I am not going to

10 discuss those.

11 BY MR. ALLEN

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

Page 21

Page 23

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 Q. 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 Q. 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?
 21 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

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

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:
 21 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

Page 24

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?

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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 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.
 4 I think that that's one possibility. He may
 5 have been -- and that could be very acute. That may
 6 be brought on by an arrhythmia.
 7 Again, the flash part of the pulmonary edema;
 8 that is, the acuity, can be brought upon by acute
 9 left ventricular dysfunction. That means the left
 10 side of the heart, for whatever reason, just all of
 11 a sudden becomes poorly functioning as a pump. This
 12 may be due to an arrhythmia. It may be due to
 13 ischemia; that is, the heart became ischemic, for
 14 whatever reason -- coronary artery disease, which is
 15 not uncommon in hypertensive, obese patients. And
 16 either one of those things may cause the left
 17 ventricle not to pump well and fluid to back up.
 18 He may have had pulmonary edema that developed
 19 a little bit more slowly, due to fluid overload,
 20 although I think that's a little less likely than
 21 the flash pulmonary edema, just by looking at his
 22 fluid balances in eyes and nose. But, it is a
 23 possibility.
 24 Finally, there may have been some problem with
 25 ventilation or with the placement of the tube or

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1 dislodgement of the tube that caused him to have
 2 some upper airway obstruction, which will also give
 3 you an upper airway pulmonary edema type of picture,
 4 not caused by the heart, per se, but caused by
 5 obstruction to breathing in and out and generating
 6 negative pressures in the chest, which sort of sucks
 7 water into the lungs.
 8 I just don't have enough data to figure out
 9 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
 13 ventricular dysfunction, two, the fluid overload.
 14 Would that also be caused by the left ventricular
 15 dysfunction, which would add to pulmonary edema?
 16 A. Left ventricular dysfunction has to play a
 17 role in that. It's very difficult to put somebody
 18 with a normal heart into pulmonary edema even with a
 19 lot of fluid. Usually, it gets put into the toilet
 20 instead. But, people who have some sort of
 21 compromised heart, as I am sure Mr. Jones did --
 22 with extra fluid, if it is not handled properly,
 23 over a period of time that can happen, yes.
 24 Q. Then the third thing was some sort of problem
 25 with the tube. For the time frame with the problem

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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 So, 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
 21 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

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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 Q. With any one of those ways, doctor, is it true
 9 that the anesthesiologist that was managing the care
 0 should have recognized the problem?
 1 A. Correct.
 2 Q. And, in your opinion, was it a breach of the
 3 standard of care by anesthesia in this case the
 4 failure to recognize the possible dislodging that
 5 led to the pulmonary --
 6 MR. CASEY: I am going to
 7 object and ask you to break it out, Charles,
 8 if you can.
 9 BY MR. ALLEN:
 0 Q. All right. Is it your opinion within a
 1 reasonable -- within -- scratch that.
 2 MR. JONES: Your question
 3 assumes dislodgement.
 4 BY MR. ALLEN:
 5 Q. Is it your opinion that that breached the

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
 1 specifically tell the resident what he or she
 2 should or should not do.
 3 BY MR. ALLEN:
 4 Q. And that should have occurred pre-operatively?
 5 A. Correct; or interop, before any other events
 6 occurred. I mean, it is a plan that changes or can
 7 change, and depending upon the patient. But, he
 8 doesn't have to spell out pre-op all the way
 9 through, but as they are going should say, "Now,
 10 before you do this," or, "Before you do that," or,
 11 "Let me know," or, "You can go ahead and do this,"
 12 et cetera.
 13 Q. So, either pre-op or interoperatively, Doctor
 14 Adamek breached the standard of care by failure to
 15 tell Doctor Senchyshak that he needed to be present

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

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

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

1 patient?
 2 A. I *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 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?

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

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.

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1 Q. 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, 160 range over

1 the apneatic episode. So, it's hard to relate the
 2 two of them.
 3 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 for 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.
 21 That is sort of the first line of hemodynamic
 22 monitoring.
 23 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 arterieline?

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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.
 21 Q. 2:00 in the morning, something like that?
 22 A. Yes.
 23 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

1 A. Yes.
 2 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 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

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1 through. What relationship did they have?

