

1 IN THE COURT OF COMMON PLEAS
2 SUMMIT COUNTY, OHIO
3 - - -
4 WESLEY W. WITHROW,)
5 Executor of the Estate)
6 of Wesley D. Withrow,)
7 Plaintiff,)
8 vs.) Case No. CV94-04-1279
9 JOHN G. MCANLIS, M.D.,) JUDGE MURPHY
10 and KARL D. SCHWARZE,)
11 M.D., et al.)
12 Defendants.)
13 - - -
14 Deposition of HOWARD NEARMAN, M.D., a Witness,
15 herein, called by the Plaintiff for
16 cross-examination pursuant to the Rules of civil
17 Procedure, taken before me, the undersigned, Linda
18 M. Yelinek, an RPR and Notary Public in and for the
19 State of Ohio, at university Hospitals, 2074
20 Abington Road, Cleveland, Ohio, on Monday, the 14th
21 day of August, 1995 at 4:34 o'clock p.m.
22
23
24
25
COMPUTERIZED TRANSCRIPTION BY
BISH & ASSOCIATES, INC.
812 society Building
Akron, Ohio 44308
(216) 762-0031

ORIGINAL

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Doc. 334

original filed w/ Ct 9-19-95
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1 APPEARANCES: Page 2
2
3 On Behalf of the Plaintiff:
4 Messrs. Scanlon & Gearing Co., L.P.A.
5 By: John F. Hill, Attorney at Law
6 1100 First National Tower
7 Akron, Ohio 44308
8 On Behalf of the Defendant John G.
9 McAnlis, M.D. :
10 Messrs. Fauver, Tattersall &
11 Gallagher
12 By: John Gallagher, Attorney at Law
13 400 Lorain county Bank Building
14 Elyria, Ohio 44035
15 On Behalf of the Defendant Karl D.
16 Schwarze, M.D. :
17 Messrs. Buckingham, Doolittle &
18 Burroughs, Co., L.P.A.
19 By: Gary A. Banas, Attorney at Law
20 3271 Whipple Avenue
21 Canton, Ohio 44735
22
23
24
25

1 (Plaintiff's Exhibit No. 1 was
2 marked for identification.)
3 HOWARD NEARMAN, M.D.
4 of lawful age, a Witness herein, having been first
5 duly sworn, as hereinafter certified, deposed and
6 said as follows:
7 - - -
8 CROSS-EXAMINATION
9 BY MR. HILL:
10 Q. Doctor, Mr. Banas has provided me through
11 the mail a copy of your CV. It may or may not be
12 current, but I just wanted to identify it for the
13 record. Is that reasonably a current copy?
14 A. Uh-huh, yes, it is.
15 Q. Okay. As you know, we're here today to
16 take your discovery deposition. I am the
17 Plaintiff's attorney.
18 Will you tell me your current
19 employer.
20 A. University Hospitals -- well, my --
21 technically, I guess, my employer is University
22 Anesthesiologists, Incorporated.
23 Q. Uh-huh. Are you a shareholder, partner?
24 A. Yes.
25 Q. Okay. Do you spend 50 percent or more of

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1 your time -- your professional time in the active
 2 clinical practice of medicine?
 3 A. Yes, I do.
 4 Q. And what areas do you practice currently?
 5 A. I practice currently in the giving
 6 anesthesia in the operating rooms and attending
 7 intensivists in the surgical ICU.
 8 My titles are -- I am the clinical
 9 director of operative services at University
 10 Hospitals of Cleveland, and I am the co-director of
 11 the surgical intensive care unit at the same
 12 institution.
 13 Q. And operative services title, does it have
 14 to do with anesthesia, in-operating room
 15 anesthesia?
 16 A. It has to do with operating room
 17 management. Giving anesthesia is sort of a part
 18 and parcel, part of the package.
 19 Q. And what's the -- what are your titles and
 20 responsibilities regarding the intensive care unit?
 21 A. I'm co-director of the surgical intensive
 22 care unit. I spend approximately 25 percent of my
 23 professional time in the intensive care unit. The
 24 other 75 percent revolves around the operating
 25 room. At this point I'm one of four attending --

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1 four or five, I think we're up to five now,
 2 attending intensivists who cover the surgical
 3 intensive care unit.
 4 We're all anesthesiologists. We're all
 5 critical care trained. We're all Boarded or Board
 6 eligible in critical care medicine as well, and as
 7 such we help the surgeons take care of their
 8 patients.
 9 Q. What Board certifications have you?
 10 A. I'm Board certified in anesthesiology in
 11 1983, I believe, and I passed the special
 12 certifications in critical care medicine as given
 13 by the Board of Anesthesia the first time it was
 14 given in '86, I believe,
 15 Q. Is that a common linkup, people who have
 16 anesthesia practice and then they also take on
 17 intensivist-type practice as you described?
 18 A. I don't think what you describe is
 19 common. I think the converse is true; that is,
 20 critical care intensivists are a majority of
 21 critical -- a significant portion, I guess I should
 22 say, of critical care physicians or intensivists
 23 have anesthesia background. There a very small
 24 percentage of anesthesiologists are intensivists.
 25 Q. Three-quarters or about three-quarters of

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1 your time is related to what we understand to be
 2 the typical anesthesiology practice, you're in the
 3 operating room with the surgeon handling the
 4 anesthesiology part of that case?
 5 A. Correct.
 6 Q. About a quarter of your time, rough
 7 estimate, is managing patients who are in the
 8 surgical intensive care unit?
 9 A. Correct.
 10 Q. And in that regard, are your -- are your
 11 cases all or most of your cases referred to you by
 12 surgeons?
 13 A. We -- the way that our ICU runs -- and
 14 almost all ICU's are different as far as the actual
 15 -- who actually takes care of the patients -- is
 16 that all of our patients come with sort of an
 17 automatic consult. The surgeons are still
 18 primarily responsible for the patients, their
 19 patient, but we participate what we call conjoint
 20 care, meaning that we -- we write orders on the
 21 patients, we take care of the patients. The
 22 consult is not needed, it is assumed.
 23 We don't write a consult. We write
 24 daily orders, daily progress notes along with the
 25 surgeons.

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1 Q. And that's a matter of a practice here at
 2 the hospital?
 3 A. That's correct.
 4 Q. For how long approximately has that been
 5 the practice?
 6 A. At least 14 years because that's how long
 7 I've been director or co-director of the SICU here.
 8 Q. Are there criteria, you know, for what
 9 types of patients follow that and what types of
 10 patients are exceptions to that?
 11 A. There really are no exceptions. Well, I
 12 take that back. I guess starting about a year ago
 13 there have been some exceptions to that because we
 14 got a new group of physicians here who are not
 15 full-time faculty. They're with the Mednet group,
 16 which is HMO based, and they use our hospital as
 17 their admitting hospital and they see their own
 18 patients.
 19 So there's a small percentage of the
 20 patients in the unit, probably less than ten
 21 percent, who are followed by their own private
 22 physicians or consulting physicians. The other 95
 23 percent or so are -- are -- is a conjoined care,
 24 like I said. And within that, as you are probably
 25 asking, there are some groups that have more active

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1 -- some of the surgeons have more active interest
2 in taking care of the patients, others have a very
3 less active interest. The cardiac surgeons, by
4 virtue of how they practice, have an active
5 interest because it is critical care what they do
6 every day.

