DEPOSITION OF R.E. SCHLANGER, M.D., Ph.D. AUGUST 4,1997

PAGE 1 TO PAGE 124

ANDERSON DILLMAN REPORTING

(614) 487-1778

CONDENSED TRANSCRIPT AND CONCORDANCE

PREPARED **BY:**

ANDERSON DILLMAN REPORTING
2IO9 West Fifth Avenue
Columbus, OH 43212
Phone: (614) 487-1778
FAX: (614) 487-0332

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IN THE COMMON PLEAS COURT OF CUYAHOGA COUNTY, OHIO

- - -

Dewey Glenn Jones, et al., :
Plaintiffs, :
-vs- : No. 306012
Meridia Huron Hospital, et al.,:
Defendants. :

DEPOSITION OF R.E. SCHLANGER, M.D., Ph.D

- - -

Monday, August 4, 1997
3:00 p.m.
1492 East Broad Street
Suite 1300
Columbus, Ohio

- - -

SHAYNA M. HERRING

Registered Professional Reporter

- - -

ANDERSON DILLMAN REPORTING
2109 West Fifth Avenue
Columbus, Ohio 43212
(614) 487-1778
FAX (614) 487-0332

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APPEARANCES:

CHARLES AiLEN, Attorney at Law
Landskroner Law Firm, Ltd.
55 Public Square
Suite 1040
Cleveland, Ohio 44113
On behalf of the Plaintiffs

R. MARK JONES, Attorney at Law
Jacobson, Maynard, Tuschman & Kalur Company, LPA
1001 Lakeside Avenue
Suite 160
Cleveland, Ohio 44114
On behalf of Rafal Badri, M.D.

JAMES S. CASEY, Attorney at Law
(Via telephone]
Reminger & Reminger
The 113 St. Clair Blvd.
Seventh Floor
Cleveland, Ohio 44114

On behalf of Meridia Huron Hospital

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MONDAY AFTERNOON SESSION
August 4, 1997
3:00 p.m.

- - -

STIPULATIONS

- - -

It is stipulated by and between counsel for the respective parties herein that this deposition of R. E. SCHLANGER, M.D., Ph.D., a witness herein, called by the Plaintiffs under the statute, may be taken at this time and reduced to writing in stenotypy by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; and that proof of the official character and qualifications of the Notary is waived.

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PROCEEDINGS

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R. E. SCHLANGER, M.D., Ph.D.,

being by me first duly sworn, as hereinafter certified,

testifies and says as follows:

CROSS-EXAMINATION

BY MR. ALLEN:

Q. Doctor, if you'd state your name for the record

for me.

A. Richard Edward Schlanger, S-c-h-l-a-n-g-e-r, M.D., Ph.D., F.A.C.S.

Q. Okay. What medical records have you reviewed

for this case, Doctor?

A. Okay. I'm going to go over them with you right

now. I have in front of me the Meridia Huron Hospital

admission records October 17 through November 21, '94. I

have the office chart of Dr. Azem from 12-4-92 to 9-3-94.

I've got records of Community Hospital of Bedford which

concerns a 9-3-94 to a 9-9-94 admission. I also have the

Meridia Huron Hospital 9-19 to 9-20-94. And the only other

thing that I do have is the Dewey Jones versus Meridia

Huron deposition of Rafal A. Badri.

Q. Did you look at any other depositions besides

that?

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A. No, I have not looked at any depositions

besides that one.

Q. All right. Did you generate any materials

besides the opinion letter?

A. That's it.

Q. That's the original letter?

A. That's the letter.

Q. The one and only?

A. That's correct.

Q. Did you review any specific literature for this

case?

A. No, I did not.

Q. When were you first contacted?

A. I believe I was contacted around April 8th, 1997.

Q. Okay. And was the materials

given to you at
that time?
A. Yeah, I believe so, that's correct.
Q. Okay. And you first discussed your opinions
with Mr. Jones when?
A. Soon after.
Q. Soon after?
A. Soon after. I **can't give you the exact date,**
but the date of the letter is April 11.

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Q. Okay. Did you create any independent notes,
etcetera?
A. No, I **don't.**
Q. Okay. Now, were you retained to give opinions
only for Dr. Badri or -
A. I was asked basically to look at this case from
the general surgeon's point of view.
Q. Okay. And are you prepared today to testify as
to the standard of care as to the internal medicine
internist and the anesthesiologist?
A. No, I **am not.**
Q. Okay. Are you prepared to testify as to the
standard of care as it relates to the residency program or
the residents themselves?
A. No, I'm **not.**
Q. Okay. Are you intending to give expert opinion
as to what's known as causation, what happened to Dewey and
why it happened?
A. Well, I don't think I can based on what I've
reviewed.
Q. Okay. And what about life expectancy?
A. I'm not an expert in that field. I would like
to not give an opinion.
Q. That will shorten things up; right?

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MR. JONES: Unlike the plaintiffs' our experts
tend to stay within their areas of specialty, you'll find.
BY MR. ALLEN:
Q. All right. So I just want to ask you a couple
questions as it relates - I know you didn't look at the
deposition of Dr. Orloff, but there were several areas in
his deposition I just want to ask you whether you agree or
disagree with about three or four

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areas.
A. That's fine.
Q. Is that fair?
A. Yes.
Q. All right. On Page 31 in his deposition he
stated that he felt Dewey Jones was not at any substantial
risk for biliary obstruction. Do you agree with that?
A. I agree.
Q. Okay. And on Page 36 of his deposition he
stated that he felt that a biliary ultrasound does not show
thickening of the gallbladder wall or any fluid around the
gallbladder, but only shows the echoes or presence of the
stones within the gallbladder. Do you agree or disagree?
A. I want to look at the review, because I
remember there was some thoughts of some thickening on the
last ultrasound. But, yes, there was no fluid in the
perivesicular space.

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Q. And -
MR. JONES: Do you want him to look at the
records or do you want -
BY MR. ALLEN:
Q. I'm asking you in general can an ultrasound
determine whether or not there has been thickening of the
gallbladder?
A. Oh, yes, absolutely.
Q. Okay. And an ultrasound can show whether there
was any fluid around the gallbladder?
A. Yes, that's correct.
Q. All right. And you were able to compare
previous ultrasound reports?
A. Yes.
Q. And determine that the - there was thickening
of the gallbladder wall?
A. There was some suggestion of thickening on the
last echo.
Q. Okay. And how did you determine that?
A. I think it was mentioned.
Q. Okay. Can you turn to that?
A. I'd like to, if I may.
Q. Okay.
MR. JONES: It is under the radiology report

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section, just to try to help you save some time. Oh,

(2) you've got it there?
(3) A. Yeah, yeah, yeah. I must have gotten it from
(4) somewhere else. This one on the - dated the 18th shows
(5) multiple images transfer scan, number of internal echoes
(6) with acoustic shadowing distally as in cholelithiasis.
(7) There is no mention of thickening. I was mistaken. I'm
(8) sorry.
(9) Q. But it's your opinion that in general you can
(10) - on ultrasound you can determine whether the waits had
(11) been thickened?
(12) A. That's correct.
(13) Q. And in your opinion - do you have an opinion
(14) as to this case whether there is thickening of Dewey
(15) Jones's gallbladder wall as opposed to previous ultrasound?
(16) A. On echo they made no mention, so I'm suspecting
(17) that what they were seeing was basically gallstones, but
(18) did not determine or mention any changes in the wall.
(19) Q. Okay. So do you expect to testify at trial
(20) that you feel that the gallbladder wall was thickened?
(21) A. Well, I will just read what it said on the
(22) report, which they did not mention thickness on that
(23) ultrasound.
(24) Q. Okay. He also on Page 36 of that deposition on

Page 11

(1) Line 22 says he did not see any evidence of any dilatation
(2) of the cystic duct. Did you -
(3) A. Well, I don't - hardly I don't know anybody
(4) that will look and tell you that the cystic duct is dilated
(5) on an ultrasound. They will mention the common duct
(6) dilatation.
(7) Q. Okay.
(8) A. But the cystic duct is very, very rarely
(9) dilated unless there's a stone impacted in it.
(10) Q. And on pathology later there was no evidence of
(11) that; true?
(12) A. Well, that's something, again, in years of
(13) gallbladder surgery I've never had that mentioned in a path
(14) report.
(15) Q. Okay. Can you tell by reading a

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path report
(16) whether or not that was the case?
(17) A. I would - if they mentioned it.
(18) Q. Only if they mentioned it?
(19) A. Only if they mentioned it. But it has very
(20) little to do with it, unfortunately.
(21) Q. All right. Do you agree with Dr. Orloff that
(22) thickening of the gallbladder wall means a previous
(23) inflammation of the gallbladder?
(24) A. It means that there's chronic inflammation.

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(1) Q. Can you define what you mean by chronic?
(2) A. Long-standing. It means a process that's been
(3) going on for a while; months, years.
(4) Q. Minimum being months?
(5) A. Minimum being months.
(6) Q. Okay. All right. And on Page 40 he stated
(7) that an obstructive gallbladder is thickened, enlarged and
(8) produces a palpable tender mass in the right upper
(9) quadrant. Do you agree with that?
(10) A. Oh, that's - no.
(11) Q. What do you disagree with about that statement?
(12) A. Well, basically that's taking everything into a
(13) tremendous amount of conjecture. There are gallbladders
(14) that will become dilated from other obstructions. I have
(15) seen patients that have had tremendously dilated
(16) gallbladders that have not been obstructed. I've had
(17) patients that have had dilated gallbladders that do not get
(18) obstructed.
(19) The whole situation is if a stone lodges in the
(20) gallbladder to cause biliary colic, the gallbladder will
(21) compensatorily dilate, and depending on how residual -
(22) excuse me, how elastic the wall is, it will either dilate
(23) non-painfully, or if it is thickened, or if it is diseased
(24) in any way such as adhesions or any other constricting

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(1) forces, it cannot dilate in that situation. It's painful.
(2) So not all gallbladders that are obstructed dilate and are
(3) painful and produce a painful mass.
(4) Q. So if there's previous thickening of

the
(5) gallbladder wall, then you expect there not to be pain,
(6) palpable pain or -
(7) A. I expect to find that the gallbladder is having
(8) trouble distending. Some of those can be painful. In
(9) diabetics, for the most part, it is totally innocuous, and
(10) when you get in there you find that the gallbladder has
(11) been ruptured for days. There are so many co-morbidities
(12) that can lead to the situation that a generalized statement
(13) of that nature is just that; it's just too general.
(14) Q. Too general, okay. Okay. How many times have
(15) you - this is a general - how many times have you been
(16) asked to - have asked an internal medicine doctor, an
(17) internist, to medically clear a patient before a
(18) non-cardiac surgery?
(19) A. I would suspect in at least 25 percent of my
(20) cases, and I do 890 to 900 cases a year.
(21) Q. Why do you do that?
(22) A. Basically it's a patient that has some other
(23) co-morbidities in which I'm not familiar in managing.
(24) Q. And the need for that being getting their

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(1) opinion as to whether he's a surgical risk or surgical -
(2) is ready for surgery?
(3) A. Well, to make sure that the surgical risk is
(4) appropriate, that they are medically tuned to their best
(5) performance status and proceed with surgery.
(6) Q. And when you get that internal medicine review
(7) do you expect that doctor then to get subspecialist
(8) reviews?
(9) A. Not always.
(10) Q. Okay. You have in the past had an internist
(11) review a case for you or give you a consult, and have you
(12) in the past also asked for a cardiology consult at the same
(13) time?
(14) A. It depends on what the co-morbidities of the
(15) patient are, whether they are end stage or not, whether the
(16) internist has prior knowledge of

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the patient. And I will
(17) base my opinion on his clearance, or if there's any
(18) question on his part we will discuss it. But if he clears
(19) it and I feel comfortable with his clearance, I'll go
(20) ahead.
(21) Q. But if you don't feel comfortable, if you have
(22) no reason to not go ahead and get a cardiology consult or
(23) pulmonology consult, if you feel that's necessary -
(24) A. If I feel it's necessary, that's correct.

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(1) Q. All right. And you've had occasions in the
(2) past in which an internal medicine doctor has maybe
(3) medically cleared a patient and you've decided that maybe
(4) you should not operate on him? Has that occurred?
(5) A. No, that has not occurred. Nine times out of
(6) ten, or even higher, if my internal medicine physician has
(7) had knowledge of the patient in the past and has a good
(8) working knowledge and feels comfortable, I trust my
(9) internal medicine docs. And I've had really no cause to go
(10) beyond that unless they have mentioned that they would like
(11) to have someone else see the patient.
(12) Q. Do you feel that Dr. Ho had good working
(13) knowledge of Dewey Jones?
(14) A. From what I read in the records I felt he was
(15) familiar enough with his case to give clearance.
(16) Q. Okay. Was he familiar enough to give clearance
(17) without Dr. Badri questioning whether or not this patient
(18) was medically able to go to surgery?
(19) A. From what I read I felt that Dr. Ho gave a
(20) pretty lucid account, and I think taking him to surgery was
(21) probably reasonable.
(22) Q. In the same lines, as a surgeon, if anesthesia
(23) believes that a patient should stay intubated for a few
(24) days after surgery or an extended length after surgery, you

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(1) wouldn't interfere, but you would defer to that - to the
(2) anesthesia as to whether or not the

patient need to stay
(3) intubated?
(4) A. Most times there would be a discussion in the
(5) room, but if a patient needed to be intubated based on
(6) anesthesia, I would defer to them.
(7) Q. Okay. Having gallstones doesn't necessarily
(8) mean that they will obstruct - obstruct the biliary tract,
(9) does it?
(10) A. No.
(11) Q. Okay. So just upon the fact that Dewey Jones
(12) had gallstones didn't mean that he was in an overwhelming
(13) risk at that moment to get obstruction; correct?
(14) A. Well, I don't think we're dealing - I think a
(15) lot of people are putting the word obstruction. There are
(16) two things that can happen from gallbladder disease; one,
(17) we worry about obstructing the common duct or we worry
(18) about obstructing the pancreatic duct and getting
(19) pancreatitis. The fact in this case, as I constructed it,
(20) this is his third admission for pain, nausea and vomiting,
(21) so he had symptomatic gallbladder disease, he had
(22) symptomatic biliary colic. And to me that is an indication
(23) for surgery; not waiting for him to obstruct or any of the
(24) other complications down the road. This presentation would

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(1) have made me take him to surgery.
(2) Q. Due to the fact it was his third nausea and
(3) vomiting, period?
(4) A. Correct.
(5) Q. Okay. Tell me when the other two admissions
(6) were for nausea and vomiting
(7) A. Based on my report, let's see, in September he
(8) was worked up for pain, nausea and vomiting and had a
(9) sonogram showing multiple small stones, including diagnosis
(10) of cholelithiasis. Admitted again in early October with
(11) nausea and vomiting, and again diagnosed this time as
(12) gastritis. And then on October 17 finally came in again
(13) with intermittent abdominal pain and nausea and vomiting.
(14) So in a very brief period of about a

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month and a half, two
(15) months max, we've got three admissions for workup of
(16) nausea, vomiting and abdominal pain. And in a patient with
(17) his co-morbidity I take that very serious this is a
(18) symptomatic biliary tract.
(19) Q. Why? With a patient with his - what was the
(20) phrase you used, co?
(21) A. Co-morbidities.
(22) Q. Co-morbidities being what?
(23) A. Co-morbidities being his hypertension, his cor
(24) pulmonale, end stage heart disease, cardiomyopathy, recent

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(1) TIA, and I believe he's got diabetes on top of that, morbid
(2) obesity.
(3) Q. Right.
(4) A. Anything that could throw whatever balance he's
(5) in into an absolute trash can such as biliary tract disease
(6) which causes dehydration, probably prerenal azotemia and
(7) some other problems, he doesn't need. So he's had three
(8) episodes of biliary colic. This to me is an indication of
(9) a gallbladder that's been diagnosed as having stones.
(10) Q. So the early October admission you're saying
(11) for gastritis was biliary colic?
(12) A. Most likely, yes.
(13) Q. Can you turn to those notes or those records
(14) forme?
(15) A. Sure.
(16) MR. JONES: You're talking about which ones?
(17) Q. Early October, gastritis.
(18) A. Early October, all right. We've got to go back
(19) to this one. All right. Which chart? I had somebody's
(20) chart from that time. I think I covered them up. Let me
(21) see, I'll get there. October. October 7, 1994, patient
(22) is a 32 year old black gentleman. He's having nausea,
(23) vomiting. No diarrhea. Admitted with diagnosis of
(24) gastritis. Given IV fluid and discharged.

