#653

ARBITRATION HEARING

In the Matter of:

FRANCES SMITH)
)
v.) Case No. 100877
)
ST. LUKE'S TIOSPITAL, et al.)

- - -

Excerpt of Arbitration Hearing had in the above-captioned matter before Mr. William Coyne, Arbitrator, at 17-D Justice Center, Cleveland, Ohio, commencing at 9:30 a.m., on Monday, the 26th day of October, 1987.

- - -

APPEARANCES:

Charles Kampinski Co., LPA, by:
Charles Kampinski, Esq.,

On behalf of the plaintiff.

Arter & Hadden, by:
Michael C. Zellers, Esq.,

On behalf of Defendant
St. Luke's Hospital.

Reminger & Reminger, by:
Marc W. Groedel, Esq.,

On behalf of Defendants
Timothy L. Stephens, Jr., M.D. and
Curtis W. Smith, M.D.

APPEARANCES: (continued)

Jacobson, Maynard, Tuschman & Kalur, by:
Joan Tomasco, Esq.,

On behalf of Defendant
S. J. Lee, M.D.

Kitchen, Messner & Deery, by:
Gene Meador, Esq.,

On behalf of Agnes Sims, R.N.

- - -

* * * * *

MR. KAMPINSKI: I would call Dr. Smith at this time as if on cross-examination.

MR. COYNE: Dr. Smith, you want to raise your right hand?

CURTIS W. SMITH, M.D., PLAINTIFF'S WITNESS, SWORN

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your full name, sir?

A. Curtis West Smith.

Q. And you are a doctor, is that correct?

A. That is correct.

Q. Orthopedic surgeon?

A. That is correct.

Q. Are you Board-certified, sir?

A. No, I am not.

Q. How many times have you failed the test?

A. I have taken the test three times, and I have failed all three times.

Q. You were an attending physician of Dr. Smith, were you not, sir?

A. Yes, I was.

Q. And as the attending physician, was it not your responsibility, sir, to be apprised of and aware of the various tests, testing that was

done on Mr. Smith during his hospitalization, and the lab value findings?

A. It was my responsibility to oversee his management, that is correct. In dealing with a patient who is as complicated as Mr. Smith was, these, parts of these responsibilities are assigned to others because of their expertise in those particular areas. That was done.

Q. I see.

A. I was apprised of the values that those people thought were appropriate.

Q. And are those people you are referring to residents in the hospital?

A. I am referring to Mr. Smith's long-time internist, Dr. Edgar Jackson, and the anesthesiologist who was in charge of both cases Dr. Trusso and Dr. Lee, and to Dr. Oliver who was the intensivist who was taking care of Mr. Smith for a period of approximately 48 hours after the first surgery.

Q. So that you were apprised then, were you not, of Mr. Smith's elevated CPK and the finding that there was two percent Mb band, therefore related to the heart; you were apprised of that?

A. Those specific --

Q. Were you apprised of it?

A. If you will allow me to answer, I will.

Q. I think it's a simple question, Doctor; yes or no.

MR. COYNE: What time are we talking about?

MR. KAMPINSKI: Any time after they were taken on the 14th.

Q. (BY MR. KAMPINSKI) At any time are you aware of it?

A. I am not sure at this time that I was.

Q. Were you aware of the drop in hemoglobin, Doctor?

A. Yes, I was.

Q. When were you aware of the drop in hemoglobin, sir?

A. I was aware throughout his course.

Q. Do you recall your deposition being taken, Doctor?

A. If you're asking me specific numbers, I will submit once again that the individual numbers I may not recall specifically, but the trend, certainly the trend for any major orthopedic surgery such as this requires or entails a significant amount of dissection, cutting into

large muscles in the body. Postoperative bleeding and subsequent drop in hematocrit is expected, not unexpected.

Q. Sure.

A. But the level to which he dropped was not an unacceptable level, and certainly higher than any level that we normally transfuse for.