7 When an orthopedic surgical patient
8 lands in -- in our ICU or urology patients or
9 obstetrical patients, GYN, ENT patients, the
10 surgeons are more than happy to follow the patient
11 along, and they will be glad to take care of them
12 once they come out of the unit. We're primarily,
13 for all practical purposes, are all physicians of
14 record at that point.

15 Q. And on those types, the non-cardiac cases
16 that you listed before, what -- how do you work
17 out, how do you hash out amongst you, the
18 intensivists and the surgeon, you know, under what
19 circumstances the surgeon is reintroduced into the
20 postsurgical care and under what circumstances you
21 are just kind of left to make the decisions and
22 make the, you know, orders?

23 A. We're the -- we maintain a presence during
24 the day, you know, seven days a week. Five days a
25 week we're there ten, twelve hours a day. The

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1 other two days of the week, weekends, we're there
2 for rounds a few hours a day.

3 We -- we're there -- we're there if
4 anything happens. If something happens when we're
5 not there, then usually the house physician for
6 that service, the surgical resident gets called for
7 that incident then. If it's a critical care issue,
8 we'll usually call our critical care fellow or one
9 of us. If it's a surgical issue, like, you know,
10 the wound looks bad or something like that, then
11 they'll call their attending surgeon.

12 Oftentimes they'll call both and do a
13 lot of communication; depends on the patient,
14 depends on the problem.

15 Q. Now, what information do you have or what
16 assumptions are you making as to what sort of an
17 arrangement Barborton Citizens had; similar to
18 yours, different from yours, how would you
19 characterize?

20 A. I would assume everybody's different from
21 ours.

22 Q. I do, too.

23 A. It would be nice if everybody's not
24 different from everybody else's. I assume
25 Barborton was -- is what would be typical of most

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1 non-academic medical centers where they do not have
2 in-house residents or in-house house physicians.
3 They may or may not have in-house house physicians.

4 I don't know, but I assume that the
5 consults are put into other specialties, that is
6 cardiologists or pulmonologists or intensivists and
7 that there's some working arrangement among those
8 physicians as to who gets called for what.

9 Q. I guess what I'm getting down to --
10 instead of dancing around, I'll just mention it.
11 You're going to render some opinions, I take it, on
12 Dr. Schwarze and whether he complied with the
13 standard of care and perhaps others.

14 As you have analyzed those issues, you
15 are analyzing them from the perspective of the work
16 environment they're in and not the standards and
17 practices here at University Hospitals?

18 A. Correct.

19 Q. Okay.

20 A. I'm analyzing them from what I can see.
21 You know, I'm not even making a lot of assumptions,
22 I don't think, about the work environment. I'm
23 making -- I'm analyzing it from things, actions
24 that I've seen taken or not taken, communications
25 I've seen given or not given, et cetera.

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1 Q. Uh-huh.

2 A. Some of those may implicitly imply a
3 certain work environment or certain way things are
4 handled routinely. I feel that many of them are
5 not.

6 Q. Do you personally have experience with the
7 postoperative management of Whipple patients,
8 Whipple procedures?

9 A. Sure.

10 Q. Categorize it for me, roughly.

11 A. How many this month or how many this
12 year?

13 Q. However you can tell us so I get a feel
14 for it.

15 A. I would probably say we do -- and it's not
16 -- it's not a common operation anymore even in the
17 -- even in the major medical centers probably
18 selectively grouped regionalized -- but I would say
19 we probably do one or two a month here. So
20 multiply that by fourteen years.

21 Q. In the last five years or so, from '90 to
22 the present, let's say, has the standard
23 postoperative care and treatment of Whipple
24 patients changed in any way in a material respect?

25 A. No. The immediate critical care part of

1 it?
 2 Q. (Nodding head up and down.)
 3 A. No. I can't speak for what the surgical
 4 enhancement, which is when the N.G. tube -- how
 5 many days it takes the N.G. tube to take it out or
 6 when you start feeding them, et cetera, but the
 7 standards of critical care, when you're following
 8 them in the first 24, 48 hours, you know.
 9 Q. Okay. You have previously testified at
 10 deposition, I take it?
 11 A. (Witness nodding head up and down.)
 12 Q. Yes?
 13 A. How you take it as such?
 14 Q. Just a guess, just a lucky guess.
 15 A. Yes, I have.
 16 Q. Have you previously testified live at
 17 trial?
 18 A. A couple of three, four occasions over the
 19 last fifteen years, yes.
 20 Q. And aside from the deposition of Dr.
 21 Black, Dr. Schwarze --
 22 A. Schwarze.
 23 Q. -- you read a summary of Dr. Mir's
 24 deposition, correct?
 25 A. Uh-huh. Dr. McAnlis.

1 Q. Dr. McAnlis' deposition. Any of the
 2 nurses' depositions did you read?
 3 A. No.
 4 Q. What you've read you have here in front of
 5 you?
 6 A. Correct.
 7 Q. You looked through the chart, I take it?
 8 A. Yes. The chart with the autopsy, I think,
 9 and the medical records --
 10 Q. Okay.
 11 A. -- of Mr. Withrow's admission.
 12 Q. When were you hired by Mr. Banas' firm or
 13 retained by Mr. Banas' firm to look through this
 14 case and to evaluate it for him?
 15 A. Gee, I don't know. I don't recall how
 16 long it's been, a while back.
 17 Q. Has it been --
 18 A. Year.
 19 Q. -- more than six months?
 20 A. Probably more than six months, less than a
 21 year, something like that.
 22 Q. Okay.
 23 MR. BANAS: It's probably right.
 24 BY MR. HILL:
 25 Q. Have you ever personally talked with Dr.

1 Schwarze or Dr. McAnlis or any of the players in
 2 this case?
 3 A. No, don't know them, haven't talked to
 4 them.
 5 Q. Have you relied upon any literature in
 6 forming your opinions about this case?
 7 A. Specifically, no. Just things that I
 8 would remember from the past, but no, I do not.
 9 Q. Okay.
 10 A. Did not go to any books or journals to
 11 look up anything, no.
 12 Q. Do you consider any literature, medical
 13 literature authoritative on the subjects or the
 14 issues raised by this case?
 15 A. A lot of good books about the things that
 16 are raised in this case. No, I never considered
 17 any one piece authoritative.
 18 Q. There's not a piece of literature or
 19 textbook or treatise that you would cite off the
 20 top of your head as being particularly
 21 authoritative or relevant to this case and these
 22 issues?
 23 A. No.
 24 Q. Okay. Do you have an opinion, Dr.
 25 Nearman, to a reasonable degree of medical

1 certainty as to the patient's cause of death?
 2 A. Yes, I do.
 3 Q. What is it?
 4 A. I think he -- he bled -- bled to death,
 5 essentially died of a hypovolemic shock.
 6 Q. Hypovolemic shock?
 7 A. Uh-huh.
 8 Q. And do you have an opinion to a reasonable
 9 degree of medical certainty as to the source of the
 10 bleeding?
 11 A. Upper G.I., and it appears it was nares
 12 gastroesophagitis.
 13 Q. Do you have opinion held to the same
 14 degree as to the timing or the cause of that
 15 bleeding?
 16 A. I'm *sorry*, the cause, no, I really can't
 17 tell you what -- as I said, it was -- it appeared
 18 at autopsy to be a nares esophagitis. What
 19 caused that gastritis or esophagitis I can't tell
 20 you. And the timing of it, I mean, it was
 21 obviously quite active and was going on at the time
 22 that he died.
 23 I can't tell you whether it started
 24 four hours before, eight hours before, two weeks
 25 before, I just don't know. I mean, it doesn't

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1 to say that's -- that's, you know, that's a
2 judgment call and certainly, you know, you have to
3 sum up and say how much fluid exactly had he been
4 given. And I think, you know, by that point in
5 time he had been given quite a bit.

