IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

Doc. 454

DIANE M. CARRICK, EXECUTRIX, et al.,

Plaintiffs,

-vs-

JUDGE J. KILCOYNE
CASE NO. 185330

THE CLEVELAND CLINIC FOUNDATION, et al.,

Defendants.

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Deposition of JAY B. WISH, M.D., taken as if upon cross-examination before Aneta I. Fine, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the University Hospitals, 2074 Abington Road, Cleveland, Ohio, at 3:00 p.m. on Thursday, December 5, 1991, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Defendant
Robert Riley, M.D.

MR. KAMPINSKI: Let the record show that Mr. Spisak received notice of this deposition some time ago and that his office called me this morning to reconfirm that it was going forward at the time and place designated. He's not arrived and we're going to go ahead and get started.

It's 3:08, we're going to start without him as Mr. Gore indicated.

JAY B. WISH, M.D., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF JAY B. WISH, M.D.

BY MR. KAMPINSKI:

Q. Okay. Doctor, would you state your full name, please?

A. Jay Wish.

Q. And your current position, sir, is what?

A. Associate professor of medicine at Case Western Reserve University and director of the hemodialysis unit at University Hospitals.

Q. Have you been involved, sir, in providing expert

testimony previously for Mr. Gore or anyone in his firm?

A. No.

Q. All right. You have never testified for Arter Hadden before?

A. No. I have testified in the capacity of a material witness in one case but not as an expert witness.

Q. What does that mean, as a treating physician?

A. I was involved in a case that was being adjudicated.

Q. Were you a defendant?

A. I was not a defendant.

Q. All right. What was the case?

A. It was a patient who was being evaluated for renal transplant who had advanced renal failure who was admitted for elective cholecystectomy prior to transplant and subsequent to his cholecystectomy he had a cardiac arrest.

Q. And your involvement was as a treating physician?

A. As a treating physician.

Q. So it was a lawsuit against somebody else and you merely testified as to your involvement?

A. Exactly.

Q. Have you testified as an expert witness in other cases?
A. In other cases, yes.
Q. Have they been for the plaintiff, defendant or both?
A. Both.
Q. What percentage would you say would be for the defense?
A. I would say two-thirds for the defense, one third for plaintiffs.
Q. All right. And are we talking about malpractice cases?
A. Yes, all.
Q. How many cases are we talking about, roughly?
A. A dozen.
Q. And do you have a list of those cases?
A. I have a file.
Q. And would it be difficult for you to make up a list then from your file of the cases where you have acted as an expert?
A. No, I could do that.

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(Thereupon, a discussion was had off the record.)

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Q. And would that include or would you be able to set forth the names of the attorneys involved?
A. Sure.
Q. Okay.
MR. KAMPINSKI: Do you have any difficulty with his doing that?
MR. GORE: No. I will get it from the doctor and get it to you.
MR. KAMPINSKI: Okay.
A. You want me to indicate on each whether I was testifying for the plaintiff versus the defendant?
Q. Please.
A. No problem.
Q. And if you would set forth the attorneys representing the various parties?
MR. GORE: To the extent that you know them.
MR. KAMPINSKI: Yes.
Q. To the best of your knowledge were you deposed in each of those cases, doctor?
A. No, not in all of them. Some it was just that I would write an expert opinion letter.
Q. Okay. Did any of them go to trial?
A. Only one went to trial.

Q. And what was the name of that case?
A. I can't remember the entire name. I seem to remember the name Connie Adams as being the plaintiff, though. It was a Columbus case.
Q. All right. What were the allegations in the case?
A. I was actually testifying for the plaintiff in that one and it was several years ago so I would have to refresh my memory by looking at the file.
Q. All right. Do you recall who the plaintiff's attorney was?
A. Again, I don't, but I can look it up.
Q. Okay. Have you ever been a defendant in a malpractice case, doctor?
A. No.
Q. How is it that you were contacted in this particular case?
A. Mr. Gore called me.
Q. All right. And asked you to review --
A. Review the records.
Q. All right. You set forth the records that you reviewed in your April 9, 1991 report. Have you reviewed any records since that time?
A. I was given two letters that Mr. Gore had

received from Dr. Heyka and from the surgeon, and I read those letters.

Q. Okay. Do you have them with you?

A. Yes. It was Dr. Heyka and Dr. Broughan that I received subsequent to my report.

Q. Do you have the cover letter sending these letters, doctor?

MR. GORE: I handed it to him.

Q. You were about to reach for something?

A. I was going to see if I do but if they were handed to me then I don't. I have all my correspondence and I can tell you if I have a cover letter.

Q. Why don't you get your whole file out if you would, doctor?

MR. GORE: I'll object to him producing correspondence between me and him.

MR. KAMPINSKI: Why is that?

MR. GORE: Because I think that that's work product.

MR. KAMPINSKI: Do you?

MR. GORE: Yes. But the rest of the file that he reviewed, I have no problem with it.

MR. KAMPINSKI: Well, all right. We can deal --

MR. GORE: No, there's no cover letter to those reports.

Q. Given what Mr. Gore just indicated, why don't you identify, if you would, the dates of the letters between yourself and Mr. Gore?

A. The only letter from myself to Mr. Gore is the one that you have.

Q. Okay. How about then from Mr. Gore to yourself?

A. From Mr. Gore to myself, I have it in chronologic order here, November 29, 1990 where Mr. Gore introduced himself and asked me to review the case. December 7, 1990 which was the cover letter for the materials that he sent for me to review.

Q. Well --

A. March 22, 1991 --

Q. Doctor, let me stop you just for a second. I mean what you just referred to as a cover letter is how many pages, the December 7, 1990 letter?

A. Yes. It basically itemizes all the items that were sent to me.

Q. All right. How many pages does that consist of, doctor?

A. Three.
Q. Okay. I'm sorry, go ahead. And the first one was one page?
A. Yes. The December 7 letter also basically outlines the areas that he wants me to address in my response.
Q. Okay. As a matter of fact, you refer to that in your report?
A. Right.
Q. Okay.
A. March 22, 1991 where he just, Mr. Gore gives me a date when he hopes my response will be ready; April 15, 1991 where he acknowledges receipt of my report; June 5, 1991 where again he gives me an update of what is going on; and October 25, 1991 which confirms today's deposition.
Q. All right. All of the letters at least from what I could see that you referred to, other than the December 7, 1990 were just one-page letters, correct?
A. That's correct.
Q. All right. And apparently, the questions which you responded to were set forth in his December 7, 1990 letter?
A. That's correct.

Q. All right. Was there any information of a factual nature set forth in the December 7, 1990 letter?
A. No. It's only the questions, and the itemization of the reports that I'm to review.
Q. All right. So that at least for purposes of your retention, I mean your -- or the questions that were posed to you were posed in the December 7, 1990 letter?
A. That's correct.
Q. All right. And I take it that you saw your function as addressing those questions?
A. That's correct.
Q. All right. What else do you have other than the letters in the file, doctor?
A. I have all the records that were sent to me on December 7.
Q. Okay. The ones referenced then on your report?
A. Right. They include the hospital records from Cleveland Clinic, the hospital records from Lakewood Hospital, a number of depositions with summaries provided by Mr. Gore's firm, and that's it.
Q. Okay. To what extent did the letters from Dr. Broughan and Dr. Heyka influence your

opinions?
A. They didn't at all because I hadn't received them when I wrote my letter.
Q. Do you remember when you received them?
A. No. It was subsequent to my preparing the letter, though.
Q. Do you have any notation or any indication in your file at all indicating what period of time you would have gotten these?
A. It was -- it must have been after I sent the response in April so --
Q. It was between then and now?
A. Between then and now. That's the best I can do. It was in the spring.
Q. Okay. Just give me a moment if you would.
A. Okay.

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(Thereupon, Plaintiff's Exhibits 1 and 2 were mark'd for purposes of identification.)

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Q. Do you know why you were given these letters, doctor? I mean did you ask for the opinions of Dr. Broughan and Dr. Heyka or --
A. No. I think I was given them to show, for

Mr. Gore to demonstrate that my opinion was consistent with those, of those individuals.