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(1) Q. What was done for him in that -
(2) A. Basically the ED course he was given 10
(3) milligrams of IM Reglan with good resolution of his nausea,
(4) given IV saline, Procardia,

Cagoten. Abdominal series is
(5) nonspecific. Cardiomegaly is noted. They just went
(6) through a whole bunch of tests including a
(7) lithocardiogram. No ischemic changes. Patient is improved
(8) with the Reglan IM. Let's see. Dr. Azem is contacted, and
(9) in light of the patient's recurrent vomiting and possible
(10) medical noncompliance, this would lead to the patient's
(11) labile hypertension and they would check him further for
(12) the cause of abdominal pain.
(13) Q. Okay.
(14) A. So I – this is another hospital, I believe, so
(15) he may not have told them about his previous problem where
(16) he had a diagnosis of gallstones, which was from September.
(17) Q. What hospital was that, please?
(18) A. This is Community Hospital of Bedford.
(19) Q. Okay. So what is consistent in your opinion
(20) with biliary disease or the problems, the nausea –
(21) A. Nausea, vomiting and nonspecific, intermittent
(22) abdominal pain.
(23) Q. All right. Anything other than that?
(24) A. Not really.

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(1) Q. And based upon that admission and the previous
(2) admission, I think it was September –
(3) A. September, and the last one.
(4) Q. – now this one, you feel that it's –
(5) A. Symptomatic biliary disease based on known echo
(6) of gallstones.
(7) Q. Okay. And that then we needed to go in and
(8) have surgery and remove –
(9) A. I would suspect that would be my indication,
(10) yes.
(11) Q. Your hospital, you are?
(12) A. Park Medical Center.
(13) Q. Park Medical. Who is – who owns Park Medical?
(14) A. Quorum.
(15) Q. Quorum. Okay. How long have they owned Park
(16) Medical?
(17) A. Since 1992.
(18) Q. Now, you – if you could give me what you
(19) believe are the precipitating signs to lead a physician to
(20) believe that biliary obstruction will occur?

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(21) A. Well, biliary obstruction occurring, it's one
(22) of these things that happens. A patient comes in
(23) jaundiced, may have elevated liver function tests, but for
(24) the most part it's one of those things that he passes a

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(1) stone into his main bile duct. If it's an impacted stone
(2) he gets deeply jaundiced, has pain. If it's what we call a
(3) trumpet he has intermittent pain and then clears and his
(4) jaundice clears with it.
(5) Q. Trumpet meaning intermediate –
(6) A. It's just like – it's intermittent, the stone
(7) will impact, release, and as soon as it releases all the
(8) bile comes out. They dejaundice, defervesce or whatever.
(9) But in his case, I mean, his stones were basically in his
(10) gallbladder. And I don't think he had impending
(11) obstruction.
(12) But what I worry about in these people is
(13) possible worsening of symptoms, possible cholecystitis in
(14) which a stone will obstruct the cystic duct, not the common
(15) duct, where he gets sick, And patients that have bad
(16) livers, bad hearts, bad lungs, they get cholecystitis tend
(17) to die. And you don't want to get to that point. You want
(18) to get this guy to the OR when you think he's going to be
(19) able to survive an operation, and not later.
(20) Q. So in this case we're worried about possible
(21) cholecystitis, we're worried about possible worsening of
(22) the condition?
(23) A. Right.
(24) Q. In which Mr. Jones being in the condition that

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(1) he's in would not be able to overcome?
(2) A. Correct.
(3) Q. Okay.
(4) A. Or even go to surgery.
(5) Q. Okay. And cholecystitis, if you can define
(6) that for me?
(7) A. Cholecystitis is inflammation of the
(8) gallbladder.
(9) Q. It just simply means inflammation?
(10) A. Inflammation.

(11) . Q. And the classic signs of that are?
(12) A. Well, there are no classic signs. That's the
(13) problem. Usually it is fever, unrelenting pain,
(14) leucocytosis.
(15) Q. Okay.
(16) A. That's the classic.
(17) Q. Elevated white blood count, leucocytosis?
(18) A. That's leucocytosis, that's correct.
(19) Q. And you see that with patients with acute
(20) cholecystitis; correct?
(21) A. Usually acute cholecystitis.
(22) Q. Now, Dewey did not have acute cholecystitis;
(23) true?
(24) A. He did not have the classic signs. But the

(1) path report said earlier acute cholecystitis, which may
(2) mean he had inflammation in part or some of the
(3) gallbladder.
(4) Q. Okay. So in the absence of those classical
(5) signs, it would be less urgent to operate on Dewey Jones?
(6) A. Well, the urgency is not so much what he had as
(7) what he didn't have.
(8) Q. Meaning?
(9) A. Meaning that if I take a patient who is sick as
(10) all get out and wait for him to get sicker, I've lost my
(11) window of opportunity. Looking at Dewey's medical records
(12) the Dewey they had in the hospital at that time was about
(13) as best as Dewey was going to be. And if they wait until
(14) he gets really sick then Dewey is dead. They can't do
(15) anything to Dewey.
(16) Q. Dead from?
(17) A. From just being septic with a perforated
(18) gallbladder and a subhepatic abscess. We don't want to get
(19) there. We don't want to get anywhere near there. So Dewey
(20) is sick, there's no doubt. I mean, this guy, I feel sorry
(21) for him. He can't even change his socks without getting
(22) CHF. But you've got a very sick guy. He's got a
(23) symptomatic gallbladder. Do you wait until he gets sicker
(24) or do you go by your medical guy who says, look, he's not

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(1) in CHF right now, I think you can take him, you take him.
(2) Q. So based upon his past medical history is the
(3) reason that you do the removal of the gallbladder in your
(4) opinion?
(5) A. Absolutely.
(6) Q. Okay. And you do that in the face of even not
(7) having biliary obstruction?
(8) A. Well, biliary obstruction - I operate -
(9) Q. Or any sort of obstruction.
(10) A. Well, you've got symptomatic gallstones. You
(11) just take out the gallbladder before you get to the
(12) complicated stage where you have to go into the common duct
(13) and drain the common duct or do something else. You want
(14) to do something simple. Do an open chole, get a
(15) cholangiogram, close, go home, bye. That's what you want
(16) to do.
(17) Q. So we can agree that Dewey did not have acute
(18) cholecystitis from 10-17 to 10-20?
(19) A. He had pathologic evidence of acute, but
(20) clinically he had cholelithiases.
(21) Q. What is the pathological evidence that he had
(22) it?
(23) A. They read it as early acute cholecystitis.
(24) Q. Wouldn't you expect to see a thickening or

(1) extended thick walls?
(2) A. Basically the pathologist read it that way and
(3) I have to go on his opinion. All I know is I did not see
(4) the specimen nor was I there at the time of operation, so I
(5) have to go by the op note description and what the
(6) pathologist called it.
(7) Q. Do you categorize it as chronic cholecystitis?
(8) A. Well, let me read what he said, if I may.
(9) Q. Yeah, go ahead and turn to the path report.
(10) A. The path report, the comment, gallbladder
(11) showed recent hemorrhage in wall with focal erosion of
(12) mucosa. Finding may represent early or developing acute
(13) cholecystitis, although little or no acute inflammation is
(14) noted. Mild or moderate chronic

inflammation is noted. So
(15) this would be read out by my pathologist here as acute and
(16) chronic cholecystitis.
(17) Q. Acute -
(18) A. And chronic.
(19) Q. And chronic?
(20) A. Right.
(21) Q. But this fellow read it as mild to moderate
(22) chronic inflammation; correct?
(23) A. Right.
(24) Q. Okay. And so he felt like it was diagnosis

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(1) cholecystitis and cholelithiases?
(2) A. Correct.
(3) Q. Okay. So -
(4) A. That's not a normal gallbladder.
(5) Q. I'm sorry?
(6) A. It's not a normal gallbladder by any stretch of
(7) the imagination.
(8) Q. All right. What makes this gallbladder
(9) abnormal?
(10) A. Well, if you look down at the gross
(11) description, cirrhosal aspect is edematous and hyperemic,
(12) which is not normal. The gallbladder should be Robin's egg
(13) blue and very, very thin. Defect measuring .4 centimeters
(14) of the greater dimension is noted near the neck, so this is
(15) the ulceration that he's talking about, and there's another
(16) ulceration about one and a half Centimeters present near
(17) the fundus.
(18) Q. Let me stop you right there. Noted near the
(19) neck, what does that indicate to you?
(20) A. Well, there must be - if I look at erosions in
(21) the gallbladder it's because stones are migrating down
(22) there getting stuck, causing inflammation on the inside and
(23) then popping back up. So he's had something going on in
(24) his gallbladder to create these rubbings where he's eroded

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(1) through the wall.
(2) Q. Continue on.
(3) A. Okay. There is no exudate or adhesions in the
(4) vicinity of these defects, so these are not truly acute; in
(5) otherwords, they are not infected, there's no pus. The
(6) average wall thickness is .2, and I'm not real sure what

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(7) the normal - I think it's a little bit less than that. A
(8) number of calculi are present -
(9) Q. So you would categorize this as a thick wall?
(10) A. It's thickened. It's - anything that isn't
(11) perfectly normal, in other words, paper thin, there is some
(12) mild thickening, but we're not talking about a horribly
(13) big, thick, ugly gallbladder, gangrene.
(14) Q. Okay. Go ahead.
(15) A. And there are a number of calculi. They are
(16) somewhat rounded, green, possess large crystaline matrix,
(17) and measure up to about a centimeter, which are a pretty
(18) good size. So I agree with their comments that this is
(19) probably early acute and there is chronic cholecystitis and
(20) cholelithiases. So this was a fairly sick gallbladder. It
(21) wasn't terribly sick, but it needed to come out.
(22) Q. Tell me as far as what you would categorize in
(23) this pathology report to indicate acute cholecystitis, that
(24) could be a possible indication of acute cholecystitis?

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(1) A. Well, he mentions that there is edema.
(2) Q. Okay.
(3) A. Hyperemic; in other words, it's injected. So
(4) those two factors in themselves are acute. And this is a
(5) sick gallbladder. And the second thing is that there is
(6) ulcerations on the inside. You don't see that in just
(7) run-of-the-mill gallbladder disease.
(8) Q. And what do you think the ulcerations are due
(9) to?
(10) A. Probably just the thing contracting on stones
(11) that are getting intermittently obstructed in the neck of
(12) the gallbladder.
(13) Q. Anything else that could possibly cause that?
(14) A. Well, there could be some blood flow problems,
(15) but for the most part, just from the way he's describing
(16) it, I think it's from the gallbladder being stuck in that
(17) area, causing the symptoms and popping up and he's

(18) ,.system-free for that moment.
(19) Q. And what – what under this pathology report –
(20) sorry–
(21) **A.** That's all right.
(22) Q. – in your opinion is consistent with mild to
(23) moderate chronic inflation – inflammation, excuse me.
(24) **A.** Basically the mild to moderate, he describes

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(1) the wall thickness as being somewhat large and there is
(2) mucosa, mucosal hemorrhage. **But** usually what they do, and
(3) they don't describe it here, is they will talk about the
(4) inflammatory cells in the wall uncut, and I don't see – I
(5) may not have the second papers from the microscopic, but –
(6) Q. There's no indication of inflammation?
(7) **A. No.**
(8) Q. Okay.
(9) **A.** He **doesn't** look and describe inflammatory
(10) cells. But from what he's describing there is some
(11) inflammatory process, but you don't have exudate or
(12) adhesions in the gallbladder itself, which would be an
(13) acute infectious process rather than inflammatory.
(14) Q. You would expect if there were inflammatory
(15) cells that he would describe it?
(16) **A.** Well, he doesn't mention anything in the
(17) microscopic and I just get the gross description. If I had
(18) a microscopic, which I don't have here, I'm sure he would
(19) describe something. But there is no mention. Path reports
(20) that I'm used to have diagnosis, gross and microscopic.
(21) Q. There's no mention of microscopic?
(22) **A.** No, there's **no** mention of microscopic report.
(23) Q. And the only way in your opinion to see the –
(24) **A. Is** a microscopic.

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(1) Q. Okay. Do you believe that if a patient has an
(2) open cystic duct and a fully functioning gallbladder they
(3) can live comfortably with food and diet restrictions with a
(4) gallbladder like that?
(5) **A.** If a patient is symptomatic, has nausea and

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(6) vomiting like this guy, no. I wouldn't risk it, because
(7) that open duct – one of these stones will migrate. If a
(8) gallbladder **is** symptomatic it needs to come out.
(9) Q. So if it's functioning – Dewey had a
(10) functioning gallbladder?
(11) **A.** Yeah. That's – a lot **of** people that have
(12) stones have functioning gallbladders, it's just
(13) occasionally a stone will impact, cause them problems, and
(14) when the stone is released they are perfectly normal.
(15) Q. The fact that he's got a functioning
(16) gallbladder and an open cystic duct, but just the fact he's
(17) got nausea and vomiting, puts him into a different –
(18) **A.** I would consider him to have symptomatic
(19) gallstones, and **to** me that's ***a*** surgical condition.
(20) Q. Okay. What are the – what do the bilirubins
(21) indicate in your opinion?
(22) **A.** You have a problem with him.
(23) Q. Okay.
(24) **A.** I would not trust his bilirubin.

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(1) Q. Because?
(2) **A. Of** repeated episodes ***of*** CHF.
(3) Q. Okay.
(4) **A.** His chronic heart failure can cause absolute,
(5) astronomic perturbations throughout his range **of** liver
(6) functions.
(7) Q. Meaning they could be?
(8) **A.** They could be high, they could be normal, they
(9) could swing back and forth. His transaminases can be up,
(10) his alk phos can be up. ***So*** putting – hanging my hat on
(11) that as a reason to operate, I'd probably be a little bit
(12) more leery of his numbers.
(13) Q. Okay. So in a normal patient without
(14) congestive heart failure you would look at bilirubin levels
(15) to be abnormal to be what level?
(16) **A.** Well, anyone – anyone in ***this*** room that had a
(17) bilirubin of 2.1 would be extremely abnormal, and I'd be
(18) very worried.
(19) Q. So anything above 2.1 –
(20) **A.** Well, actually anything above 1.5 at this
(21) hospital, which is higher than normal, I would be worried.