6 I mean, I've got these notes that he
7 had 6700 by a little bit after midnight, and then
8 got -- you know, I don't have the exact cc. by cc.
9 by hour count past then, but you have to look at
0 how much fluid had been given to him and what he
1 did in response to the fluid and what the wedge
2 pressure was.

3 I think at that point in time a
4 physician may not necessarily have had to come in,
5 but at least should have gotten a hemoglobin to
6 say, you know, what are we losing -- is there
7 something that's going on? It seems to be a little
8 bit out of whack as to what the fluid -- how much
9 to keep the patient's blood pressure up. A
0 physician may not have had to come in but should
1 have had a little more investigative
2 responsibility.

3 Q. Assuming that the intensivist at that
4 point orders a hemoglobin and within a reasonable
5 amount of time receives a low hemoglobin, what's

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1 the standard of care require him to do at that
2 point? This is hypothetical but I want you to
3 assume that --

4 A. If at that point in time the hemoglobin is
5 obtained and is low and is lower than people would
6 have suspected, then I think that the blood ought
7 to be hanged and some sort of, again, investigation
8 as to why the hemoglobin is low should have gotten
9 into; whether that requires a physician to come in
0 or not, again, is a judgment call. What's the
1 patient look like? Is there any obvious bleeding,
2 et cetera, drop an N.G. tube, reposition the N.G.
3 tube, suction it back out, those kinds of things.

4 Again, you know, it's one thing in
5 terms of investigation whether -- whether the
6 actual presence is necessary for the preliminary or
7 not, I'm not going to venture an opinion.

8 Q. At 3:15, we can assume that the nurse's
9 notes are right and that at or around 3:15 Dr.
0 McAnlis is called and that he is notified of the
1 patient's status?

2 A. Uh-huh.

3 Q. What does the standard of care require
4 from him, if you have an opinion about that?

5 A. I don't -- in standard of care requires

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1 that same thing of any reasonable and prudent
2 physician no matter what their specialty is, either
3 -- either -- because you've got something that's
4 not going on.

5 That's correct, that is at 3:15, it
6 appears that the Dopamine had been started for low
7 blood pressure, that, you know, multiple fluid
8 pushes have gone on, and that's just not very
9 usual.

10 So either you investigate it or if you
11 don't know what to do, you find somebody that does,
12 and make sure it's being done because if it's your
13 patient and things aren't going right, then you
14 need to take corrective actions.

15 Q. Are Hespan and Dopamine appropriate
16 medications to be given this patient through 5 a.m.
17 or so; and if so, why?

18 A. Well, Hespan is very appropriate. It's a
19 volume resuscitating agent, very effective volume
20 resuscitating agent. And this patient seems to
21 need volume, and that's a great thing to give him.

22 Dopamine is something that makes the
23 heart beat a little bit more effectively. And it
24 also will shrink the blood vessels down, and by
25 doing so both actions cause the blood pressure to

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1 be raised again. This patient's blood pressure was
2 low and I feel that Dopamine is not out of the --
3 out of the range of therapeutic possibilities here.

4 Q. Have you noted or are you assuming what
5 orders were made by Dr. Schwarze for H & H or other
6 lab work testing postoperatively?

7 A. I think Dr. Schwarze did -- did a trail of
8 blood gases sometime around 7 or so in the
9 morning. I don't see an order for an H & H,
0 although I know one was drawn earlier. And I
1 assume that was Dr. Schwarze who ordered it, but I
2 don't -- I don't at least not going to start -- oh,
3 he ordered it, that is the day before, I'm sorry,
4 he ordered it the day before for the morning.

5 Q. That's why I wanted to ask you about it.
6 I think if I read the records properly, when or
7 shortly after Schwarze is consulted he puts on an
8 order that says blood work every morning?

9 A. Yeah, P7, CBC q, correct.

10 Q. Is that an appropriate order?

11 A. Yeah.

12 Q. Do you not -- do you believe that blood
13 should have been ordered with any more frequency or
14 at an earlier interval than the next morning?

15 A. Not as a routine, correct.

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1 Q. Okay.
 2 A. There is a routine postoperative
 3 evaluation done on a patient who at that time was
 4 stable, and I think those were appropriate orders.
 5 Q. Okay. As a matter of routine --
 6 A. Correct.
 7 Q. -- right?
 8 A. For that patient. Well, not even as a
 9 matter of routine. For that patient, that setting
 10 at that time and those clinical circumstances I
 11 thought those were appropriate orders.
 12 Q. Uh-huh. I guess what I'm getting to is
 13 you mentioned earlier that at some point during the
 14 night, I think you said 3 o'clock, some H & H
 15 orders should have been made?
 16 A. Routine, but the circumstances are changed
 17 markedly by that time.
 18 Q. Right, that's all I'm getting to.
 19 A. Yes.
 20 Q. Now, do you have an understanding, are you
 21 making an assumption about -- let me take a step
 22 back.
 23 Did you see the lab work that indicates
 24 or the lab paperwork that indicates a 6:06 a.m.
 25 hemoglobin and hematocrit result?

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1 A. Yes, I did.
 2 Q. Do you know or make an assumption as
 3 whether 6:06 is the time it's drawn or 6:06 is the
 4 time it's reported?
 5 A. My assumption I would make would be that
 6 would be the time it was drawn.
 7 Q. Okay.
 8 A. Because that's what usually is the way
 9 hospitals report things.
 10 Q. Okay. And what -- what information do you
 11 have or assumption are you making about whether
 12 it's reported to Dr. Schwarze?
 13 A. My assumption is reported sometime before
 14 8:10 a.m. because that's when Dr. Schwarze orders
 15 four units of packed red blood cells.
 16 Q. Right. Dr. Schwarze, according to the
 17 records, was in to see -- well, let me withdraw
 18 that.
 19 Does Dr. Schwarze, in your opinion, act
 20 appropriately when he receives word of the low
 21 hemoglobin at, you know, or immediately before
 22 8:10?
 23 A. I think so, yeah. I mean, he -- he now
 24 has an answer as to what's -- at least partially as
 25 to why this patient was requiring volume, and that

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1 the patient obviously was bleeding. And the volume
 2 that you give, even Hespan, which is an effective
 3 resuscitating agent, doesn't -- isn't as good as
 4 blood, which is if you assume lose -- if you're
 5 losing blood, you got to get blood in.
 6 And Dr. Schwarze orders blood and I
 7 feel that's a reasonable and correct order at that
 8 point in time.
 9 Q. Do you assume that Dr. Schwarze at that
 10 point concluded that there was a bleed somewhere?
 11 A. I would assume that, yes.
 12 Q. Yes.
 13 Are you familiar with the order that he
 14 gives over the telephone which says -- I'll tell
 15 you what it says, 50 percent v. mask, ABG's 30
 16 minutes, transfuse 4 units PRBC now?
 17 A. Uh-huh.
 18 Q. Is that order appropriate?
 19 A. Yeah.
 20 Q. Should anything else have been done to
 21 comply with the standard of care?
 22 A. Well, I think that, you know, again, this
 23 is what is one of those gray areas where I'm not
 24 sure what Dr. Schwarze was thinking. I'm not sure,
 25 when you started this deposition off you asked me