Q. Okay. You do indicate in your report that you reviewed Dr. Heyka's and Dr. Nakamoto's depositions, correct?

A. That's correct.

Q. Do you agree with Dr. Heyka's opinion that Dr. Riley failed to adhere to the appropriate standard of care required of him in the treatment of Mr. Carrick prior to his coming to the Cleveland Clinic and that that failure contributed to cause Mr. Carrick's death?

MR. SPISAK: Note my objection.

A. I wasn't asked to --

Q. I know that. That's why I'm asking the question.

A. There are several aspects of Dr. Riley's care that I find fault with, whether those were a proximate cause of Mr. Carrick's death, I couldn't say that they definitely were.

Q. Well, proximate is a legal term?

A. Yes. Whether they led to his death, I couldn't say that.

Q. Well, did they contribute to cause his death?

A. I think they contributed to make him very sick,

but whether they contributed to his death, no.
Q. You can't say one way or the other?
A. No.
Q. So you don't agree or disagree with Dr. Heyka's opinion, you just have no opinion regarding --
A. I have no opinion.
Q. Okay. What about the adherence to the standard of care? I mean I tried to listen closely to what you just said.
A. Yes.
Q. You do, I take it, then find fault with his --
A. I find fault with his care.
Q. All right. What do you find fault with, doctor?
A. That he didn't appropriately evaluate the nature of the arthritis. He was treating gout empirically without getting a diagnosis and I made a reference to that in my letter that he probably should have done a joint aspiration, examined to see whether there were uric acid crystals there.

He didn't work up the renal disease. The patient had progressive renal failure, probably should have had a renal dialysis bio and referred to a nephrologist for that investigation.

Q. He had been treating him for I think 15 years?
A. Yes.
Q. And what step of the process should that have been done?
MR. GORE: What, the referral to the nephrologist?
A. The referral to the nephrologist?
Q. Yes, sir.
A. Probably when a serum creatinine was around two or three.
Q. And that I believe was in the early 80's?
A. Uh-huh.
MR. GORE: You have to say yes or no, doctor. You can't just say uh-huh.
A. Oh, I can't remember when that was.
Q. Okay. In your report you also indicated, doctor, that there was some confusion at least in your mind from reading Dr. Riley's deposition apparently as to the extent to which he prescribed Indocin.
I don't want to paraphrase you incorrectly. If you need to look at your report at all, you know, feel free to do so.
A. Okay.
Q. What I'm referring to is page two of your

report, it's really the, what, the middle paragraph starting with whether.

A. Well, I said, It is known that continuous use of these agents may lead to chronic interstitial nephritis. However, it appears from Dr. Riley's records and deposition that Mr. Carrick was treated only intermittently with these agents.

Q. Okay. When you say it is known that continuous use of these agents may lead to chronic interstitial nephritis, what do you mean by continuous use? I mean give me some parameters of what you're talking about?

A. Use over a long term without interruption.

Q. Well, would use over a period of 15 years without interruption fit the definition of continuous use?

A. Yes, it would.

Q. And would it require any particular dosage over that period of time or is that --

A. It's a dose-related effect but could occur at a low dose as well.

Q. Having been used for that period of time?

A. Yes.

Q. Okay. I take it you weren't provided with the deposition of Mrs. Carrick?

A. No, I was not.
Q. Were you provided with any information other than Dr. Riley's testimony as to how often Mr. Carrick was using Indocin?
A. No.
Q. You weren't provided?
MR. GORE: Riley's records?
MR. KAMPINSKI: Yes.
A. Riley's records and deposition?
Q. Sure. You weren't provided with the --
A. Pharmacy receipts or anything like that?
Q. Right.
A. No.
Q. If, in fact, the use was continuous as we have just defined it, then would that affect your opinion contained in this paragraph?
A. Yes, it would.
Q. All right. How would it affect it, doctor?
A. It would make me feel that it was more likely that the Indocin contributed to his renal disease.
Q. And ultimate death then?
A. No.
Q. No?
A. Because he didn't die of renal failure.

Q. Well, do you believe that the hyperparathyroidism was secondary to the uremia?
A. Yes.
Q. And if -- and what is uremia?
A. Uremia?
Q. Yes, sir.
A. Is a clinical syndrome characterized by a variety of biochemical abnormalities, signs and symptoms that are due to the failure of the kidney to perform its normal functions.
Q. Renal failure?
A. Yes.
Q. So if, and maybe I'm not following what you're saying, if the renal failure was caused by the use of the Indocin, assuming that there was continuous use of it, and the hyperparathyroidism was secondary to that --
A. Well, I didn't say that the renal failure was caused by the use of Indocin.
Q. You didn't. I know you didn't. You responded, however, to my hypothetical based upon if there was continuous use?
A. Then it would be more likely that the Indocin was a contributing factor.
Q. Renal failure?

A. Right.
Q. And to the secondary hyperparathyroidism?
A. Yes. Which resulted from the renal disease.
Q. And his death then?
A. Well, secondary hyperparathyroidism didn't kill him either.
Q. What killed him, doctor?
A. A number of complications which followed his hyperparathyroidism.
Q. All which stemmed from the treatment of the hyperparathyroid?
A. Right. But not everybody that's treated for hyperparathyroidism get the complications that he does. It was an unfortunate sequence of events but I don't think it was ultimately related to step one.
Q. If step one wouldn't have happened step five wouldn't have happened?
A. That's true.
Q. So that if, in fact, his condition was, not assuming that it was, it was caused or that the Indocin contributed to cause the problem to begin with, assuming that had not been inappropriately given for 15 years, he wouldn't have had the problem for which he was treated

that he ultimately got complications from and died from?

A. That's correct.

Q. And it would be substandard care in your opinion, would it not, to provide continuous use of Indocin to a patient such as Mr. Carrick?

A. No, it would not be substandard care just to provide the Indocin, it would be substandard care to provide the Indocin continuously, note that the renal function was declining and not do something to intervene at that point.

Q. And that's exactly what happened, isn't it?

A. That's correct.

Q. If what you say is correct, that he was treated continuously for which I have no direct evidence, do you agree that if Mr. Carrick had been stabilized that he would have been a good candidate for transplant?

A. I found nothing in his history that would be a contraindication for transplant.

Q. All right. So does that mean you agree or --

A. Well, there's a big if there. If he had been stabilized. He had a lot of things going wrong with him.

Q. I said if he had been stabilized?

A. I think, yes, if all those things would have been straightened out he would have been a candidate for transplant.
Q. And do you believe that his uremic compromise was the cause of his pneumonia?
A. No.
Q. Why not?
A. I think the fact that he had uremia may have made him at greater risk for developing a variety of infections but I think the direct cause of his pneumonia was the combination of his musculoskeletal pain, his narcotic analgesics which decreases cough reflex and the fact that he was a post-operative patient. All post-operative patients are a great risk for pneumonia.
Q. Okay. Did the uremia contribute to his pneumonia?
A. No. It made him at high risk for developing pneumonia but did not contribute to the pneumonia. Broad distinction there.
Q. Okay. Did you agree with Dr. Nakamoto's decision to dialyze Mr. Carrick, I believe it was on April 14, after the operation?
A. Yes.

Q. All right. Why would it have been appropriate then for him to be dialyzed at that time and not before the operation at some point in time?
A. Because his renal function had declined further after the operation.
Q. Okay. Renal function as measured by what standard?
A. His serum creatinine.
Q. And what was it before and what was it after, doctor?
A. I'm going to have to refresh my memory, but as I recall it was in the six range when he was admitted and it rose to around the ten range in the post-operative period.
Q. Okay. And once it reached that point you believed he should have been dialyzed?
A. I think it was appropriate at that point.
Q. You don't think it was appropriate at the preoperative range?
A. No. No.
Q. Did he have hyperparathyroidism in your opinion?
A. Absolutely.
Q. And was that taken care of, that condition taken care of by virtue of the operation?
A. Yes, that was the treatment of choice for his

hyperparathyroidism.

