Doc. 345

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

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IN THE COURT OP COMMON PLEAS

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DEWEY GLENN JONES, ET AL., Plaintiffs,	)	
-v-	)	Case Number 306012
	)	Judge Lillian J. Greene
MERIDIA HURON HOSPITAL, ET AL., Defendants.	)	

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TELEPHONE DEPOSITION OF MARSHALL J. ORLOFP, M.D.
Thursday, July 3, 1997

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Telephone deposition of MARSHALL J. ORLOPP, M.D., called by the Defendants for examination under the Ohio Rules of Civil Procedure, taken before me, the undersigned, Aimee N. Szinte, a Notary Public in and for the State of Ohio, at the offices of Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., 1001 Lakeside Avenue, Suite 1600, Cleveland, Ohio 44114, commencing at 11:35 a.m. the day and date above set forth.

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APPEARANCES:

On Behalf of the Plaintiffs:

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On Behalf of the Defendants Meridia Huron Hospital, Winston Ho, M.D. and Lakeland Medical Group:

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

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MARSHALL J. **ORLOPP**, M.D.

called by the Defendants for examination under the Ohio Rules of Civil Procedure, after having been first duly sworn, as hereinafter certified, was examined and testified as follows:

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EXAMINATION

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BY MR. JONES:

Q Doctor, we were just introduced. My name is Mark Jones. I represent Dr. Rafal Badri in the lawsuit that we're here about today.

a Pleased to meet you, Mr. Jones.

Q Nice to meet you too, Doctor.

A I'm sorry you're not here because it's absolutely beautiful here.

Q Well, isn't it always beautiful in San Diego?

A Almost always. The **sun** is out and the temperature is 79 degrees and the birds are singing.

a Well, you know we're not having a bad day here in Ohio either.

A That's right. We should be talking in the winter.

Q That's right. What I want to do, Doctor, is get your deposition done so we can both get outside and enjoy this lovely day.

A I have to go to work after this deposition.
Q Okay. Well, then so you can get back to work, which I'm sure you would rather be doing.
Doctor, could you please just for the record give us your full name and your primary business address?
A Yes. My name is Marshall, that's M-a-r-s-h-a-l-l, middle initial J., Orloff, O-r-l-o-f-f. And my address is UCSD Medical Center, 200 West Arbor, A-r-b-o-r, Arbor Drive, San Diego, California 92103-8999.
Q Doctor, how old are you?
A I'm 79 years old.
Q I've got a copy of your curriculum vitae. It is not dated, but the last entries on this are for publications 358, 359 and 360, which would have been submitted for publication. Is that a current CV, Doctor, do you know?
A The CV within six months.
Q All right. Are there any additional publications within the past six months, Doctor?
A I think there are five or six additional publications within that time frame.
Q Would any of those publications have any relevance to the issues presented in this particular medical/legal matter?
A They do not.
Q How about your current positions as far as employment

and your practice, is that still current within the last six months?

A Yes. I think everything else in the CV is correct. It has not changed in the last six months.

Q Okay. Doctor, could you describe for me your current professional activities, let's start with any administrative activities that you are regularly involved in.

A The administrative activities are minimal.

Q Okay. How about teaching activities, Doctor?

A Teaching activities are large. They're really intimately related to my clinical activities. The two go hand in hand. They really can't be separated out.

So just to shorten it for us, I spend about 70 percent of my time in clinical activities, and all of those clinical activities involve students, medical students or interns or residents. So they're intimately involved. And then I spend about 25 percent of my time approximately in research. And I spend about 5 percent of my time in administrative activities.

And those administrative activities have to do with the University, serving on special committees of the University. I try to avoid that as much as possible. And some national committee assignments that I have or functions that I have. But those have become a small part

of my activities.

Q Your current research activities, Doctor, can you give me the area or areas of research that you're currently involved in?

A Yes. They have to do currently with two areas, liver disease, and the other area is with transplantation of the pancreas for diabetes.

Q Your clinical practice, Doctor, can you describe your clinical practice to me?

A Well, it's a practice mainly of general surgery, some noncardiac thoracic surgery. That part is a small part of my practice. And I do the full spectrum of general surgery, that is everything that falls within general surgery. But I would have to say that I do surgery of the biliary tract, the liver and the pancreas more than any other area of surgery, not to the exclusion of, but more than other areas of surgery.

Q When you talk about surgery on the biliary tract, does that also include surgery on the gallbladder?

A That's part of the biliary tract.

Q Can you tell me the last time, Doctor, you did an open cholecystectomy yourself?

A Two weeks ago.

Q Can you give me an idea of how often you do an open cholecystectomy, Doctor?

A I would say about 30 times a year.
Q And in those 30 times per year, Doctor, considering your current status at the medical center, are you the lead surgeon or are you supervising residents or fellows in this type of surgery primarily?
A No. I think both of those things. Sometimes -- There are always residents involved in all of the operations that I do. Sometimes I do the entire operation, sometimes I do part of the operation and supervise the resident in part of the operation, and sometimes I supervise the resident for the entire operation. So it varies.
Q Doctor, can you tell me the last time you did a laparoscopic cholecystectomy?
A Oh, that would be probably about a month ago.
Q And approximately how many laparoscopic cholecystectomies do you do per year, per month, however you want to --
A I would say approximately 15 laparoscopic cholecystectomies a year.
Q I'm sorry, was that 15?
A Yes, 15. 1-5.
Q Okay. Do you do surgical drainage of the gallbladder yourself, Doctor?
A You mean a cholecystostomy, is that what you're

talking about?

Q Correct.

A Yes, I do.

Q Can you give me an idea of how many of those you do a year or how often you do those?

A Well, those are for me and I think for everybody else not very frequent operations, and maybe I do a couple of those a year.

Q Two or three?

A Something like that.

Q Okay. How often do you refer a patient to an invasive radiologist for percutaneous drainage of the gallbladder, Doctor?

A Again, maybe once or twice a year.

Q And when was the last time or how often a year do you refer patients for electric shock wave lithotripsy for gallbladder stones?

A That would be infrequently in the past year. More frequent a few years ago, but right now it would be infrequent. Maybe once or twice a year.

Q Why have the number of patients you have referred for lithotripsy decreased over the last few years?

A Well, I think that that's the general experience throughout the United States. With the advent of laparoscopic cholecystectomy, lithotripsy really declined

markedly. And in my practice and in my department we use lithotripsy mainly for poor risk patients. Those are the circumstances under which we use it.

Q And that occurs approximately once or twice a year at this time?

A For that specific'modality,yes.

Q Okay. How about repairs for percutaneous drainage of the gallbladder, is that something that's been increasing in frequency over the past few years or decreasing or about the same?

A No. I think similarly it has remained about the same, and the reasons are similar.

Q So those types of patients are referred primarily because they're poor surgical risks?

A That's correct.

Q How about your experience with cholecystotomy, is that increasing over the past few years, decreasing or about the same?

A Mr. Jones, I don't think you're using the right term.

Q Correct me if I'm misstating it, Doctor.

A I think if we are talking about what we started out talking about a few moments ago, we are talking about cholecystostomy, which is a drainage procedure of the gallbladder done surgically. I think that's what you want to ask me.

Q Yes. I left out an S. I'm sorry.
A Yes, cholecystostomy. And the frequency of that has remained about the same over the years.
Q I would expect that the incidence of laparoscopic cholecystectomies has increased dramatically over the last several years.
A There is no question about that. That's true throughout the world.
Q How about your own experience in performing laparoscopic cholecystectomies, has that increased dramatically over the last few years?
A No, it hasn't, but that's by my own design.
Q Why have you elected not to become more involved in laparoscopic cholecystectomies?
A Well, I tend to do complicated cases of biliary surgery and cholecystectomy and have the younger men of my department and women do the straightforward laparoscopic cholecystectomies, so that I don't seek to do a larger number.
Q Doctor, what is the primary hospital in which you practice?
A It's called UCSD Medical Center and it is the one where my office is located. The address is similar.
Q And is that a large facility?
A You have to define large for me.

Q How many beds is it?
A About 380 beds.
Q Do you have any other hospital affiliations? I'm limiting this only to affiliations where you regularly perform surgery.
A Regularly is the key word. I have a number of other ones, but that's the one where I do most of my surgery. The University -- UCSD Medical Center has two facilities. That's one of them. And the other one is in LaJolla. It's a newer and smaller facility and it's called the Thornton Hospital. And I do I would say an occasional operation there, but most of them are done where I said I do them.
Q Okay. Doctor, could you just briefly describe for me your experience in doing medical/legal work?
A You would have to focus that question a little bit.
Q All right. Can you give me just an idea, however you want to describe it, as to your personal involvement in the review of cases that involve allegations of medical negligence.
A I would say over the years, and the years are many, I have been involved in the situation that you described perhaps, and this is a gross estimate, about 50 times.
Q Has the amount of time and the number of cases that you have reviewed in this area increased over the years or decreased?

A It has increased. It has increased in the recent years.

Q How recent, Doctor?

A Oh, I would say in the past five or six years it has increased.

Q Do you have any understanding as to why you have increased your involvement in this type of medical/legal work?

A It is entirely a time factor. Earlier on as the Chairman of a large department with very heavy administrative responsibilities as well as the other kinds of responsibilities I described, I simply didn't have the time to do that kind of thing very often, and so I declined most of the invitations that I received. I am no longer the Chairman of the department. As you can see, I have limited the amount of administrative work that I do substantially, and so I have more time to consider that kind of work.

Q I noticed when you gave me a breakdown of your professional time you didn't include any percentage for the amount of time spent in medical/legal work, Doctor. Is there a percentage of time that you can put into that?

A I don't think I can, but I want to assure you it's very small.

Q Can you give me an idea, Doctor, within say the last

year how many cases you have reviewed?

A I would say approximately six or seven cases.

Q And are you asked to review cases in any particular area of medicine?

A Well, I have never been asked to review a case in psychiatry. I'm asked to review cases within the fields of general and thoracic surgery by and large.

Q Other than the field of psychiatry do you feel that you are competent to render expert opinions in every other field of machine?

A No. You know I'm not. I use that as an example. And if you want me to go through the specialties in which I have been asked to review cases, I'll stretch my mind and do that. But I focus on the fields in which I practice and in which I have expertise, which are general and thoracic surgery.

Q Do you feel that you are expert in the area of let's say anesthesia?

A No, I'm not expert in the area of anesthesia.

Q Are you an expert in the area of internal medicine?

A Well, that's much too broad a question. There are areas within what might be called internal medicine where I have a great deal of experience and have rendered expert opinions about those areas.

Q Are those areas limited or are they far flung?

A I think they're limited.
Q How about the area of cardiology, are you competent as an expert in any particular aspect of cardiology care, Doctor?
A No. I'm not a cardiologist. I deal with patients with heart disease very frequently and I'm Board certified in cardiothoracic surgery, so though it's not an area of ignorance, I don't consider myself an expert cardiologist.
Q Okay. Doctor, what do you charge for your review time in a medical/legal case?
A I charge $500 an hour.
Q Is that for any time that you spend involved in medical/legal matters?
A For all time that I spend.
Q Okay. Doctor, when were you first contacted about this particular case involving Dewey Jones?
A I think it was in the month of February 1997. February 1997.
Q And how was this first contact made, Doctor, do you know?
A It was made by letter.
Q And who was the letter sent from, do you recall?
A I'm sorry. Would you mind repeating that question?
Q Sure. Who was the letter from?
A The letter was from Don Keenan.

Q I hear the shuffling of papers, Doctor. Do you have that letter with you today?

A I'm looking for it, but I'm not sure that I have identified it.

Q When you have it, Doctor, let me know.

A I'm sorry. I can't find it.

Q Do you think that that letter has been retained by you somewhere, Doctor?

A I think that's likely. Probably would have been retained by my secretary.

MR. JONES: Charles?

MR. ALLEN: Yeah.

MR. JONES: I would like you before you leave there today to see if you can find that letter or if you have a copy of it in your own file.

MR. ALLEN: Sure.

MR. JONES: I don't know if you have your whole file there and can show the doctor the letter that was sent by Mr. Keenan.

MR. ALLEN: I don't have it with me, but we'll find it and we'll either attach it or --

MR. JONES: Instead of formally

attaching it, because we don't have it here right now.

MR. ALLEN: I'll make sure we locate it and I'll get you the original copy of it.

MR. JONES: Okay. I would appreciate it.

MR. ALLEN: Sure.

Q Doctor, other than this first letter sometime in February of this year have you had any further contact before today with anyone from Mr. Keenan's firm?

A Yes, I have.

Q Has there been any more correspondence between yourself and Mr. Keenan's firm?

A There has been correspondence.

Q Do *you* know how many letters you have received from Mr. Keenan's office?

A I'm looking at my file and I find a letter that has a date 7 February, and it says -- Would you like me to read it to you? It's short.

Q If it's short,

A "Please find enclosed a check to cover your retainer fee and a complete copy of Mr. Jones' medical records for your review. The second set of records you requested will be forwarded to you on Monday. If you have any questions, please give me a call at" *so* on so forth. "I look forward

to working with you on this case. With warm regards, Sincerely, Karen D. Parley for the firm."

Q Do you know which records you actually received with that first letter, Dr. Orloff?

A The set of records consisted of two volumes. One was a volume that was labeled past history records, and the other was a volume covering the Meridia Huron Hospital admission from 10-17-94 to 11-21-94.