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1 about certain assumptions that I would *make* about
 2 how things are handled in ICU, and this is one of
 3 the areas where I think that that comes in.
 4 Now, I think that, again, a reasonable
 5 prudent physician would not only order the red
 6 cells, which he did to correct the deficit, but
 7 would have an interest in seeing where the deficit
 8 was coming from as well. Now, Dr. Schwarze, again,
 9 may have said, I'm the intensivist handling the
 10 intensive care part of this, the surgeon -- if this
 11 guy's bleeding, it ain't because there's a medical
 12 bleeding going on, it's probably related -- 99.9
 13 percent related to the past surgery.
 14 I assume my surgeon is coming in to see
 15 the patient the day after a major operation, he
 16 will see the hemoglobin and hematocrit, he will
 17 then go ahead and investigate what's going on.
 18 Now, that would be -- and under those assumptions
 19 then I think Dr. Schwarze ought to have acted
 20 within a reasonable standard.
 21 Q. On these facts and at that time, if we set
 22 aside whose fault it is and just talk about what
 23 should have been done --
 24 A. Uh-huh.
 25 Q. -- not only should blood have been hung

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1 appear to be obviously started two weeks before,
2 probably wasn't going on actively in surgery or at
3 least not to a voluminous extent, but I can't
4 really pin it down to any more specifically than
5 that.

6 Q. Do you have an opinion to a reasonable
7 degree of certainty as to the cause or causes of
8 the patient's falling hemoglobin in the week or so
9 prior to the surgery'?

10 A. I don't have an opinion on that.

11 Q. Would you cat- -- if this is something you
12 can answer for me, would you personally categorize
13 this Whipple procedure on this patient as elective,
14 emergent or something else?

15 A. Well, I'm not a -- a surgeon.

16 MR. GALLAGHER: Objection. Go ahead.

17 MR. BANAS: Overruled. You may answer.

18 THE WITNESS: I'm not a surgeon, but it
19 -- I think this is -- this is certainly not one of
20 those elective things. It certainly was elective
21 as the patient was waiting at home and comes in the
22 same day of admission.

23 The patient was obviously hospitalized
24 and having problems, so I wouldn't call it
25 emergent. It wasn't life-threatening in the next

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1 12 to 24 hours, so I think it falls somewhere in
2 that semi-urgent perhaps.

3 BY MR. HILL:

4 Q. Do you have an opinion as to the propriety
5 of taking the patient to surgery at the time he was
6 taken to surgery?

7 A. I don't have an opinion on that.

8 Q. Okay. The quickest way for me to do this
9 is to start by asking you what opinions you have as
10 to whether any of the physicians or health care
11 providers who provided care to Mr. Withrow
12 satisfied or deviated from the standard of care?

13 MR. BANAS: I think I'm going to back
14 up here because I think this is going to take a
15 while.

16 MR. HILL: He's not going to throw
17 anything, is he?

18 MR. BANAS: I don't know.

19 THE WITNESS: I might be very
20 demonstrative. That's a good question. That's a
21 fair question. I'll start with a fair answer.

22 I think that -- that certainly all of
23 the physicians involved in this case at some point
24 in time deviated from the standard of care in their
25 care of Mr. Withrow.

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1 I think that some were omissions, some
2 were co-omissions, some were blatant, some
3 weren't. And I think that some of the nursing
4 personnel could have done things a little bit
5 better and could have done things a little bit
6 quicker or expeditiously.

7 I guess that falls within the standard
8 of care as well, although, you know, I'm much more
9 assured of my opinions in the -- as far as
10 definitions of standard of care because I am a
11 physician. Certainly I will say that certain
12 things that the nurses did or didn't do didn't
13 comply with what I feel would be nursing standard
14 -- standard practices or hospital practices.

15 BY MR. HILL:

16 Q. As it concerns the physicians, there were
17 a lot of them so I want to make sure we're
18 communicating when you say all the physicians at
19 some point.

20 A. Okay. I'm going --

21 Q. Go ahead. And --

22 A. Let me tell you which physicians because I
23 really looked at three of them. I really have no
24 opinions on Dr. Mir. I have an opinion --

25 Q. M-I-R is Mir, Dr. Mir, *sorry*.

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1 A. I have opinions on Dr. Black. As I said,
2 I have opinions on Dr. McAnlis and, of course, I
3 have opinions on Dr. Schwarze.

4 Q. And the nursing personnel?

5 A. And -- okay, You asked me physicians.
6 And nursing personnel?

7 Q. I'm following up.

8 A. Okay.

9 Q. Okay. Do you have an opinion as to a
10 point in time or range of times when this patient
11 became unsalvageable?

12 A. I think the patient was -- was
13 unsalvageable peri-arrest, meaning, you know, when
14 this patient arrested there's no question, I think,
15 that that was -- the dye was cast.

16 When you're in hypovolemic shock and
17 you arrest from that, you're usually so far behind
18 it's pretty hard to resuscitate, especially if
19 you're not 21, 22 years of age. I can't -- you
20 know, it's hard for me to say, okay, half hour
21 before he was salvageable, an hour before he was
22 salvageable, but it doesn't extend much beyond --
23 beyond that.

24 I think he was probably salvageable up
25 to maybe even 15, 20 minutes, half hour before. I

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1 wasn't -- that would be -- I don't have -- I don't
2 have documentation, charts or notes as to how
3 exactly he looked and what he was doing in that
4 period of time to say exactly, but certainly
5 probably to a greater probability than not
6 certainly if the appropriate steps have been taken
7 even up to half hour, 35 minutes before the arrest
8 he probably would have been salvageable.
9 Q. Okay. I'm going to start with -- in the
10 order that you listed them.

11 A. Could we go in the -- I'd rather start and
12 go through what chronologically happened.

13 Q. Okay.

14 A. Therefore it may be easier for me to go
15 through the story and relate the parts where I
16 think steps should have been taken.

17 Q. Sure. I'll do that.

18 A. If that's okay with you.

19 Q. That's fine.

20 A. I mean, I first feel that -- that things
21 were missed the evening after the surgery or early
22 morning thereof. Let me get technical here. Let
23 me refer to my notes so we can pinpoint exact
24 times.

25 Certainly, I guess, we'll start talking

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1 about the morning of -- the morning after,
2 technical sense, because it pretty much starts
3 around midnight or a little bit thereafter, where
4 the patient has already been seen by Dr. Schwarze.
5 He's been officially consulted. He's been seen by
6 Dr. McAnlis that evening before going home. And
7 then throughout the night and early morning patient
8 is hypotensive.

9 He's hypotensive on multiple
10 occasions. Dr. Schwarze gets notified on multiple
11 occasions; at 1:15 in the morning, according to
12 nurse's notes, again at 3 o'clock in the -- in the
13 morning. Fifteen minutes later Dr. McAnlis gets
14 notified. Schwarze gets notified again around 4 or
15 4:30 and again at 6:30. Dr. Schwarze is given an
16 update.

17 So over that six and a half, seven hour
18 time span the multiple -- multiple -- both Dr.
19 Schwarze at least three or four times and Dr.
20 McAnlis at least once are notified that the patient
21 is having hypotensive episodes as -- as requiring
22 or has required and gets ordered a lot of fluids.
23 And at one point a blood pressure raising agent,
24 vasopressin, Inotrope, that's I-N-O-T-R-O-P-E,
25 Dopamine gets started now.

