IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

GERALD MEEKER, Individually and as the Putative Administrator of the Estate of Phyllis Meeker,	CASE NO. CV 10 735463
	JUDGE DAVID MATIA
Plaintiff,	
-vs-	
THE CLEVELAND CLINIC FOUNDATION, et al.,	
Defendants.	

DEPOSITION OF CARL ADAMS, MD, FACS, FAACP
OCTOBER 25, 2011, 9:15 a.m.
Durango Office Suites
1099 Main Street
Durango, Colorado 81301

PURSUANT TO THE RULES OF CIVIL PROCEDURE, this deposition was:

TAKEN BY: WILLIAM A. MEADOWS, ESQ.
ATTORNEY FOR THE DEFENDANT
CLEVELAND CLINIC FOUNDATION

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I N D E X

E X H I B I T S

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CARL ADAMS, MD, FACS, FACCP,

after having been first duly sworn under oath, was questioned and testified as follows:

EXAMINATION

BY MR. MEADOWS:

Q. State your name, please, for the record.

A. Carl Warren Adams.

Q. Doctor, as you know, my name's Bill Meadows. I represent the Cleveland Clinic with regards to a lawsuit that was filed against it by Gerald Meeker. I'm going to ask you some questions this morning that have to do with your opinions in that case. You know that you've been identified as an expert on behalf of the Plaintiffs.

A. Correct.

Q. You've given deposition or two or three or more before, so I won't belabor the preliminaries, but I would like to make sure that we have an agreement at the outset here that if I ask you any question that you do not understand that you'll let me know that.

A. I will.

Q. Okay. What is your current address?

A. My home address is 101 Becket Lake Drive, Durango, Colorado, and my office address is St. Joseph Hospital, 2700 East Dolberr, D-o-l-b-e-r-r, in Eureka,

California.

Q. So the report that you've issued in this case bears the address -- your home address, true?

A. That's correct.

Q. And the CV that I was provided also shows the address as your home address.

A. Correct.

Q. Do you have an updated curriculum vitae with you? The one I have is dated December, 2010.

A. Yes, I have one updated April, 2011.

Q. Do you know offhand what changes were necessary from the December, 2010 to the April, 2011?

A. Basically called back to Reserve in the Army and a couple presentations, but basically -- oh, and my general surgery recertification.

Q. Okay. So the first question that I'd like to ask you about your background is how is it that you live in Durango, Colorado, and work in Eureka, California?

A. Basically, I left my private practice in Honolulu in 2000 and had visited here before with my father, so I bought property here. And I was looking for a -- basically, a position where I could work part-time and do other things, some charitable work.

Q. So in 2000 you left your practice in Hawaii and moved your home to Durango.

A. Correct.

Q. And when you moved your home to Durango, did you have a practice, an existing practice, or arrangement in place when you first moved to Durango?

A. I had an arrangement where I was covering in Pueblo and Colorado Springs and in Rapid City, South Dakota, and Eureka. So I was doing basically coverage for my friends, allowing me to work basically two weeks off, too.

Q. Were you employed when you were doing that coverage in those three locations when you first came to Durango?

A. I was employed by the hospitals in Colorado Springs and Pueblo and California, and I was doing locum tenens work in South Dakota.

Q. Are you -- when you were doing locum tenens work, was it through a locum tenens organization?

A. It initially started of with Comp Health and then the hospital gave me a contract to provide coverage in South Dakota.

Q. And when you would work two weeks on and two weeks off, was it two full weeks on and then two full weeks off?

A. Correct.

Q. And am I correct in my understanding that at

some point then you began to only work at Eureka?

A. In 2005, I gave up the work in Rapid City, South Dakota. We were trying to start a heart program there and that fell through, so I was employed by Parkview and Sister Mary Corwin in Memorial in Pueblo and Colorado Springs. And I worked more, I worked three weeks on and one week off, and then I was covering in California on a less frequent basis.

In 2008, the Heart Institute in California asked me to do a contract with them, so now it's basically 190 days a year exclusive St. Joseph Hospital, Eureka, California, and no longer in Pueblo and Memorial in Colorado Springs.