2 A. In a teaching institution where residents

3 function and learn anesthesia, the attending

4 anesthesiologist is the person who directs the care

5 of the anesthetic. The way that it usually runs is

6 that they discuss the patient pre-operatively

7 together. They identify what the risk factors are,

8 what the procedure will encompass, how long the

9 procedure will take, and then come to an anesthetic

0 plan, which will include the type of anesthetic, how

1 it is administered, the specific names of which

2 agents are you going to give, what are the things

3 that you are going to look out for, et cetera. The

4 attending should be there, is required to be there

5 for all critical parts of the anesthetic phase.

6 Q. Being which phases?

7 A. Well, I mean, most people consider induction

8 and extubation as the critical parts of any even

9 routine case. And there may be critical parts of

0 other cases, depending upon what is being done and

1 how the patient is tolerating things.

2 Q. In this case, was there any other times -- a

3 critical time when Doctor Adamek should have been

4 there?

5 A. Well, I think that that depends upon the

1 Q. Or call --

2 A. Okay. We get real upset about those things.

3 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,

0 where they are not sure what is going on, or

1 anything like that, then, yes, they have the

2 opportunity and duty to call the attending

3 anesthesiologist.

4 Q. And do that in a timely manner?

5 A. Correct; of course.

6 Q. Was there anytime that Doctor Senchyshak

7 failed to timely notify Adamek of any problems?

8 A. Not that I am aware of. I mean, it looks like

9 the first problem he has is around the time of

0 reversal. And according to what I read, that's when

1 Doctor Senchyshak called and said, you know, "We are

2 having some difficulty here."

3 Q. And going through the records, how long did it

4 take the resident to call the attending in at that

5 point when he thought he had problems?

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1 attending anesthesiologist, in particular -- in

2 general, rather -- in particular, Doctor Adamek's

3 assessment of the patient, and how things are

4 going. And, you know, the patient -- it seemed like

5 a fairly smooth interoperative course until, as we

6 talked, about 12:30ish; and, therefore, may not have

7 needed to be there. There didn't appear to be any

8 critical incidences around that time.

9 But, Doctor Adamek should have discussed with

0 Doctor Senchyshak -- I got it that time -- you know,

1 "I want to be called if such and such happens," or,

2 "I am worried about this guy. I will stop back,"

3 or, "If nothing happens, don't bother to call me,

4 because you should have a smooth course." I don't

5 know what was said. I don't know. I am just trying

6 to give you the general gestalt of how residents

7 work with attending physicians.

8 Q. And I may have taken you off that course. And

9 I apologize. Let me ask you a couple of specific

0 questions.

1 Is it Doctor Senchyshak's, the resident's,

2 duty to communicate to Doctor Adamek at any stages

3 along the operation -- he had an independent duty to

4 go out and talk to Doctor Adamek about anything?

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

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 should have 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

0 opinion, do anything incorrectly that just did not

1 impact on Dewey Jones' outcome?

2 A. I think that Doctor Ho wrote in his note that

3 he was going to look at the echo and review it with

4 cardiology, if need be. And he did not follow up on

5 that.

6 Q. And do you understand that you can breach the

7 standard of care, but not cause damage to a

8 patient? Do you understand that concept, doctor?

9 A. Yes.

0 Q. Was that a breach of the standard of care --

1 his failure to get with cardiology on that

2 echocardiogram?

3 A. I think that any time that you state in a

4 chart that, "I am going to do something," and you

5 don't do it, then you are not honoring the

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1 contract. Is that a breach of the standard of
 2 care? I am not sure how you define it in those
 3 terms. I think a breach of the standard of care is
 4 something that should have been done to a patient
 5 and wasn't done. This is not done to a patient.
 6 This was an information gathering type of
 7 thing that, again, was not necessarily an impact
 8 upon anybody's care of the patient, because, again,
 9 there were certain things that happen, as we discuss
 10 down the line.

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

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

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

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

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

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

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 Q. 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.

21 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

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

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

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

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

13 A. Well, yes.

14 Q. -- Is that true?

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

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

1 contraindication to surgery.

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

4 A. That is my opinion; correct.

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

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

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

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

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

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

3 ---o0o---

4 Recess off the record.

5 ---o0o---

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

8 ---o0o---

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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 by

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 witness

15 as aforesaid; that I am not a relative, attorney, or

16 counsel of 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 _____ day of _____, 1997.

21

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

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