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1 And I feel that the -- the amount of
2 fluids that this patient required and the number of
3 times that the patient was hyp- -- the degree and
4 severity of the hypotension coupled with the amount
5 of fluids and the fact that the fluids didn't
6 totally correct that for this patient not to have
7 been seen by a physician or at least have a H & H
8 set up, hemoglobin and hematocrit, set up is below
9 standard of care.

10 And I think this is both Dr. Schwarze
11 -- I think this is primarily Dr. Schwarze's
12 problem. Dr. McAnlis may have some -- some party
13 to this as well. He is notified at least -- at
14 least once that there's -- that there's a problem.

15 Q. What's your opinion as to the cause of the
16 patient having this extremely low blood pressure
17 and becoming tachycardic and requiring fluids at
18 midnight, 1 a.m., 2 a.m.!

19 A. It may be different at midnight than 2
20 a.m. I mean, this patient had started to bleed
21 somewhere after midnight for sure, whether it's at
22 1 a.m. or 3 a.m., I don't know.

23 Whipple patients, typically the
24 patient's large dissections will have a lot of
25 third spacing, often will require a lot of fluids.

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1 It begins to be difficult to draw the lines as to,
2 you know, whether it's the three-thousandths cc.s
3 or four-thousandths cc.s in -- that's a little bit
4 abnormal.

5 But it -- in a pattern here, certainly
6 I don't hold Dr. Schwarze at fault at 1:15 with the
7 first call or maybe it's not the first call, but if
8 maybe the first call that morning, but the first --
9 not -- certainly not the first time the pressure's
10 low to respond with Hespan. I think that's pretty
11 normal.

12 At 3 o'clock when he's notified that
13 the pressure is down, he probably -- something
14 ought to say, gee, maybe at that point it's a
15 little bit abnormal.

16 Q. And I want to ask you, specifically let's
17 take that 3 o'clock point where we know that Dr.
18 Schwarze has been called at or around 1:15 and is
19 called again at 3 o'clock. Considering the status
20 of the patient then and the efforts that have been
21 taken to that point, what does the standard of care
22 require from the intensivist under these facts?

23 A. At 3 o'clock?

24 Q. (Nodding head up and down.)

25 A. At 3 o'clock I think you're going to have

<p style="text-align: right;">Page 33</p> <p>1 but some physician at that point should have 2 actively been investigating to find the source of 3 the bleed; is that correct? 4 A. correct. 5 Q. Don't you think that -- I'm not trying to 6 be argumentative but ask it the only way I can. 7 A. Really? Just joking. 8 Q. Don't you think that Dr. Schwarze should 9 have come in to see the patient at that point? 10 A. Having already been there before, no -- I 11 think that Dr. Schwarze's duty at that point is to, 12 as I said, is to correct the blood -- blood 13 deficit, is to volume resuscitate this patient at 14 that point in time. 15 I think that then there needs to be 16 somebody to investigate that or at least some 17 communication from Dr. Schwarze. Dr. Schwarze may 18 not necessarily need to come in to see it, but 19 probably was assuming that Dr. McAnlis is going to 20 be following up shortly. 21 Now again, if Dr. Schwarze doesn't know 22 that Dr. McAnlis -- if he doesn't know his schedule 23 and can't assume that he's going to be in within a 24 reasonable period of time, within the next hour or 25 so, isn't going to come in till noon that day</p>	<p style="text-align: right;">Page 34</p> <p>1 in as fast as -- essentially saying get it in as 2 fast as you can or get it in within these 3 parameters that I give you. And that wasn't done 4 here obviously. 5 Q. I will tell you that Dr. McAnlis -- you 6 may know this but for the purposes of this question 7 I will tell you -- that Dr. McAnlis testified that 8 he came in at approximately 9 o'clock to see this 9 patient. I will also tell you that 9 a.m. nurse's 10 notes says bright red drainage noted from N.G. 11 tube, large amounts, and then it says some other 12 things. 13 A. Uh-huh. 14 Q. Large amounts of bright red drainage from 15 the N.G. tube of this patient is the source of that 16 is what in your opinion? 17 A. Is what finally killed him, that is the 18 upper G.I. bleed, erosive esophagitis. 19 Q. If we assume, as Dr. McAnlis testified, 20 that he was in in or around that time, what does 21 the standard require him -- require of him? 22 A. If he's in at that time and he's looking 23 at his patient, he sees large amounts of bright red 24 blood coming out and he sees available to him an 25 H & H of hemoglobin to 5.3, what was it?</p>
<p style="text-align: right;">Page 34</p> <p>1 because he's in surgery in some other hospital or 2 something else, then, yeah, I think a physician 3 should see the patient. Again, that's one of those 4 areas I think is up for interpretation as to what 5 is the custom and practice as to how the patient 6 gets seen in that particular ICU. 7 Q. Does the order to transfuse four units 8 PRBC's <u>now</u> indicate to you based on your experience 9 anything about the repetitiveness with which the 10 blood should be hung? 11 A. Yeah. I use the same Webster's dictionary 12 everybody else does, now means now. 13 Q. Does it indicate anything as to whether 14 pressure bags or manual pressure should be used, or 15 what would that tell -- 16 A. That order does not, no. 17 Q. Okay. If you wanted to indicate to -- and 18 I'm talking about Dr. Nearman now -- if you wanted 19 to indicate to a nurse that she should -- he or she 20 should hang PRBC's and use pressure or get it in 21 faster, what kind of language typically would you 22 use? 23 A. Transfuse -- transfuse four units of PRBC 24 now, each unit going over half hour or less. You 25 -- you <i>make</i> time specific saying, you know, get it</p>	<p style="text-align: right;">Page 36</p> <p>1 Q. Yes. 2 A. Then it requires of him to resuscitate his 3 patient while he's attempting to find out what 4 patient's bleeding from and to perhaps stop the 5 bleeding if it's at all possible medically or 6 surgically. 7 Q. In your opinion -- do you have an opinion 8 as to a reasonable degree of medical certainty as 9 to whether this patient should have been intubated 10 at any point before the arrest? 11 A. I feel based on -- on patient's, you know, 12 blood gases and upon his increased respiratory rate 13 that we were rodren -- we were riding sort of thin 14 on whether or not he should have been intubated 15 prior to that. I mean, we have a fall -- we have 16 blood gas early in the morning that shows a 17 significant fall in pO2 on four liters. That gas 18 is repeated. 19 Dr. -- Dr. Schwarze is notified of that 20 obviously because at 8 o'clock part of the order 21 that you read back to me says 50 percent 22 Venti-mask, repeat the blood gases in half hour. 23 And what we still see is that the pO2 is somewhat 24 corrected but it is down. The patient is breathing 25 harder, he is breathing off his end-tidal CO2. And</p>

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1 to me there's no question that -- that somewhere
2 around 9:30, 10:30, somewhere at least around 10:30
3 the patient probably would have been better off
4 intubated.

5 Again, that's a decision that's
6 difficult to make based on data I have here without
7 looking at patients. We get called as
8 anesthesiologists to come in and intubate patients
9 all the time; some of which we do, some of which
10 you don't do. And over the phone you can be told
11 one thing and when you actually see the patient you
12 can see how hard or labored their breathing is that
13 may be a different story.