Q. I have read your report, I know you disagree with Dr. Gorbaty, but can you, in fact, treat medically the condition, just in the abstract, of hyperparathyroidism by dialysis, reducing the symptomatology that caused the hyperparathyroidism?

A. Dialysis, no. Dialysis is not a treatment for hyperparathyroidism.

Q. It's a treatment for uremia?

A. But it's not a treatment for the hyperparathyroidism that goes along with uremia.

Q. If you treat the uremia successfully, does that then alleviate the symptomatology due to the hyperparathyroidism?

A. Not dialysis alone. Dialysis in conjunction with other therapies.

Q. All right. Such as?

A. In conjunction with Vitamin D supplementation, good diet, and phosphate binders and diet, yes.

Q. So that there's then a medical versus a surgical treatment in the abstract for hyperparathyroidism?

A. For hyperparathyroidism but not to the degree that Mr. Carrick had it at the time of his

presentation.

Q. So your real disagreement, at least in terms of what we're talking about now, this particular issue with Dr. Gorbaty, is the degree of, the degree to which Mr. Carrick was suffering from his hyperparathyroidism at the time he went into the Clinic?

A. Yes. But that's a very essential distinction.

Q. I'm not suggesting it's not, but that is the difference?

A. Yes.

Q. Correct?

A. Yes.

Q. Okay. And I take it then you would agree that Mr. Carrick should have therefore been treated for this condition long before, in fact, he was in order to have allowed an alternative treatment?

MR. GORE: Okay. Clarification. Treated for this condition.

Q. The hyperparathyroidism?

A. Yes.

Q. And that would be a failing on the part of Dr. Riley again?

A. To either treat or to refer him to someone who

could, yes.
Q. Do you know Dr. Riley?
A. No.
Q. You're not a surgeon, I take it?
A. That's correct.
Q. All right. So that in the event that you have patients that you believe require surgical management, you would then refer them to a surgeon?
A. That's correct.
Q. Do they make the decision as to whether surgery is the appropriate modality or do you make it in conjunction with them?
A. We usually make it together but the fact that I have referred the patient to the surgeon usually implies that I'm requesting surgical intervention and it's ultimately up to the surgeon to agree or disagree with me.
Q. And do you typically do that after trying a patient on a course of medical treatment or just depends on his --
A. Depends on the problem. If there's a ruptured appendix there's no medical treatment.
Q. I'm talking about kidney failure basically, I'm not talking about --

A. Are you talking about hyperparathyroidism, parathyroidectomy?
Q. Yes, sir.
A. Yes, I'll usually try medical treatment first.
Q. At what level did Dr. Chulak tell you that azotemia -- am I pronouncing that right?
A. Uh-huh.
Q. -- would be a contraindication to a parathyroidectomy?
A. He didn't think that any level of azotemia alone would be a contraindication to a parathyroidectomy.
Q. And that was how you posed the question to him?
A. Uh-huh.
Q. When you said alone?
A. Well, azotemia may occur in conjunction with other metabolic disorders and it often does and any one of those metabolic disorders may be a relative or absolutely contraindication.
Q. Such as?
A. Such as hyperkalemia or severe metabolic acidosis or volume overload which sometimes occurs in patients with renal failure, but a high BUN alone is not a contraindication to surgery.

Q. Did Mr. Carrick have any of those other conditions?
A. Not at the time of his presentation.
Q. Well, so that I see, okay. You make the statement in your report, doctor, that Mr. Carrick was not suffering any clear complications of his renal failure prior to his parathyroidectomy that could be expected to be immediately reversed by dialysis. The sentence actually was Mr. Carrick was not suffering?
A. Right.
Q. And then you go on to say the decision not to perform dialysis preoperatively is justified?
A. That's correct.
Q. And my question, sir, is you qualify that by it being immediately reversed. I take it you're not saying that there wouldn't be a reversal of the complications of renal failure by use of dialysis, I take it the operative word is immediately?
A. Well, if the question was whether dialyzing him preoperatively for a day or two would have made a difference, that I consider to be more of an immediate time course than dialyzing him for six months before the surgery which would be a more

long-term type course.

Q. Well, so that you're then posing the issue as an immediate one and you're doing that by virtue of Mr. Carrick's condition?

A. Well, I'm doing it on the basis of the issue that I thought I was addressing, that I was supposed to address, and that was whether or not preoperative dialysis was indicated here.

Q. All right. The difficulty perhaps I'm having is I'm not privy to the issues you were asked to address and that's contained in Mr. Gore's letter.

A. Well, it's basically on the basis of Dr. Gorbaty's statement that the patient should have been dialyzed preoperatively and I'm responding to that.

Q. Sure. But his position was that a course of six to 12 months of dialysis would have reversed the condition?

A. That is totally unjustified.

Q. Well, I understand, and you said that?

A. Yes.

Q. But my point, and I don't want to be talking cross-purposes, I guess what I'm interested in knowing is why you chose to frame the issue as

an immediate reversal of the --

A. Because I was addressing the issue of whether or not the fact that his BUN was high would have put him at higher risk for some of the complications that Dr. Gorbaty alleged resulted from the failure to dialyze him preoperatively such as an increased tendency to bleed, or the fact that he developed an ileus and those kinds of things. Those things would not have been affected by his being dialyzed preoperatively.

Q. Okay. What -- well, all right. I mean you're choosing certain things that you disagree with Dr. Gorbaty about, but the basic premise, and that is that dialysis over a long period of time would have reversed the effects of the hyperparathyroidism, if that wouldn't have worked you could always do the hyperparathyroid -- the operation later on?

A. No, you couldn't. He needed the parathyroidectomy then.

Q. Because of his deteriorating condition?

A. Yes. He was getting worse and worse and dialysis and Vitamin D and calcium and all the things that we would normally do to treat patients who are not as severe as he was, may

have stabilized their condition but would not have stabilized his condition. His condition was terrible. He needed surgery.

Q. How did he do after surgery?

A. He died but that doesn't necessarily mean that the decision to do surgery was inappropriate. You don't judge the quality of a decision by the outcome, you judge the quality of the decision by the facts that were taken into account when the decision was made.

If I hold a basket over your head and I say there's ten balls in this basket, nine of them are red, and one of them is white, and I'm going to ask you to, before you reach in to tell me what color ball you are going to pick out, you're obviously going to say I'm going to pick out a red ball because you have a 90 percent chance of being right. And if you pick out a white ball and you were wrong does that mean your decision was wrong? No. Your decision was justified on the basis of the odds; you just had an adverse outcome. And that's what happened to Mr. Carrick, he had an adverse outcome but the decision to perform surgery was correct.

Q. What would have been the outcome had the

decision been made to treat him medically?
A. What would have been the outcome? I can't say. He may still have died.
Q. Or it may have worked?
A. No. His parathyroidism would have continued to ravage his bones and he probably would have died from some other complication.
Q. When we talk about secondary hyperparathyroidism, what mechanism resulting in renal failure causes that?
A. The elevated serum phosphorous.
Q. And does dialysis and the medical treatment that you refer to that would go along with it reduce the serum phosphorous?
A. It reduces it but it does not normalize it. So the phosphorous normally remains elevated and that's why we have to give them the phosphate binders and Vitamin D as well.
Q. But you said dialysis and the other treatment you talked about --
A. Uh-huh.
Q. -- would then reduce it, giving the phosphate binders and the other treatment as well?
A. Yes. But the horse was already out of the barn here. This man's bones were already falling

apart. Normalizing the serum phosphorous is not going to make what already happened better.

Q. Well, what fact does the hyperparathyroid surgery have on the serum phosphorous?

A. What effect does the hyperparathyroid surgery itself have on the serum phosphorous if nothing else was done?

Q. Yes.

A. It would cause the phosphorous to go up.

Q. And what effect would that have on his bones, any?

A. But you wouldn't do that in isolation. That's the point. You would do this in conjunction with medical therapy which is what they do.