(22) Anything above 120 for alk phos I would be worried.
(23) Q. Worried for what?
(24) A. Obstruction, that there would be a stone in his

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(1) common duct.
(2) Q. Okay. And would that then indicate to you that
(3) – the need to take out the gallbladder?
(4) A. Well, there would be other things I'd have to
(5) do too. Okay?
(6) Q. Okay.
(7) A. I mean, in Dewey's case the one thing I would
(8) not want to subject him to would be a prolonged procedure,
(9) and at that time I would probably have an ERCP done to open
(10) the common duct, drain the stone, and then go in and take
(11) his gallbladder out.
(12) Q. Okay.
(13) A. I would not want to do a common duct because I
(14) don't want tubes in this guy who is enormous.
(15) Q. So what was done here?
(16) A. Well, in this case the echo that was done
(17) initially showed that the cystic – the common duct was not
(18) dilated, so most likely his bilirubin and alk phos were
(19) coming from his previous what I calf an accordion liver,
(20) and therefore it was safe to go aheadanddoanopen
(21) cholecystectomy, a cholangiogram which proved to be normal,
(22) and close.
(23) Q. Okay. And the cholangiogram was normal in your
(24) opinion?

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(1) A. I believe it was, yes.
(2) Q. What are dilated intrahepatic radicals?
(3) A. If you look at the gallbladder and the common
(4) duct, the common duct forms a single structure coming out
(5) of the duodenum. As it gets up near what we call the hilum
(6) of the liver it splits into two segments; right and left.
(7) Each of those arbor into the liver. Now, when you have an
(8) obstruction of the common bile duct, the back force will
(9) dilate all these radicals, so on ultrasound you will see
(10) that the intrahepatic portions of these two bile ducts are
(11) dilated.
(12) Q. Okay. Is that Dewey? Did Dewey have that?
(13) A. It was not mentioned in the original echo, and
(14) that would have been something they would have seen as a
(15) very, very prominent feature.
(16) Q. What would that indicate?
(17) A. A biliary tract obstruction, or something else,
(18) a tumor or something.
(19) Q. So obviously Dewey did not have advanced
(20) biliary tract disease?
(21) A. He did not have obstructive biliary tract
(22) disease. I think he had significant gallstone disease, but
(23) he did not have what I would consider obstructive
(24) gallbladder disease.

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(1) Q. Okay. And what would be the difference between
(2) that and advanced biliary tract disease?
(3) A. Well, advanced biliary tract disease is
(4) cirrhosis, sclerosing cirrhosis, biliary cirrhosis. It can
(5) be a biliary tract tumor. It can be common duct stones.
(6) It can be a whole feast of different things. You can also
(7) have advanced biliary tract disease as a carcinoma of the
(8) gallbladder. In his case he had symptomatic gallstones.
(9) Q. The fact that you just have common duct stones
(10) and a dilated common duct with dilated intrahepatic
(11) radicals, would that be – then be advanced biliary tract
(12) disease?
(13) A. That's advanced biliary tract disease.
(14) Q. Was Dewey Jones – in your opinion Dewey
(15) Jones's gallbladder was emptying; correct? It was working?
(16) A. Well, they didn't do any tests to prove that,
(17) but I'm suspecting that the cystic duct was working.
(18) Q. What could have been done to test that?
(19) A. A nuclear medicine scan called a hep HIDA or a
(20) HIDA, and that's basically injecting a nuclear material
(21) that uptakes the liver, excretes into the gallbladder, and
(22) watch the gallbladder empty.

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(23) Q. Okay. Now, the cholangiogram that was done
(24) intraoperatively – and can you turn to whatever that note

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(1) is?
(2) **A.** Yes. I'll take a look at the op note. Okay.
(3) Q. That was normal because they were able to do
(4) what?
(5) **A.** Okay. The contrast material flowed freely into
(6) the right and left hepatic ducts and through the common
(7) bile duct and into the duodena. So basically what they did
(8) is they took a small catheter, cannulated the cystic duct,
(9) injected dye and were able to visualize the entire
(10) trajectory of the common bile duct, both into the liver and
(11) into the duodenum without obstruction.
(12) Q. So the urgency to remove Dewey's gallbladder in
(13) your opinion is based upon two other episodes he had of
(14) nausea and vomiting?
(15) **A.** That's correct. That's correct.
(16) Q. Okay. What is a – make sure I get this right,
(17) chote – oral cholecystogram?
(18) **A. OCG's,** as they were known –
(19) Q. Okay. It's easier.
(20) **A.** – are something that were done a while ago.
(21) Patients were given several tablets. They would eat them
(22) and it would do the same thing as a **HIDA.** It would show
(23) the gallbladder and it would show gallstones on a plain
(24) x-ray. After a while I think most of this was abandoned.

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(1) Q. So you would do it for HIDA now?
(2) **A.** Yeah, I would do it for HIDA if the **HIDA** was
(3) indicated.
(4) Q. And the HIDA being indicated would mean?
(5) A. If I was really suspicious of a patient that
(6) had gallbladder symptoms and I did an echo and the echo was
(7) normal, and it was someone that had bad heart disease, and
(8) I wanted to make sure the gallbladder was working, and if I
(9) had a normal echo, in other words, no Stones, and a normal
(10) functioning gallbladder, then I'd say, you don't have
(11) gallbladder disease, let's look someplace else.
(12) Q. And the HIDA would not be indicated?
(13) **A.** And in most situations if I have gallstones and
(14) I'm almost certain there's not cholecystitis, I wouldn't do
(15) it.
(16) Q. Okay.
(17) **A.** But there are a certain amount of patients that
(18) have normal gallbladders that we do do the **HIDA** and it
(19) completely shows not only that it's not functioning but
(20) their pain as it expands is there and that's a
(21) non-functioning gallbladder.
(22) Q. So is there any need to do a HIDA when you have
(23) an ultrasound that shows stones?
(24) A. In cirrhosis. In patients with cirrhosis for

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(1) the most part **I'll** do a **HIDA** to keep me from operating. If
(2) their gallbladder is open I won't touch them with a
(3) ten-foot pole. Otherwise, for the most part, if someone
(4) has the symptoms and they have the echo that's showing me
(5) stones, I won't do a **HIDA.**
(6) Q. Okay. So you simply disregard Dewey Jones's
(7) bilirubin levels –
(8) A. Pretty much.
(9) Q. – because of his CHF?
(10) **A.** Well, because of his **CHF** and the fact that I
(11) have a non-dilated common duct on echo.
(12) Q. Okay. When would it be appropriate to use –
(13) do an endoscopic retrograde pancreatical –
(14) A. **ERCP.**
(15) Q. – cholangiogram? Yeah.
(16) **A.** Well, if I had a patient that had a bile duct
(17) that was dilated and there was a possibility of stones or a
(18) tumor and I wanted to get answers, I would do the ERCP. Or
(19) if it was a very sick patient that had a dilated common
(20) duct with stones that I didn't want to take to surgery, I
(21) would have them cut the sphincter, which is the muscle
(22) opening into the duodenum, and the duct, and drain it that
(23) way, if possible, and this way I could cool them off and
(24) then go back and take the gallbladder out at a later date

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if that's needed.
Q. Why wasn't Dewey a candidate for that?
A. Normal size common bile duct, and there was no
reason to put him through that.
Q. And cutting the sphincter –
A. Would have done nothing.
Q. Why?
A. Well, it wasn't dilated.
Q. Okay.
A. And all they would have done was risk
perforating, and then you would have had a really sick
patient.
Q. Okay. How is an echo used for diagnosing
cholelithiases?
A. An echo is a sound wave exam.
Q. Right.
A. And basically what you do is you're bouncing
sound waves off of different parts of the internal organs.
Q. Right.
A. Something that is air-filled or fluid-filled
and has a wall will show the outline, and anything that has
an echo inside, solid, will have echoes coming down, so
using the sound wave test you're able to determine whether
there were stones or not.

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Q. Okay. And you can determine state of the
ducts?
A. You can see the ducts will be different than
the liver and show as very, very darkened areas. If they
are not very dilated you really don't see them.
Q. But you can't use an echo to diagnose
cholelithiases; correct?
A. That's one of the diagnostic –
Q. Cholecystitis, I'm sorry.
A. – tools. You know, if there is fluid or
thickening you can presume that you may have cholecystitis,
but its specificity is about 60 percent.
Q. And cholecystitis is definitively diagnosed on
the pathology report?
A. Yes.
Q. A gallbladder with a common duct that is not '
dilated, that's a normal gallbladder; true?
A. Well, not necessarily.

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Q. Why is that?
A. That statement – I may be confused, but if I
have an echo that shows no stones in the gallbladder and a
normal size common duct, then I'll say it's normal.
Q. Okay. So a gallbladder with a common duct that
is not dilated but has stones –

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A. Shows me that I have gallstones, but I have to
then equate the patient's symptoms with the gallstones.
There are many people walking around with gallstones that
don't have a symptom, and those are asymptomatic and I
wouldn't touch them.
Q. Right. So as long as there were symptoms of
gallstones and you had a patient that was – that was sick
like Dewey that you didn't want to risk further worsening
of the condition, then you would do surgery?
A. Yes.
Q. The cystic duct, that is patent?
A. Patent.
Q. Patent, excuse me. Is that normal? Does that
mean it's a normal duct?
A. It just means that the gallbladder is not
obstructed at its takeoff.
Q. Uh-huh.
A. And the fact that it's open, it's open. That's
all you can say at that point.
Q. Let's just focus on the role of all the doctors
here –
A. Okay.
Q. – to make sure that I understand what you feel
is going on. Dr. Ho the internist was called in to

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medically clear-Dewey Jones; true?
A. Right.
Q. And was he in charge of calling in any – all
the consults he felt necessary to medically clear?
A. I basically feel that he looked at the patient,
gave his opinion, and if he felt someone else needed to be
called in he would have either discussed it with a surgeon
or made a recommendation to have someone else brought in.
Q. He wasn't there to diagnose cholecystitis or

(10), cholelithiases?
(11) A. No. No, he was not.
(12) Q. So his job wasn't to determine whether there
(13) was alternatives to surgery?
(14) A. No.
(15) Q. Or whether surgery was indicated; true?
(16) A. No, absolutely not.
(17) Q. So his job is just to medically clear?
(18) A. Right.
(19) Q. Just – okay. And now Dr. Badri, his job was,
(20) if I – to medically clear the patient; also true?
(21) A. Actually what he did is evaluated Dewey, his
(22) symptoms, make a decision that he needed to have surgery,
(23) knew that he had medical problems, and asked Dr. Ho to come
(24) in and say, look, is this guy up for having surgery. And

(1) that's basically what he did and that was his job.
(2) Q. Okay. So his job was to call in another doctor
(3) and do what that doctor felt was medically appropriate?
(4) A. That's correct.
(5) Q. Okay. So he had no independent duty to get
(6) another consult if he felt it was necessary?
(7) A. If he was satisfied, and it sounds like he was,
(8) with what Dr. Ho said, then that's it. We go to surgery.
(9) Q. Okay. No further duty beyond that, period?
(10) A. I think he did what he thought was appropriate.
(11) Q. But his job was in the meantime from the 17th
(12) to the 20th was to diagnostically work up Dewey Jones for
(13) gallstones and determine the severity of it preoperative;
(14) is that a fair statement?
(15) A. That's a fair statement.
(16) Q. So he was the primary doctor of Dewey Jones
(17) from the 17th to the 20th?
(18) A. Yes.
(19) Q. Okay. And Ho called in – was called in and he
(20) medically cleared?
(21) A. Right.
(22) Q. And Badri determined that the gallbladder was
(23) bad enough to take Dewey to surgery?
(24) A. Correct.

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(1) Q. Correct? And it was at his determination –
(2) Badri's determination and responsibitity only to determine
(3) the approach such as what type of surgical approach to use
(4) or whether to hold off?
(5) A. Correct.
(6) Q. And Dr. Adamick, he was – he could have called
(7) in – he was the anesthesiologist. Could he have called in
(8) a consult if he felt it was necessary?
(9) MR. JONES: I'm going to object. At what
(10) point? Dr. Adamick, as I understand it, was involved at
(11) the time the surgery started or shortly after the induction
(12) started or whatever. So I just want to make sure that
(13) since you're limiting it oniy to Adamick –
(14) BY MR. ALLEN:
(15) Q. Yeah, just Dr. Adamick.
(16) A. Okay. All I know basically is the way most
(17) people function is anesthesia will see the patient that's
(18) an inpatient the night before, do an anesthesia note. If
(19) there's a problem they will call the surgeon and say, look,
(20) I want you to take a look at this guy, I think we need to
(21) stop and get "X" doctor to see him.
(22) Q. Okay.
(23) A. And apparently –
(24) Q. So the night before would be the time that

(1) anesthesia would decide whether *or* not –
(2) A. Well, that's the first.
(3) Q. Okay.
(4) A. They can also see him in the preop area and
(5) say, all right, we're not doing him, or we're going, or get
(6) a consult. They can't call one. They need to suggest that
(7) one is called.
(8) Q. They need to suggest it to the surgeon?
(9) A. Correct.
(10) Q. Okay. So they need to say, hey, surgeon, I
(11) think you need to do X, Y, Z?
(12) A. Right.
(13) Q. And but once the operation starts, it's their
(14) job then to monitor his vital signs, etcetera, in the
(15) operation?
(16) A. That's correct.
(17) Q. And their job obviously is not to

determine the
severity of gallstones or whether the gallbladder needed to
be operated on?
A. That's correct.
Q. Okay. And it's your understanding that Dr.
Adamick came in after anesthesia was started; correct?
A. From those notes, I just reviewed the notes, I
believe he came in halfway through or very early on. I

didn't pay extreme attention to who was doing what. I was
just looking at time lines.
Q. Just to clarify, you're not here to say whether
Dr. Adamick, Dr. Ho violated the standard of care or gave
appropriate care?
A. No, I'm not here - I'm not going to voice
those opinions.
Q. Okay. There could be intermittent pain with
biliary obstruction; true?
A. True.
Q. Okay. And the indication of previous
inflammation can occur in the gallbladder in the absence of
gallstones; true?
A. A calculus cholecystitis can cause problems,
yes.
Q. Okay. Is it your opinion that Dewey Jones's
hypertension was under control?
A. No.
Q. Okay. To be - have control of hypertension,
how would you define that?
A. Well, the patient has to be on medication, No.
1. That patient has to be taking that medication.
Q. Right.
A. And basically we'd like to see the patient

stable over a long period of time. But looking through
what we look through, Dewey was not that kind of patient.
Dewey had major problems with taking his medication, and he
was a noncompliant hypertensive that I don't think if we
kept him in the hospital two years Dewey would have his
blood pressure under control. I think he was just a very
difficult patient.
Q. So within the three days before surgery while
he was at the hospital, his blood pressure was not under
control; correct?
A. It was as best as I could see over the few
months period. It looks like they were getting it as well
as they were going to get it.
Q. Just from the 17th to the 20th, in your opinion
was Dewey Jones's blood pressure -
A. Let me just look at his file.
Q. - under control?
A. Let me just look at his file. For the most
part it looks like it's in decent shape. We've got the
17th he's 182/90 when he comes in. Then he's 168/90,
158/88, 124/90, 124/100, 132/92, 140/100. It's a systolic
problem but it's not terrible. So up until the time of
surgery, his blood pressure is, for what I would expect on
someone with his medications, decent, not excellent.