14 Q. Well -- did I interrupt you?

15 A. No, I'm fine. I'm finished.

16 Q. We know that Dr. Schwarze does not come in
17 to the hospital to see this patient until -- until
18 the arrest event.

19 A. correct.

20 Q. What information do you have or what
21 assumption do you make as to why he didn't come in?

22 A. I -- I have no -- I know that he was out
23 of the hospital. I think he stated in his
24 deposition he went to -- he did something other
25 than going -- going to the hospital. I don't know

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1 if he went to another hospital. He went to see his
2 kids, I think he said, see his kids at one point.

3 My assumption is that he felt that he
4 had ordered the blood and that perhaps Dr. McAnlis
5 was coming in and would -- would finish handling
6 the situation and that Dr. McAnlis would call him
7 back or the nurses would call him back if there's
8 other things going on other than just with the
9 blood gases.

10 So I don't know what other information
11 he had made available to him after that -- after
12 the blood gas that was done at 7:30 and he ordered
13 the increase in Venti-mask, et cetera. In fact,
14 I'm not sure that I see any more orders from him,
15 so I'm not sure that there was any more information
16 made available to him, I just don't know.

17 Q. I know I'm skipping ahead chronologically
18 but I'm going to stick with Schwarze while I'm on
19 it.

20 A. Go ahead, I'm flexible.

21 Q. I see that. 10:30 nurse's note, patient's
22 family visiting, continued large amount red
23 drainage from NGT. Dr. Schwarze notified of new
24 ABG's, and patient's status. Also unstable BP,
25 orders to transfuse four units PRBC's being carried

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1 out. Dr. McAnlis in and notified of bright red
2 drainage.

3 Now, Dr. Schwarze doesn't come in now,
4 do you think that's in compliance with standard of
5 care? If so, why?

6 A. I think that if he -- again, if he's
7 notified of the 10:25 blood gases, at that point
8 then I think he needs to do something because those
9 blood gases show a severe metabolic acidosis.

10 Again, it's indicative again per -- I'm
11 not going to -- I can't pin down whether, say, with
12 absolute certainty he should have been intubated at
13 that point. He probably should have been but I
14 can't really get -- I got enough of standard of
15 care breaches I can't make an assumption about that
16 one, but I think with that degree of metabolic
17 acidosis that says that the patient is troubled,
18 somebody ought to do something. If he doesn't come
19 back in, he ought to make sure that there is
20 somebody there who can do something about that.

21 So yes, either he should come in or he
22 should verify that there's somebody there who was
23 -- who was capable of covering the situation.

24 Q. Okay. Now, the records tell us that at
25 about 9:30 or 9:35 Dr. Black called Dr. McAnlis and

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1 told him in words or substance that the patient was
2 actively bleeding.

3 Do you find fault with Dr. Black's
4 involvement; and if so, how?

5 A. I really do find fault with Dr. Black's
6 involvement. I think Dr. Black, you know,
7 according to what I saw in the records and read
8 from depositions, his heart was in the right place
9 but he did absolutely nothing to verify the
10 situation.

11 I don't know Dr. Black. I really don't
12 want to get too -- too derogatory, but he saw the
13 patient was bleeding, he called Dr. McAnlis and
14 certainly let him know that the patient was
15 bleeding. Dr. McAnlis appeared to just sort of
16 yeah, yeah, give him a pat on the head and say,
17 "Don't worry about it. It doesn't appear to be
18 bad."

19 He calls and then it appears to me that
20 things get -- get off into histrionics here. He --
21 I mean, he starts writing notes that this patient
22 is essentially -- don't want to misquote anybody
23 here -- he says, I called Dr. McAnlis, told the
24 patient actively bleeding and concerned about
25 patient's demise; i.e. death. I mean, that's a

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1 little dramatic to put in a note. I don't know
 2 what is -- what is the agenda that was there, but
 3 okay.
 4 Q. Well, his concern was pretty well placed,
 5 wasn't it?
 6 A. Yes, that's right. He then -- and in
 7 another note he says this patient is in acute bleed
 8 and needs surgery. Again, I'm not sure that he
 9 needs surgery, but again, that's -- and then in his
 10 final note and, see, I think this is the 10:55
 11 note, if I'm not mistaken, he's unstable, is that I
 12 think -- is that Dr. Black's note?
 13 Q. Yes. At 10:55?
 14 A. Yeah.
 15 Q. Calls McAnlis again and tells him the
 16 patient's bleeding?
 17 A. Continues active GI bleed. Continued --
 18 and called and talked to him and told him that
 19 patient was bleeding and in need of surgical
 20 intervention **ASAP**. And I mean, yes, I think that
 21 that's fine. He was aware of the problem.
 22 He notified what I feel is an
 23 appropriate individual. And certainly Dr. McAnlis,
 24 who was the surgeon, should be capable of
 25 investigating what are the causes of bleeding and

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1 certainly should be capable of resuscitating, but
 2 Dr. Black apparently doesn't have his hands tied
 3 behind his back either at that point in time.
 4 And I, you know, I didn't want -- I
 5 don't want to get into politics here, but I know
 6 there was some concern about who was the attending
 7 and who was -- or who was the official consultant
 8 and who was not and why wasn't I called and please
 9 call me and even notes written or orders written
 10 around as to who -- who was the clarification of
 11 consultants.
 12 Well, you know, my God, there's a man
 13 bleeding to death and we're worried about who the
 14 consultants are. This strikes me as totally
 15 inappropriate behavior from Dr. Black.
 16 And for the most part, I mean, it
 17 appears that he's the only one who is upset about
 18 who the consultants are here. And if -- if he's so
 19 concerned about the man bleeding to death, why
 20 doesn't he help volume resuscitate this gentleman,
 21 which he doesn't do.
 22 Q. Let's go through it chronologically. As I
 23 noted to you before, according to the records at
 24 around 9:35 or so Dr. Black does a couple things;
 25 he calls Dr. McAnlis, he tells him in words or

1 substance the patient's bleeding to death?
 2 A. Uh-huh.
 3 Q. He orders stat clotting test, which was an
 4 appropriate thing to do at this point, do you agree
 5 with that?
 6 A. I don't see any problem with that, yeah.
 7 Q. Okay. In response to Dr. Black's
 8 telephone call, according to the nurse's notes at
 9 9:40 a.m., Dr. McAnlis comes in to see the
 10 patient. Now we're talking about the surgeon who
 11 has been told that his patient is bleeding to
 12 death. Do you presume as I do that he's aware or
 13 should have been aware of the 6 a.m. hemoglobin
 14 results at 9:40?
 15 A. Standards of care would dictate such, yes.
 16 Q. Okay. At that point he irrigates the
 17 nasogastric tube with 16 cc.s of normal saline.
 18 Did you read about this episode at all?
 19 A. I read that he -- excuse me, that he
 20 irrigated the N.G. tube. I do not know with how
 21 much he irrigated. I saw only irrigates easily,
 22 returned with mostly clear irrigation.
 23 Q. I want you to assume that Nurse Adkins has
 24 testified and will testify that Dr. McAnlis used
 25 only 16 cc.s of normal saline solution at that time

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1 and he simply inserted that into the tube and then
 2 re-drew back the same 16 cc.s in a manner which she
 3 felt was not adequate to lavage the tube. Do you
 4 feel that's appropriate?
 5 A. No, I don't feel that it is. I feel that
 6 that's not a proper lavage. I mean, the dead space
 7 of that N.G. tube alone is probably six or seven
 8 cc.s, certainly at least four to five. And that's
 9 really not appropriate to determine whether or not
 10 there's a lot of bleeding coming from there.
 11 Assuming that, that's not correct.
 12 Q. I want you to further assume that after
 13 doing that and knowing all of the things that he
 14 knew or at least having available the information
 15 that was -- that was available then, Dr. McAnlis
 16 leaves the patient and goes home. Do you believe
 17 that that's conduct in accordance with the standard
 18 of care for this surgeon?
 19 A. No.
 20 Q. That leaves Dr. Black, who's in the
 21 vicinity, and Nurse Adkins in charge of this
 22 patient. Is that acceptable in your mind?
 23 A. No.
 24 Q. At 9:40 a.m. --
 25 A. I -- to me, Dr. McAnlis' actions were not

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1 acceptable and Dr. Black's actions were not
2 acceptable. You don't have to -- see, you don't
3 have to have a quorum of people to do it. You have
4 to have somebody in charge and who can volume
5 resuscitate this patient and could have done it.