Q In the past medical history volume that you have, Doctor, do you know which medical records were included in that volume?

A That included the medical records beginning with an admission to Community Hospital of Bedford from 7-20-91 to 7-22-91, and then going on through some -- the 13 admissions, perhaps 14 admissions up until the admission to Meridia Huron Hospital on 10-17-94.

Q The letter refers to additional records that you requested. Do you know which additional records those were?

A Oh, I simply requested a duplicate copy of the records that had been sent before.

Q Why did you --

A It wasn't any new records. It was simply a duplicate.

Q Why did you request a duplicate copy, Doctor?

A That's my standard practice. I request two copies because I frequently cut out pieces of a record to provide chronological records, a much shortened record of the case. And that, of course, destroys the records, so I want to have one complete set on hand after I have destroyed parts of the other one. And it's a lot less expensive for a firm to do the duplicating than it is for me to do the duplicating.

Q And did you, in fact, go through the one volume or the first set of volumes and make a smaller compendium of those for your own use?

A Yes, I did.

Q So what you currently have as far as records is a complete set of the medical records you have described to me and in addition a shorter set, a smaller set that you have culled from the complete records?

A That's exactly correct.

Q After you received the second set, Doctor, have you received any additional medical records?

A No, I have not received any additional medical records.

Q Have you received any deposition transcripts from this case?

A Yes. I received four deposition transcripts.

Q Can you tell me which depositions those were?

A Dr. Badri's deposition, Dr. Ho's deposition, Dr. Adamek's deposition, and Dr. O'Neil's deposition.

Q Did you receive entire transcripts of those depositions, Doctor?

A I believe they're entire transcripts. I'm not sure if they contain all of the exhibits, but I believe they're entire transcripts.

Q Did you review each of those depositions?

A Yes, I did.

Q Have you made any notes from your review of those depositions?

A No, I did not.

Q Have you received any written reports from other experts in this case, Doctor?

A No, I have not.

Q Have you received any literature from Mr. Keenan's law firm in this case?

A No.

Q Have you reviewed any literature prior to the preparation of your report or prior to this deposition today for the purpose of preparing yourself for testimony in this case?

A No, I haven't.

Q I notice in the past, Doctor, from your CV that you have written chapters for the Textbook of Surgery that

Sebastian edited, correct?

A That is correct.

Q I noticed that you haven't provided chapters in the most recent editions of that text, but is that a good authority in this particular area?

A Well, it's okay. It was a good authority when I was writing the chapter.

Q Has someone else written the chapters on the two areas in the most recent texts?

A They didn't drop the chapters, yes. I reached a point that I had written -- even before Sebastian assumed the editorship of Christopher's Textbook of Surgery I had written for seven consecutive editions, and I decided that that was enough. It's a great deal of work to do that, and so I simply asked David Sebastian to be excused from next editions.

Q Are you familiar with the most recent editions as far as the chapters on the biliary tract?

A I have looked at the chapters on the biliary tract in the recent editions.

Q Do you feel that the most recent chapters on the biliary tract in the most recent editions are less reliable and authoritative than your own chapters?

A Oh, I wouldn't say that. I was really being facetious when I made that comment.

Q I thought you were too, Doctor, but that doesn't come over on the transcript.

A Well, yes, I think they're well done. You know, I can't vouch sentence for sentence for their accuracy or validity, but I think in general it's a good textbook of surgery and the chapters are well done.

Q Is it used by medical students in the teaching of medical students in the institutions that you're affiliated with?

A Yeah. It's one of the textbooks that is used.

Q What's another text that you use?

A Well, you know Schwartz textbook. Sebastian's textbook when I was writing for it was the most widely used textbook in the world. And I don't know if it was related to the fact that I stopped writing in it, but Schwartz really overtook Sebastian and now is by far the most widely read textbook in the world. It really has -- Sebastian's circulation has decreased. As a matter of fact, I should tell you that David Sebastian mentioned that to me and wondered if I wanted to come back.

Q But you're not up to that at this point?

A Oh, I'm up to it. I just don't -- I'm not interested in doing the eighth consecutive, or not consecutive, the eighth chapter in that textbook.

Q Do you think Schwartz's text is a good authority on

this particular area; that is, the biliary tract?
A Yeah. Generally speaking it's a good authority. You know, again, I can't vouch sentence for sentence for everything that's in there.
Q That's fair enough.
A But I think it's a good textbook.
Q Doctor, do you still subscribe to journals in your area of medicine?
A I do.
Q Can you just tell me which journals you subscribe to yourself?
A Yes. I subscribe to Annals of Surgery, to the journal called Surgery, the American Journal of Surgery, to Archives of Surgery, to the journal called Gastroenterology, to the journal called Hepatology, to the New England Journal of Medicine, to the Journal of the American Medical Association, to the Journal of the American College of Surgeons. Those are the ones that occur to me.
Q Okay. Doctor, I've received a copy of a two-page document that has your signature and the date of March 5, 1997. Do you have a copy of that with you today?
A Yes, I do.
Q And can you tell me, Doctor, did you prepare this document?

A Yes, I did.

Q And I mean, how was it prepared? Can you just describe it for me?

A I prepared the document. I sent the draft of the document to Mr. Allen. We had a brief conversation on the phone about the document and then the document was prepared in its final form and transmitted. I note it's signed on the 5th of March 1997.

Q Now, Doctor, the original draft of this report, do you actually have that typed in your office?

A Yes.

Q And then that was transmitted. Was it faxed to Mr. Allen?

A 1 don't remember that.

Q Okay. But you clearly recall a first draft being forwarded to Mr. Allen?

A Yes, I do.

Q Okay. Do you have a copy of that first draft, Doctor?

A It's not in my file. I don't have a copy.

M.R. JONES: Charles, do you have a copy of that first draft?

MR. ALLEN: I'm not sure. I'm not sure. I'll have to check with Bob back at the office.

MR. JONES: First of all, Charles, I'm going to ask that you check to see if you have retained a copy of that first draft, all right. And if you'll do so without a formal request, if you would forward that with the correspondence from Dr. Orloff's office also.

MR. ALLEN: Okay. No problem.

MR. JONES: If you do not have a retained copy of that, I need to ask the doctor a few more questions.

Q Doctor, the first draft of this report, was it prepared on a computer?

A I don't know the answer to that.

Q Was it prepared by a secretary in your office?

A Yes.

Q Do you know who the secretary was?

A No.

Q Do you know whether or not you have the ability to check to see whether whoever prepared the first draft has retained the data from that first draft in the computer system in your office?

A By data do you mean retained the first draft?

Q Yeah. The first draft would be contained in a computer file, I would assume. Do you know whether it's

possible in your office to check to see if that first draft is still retained within the computer files in your office?

A It is possible to check that, but I seriously doubt that it is.

Q Why would you doubt it?

A Well, because it was replaced by a final draft. And we don't fill our computers with all the early drafts and things like that with the large amount of paperwork that we do. We just throw it out.

Q Doctor, the final draft that I have here with me with your signature on it --

A Yes.

Q -- was that actually the final draft actually prepared in your office then?

A Yes.

Q Can I ask why it's not contained on a letterhead out of your office?

A Well, I can't give you a specific reason for that. It is not -- it wouldn't be uncommon to prepare it in exactly the way in which you see it there, on a plain piece of paper.

Q So in your past experience in preparing reports in medical/legal cases it's not uncommon for you to send out a report that does not contain any letterhead, any typewritten date, any information designating who typed the

report, but just a blank two pages, just a two-page report; something like that, that's not unusual?

A That's not uncommon. In fact, it is I think more common than not, not to type that on letterhead paper.

Q Prior to preparing the first draft, Doctor, did you receive any directions from Mr. Allen or Mr. Keenan or anyone from their law firm on how to prepare this report?

A No.

Q Is it your custom and practice, Doctor, to start your reports off, I, Marshall Orloff, M.D.?

A By custom, I don't know what you mean. There is no custom that I'm familiar with.

Q So it wouldn't be unusual for you to start one of your reports with, I, Marshall Orloff, M.D.?

A Identifying myself, no.

Q In this way?

A No, that wouldn't be unusual.

Q Identifying yourself in this way?

A Yeah. That's not unusual.

Q Okay. Is it your custom and practice, Doctor, in correspondence that goes out of your office that your secretary does not put on any identifying information regarding who it was that prepared the typewritten report and the date that it was prepared?

A This is not correspondence. I don't consider this

correspondence. If I were to write you a letter, it would contain the date and it would contain the secretary who typed it, her initials. But for a document such as this or similar documents, that's not unusual.

Q Doctor, after forwarding your first draft and discussing the first draft with Mr. Allen do you recall what changes were made in your report?

A Yes, I do.

Q Okay. Why don't you tell me what changes were made.

A The report remained as it was originally formulated with the addition of one phrase. And that phrase appears in the second paragraph of the document in the second line -- sorry, the third line of the second paragraph.

Q So what was the phrase that was added?

A The original said, It is my considered opinion that his misfortune, so and on and forth. And the phrase that was added is, It is my considered opinion within a reasonable degree of medical certainty that his misfortune is the result of, so on and so forth.

Q So the term reasonable degree of medical certainty was just added?

A Within a reasonable degree of medical certainty.

Q Doctor, what does the phrase within a reasonable degree of medical certainty mean to you?

A Just what it says, within a reasonable degree of

medical certainty. It's just like all those other legal phrases you use.

Q I use a lot of them, Doctor. I'm asking what this particular one means to you.

A Well, you know, it's a frequently used phrase. It really isn't a very precise phrase because it's so hard to bring precision to these opinions. And it means exactly what it says, within a reasonable degree of medical certainty.

Q Doctor, do you have any notes that were made during your review of the volumes of medical records, the depositions, et cetera in this case?

A What we talked about before is what I have, which is to extract the material that I thought was germane and prepare a chronological record using that: very same material. And those are the notes that I have. Let me add to that, if I *may.*

Q Please.

A And from that, that chronological record, I prepared a summary *of* the chronological record, the reduced, tightened, small form, short form chronological record, and that, again, is just a factual summary. it's not a summary *of* opinion.

Q But it's something that you actually typed up, had typed up in your office?

A 1 didn't have it typed up. It's in my own handwriting.
Q Okay. And how many pages is this chronology?
a The chronology? I'm sorry, I didn't --
Q Yes. This handwritten chronology that you have, how long is it?
A You mean the paste and cut chronology?
Q No. I thought you said that you had prepared a handwritten chronology.
a No. I said I prepared the paste and cut chronological record and then I made a summary of that, and the length of the summary is four pages.

MR. JONES: Okay. Charles, I would like a copy of that also when you get the correspondence together and so forth.

MR. ALLEN: Sure.

MR. CASEY: And Charles, this is Jim Casey. I would like the paste and cut as well.

Q Well, let me ask, how long is the set of culled records that you have, Doctor? How many --
A It -- well, it takes -- The first part of it is 26 pages and the second part of it, it goes on from there, consists of about 50 pages of progress notes.

MR. JONES: Well, I guess Mr. Casey

wants a copy of that too, Charles.

MR. ALLEN: Are you serious?

MR. JONES: That's what he's asking for.

MR. CASEY: At my expense.

MR. ALLEN: All right. We'll make a copy ot it.

THE WITNESS: Now; I'm sorry, who was that that wanted the copy?

MR. CASEY: Doctor, we haven't met yet. My name is Jim Casey and I represent the hospital.

THE WITNESS: Nice to meet you, Mr. Casey. I would ask that you read it word for word.

MR. CASEY: I don't know how to take that, but I will.

THE WITNESS: I hope you're smiling, Mr. Casey.

MR. CASEY: I am.

THE WITNESS: That's good.

Q Doctor, I want to turn to the report that you have prepared and I want to go through the opinions that you give, so do you have a copy of it there?

A I have the report, yes.

Q Okay. The first overall opinion is that you feel the decision to perform the cholecystectomy in this case was below standard of care, is that correct?

A That's correct.

Q And as I understand it, your first point to be made on that subject is that this was not an emergency, life-threatening situation for Mr. Jones, correct?

A That's correct.

Q Are emergency, life-threatening problems related to the gallbladder the only instances in which cholecystectomy is undertaken, Doctor?

A No, it's not.

Q Was Mr. Jones at risk for obstruction from the gallstones that he had?

A Well, the presence of gallstones in any patient gives us the possibility that they may obstruct.

Q Okay. So considering the number and size of gallstones that Mr. Jones had in his gallbladder, obviously he was at some substantial risk?

A That's your word now. You have introduced a new word, Mr. Jones, which I would take out, delete from your sentence. Substantial.

Q Okay. So you don't think he was at any substantial risk for obstruction?

A No.

Q When Mr. Jones presented at the hospital on October 17, 1994 was he exhibiting signs of obstruction?
A No.
Q How would you interpret the presentation that Mr. Jones had on October 17? What was causing his problems?
A He had what is called biliary colic. And the cause of it, of course, is speculated, but it occurs under a variety of circumstances in patients who have stones in the gallbladder. And since he had stones in the gallbladder, that's one of those circumstances.
Q As a general matter, Doctor, what are the signs and symptoms of biliary colic?
A Colic, of course, is pain. And the pain is usually in the epigastrium or right upper quadrant. And the nature of the pain is that of a continuous pain on which is superimposed waves of increasing and decreasing intensity.
That's why it gets the name colic, because the pain goes up and down, but it doesn't go away. And that pain often radiates to the back or to the infra -- the area below the tip of the scapula or to the shoulder. That's a common radiation, but that's not necessary to have -- to make the diagnosis of biliary colic. That's the nature of the pain.
Q How about the way the patient looks on presentation?
A Oh. I don't think there is a look associated with

biliary colic.