Q. Okay. But I guess I'm hung up on this word
controlled or not controlled.
A. Well, the thing is, we're talking about a
gentleman that comes in and he's 190/120, and nothing is
done and he's continuing to maintain this very bouncy blood
pressure, then he's poorly controlled.
Q. Right.
A. But here he is not excellent, but he's within
reason. And looking at those vitals I would take him to
surgery with those numbers.
Q. You can't categorize is it being controlled or
not controlled during that period; is that true?
A. Right. Yes.
Q. That's why we're going around like this.
A. Yes.
Q. Okay. All right. So in your opinion his blood
pressure within that time frame was not controlled or
controlled, but it was?
A. Acceptable.
Q. Acceptable. Okay. Acceptable for surgery?
A. Right.
Q. Okay. Hypertension will decrease with bed

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(23) rest; correct?
(24) A. Correct.

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(1) Q. A Swan-Ganz catheter can yield information as
(2) to the progression of pulmonary edema; true?
(3) A. In some cases.
(4) Q. When can it do that?
(5) A. In patients that don't have cor pulmonale for
(6) the most part. If you have end stage right heart failure
(7) your pulmonary artery pressures are so high that wedge
(8) pressures are almost indeterminate, therefore a Swan in
(9) Dewey's case would probably be nothing more than a large
(10) CVP and be rendered useless.
(11) Q. What would you use in Dewey's case to monitor
(12) –
(13) A. Basically the only thing you could do were
(14) progressive chest x-rays, auscultation, and maybe a central
(15) line, but that would be very, very difficult, because I
(16) think his opening pressures would be 30, 35. So it would
(17) be very hard to tell what margin of safety you have. He's
(18) a very difficult patient to monitor.
(19) Q. So you wouldn't have used the Swan-Ganz?
(20) A. No, definitely not.
(21) Q. The Swan-Ganz is not indicated because of his
(22) cor pulmonale?
(23) A. Cor pulmonale and end stage heart failure.
(24) It's just a very difficult thing to do.

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(1) Q. And that he could be monitored just as
(2) appropriate without it the way he was monitored in the
(3) operating room?
(4) A. I think so.
(5) Q. Is that true?
(6) A. Yes.
(7) Q. Okay. If his gallstones are asymptomatic does
(8) that then mean that he still could have gallbladder
(9) disease?
(10) A. No.
(11) Q. Okay. It's got *to* be symptomatic –
(12) A. If he has gallstones and he has no right upper
(13) quadrant pain, no nausea and vomiting, nothing, and we find
(14) doing some kind of echo on his heart that he's got

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(15) gallstones, then I would look everywhere else for a
(16) possible finding or something as to why he's having some
(17) problems. But with consistent nausea, vomiting and
(18) intermittent abdominal pain, this guy has got gallbladder
(19) disease, period.
(20) Q. Okay. But if they are asymptomatic?
(21) A. Then I –
(22) Q. You don't have gallbladder disease?
(23) A. Well, most likely not.
(24) Q. Okay. And CAT scans, CT scans can show the

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(1) presence of gallstones; right?
(2) A. They are terribly inaccurate.
(3) Q. How is that?
(4) A. Basically if the gallbladder is distended you
(5) can't see the stone.
(6) Q. Okay.
(7) A. And making a diagnosis on a CAT scan is very
(8) difficult. I mean, you may see a stone but they have got
(9) to be fairly big. You've got to remember that CAT scans
(10) pick up things quarter size or bigger, and a lot of stones
(11) are much smaller than that, you may not see.
(12) Q. Do you agree that there are other alternative
(13) treatments for cholecystitis that are less intrusive and
(14) less life-threatening than removing the gallstone –
(15) gallbladder?
(16) A. It depends. Such as?
(17) Q. Do you believe there are anything that's less,
(18) you know, life-threatening or less life

(19) A. Well, there are things that have been suggested
(20) over the years, but if I can't operate on you it's a
(21) problem. I've had people that have been elderly that we've
(22) tried to put tubes in, either percutaneous cholecystostomy
(23) or open cholecystostomy under local, but they don't – you
(24) know, if I'm going to take them to surgery to do that, I

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(1) might as well just open them and take out the gallbladder
(2) I don't believe in any of the dissolution
(3) agents. We haven't done ultrasound to break stones since

(4) 1991. The Actigall is toxic for card/heart patients, and
(5) that's a problem. There really isn't a whole bunch that I
(6) have seen. I've had a couple of gastroenterologists trying
(7) to put ethanol in, but I've taken the patient to surgery
(8) for a tremendous amount of pancreatitis and nearly lost the
(9) patient. So I feel that if we can take someone to the OR
(10) and take out their gallbladder that's still the best
(11) treatment.
(12) Q. In your opinion there was no other alternatives
(13) for Dewey that were less risky than putting him in surgery?
(14) A. I don't think so. I think his best shot was a
(15) good cholecystectomy.
(16) Q. And he was not a candidate for ultrasonic
(17) lithotripsy in your opinion?
(18) A. I don't think anyone was doing ultrasonic
(19) lithotripsy at that time. I think we had already abandoned
(20) it. I think his weight may have made it very, very
(21) difficult to do the lithotripsy, and I also think he would
(22) have had a hard time taking the Actigall.
(23) Q. And he was not a surgical - he was not a
(24) candidate for surgical chole -

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(1) A. Cholecystostomy.
(2) Q. - cystostomy.
(3) A. Being so large I would fear him having a leak.
(4) Q. Yeah.
(5) A. And if I was going to have to make an incision
(6) through Dewey to get down to his gallbladder, I might as
(7) well just take the gallbladder out.
(8) Q. And the risk there being the weight?
(9) A. He's a big guy.
(10) Q. And the tube coming out?
(11) A. Correct.
(12) Q. The risk of infection?
(13) A. Yes.
(14) Q. Okay. Anything else?
(15) A. Not really.
(16) Q. But you eliminate the risk of anesthesia;
(17) correct?
(18) A. Well, actually I would suspect that doing a
(19) local standby in Dewey with his size you still run a
(20) significant risk of him having

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tremendous pain, bucking,
(21) all kinds of problems, including aspiration. His head
(22) would have been way down compared to the rest of his chest,
(23) so he was a very, very difficult candidate looking at the
(24) whole gamut of what could have been done. The safest thing

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(1) for him would have been an endotracheal tube to prevent him
(2) from aspirating, going in and doing a very, very careful
(3) but quick cholecystectomy. And I think that's what they
(4) did, and I think they did a good job.
(5) Q. Dewey was at risk not so much for the
(6) gallbladder surgery but for any surgery; right?
(7) A. He was at risk for any procedure, period.
(8) Q. Okay.
(9) A. ERCP, whatever.
(10) Q. Would you categorize him as a high risk
(11) surgical patient?
(12) A. Yes, absolutely.
(13) Q. Very high risk?
(14) A. Yes.
(15) Q. Okay. So what makes him high risk is the
(16) previous congestive heart failure. What else?
(17) A. No cardiac reserve, pulmonary hypertension, the
(18) fact that he's had a TIA in the past which means his
(19) carotids are junk, he's had some previous surgery. I mean,
(20) he's really a time bomb, and anything could have pushed him
(21) over.
(22) Q. When was his previous surgeries?
(23) A. He had a gunshot wound many, many years ago in
(24) the remote past.

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(1) Q. Is it your opinion that there was surgery
(2) performed on him at that time?
(3) A. I think for gunshot wounds to the belly I think
(4) he had some adhesions. I'm trying to remember. He did
(5) have an exploration or something. I can't be 100 percent,
(6) but it was mentioned in H & P.
(7) Q. Okay. But if he had a previous surgery would
(8) that then put him at a higher risk for general surgery this
(9) time?
(10) A. No, not at all.

(11) Q. All right. So just the added surgery on top of
(12) the surgery being the span it was, that made no difference?
(13) A. No.
(14) (Discussion held off the record.)
(15) BY MR. ALLEN:
(16) Q. Okay. So in your opinion any of these
(17) alternatives, the success rates for these are low?
(18) A. Very low, plus his risk rate does not decrease
(19) with any of these procedures.
(20) Q. Okay. The risk rate of complication?
(21) A. Any complication.
(22) Q. Okay. And he wasn't a candidate for a
(23) sphincterectomy?
(24) A. No. That to my opinion was contraindicated.

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(1) Q. Okay. Now, of all the alternatives we've just
(2) talked about, have you ordered any of those? Have you ever
(3) done that; said, I think this patient doesn't need to be
(4) cut on, but do X, Y -
(5) A. I have done conservative management of several
(6) patients, but eventually have taken out their gallbladder.
(7) Q. What were the conservative managements that
(8) you've done; diet?
(9) A. It hasn't been diet. We had to wait for other
(10) co-morbidities to clear.
(11) Q. Okay.
(12) A. But as soon as they were ready we took them to
(13) surgery.
(14) Q. Okay.
(15) A. And I have not tried in anyone that has had
(16) symptomatic disease to let them delay. I've had one
(17) patient that had to go somewhere, we put him on a bland
(18) diet, he ended up flying back from Florida. You're dealing
(19) with patients that have symptomatic disease. As they get
(20) more and more attacks, closer and closer together, they are
(21) going to have one that's going to debilitate them. So I
(22) try not to coerce them into not having surgery, but I try
(23) to present the facts that, you've had three attacks, this
(24) puppy has got to come out.

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(1) Q. All right. So his - Dewey's

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symptoms in your
(2) opinion from the 17th to the 20th, were they worsening
(3) during that time frame?
(4) A. He wasn't getting better.
(5) Q. They weren't getting better?
(6) A. That's correct.
(7) Q. But it wasn't worsening; correct?
(8) A. No, it wasn't worsening.
(9) Q. Okay. And during that time frame did you see
(10) where he was able to eat?
(11) A. I don't - I know they offered him diet twice,
(12) but the nurses' notes were so sketchy I really have no idea
(13) what happened as far as diet.
(14) Q. If he was able to eat and was keeping food
(15) down, would that tell you that he was getting better?
(16) A. He's probably getting a little bit better, but
(17) that doesn't mean that the moment I send him out he's not
(18) going to be coming right back, in which is the risk. And
(19) as long as I have him in the hospital and he is better,
(20) which means he's probably going to be able to tolerate the
(21) surgery better, I like to operate on patients that are
(22) asymptomatic after they have had an attack.
(23) (Discussion held off the record.)
(24) BY MR. ALLEN:

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(1) Q. In Dewey's case the risk of surgery for him was
(2) general surgery under general anesthesia?
(3) A. That's correct.
(4) Q. Okay. Do you believe that the amount of blood
(5) loss of 400 cc's intraoperatively was excessive?
(6) A. No, not at all.
(7) Q. What would you call an excessive amount of
(8) blood loss in Dewey's case?
(9) A. In Dewey's case somewhere between 750 and 1,200
(10) would have been a little bit more than I would have
(11) expected.
(12) Q. Okay. Can you tell me if a Swan-Ganz catheter
(13) was placed? And you can look at the records at 11:00
(14) o'clock - excuse me, 12:00 o'clock that morning of
(15) surgery. Can you tell me what wedge pressures would have
(16) shown?
(17) A. If at 12:30 -

(18) Q. Well, no, at 12:00.
(19) A. All right. During the operation?
(20) Q. Right.
(21) A. Most likely his wedge pressures would have been
(22) very high, about 35. And the reason I'm saying that is
(23) just from knowing his underlying heart disease, Swans are
(24) very notorious for not being able to pick up. I mean, he's

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(1) got a stiff lung from his base line. You and I would have
(2) a normal, maybe eight to ten, but someone with end stage
(3) right heart failure, we're talking high 20's, low 30's is
(4) their normal base line. So if he goes into pulmonary edema
(5) at 33, which is one over what his base line is, he's just
(6) that fragile, and a Swan probably would have held it.
(7) Q. So do you have an opinion that he could have
(8) gone to pulmonary edema?
(9) A. He could have gone to pulmonary edema at any
(10) time.
(11) Q. Any time?
(12) A. Any time from anything.
(13) Q. From anything?
(14) A. Right. He was that fragile.
(15) Q. Okay. And the fluid being administered to him,
(16) would that precipitate -
(17) A. With an open abdomen and a 400 cc blood loss,
(18) the tube, I think they give him 2,100 cc's, probably was
(19) negligible. I mean, that would have been normal
(20) replacement for an open abdomen, irrespective of his
(21) heart. I don't think that would have been the problem.
(22) Q. Would the Swan-Ganz have helped to determine
(23) that?
(24) A. I really don't think so. I think our pressures

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(1) would have been so high it would have been uninterpretable.
(2) Q. Have you used Swan-Ganz before?
(3) A. Oh, yeah. Constantly.
(4) Q. Why do you use them?
(5) A. I use them on patients that are septic, that
(6) have tremendously high cardiac outputs From the
(7) hypersepsis, and almost a vasoplegia in which no matter how
(8) much fluid we put in, we can't

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keep them full. So we're
(9) giving them Dopamine, Dobutamine, other pressor agents, and
(10) we're trying to measure cardiac output and heart failure.
(11) Also on my trauma patients we put in,
(12) especially those that are so banged up, that I want to make
(13) sure that I got the - I'm keeping all the fluid where it's
(14) supposed to be. Patients with ARDS I try to keep a Swan in
(15) them because I know I'm going up on higher and higher
(16) levels of PEEP, and I want to see when my filling pressures
(17) are being comprised by the intrathoracic pressure. Those
(18) are the patients I use them on.
(19) Q. But with that cor pulmonale you wouldn't use
(20) it?
(21) A. I think it's uninterpretable.
(22) Q. You haven't used them on a patient with cor
(23) pulmonale?
(24) A. No, no.

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(1) Q. And you haven't used them on a patient with
(2) congestive heart failure?
(3) A. Usually we don't have to, unless there's some
(4) other underlying possibility. Most of the time they are
(5) older folks that we know about and we just keep them on a
(6) monitor and just watch their response. Especially if we
(7) have them on a ventilator we can see frothiness, we can
(8) listen to them and we can see what the diuresis is doing
(9) with chest x-rays. So I prefer not to put a line in some
(10) of these people if I don't have to.
(11) Q. So other than sepsis, trauma, ARDS, do you use
(12) them for anything else?
(13) A. I don't, no.
(14) Q. Okay. Did Dewey have - did Dewey have chronic
(15) obstructive pulmonary disease?
(16) A. I believe what he had was end stage pulmonary
(17) hypertension. It's not truly chronic obstructive lung
(18) disease which is an alveoli phenomenon. But the lungs from
(19) having this tremendous amount of pressure within the
(20) vascular tree made them stiff, and again, they act like a
(21) chronic lung.
(22) Q. The fact that it acts like a chronic

lung.
(23) problem would then increase the risk of surgery like COPD?
(24) A. Well, the risk of COPD people are retaining C02

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(1) when they are on a vent. That's their main risk. Or if
(2) they have a blood - with hyper pressure, you blow the
(3) blood out and they get hemothorax.
(4) His case was as long as they can keep him
(5) saturated while on the vent, he's fine. He tends to
(6) desaturate fairly quickly when he gets into trouble, **so**
(7) it's just a matter of airway protection and proper
(8) ventilation during the operation. He's at no higher risk
(9) for that.
(10) His problem is heart. Can he handle fluid.
(11) And with a stiff lung it's one of these very, very fine
(12) lines. He usually can't handle any fluid above and beyond
(13) what's normal, and you don't know what that number is.
(14) Q. So you wouldn't rate the increased risk of
(15) surgery with Dewey Jones with a patient that had COPD?
(16) A. No.
(17) Q. The difference being?
(18) A. Their heart works, his doesn't.
(19) Q. Okay. And would the fact that his heart
(20) doesn't work, would that then increase the risk of surgery?
(21) A. Sure.
(22) Q. Okay. So what would you expect over a normal
(23) patient the risk of surgery would increase; 30 percent, 40
(24) percent?