6 Dr. Schwarze could have done it or
7 written for it when he saw it. Dr. McAnlis
8 certainly should have done it. And Dr. Black, who
9 was there the whole time, certainly should have
10 done it. And that's why I think that the fault was
11 dropped all the way around at this point here.

12 Q. Now, we know that at 10:25 a.m. the blood
13 gases are reported, you've talked about that we
14 also got a hemoglobin of 4.6, co -- coag. time is
15 PT 15.9, PTT 147. Those are all abnormal, correct?

16 A. Oh, yes.

17 Q. And then five minutes later Dr. Schwarze
18 is notified of that information, we've talked about
19 that already?

20 A. He's notified at least of the blood
21 gases. I'm not sure that he's notified of any of
22 the other lab data.

23 Q. Well, it says notified of new ABG's and
24 patient's status.

25 A. (Witness shrugging shoulders.)

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1 Q. I wanted you to assume that at about 10:55
2 Dr. McAnlis is telephoned at home, is given that
3 information and does nothing.

4 A. I think that that's -- that's a gross
5 deviation from standard of care.

6 Q. I want to tell you -- or I want you to
7 assume that the order that went on clarifying the
8 consultants on the case was not Dr. Black's but was
9 Dr. McAnlis'. What, if anything, does that
10 indicate to you?

11 A. You know, again, that's just, you know,
12 I'm -- I really feel that for -- and again, there's
13 several versions in the depositions about caring
14 about -- about who was consulted and who wanted who
15 to take care of patients. And I think all of that
16 got in the way of somebody actually doing something
17 for the patient, and I'm just appalled, the best
18 way I can say it.

19 I mean, it's okay if that goes on and
20 the patient is very good and stable and doing
21 well. It's not a very good thing to involve the
22 politics of the hospital. We have politics in very
23 big hospitals as well as small hospitals.

24 MR. BANAS: Never.

25 THE WITNESS: But the patient has got

1 to come first. And to me, from reading the
2 depositions, they should have seen what's going on
3 here, it isn't apparent that the patient did come
4 first here.

5 BY MR. HILL

6 Q. Dr. Nearman, do you intend to express any
7 opinions as to Mr. Withrow's likelihood or chances
8 of surviving 30 days or any period of time after
9 that or placing a life expectancy on Mr. Withrow?

10 A. I'm not going to have an opinion on that.

11 Q. The only thing that I think I haven't
12 asked you for specifics about to my satisfaction is
13 the nursing issue, and I think you said in words or
14 substance that you thought that the nurses had not
15 done some things as promptly as they should have.
16 What -- can you give me any specifics about that
17 that we haven't talked about already?

18 A. I think it relates to hanging the blood
19 and getting the blood available and getting it in.
20 Now again, I don't know what's an acceptable period
21 of time.

22 I don't know whether the patient still
23 had blood that was in the bank, type of
24 cross-match, whether further had to be set up, but,
25 you know, the order was written for a transfusion

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1 at 8:10 and I don't think the first unit of blood
2 got hung for at least an hour or so after that.

3 Q. If we -- if we assume that McAnlis came in
4 around 9, when he testified he did --

5 A. Uh-huh.

6 Q. -- does he have obligations to check on
7 the status of whether that order's being carried
8 out or not or whether it's being carried out
9 promptly or not?

10 A. Only in the sense that he has obligations
11 to follow up on the patient, I think. But part of
12 that is if he saw that hemoglobin and saw that it
13 was 5.3 from an hour before, he should have said,
14 Gee, we better get some blood up. And if it isn't
15 hanging, he should say, When was it ordered and
16 what's the hold up, and can we hurry up on it?

17 Q. If -- Dr. Schwarze, this is a hypothetical
18 because I don't know -- let me say it a different
19 way.

20 If we assume that when Dr. Schwarze
21 ordered that blood to be transfused he wanted it to
22 be put in with pressure and he wanted it to be put
23 in with two lines instead of one, if we assume that
24 --

25 MR. BANAS: That's a good question,

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1 keep going.
 2 BY MR. HILL:
 3 Q. We've already talked about the fact that
 4 the order is not written that way, correct?
 5 A. Correct.
 6 Q. If we assume that's what he wanted and Dr.
 7 McAnlis comes in at 9 and then again at 9:40 and
 8 sees that the blood is not being hung that way,
 9 what, if anything, does the standard of care
 0 require of Dr. McAnlis?
 1 A. Well, again, when Dr. McAnlis comes in and
 2 sees the patient's status, sees where the
 3 hemoglobin is, sees the -- doesn't see physically
 4 but hears the nurse reports of and notes in the
 5 chart how much blood has come out from the N.G.
 6 tube, then his obligation is to resuscitate the
 7 patient and resuscitate the patient the most
 8 effective way possible.
 9 And if we're having blood losses to
 0 that -- to that degree, then we've got to replace
 1 it in a quick and expeditious manner, too. And Dr.
 2 McAnlis had available to him blood gasses of 9 --
 3 certainly had the first -- find this -- he
 4 certainly had the blood gas of 7:30 a.m. available
 5 and the blood gases of 9:08 available, which shows,

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1 you know, increased the base deficit and the
 2 acidosis is in, and that implies urgency in that as
 3 well. You know, to see blood drip, drip, dripping
 4 is not an effective way of doing it.
 5 Q. At that point should there have been an
 6 order made? And by that I mean at 9:40, let's say,
 7 when Dr. McAnlis comes in and does this lavaging
 8 procedure but also sees or should have done the
 9 hemoglobins and the things you just talked about,
 0 should Dr. McAnlis have made orders as to which --
 1 the repetity the blood is coming in or using the
 2 pressure or using an extra line to be put in?
 3 A. He should -- he should have put the extra
 4 line himself and pumped the bags himself. I mean,
 5 we're talking a critical situation here at any
 6 point in time. At this point in time from the
 7 numerous viewpoints, at a minimum he should have
 8 said, We need to get this blood in, we need to get
 9 it in relatively quick. At minimum he should have
 0 put an order in.
 1 Q. If that would have been put in at 9:40, do
 2 you think that would have made a difference in the
 3 case?
 4 A. That -- I think this patient, as I said
 5 before, I think that he was probably salvageable

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1 anywhere up to even half hour, maybe -- maybe even
 2 if you want to look conservatively an hour before.
 3 I mean, if you put in proper lines, you
 4 can get 4 units of blood in over a 15-minute
 5 period, 20-minute period if you put in a couple big
 6 IV's. I mean, we do that in our ICU and O.R. all
 7 the time. I think 4 units of blood in 15 minutes
 8 would have staved off this man's eventual
 9 collapse.
 10 I don't know, you know, I can't -- it
 11 would have staved off certainly that this led to
 12 the arrest. I don't know how fast he would have
 13 kept bleeding and the expediency that he would have
 14 got him endoscoped and corrected, that beyond is
 15 the line. I mean, that's anybody's guess at this
 16 point. But as far as keeping him from arresting,
 17 yes, that would have done it.
 18 Q. Could he have withstood an endoscopic
 19 procedure for the diagnosis, this procedure of 9:40
 20 or 10 o'clock or so?
 21 A. Not without being resuscitated is the --
 22 so the protocol or proper thing to do would have
 23 been to get him stabilized, for lack of a better
 24 word, and then try this endoscopy to try to see
 25 where the bleeding was coming from.