Q. What medical therapy?

A. They started him on phosphate binders which was the appropriate decision.

Q. To reduce the serum phosphorous level?

A. Exactly.

Q. And that could be done then either with or without the surgery, correct?

A. You can reduce the serum phosphorous level without the surgery. What you can't do is put the patient back into the positive calcium balance which is what you need to do.

Q. And that's what the surgery did?
A. What the surgery does is immediately to remove the stimulus for the demineralization for the bone.
Q. And how does it do that?
A. By taking away the hormone that causes the calcium to come out of the bone which is the parathyroid hormone. If you treated this patient medically it would probably take months to suppress his parathyroid hormone, so during months his parathyroid would continue to ravage his bones.

MR. GORE: Aneta, Chulak is, C H U L A K.

Q. Do you know Dr. Heyka?
A. Yes.
Q. Personally?
A. Yes.
Q. All right. And how do you know him?
A. I know him because we have been at conferences together, being that we are both nephrologists.
Q. And do you belong to the same societies?
A. We belong to the nephrology societies, yes.
Q. Have you chaired -- have you been on any committees together?

A. No.
Q. Have you chaired any studies?
A. No.
Q. Or done any studies, I should say?
A. No.
Q. When's the last time you were at a conference with him?
A. I'm trying to remember. It wasn't this year. It was probably sometime in 1990 because it wasn't at this year's conference.
Q. Do you socialize with him at all?
A. No.
Q. Is there a local nephrology group?
A. Not really. There's not any nephrology group that takes in the entire nephrology community. There's kind of two chasms if you will.
Q. What are they?
A. There's the Case Western Reserve-affiliated institutions that have kind of their own thing for nephrologists and the Cleveland Clinic seems to do their own thing.
Q. Do the two of you interrelate at all with respect to those two groups?
A. No.
Q. Share information or --

A. Not regularly.
Q. You do but then on an irregular basis?
A. On a national basis if we happen to be at the same national meeting we see each other.
Q. Okay. Doctor, of some concern is I guess you know I see it in your report and now I see it in these letters from the Cleveland Clinic doctors, is your use of adjectives as it relates to Dr. Gorbaty as opposed to just disagreeing with his opinions or setting forth yours?
A. I was quite outraged by Dr. Gorbaty's opinions. I thought they were totally off the wall and my adjectives reflect the way I felt.
Q. Well, and you're pretty certain then of the things you said in your report?
A. Very certain.
Q. Everything you said in your report is accurate then?
A. Everything I said in my report I strongly believe in.
Q. I asked you if it was accurate?
A. I believe it is.
Q. None of what you said is preposterous, right?
A. I don't think so.
Q. I take it you reviewed the record fairly

carefully before you made some of the statements that you did in your report?

A. Yes, I did.

Q. Page five of your report, sir?

A. Uh-huh.

Q. Paragraph four?

A. Number four.

Q. Sure. Where you use one of your adjectives to describe Dr. Gorbaty?

A. Right.

Q. Yes.

A. I didn't describe Dr. Gorbaty. I described the statement. I'm not using abominable arguments.

Q. And what you said is Dr. Gorbaty makes the preposterous statement that Mr. Carrick's post-operative ileus was due to obstruction by, quote, "rocks," end quote, composed of phosphate binders. There's absolutely no evidence in the medical record to support this allegation?

A. Right.

Q. Right? Was he noted, was Mr. Carrick noted to have abdominal distension on April 14?

A. Yes, he was.

Q. Does a GI consult indicate that there was distension of the large bowel?

A. Yes.
Q. And did the note indicate that there was a large amount of solid, semisolid stool?
A. Semisolid, yes.
Q. And that they tried to suction to remove solid pieces of stool from the lumen but were unable to safely keep the lumen in view?
A. I don't remember that statement specifically.
Q. Well, that's a quote?
A. Okay.
Q. Out of the record?
A. Fine.
Q. And that colonic distension persisted and a second decompression colonoscopy procedure was undertaken on April 18, 1989. Do you recall that?
A. Yes, I recall that.
Q. All right. Do you recall that in that procedure the following note was made, The transverse colon was dilated and contained hard stool. In particular the proximal transverse colon was covered with hard stool. The ascending colon revealed long columns of rock hard stool which made it both difficult and dangerous to further advance the scope.

Do you recall that, doctor?

A. I recall that but there's nothing to say that those rocks were composed of phosphate binders which is Dr. Gorbaty's allegation.

Q. When did Mr. Carrick's constipation begin?

A. Postoperatively.

Q. I beg your pardon?

A. Postoperatively.

Q. Didn't it begin two weeks prior to admission and coincide with the large dosing of aluminum containing phosphate binding agents?

A. It may have coincided temporarily and, in fact, aluminum containing phosphate binders do tend to cause constipation, but that doesn't mean that the stool in the colon is composed of the phosphate binders.

Q. You said there's absolutely no evidence in the medical reports to support this allegation?

A. That the rocks were composed of phosphate binders, that's -- there was nothing. There was an analysis of the stool chemically that says they were containing the aluminum.

Q. So that his drawing an inference from these facts you find to be preposterous?

A. Well, it shows that he doesn't understand what

phosphate binders do. Phosphate binders do instead cause constipation but they do so by decreasing gastrointestinal motility, they don't do so by precipitating into rocks.

Q. So that the finding of rock hard stool was a coincidental thing?

A. The finding of rock hard stool is perfectly understandable. What I'm saying is the rock hard stool is not composed of phosphate binders.

Q. Well, in the absence of that that you have just indicated, how do you know? You just said that there was an absence of testing to establish that it was composed of phosphate. So how do you know that it wasn't in the absence of such a test?

A. Because we're talking about milligrams of phosphate binder. If you're talking about big pieces of stool, you're talking about a much larger quantity of stool that the phosphate binder itself could compose even if it were purely phosphate binder.

I mean the order of magnitude here is totally different. Most stool happens to be bacteria and undigested foods and it tends to solidify if there's been excessive absorption or

decreased motility. It doesn't solidify if it's all composed of aluminum.

Q. Does it say it was all composed of aluminum?

A. He says it was composed of phosphate binders.

Q. To your knowledge, doctor, are there studies that would indicate that patients given treatment, medical treatment as opposed to parathyroidectomy have remarkable improvement in their lab parameters and in their condition that would have caused them to undergo parathyroidectomy to begin with?

A. I am not sure I understand your question. Could you rephrase it?

Q. Yes. I asked if there were any studies that say that?

A. That medical therapy can be successful?

Q. Is successful?

A. Sure. In some cases. In most cases it's successful. There's only a small minority of patients with renal failure that require parathyroidectomies.

Q. Would you agree that parathyroidectomy should be regarded as a treatment of last resort?

A. Yes.

Q. Do you agree that Mr. Carrick was uremic prior

to surgery?

A. He had some of the manifestations of renal failure if that's how you're defining uremia, yes.

Q. You define it for me. I don't want us to be talking cross-purposes.

A. I just want to make sure that we're not implying he was so uremic that he needed dialysis. I have already stated that he didn't need dialysis.

Q. Define uremia for me?

A. Uremia is an alteration in body metabolism characterized by certain biochemical signs and symptoms that result from kidney failure.

Q. Well, I'm sorry, go ahead.

A. Okay. Now, there's obviously a spectrum in terms of the quality and the quantity of abnormalities that can occur. Now, he had parathyroid abnormality secondary to his renal disease. That is a manifestation of his uremia, so yes, in that respect he was uremic but he wasn't uremic in other ways.

He wasn't vomiting and he wasn't having high potassium levels or congestive heart failure and those kind of issues so in some ways

he was. If that's what you're referring to.

Q. And at what level does uremia require dialysis, and I may have asked this before and I apologize.

A. There's no empirical level. Dialysis usually is instituted on a basis of specific indication.

Q. All right. And would that be when kidney function drops below a certain percentage or --

A. No. As I said, it's not a numerical indication. It's usually the patient is either sufficiently symptomatic because they are vomiting or they are lethargic or they have volume overload or they are hyperkalemic or they are acidotic. Those kind of indications.