Q. I asked you if you were aware of --

A. I was generally aware of the level. If you ask me if I was aware for each specific level, I cannot attest to that.

Q. Do you recall your deposition being taken, Dr. Smith?

A. I recall the deposition.

Q. You were under oath at that time, sir?

A. That's correct.

Q. August 25, 1986. Page 47, Counsel. I will read it if you'd like me to go ahead.

MR. GRODEL: Are you going to read it?

MR. KAMPINSKI: Yes. Just a question.

Q. (BY MR. KAMPINSKI) And do you recall the following question and answer, Dr. Smith?

"Question: It's your testimony that you

think you might have been aware of the drop in hemoglobin, or you are just not sure right now?

"Answer: I would have to say that I am not sure."

Are you sure now? You weren't sure then.

A. If you interpret that question the way you have, then it certainly -- it would reflect that I was not aware in general. What I meant to imply and what I attest to at this point is that the -- if you were asking whether I was aware of any unusual drop, then I was not, but this was not considered an unusual drop.

Q. How long after the surgery does hemoglobin drop, Doctor?

A. It may drop for several days.

Q. Isn't it normal that within 24 hours loss that's occurred normally as a result of the surgery will have occurred?

A. That's not necessarily true.

Q. But can't a hemoglobin drop also reflect other problems in the body, such as blood loss from somewhere else?

A. It certainly can.

Q. Sure. And you investigated that, didn't you, on Mr. Smith, to determine whether there was

a blood loss somewhere else?

A. Mr. Smith exhibited nothing to indicate that there was blood loss other than where it was expected at this time.

Q. How about coffee ground emesis? Why don't you tell the panel what that is, Doctor.

A. A coffee ground emesis and emesis basically are vomitus. It includes a -- vomitus generally will be reflective of the contents of the stomach or the abdomen at that point. If it is coffee ground, it is considered to potentially have blood in it.

Q. Guaiac positive means what?

A. A guaiac test is a test that can test positive for blood as well as other substances.

Q. So if it tests positive, that's another indication there is some type of bleeding going on, is that right?

A. There is an indication that there is possibly some type of bleeding, yes.

Q. And you investigated that, too, didn't you?

A. I investigated it to the point that the usual cause for coffee ground emesis after a surgery such as this is stress ulceration in the

stomach, and that is a very common finding. That is a very common occurrence after this sort of surgery.

Q. Doctor, you didn't even know that he had abdominal pain, did you?

A. I was aware that he had only in -- probably the following morning. The first abdonimal problems that I am aware of, and I would have to review the -- I'm sure you are looking at my testimony from before.

Q. Yes, I am, and I'm going to read it to you in a minute.

A. I would be happy to listen to it.

Q. Page 32.

MR. O'NEILL: Excuse me, Mr. Kampinski, I want to clarify one point. Doctor, did you say that coffee ground emesis is a common occurrence after this type of surgery?

THE WITNESS: Abdominal pain, and if the emesis happens, a gastritis, a bleeding ulceration after a significant stress, whether it be surgery, an automobile accident, or anything that would perpetrate significant stess on the body can produce symptoms of stress ulceration, stress gastritis. For the kind of surgery we are

talking about, a major orthopedic surgical procedure, stress ulceration is one of the more common findings that we find after surgery.

When patients -- the ileus that was mentioned, the slowing down of the bowel, the discomfort in this patient experienced were not out of the realm of the usual things that we can often see after this kind of surgery.

MR. O'NEILL: Okay. Thank you, Mr. Kampinski.

Q. (BY MR. KAMPINSKI) Page 32, line 12:

"Question: So he was complaining of abdominal pain?

"Answer: According to the note.

"Question: You didn't do any surgery on his abdomen, did you, Doctor?

"Answer: No, I did not.

"Question: Okay. Were you aware of the fact that he was in abdominal pain, sir?

"Answer: No. At this point, no.

"Question: This is the 17th, I mean the date that you performed surgery on him.

"Answer: If you're asking me was this information either relayed to me, or was I aware he was having abdominal pain, no, I was not."

Do you remember that, Doctor? Do you remember me asking you those questions and you giving me those answers under oath, sir?

A. I remember the question. As I read the report, I'm sure that those are my answers. But my answer still stands that I was aware in general that this person, that Mr. Smith indeed was not experiencing anything other than what we can commonly see following a major surgery such as this, and the gastritis, which was treated appropriately is a very common finding.