Q. So that's been true since 2008.

A. Correct. And it's reflected on my CV.

Q. So tell me about the efforts that you made in Rapid City to set up a heart program.

A. They asked two of us, Jim Oury and myself, to help start a heart program based from the hospital, the hospital employees. So we went through the contract negotiations and we had finalized an agreement. We wanted another guy, so we got another fellow, Tom Garcia, to join us. And during the midst of our starting to move forward, the cardiologists decided that they weren't going to allow cardiac surgeons to work for

the hospital, that we needed to be employed by them. We said we're not working for cardiologists, so we had to basically sue the hospital for a contract violation.

Q. And what came of that litigation?

A. They settled with me.

Q. When was that resolved?

A. 2005.

Q. So, essentially, for the last three years you've been working 190 days at St. Joseph in Eureka.

A. Correct, exclusively.

Q. And how is the 190 days scheduled?

A. Basically, the other guy is there, John Postell, who's the guy who started the program there in 1999. We had set up an agreement where we'll work on two, off two, sometimes together for three or four days. And just we plan like two or three months ahead of time.

Q. So in any given four-week period of time, you're working two weeks.

A. Right. Or three, off two.

Q. But as it turns out in a given year, you're working about fifty percent of the year in Eureka.

A. Correct. Well, I have a 1099 contract employee with the hospital to provide them up to 190 days a year.

Q. Up to.

A. Correct.

Q. How many days did it turn out to be in 2010?

A. About 180 plus.

Q. And what are you on track for in 2011?

A. The full year, 190 days, the full.

Q. 190?

A. Right.

Q. And when you're there for those 190 days -- or let's do it this way. If you're there for a two-week stint, how many hours are you working during those two weeks?

A. I'm on 24/7 because I'm the only cardiac surgeon there. And California has a thing called Title 21 where because the cardiologists do invasive procedures that we have to have in-house cardiac surgery. We're linked with the general surgery group and they are our first assistants and help us.

Q. Do you see patients on an outpatient basis?

A. Correct. Every Friday we have clinic.

Q. Okay. So tell me about the nature of your practice when you're there for those 190 days.

A. It's primarily cardiovascular and thoracic surgery, some vascular if the general surgeons need help, and trauma call.

Q. So that's pretty wide ranging. Between the various areas that you just described, can you break it

down for me in terms of percentages where you spend your time?

A. It's probably 60 percent cardiovascular and thoracic, 20 percent probably vascular. And then I do surgical critical care for that hospital as part of my agreement, so consults from the ICU in the remaining time.

Q. And when you say consults, do you round routinely in the ICU, or is it on a consult basis?

A. Consult basis.

Q. Are there intensivists that cover the ICU otherwise?

A. Right, our cardiac anesthesiologist is also a critical care specialist, so he runs the ICU. And then there's two pulmonologists who work part-time. It's only a 12-bed ICU, so it's not that bad.

Q. How big a hospital is it?

A. It's 160 going to 240 beds. It's the only regional hospital on the northern coast. It's part of the St. Joseph Sisters of Orange County system.

Q. And is it just you and the other cardiothoracic surgeon that covers the cardiothoracic surgery service?

A. Correct. John has limited himself to just hearts. John Postell, the guy that's there, just likes to do cardiac only. But I help them with the thoracic

and the vascular because the general surgeons have their Thoracic Department, quote-unquote, that we help them with.

Q. Is there a separate thoracic surgery group?

A. No, it's the general surgeons. One of the general surgeons thinks he's a thoracic surgeon.

Q. Between you and the general surgeon who thinks he's a thoracic, who does more thoracic?

A. He does more thoracic, simple lobectomies. We'll do esophageal surgery with him and we'll do large vessels because he does endovascular thoracic things.

Q. If there's an esophageal surgery at St. Joseph's and you said you do it with him --

A. Correct.

Q. -- who's the lead surgeon?

A. What we do are co-surgeons.

Q. How do you divide the responsibility?

A. Well, it's 50/50. Because if he's out of town, then I take care of the patients, and when I leave for my two weeks, then he's taking care of the patients.