MR. KAMPINSKI: That's all I have.

MR. GORE: Mr. Spisak.

MR. SPISAK: I don't have any questions for you today.

MR. GORE: Thanks, doctor.

MR. KAMPINSKI: I assume you want him to read it?

MR. GORE: Yes. Sure.

JAY B. WISH, M.D.

C E R T I F I C A T E

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

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named JAY B. WISH, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 __.

_____
Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 27, 1996

THE CLEVELAND CLINIC FOUNDATION

One Clinic Center 9500 Euclid Avenue Cleveland, Ohio 44195-5043

A National Referral Center An International Health Resource

Thomas A. Broughan, M.D.
General Surgery / A110
Residency Program Director
216/444-8462

December 13, 1990

George Gore, Esq.
Arter & Hadden
1100 Huntington Bldg
Cleveland, OH 44115

Re: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.
Clinic No. 1-973-492-7

Dear Mr. Gore:

In response to your November 28, 1990 letter, it is pertinent that Dr. Gorbaty is the only one of the plaintiff's three consultants who raised any criticism of the Cleveland Clinic. In the areas for which I can account, I find his claims without basis.

Mr. Carrick had very severe renal osteodystrophy. He had extensive demineralization of his bones and profuse metastatic calcifications of his soft tissues. The patient could not have tolerated a six to twelve month trial of medical therapy from a symptomatic point of view. His bone and joint pain was quite severe. Further, medical therapy and dialysis would not be expected to reverse this degree of secondary hyperparathyroidism. Dialysis and adequate medical therapy is designed to minimize renal osteodystrophy but is not capable of reversal of such severe cases.

To my knowledge, Mr. Carrick was not transfused in the perioperative period. It is true that azotemic patients have a platelet defect which theoretically raises the possibility of intraoperative hemorrhage. This is true whether or not they are receiving dialysis. It does not have a direct relationship to the BUN. From a practical point of view, the increased susceptibility to bleeding due to renal failure with or without dialysis, is not a significant clinical problem.

The dialume did not contribute to the postoperative colonic ileus. For the dialume to have caused dilatation of the colon, a fecal impaction would have needed to be present. A fecal impaction was not demonstrated. Parathyroid surgery is not associated with changes in bowel function. Bowel preps are not undertaken routinely.

I see no direct relationship between the azotemia, dialysis, and the development of Mr. Carrick's pneumonia. Azotemic patients are immunosuppressed whether or not they are receiving dialysis. Dialysis relates to fluid status and electrolyte levels, but not immune function.

Mr. Carrick had significant demineralization of his bone secondary to far advanced renal osteodystrophy. This would be another reason why surgery should be undertaken sooner rather than later. Dr. Marks of our Department of Orthopedics could provide insight as to the degree of renal osteodystrophy present. Mr. Carrick did not have aluminum bone disease. This takes years to develop, and Mr. Carrick was not receiving aluminum products for that period of time. Further, aluminum bone disease does not lead to metastatic calcifications and parathyroid hormone levels greater than 3,000. These findings are characteristic of renal osteodystrophy. I see no clinical pertinence to ordering an aluminum level in this patient.

The questions that Dr. Gorbaty raises about hearing loss and antibiotic use should be directed to Dr. Longworth who managed Mr. Carrick's antibiotic therapy carefully. The antibiotic levels were rigorously monitored by our pharmacology team. Mr. Carrick could have possibly survived had he not bitten through his endotracheal tube and had a difficult reintubation.

I might suggest that all of the physicians involved get together in a strategy planning session. We should be able to mount a successful defense to these claims.

Sincerely,

Thomas A. Broughan, M.D.

TAB/jmc

THE CLEVELAND CLINIC FOUNDATION

One Clinic Center 9500 Euclid Avenue Cleveland, Ohio 44195-5042

A National Referral Center An International Health Resource

December 17, 1990

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Cleveland, OH 44115

RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.
Clinic Patient # 1-973-492-7

Dear Mr. Gore:

Let me answer some of the issues raised by the "expert witness", Isaac Gorbaty, M.D.

1) I also have never heard of Dr. Gorbaty. I have reviewed some of the references in standard textbook on Renal Osteodystrophy and also do not find his name mentioned as any of the major authors. I would look very closely at his credentials because I think some of the statements that he makes are outrageous.

2) Concerning the question of initiation of dialysis. This is certainly a gray area in which there are no definite answers. Dr. Gorbaty apparently thinks that dialysis should have been treated because of the high BUN. BUN is a marker of both kidney function and muscle break-down and I mentioned in Mr. Carrick's instance probably related to the effect of the prednisone which had been started several weeks earlier. We assessed Mr. Carrick's urine output and physical examination. On the basis of examination and interviewing the patient there was no indication to start dialysis acutely at that time. In addition, Mr. Carrick was adamant about not starting dialysis. We always consider the patient's wishes in the initiation of dialysis as well. As recognized at the time of the second admission, Dr. Nakamoto thought that dialysis was necessary at that time for those specific indications mentioned in the record and dialysis was started. It appears that Dr. Gorbaty's main argument for starting dialysis is based on the BUN. There is no absolute BUN at which dialysis must be started. There are some

RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.
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patients who become sick with relatively low levels and some patients who are stable with much higher levels. As mentioned, the examination, urine output, and patient feelings were strong considerations in not starting dialysis at that time.

3) In addition, Dr. Gorbaty has confused the issue of dialysis and the patient's bone disease. These are two separate issues and dialysis would not have made any difference in the renal bone disease. Dr. Gorbaty's statement about the renal bone disease reversing with "standard medical treatment" is also ludicrous. He states that this would take a minimum of 6 to 12 months. Dr. Gorbaty obviously does not realize that Mr. Carrick had calcifications of his cardiac valves, frozen shoulders to the point where he was unable to elevate his arms above his shoulders and was mostly wheelchair bound. In addition there was severe bone pain that limited his mobility and was to the point that Mr. Carrick was weeping with the pain. To suggest that we should have waited 6 to 12 months and put up with these major problems and allowed the calcification of the heart valves to continue for another 6 to 12 months is also ludicrous. Dr. Gorbaty also contradicts himself when he states later on concerning Mr. Carrick's hip fracture that this was a result of his renal osteodystrophy. If the osteodystrophy was so bad that a spontaneous hip fracture occurred why should we have waited 6 to 12 months for the disease to reverse itself. It would have been very likely that spontaneous hip or other fractures would have also occurred over the 6 to 12 month period of standard treatment.

4) Concerning the issue of bleeding. There certainly is an association of chronic renal failure and increased bleeding risk. To a certain extent this was addressed because protime, PTT, and blood count were done. In addition, although Dr. Gorbaty thought that there was a high risk for bleeding. But none occurred peri-operatively. There is no mention anywhere in the record that there was need for blood transfusion or that there was any weeping from the wound. In fact, Dr. Braun stated in the chart that the wound was healing well. To me this is a non-issue since again it is a subjective interpretation and there is in fact no evidence that any damage occurred.

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5) His statements concerning the Dialume are also ridiculous. He does not seem to understand that aluminum hydroxide phosphate binder is the only option until the phosphorous level is controlled. If calcium binders (which are the only other option) are used and the calcium -- phosphorous product is elevated above 70, extra-skeletal calcification will continue to occur. This is precisely the problem Mr. Carrick was having that debilitated him to the point of being in a wheelchair. To suggest that we should have used anything other than aluminum hydroxide and thus worsen the patient's symptoms in the short term is ridiculous. The goal is to control the phosphorous level with aluminum hydroxide and then to switch the patient to calcium compounds. A Standard Textbook of Dialysis states that "in patients who have been on dialysis for at least 8 years only 37% had aluminum bone disease". I have the reference on that if necessary. Since Mr. Carrick had just been started on aluminum hydroxide and had not had dialysis for even one month, to suggest that he had significant aluminum accumulation reflects a misunderstanding of the disease. Aluminum intoxication occurs slowly and in fact patients with any residual output appear to be protected from aluminum bone disease. Since we have documented that Mr. Carrick had continued urine output, he was at minimal to no risk in the short term of aluminum intoxication. In fact, as I stated earlier to use anything other than aluminum hydroxide would have been medically reckless. It is known that aluminum hydroxide can cause constipation. However, to suggest that nephrologists routinely give patients strong laxatives prior to surgical procedures is incorrect. I would push for any references suggesting that that is the proper course of treatment. We certainly do not do this on any routine basis and I also believe that there is no recommendation in the literature to follow that course of action. Once constipation does develop it is treated by routine measures. Again, the use of aluminum hydroxide was dictated by the clinical situation and there were no options. There are also multiple reasons for developing an ileus and to claim that the binders were the only reason and that they routinely cause severe constipation is totally incorrect.