Q How about lab values?

A I said biliary colic occurs under different circumstances in patients who have gallstones, and the lab values in -- if you took the whole population of patients who have biliary colic, the lab values are normal in a substantial number of those patients. But you guys have to tell me what lab values you're talking about.

Q I'm just asking if there are any particular lab values that you would see and say, Oh, well, that sort of confirms that this is a biliary problem going on.

A No. Not so. The lab values are often, not necessarily, but often normal, the lab values that we're both thinking about, I hope.

Q We'll get to the specific ones I'm sure eventually, but I'm sure we're talking about the same ones.

Is there anything else that plays a part in the diagnosis of biliary colic, Doctor?

A Well, there are other symptoms often associated with biliary colic such as it is quite common for the patient to feel nauseated, to vomit one or more times with biliary colic, to notice that the pain was precipitated by eating and sometimes by eating specific foods such as fried or fatty foods, such as cabbage or onions, all the good things that there are. They precipitate the attacks frequently in

patients. There are those associations.
Q Okay. Then to contrast that, if you will, with biliary obstruction, Doctor, how does the presentation differ?
A There are different forms of biliary obstruction, so we have to focus that question in order for me to give you a rational answer.
Q Well, starting with the gallbladder and working down the biliary tree, the various levels that obstruction can occur, why don't you just give me an idea then as to how the patient's presentation may manifest itself and raise the question about biliary obstruction.
A Okay. I don't want to -- I want to shorten this as much as I can. Biliary obstruction starts with obstruction of the cystic duct, and some patients who get biliary colic have obstruction of the cystic duct which is intermittent; in other words, the stone doesn't get impacted in the cystic duct, but it obstructs it and then it bounces back up and spontaneously relieves the obstruction. So that's one form of obstruction.
Q Okay. Well, let's start with that form of obstruction. How do those patients typically come in as far as their history, the presenting complaints?
A The same way as what we have been talking about.
Q So it's very similar to biliary colic?

A Well, they have biliary colic. Biliary colic is a form of pain. And they have biliary colic, and that is a common way that they get biliary colic.

Q Okay. Well, what additional information can you glean either from the patient's presentation physically or from laboratory testing, radiology studies, et cetera, that will be able to differentiate between a biliary colic without obstruction and a cystic duct intermittent obstruction?

A You can't. Cystic duct intermittent obstruction or biliary colic because of an abnormal contraction of the gallbladder related to the presence of stones presents in the same way. They can't be differentiated.

Q So there is no lab work or radiology studies or anything?

A They both have -- you didn't say radiology. But they both have a normal laboratory picture.

Q I thought I did mention radiology studies too, but let me add radiology studies.

A It's the first time. I would be happy to talk about it. But we were talking about laboratory studies and when you talk about radiology, that's a different sphere. That's not considered laboratory studies.

Q Let's talk about radiology studies. Are there any that will assist in the diagnosis of a cystic duct

obstruction?

A I don't want to confuse the issue, so let me just backtrack for a moment, Mr. Jones.

We said that a patient can have biliary colic without having any obstruction at all. We said that a patient can have biliary colic with having intermittent obstruction of the cystic duct by a stone, but the stone is not impacted. We have gotten that far, to those two circumstances. And in those circumstances biliary ultrasound, ultrasonography of the right upper quadrant of the abdomen to include the gallbladder simply shows the gallstones. It does not show any thickening of the gallbladder wall, unless there is some previous reason for the thickening, and it doesn't show any fluid around the gallbladder. It simply shows the echoes that indicate that there are stones present. That's as far as we have come.

These are now further degrees of obstruction.

Q Okay. Let's just stop right here for now. I want to make sure I completely understand. And that is, in other words, an ultrasound won't show any dilatation of the duct itself, that sort of thing?

A No. You didn't don't see dilatation of the cystic duct on an ultrasound.

Q Okay. However, you could see thickening of the gallbladder wall?

A Not from that episode.
Q What would cause thickening of the gallbladder wall?
A Previous inflammation.
Q What would cause previous inflammation if it wasn't some sort of obstruction?
A Well, now we're moving along to the next level of obstruction.
Q Okay. Well, so just before we move into the next level of obstruction, thickening of the gallbladder wall is an indication of some sort of obstruction, at least in the past?
A Previous inflammation of the gallbladder.
Q I'm trying to understand, what are the things that can cause inflammation of the gallbladder if it's not an obstruction?
A Well, the inflammation of the gallbladder can occur in the absence of gallstones. See, the radiologist can't make a histologic diagnosis. All he can do is report his findings and say in a general way what they indicate. When he sees thickening of the gallbladder wall he says in his report that that indicates previous inflammation, okay.
Q Okay.
A So that he doesn't attach a histologic or microscopic diagnosis to that.
Q Correct. I understand.

A And there is such a thing as calculous cholecystitis. Not germane to this case, but it does occur.

Q In a patient who does have numerous gallstones, Doctor, and there is thickening of the gallbladder wall, what are the mechanisms, the possible mechanisms for this thickening of the gallbladder wall in that situation?

A Well, putting what is most reasonable together, it would be that the patient has or had had inflammation of the gallbladder wall and that's what led to the thickening.

Q And we're not really getting to what I'm trying to get to, and it's probably my fault.

A It is entirely your fault.

Q I'm sure. I'm trying to understand what are the mechanisms in a patient who does have gallstones that can cause this inflammation that leads to thickening of the gallbladder wall. I mean, infection? Is it obstruction? Is it irritation of the gallbladder wall from the stones? I mean, I'm just trying to understand what causes the thickening of the wall of the gallbladder in a patient with stones.

A Okay. So you know, I think that if I can just give you sequence of events, maybe it will be clear. And you stop me if I'm not being clear or if you don't like what I'm telling you.

Q Well, I won't stop you if I don't like what I hear from you, Doctor. I'll just stop you if I don't understand you.

A That's fine. Either one is okay. The ball is in your court on that.

Q All right. *So* go ahead.

A But I said that biliary colic -- Biliary colic is a term that describes a type of pain. That's what biliary colic is. Biliary colic occurs when there are stones in the gallbladder when there is no obstruction, no demonstrable obstruction of the cystic duct. That occurs because the contractions of the gallbladder are abnormal as a result of the disease produced by the stones. That's one circumstance. That is not associated with inflammation of the gallbladder wall.

A second is when the stone obstructs the cystic duct, but does so intermittently; in other words, isn't impacted in the cystic duct. And that situation may be associated with some inflammation of the gallbladder wall and it produces colic again, the pain again, but it relieves itself spontaneously.

A third degree of what we're talking about is when the stone gets stuck in the cystic duct, and that produces really complete obstruction of the outlet *of* the gallbladder. And that circumstance is associated with

inflammation of the gallbladder wall, and that inflammation results usually initially from the chemical contents of the bile that is there, but bacteria maybe superimposed to it initially or at some point. So it starts out as a chemical inflammation and it goes on to become a bacterial inflammation.

And that circumstance, which is called acute cholecystitis, is associated with thickening of the gallbladder wall, pain, is seen on the ultrasonography, also seen at operation and by the pathologist, and with something called pericholecystic fluid. That's inflammatory fluid around the gallbladder.

And it is associated with physical signs that are quite different from what we talked about thus far, because we now have an inflammation of the gallbladder, and that produces tenderness, guarding or rigidity in the right upper quadrant of the muscles. It produces often a mass. That obstructed gallbladder is thickened, is enlarged, and because it's inflamed, the surrounding tissues come up against it and stick to it and produce a palpable tender mass in the right upper quadrant. It's associated with fever, an elevated white count, sometimes because of its closeness to the liver with liver function abnormalities. So liver function tests become abnormal; not highly abnormal, but they become abnormal. That's a very

different picture from what we have been talking about thus far. That is acute cholecystitis. Okay so far?

Q You're doing great, Doctor. I haven't had to stop you once.

A I'm proud of that record. I'll tell my students about that.

Then, of course, you go down the line, and down the line is down into the common bile duct. And there if a stone enters into the common bile duct, it produces obstruction of the common bile duct. Often on ultrasound one can't really see that because the ultrasound isn't sufficiently sensitive, but there are other ways, imaging ways of demonstrating that.

But it produces a condition known as obstructive jaundice, and in that condition the bilirubin goes up substantially, along with the alkaline phosphatase, GDDP. That's another enzyme that reflects obstruction. And if the fluid that is in the common bile duct, the bile that's there has bacteria in it, it gives rise to something called acute cholangitis in which there is fever, there is sometimes some swelling of the liver, there is a marked elevation of the white count and a degree of illness that exceeds what we have been talking about thus far. So those are various degrees and sites of obstruction in patients who have gallstones.

Q Can patients pass gallstones?
A Oh, yes. They pass gallstones all the time.
Q Can patients in passing gallstones experience biliary colic?
A Yes, they can experience biliary colic.
Q Can they also --
A Because just as the gallbladder is responsible for pain, the common bile duct, similarly, is responsible for pain.
Q Okay. Can they also while they're passing the stone have indications of cystic duct obstruction?
A No. The two -- Those two circumstances don't go hand in hand.
Q Okay. Can they have some of the indications of a common bile duct obstruction while they're passing a stone?
A If the stone gets into the common bile duct, of course, there is always the potential that it will lodge in the bottom part of the common bile duct and produce obstruction. It doesn't necessarily do that. Sometimes it passes through without producing any significant or clinically detectable obstruction, but it can lodge there in the distal end of the common bile duct where it narrows and it can produce obstruction of the common bile duct and jaundice.
Q Now, does a gallstone have to be a particular minimum

size to cause obstruction, Doctor?

A Obstruction of what?

Q Well, let's start with the cystic duct.

A Well, like everything else, the obstruction depends upon the size of the stone and the size of the cystic duct. Some people have tiny cystic ducts that won't accommodate the passage of a stone. Some people have large cystic ducts that readily accommodate the passage of a stone without becoming obstructed. So it's really the relationship between the size of the stone and the size of the cystic duct that determines what will occur. There isn't a fixed size that will say that one is going to obstruct.

And interestingly, just as an aside, patients 'chat have a solitary, single stone in the gallbladder, a large single stone in the gallbladder frequently have no symptoms at all and never obstruct their cystic duct.

Q Okay. Doctor, in Mr. Jones' case you have already indicated that he had a presentation consistent with biliary colic on October 17, 1994, correct?

A That's correct.

Q Now, on his presentation do you also agree that there was some indication of biliary obstruction?

A No, I don't agree with that.

Q Well, as we went through this, as I understood it,

biliary obstruction has essentially -- this intermittent cystic duct obstruction has the same sort of presentation as a biliary colic, or did I miss something?

A The thing I'm really struggling to achieve, and I think if I achieve this I will really have accomplished something, is to separate biliary colic, the term biliary colic from the other thoughts you have about his circumstances.

Biliary colic refers to a type of pain. That is it, plain and simple. It is not a syndrome. It is a type of pain.

Now, if we go back to where we started, the first degree I said was patients who have biliary colic who do not have cystic duct obstruction. The second degree was patients who have biliary colic, the same pain, but who have intermittent cystic duct obstruction. The third degree were patients who have biliary colic and have a stone impacted in the cystic duct, and those are the ones who develop acute cholecystitis.

So what I'm saying to you now is I can't tell whether Mr. Jones had cystic duct obstruction or did not have it. He could have had the first degree that I've talked about or the second degree that I've talked about. What I know he didn't have was acute cholecystitis, which is the third degree that I talked about where a stone is impacted in the

cystic duct.

Q And how do you know he didn't have that, Doctor? What's the basis of saying that you know he didn't have the third degree, the acute cholecystitis?

a Acute cholecystitis is associated with fever, an elevation of the white count, guarding on the right upper quadrant:. When you push in the right upper quadrant the patient's abdomen isn't soft. He contracts his muscles to protect himself. That's called guarding or rigidity. Or there's peritoneal signs in the right upper quadrant, and often, not always, with the detection *of* a mass, which is the tense distended gallbladder inflamed with the surrounding tissues adherent to it such as omentum which presents as a mass that can be palpated on physical examination.

He had none of those things. He had normal temperature. He had a normal white count. He didn't have any guarding or rigidity in his right upper quadrant. He didn't have a mass in his right upper quadrant. He had none of the manifestations of acute cholecystitis on admission or at any time in his course.

Q With biliary colic without obstruction, Doctor, do you get elevations in the liver function tests?

A Elevations in the liver function tests occur from a number of different reasons. Mild elevations of the liver

function tests -- and I will just point out to you if you'll read the record, you will find that Mr. Jones during his admission for congestive heart failure had elevations of his liver function test, some of which were even greater than the mild elevations he had on this admission.

And just so we don't beat around the bush, patients in congestive heart failure in this extreme form develop a condition called cardiac cirrhosis. It's actually cirrhosis of the liver from the chronic congestion of the liver associated with right heart failure. And in lesser degrees when it doesn't get to cirrhosis they develop abnormalities with the liver function tests. And he certainly has had that intermittently over a period of years.

Q He's been admitted with acute episodes of congestive heart failure, correct?

A Right. Right.