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(1) A. He's probably 40 percent higher risk than most
(2) - a normal gallbladder.
(3) Q. So if you had a normal heart and COPD, the risk
(4) would increase by what?
(5) A. He would be about 10 percent higher.
(6) Q. Why does Dewey have stones? Is there -
(7) A. Why? Because he's fat. Excuse me. He's
(8) heavy. He's probably been on some medications. His diet
(9) probably stinks. And he's got stones. So no one really
(10) knows -

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(11) Q. So you see a correlation between diet and
(12) weight and gallstones?
(13) A. Sure.
(14) Q. And you believe the literature agrees with you?
(15) A. Sometimes, yeah. No one knows, really knows
(16) why you get gallstones, but if you're heavy you've got
(17) gallstones most likely. Just be fat and 40 and fertile and
(18) female. But Dewey kind of breaks the mold there a little
(19) bit.
(20) Q. And then he became symptomatic in your opinion
(21) back in September?
(22) A. Probably, yes.
(23) Q. And then -
(24) A. Aaain in October.

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(1) Q. In one way it got better, then early October -
(2) A. And then -
(3) Q. And then that gastritis admission was an
(4) inflammation event, and then it got worse on the 17th?
(5) A. Right.
(6) Q. Correct. On admission, just - if you could
(7) list for me the risk factors Dewey Jones had for surgery.
(8) I mean, we have - he's got history of congestive heart
(9) failure.
(10) A. Correct.
(11) Q. History of hypertension; correct?
(12) A. Right.
(13) Q. Uncontrolled hypertension?
(14) A. Poorly controlled.
(15) Q. Poorly controlled hypertension. History of
(16) cardiomegaly?
(17) A. Yes.
(18) Q. History of maybe hypotrophic cardiomyopathy?
(19) A. Correct.
(20) Q. He's got end stage heart failure?
(21) A. Yes.
(22) Q. And you define that as what?
(23) A. Basically his heart has very, very little
(24) capacity reserve to do anything. It will not expand along

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(1) Starling's curve when there is stress on the heart; in
(2) other words, his chambers are pretty much fixed. What
(3) you've described is a dead heart.
(4) Q. Okay. Then he's got a history of chronic
(5) stasis; is that true?
(6) A. Stasis of? He's morbidly obese.

(7) Q. Okay. Morbidly obese.
(8) A. He's had a TIA in the past, which most likely
(9) means that not only does he have a crappy heart, but he's
(10) 'got significant peripheral vascular disease, especially
(11) central circulation. There's no doubt Dewey is a time
(12) bomb.
(13) Q. He's noncompliant?
(14) A. He's noncompliant with meds, he's still bigger
(15) than a house, and now he has nausea, vomiting and he's got
(16) abdominal pain. We've got a definite problem. I mean,
(17) that is a tightrope for anybody to walk.
(18) Q. Okay. And you've seen patients that were
(19) noncompliant but become compliant; true?
(20) A. No.
(21) Q. Never seen that happen?
(22) A. No. 95 percent of the time if they are
(23) noncompliant they are noncompliant for the rest -
(24) Q. The illness got worse, they don't have a coming

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(1) to Jesus or anything?
(2) A. Not here. I mean, this is - we're talking
(3) about I'm in a small inner-city hospital, and we have - I
(4) must have 30 or 40 Deweys, and, you know, blood pressure -
(5) oh, yeah, Doc, I'll be fine. You know, it's the same thing
(6) when you go to the VA, the guy that's got the lung cancer
(7) and the trach and he's sitting there smoking a cigarette
(8) through his trach. If they are noncompliant, not even the
(9) fear of God is going to make these people compliant. Dewey
(10) is Dewey.
(11) Q. You've never seen that happen, a patient become
(12) compliant?
(13) A. No, not in my practice.
(14) Q. Okay. Did Dewey have a previous myocardial
(15) infarction?
(16) A. I don't know if he's had a myocardial infarct
(17) in the past.
(18) Q. TIA.
(19) A. TIA is something completely - that's a
(20) transient ischemic attack. It's a small stroke.
(21) Q. Small stroke. Now, there were -

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(22) (Discussion held off the record.)
(23) BY MR. ALLEN:
(24) Q. He had two echoes done; he had one done in

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(1) August and one done in October '94; correct?
(2) A. September or - I think it's September.
(3) Q. Of the heart?
(4) A. Of the heart, yes. He had an August one.
(5) Q. Okay.
(6) A. Right.
(7) Q. Do you - can you read echoes? Do you have any
(8) opinion as to whether or not -
(9) A. I have not -
(10) Q. August or October -
(11) A. I have not read the cardiac echo, but I can
(12) read echoes.
(13) Q. You can read echoes. And are you expecting to
(14) come in at trial and to look at the two echoes -
(15) A. I hope not.
(16) Q. - and say I believe "X"?
(17) A. No, I hope not.
(18) Q. Okay.
(19) MR. JONES: I guarantee if the Doctor hopes he
(20) doesn't have to give an opinion I'm not going to ask for
(21) such an opinion.
(22) THE WITNESS: Please.
(23) BY MR. ALLEN:
(24) Q. Do you believe that the standard of care

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(1) requires for any patient before you go in and you - and
(2) you attempt surgery for removal of the gallbladder that you
(3) determine whether or not the patient has a cystic duct
(4) obstruction?
(5) A. No.
(6) Q. Or any kind of obstruction?
(7) A. No, none at all.
(8) Q. So in a normal, everyday walk-around person,
(9) would that be the indication of whether or not to remove
(10) the gallbladder?
(11) A. No. The indication in a patient is symptoms
(12) consistent with biliary tract disease.
(13) Q. Okay.
(14) A. And an echo showing gallstones.
(15) Q. Okay. So determining whether or not there is
(16) obstruction anywhere in the gallbladder or biliary tract is

(17) not a determination as to whether or not you should operate
(18) on a patient?
(19) A. No. It's the degree of surgery that it
(20) determines.
(21) Q. The degree of, I'm sorry?
(22) A. It's the degree of surgery; what I'm going to
(23) do is going to be based on the presentation.
(24) Q. All riaht.

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(1) A. If they are jaundiced, there's obstructive
(2) jaundice, I'm going to do operation "X". If they come into
(3) the office and say, look, Doc, I gas bloat, I have pain
(4) here; I take them down, they have an echo, it show stones
(5) in the gallbladder, the gallbladder is out of here. It's
(6) not a trumpet, it's just full of stones and they are having
(7) symptoms related to biliary colic.
(8) Q. So the worst of symptoms more likely you will
(9) pull the gallbladder?
(10) A. Correct.
(11) Q. Okay. So the degree of whether or not there's
(12) obstruction doesn't really come into play?
(13) A. No, not at all.
(14) Q. Okay, All right, And do you feel in Mr. Dewey
(15) Jones's case that an echo, a HIDA or oral cholecystogram,
(16) either one of those should have been done before operation?
(17) A. He had the echo.
(18) Q. He had the echo.
(19) A. Which is a repeat and confirmatory echo of his
(20) previous echo done in September showing that he had stones.
(21) Q. Right.
(22) A. And based on nausea, vomiting and intermittent
(23) abdominal pain, I came to the same conclusion as our
(24) surgeon, that he had symptomatic aallbladder disease and

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(1) was an indication for surgery.
(2) Q. And so there was no need to go any further than
(3) that?
(4) A. No. Not in my opinion, no.
(5) Q. Did they even have to go the echo?
(6) A. Yeah.
(7) Q. Okay. He had at least to go the echo?
(8) A. Yes.

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(9) Q. Why?
(10) A. Based on the liver function test.
(11) Q. Okay.
(12) A. It basically ruled out biliary tract
(13) obstruction, and it also made him feel better, at least it
(14) did me when I read this, that most likely his liver
(15) function tests were coming from his liver rather than
(16) obstruction, and I could do a much simpler operation.
(17) Q. So his bilirubin levels were low; is that what
(18) you're saying?
(19) A. They were 2.1.
(20) Q. 2.1 -
(21) A. Which is abnormal. But if I have a common duct
(22) stone, the bilirubin is coming from the obstruction. If I
(23) have a normal common bile duct and stones in my gallbladder
(24) and I know I have a sick patient that's had heart failure

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(1) in the past, it's hepatic.
(2) Q. Okay.
(3) A. So I don't have to explore his common duct. I
(4) don't have to subject him to a possible ERCP. I can just
(5) go in, take care of business, and go home.
(6) Q. Okay, This is a little different question,
(7) but -
(8) A. Please.
(9) Q. - due to the fact that I am a lawyer, you have
(10) to walk around every stone. But could Dr. Badri have
(11) performed any alternatives on Dewey Jones?
(12) A. I don't think he would have or should have.
(13) Q. But he could have; correct?
(14) A. Well, the only thing that he could have done -
(15) Q. Right.
(16) A. - would have been the cholecystostomy, and I
(17) think that would have been poorly tolerated and fraught
(18) with complication.
(19) Q. All others -
(20) A. All others I would dismiss.
(21) Q. Wouldn't even be a possibility?
(22) A. I wouldn't even think of it. I don't think
(23) they were available and they were dangerous.
(24) Q. Okay. And he could have placed a Swan-Ganz

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(1) catheter. There's nothing on Dewey

that made it impossible
(2) to place a Swan-Ganz?
(3) A. Well, I would suspect that the risk of placing
(4) a Swan far outweighed its benefit; pneumothorax, bleeding,
(5) intraarterial stick. Dewey is not a small guy. No
(6) landmarks. Been there, done that. And I don't think it
(7) was worth it if they weren't going to be using it for
(8) monitoring appropriately.
(9) Q. If the higher risk the patient is for surgery,
(10) is there a correlation between that and investigation of
(11) whether or not there's an obstruction?
(12) A. No.
(13) Q. Okay. So those don't come into play?
(14) A. The only thing that would come into play is the
(15) first line of any workup is the echo. If there is any
(16) question that the echo, especially the intrahepatic ducts
(17) is abnormal, then we can move to step two.
(18) But in this case there is nothing abnormal. We
(19) just have gallstones. And the wait is when do you do the
(20) surgery, and the surgery is done when the guy is ready, and
(21) it looked like the guy was ready on the 20th to take him to
(22) surgery.
(23) Q. Okay. Just go ahead and mark it as an exhibit,
(24) how is that? We're going *to* mark as the first exhibit the

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(1) opinion letter.
(2) A. The letter, sure.
(3) - - -
(4) And, thereupon, Exhibit No. 1 was marked
(5) for purposes of identification.
(6) - - -
(7) BY MR. ALLEN:
(8) Q. So Exhibit 1 you just – you wrote this on the
(9) 11th of April, obviously.
(10) A. Correct.
(11) Q. Just a few questions here. You – it says
(12) first line, you reviewed several expert letters. Which
(13) ones did you review before you formulated this letter? Did
(14) you review all the –
(15) A. I'll get them for you. I'll get them for you,
(16) I have Charles R. Greenhouse,

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M.D., D.I.M. I've got, let's
(17) see – who is this guy? This is Alvin I. Kahn, K-a-h-n,
(18) M.D., F.A.C.P. I've got Marshall O-r-l-o-f-f, Orloff, M.D.
(19) I have Joseph Gibson Bussey, B-u-s-s-e-y, M.D., F.A.C.S.
(20) I have got Robert Greendyke, G-r-e-e-n-d-y-k-e, M. D. And
(21) last but not least, Francis C. Barnes, M.D., F.A.C.S.
(22) Q. You know any of these doctors?
(23) A. Yeah.
(24) Q. Which ones do you know?

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(1) A. I have heard and have seen Dr. Orloff perform
(2) portacaval shunts as a visiting professor at Ohio State.
(3) And Francis Barnes.
(4) Q. Okay. Francis is –
(5) A. Local.
(6) Q. – around here. Is he a well-trained doctor?
(7) A. He's well trained.
(8) Q. Is he good – do you have any opinions of
(9) whether he's a good doctor?
(10) A. I am staying away from that, please.
(11) Q. Okay. All right. Now, other than as just in
(12) passing professional organizations, do you know Dr. Barnes
(13) in any other way?
(14) A. No.
(15) Q. Other than Dr. Orloff coming to your school
(16) when you were a resident, is that right, a resident or –
(17) A. That's correct.
(18) Q. Have you had any other interaction with Dr.
(19) Orloff?
(20) A. No. No, I have not.
(21) Q. So you know he's pretty well respected –
(22) A. Yes.
(23) Q. – in the field. Now, tell me, those are the
(24) only letters that you wrote?

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(1) A. Yeah.
(2) Q. For our case?
(3) A. That's correct.
(4) Q. All right. You said he had some chronic
(5) obstructive lung disease as well as sleep apnea. Do you
(6) see that?
(7) A. Sleep apnea, I saw that, yes.
(8) Q. Okay. So the chronic obstructive lung disease
(9) as well as – how is that different than –
(10) A. It doesn't. It was just what I was

bringing up
from reading other histories.
Q. Okay.
A. These were the things that were mentioned. It
really doesn't make a difference because the guy has – the
heart is his limiting factor.
Q. I understand that, but, I mean, does he have or
does he not have chronic obstructive heart disease?
A. That was mentioned. What he has is sleep
apnea. That's his biggest problem.
Q. So that was in correlation, the fact he had the
sleep apnea?
A. Right.
Q. And the sleep apnea is a problem because it
increases his risk under anesthesia?

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A. Well, no. His problem with sleep apnea is this
guy just conks out because he is so large.
Q. Right.
A. And his tongue and whatever else is in the back
of his throat obstructs his airway. It's an obstructive
disease.
Q. He's at risk for obstruction?
A. Just sitting up or lying down. I mean, this
guy can just go out at any time.
Q. A high increased risk of obstruction under
anesthesia?
A. No, because if –
Q. During extubation?
A. Extubation possibly.
Q. He's at a higher risk at the time of
extubation?
A. Oh, yes, true.
Q. So the chronic obstructive lung disease that
you talk about in your opinion tetter is only in
correlation with the sleep apnea?
A. That's right.
Q. But he does have it, does he not?
A. I'm sure he does.
Q. Okay. Now, TIA with some residual, what do you

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mean by that?
A. He had some weakness left, some motor weakness.
Q. Okay. Okay. I've asked you most of these
questions. Just kind of –
A. Yeah.
Q. So on October 17th you said he came to Meridia
Huron Hospital emergency room with intermittent abdominal
pain; correct?
A. Correct.
Q. So he was not in a constant state of pain?
A. No.
Q. Okay. Does that indicate anything as far as
the severity of his disease?
A. Well, what it's basically saying is the man has
what I consider symptomatic gallbladder disease, and by
nature and definition it's intermittent biliary colic, and
that's how it is. It comes and goes. And its frequency –
as it becomes more and more frequent you get more and more
concerned that he's having more and more problems.
Q. And you're concerned with the symptoms of Dewey
Jones developing into an acute cholecystitis; correct?
A. Yes.
Q. Because he doesn't have fever and he doesn't
have the low blood count?