6) The pneumonia might well have been associated in the general picture to Mr. Carrick's over all poor health. We certainly know that debilitated patients are more likely to develop pneumonia then those who are in good health. We have stated from the beginning, however, that Mr. Carrick's medical situation was so severe at that time that we had no option but to

RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.
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proceed with the surgery. So, Dr. Gorbaty is not stating anything that we do not already acknowledge ourselves. The question is what the options to waiting would have been. As mentioned previously, I thought the options to waiting were not acceptable and would have, in fact, introduced Mr. Carrick to more risk. It is on that basis that I decided to proceed with parathyroidectomy.

7) Dr. Gorbaty also states that the hip fracture occurred post operatively. I agree with his assessment as to the causes. Again this highlights the severity of the symptoms and why standard medical treatment was not indicated. In addition, as mentioned above, I do not believe the aluminum load is a factor. If it takes up to 8 years on hemodialysis with 6 to 8 capsules per day to accumulate aluminum, Mr. Carrick is nowhere in that ballpark. In addition, as mentioned earlier, to use anything other than aluminum would have raised a much higher risk of worsening his symptoms.

8) Dr. Gorbaty also does not understand that serum aluminum is not a good index of patient aluminum status anyway. If he had suggested a DFO infusion test or a bone biopsy either might have been reasonable suggestions in a given clinical situation. The aluminum levels are routinely notorious for reflecting recent intake and not total body burden of aluminum. So even his statement of the proper screening technique is incorrect.

9) Mr. Carrick probably did suffer some hearing loss related to his antibiotics. I suggest that the Infectious Disease experts would be better able to address this question. Certainly there is a risk with use of aminoglycosides. However, if a person has life threatening infection and if the drug levels are followed this is a risk worth taking rather than allowing the patient to die from his infection. I believe, this was the case with Mr. Carrick and that he was followed very closely by the Infectious Disease expert who is well aware of this potential complication.

RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.
Clinic Patient # 1-973-492-7

10) I believe the only area that is gray enough to be disputable is whether hemodialysis ought to have been done pre-operatively based solely on the BUN. Some might argue that the patient might have done better with removal of waste products more vigorously. This is hindsight and as mentioned, I think, is a debatable question. Certainly there was no peri-operative bleeding as suggested by Dr. Gorbaty. The coagulation parameters were screened and that was a non-issue. Whether removal of waste product would have improved Mr. Carrick's immune status to the point where he would not have become infected is unknown. In reviewing the chart this is the only gray area which I have questioned about my medical treatment of Mr. Carrick. Again, this relates mostly to the peri-operative period and not to the time before he was admitted for surgery.

I hope this is helpful. In summary, I believe their expert witness has shown us more about his lack of information on the topic then any usable information for the plaintiff. As mentioned, from my perspective, the only debatable issue has to do with pre-operative hemodialysis and not from a bleeding perspective since none of this occurred but from a perspective of removing waste products to improve the immune function. All other issues that have been raised I think are spurious and not backed by any scientific information.

Best regards,

Robert J. Heyka, M.D.

RJH/ec
cc: Michael Meehan, Esq.

IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

- - - - -

CHARLES TENNEY, III, etc., et al.,

Plaintiffs,

vs Case No. 448548

URMILA PATEL, M.D., et al.,

Defendants.

- - - - -

DEPOSITION OF JACQUELINE WHITTINGTON, RN

MONDAY, APRIL 22, 2002

- - - - -

Deposition of JACQUELINE WHITTINGTON, RN, a Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Southwest General Health Center, Middleburg Heights, Ohio, commencing at 11:30 o'clock a.m. on the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiff
Becker & Mishkind
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On behalf of the Defendant Southwest General Health Center
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On behalf of the Defendant Patel
Weston, Hurd, Fallon, Paisley & Howley
BEVERLY HARRIS, ESQ.,
2500 Terminal Tower
Cleveland, Ohio 44113
216-687-3269

- - - - -

JACQUELINE WHITTINGTON, RN, a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF JACQUELINE WHITTINGTON, RN

BY MR. MISHKIND:

Q. Tell me your name, please.

A. Jacqueline Whittington.

Q. Where do you live, please.

A. Middleburg Heights, 15900 Ramona Drive, Middleburg.

Q. Zip code out there is?

A. 44130.

Q. We had a chance to chat for a few minutes before the deposition started, while Mr. Switzer was out of the room, although it was all unrelated to this case. I will say that on the record.

My name is Howard Mishkind and I represent Dawn Davis and Charlie Tenney and Charles Tenney, the father, in connection with this case. I'm going to ask you some questions and I want to learn what you know, and I want to learn perhaps what you don't know, okay?

A. Yes.
Q. Tell me whether you have ever had your deposition taken before.
A. No, never.
Q. Let me give you a couple precautionary instructions that hopefully will help you and me get through this.
Answer verbally, okay?
A. Yes.
Q. If you don't, I'll remind you.
A. Yes.
Q. Wait until I'm done with my question before you start answering it, for two reasons: To make the flow nice and neat, and also to make sure that you are understanding my question before you start to answer it. Okay?
A. Yes.
Q. A common reaction is to start answering something when you know what the answer is, because the question is going on and on, like my statement is now, and you are wondering when I'm going to finish. Wait until I am done before you start answering.
A. Okay.
Q. You are an RN?

A. Yes, an RN.
Q. And are you a BSN?
A. Diploma.
Q. From where?
A. Fairview.
Q. What year?
A. 1974.
Q. You are employed here at the hospital?
A. Yes, at Southwest.
Q. And how many years have you been employed here?
A. Twenty.
Q. In what department?
A. OB.
Q. Do you have any special certification in the area of obstetrical nursing?
A. Yes, I'm code pink certified.
Q. When did you become code pink certified?
A. They didn't have the program when I started here, so I would have to say it was within a couple years after I started. It is in connection with Metro General.
Q. How long of a program course is it to

become --

A. Code pink is an ongoing program. You go down to Metro, at least we did, went down for two days, classes, practicals and now we have to be certified. Every year we have classes. We have to be certified.

Q. Do you have to take an examination?

A. A written one, yes, and a practical.

Q. And each year you have to become recertified?

A. We alternate years. One year it's a code pink certification and the opposite year it's an NRP, it's a national newborn resuscitation program through the Heart Association.

Q. So each year you are taking some certification, whether it's the NRP or the code pink certification?

A. Yes, every year.

Q. And that's been going on since the '70s?

A. I don't know exactly when code pink started. It was when Metro started their program.

Q. Is it fair to say it's at least been

ten or more years?
A. At least 15, I would say.
Q. I take it you have been successful each year with your examinations?
A. Yes.
Q. Do you have any other certification in obstetrics or newborn management --
A. No.
Q. -- other than what you have told me about?
A. No.
Q. Do you have any family members that are in the medical profession?
A. No.
Q. Do you know Dr. Patel?
A. Yes.
Q. Have you ever had occasion to work with her outside of labor and delivery?
A. As a professional --
Q. Yes.
A. -- arrangement? I'm a patient of hers.
Q. Well, that's professional.
A. Yes.
Q. How long have you been a patient of

hers?