Q And it's your opinion that on October 17, 1994 he presented with another episode of acute cardiac or congestive heart failure?

A No. No, it's not my opinion. But you see these things take their toll. What I said to start with was the extreme form. If they develop cirrhosis, they have repeated damage to their liver and scarring of their liver and abnormalities of liver function. If congestive heart

failure occurs enough times or is persistent enough over a period of time, it leads to liver function abnormalities even when the patient is out of congestive heart failure.

Q Is it your opinion, Doctor, that to a reasonable medical certainty Mr. Jones did have cardiac cirrhosis of the liver?

A I don't think so. I said that's the extreme form.

Q Okay. So you don't think he got to that point?

A No, I don't think he got to that point. We don't have a biopsy of his liver to know that, but I don't think he got to that point.

Q Is it your opinion, Doctor, that years of episodes of acute congestive heart failure caused damage to the liver with persistent elevations in the liver function tests even when the patient isn't in acute congestive heart failure?

A He isn't in acute congestive heart failure €or sure. He doesn't have to be in acute congestive heart failure. But what I'm really saying is the mild elevations of the liver function tests that he had cannot be pinned on the stones in his gallbladder. There is no necessary relationship of those things. And, in fact, I seriously doubt that they had anything to do with the stones in his gallbladder.

Q Okay. Now, without looking at this retrospectively, Doctor, do you think that it's reasonable to question

whether the elevations in liver function tests in October of 1994 when Mr. Jones was in the hospital before surgery could be the result of some either obstruction or intermittent obstruction of the biliary tract?

A. Well, you know, I think it certainly is possible to raise that question. I don't think that's an unreasonable question. But I think if one reads the record, one quickly disabuses oneself of that notion if one finds out about his previous admissions or talks with his doctor.

The doctor, the primary care physician who has seen him through 11 or 12 admissions and umpteen office visits and knows him very well, to talk with him and ask him about these things, certainly he would know about these things. And I would expect he would say, Oh, well, he's had that for a long time. In fact, they have been higher before. His alkaline phosphatase on some of his previous admissions was up to 170, and, you know, higher than it was on this admission. So that's not --

Q. Is jaundice associated with biliary colic, Doctor?

A. Biliary colic is a pain.

Q. Okay. But I'm just saying, patients who come in with biliary colic without obstruction, do they also present with jaundice on occasion?

A. Well, biliary colic if it's due to certain forms of gallbladder disease can present with jaundice. Congestive

heart failure or the results of congestive heard failure can do the same thing; mild elevations of the bilirubin.

Mr. Jones had a very small elevation of his bilirubin, which I should point out to you if you look at the last study that was done before the operation on the morning of the operation was back down to where it had been to start with.

Q So the improving bilirubin in your estimation, Doctor, indicates that Mr. Jones had become more stable prior to his surgery?

A I wouldn't give it any weight, stable or unstable. I think the small variations in his bilirubin are nothing that one could hang one's hat on.

Q What about his presentation with scleral icterus?

A Well, scleral icterus -- I should say that I'm not sure he had scleral icterus. You know, if you look at African Americans and look at their eyes, as I do all the time, I should tell you, it's often easy to confuse scleral icterus with the kind of what we call muddy scleras as seen in African Americans. And at the bilirubin level which he presented, which there was a note that he had scleral icterus, I think only a very keen and experienced observer would pick up jaundice at that bilirubin level.

Q Have you ever noted anywhere else that any other physician indicated that there was a question about

scleral icterus on any of the numerous times Mr. Jones had been seen in the hospital?

A Frankly, I didn't look for that, so I can't answer that question.

Q Is it possible to have scleral icterus even with this law level of bilirubin as seen on the laboratory results?

A Well, I would defy any member of the staff of the Meridia Huron Hospital to pick up scleral icterus at a bilirubin of 2.1. You know, this is an area where I've had, I have to say with all due modesty, extensive experience. And picking up scleral icterus at a bilirubin of 2.1, I can't tell you it's impossible, but it's very close to being impossible, I can't detect it as a bilirubin of 2.1 and I've seen -- literally seen thousands of patients with liver disease.

Q Bear with me, Doctor.

A Certainly.

Q Doctor, from your experience with patients with gallstone disease similar to the situation that Mr. Jones had as far as the number of stones, size of stones, et cetera, is there any way to quantitate their risk for developing a biliary obstruction?

A I don't know of any way.

Q Doctor, are you familiar with the admission at Bedford Community Hospital on October 7 and 8?

A Give me just one minute please, Mr. Jones.
Q Sure.
A You know, I don't have a record of that. I have seen the references to that; to wit, I've seen the reference to it in the E.R. nurse's note when he presented, without dating it, that he was in Bedford Community Hospital a short while ago with complaints of abdominal pain. And just off the top of my head I recall another reference to that, that he was in and out of Bedford Community Hospital in the time frame of which you're talking with abdominal pain, but I have actually not seen a copy of that admission.
Q So of the dozen or so admissions that you have been provided with, an admission within ten days of October 17, 1994 was not provided to you by Mr. Allen or the Keenan law firm?
A I do not find that, that's correct.
MR. JONES: Do you have a copy of it there, Charles?
MR. ALLEN: I think I got it out in the car. Do you want to take a five-minute break?
MR. JONES: Why don't we take a five-minute and break see if you can find it.

(Recess was had.)

Q All right, Doctor.

A Yes.

Q Let me just ask you questions then since you don't have this record.

A I don't have the record. I have two references to it, and I'm happy to read you what the references state.

Q Well, where are the references you're referring to?

A I'm sorry?

Q Where are these references that you are familiar with?

A They are the E.R. admission, the E.R. nurse's note and the E.R. physician's note on his E.R. admission and the subsequent hospital admission, 10-17-94 at Meridia Huron Hospital.

Q And what is the reference?

A The E.R. nurse's note says, Complaints of abdominal pain. Same as in Bedford Community Hospital short while ago. Also complaints of headache. And the E.R. physician's note states, Was admitted overnight at BCC. ?Diagnosis. Given Compazine pills for nausea.

Q Are those the only references that you're aware of in the records that you have reviewed, Doctor?

A Yes, they are the only references.

Q And Doctor, when you read those references, in going

through this chart were you curious as to why you did not receive the actual records for that admission?

A I can't really remember what my state of mind was.

Q However, whatever your state of mind was, you never asked for a copy of that admission when you realized you didn't have it, correct?

A That is correct.

Q Doctor, patients who have -- Let me see where I go back on my notes here.

Well, nausea and vomiting, Doctor, would be consistent with obstruction or just biliary colic without obstruction, correct?

A That's correct.

Q And would this nausea and vomiting be different in any degree depending upon whether there has been just a biliary colic without obstruction as opposed to an obstruction?

A As opposed to the grade 2 that I talked about, the intermittent obstruction?

a Correct.

A No, it wouldn't be any different.

Q Would it be any different with a grade 3 obstruction?

A As I indicated, acute cholecystitis is a more severe, more persistent disease, and the symptoms are much more persistent.

Q Are there any changes in bowel habits with patients who have biliary colic or an obstruction of the biliary tract?

A Not consistent changes in bowel habits.

Q By that you mean what, Doctor?

A Well, you know, some patients say they have diarrhea. That's not a characteristic symptom. Some patients say they have constipation. That's not a characteristic symptom. So there isn't a consistent pattern of change in bowel habit in patients who have biliary colic.

Q Doctor, what significance if any is there of spillage of bilirubin into the urine in evaluating a patient with at least biliary colic?

A Well, you know, when the bilirubin is elevated in the blood it spills in the urine. The urine tests are quite inaccurate and not very sensitive and rarely used anymore in the analysis of patients who have biliary disease and have jaundice.

Q Does the bilirubin necessarily have to get to a particular level in the blood before it begins to appear or be detected on a urinalysis?

A NO.

Q Now, Doctor, you mention in your report the fact that Mr. Jones had 13 previous hospital admissions before

October of '94 for various problems over three and a quarter years and that this put him at very high risk. So I want to look at that for a minute, okay. It puts him at high risk for what?

A For having a cardiac arrest, as he did, and becoming a vegetable, as he did.

Q Does it also put him at higher risk of returning to the hospital in even worse condition than he was in in October of 19941

A No. The previous admissions don't put him at high risk for that. It all depends upon the control of the things that he was admitted for.

Q And when you say control, what are you referring to specifically?

A Well, he had, you know, he had severe hypertension, often uncontrolled hypertension. He had repeated bouts of congestive heart failure. He had cardiomyopathy. He had sleep apnea. As I say, I'm just reading what I stated. He had chronic edema of his lower extremities. Those are the things I'm talking about.

Q And in a patient who is non-compliant, as you'll acknowledge Mr. Jones was, correct?

A Yes.

Q These conditions combined with his non-compliance put him at substantial risk for re-hospitalization at an even

worse condition than he was in in October of 1994, correct?
A No, that's not correct. Non-compliance is not a permanent state of -- a permanent condition. Patients who are non-compliant may become more compliant or may become completely compliant. The objective, of course, is to put such a patient under tight medical maaagement to control his hypertension and his heart failure, to investigate and control his sleep apnea and his repeated pulmonary difficulties, and that is, of course, within the realm of distinct possibility.
Q Doctor, how many years had Mr. Jones been ill with his heart condition?
A He was first diagnosed as having congestive -- of having hypertension at the age of 21 in 1982. He was first diagnosed as having congestive heart failure due to some form of cardiomyopathy in 1987 at the age of 26. He was first diagnosed as having sleep apnea in 1992, and he had been morbidly obese for a considerable period of time.
Q Are the records replete, Doctor, with indications that Mr. Jones was non-compliant and was encouraged to become a compliant patient with his diet, his medication and other aspects of his health?
A Yes.
Q Is there any indication, Doctor, over that entire period of time, from the early '80s until his admission in

October 1994, where Mr. Jones gave any indication that he was going to become a compliant patient in any aspect of his health care?

MR. ALLEN: Object to the form of the question.

A There were periods of time when he was quite compliant.

Q Can you give me --

A And, you know, he returned to being non-compliant. But there were periods of time when he really was doing well and then --

Q Could you give me an indication, Doctor, when was the last time before 1994 where he went any period of time where you would consider him to have been a compliant patient?

A Okay. I have to look at that. If one looks at the period between 1-15-93 and 5-27-93, a period of approximately four months, during that period of time he was quite compliant. He had made five visits to Dr. -- if I mispronounce his name, correct me, please, is it Azem or Azem. Do you know how to pronounce it, Mr. Jones?

Q No, I don't.

A May I ask Charles? He's an authority on pronunciations with that southern accent of his.

MR. ALLEN: Azem.

THE WITNESS: Are you sure?

MR. ALLEN: Yeah.

A He says Azem. Well, during those visits to Dr. Azem he was quite compliant.

Q For a period of about four months?

A That's correct.

Q And based upon this history you think there was a substantial likelihood that Mr. Jones would become a compliant patient after October 1994 if other avenues of therapy for his conditions had been taken?

A Mr. Jones, you're changing what I said.

Q Oh. I don't mean to.

A You have this tendency to put in the word substantial and I didn't say substantial. I said there was a possibility that he could become compliant.

Q In your experience with patients such as Mr. Jones, which I'm sure you have had experience with such non-compliant patients, correct?

A I've had more experience than you'll ever dream of.

Q More than you would ever want, I bet.

A You know, the thing that I'm most known for throughout the world is the treatment of alcohol cirrhosis. And I have a 97 percent follow-up rate in ten years. That means almost: every patient that I treat with that disease is still seeing me after ten years.

And if you don't think the treatment of -- well, I know you know the treatment of chronic alcoholism and its associated consequences is a very, very tough go, and we have the highest abstinence rate in the world. It is 69 percent in ten years. AA, Alcoholics Anonymous, has an abstinence rate of 24 percent in five years.

So with the determination and careful management and an absolute willingness to really take care of sick people and see them closely, it is possible to achieve compliance in patients who have never been compliant in their life. So that's why I say it's possible.

Q Doctor, could you give me an opinion from your experience with patients such as Mr. Sones whether it's probable that he would have become a -- or he would have become a compliant patient?

A No. I would not be willing to put a percentage on it.

Q And compliance versus non-compliance in patients when you're considering surgical therapies as opposed to non-surgical therapies that require the patient's ongoing commitment to treatment, what part does that play; that is, does the non-compliance play in your thinking as the physician considering various options of therapy?

A I think it plays a role. I think one has to factor that into the equation of risks versus benefits.

surgery versus non-surgical approach is appropriate?
A It depends upon the non-surgical approach that one would use. But if we're talking about long-term therapy that requires his taking medicine, for example, it plays into the same kind of equation that non-compliance plays into.
Q I see. So the history of depression would mitigate against long-term medical therapies and favor, to some degree, surgical intervention?
A I wouldn't put it that way. You know, I wouldn't use the term mitigate against. It would decrease the chances of success with long-term therapy that requires a patient to take medicine, for example.
Q Okay. So the history of depression, the suicide gestures or attempts, whatever that was, and the history of non-compliance would make long-term medical therapy a more difficult proposition for Mr. Jones, correct?
A And for people who didn't have those complicating attributes, yes.
Q Okay.
A But, you know, we're not talking about a permanent state. Those things are not congenital or genetic, so all of those things are changeable.
Q I'll only raise it because you raised it in your report, Doctor.

A Yes.

