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

Doc 457

IN THE COURT OF COMMON PLEAS

Carl J. Williams, et al.,	)	
	)	
Plaintiffs,	)	
vs.	)	Case No. 253137
	)	
Jonathan C. Boyd, M.D., et al.,	)	B. Corrigan
	)	
Defendants.	)	

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THE DEPOSITION OF M. MICHAEL WOLFE, M.D.
MONDAY, MARCH 11, 1996

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The deposition of M. Michael Wolfe, M.D., called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kathy A. Vazinski, Registered Professional Reporter and Notary Public within and for the State of Ohio, taken at the offices of Jacobson, Maynard, Tuschman & Kalur, Northpoint Tower, Suite 1600, Cleveland, Ohio, commencing at 3:00 p.m., the day and date above set forth.

APPEARANCES:

On behalf of the Plaintiffs:

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On behalf of Defendant Dr. Jonathan C. Boyd:

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M. MICHAEL WOLFE, M.D.

of lawful age, called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, having been first duly sworn, was examined and testified as follows:

EXAMINATION OF M. MICHAEL WOLFE, M.D.

BY MR. LANCIONE:

Q Doctor, would you state your full name and spell the last name for the record, please.

A The last name is Wolfe, W-o-l-f-e, and the name I go by, it's M. Michael.

Q The first name?

A It's Murray, which I don't use.

Q We've just been introduced. My name is John Lancione. I'm one of the lawyers that represents Carl Williams in the case that you have been asked to consult on.

I'm going to be taking your deposition today. I assume you are familiar with the deposition process, but for the sake of thoroughness I will go through the ground rules briefly with you, okay?

A Okay.

Q If at any time you don't understand a question I ask you, stop me and tell me you don't understand. Sometimes I talk too fast and people don't understand what I'm saying. If the question, isn't clear, tell me and I'll rephrase it, I only want you to give an answer to a question you understand.

A Yes.

Q And also, keep your voice up and make the answers verbal because nods of the head and other nonverbal communications is difficult for the court reporter to take down. Is that fair?

A Yes.

Q And today I'm taking your discovery deposition to discover the opinions you hold in this case. And this is probably the only time I'll have an opportunity to discuss with you your opinions and to discover from you all your opinions in this case, unless for some reason the court should order that I'm allowed to depose you again. So please keep that in mind when I'm asking you for your opinions and I'll try to make my questions with regard to your opinions as broad as possible so we don't leave anything

out, okay?

A Yes.

Q Doctor, I have your card here. Your professional address is 75 Saint Francis Street, Boston?

a No Saint. It's 75 Francis Street.

Q Okay. 75 Francis Street. That's your professional address?

A Yes.

Q How long have you maintained that address, Doctor?

A Six and a half years.

Q Doctor, have you had your deposition taken before as an expert witness in a medical malpractice case?

A Yes.

Q On how many occasions before today?

A I think it's actually the second time. Oh, it was supposed to be another one that was cancelled. No, no. I'm sorry. This is three. This is my third case.

Q In your entire career in private practice?

A Yes.

Q When were the other two depositions given?

A When?

Q When, do you recall?
A Well, they were all in the last four years or so.
Q When did you start reviewing medical malpractice cases for attorneys?
A First of all, I don't do it that often. I think in the last -- I think they started seven or eight years ago, something in that neighborhood.
Q What issues were involved in the other two cases in which you gave depositions?
A Okay. One was a case in which, well, first of all, both were for the plaintiff the Past two times. One case was a case in which a woman died of sepsis from perforation of a diverticulum in her colon. And I testified for the plaintiff, for, well, for her attorneys, that is.

And the second case was kind of a bizarre case in which someone swallowed a dental file and had some problems because of it. And one of the problems is that he had ulcer disease and he was dwelling on his ulcer disease and I was asked specifically to provide evidence that this is not an uncommon occurrence in patients with ulcers. And that's exactly what the literature

states, that people with ulcers tend to dwell on bad things that happen to them. That's all I said.

Q Okay.

A It was a bizarre case. The first one was not bizarre. Hers was a tragic case.

Q So the second case did not involve an opinion about the standard of care in the practice of medicine?

A Not at all.

Q And the first case, however, involving the sepsis did involve opinions concerning the standard of care rendered by a physician?

A Yes.

Q And your opinion was in that case that a physician's conduct fell below the acceptable standard of care?

A Yes.

Q Do you recall what kind of physician you were critical of?

A Yes. The physician involved, the case involved a gastroenterologist who settled before they came to me because he admitted that he was liable. It involved a gynecologist; likewise, the same. I was specifically asked to -- it was

an -- I'm not sure what the legal terminology is, but the charges were being levied against family practitioners. And the feeling was that they weren't in a position, as family practitioners, to really understand the severity of the condition of the patient. Whereas I contended that that was nonsense, that that was a situation that the worst should have been thought of, and the patient should have been treated very aggressively, no matter what kind of physician was managing her.

Q And have you ever given a deposition as an expert for a defendant doctor in a malpractice case besides today?

A No, I have not.

Q Now, you said you've been doing review work in malpractice cases for about the last eight, eight and a half years?

A I can't tell you exactly. In that, yes, in that neighborhood,

Q Approximately how many cases have you reviewed, been asked to review and actually reviewed?

A Ten, twelve, around there. It comes very sporadically.

Q As far as the percentage of cases you reviewed

for defendant doctors as compared to plaintiffs, have you kept any kind of score on that?

A Fifty-fifty. Maybe sixty-forty. It's distributed --

Q Sixty-forty, would that be more defendants than plaintiff or more plaintiffs than defendants?

A If I had to guess --

MS. CARULAS: Don't guess.

Q We don't want you to guess. So the safest assessment is fifty-fifty?

A Fifty-fifty.

Q All right. Now, you are from Boston, Massachusetts but we're here today in Cleveland to take your deposition,

What's the reason for your trip?

A I was, first of all, from Ohio, born and raised in Akron.

Q I see it in the CV.

A I was here in Cleveland. I wrote a book and I was here for part of my tour, my media tour.

Q What book did you write that you are here for?

A I wrote a book -- I hope this makes records all over the place -- it's called The Fire Inside. It's a book on acid reflux disease for the layperson. It's by Norton Publishers, available

at all bookstores.

Q How much is it?

A $23. Barnes & Noble has twenty percent off on all hardcover books.

Q All right. Is this your promotional trip for your book?

A Yes.

Q When do you go back to Boston?

A Probably tomorrow morning, unless I get out tonight. Most likely tomorrow morning, 6:55.

Q Do you know how Anna Carulas got in touch with you, how she came to know you did this kind of work, how you are involved in this case?

A Yes. In the one case in which there was an -- I was the expert witness for the plaintiff attorney. The person who deposed me was a former high-school classmate of mine, one of Anna's colleagues.

Q Who is that?

A David Best.

Q Have you reviewed any cases for David Best?

A No, I haven't.

Q Have you reviewed any other cases besides this case for the law firm of Jacobson, Maynard, Tuschman & Kalur?

A Yes, I had one case.
Q Who was that for?
A Anna was the attorney. Well, actually it was -- well, at the end you weren't --
MS. CARULAS: Another crazy case.
A In the end it was -- I just worked for -- it ended up you settled it for the hospital.
MS. CARULAS: It was Marty Franey, because the case with the physician was settled out of court.
Q Did you give a deposition in that case?
A No. They decided not to depose me, Isn't that correct?
MS. CARULAS: Yes.
Q Anna was the initial attorney that got you involved in the case?
A Yes, through Dave, I assume,
Q Have you ever testified in court?
A One time in a trial.
Q When was that?
A That was this case. That was February 1994.
Q The case with Anna?
A Well, the one Anna started with.
Q You weren't deposed in that but you gave trial

testimony without a deposition being taken?

A That's correct.

Q What issues of medicine did that involve?

a It involved a woman who came in, if I can remember correctly, for gynecologic surgery, and she had a sponge left in, a sponge left in place, causing her some problems. She was placed on broad-spectrum antibiotics and as a result, she claims she became lactose-intolerant because of the antibiotics that were being used.

However, as we pointed out, it was pointed out, first of all, that she was African-American, which makes it eighty to ninety percent that she will be lactose-intolerant. Not only that, in the note before surgery to the nutritionist she was lactose-intolerant.

So I testified, first of all, that she had a likelihood that she was lactose-intolerant to start off with, just because of her ethnicity. Second of all, no doubt she was lactose-intolerant, although it didn't say it in those words. She didn't tolerate dairy products. Lastly, third of all, with the antibiotics there was, that way they could cause

her problem.

Q Did she have any other conditions? Was she septic? Is that why they put her on broad-spectrum antibiotics?

A She wasn't really septic as far as I remember. She had, I think, a foreign-body response to the sponge. I can't remember. That's two years ago.

Q Doctor, what do you charge for your deposition time?

A For deposition time, $500 an hour.

Q Doctor, in preparation for your deposition today have you conducted any research in the medical literature?

A I did a literature search initially. When I first wrote my letter in February of last year, and also I just did one yesterday, too.

Q Your literature search back to the time of your report was on Medline or --

A They're both Medline.

Q Sabiston's?

A Sabiston's, yes, Textbook of Surgery.