Q. Doctor, if you were --

A. As a matter of fact --

Q. Excuse me, sir. If you weren't aware of the abdominal pain, how do you know it was a common finding?

A. You asked me if it was a common finding.

Q. If you weren't aware of it, how do you know what it was, sir?

A. I am not going to badger you with my answers, if you don't badger me with your questions.

Q. I'd like an answer to the question. If you were not aware of it --

MR. COYNE: Wait. All right.

We'll get a complete question, and then you will get a complete opportunity to answer.

THE WITNESS: Thank you.

MR. COYNE: So ask a question, and you can answer it. Go ahead.

Q. (BY MR. KAMPINSKI) What did you do to insure that this was just a common finding, that is, coffee ground emesis and the abdominal pain and the fall in hemoglobin? Did you order any additional tests, Doctor?

A. No, I did not.

Q. Why not?

A. Because the falling in the hemoglobin at the level that it was and even at the level of his surgery was not of a magnitude that we would necessarily -- that we would commonly see with an inordinary bleed from this type of surgery.

Q. Doctor, you keep referring to "we". Let's refer to you for a minute. Okay. Let's refer to you. You testified or you did testify under oath that you didn't know what the hemoglobin was, is that correct?

MR. GRODEL: Objection. No. That's not what he said.

Q. (BY MR. KAMPINSKI) Is that correct, sir?

A. I would have to read my testimony.

Q. We'll do this again. I think I just read it to you.

Page 47 again. I will read it again if you didn't hear me the first time. It's your answer, Doctor.

MR. O'NEILL: What's the page, please?

MR. KAMPINSKI: It's 47.

Q. (BY MR. KAMPINSKI) "Question: And it's your testimony that you think you might have been aware of the drop in hemoglobin, or you're not sure right now?

"Answer: I would have to say that I'm not sure."

A. My answer --

Q. And that's what you said?

A. Yes. My answer is that I was -- if I could please make a distinction; when I answered your question initially, my impression was that you were asking me for specific values. I only know the specific values after reviewing the chart. I know the trend.

The trend was that it was dropping, however, this was not a precipitous drop. It was

the kind of drop we see after this degree of surgery. There was nothing in the hemoglobin level that would be out of line with the kind of surgery that he had.

Q. But you do recall now knowing that there was a drop? Is that what your testimony is?

A. I cannot recall specific values, sir.

Q. They were taken every day, weren't they?

A. They were taken periodically. They are routinely taken at the first day and at the third day. If there is some indication if a patient is transferred to the intensive care unit, they are taken on a more regular basis under the auspices of the intensivist.

Q. Do you ever look at them, sir, or do you leave that to your residents, or do you just not bother with them?

A. The answer is that I am aware of the values.

Q. Are you aware of the fact that on the 17th Dr. Jackson ordered tests to be done more frequently?

A. Yes, I am.

Q. You have read that note, haven't you?

A. Yes, I have.

Q. But you are not aware -- you weren't aware of that on that particular day, were you, Doctor?

A. I am not sure I was aware of that note. I can't recall.

Q. Why did he order them taken more frequently? Do you know why he wanted them taken more frequently, Doctor?

A. He was concerned, I would anticipate, that the coffee ground emesis was noted the night before, that he was concerned that this may not -- whether or not there was any significant further drop in his hemoglobin

Q. And he wasn't the attending physician, as I understand it; you were, is that right? You were Mr. Smith's attending physician in the hospital, right?

A. I was his physician in charge of his orthopedic care.

Q. And it was your testimony -- I heard Mr. Groedel say that you believe you talked to Mr. Smith?

A. Dr. Jackson.

Q. I'm sorry, Dr. Jackson, before having Mr. Smith go to surgery on the 17th, is that your

testimony?

A. That is my testimony.

Q. All right. You are aware of the fact that he doesn't recall any such conversation?

A. I'm also aware of the fact that he does not dispute if I said that I did talk with him as well.

Q. Okay. He doesn't recall it at all?

A. I did talk with Dr. Jackson.

Q. Did he tell you that the patient was unstable?

A. No, he did not.

Q. Are you aware of the fact that he's testified that that's his opinion, that the patient was unstable on the 17th? Are you aware of that?