A. I would say maybe ten years.

Q. Have you ever worked in her office?

A. No, I have not.

Q. When is the last time that you talked with Dr. Patel about Dawn Davis?

A. It would have been the day of this delivery.

Q. You have not had any conversation formally or informally?

A. No.

Q. Even though the no may still apply, let me finish first.

A. I'm sorry.

Q. That's okay, not a problem. And it's so common to do what you are doing, but try to resist that urge.

Formally or informally you have not had any conversation with her that's touched on any aspect of Dawn Davis' care since September 13th, 2000; is that true?

A. That's true.

Q. I'm not going to ask you to tell me what you talked about with Mr. Switzer, and he wouldn't let me ask you anyway, but I do

understand that there was a meeting that was held where a number of nurses were present; true?

A. True.

Q. Have you had conversations with any of the nurses that were involved in the labor and delivery or the postpartum period that you have had privately and outside of the presence of an attorney from the hospital?

A. No, not about the case, no.

Q. Tell me what you can about Lisa Piscola, why she left the hospital.

A. I really didn't know her. She was an orientation, so we just worked in the delivery room. You know, I actually hadn't even remembered anything about her until we saw this chart.

Q. You have reviewed the chart?

A. Yes, I have.

Q. What aspects of the chart did you review?

A. What I have looked at is the parts that were pertinent to me. I looked at the mom's chart, but I am not a labor nurse.

Q. When is the last time you worked as a

labor nurse?

A. I have never been a labor nurse.

Q. That answers that question.

A. Never.

Q. Have you ever been involved in a delivery assisting an obstetrician in managing a shoulder dystocia?

A. No.

Q. I take it you were not involved in any aspect of the management of the shoulder dystocia that Charlie Tenney experienced?

A. No.

Q. Were you in the OR before Charlie was delivered?

A. It was a birthing room.

Q. I'm sorry. I stand corrected. And I knew that, but sometimes you just get OR in your brain.

A. I don't remember, but I would have been there a few minutes before he was born.

Q. And on what do you base that?

A. The routine that we have when a baby is born, when the mother reaches a point where the delivery is imminent, the labor nurse calls to the nursery and one of us goes to the

birthing room. We prepare our equipment and then we wait for the baby to be born, so if you want a time frame, I don't have an exact number.

Q. There was code pink called due to the shoulder dystocia.

Would you have been responding to the birthing room as a result of the code pink or for other reasons?

A. I would have already been in there.

Q. And at that time, obviously, Dr. Patel would have been there in the room with mom; true?

A. Yes, at the time of delivery, yes.

Q. From looking at the record, is it likely that Lisa Piscola was also in the room?

A. According to the record, yes.

Q. According to the record, who else likely would have been in the room by way of medical staff when you arrived?

A. When I arrived in the room, according to the record, it would have been Dr. Patel, Lisa Piscola and Lois Cricks.

Q. What is Lois Cricks' position?

A. She is a labor RN.

Q. Have you had occasion to talk with

Lois at all about her relationship with Lisa Piscola that existed back in September of 2000?

A. Only when we were with Mr. Switzer, he talked to each one of us what our role was in the room.

Q. Have you talked privately or outside of the presence of Mr. Switzer concerning what Lois' title or position was as it relates to Lisa?

A. No.

Q. When is the last time you talked to Lisa?

A. Last week when we went with Mr. Switzer. That was, I believe, Wednesday or Thursday.

MR. SWITZER: Thursday.

Q. So you believe that Lisa would have been in the room, Lois would have been in the room, Dr. Patel would have been in the room as medical care providers before you arrived; true?

A. I don't know. I don't remember. I'm just reading what's on here.

Q. And on here is the summary of the pregnancy, labor and delivery record?

A. Yes.

Q. But based upon that, do you conclude that what I just said is accurate?
A. That when I came into the room, it would have been Dr. Patel, Lisa, and Lois.
Q. Now, you were coming into the room as a routine to just assist in managing the transition of the baby from delivery to preparing the baby for the newborn period; is that why you were coming in?
A. Yes.
Q. You weren't coming in in response to any type of a crisis or a code?
A. No.
Q. Do you have any recollection of witnessing the delivery?
A. No, I don't remember this delivery at all.
Q. Do you have any recollection, vague or otherwise, of anything that was being said or done in the birthing room when you arrived?
A. No.
Q. Ever have any conversation with Dr. Patel about what she encountered at the time that the shoulder dystocia was encountered?
A. No.

Q. Do you have any knowledge as to why Charlie Tenney suffered a permanent brachial plexus injury as a result of this shoulder dystocia?

MS. HARRIS: Objection.

A. No.

Q. You come into the room under normal circumstances. What would be your custom and practice in terms of what you would do preparatory to the delivery?

A. When you come into the room, the warmer, where you place the baby after it's born, is in a corner. So we go back there, make sure the heat is on, check all our equipment, all our resuscitation equipment for every delivery, whether there is risk factors or not. We make sure the oxygen is on, the suction is on, check the anesthesia bag, make sure that's working, gather all of our -- like the measuring tape, the eye ointment, all the paperwork, concur with the labor nurse just to see what the status is, how soon it will be, if there is any risk factors.

Q. I have already been told that the bed in this birthing room is perpendicular to the

door; that the stand where the computer is would either be to the right or to the left of the head of the bed.

A. Yes.

Q. With mom laying her head furthest from the door, her feet closest to the door, would the computer be to mom's right or to mom's left?

A. It would depend on what room she was in. I don't remember the room.

Q. 316.

A. Because sometimes the bed is here and sometimes the bed is on this side of the door.

Q. Do you know back in September whether the computer would have been to mom's left or to mom's right?

A. I don't know. I would have to go up and look at that room and see what the setup of the beds is. The computer is at the head of bed, but depending on if the bed is on this wall or this wall is what side the computer is on.

Q. Did you make any entries in the computer?

A. No, I have no access to that computer.

Q. The warmer that the baby would ultimately be placed in after delivery, where in relationship to the head of the bed would that be?

A. The bed would be here, the computer would be here, and then the warmer would be here.

Q. So the warmer would be furthest from the door behind the computer?

A. Closest to the door.

Q. Would you mind drawing? I have not asked anybody else to do it, but I want to try to get an idea of the total layout.

MR. SWITZER: She may not remember this particular room.

A. The rooms are set up, but I couldn't tell you the direction.

Q. But in terms of the relationship of the computer and the warmer, they all pretty much follow the same pattern, do they not?

A. Yes.

Q. So that while it may be to the right or the left of the birthing bed, you can give me a general layout of where the door is and where the --

A. Yes.

Q. I'm going to have you draw this for me, but do it silently. We will go off the record, because if you start saying here and there or this, the court reporter has to take everything down. So draw it silently off the record and then we will go back on the record and have you identify what you have drawn, okay?

A. Okay.

(Pause.)

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(Thereupon, Plaintiff's Deposition Exhibit 1 was marked for purposes of identification.)

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Q. At least to get a framework for what we are talking about, Plaintiff's Exhibit 1 with your name on it for this deposition is a sketch that you have made of a birthing room. Whether it is identical to what birthing room 316 looked like back in September of 2000, you are unclear about, but this at least shows the relationship of the birthing bed, the computer, the warmer, and the armoire in relationship to the entry to the room; true?

A. True.
Q. The armoire, is that just with supplies and things of that nature?
A. Yes.
Q. And then the window looks out over the parking lot?
A. It looks out over the courtyard.
Q. So you would have come into the room in anticipation of the delivery of Charlie Tenney; true?
A. True.
Q. And that would have been because Lisa would have let you know that the delivery was imminent?
A. It may not have been Lisa particularly, it may have been someone else who called.
Q. Where would you have been stationed prior to getting notified that the delivery was imminent?
A. In the newborn nursery.
Q. And as I understand it, the newborn nursery was basically across the hall from room 316?
A. Yes.