Q Right. And you did another search yesterday on Medline?

A Medline, and I looked in an emergency textbook,

which I'm one of the editors of, and also in Sleisenger's & Fordtran Gastroenterology Textbook.

Q What was the purpose for your search on Medline yesterday?

A I wanted -- I didn't think there would be anything. I wanted to find out if there was any literature on how commonly constipation occurred postoperatively. But it's so common that there's nothing, there's absolutely -- well, that's my opinion. It's so common that there was not one article specifically on that topic that I could find.

Q The book that you consulted that you were a editor on was which?

A Gastrointestinal Emergencies.

Q That's in your CV.

A Yes.

Q A '92 book.

A We're presently finishing up our second edition, published in '91, actually, I think.

Q Let's see here.

A That was published in '91. '91 or '92. The '92 came out in '91. It was Pike the car models. They come out the year before.

Q Okay. And did you find anything of any import in your book, Gastrointestinal Emergencies?

A The only thing I looked at specifically, I couldn't find anything, again, on postoperative constipation with regard to the incidence of it.

What I did look at was the treatment of ileus, the treatment of ileus and the delays in treating ileus.

Q Now, your initial search on Medline was to find -- well, you tell me. What was the purpose of your initial search on Medline at the time of the writing of your report in February of '95?

A I wanted to see if there was any relationship between penile prostheses and ileus.

Q And your review of Sabiston's Principles or Textbook of Surgery at that time, back in February of '95 was for what purpose?

A Same reason.

Q Do you have a file that you maintain for this case?

A Yes, but -- that's my letter and that's actually in my briefcase downstairs.

Q What do you have?

A It's my letter.

Q Are those records your records that you brought

with you?

A These are my records.

Q Can I take a look at those real quick?

What else do you have in your briefcase besides that letter?

A I have --

MS. CARULAS: Regarding this case?

Q Regarding this case. No. Regarding everything.

A Let's see. I have phone numbers. Oh, no. Just some letters. I have my letters and your letter back to me, and that's about it.

Q How many? Did you have more than one draft of the letter?

A Oh, wait. I actually also have copies of some of the other letters to the other physicians, too.

Q When you prepared your report did you make more than one draft or did you just make one draft and send it off?

A I can't remember. I can't remember, specifically. Occasionally, sometimes I do make a draft, but I'm not sure I did that in this case. I couldn't remember.

Q Do you do that on your own word processor or

dictate and have a secretarial staff member type it up?

A Since I really -- it's not part of my job description but I do it on my own. I type it myself.

MS. CARULAS: He didn't bring the second volume.

A Third.

MS. CARULAS: Yeah, you know, the second volume of the second hospitalization.

A That's all from my briefcase.

Q Okay. Did you discuss this case with any colleagues back in Boston at any time?

A I don't think so. I don't think I did.

Q Since you refer to Sabiston's and the Sleisenger book, I take it in your practice you, from time to time, refer to those books?

A I refer to a lot of different sources.

Q Including those two?

A Including those two. Sabiston's is very infrequently because I'm not a surgeon.

Q Do you consider, well, the Sabiston's or Sleisenger book authoritative in their respective fields?

A Nothing is absolutely authoritative. I use

different sources for different things. And in some ways I consider our textbook authoritative. Since I wrote part of it, I consider that pretty authoritative.

But I look at different sources for different things for different items. And I like Sleisenger. I think it has deficiencies. There are other GI textbooks around that I Pike but I happen to have Sleisenger's.

I have a preface I wrote in a textbook for Saunders.

Q Of the parts you disagree with, do you consider those to be authoritative?

A To some extent, as much as any textbooks can be authoritative, yes.

Q So if the textbook had language in it that was inconsistent with your opinions in this case, would you consider that a non-authoritative textbook, or at least for that particular section?

MS. CARULAS: Wait. For the record, I think he already said he doesn't consider any textbook to be authoritative. Now you are saying --

MR. LANCIONE: Well, he says

that parts are good and parts are bad.

BY MR. LANCIONE:

Q So some areas are authoritative and some aren't?

A It depends on who the author is. These are multi-author. I know some of the authors and I agree with a lot of -- I think what they do, they write about an area in which they have expertise, so I would consider that more authoritative. And in other parts in which I don't know the author, I couldn't consider it to be authoritative.

Q What about the Yamada book on gastroenterology, do you have that in your office or library?

A I have it available to me but --

Q Do you refer to that from time to time?

A Occasionally, but not as much. I don't have it myself but I do have access to it and I do occasionally look at it.

Q You refer to Sleisenger more frequently because you have a copy?

A Well, also because Sleisenger was considered the GI bible for the longest time and what's been out there the longest. Yamada, I know Yamada very well and I have nothing against him. It's just the textbook I chose to use as my reference

was Sleisenger.

Q What are the primary journals in gastroenterology that you receive and read on a regular basis?

A Gastroenterology I read. Every month it comes out. American Journal of Gastroenterology I also get. I do occasionally read Digestive Diseases & Sciences and I read selected articles out of Gut. That's a British journal. They're straight to the point.

Q Do you consider those journals that you receive and read on a regular basis to be authoritative in gastroenterology?

A Gastroenterology **is**. That's about it. The rest are kind of really picking and choosing. They're not really that good compared to Gastroenterology. That's the class journal.

Q Are you somehow involved in that journal?

A No.

Q Okay.

A It's just a very good journal. Very competitive. Has really good articles.

Q Doctor, describe for me the nature of your current practice in medicine.

A Okay. What I do is clinically I see patients

one day a week and in the private setting. They're my private patients. And I do procedures throughout the week and I attend on in-patient two months out of the year. One month on gastroenterology consults and the other one with internal medicine. And I also attend as a pre-attending. In other words, the fellows trainees have to have staff conference so I do that approximately twenty days a year.

So I do in-patient, not necessarily my patients, but I will learn about the case and cover the case with. a fellow, with a trainee.

Q Twenty days a year did you say?

A For them. I do my own cases, too,

Q Right. When you say "procedures throughout the week," do you have scheduled days and times for procedures?

A Whenever I get a time slot that suits me and the patient. So it's throughout the week. It depends. Some weeks I'll have seven or eight procedures to do. Some I'll have two to do.

Q What is the primary source of your patient's referrals?

A Primarily referrals. Some are self-referrals. Mostly they're physician referrals.

Q Which day during the week do you see patients?
A Wednesdays.
Q And where are those patients seen at, 75 Francis Street?
A The address is actually 45 Francis Street. The hospital. takes up two city blocks.
Q Okay. So 75 Francis Street is the Brigham and Women's Hospital? That's the address for the hospital?
A Correct.
Q And that's where Harvard Medical School is located?
A No. Harvard Medical School is located next door on Shattuck Street, S-h-a-t-t-u-c-k. And Brigham and Women's Hospital is one of the main teaching hospitals for Harvard. There's no Harvard Hospital per se. There's Brigham and Women's, Massachusetts General, Beth Israel, Children's.
Q I'm sorry. What day did you say is your day for seeing patients in the office?
A Wednesdays.
Q Wednesday. When you are not seeing patients in the office on Wednesday and you are not doing procedures, what are you involved in? What kind

of work are you involved in?

A Research, teaching, things like that. But, basically, clinical research, administrative work.

Q As far as your teaching, do you teach both in the didactic manner as well as clinically?

A More clinically than didactic. I give about six to eight lectures a year. Two are to the medical students. The rest are to, well, some are to residents, some are to fellows, Some are post-graduate in continuing education courses. But also clinical teaching, you know, by example, to both students and residents and interns. Also fellows.

Q What percentage of your practice is dedicated to a clinical practice?

A Of my career? Or my practice, meaning how much of my patient practice?

Q Right, of your patient practice.

A That what? I'm sorry.

Q What percentage of your overall practice of medicine is patient practice?

MS. CARULAS: If you are able to give it.

A I'm not sure what you mean. You mean what I do

on an average week, how much is devoted to patient care?

Q Yes, outside of the research, the clinical.

A About 25 percent.

Q Okay. What percentage is involved in teaching?

A About ten to fifteen percent.

Q What percent is devoted to administrative work?

A Too much. About probably ten to fifteen percent also.

Q Research?

A The remainder, about fifty percent.

Q What type of research are you involved in currently?

A My Laboratory is involved in examining the regulation of a certain gene that is in codes of protein or hormone in the small intestine that serves as a signal between the small intestine and the pancreas, looking at how that gene is regulated both in the Large and small intestine and also how its receptor is regulated, how the receptor actually works. That's my basic research.

Q Has the nature of your practice changed at all since 1991?

A The only way it has changed is that because of

the book I have written, I'm getting a little bit more in the way of people with bad reflux disease. I seem to be getting more of those as far as referrals. But that's only a slight change.

Q When was the last time you were called in to consult on a patient with postoperative ileus?

A Called in for --

Q When was the last time you were called in to consult?

A Every time I'm on call there's at least one patient Pike that. I was on call -- I'm actually, these six months, I'm not taking call for -- I'm being given off these six months because the laboratory is moving. It's changing labs.

But the last time I was on call was sometime in October, on the weekend. And every time I'm on call we have at least one we're asked to cover for.