Q Percutaneous drainage of the gallbladder, Doctor -- we're going to finally get at some of these options, Doctor, that you have been chomping at the bit to get to, all right?

A Pine.

Q I'm going to skip the low fat diet kind of thing because that fits into our discussion regarding non-compliance and so forth. Percutaneous drainage of the gallbladder, Doctor, what are the indications for that procedure as opposed to cholecystectomy for a patient with gallbladder disease?

A Percutaneous drainage under local anesthesia by an interventional radiologist, that as I indicated in my own practice is used in high risk patients, patients who are poor surgical risks such as Mr. Jones.

Q And what is the success rate of percutaneous drainage in these types of patients?

A It has a high success rate initially. The long-term success rate, which, of course, is another way of saying whether the stones will recur or not, the long-term success rate is not known with the latest dissolution agents, but the immediate success rate is high.

Q In the order of what percentage?

A In the order of 80 percent.

Q If there is a recurrence, can further percutaneous drainage be done or is this sort of a one-shot deal and if there is a recurrence, the patient has to have a cholecystectomy?

A No. It should be done again.

Q Well, can you explain to me, Doctor, why if this is such an easy procedure with such low morbidity and mortality that this is not essentially the standard of care for all patients with gallbladder disease?

A Well, you just said something that I didn't say.

Q Oh, okay.

A But I'm going to -- It happens to be something I agree with, which is low morbidity and mortality. And those things are true. But the key, of course, is the recurrence rate of the stones, and that has not been defined.

And with cholecystectomy, of course the problem settles in one fell swoop. It's over and done. And whereas with this there is this uncertainty about recurrence. So that's the reason why it has not been adopted as the standard of ordinary care.

Q What are the risks of percutaneous drainage?

A Well, there are some small risks associated with not puncturing the gallbladder, puncturing surrounding organs, technical complications associated with the insertion of

the tube into the gallbladder. They're very small in number, but those are some of the risks associated with it. Most of the risks are technical risks, procedure-associated risks, and they're small.

Q On the order of what percentage, Doctor?

A Less than 5 percent.

Q Was Dewey Jones a candidate for percutaneous drainage of the gallbladder when he was in the hospital in October 1994?

A Yes.

Q In your report you have got what you describe as surgical cholecystectomy.

A No.

Q I think that's a misstatement, isn't it?

A It is. That's a typo.

Q Yes, I thought it was.

A Cystostomy.

Q I'm sorry, Doctor?

A Cholecystostomy.

Q The one I mispronounced before?

A Cystostomy. In item B and C the term cholecystectomy, that's a typo. That should.be cholecystostomy.

Q Okay. That's the same procedure as percutaneous except it's an open procedure?

A Yes. Well, it is open, but it's a little open procedure.

Q And what would mitigate doin'g that procedure as opposed to a percutaneous drainage of the gallbladder?

A It's another alternative way. It was around long before the percutaneous drainage came along. It is another way of doing it.

Percutaneous drainage by the radiologist requires a skillful interventional radiologist. I don't know if that's available at Meridia Huron Hospital. So it's another alternative.

Q And both percutaneous drainage and surgical drainage of the gallbladder are done under a local?

A Yeah, it's done under local anesthesia.

Q Was Mr. Jones a candidate for surgical cholecystostomy?

A Sure.

Q Ultrasonic lithotripsy, which is the last of the alternatives to therapy for Mr. Jones that you list; in your report --

A Yes.

Q -- what are the indications for that as opposed to doing a percutaneous or surgical drainage of the gallbladder?

A Well, of course, there is no -- it's a totally

non-invasive procedure. There is no incision. There is no injection. There is no stick of any kind. One doesn't have to precisely locate the gallbladder. So it's a totally non-invasive procedure.

Q What are the risks?

A The risks are, again, very small. They have to do with breaking up the stones into fragments that pass and one of the fragments getting caught and obstructing the common bile duct. That's a very small risk, but that can occur.

Q What's the rate of success?

A Rate of success is actually quite high. It's in the neighborhood of 60 to 80 percent.

Q And how long has that success rate been accomplished with ultrasonic lithotripsy?

A Well, it's been around now for a period of about ten years. And it's widely used in Europe, particularly in Germany, but in other parts of Europe. And its use in -- as we discussed some time ago, its use in the United States has declined because it has been replaced by laparoscopic cholecystectomy. So it is used less commonly, and largely for patients who are poor operative risks.

Q I would expect that it's not a favored therapy primarily because of the incidence of recurrence then, Doctor?

A Yeah. That, of course, is the other question. Again, that is a long-term question. But there is an incidence of recurrence with that after some years because one doesn't solve the fundamental problem of removing the gallbladder.

Q Was Dewey Jones a candidate for ultrasonic lithotripsy in October of 1994?

A Yes, he was.

Q Okay. So he was a candidate for all therapies except laparoscopic or surgical open cholecystectomy?

A At the time of the admission?

Q Correct.

A That's right.

Q All right. And as I understand it, the reason cholecystectomy was not an appropriate approach for Mr. Jones was because of what you feel was his unacceptable high risks to undergo a general anesthetic for the period of time that would be required by either a laparoscopic or open cholecystectomy?

A Right. I would package the whole thing together, to undergo a major operation under general anesthesia.

Q I'm not sure how that differed from what I said.

A Well, you left out the operation. You seemed to imply, at least I understood you to imply that the risk was involved with putting him under general anesthesia, and I'm

just emphasizing that the surgery itself carries with it the risks.

Q But the actual risk intendant to the cutting of tissue and **so** forth is not the primary risk for a patient such **as Mr.** Jones, is it?

A I don't separate it into primary and secondary. What happens when you cut a big blood vessel, as occurs in an open cholecystectomy, the patient loses **a** liter of blood and becomes hypotensive during the course of your cutting. So, you know, an otherwise healthy person can withstand that variety of loss of bleeding. A patient such as **Mr.** Jones might die right there on the table in such an event. ***So*** the operation itself is not some trivial event in this whole undertaking. It's the whole thing that carries the risk.

Q In your appreciation of what happened intraoperatively as far as the surgery itself, putting aside anesthesia issues for the moment, Doctor, was there **any** indication of any unusual events or untoward events during the actual procedure itself?

A I have to answer that without just a yes or no. The dictated operative note said that the conduct of the operation was appropriate and without complications. The loss of 400 cc's of blood in a straightforward open cholecystectomy is substantial, to borrow **a** term, but I

wouldn't put it outside of the standard of care. Because if one looks at the anesthetic record, he became seriously hypotensive at an early point in the procedure.

Q When was that, Doctor?

A If we could look at the anesthetic record. Do you know where that is?

Q Sure.

A It occurred -- It occurred at what seems to be about 10:45 a.m.

Q Looks like a little bit more than 10:30 to me, Doctor, but --

A Yeah. E said 10:45. I'm sorry. Correction. Let me say that again. It's sometime between 10:15 and 10:30. But it actually starts on down at about 10:10 and goes all -- reaches its lowest point at what is approximately 10 -- I would call it 10:20 or 10:25.

Q And what in your opinion, Doctor, is the cause of that decrease in the blood pressure?

A Well, I don't know.

Q What significance does it play in your opinions as to how this operation went as far as the operative procedure itself from Dr. Badri's situation as the general surgeon performing the surgery?

A It's a very serious event, a very serious event in this patient. And it wasn't just a momentary event, if one

looks at that record. You know, it's some time before it returns to the level where it started. And I can't, you know, I can't relate it to a specific event here. I can't even tell you what the cause of it was, other than to say it was very serious.

Q Doctor, at the time of that hypotensive episode during the procedure do you know if the procedure had actually even started?

A Let me just check on that. You see where it -- You have that before you?

Q Sure do.

A See where it says number 1?

Q Sure do.

A That was where the incision was made, okay. And so it looks as if that reached its lowest point just before the incision was made and then continued on after the incision was made for -- actually for some time.

Q Now having clarified that, does that bear any significance in your mind other than to say that this was a very serious episode of hypotension in your opinion?

A Well, I think the latter is the critical conclusion about it.

Q I'm not sure what the latter is referring to, Doctor.

A That it was a very serious event in this specific patient. That in actual fact he had the incision made when

he was hypotensive, and that is a serious event. That's not a description of causation.

Q Okay. Is there anything else that you can refer to, Doctor, that raises any suspicions in your mind that any untoward event occurred during the actual surgery itself, not during the anesthesia time, but actually during the operation itself?

A You mean during the course of the surgery? Is that what you mean by that question?

Q Yes.

A The hypotension is not something that was just momentary. It was, in fact, repeated, And that is the only thing that I could find in this case as far as during the course of the operation.

Q Okay. This episode of hypotension as you describe it from the anesthesia record, Doctor, would you agree with me that you would have to refer to a well qualified anesthesiologist as to the cause of that hypotension?

A Well, I would be interested in a well qualified anesthesiologist's opinion about what caused it.

Q And its significance during this procedure, correct?

A Significance is something I'm fully prepared to talk about.

Q But that's just it. I'm not exactly sure what you feel the significance of this hypotension was during the

procedure itself, what it caused.

A Well, for a man who normally has hypertension with a substantially higher blood pressure and when he walks around he's used to that higher blood pressure, in fact, he enters the hospital with a much higher blood pressure, and you subject him to a period of hypotension in someone who has heart disease, cardiomyopathy, that is an obstructive kind of event that may seriously effect his cardiac function, might damage his heart, in other words, and may be an event that, in fact, leads to cardiac arrest at some point down the line or during that period. And those are things that I'm prepared to comment on.

Q Okay. Are you prepared, Doctor, and do you feel qualified to give an opinion to a reasonable medical certainty that this period of hypotension that you refer to from the anesthesia records actually played any part in the subsequent problems that Mr. Jones had after the surgery?

A Well, that -- You see, I don't think anybody can say what part it played. All one can do is say that it is a very serious event that one really tries to avoid in a patient such as this because of its serious consequences.

Q But as far as the actual consequences, if any, caused by this period of hypotension in Dewey Jones' case, you're not in a position to state what consequences were the probable result of this episode of hypotension?

A No. I don't think that can be stated.
Q Doctor, is it appropriate for the surgeon who may be considering a cholecystectomy in a patient such as Mr. Jones with his prior medical history to obtain medical clearance for the surgery?
A I wouldn't use the term clearance. It's appropriate for him to obtain the opinion of an expert who deals with the diseases which the patient has prior to operation.
Q Well, is it inappropriate to start with an internist to evaluate the patient and give any direction as far as what additional input may be necessary from other specialists?
A Well, I think the patient so obviously needs a cardiologist, that's so unmistakable. But it's okay to invite -- to ask the opinion of an internist, but it is the responsibility of the surgeon to obtain appropriate consultation, and that appropriate consultation includes a cardiologist.
Q Any other consultations that you feel are required for this patient prior to having him undergo a cholecystectomy?
A I think that the most important one would be the cardiologist, but I do think that it would be very important to have him thoroughly investigated by a pulmonologist.

Q Anyone else?

A I think that would be -- those are the appropriate consultants.

Q Okay. You're aware of the fact that the patient was, in fact, seen by a pulmonologist, correct?

A I don't think the patient was seen by an attending pulmonologist. I think the patient was seen by a resident or a fellow on the pulmonary service on the day before the operation.

Q Doctor, I thought you had read the deposition of Dr. O'Neil?

A I did.

Q And from your review of that deposition it was your impression that she was a resident or a fellow?

A Oh, no. No. I was quite clear on that. She was not a resident. But she clearly stated that she didn't see the patient for the operation. That, in fact, the first time she saw the patient was in the SICU for -- at least it was after the event had occurred, the cardiac arrest had occurred. I said SICU. I misspoke. I meant ICU. More specifically, it was after the patient had had a cardiac arrest. And she did say in her deposition that it was a resident or fellow, I can't remember, his name was Dr. Cacciatore or something similar to that, and I don't mean to do him a disservice by mispronouncing his name, but it

was a name similar to that who saw the patient.

MR. **JONES:** Give me half a second, would you, Doctor?

THE **WITNESS:** Sure.

(Recess was had.)

Q Okay. Doctor, **I** had to just look around for something here. Are you aware *of* the fact that there was a request for a pulmonology consultation on this patient prior to surgery?

A Yes, **I** was. **I am** aware that that request was made.

Q And would it be your understanding, Doctor, that a request for a pulmonary consultation from the physicians in this case would require that a pulmonologist, an attending pulmonologist see the patient prior to the procedure?

A Well, isn't that what pulmonary consultation is?

Q That would be my understanding. But I just want to make sure that somebody who's in there asking for pulmonary consultations on a regular basis such as you would also interpret it that way. So would I be correct?

A If I ask €or **a** pulmonary consultation, it would demand that an attending pulmonologist saw the patient.

Q Okay. So the fact that from your understanding of the case that the attending pulmonologist, in fact, did not see the patient, would you be critical of the pulmonologist for failing to see the patient prior to the surgery?

A It would be critical of the surgeon for going ahead with the operation. You know, Dr. O'Neil in her deposition explained how these last-minute requests for consultation, how they're routed and how they take place in actual fact. And don't hold me to this, but I think she said she first knew of the consultation on the day after the operation or the day when the operation had been completed, but not on the day before. And I want to correct myself. It's Dr. Caraicioni who is the person who saw him, and I think he was a resident who happened to be on the pulmonary service at the time. But -- Okay. The end of my comment.