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A. Not at this point.
Q. Not at this point, but he is – your opinion
with the fact he's three previous admissions –
A. Right.
Q. Including this one.
A. Right.
Q. Three admissions that he's –
A. He's on the road –
Q. Right around the corner from acute?
A. That's correct.
Q. Okay. Are you – in a patient with
hypertension, putting – taking them off their meds,
hypertension meds the night before surgery, that's not a
good thing, is it?
A. It's not infrequently done.
Q. Okay.
A. The combination of medications that are being
given during the surgery sometimes have a secondary and
nefarious effect on normal preparations such as some of the
medications he's on, and we do it constantly with our
hypertensives. They are taken off most of their
medications the night before and come in and we will give
them either sublingual Procardia

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or start them on IV
(24) medication as soon as they are brought to the room. But

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(1) anything that's putting you to sleep, any of the paralyzing
(2) agents, will just bottom you out completely if you're on
(3) your hypertensive medications.
(4) Q. So there was no need to continue Dewey's the
(5) night before?
(6) A. Not the night before, no.
(7) Q. Okay. The urgency to remove this gallbladder
(8) was based upon nausea, vomiting and three previous
(9) admissions with the same; that's it?
(10) A. The thing is we need to discuss urgency.
(11) Q. Okay.
(12) A. Now, urgency to me is a patient that has a
(13) life-threatening situation that goes to surgery within 24
(14) hours of the admission.
(15) Q. Right.
(16) A. That's urgent. He went several days down the
(17) road. This was still in my opinion elective.
(18) Q. Okay.
(19) A. The reason to take out his gallbladder at this
(20) setting is exactly what you said, that he has three
(21) previous and getting closer together episodes of nausea,
(22) vomiting and abdominal pain, therefore he's in, we're
(23) getting him ready to go, and we go to surgery.
(24) Q. Okay. So from the admission to the 20th was

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(1) spent basically getting him as good as he could get?
(2) A. I think so.
(3) Q. Okay. The patient was coming out - you said
(4) the patient was coming out of anesthesia when he developed
(5) an acute onset of pulmonary edema, became hypoxic and
(6) arrested.
(7) A. Right.
(8) Q. Do you stand by that?
(9) A. Well, basically from - I only have anesthesia
(10) records to look at which are sketchy.
(11) Q. All right.
(12) A. And all I know is that he was still in the OR,
(13) an event happened, and I'm suspecting it was pulmonary

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(14) edema again.
(15) Q. Well, the records are pretty replete that it
(16) was pulmonary edema.
(17) A. Right, right.
(18) Q. So it would be more likely that it was
(19) pulmonary edema, and then you develop heart problems and
(20) then hypoxia?
(21) A. However it's put together, it's a catastrophic
(22) event.
(23) Q. At the same time.
(24) A. Right.

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(1) Q. Okay. But you're not - you're not going to
(2) testify that "X" happened and then "Y" happened, and then
(3) this causes brain damage?
(4) A. My review of this stops pretty much when my
(5) surgeon leaves the OR to go talk to the family.
(6) Q. But he comes back and helps?
(7) A. He comes back after, I don't know how you can
(8) put this, the shit hits the fan.
(9) Q. Okay.
(10) A. I don't know a graceful other way. He is out,
(11) things happen, and he comes back in to help.
(12) Q. Okay. But do you agree with me he would have
(13) never - he coded; right?
(14) A. Oh, he coded, yeah.
(15) Q. He would have never coded had he not been
(16) operated on?
(17) A. No. There's no way you can say that.
(18) Q. Why?
(19) A. He could have coded any time, any place, any
(20) where. This guy is a walking time bomb. I mean, he could
(21) have had sleep apnea at home, coded. He could have been
(22) sitting up and had something to drink, coded. He is that
(23) fragile. You know, the fact that he had surgery - he got
(24) through the operation, the operation is done, they are

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(1) closing.
(2) Something happened between the time that our
(3) surgeon left and came back in. What that is, I haven't the
(4) foggiest idea. But if he was really in dire straits, they
(5) never would have been able to induce him. He never would

(15) A. Basically he had absolutely no cardiac reserve.
(16) Q. Okay.
(17) A. His heart was stiff.
(18) Q. Due to?
(19) A. Just due to his cardiomyopathy. It was
(20) hypertrophic which meant it was not elastic whatsoever. He
(21) had high, high pulmonary filling pressures. So any shock
(22) to the system could put him in fulminant pulmonary edema
(23) within a matter of milliseconds.
(24) Q. Was he at high risk for developing cardiac

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(1) arrest or collapse?
(2) A. Again, he had no reserve, so any insult to any
(3) system could put this guy over into an arrest situation.
(4) Q. Because of the heart?
(5) A. His heart. He had one myocardial cell left.
(6) Q. I'm sorry?
(7) A. He had only one - no, you can strike that. He
(8) just was sick. He had a dead heart.
(9) Q. All right. Now, he have given - Dewey was
(10) given oxygen before surgery?
(11) A. Yeah.
(12) Q. Why was he given oxygen?
(13) A. I have no idea.
(14) Q. Is it done consistently by you?
(15) A. No, it's not. But I don't see any order, nor
(16) do I see any change in his saturations. I mean, the guy is
(17) running 96, 97 percent sat when aroused on the floor, so I
(18) don't know who wrote or gave the 02, and I don't see any
(19) change in his saturations.
(20) Q. Okay. So giving him the 02 didn't make any
(21) difference?
(22) A. I don't think so, because I can't find the
(23) reason why the wherefor or a change in his 02 sats as
(24) recorded in the nurses' notes. There's one note that he's

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(1) sleeping soundly and has an 87 percent sat, but when they
(2) arouse him he's up to 97. So the 02 was superfluous. I
(3) don't see a reason for it.
(4) Q. Okay. So whether or not Dr. Badri, Dr. Adamick
(5) or anybody knew that he was on oxygen, secondary oxygen
(6) before surgery, just doesn't matter?

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(7) A. With an airway control it probably wouldn't
(8) have mattered, no.
(9) Q. Okay. Do you ever put patients on secondary 02
(10) before you go to surgery?
(11) A. Some patients do need it, yes.
(12) Q. And why would that be?
(13) A. Old chronic lungers, anxiety, sometimes they
(14) get hyped, they get tired. We put them on just to ease
(15) them, make them relax a little bit.
(16) Q. Okay. Did Dewey have any signs of jaundice
(17) according to the records?
(18) A. Someone in the ER said he had injected icteric
(19) sclera.
(20) Q. Which is the eyes?
(21) A. Just the eyes. But, you know, I've taken care
(22) of a multitude of Afro-Americans that have had injected
(23) sclera and it really was not much an a finding with normal
(24) bilirubin. So I just think that was an aberrant finding

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(1) that had no clinical value.
(2) Q. Okay. And there's no way to quantitate a risk
(3) or the risk for developing biliary obstruction with Dewey
(4) Jones; true?
(5) A. No.
(6) Q. Okay. There was no HIDA scan done; correct?
(7) A. Correct.
(8) Q. There was no oral cholecystogram; correct?
(9) A. That's correct.
(10) Q. There was an echo done; correct?
(11) A. Yes.
(12) Q. For the gallstones. And was there a CT scan
(13) done?
(14) A. I don't remember if they did a CT. I would
(15) kind of doubt it due to his size.
(16) Q. Do you have an opinion as to whether or not
(17) Dewey Jones was extubated?
(18) A. I can't tell that from the records. I really
(19) can't.
(20) Q. Okay.
(21) A. I really can't.
(22) Q. Have you read things that he wasn't extubated
(23) and some records indicate that he may have been extubated?
(24) A. I know where we're going with this.

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(1) Q. Yeah.

(2) A. It's all over. I just can't tell.
(3) Q. Okay.
(4) A. I can't tell.
(5) Q. And that doesn't have any effect on your
(6) opinions because you ain't giving opinions of that point?
(7) A. Well, I can't give an opinion, I just don't
(8) have enough data -
(9) Q. All right.
(10) A. - to say anything. All we know is something
(11) happened and I just don't know what it is.
(12) Q. Do you agree with me that the term extubation
(13) is a specific term meaning pulling a tube out?
(14) A. Yes.
(15) Q. It's not a process, but a term; correct?
(16) A. Correct. At least that's my belief.
(17) Q. Okay. Do you know anybody that believes that
(18) extubation is a process?
(19) MR. JONES: Objection.
(20) A. I can't answer that.
(21) Q. You don't -
(22) A. I don't even -
(23) Q. You don't walk around using that in this
(24) hospital; correct?

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(1) A. No.
(2) Q. You've got obviously no opinions on life
(3) expectancy.
(4) A. No. I can't even begin to guess.
(5) Q. What did the role of the TIA *or* the ischemic
(6) attack have on his condition before surgery?
(7) A. It probably had none.
(8) Q. Okay.
(9) A, It just showed that he was really poor
(10) protoplasm to begin with.
(11) Q. Okay. And you have no opinion of what caused
(12) the pulmonary edema?
(13) A. No, I do not.
(14) Q. Okay, Do you have an opinion that he was in
(15) active congestive heart failure prior to surgery?
(16) A. I didn't see any evidence of active congestive
(17) heart failure.
(18) Q. Are you going to give any opinion at trial that
(19) he was in active - or not active -
(20) A. I'll answer questions, but -
(21) MR. JONES: He just answered your question. He

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(22) didn't see any evidence of it.
(23) A. I didn't see any evidence of it.
(24) Q. Okay. Well, I guess I was thinking about the

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(1) echo, the echo - if you looked at the echo.
(2) A. I did not look at the echo, the second echo, so
(3) I really can't tell you, which is based on nurses' notes.
(4) I didn't see any evidence of active pulmonary edema or
(5) chronic failure preoperatively.
(6) Q. And just in day-to-day, everyday activity, he
(7) is at risk for going into active -
(8) A. Oh, yes. He was at risk for dying.
(9) Q. All right. You're board certified; correct,
(10) Doctor?
(11) A. Correct.
(12) Q. Okay. And why are you board certified?
(13) A. In order to become a general surgeon in an
(14) approved program the next logical step once you finish
(15) training is board certification for recognition that you
(16) are a capable and able surgeon.
(17) Q. Do you teach?
(18) A. I teach.
(19) Q. And does the hospital have protocol that all
(20) teaching surgeons be board certified?
(21) A. Not at this institution, no.
(22) Q. But are all teaching physicians or surgeons
(23) that you know of board certified?
(24) A. Yes.

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(1) Q. Okay. Have you ever had surgery yourself?
(2) A. Yes.
(3) Q. Was it performed by a board certified surgeon?
(4) A. Yes.
(5) MR. JONES: Objection.
(6) BY MR. ALLEN:
(7) Q. Would you ever have a surgery that was done by
(8) a non-board certified surgeon?
(9) MR. JONES: Objection.
(10) A. Most surgeons today are board certified.
(11) Q. But you wouldn't put yourself under the knife
(12) of a non-certified board surgeon; true?
(13) A. It would have to be, you know, someone that I
(14) knew and respected, irrespective of their board status.

(1a) **It's a hard question to answer.**
(16) Q. Okay. Would you allow your family –
(17) MR. JONES: Objection. Stop. Don't answer.
(18) Move on.
(19) MR. ALLEN: Same –
(20) MR. JONES: Ridiculous.
(21) MR. ALLEN: Same answer goes for your –
(22) MR. JONES: Objection. Don't answer.
(23) THE WITNESS: I'm obeying my attorney.
(24) MR. ALLEN: Obeying your attorney.

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(1) MR. JONES: He'll obey this one. This is
(2) ridiculous. Move on.
(3) BY MR. ALLEN:
(4) Q. You ever had a family member or close relative
(5) go into a coma?
(6) MR. JONES: Objection. Don't answer that
(7) question, Doctor. You're not going into that.
(8) THE WITNESS: No, I have not.
(9) MR. ALLEN: Why can't I ask him that?
(10) MR. JONES: You can't ask him about his
(11) personal experience with his own family members.
(12) MR. ALLEN: Why?
(13) MR. JONES: That has absolutely no relevance to
(14) his opinions in this case. You tell me where it's relevant
(15) –
(16) MR. ALLEN: He can tell me if that has any –
(17) MR. JONES: No, no. You tell me what possible
(18) relevance –
(19) THE WITNESS: No.
(20) MR. JONES: I don't care what the answer is,
(21) Doctor, whether you have or you haven't. This is getting
(22) – this is becoming – this is a start of something that
(23) we're going to put a stop to right now. You're not asking
(24) the doctor about his personal health history any more or

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(1) his family's health history. It has absolutely no
(2) relevance *to* any of the issues in this case, nor to the
(3) doctor's opinions in this case.
(4) BY MR. ALLEN:
(5) Q. All right. Doctor, have you ever had a patient
(6) go into a coma after operating on

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him?
(7) **A. Yes.**
(8) Q. Okay. Now, have you ever advocated that the
(9) patient – to pull the plug of the patient in a coma?
(10) **A. I have talked to families about no code status,**
(11) **and in certain cases we have gotten into the situation**
(12) **where the quality of life was so poor and the prognosis was**
(13) **so poor that we've actually taken them off the ventilator,**
(14) **yes.**
(15) Q. And you advocated taking them off the
(16) ventilator?
(17) **A. Yes.**
(18) Q. When was the last time that was done?
(19) **A. Three weeks ago.**
(20) **Q.** And I believe there was the quality of life –
(21) **A. Yes.**
(22) **Q.** Have you ever witnessed a doctor performing
(23) malpractice or breach the standard of care?
(24) **A. No.**

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(1) MR. JONES: objection.
(2) BY MR. ALLEN:
(3) Q. Are you a shareholder in – or who is your
(4) insurance company?
(5) A. OHIC.
(6) Q. So you don't have any relation to any insureds
(7) in this case; correct?
(8) **A. No.**
(9) Q. Do you know any of the doctors – any doctors
(10) at Meridia Huron Hospital?
(11) **A. No, I do not.**
(12) **Q.** Okay. You ever met any of the attorneys
(13) involved in this case before this case was involved?
(14) **A. No, I have not.**
(15) Q. Do you know all the attorneys?
(16) **A. I just know him now, and I just met you.**
(17) **That's about it.**
(18) Q. Okay. How about Susan Rancor?
(19) **A. No.**
(20) Q. Jim Casey?
(21) **A. No.**
(22) Q. Steve Waiker, Jim Mallone?
(23) **A. No.**
(24) Q. Bill Meadows. Okay.