Q Are there any publications that you have been involved in that are specifically related to ileus?

A No.

Q Are there any publications that you are involved

in that's specifically related to constipation?

A No.

Q The book Gastrointestinal Emergencies --

A I'm sorry, the book is -- I didn't personally write those. That I personally wrote or been involved with?

Q Been involved with.

A Yes. Gastrointestinal Emergencies, McBride's Signs and Symptoms. That was a long time ago, back in the early eighties. I wrote a chapter on anorexia, nausea and vomiting. That was the other end.

Let me see what else. There's a book that actually I'm sole editor of, Gastrointestinal Pharmacotherapy in which we talk about drugs that treat constipation, and to treat diarrhea, the other way around.

Q Let me ask you this. Excuse my ignorance, but when you are involved in editing a book, for example, like Gastrointestinal Emergencies, what role do you play as editor?

A There are certain sections of the book which I will take and work with the authors, and they'll send the chapters to me and I'll read them over for content as well as style and make

recommendations regarding their content, if I think there are deficiencies. If there's minor editing, I will edit to put in stylistic changes. I also procure the authors.

Q So as far as, again, if there's something you don't agree with, you will have a discussion with the author and make sure that it's a statement made in the chapter, a statement that you feel is appropriate?

A Or also they'll enlighten me when they think their point of view is appropriate. Mostly if I think they left something out. That's mostly what I will do. I'll tell them, "Please write something about this. You didn't say anything about this condition."

Q So you feel that the book that you have edited, or participated in editing, Gastrointestinal Emergencies, is authoritative? I think you already said that.

A For the emergency setting, yes.

Q Okay. You are talking emergency setting or emergencies in gastroenterology?

A Emergencies in gastroenterology, not emergency room. Emergencies, acute situations.

Q Okay. Is ileus a gastrointestinal emergency?

A It's covered in the book. It's, my definition, it wouldn't be an emergency, but it's covered in the book. It's an acute situation. So we couldn't call gastrointestinal acute. It's covered under the emergency situation heading.

Q Is acute constipation a gastrointestinal emergency?

A No.

Q Can constipation be acute?

A There's no such thing as acute constipation,

Q Okay. Why not?

A Because someone is constipated. Someone is impacted, constipated. They're not acute. They've recently become constipated. But you don't suddenly become constipated.

Q It takes time to realize you're constipated?

A Yes, it takes time. That's why it's not considered an emergency.

Q Is unresolved constipation a gastrointestinal emergency, or can it be?

A Uncommonly. That's a semi-acute situation which needs to be evaluated. Somebody's having bowel movements. You have to work with the possibility of some kind of obstruction.

Q Small or large bowel obstruction?

A Some type of obstruction, yes.
Q Let's talk about constipation for a couple minutes. That's a subject that is covered in the field of gastroenterology, constipation?
A Yes.
Q Do you agree that a bowel movement that is soft and easy to pass with a frequency ranging from three per day to one every three days is a normal bowel movement pattern, falls within the range?
A That's my range. I don't know if I said soft, but the range is exactly as you have stated. A nine-fold difference.
Q Do you believe a patient whose bowel function falls outside of that limit or a patient with a change in bowel habits deserves evaluation?
A Yes.
Q And a bowel obstruction can cause constipation?
A Yes.
Q For constipation caused by bowel obstruction, would you agree that abdominal distention, nausea and vomiting and obstipation are the classic associated findings?
A Yes, plus abdominal tenderness as well.
Q Would you add any other clinical features to the

definition of constipation that we've talked about, other than what we talked about?

A No. Definition, I specifically tell patients is anything outside of the definition we just discussed. The frequency is the most important thing for me. And that is, again, anything less than one every three days. One bowel movement every three days I would consider constipation. But that may be the patient's normal. I don't become alarmed. I see patients that have one bowel movement a week. And at that point, after an evaluation, if I can't find anything structural, we try certain medications, If that's all they can achieve and they're relatively comfortable, that's what they live with.

Q When they come in to you constipated, do you ask them, "What has been your pattern until your recent problems?"

A Yes.

Q That's an important factor?

A This is very important. And also I ask them, "What has happened along the way that may have changed your pattern?"

Q Is ileus a form of bowel obstruction? Does it

fall under the general category of bowel obstruction?

A No. You get an ileus if you are obstructed. But there is also paralytic ileus, which is a pseudo-obstruction. You don't -- ileus means that your bowel is paralyzed.

Q Well, don't you find ileus under chapters in books for bowel obstruction because it's a pseudo-obstruction?

A No. You find obstructions is the reason for the ileus. But ileus can occur without an obstruction.

Q So your --

A More commonly without an obstruction.

Q When you say "obstruction," could you define that for me, bowel obstruction?

A It's something is blocking the lumen or the opening of the intestine.

Q Whether it's --

a Or a hollow viscus.

Q Whether it's the lumen itself or a lesion, an obstructing lesion or impacted feces, something like that?

A Something is obstructing the flow. But again, obstruction, the connotation of obstruction,

when we say it means that you have a mechanical obstruction, not that -- because if you get a paralytic ileus, a pseudo-obstruction that causes stool to impact, and that's like the chicken or the egg. What came first in the case of an ileus is the bowel not moving and then still getting in there and impacting. When in the case of obstruction, well, the obstruction was first and then the stool got backed up,

Q Could you have an ileus where you don't have a resulting mechanical obstruction?

A Sure. All the time. That's more common.

Q How do you define complete obstipation?

A It means that someone doesn't have a bowel movement. They're obstipated.

Q And in a patient with a paralytic ileus you are going to have a complete obstipation?

A No. Obstipation is not a term you use with someone with ileus. That's one of the things you asked me before. Obstipation is constipation occurring over a long period of time.

Ileus is more of an acute situation. Someone's bowel is not functioning. Motor activity has ceased. That's very different. By

definition, someone who has an ileus won't have -- we don't call them obstipated. They have an ileus.

Q A person with an ileus won't move the bowel during the period of time of the ileus?

A That's correct. They can't move their bowels.

Q Bo you agree that distention is the hallmark of ileus?

A That's one of the hallmarks. It's not pathognomonic of but it's one of the hallmarks.

Q Would you agree that the absence of bowel sounds is not a requirement for the diagnosis of a paralytic ileus?

A Absence of, no. You can't have an ileus without having an absence of bowel sounds.

Q So if you have a patient with bowel sounds you are going to exclude ileus?

a That's correct. If someone has very high-pitched bowel sounds, high-pitched is the runs, we sometimes think of the possibility of they could have a mechanical obstruction.

Very specifically, very specifically, as a matter of fact, William Silen, who's one of the better-known surgeons in the United States, when we teach the same courses for the purpose of

physical diagnosis, points out that the presence, any presence is normal. In order to have an ileus there can be no bowel sounds.

Q And what is the criteria for determining no bowel sounds?

A You listen with a stethoscope over the abdomen for a long period of time in different quadrants.

Q How long?

A We listen for several minutes sometimes. There's no set time we listen. I'll listen for at least two minutes.

Q Would you agree that decompression with nasogastric suction and i.v. hydration is the appropriate treatment for a paralytic ileus?

A Yes.

Q Would you agree that ileus is expected after any type of abdominal operation in which the peritoneal cavity is entered?

A Is expected? We assume it's going to happen. It doesn't always but we'll assume it's going to happen transiently. But, yes, I'll --

Q What do you mean, transiently?

A First of all, it is always transient. It could be very short. You just enter the peritoneal

cavity. For example, taking out a gallbladder, you won't get an ileus maybe for an hour or two, but that's about it. But when you talk about any kind of bowel surgery, yes, you will have an ileus. That's expected.

Q When you say "transient," it could last for an hour, does the term "transient" include the onset, the timing of the onset of the ileus?

A Transient was probably a poor choice of terms. They're all transient. Every single one is transient. I meant very short-lived. You know, a very short period of time. And again, I'm not a surgeon. But my understanding from the surgeons, and I found it, too, at least in my observations, is that the ileus will last generally longer if more bowel is manipulated during the surgery.

Q Can you have an ileus if you have got uncoordinated intrinsic bowel motor activity and the elimination of effective peristalsis?

A I'm not sure what you mean.

Q Well, can you have peristalsis going on that's not coordinated and effective in moving bowel content? Does that constitute an ileus when you are moving bowel content but you have an

uncoordinated peristalsis going on?

A Theoretically, I guess. But I don't know of any case like that. That's very hard to prove, except in animal studies.

Q Why would that be?

A How do you show uncoordinated peristaltic activity? As a matter of fact, if you do experiments -- and this has been done -- in which you take a piece of the gut and move it to a new area, you will then see that new area of the gut has its own brain and coordinates much activity along the way. It propagates the food bolus in an organized fashion.

So disorganized peristaltic activity is extremely difficult to demonstrate. I'm not aware of it being demonstrated but I imagine anything can happen. There are very rare occurrences in which people get neuropathies, like hollow visceral myopathy, a very rare condition, which I guess could happen.

But as far as disorganized motor activity, I'm not aware of that being a syndrome at all, let alone of any frequency.

Q Would you expect to hear bowel sounds if you had this kind of uncoordinated peristaltic activity?

A Yes.