A. I am aware that he spoke with Dr. Jackson, apprised him of Mr. Smith's dislocated hip and apprised him of the necessity of reducing the hip, that we would try to do this as a closed procedure, so we would not -- we would subject Mr. Smith to as little risk as possible.

Q. Was it an emergency, Doctor?

A. It was urgent.

Q. Could it have waited for Mr. Smith to

have been stabilized if, in fact, he was unstable?

A. The difficultly with which these reductions are done make expediency, in terms of reducing the hip, a primary concern.

The longer a hip is left out, the more probable an open, meaning a cutting reduction, meaning more blood loss, further danger to the patient being a necessity.

The speed with which these reductions are achieved greatly enhances your ability to reduce it without a cutting procedure.

Q. Is that a yes or no, Doctor?

A. That's my answer.

Q. Well, could it have waited, if in fact, he was unstable for him to be stablized? That was my question.

A. The answer is that it could have waited. It probably would have made the surgery more difficult.

Q. From an orthopedic standpoint, correct?

A. Probably from every standpoint.

Q. When you did the first operation, you weren't planning to use methyl methacrylate, were you, Doctor?

A. Methyl methacrylate is a bone cement

that was commonly used. I was not planning to use it, but I am prepared to use it on each case.

Q. Well, the reason you used it is that while you were doing the reduction -- or the procedure, the arthrotomy, you cracked his bone, right?

A. The osteotomy, the hip into the joint.

Q. Okay.

A. It was not at that point. It was in the process of fitting the components of a hip replacement to --

Q. Whatever. You cracked it while you were in the process and that's why you cemented it, right?

A. If you are asking for clarification, I am happy to give it. I was trying to explain what happened, if that's okay.

Q. It cracked during your procedure?

A. During the procedure.

Q. And that's why you used cement, right?

A. That's why we cemented.

Q. What if any discussion did you have with any cardiologist or any other orthopods or anybody with respect to the potential effect of that cement on Mr. Smith, who you knew to be

hypertensive; you knew that, didn't you?

A. Sure.

Q. All right. Sure. And did you discuss that with Dr. Jackson or anybody else before you used that cement?

A. In general terms, I can't recall. When I discussed these procedures with the attending who refers the patient, I let them know my initial or my initial treatment plan.

Mr. Smith was a young man. I planned to do a procedure that did not involve cement, since cement has some of its own risk, but I always imply that if the procedure does not go as planned, and we have to do something different, you always have alternatives, and backup procedures to do that are equally as well accepted as good orthopedic procedures.

Cementing a prosthesis is a very fine, and up until five years ago, was the only way to cement in prostheses. This is not a deviation from standard care. It is actually the most common way to fit a femoral prosthesis into the bone.

Q. Are there adverse cardiovascular effects with a cardiac patient undergoing total hip

replacements with the use of methyl methacrylate?

A. Yes, there are.

Q. Is that why you didn't want to use cement originally, Doctor, or did you even give it any thought, sir?

A. The reason I did not want to use cement was primarily a consideration of age. The studies that have been done more recently on cement, those were compiled as a possible risk of cement, but the fixation of attaining a hip prosthesis that is useful to the patient, you have to use those techniques that are commonly in practice, which methyl methacrylate still is, to secure the best figuration, the best hip replacement you can for Mr. Smith.

When you are in the operating room, you make a judgment. You make a judgment as to the quality of the bone, as to which method of figuration will work best. In my judgment, because of the crack in the calcar, I wanted to secure a more stable fixation. Methyl methacryate, although it has some risk, is a widely-acceptable way to secure the femoral component in the bone.

Q. And you did that knowing that he was

hypertensive and that there were potential cardiovascular complications as a result of its use; you knew that, right? And you did it despite that, right?

A. I did it because that was the way to secure his fixation. The anesthesiologists are alerted when we put in cement, we are aware of a blood pressure drop that happens with the insertion of methyl methacrylate. We did it in the usual manner for inserting the cement, which is the standard way to perform a hip prosthesis.