Q So what you're saying is that reviewing the consultation note for the pulmonary consultation, you hold Dr. Badri responsible for understanding that, in fact, it wasn't a pulmonologist who saw and cleared this patient from a pulmonology standpoint, but it was just a resident?

A Well, number one, I don't think that the resident who saw the patient cleared the patient from a pulmonary standpoint. I don't find evidence that that was the case. But I do hold him responsible as the person who is undertaking this operation with the patient, putting his -- the patient's life in his hands, for seeing to it that the operation can be conducted with acceptable risks, with all the advice that he needs from consultants, and when he doesn't have that, he should not go ahead with the

operation. That's his responsibility.

Q Well, I'm just trying to understand that from the consult note that appears in the records you would hold Dr. Badri to the knowledge that, in fact, that consult note was not the result of a pulmonologist seeing the patient?

A Of an attending pulmonologist. That's what you mean, is that right?

Q Correct. The person you would expect to see the patient when you asked for a pulmonary consultation.

A Yeah, an attending pulmonologist, as I had said a moment ago, that's right. I think Dr. Badri in the ordinary course of events would know that. He's worked at this hospital almost all of his time.

Q How does he have that knowledge? How is he to get that knowledge?

A The knowledge that the attending didn't see the patient.

Q Correct.

A Sees no note by an attending in the chart.

Q As I understand it, Doctor, you also hold Dr. Badri responsible for Dr. Ho's clearance of this patient for surgery, is that correct?

A Yes, that's correct. I do.

Q And just so I'm clear, what was it Dr. Badri was to do after he received Dr. Ho's report on what Dr. Ho felt

was appropriate for this patient? What was he supposed to do?

A What he was supposed to do is request a cardiology consult.

Q Okay. So even though Dr. Ho didn't feel one was necessary, Dr. Badri had an independent responsibility to get the cardiology consult?

A Yes. Dr. Ho is not doing this operation.

Q I understand that, okay. Other than that, do you hold Dr. Badri responsible for anything else that Dr. Ho did or did not do in this case?

A No.

Q Doctor, would you agree with me that Dr. Ho could have stopped this procedure?

A I don't know that that's so.

Q If an internist contacted by a surgeon for the purpose of medical clearance on a patient gets a report from the internist that, in fact, he did not feel the patient was an appropriate candidate for surgery at that time or that additional consultations were necessary before surgery should be undertaken, you have no opinion whether or not that would effectively stop the surgery from going forward?

A Well, stopping the surgery depends upon Dr. Badri. I think that he, if he had good sense, he would cancel the

operation.
Q Well, what is the purpose of getting an internist to look at the patient if it's not for some determination as to whether or not from a medical standpoint the internist felt the patient was in good enough physical condition to undergo the contemplated procedure?
A That is the purpose, to get the advice of experts, as I said, in the -- in people who have expertise in the areas of disease that the patient has to give their opinion on what they think. Mow, that opinion does not have to be taken, that advice does not have to be taken, but it is an important part of the process.
Q And ideally you would like to get someone who claims to have knowledge of this particular patient's medical history, correct?
A Well, that would be helpful to have somebody who knows about the patient. I think that would be helpful. Not as important as getting an expert cardiologist to see the patient, but nevertheless, would be helpful.
Q You indicated in your report that Dr. Ho had only seen Mr. Jones during one of his prior episodes, an admission to the hospital in September of 1994 for two days. Are you critical of Dr. Badri for not understanding or knowing that was the extent of Dr. Ho's familiarity with the patient?

A No.
Q The rest of your report has to do with Dr. Eo and the anesthesia care, so I'm going to turn this over to Mr. Casey at this point, Doctor, although 1 may come back later, depending on what else is brought up by Mr. Casey.
A That's fine, Mr. Jones.
MR. CASEY: Doctor, I am Mr. Casey. Do you want to take a break or do you want to keep going?
THE WITNESS: No, Mr. Casey. If you're ready, I'm ready.
MR. CASEY: Okay. I will attempt to be ready.

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EXAMINATION

BY MR. CASEY:
Q First let's talk about the residents in the case, Doctor. You have extensive experience in dealing with residents, correct?
A Yes.
Q Are you critical of any of the residents in this case?
A No.
Q Do you believe that any of the residents deviated

from any acceptable medical standards of care?
A No.
Q Well, that takes care of the residents. As to --
A I want to correct that statement. I'm sorry. May I amend that statement, Mr. Casey?
Q Sure.
A The one resident where I have some I think real questions about performance was Dr. Sencho --
Q Senchysak.
A Say that again.
Q His name is Nick Senchysak.
A Senchysak, yes.
Q He was the anesthesia resident in this case.
A Yes.
Q You have told us earlier that you don't profess to be an expert in anesthesia, correct?
A That's correct.
Q I don't understand how you make comments then saying that the anesthesiologist in this case deviated from acceptable standards of care.
A Well, I can make comments about it. 1 do operations all the time and work with anesthesiologists all the time. I have some considerable knowledge about what's appropriate in the operating room from the anesthesia standpoint.
Q Okay. Then let's talk about Dr. Senchysak, the

resident anesthesiologist who was on the case.

A Yes.

Q What criticisms do you have of him?

A I said I had questions about it. And the questions I have about it have to do with the induction phase of the anesthesia where I think it's very possible he induced this high-risk patient without an attending being there, at least the attending came in in the middle of the induction.

Secondly, I think that he extubated the patient without an attending being there. The attending came in after he extubated the patient, And those things I think were inappropriate. There is no question in my mind that the patient was not properly monitored during the case, but I can't put that on the shoulders of Dr. Senchysak. That, in fact, must go on the shoulders of the attending anesthesiologist.

Q All right. Let's deal with these one at a time then.

A Okay.

a You talked about the patient being induced without the attending being present. Where did you get that information?

a I got it from Dr. Adamek -- Am I pronouncing his name correctly?

Q It's correct, Adamek.
A From Adamek's deposition in which he said that he came in in the middle of the induction.
Q Okay. Have you reviewed Dr. Senchysak's deposition?
A No, I have not.
Q Okay. I want you to assume that Dr. Senchysak has testified that Dr. Adamek was there at induction, at the beginning. Would you be critical of Dr. Senchysak if Dr. Adamek was present for the beginning of this anesthesia?
A No, I would not.
Q Okay. Now let's deal with the monitoring issue, because I think we can deal with that one rather quickly as well. I take it that your criticism of Dr. Adamek is a failure to have a Swan-Ganz catheter?
A Not only that. The failure to have a Swan-Ganz catheter, a failure to have an arterial line, the failure to be present throughout the case with a first year anesthesia resident in a very high risk patient, those are all criticisms.
Q Okay. Now, I don't think that Dr. Senchysak has anything to do with how often Dr. Adamek would be in the room. Can you and I agree on that?
A I certainly do agree.
Q Okay. As to the Swan-Ganz catheter, I want you to assume that Dr. Senchysak has testified that he made a

suggestion to Dr. Adamek for the use of a Swan-Ganz catheter and that that suggestion was not implemented. Would you then have any criticism of Dr. Senchysak in this case?

A No, not regarding the Swan-Ganz catheter I would not.

Q He did not suggest the use of an arterial line. Are you critical of him €or not suggesting that use?

A I would expect that Dr. Adamek would insist on an arterial line for this case.

Q So you're not critical of the resident for failing to suggest the arterial line?

A That is correct.

Q Okay. Now let's talk about the extubation. How do you define extubation?

Do you need to answer that?

A That's my beeper going off. Let me just -- May we --

Q Five minutes, Doctor?

A No. Our other line is busy from someone else in the house and I'll wait. And at some time I may have to take a couple of minutes to answer it.

You were talking about the extubation. You said would I define extubation?

Q Yes.

A The definition is removal of the endotracheal tube. There is a whole process that is associated with that, but

it is the removal of the endotracheal tube. That's what the term means.

Q Can you and I agree that the process of extubation starts with a reversal of the patient?

A That is correct.

Q And ends with the taking out of the tube?

A That is correct.

Q Okay. Now, so you and I are clear, is it your belief that the tube was taken out of this patient?

A Yes, it is my belief.

Q And where did you form that belief?

A Well, because the patient was reintubated. There are two terms that are used, one is difficult extubation, and if need be, we can identify where that appears.

Q I want to understand all references in the chart upon which you base your belief that the tube was taken out of this patient.

A May I pursue that line for a moment?

Q Yes.

A Okay. It is stated in the chart that it was a difficult extubation.

Q Where?

A May I just finish this and then I'll identify where it says that, okay?

Q Okay.

A And of course, if that is indeed the case, that means that the removal of the tube was difficult. There is no other way I can interpret that in English.

And then second, there is in the chart a phrase where it says the patient was intubated with I think it was a No. 8 tube, put aside for a moment the size of the tube, at approximately 12:30.

Okay. What I said was that it said that it was approximately 12:30 that the patient was intubated with a number -- I believe it was a No. 8 tube. Put that aside for a moment. But you can't intubate a patient who's already intubated. You could only intubate somebody who has been extubated. So that is why I have come to the conclusion that this patient was extubated.

Q Okay. And when you say extubated, you aren't talking about the process, you're talking about the tube actually being taken out?

A That's what the word means. It means taking the tube out.

Q Well, can you and I agree that the term extubation refers to the actual process?

A No. You asked me the term, what does extubation mean, and what that refers to is the removal of the endotracheal tube. I don't think there is anything else that can be associated or substituted for that, which means

the removal of the endotracheal tube.
Q Is there a term that is used to describe the process that we spoke of, that being starting with the reversal and ending with the removal of the tube?
A Well, the term is that which you have just described, one is called reversal and the other is called extubation.
Q What is that whole process called? Isn't that whole process commonly referred to as extubation?
A I've never heard it referred to as that. Extubation means removal of the tube.
Q Okay. You have not reviewed Dr. Senchysak's deposition, have you?
A No, I have not.
Q Did you see anywhere in Dr. Adamek's deposition where he indicated that the tube had actually been removed prior to him coming into the'room?
A Dr. Adamek said at first in his deposition that it hadn't been removed, but then when he was presented with the specific statement about at approximately 12:30 a new tube or a tube being put in, intubated with a No. 8 tube, he agreed that the patient must have been extubated if the patient were intubated at that time with a tube. So Dr. Adamek gave what I would consider inconsistent testimony.
Q Do you know what type of a tube this patient was originally intubated with?

A I think it was the same kind of tube that he was subsequently reintubated with, which would be the usual state of affairs.
Q Can you and I agree that nowhere in this chart does it say that this patient was reintubated?
A The term reintubated?
Q Yes.
A I don't recall seeing the term reintubated.
Q Okay. So we can agree that nowhere in the chart does the term reintubated appear, at least to your recollection?
A That's right. To my recollection I didn't see the term reintubated.
Q So your interpretation of the Dr. Heart record is that this patient was reintubated at 12:30?
A Well, it was -- the patient was intubated. I mean, it doesn't --
Q Let me ask you this.
A Wait a minute. Let me finish, Mr. Casey. One doesn't have to use the term re if one puts an endotracheal tube into a patient. It's just that you don't put endotracheal tubes into patients who already have endotracheal tubes.
Q Is a fair interpretation of the Dr. Hart record the fact that the patient was still intubated at 12:30 with an 8?

A No, I don't think so.
Q Why? Because that's good for Mr. Jones in this case?
A That is what I would consider to be a snide comment.
Q I want you to assume that Dr. Senchysak has testified that the tube was never taken out of this patient. Are you going to come into trial and testify that the tube was taken out of this patient?
A I would ask you to examine Dr. Adamek's testimony and let it speak for itself.
Q Dr. Orloff, what I want to know is if Dr. Senchysak comes into trial and testifies that the tube was never taken out of this patient and the nurses who were in that room come into trial and testify that the tube was never taken out of this patient, are you going to testify that they aren't telling the truth?
A I'm going to testify to my interpretation of the records and everything that I see that bears on this issue, which I have already stated.
Q Would you agree with me that words can have different interpretations?
A As a general principal?
Q Yes.
A I would agree with you.
Q Would you agree with me that the people who wrote words in a chart are a better source of interpreting those

words than people who are looking at the chart in retrospect?

A Well, I don't think that's germane.

Q So asking the person who actually wrote what is in the chart is not as important as asking someone who is looking at it in retrospect?

A I didn't say that. I said let the record stand as it stands. And I have given you my interpretation of the record. And, of course, you know it is possible that there is self interest involved in these interpretations, so one has to take all that into account. I simply am looking at the record.

Q How do you believe Mr. Jones became hypoxic?

A I don't know the sequence of events that occurred because they're not sufficiently described in the medical records.

Q So are you going to be offering any opinion as to the I guess the word is pathophysiology of how this brain damage occurred?

A Well, I have no doubt about how the brain damage occurred. There is little question about that. I don't think that is a point of debate.

Q That was from the pulmonary edema?

A No. The brain damage occurred because of an insufficient blood supply to the man's brain.

Q Which was caused by the pulmonary edema?
A Which was caused by his heart stopping.
Q Which was caused by the pulmonary edema?
A No, no, no.
Q That's what I want to understand, Doctor. What are you going to testify to at trial as to how this whole event unfolded and how Mr. Jones ended up in a chronic vegetative state?
A What I said is there isn't sufficient information in the record to say with certainty what the sequence of events was, and that describing the pathophysiology involves speculation because there isn't sufficient hard data in the records. We have what went on before and we have the end result, and that's what I will testify to.
Q Okay. So you will not be offering any testimony as to that sequence of events because you don't have the information?
A I will not be offering any testimony to say with any certainty that a certain sequence of events led to his cardiac arrest.
Q Okay. So if this patient was indeed extubated, as you have just told me that you believe, you will not be offering any testimony as to what that extubation caused?
A Will you repeat that question?
Q You have told me that it is your belief that the tube

was taken out of Mr. **Jones** at around 12:30, is that not your testimony?