Q When a patient does have ileus, would you expect a return to normal peristalsis within 24 hours, of the small intestine?

A It depends.

Q It all depends --

A That's the reason I said transient. Transient could be two weeks. That's still transient.

It's a poor term. Ileus can last a few hours to two days.

Q Do you agree that the passage of flatus represents the end of ileus?

A We always look for gas, of course, and you listen for bowel sounds.

Q Do you agree that electrolyte imbalances can delay the resolution of ileus?

A Yes.

Q Doctor, how do you make the diagnosis of ileus?

A Okay. Again, the history we discussed before were, first, abdominal distention, abdominal pain and not having passed any fecal material for a certain period of time. Physical signs, distention and no bowel sounds. And we generally get an abdominal x-ray showing dilated loops of bowel consistent with the diagnosis.

Q What kind of criteria do you use as far as the length of time where the patient has had no bowel movements?

MS. CARULAS: You are talking now in a setting where the patient hasn't had surgery or hasn't had narcotics? Or are you talking just in the patient that walks into the emergency room without those events?

MR. LANCIONE: I didn't give any criteria for the setting.

A I can answer that. The bowel movements isn't part of it. That doesn't mean is the person having bowel. sounds. People are constantly complaining of no bowel movements. That's a big complaint. They almost always have bowel sounds.

Q Do you differentiate between ileus and postoperative ileus?

A Well, there's ileus and then one of the --

Q I mean, can people get ileus without having intra-abdominal surgery?

A Yes.

Q And have you seen patients in your practice that come in with no history of any surgery anywhere and have ileus?

A Yeah. Very commonly.
Q What other conditions, other than surgery, can cause ileus?
A The most common cause, at least that I see as a consultant, is someone who's been in a hospital taking large amounts of narcotics for pain or for other reasons, And sometimes -- that's most commonly seen in ileus. Because the surgeons expect it. As we said, anybody who's a general surgeon will see it,

By the time I see it most commonly it's someone who's been over surgery for two weeks and is getting narcotics. You know, this guy hasn't had a bowel movement in two or three weeks and they call and the person has taken narcotics. That's the most common reason.

Electrolytes, we do see it, of course. But people are pretty attuned to making sure electrolytes are normal or at least close to normal.

Q How do you know that?
A You measure them in the blood. It's measured very frequently, usually in a hospital.
Q So you agree that ileus can occur as a postoperative complication in a surgery that did

not enter the peritoneal cavity if you have got the use of narcotic painkillers?

MS. CARULAS: Objection.

A Yeah.

MS. CARULAS: I think that was a stretch from your prior questions but --

A Yeah. It's the narcotics doing it, not the surgery. It's the narcotics. Any kind of pain can do it if you are taking narcotics, yes. It's narcotics. That's one of the most notorious reasons for an ileus.

Q What about in the patient who's had a surgery that does not enter the peritoneal cavity and does not take narcotic painkillers postoperatively?

A Again, I'm not a surgeon. I imagine it might happen but it's not the usual occurrence. It would be unusual, as far as I know. It may not even occur. There's no physiological reason for it to happen if one doesn't enter the peritoneal cavity.

Q Is peritonitis associated with paralytic ileus?

A Peritonitis, one of the signs of it is an ileus. That's one of the signs.

Q Can you develop peritonitis as a consequence of

ileus?

A If somebody -- okay, I'm stretching, but if someone has obstruction, gets an ileus and perforates, yes.

Q It perforates. Okay.

Let's turn our attention now to Carl Williams. During the first hospital admission from December 19, 1991 to December 21, 1991, that was a Thursday to Saturday.

Is that consistent with your memory?

A I don't know, those two days, I'm not sure of what days of the week.

Q I looked it up on my calendar.

A It was a Saturday he was discharged, so it would be two days.

Q Doctor, I take it you did a thorough review of the records before you wrote your opinion letters and before your deposition today?

A Yes.

Q Was there any indication that you found in the chart that he had had a bowel movement or passed flatus during his hospitalization?

A It was -- he did pass some material, yes, some stool. It was in one of the nurse's notes, if I'm not mistaken.

Q Well, go on over here, just because you mentioned that. Let's see. On 12-21-91 at 10:30 a.m. there's a note: "Left bathroom, Expelled small amount liquid stool and suppository."

Is that what you are referring to?

A Yes.

Q And I guess there's another note here at 11:45 a.m. on 12-21-91?

A Nurse's notes?

Q Yeah. Well, here, Plaintiff's Exhibit 4. We'll just use the court reporter's copy. This is a narrative note.

A Okay.

Q At 10:30 it talks about a liquified stool and suppository.

A Yes.

Q And then in Exhibit 5 it says: "States he has been to bathroom for liquified suppository material streaked with stool in minimal amount."

Is that the other reference?

A Yes.

Q And your opinion is that constitutes a bowel movement?

A It constitutes, yeah, constitutes a bowel

movement. It's a helped, it's an assisted bowel movement, yes.

Q What about flatus? Is there any indication that he had any flatus during his hospitalization?

A No. Can I put a "but" there?

Q You can do anything you want.

A In my experience, rarely do people comment upon flatus unless there's an ileus or unless there's another reason. Rarely is it commented upon, unless there's a reason to comment upon it.

Q By comment you mean --

A If one's worried.

Q -- for a nurse to ask about flatus means they're concerned about ileus, if they say, "Have you had any flatus?"

A That's correct. They're only concerned, yeah. Why would you ask about something which isn't considered to be a problem? If it's not perceived to be a problem, why would you ask about it?

Q So is the lack of an inquiry of flatus an indication that they weren't concerned about ileus to you?

A That's right.

Q Okay.

A Let me just say one other thing. I feel very bad for that man. What happened to him I think is very sad, what happened to him. But because, I mean, you're asking me questions and it will sound like I'm callous. I'm not. I feel terrible about what happened.

Q My questions don't imply that you're being callous at all, trust me.

A Okay.

Q I've marked the Data Collection Sheet from 12-20-91 as Plaintiff's Exhibit 1 and in there there's a note of positive bowel sounds on all three.

Do you see it?

A Yeah. I saw it.

Q Okay. Now, in an individual who's constipated and hasn't moved his bowel, does the presence of bowel sounds indicate that he's not having effective peristalsis in moving the bowel down to the anal verge and into the reservoir prior to elimination?

A If somebody had no bowel sounds and they were listened to appropriately, listened for a couple minutes, then, yes, that would be correct, it would be the case. Especially in a proper

setting.

Q So if they listen to bowel sounds --

A They must listen. Again, when someone says no bowel sounds -- you're referring to the nurse's notes?

Q Exhibit 1, right.

A The nurse's notes?

Q I can't remember, It says positive bowel sounds. It says positive BS is present and positive BS for 5, or, 8, 4 and 1. I think those are the times listed.

A Yes. Bowel sounds are present, which means -- well, yes.

Q And considering that in light of his comment that he hasn't moved his bowels since Wednesday, do you recall that he stated to the nurses on Friday or Saturday that he hadn't had a bowel movement prior to admission?

A Yes. I remember reading that someplace. It was since Wednesday, though. I don't know exactly.

Q I'll find it for you. It's on this narrative note for 12-20-91 and the 12-21-91, Exhibit 3. It says: "Complaint of nausea. Abdomen slightly distended. States 'I haven't moved my bowels since Wednesday.'" Colace was given.

Here's Exhibit 3. It's for the entry at 12-21 at 6:30 a.m.

A Yeah.

Q In fact, he hasn't had a bowel movement since Wednesday, and 12-20 is when they chart bowel sounds. That's Friday.

A Yes.

Q Does the fact he's having bowel sounds but hasn't moved his bowels means he's not having effective peristalsis?

A Not at all.

Q What does it mean?

A It means he's not having bowel movements.

Q Why not?

A Because in a hospital I find -- and I tried to make a search before I came here -- three-quarters of the patients, or at least half, regardless of -- these people don't have bowel movements for two days. They go from being ambulatory to lying down in bed. They go to a situation in which they're not eating properly or they're eating differently and just lying around. They completely change their habits, completely change everything. And add to that narcotics. This is the rule rather than

the exception.

Q Does anesthesia contribute to constipation?

A Spinal anesthesia?

Q Yes.

A Or general?

Q Let's take spinal first.

A I don't think so.

Q What about general?

A General, I'm not sure. It usually depends on what they use. For halothane, I don't think it does. They usually use something as a paralyzer, and that is for general anesthesia.

Q But spinal anesthesia, as far as you're concerned, is not associated with constipation?

A No. And the reason it's not is that the bowel has its own enteric nervous system it's called. If you know a person who's a quadriplegic, they still have bowel movements. The gut has its own brain and is able to move things by itself, so it doesn't happen.

Q So spinal anesthesia is not going to be a cause of ileus either?

A Again, I'm not an anesthesiologist either. But in itself, not that I'm aware of. And I don't recall ever getting a call for a person with

merely spinal anesthesia and nothing else getting an ileus. Almost always there's mitigating circumstances, which are generally narcotics.

Q Are narcotics going to cause ileus?

A Yes.

Q Like Demerol, like what Carl was taking?

A Yes.