Q. Why did he go to intensive care after the surgery on the 14th?

A. He went to intensive care because the anesthesiologist, who happened to be Dr. Trusso in that situation, was concerned because of his pressure drop at the time of the induction, and the blood gases that were done during the case showed some oxygenation that was not consistent with the amount of oxygen he was receiving via his endotracheal tube, so he thought it would be a good idea to take him to surgical intensive care.

Q. And as the attending physician for Mr. Smith, you of course, followed up on his condition in intensive care?

A. Yes, I did.

Q. You checked the CPK and the Mb so you knew that he had had a heart attack, you are aware of that?

A. The CPK indicates myocardial damage. The EKG on the initial visit, on the initial admission to the hospital, shows myocardial ischemia, heart damage, the subsequent EKG shows myocardial ischemia, heart damage, the Mb fraction ordered by Dr. Oliver as part of the monitoring for him in the intensivist situation, he thought that fraction not to be of significance in light of his prior EKG history.

He did not think that reflected new damage.

Q. When?

A. I relied on -- not specifically that value, but the general notes that are entered in Mr. Smith's chart from the time after his initial surgery by Dr. Jackson, by the intensivist, Dr. Oliver, all of which say that he was stable, cardiovascularly, throughout the whole procedure.

Q. Dr. Jackson says he wasn't aware of that value, sir.

A. I didn't say that value. I said

cardiovascularly. I didn't say that value.

Q. You were aware of the value, weren't you?

A. No, I was not.

Q. I see. You wouldn't have even known what to do with it, would you; you are not an expert on CPK or Mb bands, are you?

A. If you're asking me do I treat cardiovascular problems, I do not.

Q. So that you got a cardiology consult, is that right?

A. No, I did not.

Q. Why not?

A. I think I have just elucidated on that, sir.

MR. O'NEILL: What was the response?

THE WITNESS: I have --

MR. GRODEL: Tell him again.

THE WITNESS: I did not get a cardiology consult because the experts that were helping manage this patient medically --

Q. (BY MR. KAMPINSKI) Excuse me. The expert, you say Dr. Oliver, the resident?

A. Dr. Oliver is not a resident. He is the intensivist. He's not a resident.

Q. Okay.

A. He is the attending physician in charge of the intensive care unit.

Q. I'm sorry. Go ahead.

A. Dr. Jackson, his internist; Dr. Oliver, the intensivist in the intensive care unit, repeatedly concluding the premature atrial beats on the EKG. Dr. Jackson even in his readmission note to the hospital indicated that he had done periodic EKG's on Mr. Smith in his office, indicating basically the same pattern of EKG that was noted throughout the hospital stay, that these had been stable.

Dr. Oliver, the intensivist, noted that as well, thought that he was stable cardiovascularly. Both of those experts in the medical area said that he was stable. I relied on their opinion.

Q. Okay. He was returned to the floor on the 16th then from the intensive care?

A. Yes, he was.

Q. And did you rely on them, then, from the 16th through the 17th? Did Dr. Oliver see him?

A. Rely on him in what manner are you saying?

Q. In any manner. I mean, did you have Dr. Oliver, the intensivist, come back to see him, or did you have any other cardiology consults? Did you?

A. I did not get a cardiology consult.

Q. When you made the decision that Mr. Smith was going to go back to surgery, why didn't you?

A. In terms of his cardiovascular status, nothing had changed.

Q. Well, you were going to do an operation on the man, weren't you?

A. I was going to do a closed reduction.

Q. Pretty simple procedure?

A. It is a procedure that requires some effort on the part of the person who is performing the closed reduction, but in terms of simplicity from a surgical standpoint, yes, it's a relatively simple procedure.

Q. And did you get an anesthesiologist to clear him for anesthesia, Dr. Lee?

A. I called an anesthesiologist on call.

Q. And you discussed Mr. Smith with him, did you?

A. I don't recall at that point. I believe

Dr. Lee was in another surgery at that time.