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(1) MR. JONES: Bill is no longer in this case, I
(2) believe. Is he?
(3) MR. ALLEN: Who? Oh, he –

(4) MR JONES Isn't Bill Meadows out of this
(5) case?
(6) MA. ALLEN: That's true. He is out *of* this
(7) case.
(8) THE WITNESS: Still haven't met him.
(9) BY MR. ALLEN:
(10) Q. Have you ever met him?
(11) A. **No.**
(12) Q. Okay. Do you know any - any of the lawyers
(13) from Mr. Jones's firm?
(14) A. One.
(15) Q. What's his name?
(16) A. **It's** her. What was her name?
(17) MR. JONES: Anna Carulas.
(18) A. Anna Carulas, that's right, Thank you.
(19) Q. And how do you know her?
(20) A. I worked on a case with her.
(21) Q. When was that?
(22) A. Two, two and a half years ago, I think.
(23) Q. Okay. And what was that case?
(24) A. Jeffery Ponske is a reknowned Cleveland surgeon

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(1) was being sued by a woman who ten years prior had an anal
(2) sphincterotomy, and she sued for ten years later becoming
(3) incontinent, and I defended him.
(4) Q. Okay. And this was two and a half years ago?
(5) A. About that.
(6) Q. Other than that have you done any work with
(7) their firm?
(8) A. The Cleveland office?
(9) Q. Yeah.
(10) A. I think that was the only case.
(11) Q. What about any office?
(12) A. Well, I do an occasional legal review for the
(13) Columbus office.
(14) Q. How many times have you done that?
(15) A. About half a dozen.
(16) Q. Okay. How many times have you testified for
(17) the Columbus office in deposition?
(18) A. Not many. I can't even give you a number.
(19) It's infrequent.
(20) Q. Half of those?
(21) A. Maybe.
(22) Q. Okay. You ever gone to trial and testified at
(23) trial for this local office?
(24) A. **No.**

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(1) Q. Okay. Other than roughly half a dozen times
(2) Cleveland and the one - I mean half a dozen in Columbus

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(3) and one time in Cleveland, any other cases?
(4) A. I do occasional plaintiff work.
(5) Q. Okay.
(6) A. For a local firm, Michael Colley, and I do
(7) occasional work for another attorney called Donna Taylor
(8) Kolis.
(9) Q. Who?
(10) A. Donna Kolis.
(11) Q. Kolis.
(12) A. But for the most part my partners do the vast
(13) majority of med/legal. I do occasional cases.
(14) Q. Do you know any - anybody at Reminger &
(15) Reminger?
(16) A. Jeff - just Jeff Beausay.
(17) Q. And why is that?
(18) A. He's handling a case for me.
(19) Q. You're a defendant in the case?
(20) A. That's correct.
(21) Q. Tell me about that case. What's -
(22) A. It's ongoing. **It's a** hernia repair.
(23) Q. Okay. And it arose from a hernia repair
(24) operation that you performed?

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(1) A. That I did.
(2) Q. What happened to the person?
(3) A. Chronic infection and mesh.
(4) Q. Is that person alive or dead?
(5) A. Oh, he's alive.
(6) Q. Okay, And how long - when was that case -
(7) when were you notified that case was filed?
(8) A. About four or five months ago.
(9) Q. Okay. Other than that case have you been sued
(10) before?
(11) A. Once before.
(12) Q. Okay. When was that?
(13) A. It was 1993.
(14) Q. Okay. Before I get back, have you given your
(15) deposition in this four or five-month old case? Have you
(16) given your deposition?
(17) A. No.
(18) Q. In the 1993 case did you have to give a
(19) deposition?
(20) A. Yes.
(21) Q. Did it go to trial?
(22) A. No, it settled.
(23) Q. It settled. Were you - did you - did you
(24) pay?

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(1) A. Yes.
(2) Q. Okay. Tell me about the 1993 case. Where was
(3) it filed?

(4) A. It was filed in Columbus.
(5) Q. Okay. And who represented you?
(6) A. I was represented by Dan White.
(7) Q. And who was the plaintiff's lawyer?
(8) A. Wolske & Blue.
(9) Q. Excuse me?
(10) A. Wolske & Blue.
(11) Q. Wolske & Blue?
(12) A. Blue.
(13) Q. Blue, okay. Just tell me about that case.
(14) What were the allegations?
(15) A. The patient developed an empyema postop and
(16) went to another physician and felt that we were substandard
(17) and we got sued.
(18) Q. And you settled?
(19) A. Yes.
(20) Q. Before triai. So other than '93 and the one
(21) this year, that's it?
(22) A. That's it.
(23) Q. You've never been a defendant in any other
(24) case?

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(1) A. Huh-uh.
(2) Q. That includes any cases that may have come and
(3) then gone; summary judgment?
(4) A. That's correct.
(5) Q. Or any other legal technicality?
(6) A. That's correct.
(7) Q. Okay. Other than medical malpractice cases -
(8) huh?
(9) MR. JONES: He's living a charmed existence -
(10) I say, he's lived a charmed existence to have only one or
(11) two cases in his life.
(12) BY MR. ALLEN:
(13) Q. Other than med mal cases have you been sued?
(14) A. No.
(15) Q. Okay. You've never been divorced; right?
(16) **A. No.**
(17) Q. Now, I'm going to name off to you the following
(18) doctors that are defendant experts, and if you know anybody
(19) just tell me, okay? Dr. Rapkin, R-a-p-k -
(20) A. No.
(21) Q. Dr. Conomy?
(22) A. Don't know him.
(23) Q. Dr. Cascorbi?
(24) A. No.

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(1) **Q.** Dr. Nearman, Dr. Downs?
(2) A. John Downs?
(3) Q. John Downs.
(4) A. Is that John Downs?

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(5) MR. JONES: Yeah.
(6) MR. ALLEN: He's out of Tampa.
(7) MR. JONES: He's an anesthesiologist in
(8) Florida.
(9) A. I know him.
(10) Q. How do you know him?
(11) A. He was up at OSU when I was up at OSU.
(12) Q. Meaning you went to school together?
(13) A. No. I was a staff and he was anesthesia staff
(14) when I was up there.
(15) Q. Okay. And so you worked with him?
(16) A. Yes.
(17) Q. Have you talked to him about this case?
(18) A. No. I haven't talked to him since he left OSU
(19) about eight years ago.
(20) Q. Okay. We named some of plaintiffs' experts
(21) here, but I'm going to list the rest of them. I may
(22) duplicate them. Tell me if you know any of these guys.
(23) Dr. Joel Kaplan, Dr. Mark Semigran, Dr. Alvin Kahn, Dr.
(24) Paul Thompson?

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(1) **A.** No.
(2) Q. Dr. Terry Winkler?
(3) A. Don't know him.
(4) - - -
(5) And, thereupon, Exhibit No. **2** was marked
(6) for purposes of identification.
(7) - - -
(8) BY MR. ALLEN:
(9) Q. Exhibit 2 is your C.V. This is correct and
(10) up-to-date?
(11) A. Yes.
(12) Q. Okay. Just tell me about your present
(13) practice, what you do, percentage of time you're in the
(14) office, etcetera.
(15) A. Basically I'm a general surgeon, surgical
(16) oncologist, non-cardiac, thoracic surgeon. Do about 80
(17) percent of my clinical work here, the rest of it is done at
(18) Mount Carmel East. I teach EMS. And the vast majority of
(19) my time is - I have office hours Wednesday morning and
(20) Friday morning, and the rest of the time I'm in the OR.
(21) Q. So you're in the OR out of 100 percent of time
(22) quantitative?
(23) A. All right. Let's put it this way:

All day
(24) Monday, Tuesday, Wednesday afternoon, all day Thursday, and

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(1) Friday afternoon. About 75 percent of my time is
(2) operative.
(3) Q. Is operation, okay. And then how much of your
(4) time is spent on administrative work?
(5) A. Oh, maybe five percent.
(6) Q. Five percent. And the other 20 percent of your
(7) time is?
(8) A. Right here in the office or patient care.
(9) Q. Patient care. Okay. And how big is the
(10) hospital you practice at?
(11) A. 404 beds.
(12) Q. How many surgeons?
(13) A. There are about eight surgeons on staff.
(14) Q. How many OR suites?
(15) A. Nine.
(16) Q. What percentage of your time is taken up in
(17) medical/legal review?
(18) A. Very little.
(19) Q. Okay. Out of that little 20 percent; two
(20) percent, five percent?
(21) A. Maybe, if that.
(22) Q. Two percent?
(23) A. Yeah.
(24) Q. Do you do any teaching?

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(1) A. EMS, which is the emergency medical services.
(2) Q. Right.
(3) A. And I do that after hours, probably twice a
(4) month.
(5) Q. Okay. And what do you – what do you teach
(6) there, life – advanced life –
(7) A. Basically what I do is teach them recognition
(8) of surgical injuries, first aid. I'm also on the
(9) Governor's board for EMS strategy for the State of Ohio.
(10) Q. Okay. Do you know how they got your name in
(11) this case?
(12) A. Well, basically it was a long story.
(13) Apparently I was representing a plaintiff against a case
(14) that he was doing, don't remember it, and from my work
(15) there he got my name, and that's how we hooked up.
(16) Q. So he was on the opposite side?
(17) A. You bet 'ya.
(18) MR. JONES: The doctor was an

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expert who
(19) represented the plaintiff.
(20) A. (Witness nods head.)
(21) Q. And this was how many –
(22) A. Number of years ago.
(23) Q. Number of years ago. So he saw you on that end
(24) of the stick?

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(1) A. I guess so.
(2) MR. JONES: Let me be clear. It never went to
(3) a deposition. I never actually had to meet him. Just so
(4) it's clear, he got into – if you want to know, he got into
(5) my rolodex because he had been an expert retained by
(6) plaintiff, got the report, had gotten it reviewed, the case
(7) was settled, and he's in my rolodex.
(8) BY MR. ALLEN:
(9) Q. You never produced a report?
(10) MR. JONES: Yes. That's how I knew him.
(11) That's how I got his address.
(12) BY MR. ALLEN:
(13) Q. You did a report. You didn't do anything else?
(14) A. No. No, right.
(15) MR. JONES: My review agreed with him.
(16) BY MR. ALLEN:
(17) Q. Is there anything on your C.V. here that
(18) relates to standard of care or issue of causation to this
(19) case?
(20) A. Shouldn't be.
(21) Q. Okay. I hate these questions. You ever had
(22) staff privileges suspended or declined?
(23) A. No.
(24) Q. You ever been treated for a mental disorder,

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(1) drug abuse or alcohol addiction?
(2) A. No.
(3) Q. Okay. Have you ever held any national offices
(4) in the American College of Surgeons?
(5) **A. No.**
(6) Q. Nothing like that. Any local offices?
(7) A. No, no offices.
(8) Q. And you're board certified by what group?
(9) A. American College – actually the American Board
(10) of Surgery.
(11) Q. American Board of Surgery. And then any other
(12) sub boards?
(13) A. No, I do not have any other sub

buards.
(14) Q. Okay. You ever written a technical bulletin or
(15) guideline or anything for that group?
(16) A. Not for that group, no.
(17) Q. But you have with other groups?
(18) A. It's in the back of my C.V., numerous
(19) publications and presentations.
(20) Q. But none of those relate to -
(21) A. Not this case.
(22) Q. - this case, gallbladders?
(23) A. Well, there's multiple gallbladder articles,
(24) especially laparoscopic, but it doesn't have to do with the

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(1) critically ill patient.
(2) Q. So nothing in a high risk patient for surgery?
(3) A. No.
(4) Q. But it - you do have numerous articles on
(5) gallbladders -
(6) A. Yes.
(7) Q. That's pretty self-explanatory?
(8) A. Yes.
(9) Q. Okay. But nothing that you feel would hold any
(10) bearing -
(11) A. No.
(12) Q. - in the facts of this case; correct?
(13) A. No.
(14) Q. Okay. Do you know the size of the hospital in
(15) 1994, Meridia Huron Hospital?
(16) A. No, I do not.
(17) Q. Do you know the number of OR rooms?
(18) A. No.
(19) Q. Did you know the number of surgeons they had?
(20) A. No, I do not.
(21) Q. Know the number of board certified surgeons
(22) they had?
(23) A. No.
(24) Q. Okay. Do you - is it your opinion that Dr. Ho

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(1) was board certified at the time of this surgery?
(2) MR. JONES: That's not an opinion - or not an
(3) opinion. It's either a fact or not a fact.
(4) A. I have no idea if he was or not.
(5) Q. You don't know if he was or not?
(6) A. No.
(7) Q. I guess I kind of mixed two questions. Would
(8) it make any difference as to your opinions whether he was
(9) board certified or not?
(10) A. No, not at all.
(11) Q. Okay. Do you know anything

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about the
(12) availability of echocardiograms and people to form and read
(13) them at Meridia Huron in 1994?
(14) A. I have no idea.
(15) Q. Okay. Ever spoken to a group of lawyers or
(16) insurance people or risk managers?
(17) A. Yes.
(18) Q. Okay. When was the last time you did that?
(19) A. About four years ago.
(20) Q. Okay.
(21) A. I spoke to the Ohio Insurance Group and talked
(22) about lap choles, lap hernias and lap nissen, n-i-s-s-e-n.
(23) Q. And the idea was to educate?
(24) A. How - have them pay for them, show them what

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(1) they are, what their benefits are and why we should be
(2) paid.
(3) Q. Didn't have nothing to do with standard of
(4) care?
(5) A. No. I just wanted to educate them to the
(6) procedures, how they are done, why we do them, and what the
(7) reimbursement should be.
(8) Q. Okay. And other than that have you given any
(9) talks to any groups like that?
(10) A. No.
(11) Q. Okay, Have you ever testified outside of the
(12) State of Ohio?
(13) A. Once.
(14) Q. Where was that?
(15) A. It was in Beckley, West Virginia.
(16) Q. Okay. For what?
(17) A. It was a surgeon that was being sued for an
(18) operation of the common bile duct.
(19) Q. Lap?
(20) A. Just during a regular procedure it turned out
(21) it was the guy who did the ERCP.
(22) Q. Okay.
(23) A. So I was a defendant - defense expert.
(24) Q. When was that?

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(1) A. Must have been a few years ago.
(2) Q. Okay. When was the first time that you
(3) reviewed any medical/legal cases?
(4) A. I started practice in 1988. First cases I
(5) looked at were 1991.
(6) Q. '91?
(7) A. I would believe, yes.

(8) Q. Okay. Since 1991 how many cases have you
(9) reviewed?
(10) A. Less than a dozen a year.
(11) Q. Okay. How many of those were for the plaintiff
(12) and how many defendant?
(13) A. About 30 percent plaintiff, 70 percent defense
(14) work.
(15) Q. And the 30 percent plaintiff with Michael
(16) Colley and -
(17) A. Donna, and I've done occasionally for Nurenberg
(18) and Plevin out of Cleveland, and there's an odd and end
(19) case that comes in from someplace.
(20) Q. Okay. And how many times have you given
(21) deposition testimony since 1991?
(22) A. Probably four a year.
(23) Q. Okay. And how many times have you testified
(24) since 1991?

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(1) A. In trial?
(2) Q. In trial.
(3) A. Three times.
(4) Q. Okay. Other than testifying in trial for a
(5) medical/legal case and the one time in the previous defense
(6) case, have you testified in trial before at all?
(7) A. No.
(8) Q. Okay. Have you noticed that the number of
(9) cases has increased or decreased over the years or has it
(10) basically stayed -
(11) A. Increased.
(12) Q. it's increased, okay. So '91 you reviewed -
(13) A. It's increased, but we've been steady the last
(14) few years. The number of malpractice cases, especially
(15) laparoscopic, have been existential. We're seeing - the
(16) old firm, my partners review quite a bit more, and it's
(17) basically we're seeing an influx to their offices,
(18) tremendous amount.
(19) Q. But as far as you're concerned -
(20) A. It hasn't changed much.
(21) Q. - it hasn't changed much since 1991?
(22) A. Right.
(23) Q. If it has changed it's been in the last couple
(24) years it's increased one or two?

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(1) A. Probably two to three.