Q Exhibit 2 is a Data Collection Sheet from 12-21-91. It looks like an 8:30 a.m. entry. And the nurse's notes noted that the bowel sounds were sluggish at that time. See that?

A Yes.

Q Does that represent a change in the status of his bowel that was noted by the nurses?

A That's meaningless. As I discussed before, Dr. Silen, William Silen --

Q Can you spell the last name?

A S-i-l-e-n, William Silen, who's now retired from being chairman of surgery at Beth Israel Hospital in Boston. He's the author of Cope's The Acute Abdomen.

Q Sure. I have it in my office.

A And Bill -- Dr. Silen -- and I was there when I heard him teaching students. And specifically

he pointed out, and I agree, that the whole business about bowel sounds being sluggish or decreased -- are they absent or present, period.

The other thing, if you hear a high-pitched run the next six seconds. You listen for absence or presence or high-pitched runs.

Q Are high-pitched hyperactive bowels?

A No. Well, sort of. It usually means it's contracting against an obstruction. You hear it pushing, pushing hard. That's the only thing that I even consider is absence or presence with mechanical, obstruction or high-pitched occasional sounds in the setting of a very silent, tender abdomen.

Q with a mechanical obstruction will you have bowel sounds?

A That's what I just mentioned. You'll have -- I'm sorry.

Q You said the high-pitched sound --

A No. It's a relatively silent abdomen. What you will hear is a really high-pitched sound occasionally.

Q So the enteric nervous system is shut down. The peristalsis is preventing the --

A It's a defense mechanism, more or less, the enteric nervous system. If it keeps contracting it will cause pain and it's going to cause a perforation. I'm talking teleologically. It will shut down.

Q So the fact that you note sluggish bowel sounds means the --

A To me it's meaningless.

Q It doesn't represent any change in the function of the bowel as far as you are concerned?

A Is it the same nurse even?

Q No, it's a different nurse.

A I can't tell. I'm not a handwriting expert. But I would assume that this is a different nurse because they write different things down. So different things mean different things to different people. It's absent or present. That's all it really means.

Q Exhibit 3, the first entry, 12-21, 6:30 a.m., a complaint of nausea, abdomen was slightly distended.

Does that represent a change in the patient's abdomen?

A I don't know. That's very hard to determine. Possibly. Most commonly, again, he's been

getting narcotics. Narcotics, one of the major side effects is nausea. Especially Demerol.

Q Isn't nausea a symptom of ileus, as well?

A Not -- yeah. But one of the minor symptoms. The biggest, far and away, is distention and pain.

Q And this is the first note of abdominal distention, 6:30 a.m. on the 21st?

A As far as I remember. It's slightly distended.

Q And this alone is a physical finding that could be associated with ileus, abdominal distention?

A Yes, it can be.

Q Do you think that the fact that he hasn't moved a bowel and his abdominal distention should have raised a concern that this patient should be looked into for ileus?

A No.

Q Why not? Because of bowel sounds?

A Because of his bowel sounds, because of narcotics and because he's lying in the bed two days. And if we did that, we would have workups on everybody in the hospital.

Q Well, what would the workup have been? Let's say Dr. Boyd thought ileus. What should he have done?

A Get him off narcotics, prolong the hospitalization, start doing x-rays on him, start doing flat plates, put NG tubes down.

When I look at these cases, I think what I'm pretty good at doing is putting myself in the physician's position and trying to see if I would have done anything differently at that point. And there are situations where I've been asked to defend and in which I say, "I'm sorry, I can't defend it. It's substandard care."

I'm looking here and I know the situation in which physicians are under pressure these days to get them out of here as soon as possible. Get the patients out. We hear this all the time, "Get the patients out," get them out, get them out.

And you see a patient here who's definitely going to get constipated without question. He's on narcotics. He's an older guy. He's going to get constipated. I would say virtually a hundred percent of these patients get constipated and with a little constipation, a little distention. And unless you see a disaster happening, which wasn't happening there, you get them out of the

hospital and back to normal activity.

As a matter of fact, I encourage my patients. I tell them, "Get out and get moving. And if sometime you see there's a problem, you give me a call." And I keep in contact with them.

But constipation itself is not an indication for further hospitalization. I mean, this is a serious -- again, I'm --

MS. CARULAS: You've answered the question.

A This is a serious situation, We're being asked to get patients out as soon as possible. And there's nothing wrong with them. Get them out.

And I look at it. I put myself in their position. And they feel there's nothing wrong with him and they send him out. And I'm not sure. I think they kept in contact with him. I'm sure he had a phone number to call them if there was a problem going on.

Q He was given Colace at that time?

A Yes.

Q That was for the constipation?

A All these old guys give Colace. They give Colace to everybody.

Q What's he supposed to do?
A Colace is soap, encapsulated soap. That's all it is.
Q What does it do?
A It softens the stool up. It's given to ICCU's for people who have had heart attacks. So they don't -- everybody gets Colace at the hospital. Constipation is so common in hospitals it's just -- everybody. It's the rule rather than the exception. That and sleep deprivation.
Q Okay. Exhibit 4, the entry at 9:30 a.m. notes an alteration in the comfort status related to constipation.

Do you see that?

A Yeah, I saw that.
Q Could that pain related to constipation, is that the same kind of pain that you would find with abdominal tenderness with ileus?
A Yes. But usually with tender, I mean, again, you are going from pain to more or less full excruciating pain. Again, the pain has not been graded here. It's pain.
Q Are you saying that the abdominal tenderness with ileus is an excruciating pain?
A It -- well, that's interesting, Yes. But

sometimes it is. Sometimes it's actually pains --

Q So the range patients report is zero to ten on a scale?

A Yes, The thing of Ogilvie's syndrome, which was actually mentioned in the chart, which is, surprisingly, these people have balloons for abdomens and they're from an ileus and they have a cecum which is about to explode and they're smiling away and sometimes feel very good.

Q The plan, the entry under Plan, Intervention, the nurse reported "distended, hard abdomen. Dr. Boyd."

As far as the way she's described it, distended and hard, does that represent a change from the last entry of slightly distended abdomen at 6:30?

A Yes, from what she wrote, yes, there's a difference. The patient also was given hot water to drink. People with ileus don't have much of an appetite. He was given something to eat. He's still eating. That goes against it. You've got an acute, you know, ileus. One of the things we see is anorexia. He doesn't -- at least he's drinking there. That speaks against

it.

Q Isn't eating contraindicated for a patient with ileus?

A If they have an ileus.

Q If they have an ileus you don't want them eating?

A No. But don't worry, they won't. One of the signs, as a matter of fact, I use is that if they ask for food, if they're ready to eat, it's a good sign that they're getting better.

Q Dulcolax suppository, is that the kind that liquifies, it kind of melts when it's put in the rectum?

A Yeah. It gets things moving. I forget how that works specifically. I forget the mechanism of how it actually works, but it's a bowel stimulant, more or less.

Q So the entry at 10:30 by Nurse Boley looks like: "Up to bathroom. Expelled small amount liquid stool and suppository."

For a guy that hasn't had a bowel movement since Wednesday and this is now Friday, wouldn't you expect a larger amount of stool?

A How much is he eating at this point?

Q Well, do you recall what the nurse's notes say

about the amount he ate?

A No, I don't. I mean, you can get -- again, this is not unusual for someone taking narcotics. It's just not unusual at all.

Q Okay. Exhibit 5 has two entries there. The entry at 11:45 indicates he is short of breath.

Was there any other entry in the chart that you saw that indicated that he became short of breath at any time during his hospitalization?

A No. With exertion, short of breath. But I do know that he has severe COPD and they were very concerned. Two operations were canceled prior to this one because of COPD, chronic lung disease. He gets short of breath.

Q And what caused him to become short of breath?

A I don't know.

Q Was it --

A It says with exertion. "Patient dressing for discharge. Extremely short of breath with slight exertion. Rales heard." I can't read it. Faces? It says "with exertion."

Again, I saw his pulmonary function tests indicating he had a combination of restrictive obstructive lung disease. I don't know what

his -- again, the picture I have here is a man lying around in bed, so he really hasn't gotten up for a couple days.

a Do you feel that his vital signs that are noted there are abnormal?

A His pulse is a little bit high, 104. Respiratory rate.

Q No. 120.

A Oh, there. I'm looking here. It's a little high. But again --

Q It's still a little high at 12:15 when the house officer --

A Normal is up to a hundred.

Q Isn't over a hundred considered tachycardic?

A Yes. But then again, at rest. Resting pulse.

Q In Exhibit 6, which is the progress note written by Dr. Boyd, this final entry, do you agree that there's no difference of diagnosis stated there?

A Difference from what?

Q Difference of diagnosis. The only thing that was considered was constipation?

A That's what he says. I also read that he was discharged. Acute -- alert, no acute distress, under Nurse Boley.

Q Let's turn to your report, Doctor.

A Okay.

Q The first question 1 have is, on page one, the third full paragraph you say: "I'm not qualified to comment on Mr. Williams' surgery or his immediate postoperative care."

What do you mean by immediate postoperative care?

A Recovery room. I'm not a recovery room physician.

Q So as far as the care, when he was out of the post-anesthesia and is admitted to the floor, you feel qualified to comment on that care?

a Yes. Oh, yeah.