Q. All right. So before you had the surgery on Mr. Smith, the two of you sat down, you apprised him of his prior cardiovascular problems, and the two of you discussed the risks attendant to that additional surgery, didn't you? Right?

A. Specifically, I don't remember. In general, that is what we do, yes.

Q. In general. Well, what did you tell him specifically about his cardiovascular status?

A. I don't recall my specific conversation with Dr. Lee other than to inform him of what we -- what I basically needed to do, the urgency with which I needed to do it.

Q. Are you telling me that you didn't discuss his cardiovascular status with the anesthesiologist; is that what you're saying?

A. If you're asking me did I discuss specifics of it, I don't recall. I recall the things that at that point that orthopedically were of an urgent nature. Those were to reduce his hip as soon as possible to avoid an open operation.

Q. Okay. And then you got a consent form signed, right? Right?

A. I don't recall that specifically. I

believe that it was. If it was not --

Q. Okay. Why don't you find it for me, if you would.

MR. GRODEL: We'll stipulate that there is no consent form signed.

A. I specifically talked with Mr. Smith, and he agreed to the procedure.

Q. (BY MR. KAMPINSKI) During the -- after the surgery, what condition was Mr. Smith in?

MR. O'NEILL: I can't hear your question, sir.

Q. (BY MR. KAMPINSKI) I'm sorry. I said what condition was Mr. Smith in after the surgery, Dr. Smith?

A. Mr. Smith after the surgery was awake, alert and talking with me on the way from the recovery room, from the operating room to the recovery room, a distance of probably 50 feet.

Q. Well, he was awake because he wasn't put to sleep, right?

A. Awake, alert and talking. The anesthetic, whether it's spinal or not, can induce a sleepy state, so it is not unusual even after a spinal for some people to be difficult to arouse.

Q. And in fact, the operative note is

signed by Dr. Gill, was it?

A. That is correct.

Q. Yeah. Dr. Gill. He was what, the chief resident?

A. Chief resident.

Q. Said that he -- and you countersigned this; as a matter of fact, you countersigned it after Mr. Smith died, I believe. The patient was then transferred to the recovery room in good condition and tolerated the procedure well without intra-operative complications, right? So he was in good condition, right? Is that your testimony, Dr. Smith?

A. He was in good condition as far as we're aware, that's correct, and as a matter of point, it was impossible to countersign that prior to his death because a dictated summary does not come back to the chart for several days.

Q. Why is it, Doctor, that in your expiration summary you said that he went to intensive care?

A. It was just an error in dictation.

Q. And you went into the recovery room, with him, didn't you?

A. Yes, I did.

Q. Because you went right from the operating room into the recovery room?

A. That is correct.

Q. And as a matter of fact, the nurses' notes reflect that you were there at 5:25, right?

A. The chronology, in terms of -- if you look at the way the entry is written, it would appear that I entered at some time later. In fact, I entered as the patient entered.

Q. So in fact, you were aware of what was written there on that first note, right, Doctor?

A. Was I aware of what was written?

Q. Sure.

A. Or what the patient's status was?

Q. Both. Are you saying that they are different, that the nurse put down something false; is that what you're saying?

A. If you will look at the nurses' note, which is the same day --

Q. Do you have it in front of you, by the way?

A. Yes, I do.

Q. Okay. Go ahead.

A. If you read the note, which is dated the same time from the nurse in the operating room,

also dated at 5:25, it states that the patient was awake, alert, skin was dry and warm.

MR. COYNE: What page are you reading from? What page is this?

MR. GRODEL: 154, I believe.

THE WITNESS: This is dated at the same time, 5:25.

MR. COYNE: I just want to know what page.

MR. GRODEL: 154.

MR. COYNE: Thank you.

A. It's the bottom paragraph or the bottom set of entries. Postoperative level of response, postoperative skin condition, disposition, and the entry, the time that this patient left the room, 5:25, the same time that it was listed as entry into the recovery room.

Q. (BY MR. KAMPINSKI) And she checked the patient as you were taking him from the operating room to the recovery room, this nurse, this D. Palmer, is that right?

A. That entry is made as the patient is preparing to leave. I don't know whether that assessment is made in transit or not, but I can attest that the patient's condition was as is

described there.