Q. Does that sound right?
A. It is across from the birthing rooms.
Q. So you would have come in, gotten equipment prepared, and would have then waited for the delivery to take place?
A. Yes.
Q. You would not have participated in the delivery of the baby?
A. No.
Q. Do you have any recollection of the position of any of the nurses that were in the room during the management of the shoulder dystocia?
A. No.
Q. Do you have any knowledge or recollection as to how many nurses were in the room at the time that the shoulder dystocia was being managed?
A. No.
Q. Do you recall Dr. Patel calling out that the head was stuck?
A. No.
Q. That doesn't ring a bell at all?
A. Not at all.
Q. Are you able to help me at all in

terms of the number of family members that were in the room at the time that the baby's head was delivered?

A. No.

Q. Or how many family members were in the room and their position from the time the baby's head was delivered until the time the baby was delivered?

A. No.

Q. Do your notes reflect any of that information?

A. My particular notes?

Q. Yes.

A. No.

Q. And do you see as you are looking at the notes any reflection as to how many family members were present in the delivery, in the birthing room immediately prior to the shoulder dystocia being encountered, as well as up through the time that the baby's body was delivered?

A. On the delivery summary it says support person present in delivery room and it says Charles.

Q. And whose note is that; do you know?

A. No, I don't know. But it's on the summary.

Q. Got it. So if the parents of Dawn Davis were also in the room during the delivery, would you have any explanation for why their name would not be reflected on this summary of pregnancy, labor and delivery?

A. I'm not the labor nurse. I don't fill this out, so no, I don't have any explanation.

Q. Who is Dr. McKnight?

A. Dr. McKnight is a pediatrician who is from University Rainbow. He is what we call them here at Southwest our hospitalist. They work in the hospital. There is a group of four of them.

Q. Dr. Patel's note reflects that respiratory and house physicians came into the birthing room. Do you have any recollection of Dr. McKnight coming into the birthing room?

A. No, I don't remember.

Q. The record reflects that Dr. McKnight did come in.

A. Yes.

Q. Correct?

A. Yes, the record says that.
Q. Now, tell me what was Charlie's condition when you received him?
A. I don't remember the delivery. But according to the notes, at one minute of age he had an apgar of seven.
Q. Are you referring to the newborn resuscitation record?
A. Yes, I am.
Q. This newborn resuscitation record would have been created in the birthing room; true?
A. Yes, it is.
Q. The comment section at the very bottom, would that also have reflected events that occurred in the birthing room?
A. Yes, in the birthing room.
Q. Do you know why Charlie's breathing became labored with audible grunting shortly after delivery?
A. No, I don't know why.
Q. Did anyone explain to you why that was?
A. No.
Q. Do you know why Charlie developed

bilateral pneumothoraces?

A. No, I don't know why.

Q. Has anyone explained that to you?

A. No.

Q. Do you know why Charlie had a cephalohematoma at birth?

A. From my experience, that's a common thing for a baby to have swelling of the head, but as to what anyone explained to me about him, no.

Q. Any place on this newborn resuscitation record for you to record abnormalities as it relates to the brachial plexus or any type of trauma to the shoulder or to the neck that you see when you are handed the baby?

A. On this particular paper?

Q. Yes.

A. No, there is not.

Q. What did you do as part of the newborn resuscitation? You were the one that recorded the apgars?

A. I am the recorder. The doctor assigned the number.

Q. Got it. And at one minute of life,

the baby's apgar was seven?
A. Correct.
Q. At five, it was eight, and at ten, it was eight?
A. Correct.
Q. The apgars do not reflect anything as it relates to a shoulder or a brachial plexus type of injury as a factor in evaluating the apgars; true?
A. No.
Q. What else was part of your responsibility, ma'am, during this newborn period over the first ten minutes in the birthing room? What else would you be doing?
A. As I said before, in this case, I don't remember, but as our usual routine, we receive the baby in a warm blanket, take it over to the warmer. The doctor is there. He looks at the baby, we dry the baby off. If he has anything he wants us to do as far as any interventions, we follow his order.
Q. Dr. McKnight's deposition was taken and he testified that he transferred the baby to -- is it the special care nursery?
A. That's what we call it.

Q. SCN?
A. It's just a room off the nursery with resuscitation equipment and isolettes.
Q. Any recollection of him doing that?
A. No.
Q. Has anyone ever explained to you -- Dr. McKnight, Dr. Shaw, or anyone -- why Charlie had to be resuscitated, why he had to be intubated shortly after birth in light of relatively good apgar scores during the first ten minutes of life?
A. I'm not sure I understand the question.
Q. Do you know what transpired after the first ten minutes of life to cause his respiratory condition and his overall hemodynamic status to deteriorate?
A. As I said before, I don't remember, but in reading the notes, it says when the baby came to the nursery, he became dusky.
Q. Is it your responsibility in assessing the newborn to look for signs or symptoms that would suggest an impending respiratory failure or respiratory distress?
A. I'm not sure I understand that.

Q. When you assess the baby and do the apgars, you are looking for any abnormalities; true?

A. When I'm working with a physician, the physician gives the apgars.

Q. Would the apgars have been given by Dr. McKnight or Dr. Patel?

A. Dr. McKnight.

Q. Once Charlie was transferred to the special care nursery, the room next to the nursery, for further attention, were you involved in any aspect of that?

A. As I said before, I don't remember.

Q. According to the record, were you?

A. According to the record, the baby was brought to the nursery and Darlene Vacca was taking care of the baby.

Q. According to the record, when was your last involvement during the newborn period?

A. Do you mean during the --

Q. The immediate newborn period.

A. In the birthing room, and then I took the baby from the nursery to her. She started taking care of the baby and then down the road I came in to help her.

Q. Tell me, looking at your notes, what was the baby's condition when you came in to help her?

A. According to the record, the next time that I had hands on contact with the baby was at 1325 I hung an IV.

Q. What was the baby's condition at that time?

A. According to the notes, he had a UAC catheter, which is a uterine artery catheter. He was intubated, receiving oxygen, and he had two chest tubes in.

Q. I take it that he was being treated for the bilateral pneumothoraces?

A. According to the record, yes.

Q. And again, no one has explained to you why this baby experienced bilateral pneumothoraces?

A. No.

Q. Have you ever encountered bilateral pneumothoraces in a newborn baby?

A. Yes.

Q. Have any of those situations where you have encountered bilateral pneumothoraces been secondary to trauma at the time of birth?

A. I can't recall. I have had several babies. I know one in particular that was a preterm baby and the other one I can't recall why. It is a common occurrence, a pneumothorax.

Q. And do you know whether there is any association between trauma at birth and pneumothoraces?

A. No.

Q. No, there isn't, or no, you don't know?

A. No, I don't know.

Q. Fair enough. Did you help with the transfer team, getting the baby ready to go to RB&C?

A. Our role once the transfer team arrives, we step back and they take over the care and they assume care of the baby and we are done.

Q. Did you have any contact with anyone over at UH at RB&C once the baby was transferred to get a sense of what the baby's condition was?

A. No. For patient confidentiality, they don't talk to us at all.

Q. Did you have any interaction, after the baby was transferred, with mom, with Dawn?

A. I don't recall talking to her.
Q. Would that be your normal practice that you would see the mom after her baby has been transferred?
A. Yes, we usually go out and talk to them. The transfer team also takes the baby out to the room.
Q. There is a description of the baby being in critical condition at the time of transfer. Is that consistent with what your understanding is, as well?
A. Any baby that has to be transferred is considered to be critical. As far as this baby, the record says that, yes.
Q. After the transfer team arrived and you stepped aside, other than perhaps some casual conversation with mom, just trying to comfort mom and assist in the process of maintaining calmness, if you will, did you have any other involvement in any care of mom or any other aspect of the baby's care?
A. As I said before, I don't remember talking to the mother, but no, I never took care of her as a nurse/patient relationship, no.
MR. MISHKIND: That's it. Nothing

further.

MS. HARRIS: No questions.

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(Deposition concluded at 12:15 p.m.)

(Signature not waived.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 30 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

JACQUELINE WHITTINGTON, RN

Subscribed and sworn to before me this day of , 2002.

Notary Public

My commission expires .

CERTIFICATE

State of Ohio,

SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named JACQUELINE WHITTINGTON, RN was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 29th day of April, 2002.

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.