Q The observations made by the nursing staff and by Dr. Boyd and the decisions and findings?

A Yes. There's not much in the way of physician's notes to read.

Q And your opinion is that his discharge was appropriate. And what is the basis of your opinion that it was appropriate to discharge him when they did?

A Based on the experiences I've had caring for patients, both as the primary physician as well as the consultant, is that constipation following hospitalization is common.

Constipation following hospitalization plus narcotics is even more common. And it's important to get people who are -- this man's 65. I get a feeling of an older 65. And with these kind of people, I like to get them out, back to the normal routine as soon as possible whether or not I'm being pressured to get people out of the hospital.

Q And this gentleman, would you agree that if the diagnosis of the ileus was made, right or wrong, it would have been inappropriate to discharge him at that time?

A If he had an ileus documented, at that point it would have been inappropriate to discharge him.

Q And ileus is an indication for continued hospitalization?

A It's an indication for treatment, for a nasogastric suction, for a patient not eating, i.v. fluid, hydration, ruling out mechanical obstructions.

Q So is it your testimony that narcotic analgesia will actually bring on an ileus to a point where there's no bowel sounds whatsoever?

A. Very commonly.

Q And is that your opinion that that's what

happened to this gentleman?

A Yes.

Q After he was discharged he developed a paralytic ileus secondary to the narcotic analgesia?

A He stated in his notes he likes IM narcotics much more than the little pills. "I like shots better," quote.

Q Where is that quote? Let's find that.

A Okay. Page -- 12-20-91, stated "relief but pills aren't as good as the shots." That's the quote.

MS. CARULAS: 3 p.m.

Q I know. It's not exactly what he said.

A He likes the shots better. I'm sorry. You're right.

Q Well, I mean, so you are taking from that that what, that he has a propensity to use more narcotic drugs than a different patient?

A No. He's using it like anyone else uses it. People get into trouble with narcotics. They go home with them and to get the same level of relief, oral medication requires more oral medication, and one of the many side effects of the drugs is constipation.

Q Do you get the same effect on the bowel with

intramuscular narcotics as opposed to oral?

A It really depends more on the type of drug. Demerol causes it to a large extent. Percocet causes it a little less than codeine. Codeine also causes it worse than Demerol does. But that's my opinion. That's not based on anything in the literature. They cause it. One of the accepted unfortunate complications of narcotics is getting constipation.

Q Bo you know how much he used at home after discharge?

A I have no idea. That 1 don't know. And again, I have no proof of this, but I would assume that he did use it at least a few times a day because he was probably in pain. I know I would be. I'm in pain just thinking about it.

Q The second page of your report, the first few paragraphs, it starts: "The next question is, of course, whether continued hospitalization would have prevented the complications from arising."

And when you say "complications," I take it you are meaning the ileus, the sepsis, the respiratory decompensation and the CVA? Those are the complications you are talking about?

A No. Really, mostly prevented an ileus from developing.
Q So in the first sentence you are just talking about ileus from arising?
A Yes. It's the ileus.
Q Would that have happened if he would have stayed in the hospital?
A Yeah, probably.
Q Okay. Then you say: "The answer to this question is impossible to determine with any degree of certainty but I would surmise that it would be highly improbable."
A Let me read the whole letter again. No. It's all the complications in that situation. It's all of the complications. I mean, it's in order. Would you prevent the ileus with all the other complications? After that would we have not had a respiratory decompensation or CVA? I doubt it but I don't know.
Q Are you able to state that to a reasonable degree of medical probability?
A Yes. I would say it's a greater than fifty percent chance that they are, okay. Which one? All of them? Yeah, all of them, except for the ileus. The ileus probably would have developed

whether he was in or not. That wouldn't have made any difference.

Q So had they kept him in the hospital he still would have developed ileus?

A Yes, probably. This man.

Q Yeah, this man.

A Had they, on the 21st, put a nasogastric tube in, put him on NPO and given him an i.v. hydration, would he have gone on to develop ileus? I don't know. Maybe they didn't think it appropriate to do that.

Q Do you think it would have been inappropriate, based on what you read in the chart, to put a tube down this man?

A That's not a fair question.

Q 'Why not?

A That's Monday morning quarter-backing. From what I read there, at that point it sounds like he left alert, happy as a clown. He left feeling fine. So I'm not going to stick an NG tube down someone like that.

Q That's what I want your opinion on. Our experts say they should have done that and I want your opinion.

A I don't think so.

Q You don't. But would it have been inappropriate to do so?
A Yes.
Q Follow me?
A Yes. Those NG tubes rarely, but they do, cause complications. I can see, sitting here, a blood vessel causing an arterial bleed.
Q Those complications are less than one percent for insertions of nasogastric tubes?
A Finding an ileus is less than that.
Q Well, we'll get to that in a minute.
There's a very low complication rate for the insertion of a nasogastric tube?
A Have you ever had one down yourself before?
Q No.
A Try it sometime.
Q Don't want to.
A I have. They're really uncomfortable and I try to avoid them as much as possible in my patients. They're uncomfortable, unless there's a real reason.
Q And ileus is a real reason because the complications are worse than the pain that the patient suffers from a nasogastric tube?
A All you are accomplishing is the tube. You are

not decompressing. If they think they're decompressing, they're not sure what they're doing. All you're doing is helping to make sure that it doesn't get any worse. If you can't --

Q Right.

A -- you suck air out from the gut, from the stomach? No way.

Q You get nothing from the small intestine, just from the stomach?

A For the first -- yeah, but you are getting it from the stomach, making sure it doesn't get worse. But if he's able to belch --

Q But that's the treatment?

A We all -- paralytic ileus responds spontaneously. Pancreatitis used to be treated routinely with an NG tube, until my boss said, "Why are you doing that? There's no reason to." And we don't unless it's a very severe case. A lot of things we did in the past. And surgeons like NG tubes a lot. We don't. I personally don't either. I had one down me. They're uncomfortable.

At this point I have nothing here indicating to me that this patient needed an NG tube. But then again, medicine is so --

Q I understand. The original question was, based on your statement in your report which is that had they put in an NG tube and treated this man like an ileus, do you know if his ileus would have resolved sooner? That wasn't my question, that's a new question, but we're moving on.

Had they done the NG tube would his ileus have resolved sooner?

A This man?

Q Yes.

a Probably not. He had a very long ileus afterwards. He had an ileus that lasted a little over a week. For that reason I don't think it made a difference.

Actually, from what I read, the delay you are talking about is not two days. It's a delay of four days before they -- it's a delay of two days only. And I don't think it would have made much of a difference. Again, I can't deal with absolute certainty. You are asking me probabilities, and the probability is that that would not have made a difference.

Q The statement in here, you said the physicians caring for Mr. Williams acted in a most appropriate manner -- here's what I don't

understand -- excluding those causes of an ileus that were reversible.

What do you mean by that?

A Okay. They looked for causes of electrolyte abnormalities. They looked for any kind of mechanical obstruction. I mention here the only thing they didn't do right away, which they did later, was a serum magnesium and thyroid function test. But that was reversible. I think what they did was appropriate. And I don't always say that.

Q And timely?

A I think so.

Q They ruled out a mechanical obstruction?

A As well as they could. They had a little trouble. I read they had a little trouble doing it from the small bowel point of view. From the colon they did it pretty well. But they did it fairly timely.

Q During the second hospitalization, the x-rays, at least the x-ray -- have you seen the x-rays, by the way?

A No, I haven't.

Q The reports indicate findings consistent with paralytic ileus.

A Correct.
Q And that was on the 23rd, the first day?
A Right.
Q Do you have an opinion, to a reasonable degree of medical probability, as to the cause of his acute respiratory decompensation?
A Which one? Did he have it twice? You mean his first one, when he first came in?
Q Right.
A I would say in that case he probably decompensated as a result of his CGPD, plus -- the underlying CGPD plus probably his acute medical condition, which was the ileus, the ileus pushing up his abdomen, making his restrictive lung disease that much more restrictive.
Q The distended abdomen pushes up on the diaphragm, which doesn't allow the lungs to expand fully and that --
A Makes it more restrictive.
Q Right. Okay.
A 'We're overlapping a little bit so I have to stop that.
Q You say that a CVA is not a known complication of ileus, right?

A That's right.
Q But is CVA a known complication for sepsis?
A Sepsis per se? Not that I know of.
Q Doesn't it increase the risk for a CVA?
A Not that I know of.
Q What about acute hypertension?
A Yes.
Q Hypo?
A Hypotension? Both hyper and hypo could.
Q Anoxia?
A Oh, yeah, definitely.
Q And emboli?
A Well, embolus is the cause, not -- just actually it causes the stroke, yes. Okay.
Q Yes. You are saying it's impossible for a patient to have an ileus after penile implant surgery as a result of the penile implant surgery?
A Nothing is impossible. I've learned that a long time ago. There are cases I did cite, actually, I did Leave out in my briefcase, I have a Medline search and there's a couple cases of a penile prosthesis migrating into the peritoneal cavity causing a bowel obstruction after a year or so. But not in the acute setting. And that

didn't happen here as far as I know. Otherwise, by itself, there's --

Q You are not saying that it never has happened and never will happen in the future that someone is going to have a paralytic ileus so -- let me finish so Kathy can take it down.