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(2) Q. Two to three. As far as depositions how many
(3) depositions have you given for a plaintiff?
(4) A. Not many. I can't even - it's very, very few.
(5) Q. Of the four, one?
(6) A. Maybe two, two or three max.
(7) Q. So half of them would be for the plaintiff?
(8) A. I can't - I really don't know unless I take a
(9) look at everything, but it's - most of the plaintiff cases
(10) have been a report that they don't have a case.
(11) Q. Okay. Most of them have been turning them
(12) down?
(13) A. Yeah. But I do review - of the reports that
(14) I'm willing, something happens and it gets settled. But I
(15) don't do any depositions for the plaintiff.
(16) Q. So of the three you went to trial, were those
(17) - any of those were plaintiff?
(18) A. No.
(19) Q. Okay. When was your last deposition other than
(20) - medical/legal other than this?
(21) A. About ten weeks ago.
(22) Q. And when was the last time you testified in
(23) trial?
(24) A. I can't even remember. It's been a couple

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(1) years.
(2) Q. Couple years?
(3) A. Yeah.
(4) Q. Okay. Are you scheduled for any upcoming
(5) trials?
(6) A. I haven't the slightest. I don't even
(7) remember.
(8) Q. You haven't reserved a day yet for this case?
(9) A. No.
(10) MR. JONES: Not possible to reserve a date.
(11) MR. ALLEN: Jim, you still there?
(12) MR. CASEY: Yes.
(13) MR. ALLEN: All right. Just a wakeup call.
(14) That's all.
(15) MR. CASEY: Are you all done?
(16) MR. ALLEN: No. We're close.
(17) (Discussion held off the record.)
(18) BY MR. ALLEN:
(19) Q. You ever read any materials, seen any videos,
(20) been the part of any lectures on how to give testimony in

(21) deposition?
(22) A. No.
(23) Q. Trial testimony?
(24) A. No, absolutely not.

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(1) Q. Or how to be an expert witness?
(2) A. No, none.
(3) Q. Okay. You ever authored any articles on that?
(4) **A. No.**
(5) **Q.** Have you given any talks on that?
(6) A. No.
(7) Q. Do you think that's just a waste of time to do
(8) that?
(9) A. It's not part of my practice. I'm a doctor.
(10) Q. Okay. Let's talk about fees. How much do you
(11) get to review?
(12) A. All right. Where is it? Since I don't do much
(13) of this, where the heck is my fee schedule? My partners
(14) have come up with what they have as the general practice
(15) list. To review a chart and a telephone/written report,
(16) $500.00 retainer is required at $250.00 an hour.
(17) Deposition and preparation $1,500.00 retainer required,
(18) $500.00 an hour. Depo cancellation within 48 hours,
(19) $500.00. Trial out of town, 3,500 a day. In town, no more
(20) than half day full retainer required, 2,500. Trial
(21) cancellation within one week of trial $1,000.00. There you
(22) have it.
(23) Q. When was the last time the fee schedule was
(24) increased?

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(1) A. It hasn't been. This has been the – there
(2) forever.
(3) Q. Okay. And how long have you gone under that
(4) fee schedule?
(5) A. Since '92.
(6) Q. And you've been here since '92?
(7) A. Uh-huh.
(8) Q. Before that you were –
(9) A. Before that I was kind of, okay, that sounds
(10) good.
(11) Q. Can you just – you didn't have any set –
(12) A. No.
(13) Q. And where does the money go when the check is
(14) written?
(15) A. Everything goes into the pot.
(16) Q. Okay. So it goes to the firm?

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(17) A. Right.
(18) Q. Write the check to the group here?
(19) A. Yeah. It just goes in and we all divide at the
(20) end of the month.
(21) Q. Okay. Total number of hours spent reviewing
(22) this case?
(23) A. I would suspect anywhere between four and a
(24) half and five.

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(1) Q. Okay. Number of hours spent in preparation for
(2) the deposition?
(3) A. Oh, reviewing the stuff probably about an hour
(4) and a half.
(5) Q. Have you put out a bill to date?
(6) **A. No.**
(7) Q. Okay.
(8) A. I trust him.
(9) Q. Okay. Have we gone through or do you feel like
(10) you have enough information that you are set in stone your
(11) opinions today?
(12) A. Yes.
(13) Q. Okay. Have you ever testified in a case that
(14) was similar to Dewey Jones's case?
(15) A. No, I have not.
(16) Q. You never testified that a patient required the
(17) use of a Swan-Ganz catheter intraoperatively?
(18) A. I have not testified, but I've had patients
(19) that have needed it.
(20) Q. Testified?
(21) A. No.
(22) Q. Okay. Medical/legal stuff?
(23) **A. No.**
(24) Q. Testified in similar cases. Have you ever

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(1) testified in a – that the standard of care required a
(2) physician not to operate on a patient because the medical
(3) condition was unstable?
(4) **A. No.**
(5) Q. Needed to be put *off.* Have you ever testified
(6) that the standard of care required the physician not to
(7) operate on the patient because there was no cystic duct
(8) obstruction?
(9) A. No.
(10) **Q.** You ever testify that standard of care required
(11) that a physician not operate because there was no
(12) obstruction anywhere, period?
(13) **A. No.**

(14) Q. Okay. You ever testify that the physician
(15) breached the standard of care because he did not do a
(16) thorough investigation and where there were stones causing
(17) obstruction?
(18) **A.** No.
(19) Q. Okay. You ever testified that the standard of
(20) care required or did not require cardiology consult?
(21) **A. No.**
(22) Q. Or internal medicine consult?
(23) **A. No.**
(24) Q. Okay. What would you estimate the total

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(1) percentage income of medical/legal reviews to you?
(2) **A. Have no idea.**
(3) Q. Minimal would be along two to three percent;
(4) right?
(5) **A. The revenue, as I said, I never see it. It**
(6) **goes there. I don't care.**
(7) Q. It comes back in, whatever your share is?
(8) **A. Whatever it is, I have no idea.**
(9) Q. Whatever your share, whatever... Any – is
(10) there any specific authoritative literature upon which you
(11) base your opinion on the standard of care in this case?
(12) **A.** No.
(13) Q. Any authoritative literature you base your
(14) opinion as to causation?
(15) **A.** No.
(16) Q. Okay. You assume the medical records were
(17) correct when you formed your opinion?
(18) **A. Yes.**
(19) Q. And within a reasonable degree of medical
(20) certainty means what to you?
(21) **A. I agree with 51 percent.**
(22) Q. You understand that the standard of care can be
(23) breached but cause no damage?
(24) **A. I'm not –**

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(1) MR. JONES: You want a legal opinion?
(2) BY MR. ALLEN:
(3) Q. Do you understand that legal sense that you can
(4) breach the standard of care and not do any damage to the
(5) patient, thus not cause any problems?
(6) **A. I suspect that's correct.**
(7) Q. Okay. Did you see anything in these medical
(8) records as it relates to your opinions in your opinion that
(9) there was a breach of the standard of care but it just
(10) didn't matter?
(11) **A. No. I didn't see any breach of the standard of**
(12) **care.**
(13) Q. Period?
(14) **A. Period.**
(15) Q. Okay. You did not review the life care plan;
(16) correct?
(17) **A. Correct.**
(18) Q. Do you know Dewey's present condition?
(19) **A.** No.
(20) Q. Do you recommend any additional studies?
(21) **A. Well...**
(22) Q. Any workups for Dewey Jones?
(23) **A. From now?**
(24) Q. Right now, yeah, to anybody.

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(1) **A. No. I have no idea what Dewey is doing.**
(2) MR. ALLEN: Okay. Thank you very much,
(3) Doctor.
(4) CROSS-EXAMINATION
(5) BY MR. CASEY:
(6) Q. Doctor, can you hear me?
(7) **A. Oh, yeah. I'm right here.**
(8) Q. You peaked my curiosity on one topic.
(9) **A. Okay.**
(10) Q. Heart failure.
(11) **A. Okay.**
(12) Q. Question.
(13) MR. JONES: We didn't hear you, Jim.
(14) **A. What's the question?**
(15) Q. How about now?
(16) **A. Okay.**
(17) MR. ALLEN: Got you.
(18) Q. Why do you think Dewey Jones had end stage
(19) heart failure?
(20) **A. He had end stage heart disease.**
(21) Q. Why do you think that?
(22) **A. Cardiomyopathy, cardiomegaly, the fact that he**
(23) **had such high cor pulmonale, that's a bad heart.**
(24) Q. Okay. So it's the cardiomyopathy and the

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(1) chronic cor pulmonale that the – that's really what's
(2) driving that opinion?
(3) **A. Yes.**
(4) Q. You also talked about end stage pulmonary
(5) hypertension. I think that's the chronic cor pulmonale.

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(6) A. That's correct.
(7) Q. So you don't think that Dewey Jones had long to
(8) live before he went into surgery on October 20th?
(9) A. Well, I'm not going to give an opinion on his
(10) -
(11) MR. ALLEN: Objection.
(12) A. - longevity. All I made a statement is this is
(13) a poor protoplasmic patient that really was a high risk
(14) surgical patient. As far as how long he had to live, I am
(15) not going to render an opinion.
(16) Q. The patients who are in end stage - who have
(17) end stage heart disease do not live long, do they?
(18) MR. ALLEN: Objection. Asked and answered.
(19) A. Well, they don't do well long-term, but I'm not
(20) going to give you a specific answer. I can't.
(21) Q. Okay. You would defer that to a cardiologist?
(22) A. I would defer that to anyone that takes care of
(23) these patients long term.
(24) MR. CASEY: Okay. That's all.

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(1) RECROSS EXAMINATION
(2) BY MR. ALLEN:
(3) Q. If I could ask one question. Define for me the
(4) difference between end stage heart disease and end stage
(5) heart failure, because you made that distinction with his
(6) question.
(7) A. I would look at my deposition and correct it.
(8) End stage heart disease is basically what this gentleman
(9) had. He had a very poorly, if not dysfunctional, heart.
(10) Q. Okay.
(11) A. And the end stage heart failure I have to look
(12) and see where I put that because that may have been a
(13) misstatement.
(14) Q. Tell me what that would mean.
(15) A. Someone that has end stage heart failure dies.
(16) MR. ALLEN: All right. Simple enough. Okay.
(17) Thank you for your time. All right, Jim.
(18) (Signature not waived.)
(19) - - -
(20) And, thereupon, the deposition was
(21) concluded at approximately 5:05 p.m.
(22) - - -
(23)
(24)

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(1) State of Ohio :
(2) SS:
(3) County of Franklin :
(4)
(5) I, R. E. SCHLANGER, M.D., Ph.D., do hereby
(6) certify that I have read the foregoing transcript of my
(7) deposition given on August 4, 1997; that together with the
(8) correction page attached hereto noting changes in form or
(9) substance, if any, it is true and correct.
(10)

(11) R. E. SCHLANGER, M.D., Ph.D.
(12)
(13) I do hereby certify that the foregoing transcript
(14) of the deposition of R. E. SCHLANGER, M.D., Ph.D. Was
(15) submitted to the witness for reading and signing; that
(16) after he had stated to the undersigned Notary Public that
(17) he had read and examined his deposition, he signed the same
(18) in my presence on the day of ,1997.
(19)

(20) Notary Public
(21) My Commission expires

- - -
(22)
(23)
(24)

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(1) State of Ohio :-
(2) SS: CERTIFICATE
(3) County of Franklin :
(4) I, Shayna M. Herring, Notary Public in and for
(5) the State of Ohio, duly commissioned and qualified, certify
(6) that the within named R. E. SCHLANGER, M.D., Ph.D. Was by
(7) me duly sworn to testify to the whole truth in the cause
(8) aforesaid; that the testimony was taken down by me in
(9) stenotypy in the presence of said witness, afterwards
(10) transcribed upon a computer; that the foregoing is a true
(11) and correct transcript of the testimony given by said
(12) witness taken at the time and place in the foregoing
(13) caption specified.

(14) I certify that I am not a relative, employee, or
(15) attorney of any of the parties hereto, or of any attorney
(16) or counsel employed by the parties, or financially
(17) interested in the action.
(18) IN WITNESS WHEREOF, I have set my hand and
(19) affixed by seal of office at Columbus, Ohio, on the
(20) day of , 1997.
(21)

(22) SHAYNA M. HERRING, RPR
My Commission expires: Notary Public in and for
(23) April 5, 2001. the State of Ohio
(24)

NOTES

DEPOSITION OF R.E. SCHLANGER, M.D., Ph.D. **AUGUST 4,** 1997

PAGE 1 TO PAGE 124

ANDERSON DILLMAN REPORTING

(614) 487-1778

CONDENSED TRANSCRIPT AND CONCORDANCE

PREPARED **BY:**

ANDERSON DILLMAN REPORTING
2109 West Fifth Avenue
Columbus, OH 43212
Phone: (614) 487-1778
FAX: (614) 487-0332

Look-See Concordance Report

- - -

UNIQUE WORDS: 1,873
TOTAL OCCURRENCES: 6,492
NOISE WORDS: 385
TOTAL WORDS IN FILE: **20,295**

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

NOISE WORD LIST(S):
NOISE.NOI

- - -

COVER PAGES = 4

- - -

INCLUDES ALL TEXT OCCURRENCES

- - -

DATES OFF

- - -

IGNORES PURE NUMBERS

- - -

POSSESSIVE FORMS OFF

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

- - -

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: **8**

- - -

LIST OF THRESHOLD WORDS:

- - -

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gallbladder [95]
Okay [237]
opinion [56]
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– V –

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COPY

Anderson Dillman Reporting
2109 West Fifth Avenue Columbus, Ohio 43212
(614) 457-1778 FAX (614) 487-0332

August 7, 1997

Doc
Re: 386

R.E. Schlanger, M.D., Ph.D.
Park Medical
1492 East Broad Street
Suite 1300
Columbus, Ohio 43205

Case: Jones vs. Meridia Huron Hospital, et al.
Case No.: 306012

Dear Dr. Schlanger,

A condensed copy transcript of your deposition of August 4, 1997, is enclosed herewith. As you will recall, signature was not waived; and we would ask for your assistance in obtaining your signature as soon as possible.

Please do not mark on the transcript. Any corrections or changes you wish to make in the testimony should be typewritten or printed on the attached Errata Sheet, indicating the page number, line number, and desired correction or change.

After reading the transcript, please sign the Signature Page before a notary public. Do not make a copy of this transcript or allow anyone else to make a copy, or you will be charged the customary rate of $2.00 per page.

Please return the entire transcript, Signature Page, and Errata Sheet to my office within seven (7) days, pursuant to the Rules of Civil Procedure.

Your prompt attention to this matter is greatly appreciated.

Sincerely,

Katherine Gregg
Office Manager

CC: Allen, Jones, Casey

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CLEVELAND, OHIO 44113-1792
(216) 621-2300
FAX (216) 771-2242
www.nphm.com

DIRECT DIAL NUMBER
694-5206

December 5,2000

WILL PICK UP
Mr. Roger Bundy
Dennis Seaman & Assoc.
614 Superior West #1600
Cleveland, Ohio 441 13

Re: *Richard R. Schlanger, M.D.*

Dear Roger:

Pursuant to your request, enclosed please find the deposition which we have in our brief bank regarding Richard R. Schlanger, M.D.

Please return the deposition to our office once you have made whatever copies you need together with providing us with two depositions and/or reports that you may have so that we can increase our bank.

If you should have any questions, do not hesitate to call me.

Very truly yours,

Rose

Rosemary Graf, Legal Assistant to
David M. Paris

/rg

Enclosure