A It is my testimony.

Q Now, my question then is, assuming that that is your belief, you will not then be testifying at trial as to what you believe taking that tube out of Mr. Jones caused?

A Well, we know that Mr. Jones became hypoxic.

Q That's my question to you, Doctor, is what do you believe happened in this case, and I need to know your opinions before I get to trial.

A Mr. Casey, if I may just ask you, usually at the beginning of a deposition the attorney instructs the witness to wait until the answer is given before interrupting and interjecting another question, so I would ask the same thing of you. You know, I start to answer a question and then it may be awfully hot there in Cleveland, or I don't know what the reason *is,* but then you interject another question, and I think that's not appropriate.

Q Are you done with your answer?

A I'm done with my suggestion to you.

Q Okay. My question to you, Doctor --

A Which I hope you'll take to heart.

Q My question to you, Doctor, *is,* when this case comes to trial will you be offering testimony as to what you believe the extubation of Mr. Jones at 12:30 caused?

A I will be offering testimony as to the events surrounding the extubation.

Q And what will that testimony be?

A That testimony will be that the patient became hypoxic, that there was some difficulty associated with the extubation, the exact nature of which is not stated, and that that played a role in his subsequent cardiac arrest.

Q Okay. Do you believe that the extubation of Mr. Jones directly and proximately caused the hypoxic event which he suffered?

A I have the record which shows that his oxygen saturation dropped precipitously, and so my conclusion from that is that such was the case.

Q Can you and I agree that you were not in the room, Doctor?

A We don't even have to ask that question.

a Okay. I guess my question to you is that if every single person who was in that room at the time of Mr. Jones' operation testifies that they never saw the tube taken out of his throat, will you defer to that testimony3

A I won't defer to anyone that varies from the record that I have read.

Q Okay. Now let's go to the record that you have read.

A Okay.

Q I think the second indication that you had mentioned was a nurse's note attached to the anesthesia record that says, difficulty trying to extibate. Am I correct?
A Yes, that is one of the notes that I saw.
Q Is that the only other one that you were talking about?
A No. That's one of the notes that I saw.
Q I want to understand all of them, so --
A Well, I'm going through the process. There is another note in the operative note dictated by Dr. Badri, the written note that he wrote in the chart which says the same thing.
Q So the notes upon which you base your belief that the tube was taken out of this patient are the Dr. Heart record that we have already talked about?
A Yes.
Q This nurse's note that's attached to the anesthesia record that we're about to talk about, the operative note of Dr. Badri, the typed one, and the written note of Dr. Badri?
A No, no. The written note of Dr. Badri. I corrected myself there. I would have to consult the typed operative note, and I'll do that for just a moment.
It's the written operative note written by Dr. Badri.
Q Okay. Let's deal first with the nurse's note. Do

you have that there in front of you?
A I'll get it there in front of me. Now I have it in front of me.
Q Can you read into the record what it says that you base your belief that this patient was extubated?
A It says, Operation ended at 12:30. Patient appeared to have difficulty trying to extubate.
Q Can we agree that that note in and of itself does not say that the patient was actually extubated?
A How do you determine if there was difficulty trying to extubate a patient unless you extubate the patient?
Q That's my question to you, Doctor. Can we agree that this record does not say that the patient was actually extubated?
A The record does not say that.
Q The other record that you were speaking of was the progress note of Dr. Badri?
A That is correct. I'm turning to that because I don't have that in front of me.
Q Can you tell me where in that record you believe -- on what in that record you base your belief that this patient was actually extubated?
A It says, Patient developed acute pulmonary edema at time of extubation.
Q And there is a --

A Cardiac arrest.
Q There is a signature right next to that, is there not?
A Next to that statement? There is not a signature other than Dr. Badri.
Q Do you see at time of extubation right next to that?
A Yes.
Q Is there a signature there on your copy?
A There is a signature there, but I interpreted that signature related to what went with the note that went before it.
Q Okay. And it is this note upon which you also base your belief that the tube was actually taken out of this patient?
A Yes.
Q But again, you have not read Dr. Senchysak's deposition to know what his explanation is for these notes, have you?
A I said that I hadn't read his deposition.
Q You have, h-a-v-e?
A No, no. You -- Asked and answered.
Q You're not allowed to object to the deposition, Doctor.
A I'm not objecting, but you asked me that question four times and the fifth time I'll telling you again that I

have not read the deposition.

Q Okay.

A So I want to make it blanket for any other times that are coming down the pike.

Q What I want you to assume is that Dr. Senchysak has testified that it was after this patient was reversed but before the tube was actually taken out of this patient that his pulse oximetry levels started to fall, and it was at that time that he called Dr. Adamek into the room. So it was during this process of extubation that the patient began to have trouble but that the patient was not actually extubated. Are you going to testify at trial that Dr. Senchysak is not telling the truth?

A Again, to answer that question I'm going to testify to what I read in the records, and that's it plain and simple.

Q Do you believe that the explanation that I have just given you is consistent with the notes which you have just read?

A No, I don't.

Q Why?

A Well, I've cited three bits of evidence that are to the contrary.

Q But you have not shown me one piece of evidence that says the tube was actually taken out of this patient.

A Well, that is your interpretation. If those are the words that you're looking for, then I cannot say that I saw those words in the record. But I did see other -- what I regard as clear evidence that extubation took place, including in the Heart record a specific time when the patient was intubated with an 8.0 endotracheal tube at 12:30 p.m. I mean, that statement is clear and simple, including what the nurse said, which I interpret it's hard to have difficulty in extubation if you don't do extubation.

Q Well, we have already discussed that the process starts with reversal, correct?

A The process of what?

Q The process of extubating a patient.

A If you're asking me what process takes place prior to extubation, then, in fact, that's right, reversal takes place. But extubation is a very specific term. It's not a vague term. It means removal of the endotracheal tube. It's not a process. It an act.

Q Doctor, can you and I agree that based on Dr. Badri's deposition he was not present at 12:30 when this patient was reversed?

A Yes.

Q So if this note is Dr. Badri's in the chart, that would be based on something that he did not personally

observe?
A He said it was witnessed by anesthesia. You know, it would be farfetched to think that he dreamt that up.
Q Have we covered all the notes in the chart upon which you base your belief that the tube was taken out of this patient?
A The notes in the chart, yes.
Q Is there anything else besides the testimony of Dr. Adamek upon which you base your belief?
A No.
Q Assuming that the tube was never taken out of this patient, do you have a medical explanation as to why Mr. Jones became hypoxic?
A Well, again, I return to what I said. There is not enough data to specifically state the sequence of events that led to his hypoxia, but there are all sorts of possibilities with or without the endotracheal tube.
Q Okay. I guess what I want to know is if you're asked at trial by the plaintiff, do you have an opinion to a reasonable degree of medical certainty the mechanism which caused Mr. Jones' hypoxia and, therefore, brain damage, will you be offering such an opinion,?
A I answered that question before.
Q And your opinion is that you don't know?
A I've answered that question before.

Q Okay. If we assume, and I know this is a big assumption because you don't believe it's true --

A But nevertheless we'll do it.

Q Yeah. I mean, assuming that the jury believes that Dr. Senchysak never pulled the tube out of this patient, do you have any other criticisms against him?

A No. If indeed you're assuming that Dr. Adamek was there prior to extubation and during extubation, as you have stated, if that's included in the assumption, then the answer is no. If Dr. S undertook this on his own, then I'm critical of him.

Q Okay. Do you believe that this patient was fluid overloaded?

A I cannot determine that.

Q Are you aware of the fact that Mr. Jones prior to coming into the hospital on 10-17 of '94 was on Social Security Disability for his heart condition?

A No.

Q I want you to assume that fact.

A Okay.

Q That he was not working and that he was completely disabled in terms of the Social Security Administration.

A Okay.

Q Can you and I agree that an all probability Mr. Jones was never going to return to work?

A We cannot agree to that.
Q This goes back to the comments that you were -- the questions that you were asked by Mr. Jones concerning him ever becoming compliant. You have testified that you aren't going to give an opinion to a reasonable degree of medical probability that Mr. Jones would have become compliant in the future, is that your testimony?
A Yes.
Q Is it your testimony to a reasonable degree of medical probability that we can say Mr. Jones would not have become compliant in the future?
A No.
Q So your testimony is you can't say one way or the other?
A That's correct.
Q Prior to Mr. Jones coming into the hospital I think you and I can agree that he had a pretty serious heart condition, is that fair?
A We can agree on that.
Q Do you believe that while he was in the hospital from 10-17 of '94 to 10-20 of '94 he was in active congestive heart failure?
A No.
Q Do you have any criticisms of the preoperative anesthesia clearance of this patient?

A Yes.
Q What is that criticism?
A I think the system -- for one thing I don't know that the patient has any formal clearance, but I think that the system used at the Meridia Huron Hospital is below the standard of care.
Q In what way?
A The patient was seen by the resident X the night before, according to Dr. Adamek. The experience of that resident as a year of training is unknown to me. Dr. Adamek indicated that the attending would get involved, and I'm paraphrasing now, if the resident came with specific questions to the attending about the patient. If the resident did not come with questions, then the process would go forward. I think that's an unacceptable process.
Q Okay.
A Secondly, the patient started out with one attending, and E can't figure out whether the attending actually saw the patient or not, but it is stated by Dr. Adamek that one attending was involved before the operation up to the time when he entered the room during induction of the anesthesia knowing nothing about the patient. I think that process is below the standard of care.
Q For who?
A To assure a careful, thoughtful evaluation of a high

risk patient.
Q It's below the standard of care for who, the hospital or the attending?
A Below the standard of care that the hospital allows a system like that to go forward.
Q Okay. Now I want you to assume the following. I want you to assume that the resident who saw this patient preoperatively did so at 16:15 of **10-19**, okay?
A Okay.
Q At that time he ordered the patient to have 120 cc's an hour after midnight of fluid. Do you believe that that order violated the standard of care?
A No.
Q Do you believe that order was appropriate?
A It was okay. I have no criticism of that order.
Q At that time the anesthesia -- the resident anesthesiologist -- Do you need to get that, Doctor?
A No. It's on another line and we'll just wait for it to -- it's now been answered.
Q Okay. At that time the resident anesthesiologist made the notes that are on the anesthesia record regarding the preoperative clearance of this patient, those notes being that the patient had a past medical history of hypertension, congestive heart failure, sleep apnea and obesity, do you believe that was an adequate history taken

by the resident?

A I think that that was a history, a very brief history taken by the resident.

Q Do you think that was an adequate history taken by the anesthesia resident?

A Well, considering how he classifies the patient, I don't think it was adequate.

MR. CASEY: We're going to take a break so the court reporter can change her paper, Doctor.

(Recess was had.)

Q Doctor, it is your assumption that the classification of the physical status of the patient was made at the time of the preoperative clearance?

A It was made prior to the operation.

Q Okay. I would have to locate that specific document, which I don't have before me at this moment.

A Okay.

Q Do you have the anesthesia record in front of you now?

A I do.

Q Do you see the last page of the anesthesia record that talks about the preoperative clearance where it says, anesthesia record and then preoperative exam?

MR. ALLEN: What's the number on the

bottom of the page?

MR. CASEY: 77.

MR. ALLEN: Got it.

Q Okay. What I'm reading from, Doctor, is down on the bottom that talks about other, and I guess my question to you is, by putting down the past medical history of hypertension, congestive heart failure, sleep apnea and obesity, was the resident anesthesiologist giving the anesthesiologist enough information from which to classify this patient and decide on the appropriate monitoring?

A No.

Q What more should he have given him?

A This patient had a very complicated and extensive history of congestive heart failure with some **14** admissions to the hospital in three or four years.

Q Are --

A Let me finish, Mr. Casey.

Q Go ahead.

A And he had uncontrollable hypertension over this period of time, and these are elements of the past medical history which should be known to the classifier, whoever the classifier is going to be.

Q And what about that past medical history are you saying was not known?

A It just says hypertension, congestive heart failure,

sleep apnea, obesity. It says it in simple terms without giving a picture of how seriously compromised this disabled individual had been.

Q And you think that there should have been more explanation?

A I certainly do.

Q And you think the standard of care required more explanation?

A Yes.

Q Now I want you to assume because you have not yet read Dr. Senchysak's deposition that your testimony regarding -- that the testimony of Dr. Adamek regarding the next morning is not actually what happened, but that Dr. Senchysak actually did sit down and speak with Dr. Adamek before taking this patient to surgery.

A Are you saying that Dr. Adamek was lying?

Q No, I'm not. I'm saying that --

A I want to be sure of that now.

Q I'm saying that his recollection was not clear at his deposition and Dr. Senchysak's recollection was clear. That's what I'm saying.

A So we have a difference in the clarity of the recollection?

Q That's my belief in my reading of the deposition. But Dr. Senchysak has testified that he did present this

case with Dr. Adamek, that it was not Dr. Badri, okay?

A What are you asking me to do?