A I'm sorry.

Q So after a penile implant surgery --

A Anything is possible.

Q Okay. And just because something isn't published doesn't mean it can't happen. Do you agree with that?

A Yeah. But people love to publish. But, yeah, anything's possible.

Q Was Mr. Williams septic during the second hospitalization?

A Now, I kept seeing the term "sepsis" but I didn't see positive blood cultures. My understanding is he had atelectasis. My understanding is he had that. And probably from -- they give him low-grade pneumonia. But as far as I know he doesn't have positive blood cultures.

Q He had a grossly elevated white blood count, didn't he?

A That's not sepsis.
Q I know. We're moving from sepsis and talking about the white counts.
A Yeah. He had leukocytosis.
Q Leukocytosis, and the white count was up to 28,000 at one point?
A It was high.
Q It was high. And that's indicative of some type of infection?
A Not always.
Q I know not always, but it's indicative of an infection somewhere?
A It can be. We see elevated white counts in people with -- it's like a whole reaction with severe stress. We see it with pancreatitis, which may be the stress causing it. Obviously, we see it with leukemia.
Q Let's talk about Mr. Williams. What do you think caused it, leukocytes and --
A Probably the pneumonia and stress from the ileus.
Q And the elevated white count?
A I don't know for sure. That would be --
Q You don't have a --
A That's my medical opinion.

Q Based on reasonable medical possibility?
A Pneumonia and stress from his ileus.
Q More likely than not caused the elevated white count and leukocytes?
A Yes.
Q And you agree he had a normal white count going into the hospitalization on the 23rd?
A I think so. I think I remember that. You may want to refresh my memory. I think he did.
Q Do you have an opinion, based on reasonable medical probability, as to the cause of his seizures?
A Yeah. Most likely it was a lacunar infarct, CVA.
Q I know lacunar infarcts can cause seizures. One of the presentations of stroke is seizures.
A I thought seizures only happened from infarcts from gray matter, not white matter.

First of all, you have the lacunar infarct which goes through where all the motor pathways pass right through there, through to the area. It's very -- one of the presentations of stroke is seizure activity.

Q Right. All right. Do you have an opinion, based on reasonable medical probability, as to

the cause of his CVA?

A Well, it was caused by embolic or thrombotic -- my guess is he had a thrombotic event. He had a thrombosis in his capsule, someplace in one of his blood vessels in his brain.

Q You are talking about reasonable medical probability?

A Reasonable.

Q Or do you have --

A That's my reasonable -- that's what I surmised from reading the chart.

Q Would you defer to a neurologist or do you feel qualified to make opinions on neurosurgery?

A I would also defer to the neurologist. But I feel very qualified since it's neurology and I did quite well in stroke localization.

Q Can we safely assume he did not have a bleed to cause the stroke?

A with a certain degree of -- a certain amount of -- what's the word -- with a certain degree of certainty I think I could safely say that.

Q The last question doesn't have to do with medicine. Let me give you a hypothetical. I'm driving down the street in my car and I come to an intersection and I don't have a stop sign but

the crossing lane of traffic does have a stop sign and someone runs through the stop sign and broadsides my car and I had an open fracture in my arm.

Now I go to the hospital for an open reduction internal fixation for my fractured arm and I get a postoperative infection, due to nobody's fault, and I lose my arm.

Would you agree that, but for the negligence of the guy that ran the stop sign and hit my car, I wouldn't have lost my arm?

MS. CARULAS: Well, note my objection.

A I agree with you.

Q All right.

A Can I go further on that? I think the analogy is poor.

Q Okay. I didn't ask you for that.

MS. CARULAS: You have a right to read the transcript.

THE WITNESS: I'd like to see it.

EXAMINATION OF M. MICHAEL WOLFE, M.D.

BY MS. REID:

Q For the record, Doctor, I'm Christine Reid. I'm

here on behalf of Meridia Huron Hospital,

Do you have any criticism of the hospital staff?

A I don't have any criticism in this case. And I'm going to say that I've had cases for the defense before and I'd tell them, "Forget it. They were negligent." And I really, I do not -- and I really think they did a fine job under the circumstances.

It's a very difficult case. It's a man who had advanced COPD. And everybody gets constipated in the hospital. Just virtually everybody does, unless they have diarrhea they come in with. And we just can't hospitalize every single patient and put them in the hospital for constipation.

Q Was there -- I'm sorry.

A Go ahead and ask.

Q Was this man at a higher risk for developing ileus because of his fragile state of health?

A No, no, not at all.

Q Is there like a risk stratification for people who are going to develop ileus?

A Not that I know of.

Q I haven't read anything about it.

A We tend to see Ogilvie's in people who are chronically ill, which he was not. COPD isn't chronic illness.

We have seen people with multiple strokes in the past. They've had cancers and big operations. As we say, not this kind of guy. We just don't see it in this kind of patient.

I would have done the same kind of thing. That's how I judge it. I'm fairly conscientious, conservative in management, and I tend to see people longer than I should sometimes. I don't think I would have done anything differently here.

As far as medical-ma%, which isn't under my purview, did he have adequate follow-up? That's one thing. Could he have called, was someone there, someone he could get in touch with? Was there adequate follow-up?

Q Are you aware that he talked to Dr. Boyd several times over that weekend about his unresolved constipation?

A Sounds like he was admitted appropriately. They finally said, "Come on in."

Q Well, do you know, one way or the other, whether he had any conversation with Dr. Boyd?

A I wasn't aware until Anna told me they did talk to him. I'm not sure how many times. Finally he came in. He probably said, "Come on in." And I don't think he waited too long.

Q For a patient who's constipated -- well, strike that.

In a patient who has paralytic ileus, is the ordering of milk of magnesia, would that be contraindicated for ileus?

A If he had an actual ileus. If he had an actual ileus, probably, if they knew he had an ileus, you wouldn't want to do that because you get a pretty violent contraction. It actually wouldn't do very much.

Q Since he had an ileus on the 23rd, based on the x-ray, do you think he had the ileus on the 22nd, Sunday?

A I have no idea. And I have no reason to even venture to guess. It could have happened the 23rd, the second he hit the emergency room. It could have happened the 21st. I don't know. No one knows. And no one can guess, either.

Q They made a diagnosis of ileus. But did you note in the chart there were notations about bowel sounds in the chart?

A He had, absolutely, bowel sounds when he came in, I'm pretty sure. It wasn't they were absent, if I remember correctly.

MS. REID: Thanks. Nice meeting you.

- - - - -

THE STATE OF OHIO,)
COUNTY OF CUYAHOGA,) SS: CERTIFICATE

I, Kathy A. Vazinski, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, M. Michael Wolfe, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed on a computer/printer, and that the foregoing is a true and correct transcript of the testimony so given by him, as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 28th day of March 1996.

Kathy A. Vazinski, Notary Public
within and for the State of Ohio
My Commission expires January 11, 1998.

THE STATE OF _____)
) SS:
COUNTY OF _____)

Before me, a Notary Public in and for said state and county, personally appeared the above-named M. Michael Wolfe, M.D., who acknowledged that he did sign the foregoing transcript and that the same is a true and correct transcript of the testimony so given.

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at _____, this _____ day of _____, 1996.

_____
M. Michael Wolfe, M.D.

_____
Notary Public

My Commission expires: _____

ERRATA SHEET

Page	Line	

WANOUS REPORTING SERVICE

121891

378-M

MERIDIA HURON HOSPITAL
DEPARTMENT OF NURSING SERVICE

DATA COLLECTION SHEET

DATE: 12-20-91

NOTE: N/A IF ASSESSMENT PARAMETER IS NOT APPLICABLE.

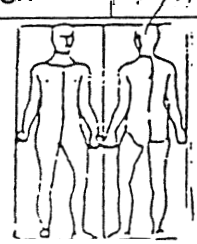
☑ PT. I.D. BAND
☑ ALLERGY I.D. BAND

WILLIAMS, CHAD
02/23/26 55Y M FC AC
BOYD, JONATHAN C
91353-00012 443495
12/12/91 12/19/91 Addressograph

		☐ ADMISSION ASSESSMENT		☐ ADMISSION ASSESSMENT		☐ ADMISSION ASSESSMENT	
	ASSESSMENT PARAMETERS:	TIME: 5 pm	SIGNATURE: K Bang RN	TIME: 4p	SIGNATURE: L Poole LPN	TIME: 1	SIGNATURE: M Wilmoth RN
WELL-BEING	PSYCHOSOCIAL	calm		pleasant		cooperative	
	COMFORT	c/o INCISIONAL PAIN		same		c/o "nervous"	
NEURO	PUPILS	PERRLA		n/a		N/A	
	ORIENTATION	x 3		oriented X3		x 3	
	MOVEMENT	MAE		mae		x 4	
	LEVEL OF CONSCIOUSNESS	ALERT		alert		alert	
RESPI-RATORY	LUNG SOUNDS / RESPIRATIONS	CLEAR		clear, even		clear	
	COUGH/SUCTIONING	ABSENT		no cough noted		same	
	ACCESSORY EQUIP.	n/a		n/a		N/A	
CARDIO-VASCULAR	APICAL	REGULAR		reg		reg	
	PERIPHERAL PULSES	PALPABLE		palpable		palpable	
	EDEMA	NONE NOTED		scrotum		scrotum	
	SKIN	warm & dry		warm & dry		warm / dry	
G.I. / G.U.	ABDOMEN/BOWEL SOUNDS	(+) BS		present		(+) BS	
	GI TUBES	N/A		n/a		N/A	
	G.U. TUBES/URINE FOLEY	16 fr @ 9 mm		yellow		↓	
	INCONTINENCE	N/A		n/a		↓	
INCISION/ WOUNDS	1. INCISION ABDOMINAL	DRSG DRY & INTACT		dry & intact		same	
	2.						
	3.						
	CAST/TRACTION	N/A		n/a			

SKIN INTEGRITY

Circle and number location if more than one area is involved.