Q. So that in the minute that it took to get from the operating room to the recovery room, his condition drastically changed, is that right?

A. His condition never changed while I was there.

Q. Why don't you read the note to the panel, if you would, of 5:25 in the recovery room?

A. 5:25, awake --

Q. By the way, before we get to that, up at the top it's got skin temperature?

A. Right.

Q. Admission 5:25?

A. Right.

Q. Diaphoretic?

A. That is correct.

Q. Dusky nail beds?

A. Yes.

Q. Go ahead.

A. The remarks, as best as I can, it says awake, looks like responsive and --

Q. How about respirations?

A. Okay. Awake -- I cannot read that.

Q. Okay. Go to the second sentence then if you would.

A. Dypsneic.

Q. What's that?

A. It implied a difficulty breathing.

Q. Go ahead.

A. Complained of shortness of breath. Dr. S. J. Lee aware. Breath sounds clear throughout. Dr. Smith visited.

Q. Okay. So chronologically, it's got you visiting after the entry of these other notations by the nurse, right?

A. As a matter of record and as a matter of general principle, these notes are virtually impossibly written at the time they're entered. They are given an approximate time and a summary of what has happened in a given time frame is written.

Whether I accompanied Mr. Smith from the operating room to the recovery room, the fact that this note was written here only says that this nurse's recollection of the events and the chronology as they happened. I have given you my remembrance of the events as they happened.

Q. As at least in terms of her recollection, she's got him complaining of shortness of breath, being dypsneic, and were you aware of the

uncontrolled ventricular rate, frequent multifocal PVC's and his atrial fibs; were you aware of those, Doctor?

A. No, I was not.

Q. Had you stayed for a few minutes, you might have been, because the next entry is 5:40, right, so at least even -- as far as your testimony goes from 5:25 to 5:40, these notes would have been written somewhere in that period of time, is that right?

A. Or at the end of a shift, or whenever the nurse who is in charge has time to write the notes.

Q. Knowing, Doctor, that Mr. Smith had exhibited some coronary insufficiency and that he had been taken to the intensive care unit after the first surgery, and that his hemoglobin had been dropping and that he had coffee ground emesis, didn't you think it advisable to at least stay there for a while to insure that he was stable after you left?

A. Mr. Smith was stable throughout his surgery, stable when I accompanied him to the recovery room. If there had been any change, I would assume that either I or my service would

have been apprised.

Q. My question is didn't you think it advisable to stay, Doctor?

A. When the patient was stable, no, I did not.

Q. So that these notes don't reflect what you observed, right?

A. They do not.

Q. Had you observed these conditions, I take it you would have stayed, is that correct?

A. I wouldn't have left.

MR. O'NEILL: I didn't get that.

THE WITNESS: I would not have left.

Q. (BY MR. KAMPINSKI) Where did you go?

A. I don't recall.

Q. I take it you called back, what, a half hour later, hour later, to see how he was doing?

A. I called my associate and apprised him that Mr. Smith was in the recovery room doing fine, and that -- as a matter of record also, I was actually not on duty that particular day. I came back in because this was my patient, did the closed reduction, after the closed reduction was performed successfully, without problem, I signed

out to Dr. Stephens who was on call that day anyway.

Q. Is the answer to my question that you didn't call back, Doctor?

A. No, I did not call back.

Q. This was what, a Saturday?

A. As you have already said, yes.

MR. KAMPINSKI: That's all I have.

* * * * *

CERTIFICATE

I, Nancy A. Nunes, a Registered Professional Reporter, do hereby certify that I attended the foregoing proceedings in their entirety; that I wrote the same in stenotypy which was subsequently transcribed into typewriting by means of computer-aided transcription under my direction; and that the foregoing Excerpt of Transcript of Proceedings is a true and correct transcript of my stenotypy notes.

Signed this 10th day of November, 1987.

Nancy A. Nunes

Nancy A. Nunes, RPR
Mizanin Reporting Service
540 Terminal Tower
Cleveland, Ohio 44113

LAWYER'S NOTES

Page	Line	

BAYONNE, N.J.