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1 If a man gets shot with a bullet, you
 2 don't try to look for what caliber it was. First
 3 you resuscitate the patient, then look for it.
 4 MR. HILL: Okay. That's all I have.
 5 - - -
 6 BY MR. GALLAGHER:
 7 Q. Doctor, do you have any opinion as to
 8 whether or not Dr. McAnlis in any other way other
 9 than you've already expressed, fell below the
 10 standard of care which caused the death of Mr.
 11 Withrow?
 12 A. No, sir.
 13 Q. What is that?
 14 A. I said --
 15 Q. You said no?
 16 MR. BANAS: He said, "No, sir."
 17 THE WITNESS: I do not have any other
 18 opinions concerning Dr. McAnlis' care other than
 19 what we've talked about in the post and immediate
 20 postoperative procedure.
 21 MR. GALLAGHER: Thank you. I have no
 22 further questions.
 23 THE WITNESS: Okay.
 24 MR. BANAS: Mail him a copy to read.
 25 - - -

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(Deposition concluded at 5:36 o'clock p.m.)

CERTIFICATE

STATE OF OHIO,)
) ss
 SUMMIT COUNTY)

I, Linda M. Yelinek, an RPR and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, HOWARD NEARMAN, M.D., was by me first duly sworn to testify the truth, the whole truth and ~~nothing~~ but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to Stenotypy in the presence of said witness, afterwards transcribed upon a computer; and that the foregoing is a true and correct transcription of the testimony so given by the witness as aforesaid.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Akron, Ohio on this 28th day of August, 1995.

Linda M. Yelinek
 Linda M. Yelinek, an RPR and Notary Public in and for the State of Ohio.

My Commission expires July 31, 1996.

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I, HOWARD NEARMAN, M.D., do verify that

I have read this transcript consisting of fifty-four (54) pages and that the questions and answers herein are true and correct with corrections as noted on the errata sheet.

HOWARD NEARMAN, M.D.

Sworn to before me, _____,

a Notary Public in and for the State of _____,

this ____ day of _____, 19__.

Notary Public in and for the

state of _____

My commission expires _____

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Martin R, Nearman H, Katona P and Klaus M: A Deflation Herring-Breuer Reflex in the Preterm Infant. A Mechanism by Which a Low Continuous Positive Airway Pressure Decreases Apnea? Pediatric Research 10:4 p. 428, April 1976.

Henning R, McClish D, Daly B, Nearman H, Franklin C and Jackson D: Clinical Characteristics and Resource Utilization of Patients in a Medical and Surgical Intensive Care Unit. Critical Care Medicine 13:4 p. 262, April 1985.

MAJOR
PRESENTATIONS:

Pharmacology of Resuscitation. Trauma Symposium - 1983, Cleveland, Ohio, June 1983.

An Operating Room Data Management System. Microcomputers in Anesthesia IV Scientific Program Asheville, North Carolina, October 1983.

MAJOR
PRESENTATIONS:
(continued)

Perfluorocarbons. Meeting of the Seven Universities Anesthesia Departments, Hershey, Pennsylvania, January 1984.

Artificial Blood. Advances in Cardiopulmonary Intensive Care - Fourth Annual Symposium, Cleveland, Ohio, April 1984.

Ventilatory support in Trauma. Trauma Symposium - 1985, Cleveland, Ohio, June 1985.

Drug Interactions in Anesthesia. Ohio Medical Education Network, Columbus, Ohio, April 1986.

Vasopressors and Inotropes. Critical Care Conference, Cleveland Clinic Foundation, Cleveland, Ohio, October 1986.

Adult Respiratory Distress Syndrome. Critical Care Grand Rounds, Cook County Hospital, Chicago, Illinois, December 1986.

Respiratory Distress Syndrome, Trauma Symposium - 1987. Cleveland, Ohio, June 1987.

Septic Shock. Anesthesia Update IV - Cleveland Society of Anesthesiologists, Cleveland, Ohio, October 1987.

Endotracheal Intubation. Critical Care Grand Rounds, Cook County Hospital, Chicago, Illinois, December 1987.

Pharmacologic Implications of Septic Shock. School of Pharmacy, University of Illinois, Chicago, Illinois, December 1987.

Ethics of Decision Making on Prolonged Care, Ohio Society of Anesthesiologists Annual Meeting, Columbus, Ohio, September 1988.

Mixed Venous Oxygen Saturation - What It Is and What It Isn't. Society of Critical Care Medicine, Michigan Chapter Annual Meeting, Ann Arbor, Michigan, October 1988.

What's New in Mechanical Ventilation. Critical Care Grand Rounds, Cook County Hospital, Chicago, Illinois, December 1988.

MAJOR
PRESENTATIONS:
(continued)

Monitoring Mixed Venous Oxygen Saturation in the Critically Ill. Surgical Grand Rounds, Jewish Hospital, Cincinnati, Ohio, June 1989.

Ultra-short Acting Beta Blockade. Kentucky Medical Association Annual Meeting, Louisville, Kentucky, September 1989.

Fluid Resuscitation. Anesthesiology Grand Rounds, Temple University Hospital, Philadelphia, Pennsylvania, October 1989.

Adult Respiratory Distress Syndrome. Critical Care Seminar, St. John's and Westshore Hospital, Cleveland, Ohio, May 1990.

Vasodilators in the Critical Care Setting. Conference for Critical Care Professionals, Sandusky, Ohio, June 1990.

Current Issues in Nutritional Support. Advances in Clinical Nutrition Seminar, Cleveland, Ohio, August 1990.

Clinical Pharmacology of Colloids and Crystalloids. Symposium on Fluid Resuscitation in the Critically Ill: Consensus, Controversies & State of the **Art**. University of Louisville, Louisville, Kentucky, November 1990.

Chemistry - Physiology of Colloids/Crystalloids. New Concepts in the Resuscitation of the Critically Ill and Injured. Critical Care Symposium, Wayne State University, Detroit, Michigan, May 1991.

VISITING
PROFESSORSHIPS:

Critical Care Medicine
Cook County Hospital
September, 1983

Department of Anesthesiology
University of Michigan
October, 1985

OTHER ACTIVITIES:

Review Board for Hospital Formulary (A Refereed Journal for the P&T Committee)
1989 - Present

Panel member for American Medical Association's Diagnostic and Therapeutic Technology Assessment Program of the Council on Scientific Affairs
March 1990