Q Well, I'm asking you now to consider your other criticism of the hospital. That is you were critical because one attending saw the patient before the operation and then the other attending came in at the induction. I'm asking you now to assume that Dr. Senchysak presented the case with the same attending who actually was present at the induction. Would that alleviate your criticism of the hospital?

A Well, since my criticism is very specific about this point and you're saying that that's not the way it is, that, of course, immediately eliminates the criticism, doesn't it?

Q That was my question to you. I just wanted to get it on the record.

Whose responsibility was it to classify this patient, Doctor, in terms of anesthesia?

A The attending.

Q Whose responsibility was it make sure that they had an adequate history?

A It would be the attending.

Q Prior to Mr. Jones going into surgery on October 20 of 1994 do you have an opinion which you hold to a reasonable degree of medical certainty as to how long he

would have lived but for what happened on the 20th?
A You mean to give you a specific number of his life expectancy?
Q Can you and I agree that his life expectancy was diminished because of his cardiac status?
A I can agree with that.
Q You cannot?
A No. I said we can agree with that.
Q I'm sorry. I misheard you. Can we agree that his life expectancy was further diminished by his morbid obesity?
A Yes.
Q Can we agree that his life expectancy was diminished by his longstanding uncontrolled hypertension?
A Yes.
Q Can you then give me any type of a range upon which you believe Mr. Jones would have lived to if those problems had gone uncorrected?
A Uncorrected?
Q That's my assumption.
A And you're asking me to make an assumption that they wouldn't be corrected?
Q That's my assumption to you.
A Okay. No, I don't.
Q Do you believe that he would have lived another 33

years?

A I can't put a number on this assumption.

Q Okay. Turning now for a minute to Dr. Ho, why do you believe Dr. Ho deviated from the standard of care, because he cleared the patient?

A Yes.

Q And the standard of care would have required him not to clear this patient?

A That is correct.

Q Do you believe that Dr. Ho considered this patient's cardiac status when he cleared the patient?

A Well, I don't think he really knew his cardiac status.

Q Did you read in Dr. Ho's deposition where he testified that he had reviewed the August 25, 1994 echocardiogram before he made the decision to clear this patient?

A Yes, I read that in his deposition.

Q Okay. Would you agree with me that the August 25 of 1994 echocardiogram would give and did give a good indication of this patient's cardiac status?

A No.

Q Why?

A It was an inadequate echocardiogram, as was stated. It was technically unsatisfactory.

Q In looking at the echocardiogram which was performed on 10-18 of '94, can we agree that there is really no substantial difference in those readings?

A Well, when something is technically unsatisfactory twice in a row, gives unsatisfactory results, you can't make a judgment on the basis of it. There was plenty wrong, but this was an inadequate study.

Q Do you believe that Dr. Ho had a responsibility to obtain a cardiac clearance?

A Yes, I do.

Q Wow do you believe a cardiac clearance would have made a difference in this case?

A It would have stayed the hands. A cardiologist would have said you better not operate on this patient at this time. I better do an extensive workup.

Q Would you defer your opinion on that subject to a Board certified cardiologist?

A A Board certified cardiologist, of course, would contribute to me a meaningful opinion, but I would not waiver from that judgment that I just made.

Q So if a Board certified cardiologist in this case testifies that I would have cleared this patient for surgery just like Dr. Ho, you would not defer to that opinion?

A No, I certainly wouldn't.

Q Even though you're not a cardiologist?
A I'm a cardiothoracic surgeon. This is not a field that's foreign to me. I've had two heart operations, so, you know, I'm not a fish out of water here.
Q You say that Mr. Jones should have had cardiac anesthesia. What do you mean by that term?
A Cardiac anesthesia is a term given for intensive monitoring using a Swan-Ganz catheter, an arterial line, frequent determinations of blood gasses and adjustments of all of the aspects of anesthesia according to the parameters one finds.
Q When do you believe a Swan-Ganz catheter should have been placed in this patient?
A Before he went to sleep.
Q How do you believe a Swan-Ganz catheter would have changed the outcome of this situation?
A Well, given an anesthesiologist who monitored it, it would have led to a series of adjustments during the case which would have I think played an important role in preventing what occurred.
Q Do you hold the opinion to a reasonable degree of medical certainty that if a Swan-Ganz catheter had been placed in this case, a different result would have been obtained?
A A Swan-Ganz catheter and arterial line and careful

attention to the results by an experienced person, that's a package there, and I think the answer to that is yes.

Q How do you believe the results would have been different?

A I believe the patient could have been treated differently. He would have been given appropriate medications. Hypotension would have been avoided. He would not have been -- gone through the process that he went through at the end of the operation. All of those things. There would be a different degree of attention to this case had that been done.

Q So are you saying that assuming a different degree of attention had been paid to this case in terms of what you just stated, the Swan-Ganz catheter, the arterial line and the more careful monitoring --

A And experience.

Q And an experienced --

A Attending in the room, not a first year resident, and not making an attempt to extubate the patient, all of those things together would have had a different outcome.

Q The onset of pulmonary edema would not have occurred?

A Pulmonary edema I seriously believe was a secondary phenomena.

Q Do you believe that the person suffered cardiac arrest before the pulmonary edema?

A I don't know that, because we simply don't have the data to make that judgment, but I don't think pulmonary edema was a primary event.

Q So you do not believe the pulmonary edema was what caused the downfall of Mr. Jones, you believe it was his cardiac status?

A I do.

Q Would you agree with me that it is possible that the pulmonary edema is what actually lead to the downfall of his cardiac status?

A You mean pulmonary edema suddenly developing?

Q Yes.

A I want to tell you I don't believe that.

Q So you don't believe it was an acute onset of pulmonary edema?

A No, I do not.

Q Do you believe this man suffered an infarction before his pulmonary edema onset?

A That simply wasn't carefully monitored. There is not enough data to know that.

Q Would you defer to a Board certified cardiologist in that opinion?

A No.

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FURTHER EXAMINATION

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BY MR. JONES:

Q Doctor, I forgot one thing to look at with you, and that's the pathology on the gallbladder that was removed. Can we turn to that for a second?

A Certainly.

Q Let me know when you have it.

A Okay. I have it now.

Q I'm looking at the comment of the pathologist. What's your interpretation of what the pathologist is describing there?

A My interpretation is that the patient did not have acute cholecystitis.

Q And why do you reach that conclusion?

A Be says, no acute inflammation was observed. The earmark of acute cholecystitis is acute inflammation. No acute inflammation was observed. And instead he said, mild to moderate chronic inflammation was noted.

Q What about the recent hemorrhage in the wall *of* the gallbladder?

A Yes.

Q What does that represent?

A Well, it could represent two different things. First thing, which is most likely, is that it represents operative manipulation of the gallbladder producing

hemorrhage into the wall. That is in my opinion the most logical thing.

The second thing is, of course, his failure to represent prior hemorrhage, but to me that is -- would be very unlikely in this setting.

Q Okay. So that's just a finding from the manipulation of the gallbladder and removing it from the surgery?

A Yes. And it's not unusual, I have to say. You put clamps on it, you pull on it, you do all sorts of things while its blood supply is still intact, and that causes hemorrhage into the wall.

Q What would cause mild to moderate chronic inflammation of the gallbladder?

A Typical chronic cholecystitis simply means that he has had at least one previous episode of cholecystitis, gallbladder disease associated with gallstones. And that too I have to tell you, Mr. Jones, that is the rule rather than the exception in cases who undergo resective cholecystectomy for gallstones.

Q That they have typically had at least one prior episode of acute cholecystitis?

A Well, sometimes the episode is not acute. I didn't use that term.

Q Oh, I'm sorry.

A That they had previous episodes of gallbladder

disease associated with their gallstones. In actual fact, sometimes that episode was not even realized by the patient, so that patients who have this very typical finding of mild to moderate chronic inflammation sometimes have it with their first recognized episode of gallbladder disease associated with gallstones, but not acute cholecystitis. It no way implies that there was previous acute cholecystitis.

Q It could be consistent with a prior episode of acute cholecystitis, correct?

A Yes, it could be. There is this thin wall of two millimeter thickness. That's a thin-walled gallbladder.

Q Isn't that the upper level of normal for the thickness of a gallbladder wall?

A I'm sorry?

Q Isn't 2.2 sonometers the upper end of what would be considered normal?

A Yeah. We call that a thin-walled gallbladder. It's not a gallbladder that one finds in adute cholecystitis or in patients who have had repetitive attacks. It is -- We call that a thin-walled gallbladder. Just think of what two millimeters is.

Q That wouldn't mean anything to me in relation to a gallbladder, Doctor, because I have not seen enough gallbladders in my day to make a judgement of what is thin

or thick.

A Have you had your gallbladder taken out yet?

Q No. Thank goodness, I still have it.

A If you come out here, we would offer you a free ultrasound.

Q You would love to get your hands on me, Doctor, but I would love to resist.

If a previous episode of acute cholecystectomy did not cause the changes in the gallbladder, what other kinds of processes in this gentleman's past could have caused this kind of mild to moderate chronic inflammation?

A Well, you know, associated with the attacks of biliary colic, the pain that occurs, there may be some mild chemical inflammatory changes resulting from I'm going to use a term stasis. It means that the irritating bile sits there in the gallbladder and causes mild inflammation of the wall. Those are the processes. But most of these have no recognized episode of acute cholecystitis with all of the symptoms and signs that I described.

Q The stasis of bile that irritates the wall, is that a result of some obstruction of outflow from the gallbladder?

A Sure. Obstruction of outflow or the fact that the gallbladder doesn't empty properly. After all, it's a dysfunctional gallbladder. It doesn't contract properly and stuff sits there.

MR. JONES: That's all I have, Doctor. Thanks.

MR. CASEY: I have nothing else, Doctor.

MR. JONES: Doctor, you have a right to read a transcript of this deposition.

MR. ALLEN: I would like to say let's read and sign it.

(Deposition concluded.)

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I, Marshall Orloff, M.D. am a licensed physician, board certified surgeon. I have reviewed the records of Dewey Jones, including the hospital records from July 20, 1991 to September 20, 1994 of the Community Hospital Bedford; and the September 17, 1994 through November 21, 1994 records of Meridia Huron Hospital.

Mr. Jones is in coma and on a ventilator as a result of having sustained a cardiac arrest during a cholecystectomy performed over two years ago. He has permanent, severe brain damage. It is my opinion that his misfortune is the result of negligence on the part of (1) the surgeon, Dr. Badri; (2) the internist, Dr. No; (3) the anesthesiologists, Dr. Adamek, Dr. Senchyll, et al; and (4) Meridia Huron Hospital. It is my considered opinion, within a reasonable degree of medical certainty that the negligence of Defendants, includes but not limited to the following:

1. In this very high risk patient, operation was not indicated on 10/20/94 for several reasons. Firstly, the cholecystitis was *not* severe or in any way life-threatening. His symptoms and signs were subsiding he had no signs of acute inflammation or infection, and his bile duct was of normal size and free of stones, with no evidence of obstruction. Secondly, Mr. Jones had an incredible record of 13 previous hospital admissions for serious diseases in *the* short span of 3-1/4 years, and any major operation would have been associated with very high risks. In a morbidly obese patient with an established record of uncontrolled hypertension, repeated congestive heart failure, cardiomyopathy, sleep apnea, chronic edema, depression, attempted suicide, and noncompliance with medical therapy, the decision to operate on him represented poor judgment and was below the standard of care.

2. Alternatives to cholecystectomy, to include but not limited to:

   A. Dietary therapy with a low-fat diet while, at the same time, performing a detailed diagnostic workup of the cardiovascular disease in order to prepare Mr. Jones for an operative procedure, should one ultimately become necessary.

   B. Percutaneous drainage: of the gallbladder (cholecystectomy) under local anesthesia by an interventional radiologist, with subsequent chemical dissolution of the gallstones.

   C. Surgical cholecystectomy (drainage of the gallbladder) under local anesthesia.

   D. *Ultrasonic* lithotripsy - destruction of the gallstones with sound waves.

3. There was not an adequate diagnostic workup of Mr. Jones' cardiovascular disease performed at Meridia Huron Hospital. Mr. Jones was not well known at MHH. Dr. Winston Ho had seen Mr. Jones in only one of his episodes of uncontrolled hypertension when he was admitted to MHH on 9/18/94 for two days, and he had not performed a detailed cardiac diagnostic workup.

4. It was inappropriate for Dr. Ho to state on 10/19/94 that "He is medically cleared for surgery". Dr. Ho's "clearance" was below the standard of care. He issued the "Clearance" after performing a superficial workup and, by his own statement, without having seen *the* results of the 2-D echocardiagram. I should add that Dr. Ho's consultation did not relieve Dr. Badri of making the decision about whether or not to operate, and the associated responsibility.

5. The conduct of anesthesia was below the standard of care. There is no indication that the anesthesiologists appreciated the severity of Mr. Jones' illnesses. Furthermore, there is no indication that Mr. Jones was adequately monitored. He should have had "cardiac anesthesia," as is performed in heart surgery, which includes insertion of a Swan-Ganz catheter and monitoring of cardiac performance. An experienced attending anesthesiologist should have been in the operating room at all times.

In summary, Dewey Jones should not have undergone cholecystectomy on 10/20/94 and, more likely than not, he should not have suffered a cardiac arrest at the end of the procedure.

Marshall J. Orloff, M.D.

MARSHALL J. ORLOFF, M.D.

3/5/97