☑ NO IMPAIRMENT NOTED
TO BE DONE BY DAY SHIFT

ABBREVIATION CODES
Color: (R) RED (Y) YELLOW (B) BLACK
Size: Measure in cm
Drainage: (N) NONE (L) LIGHT
(M) MOOERATE (H) HEAVY

Stages:
1. Reddened area
2. Blister or skin break
3. Exposed subcutaneous tissue
4. Exposed muscle and/or bone

NUMBER:	
Color (R/Y/B)	
Length	
Width	
Depth	
Drainage (N/L/M/H)	
Stage (1–4)	

PLAINTIFF'S EXHIBIT
1 - Wolfe
3/11/96

FMR-14 REV 12/89

12207 378

MERIDIA HURON HOSPITAL
DEPARTMENT OF NURSING SERVICE

DATA COLLECTION SHEET

DATE: 12-21-91

NOTE: N/A IF ASSESSMENT PARAMETER IS NOT APPLICABLE.

☑ PT. I.D. BAND
☑ ALLERGY I.D. BAND

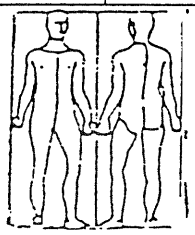
WILLIAMS, CARL J INP
02/23/26 65Y M FC AC
BOYD, JONATHAN C
91353-00012 443495
12/19/91 12/19/91

- Addressograph--

	ASSESSMENT PARAMETERS:	☐ ADMISSION ASSESSMENT TIME: 8 AM / SIGNATURE: C Bailey SN	☐ ADMISSION ASSESSMENT TIME: / SIGNATURE:	☐ ADMISSION ASSESSMENT TIME: / SIGNATURE:
WELL-BEING	PSYCHOSOCIAL	pleasant		
	COMFORT	denies pain, ↓ restlessness c/o gas - abd. soft + distended		
	PUPILS	PERRLA		
	ORIENTATION	oriented X 3		
	MOVEMENT	MAE		
	LEVEL OF CONSCIOUSNESS	awake + alert		
RESPIRATORY	LUNG SOUNDS / RESPIRATIONS	L - wheeze at base, frictionless after L - diminished throughout		
	COUGH/SUCTIONING	none		
	ACCESSORY EQUIP.	none		
CARDIO-VASCULAR	APICAL	regular		
	PERIPHERAL PULSES	3+ X 4		
	EDEMA	none		
	SKIN	warm + dry		
G.I. / G.U.	ABDOMEN/BOWEL SOUNDS	sluggish		
	GI TUBES	none		
	G.U. TUBES/URINE	none		
	INCONTINENCE	none		
INCISION/ WOUNDS	1. surgical	clean, well approximated		
	2. JJ	⊖ redness, staples x		
	3.	place		
	CAST/TRACTION			

SKIN INTEGRITY

Circle and number location if more than one area is involved.



☑ NO IMPAIRMENT NOTED

TO BE DONE BY DAY SHIFT

ABBREVIATION CODES
Color: (R) RED (Y) YELLOW (B) BLACK
Size: Measure in cm
Drainage: (N) NONE (L) LIGHT (M) MODERATE (H) HEAVY

Stages:
1. Reddened area
2. Blister or skin break
3. Exposed subcutaneous tissue
4. Exposed muscle and/or bone

NUMBER:	
Color (R/Y/B)	
Length	
Width	
Depth	
Drainage (N/L/M/H)	
Stage (1–4)	

PLAINTIFF'S EXHIBIT 2 - Wolfe 3/11/96

FMR-14 REV 12/89

2

SIGNATURE KEY	
INITIALS	SIGNATURE
R.B.	Bryant LT
L.G.	L. Goble Lpn

MERIDIA HURON HOSPITAL

DEPARTMENT OF NURSING SERVICE

PATIENT'S PROGRESS/CARE RECORD
NARRATIVE NOTES

Altered Comfort

DATE TIME		PATIENT PROBLEM/CONCERN	PLAN ACTION/INTERVENTION	EVALUATION PATIENT RESPONSE/OUTCOME	SIGNATURE
12-30-91 3pm	# 1	Altered Comfort Status	Medicated for pain	Stated relief but pills aren't as good as the shots	R Bryant
12/30	#1	Alt Comfort Status	P.O.C.	medicated ē Demerol 75mg & Vistaril 50mg IM ē good relief.	L. Goble Lpn
12/31	6[a]			C/o nausea — [illegible] States "I haven't moved my bowels since [illegible]." [illegible] 10 mg given as ordered	[illegible]

MERIDIA HURON HOSPITAL

DEPARTMENT OF NURSING SERVICE

PATIENT'S PROGRESS/CARE RECORD

NARRATIVE NOTES

SIGNATURE KEY	
INITIALS	SIGNATURE
[illegible]	C Daley, SN

DATE / TIME	#	PATIENT PROBLEM/CONCERN	PLAN ACTION/INTERVENTION	EVALUATION PATIENT RESPONSE/OUTCOME	SIGNATURE
12/21/91 9:30 AM		Alteration in comfort: pain related to constipation.	Reported distended, hard abd to Dr. Boyd. Dulcolax suppository given per order, hot water for oral intake per pt. request.		
10:30 AM				Left BR, expelled sm amt liquid stool & approx. 1/2 cup urine. Given additional hot water to drink per pt. request.	C Daley SN

PLAINTIFF'S EXHIBIT 4-Wolfe 3/11/96

MERIDIA HURON HOSP
CLEVELAND, OH

Page 1

S / MISC.

ACTIVITY	OOB EVE OF SURG,AMB. HALL	
FEEDING	SELF	
HYGIENE	SELF	
TOILETING	BRP	
VITAL SIGN	Q 4H	
SAFE	CALL BELL WITHIN REACH	
SAFETY	HALF RAILS 2 UP	
SAFETY	BED LOW POSITION LOCKED	
TRANSPORT	WHEELCHAIR	
TRANSPORT	IV	

PLAN OF CARE
✓ = Completed elements

Prc: SURGICAL TEACHING
FULL CODE

Diet: HOUSE-REGULAR

ACTIVE ORDERS

PAT EKG	12/19	07:52A
TAT FAX 2862		
AI I-EMBOL HOSE, TED, MEDIUM-X LENGTH	12/19	01:54P
IV THERAPY-PERIPHERAL	12/19	06:10P
CBC W/ PLATELET	12/19	07:51A
STAT FAX 2862		

TREATMENTS

12/19 06:22P

1:DIETARY INTAKE
W/ F/ P/ B R/ L
W/WELL F/FAIR P/POOR R/REFUSED
ENTER:B-BREAKFAST L-LUNCH D-DINNER

12/19 06:21P

2:IV THERAPY I:

SITE	SOL'N	MED.	RATE	U/R
1. LT	D5LR		175	U
2.				

U/UNREMARKABLE R/REMARKABLE

CONSULTATIONS

PLAINTIFF'S EXHIBIT
5-Wolfe
3/11/96

DATE	TIME	NURSING NOTES
12/21/91	10:15AM	Heplock D/C R Boley SN
12/21/91	11:45AM	Pt dressing for D/C, extremely SOB c sl exertion. Rales heard throughout lungs. VS 170/106-120-36. States he has been to BR for liquefied suppository material streaked c stool in minimal amt. Continues to c/o discomfort r/t constipation. B. Yelocker, R.N. notified. R Boley S.
	12:15PM	H.O. in to assess pt. VS 142/88 [illegible] -104-36. To be discharged. R Boley S

	SIGNATURE
rb	R Boley SN

Dx : IMPOTENCE
Alg: ASA
Iso: UNIVERSAL Smk: UNK
Sgy: 12/19/91 INSERTION PENILE IMPL
Type: INP
378-W 443495 91353-00012
Adm : 12/19/91 DOB: 02/2?/26 65Y
Phys: BOYD,JONATHAN C Level:
WILLIAMS,CARL J Sex: M

Sat Dec 21, 1991 06:20A Shift S
PATIENT CARE PROFILE # 7

NAME HOSPITAL NO.

DATE	
90	AVSS [illegible] clear modest swelling [signature]
12/22/90	Tm 37° - Asthma modest swelling modest swelling c/o constipation P. Ducolax D/C home Rx Cipro / Percocet. [signature]

PLAINTIFF'S EXHIBIT
6 - Wolfe
3/11/96