Q. I guess intraoperatively, how do you divide responsibility?

A. I can't answer that, it's a hard one. I mean, he'll do a thoracotomy, I'll mobilize the esophagus. Sometimes whoever is closer will do the anastomosis. If

we're doing a colonic in position, he'll mobilize the colon and then I'll help do the anastomosis in the neck.

Q. Are there times when patients at St. Joe's need to be sent to a tertiary care facility?

A. Correct.

Q. And what tertiary care facility is utilized?

A. Stanford or UCLA. Sometimes for our complicated cardiac cases, we'll send them to Pacific Medical Center in San Francisco.

Q. You've described for me your practice during the last three years or so. In terms of how you divided your time amongst the various areas of surgery, was it different when you were doing what you were doing between 2000 and 2005 than 2005 and 2008?

A. A lot more general surgery and trauma at Parkview and Corwin Memorial.

Q. What time frame was that?

A. 2002 to 2008. Predominantly cardiac and vascular in Rapid City and less general surgery thoracic in Eureka until 2008.

Q. Does the contract that you have for St. Joseph's have a term?

A. Three years.

Q. When's the three years up?

A. I just re-signed one last year, so two more

years.

Q. And do you have plans on what you intend to do after that?

A. I'm going to stay there.

Q. So where do you currently have privileges?

A. At St. Joseph Hospital in Eureka, California only.

Q. Have your privileges ever been suspended, revoked, or limited for any reason?

A. Never.

Q. Where do you have a license currently?

A. California and Colorado.

Q. Has your license ever been revoked, suspended, or limited for any reason?

A. Never.

Q. What areas are you currently certified?

A. Board certified in cardiovascular and thoracic, which is called the Thoracic Board, and just have completed my recertification in surgery and gave up my surgical critical care -- well, didn't give it up, I just didn't recertify in 2005.

Q. In critical care?

A. Correct.

Q. Does the Board Certification in thoracic require recertification?

A. Yes, every ten years. I just recertified last year, so this is my third ten-year stint.

Q. Have you performed the surgery that Dr. Pettersson was performing on Mr. Meeker?

A. Yes.

Q. On how many occasions?

A. In my career, probably over 50, 60 times. I'm not a current fan of the maze procedure the way this was performed. This was a radiofrequency ablation, so --

Q. When was the last time you did a mitral tricuspid repair?

A. September of last year.

Q. So September, 2010?

A. Correct, on both a tricuspid and mitral annuloplasty using the Cosgrove Ring.

Q. And how do you remember that specifically from 2010?

A. Because I'd just had two coronaries in December of that year.

Q. Wait, say that again. I lost it.

A. So September of last year I did a bilateral -- a dual valve repair and then in December I had to go back and do a coronary.

Q. The same patient?

A. The same patient, right.

Q. In the last three years, how many times have you done that type of procedure, a mitral tricuspid repair?

A. Infrequently for dual valve, usually just mitral valve or isolated aortic valve.

Q. So you're saying infrequently. Over the last three years, how often have you performed that procedure that Dr. Pettersson performed?

A. Probably three times.

Q. In the last ten, how many times have you -- the last ten years?

A. About 50 times, but not with a maze procedure. Because the maze procedure, we usually do it endoscopically.

Q. So 50 times -- you told me you had done it 50 or 60 times in your career, so all 50 of those were in the last 10 years?

A. No, no, not in my career. In my career, I've probably done 250 plus. In the last 10 years probably 50.

Q. So earlier when I asked you how many times have you done the procedure Dr. Pettersson was doing, you said 50 to 60. What were you referring to?

A. In the last 10 years.

MR. DOLESH: Objection.

Q. So that I'm clear, you believe that you've done the procedure that Dr. Pettersson did in this case 250 times in your career.

A. Correct, if not more.

Q. And the last 10 years 50 to 60 times.

A. Correct. Without the maze procedure.

Q. Okay. Based upon the types of surgeries you're doing now, how frequent is a transesophageal echocardiogram utilized in conjunction with your procedures?

A. I would say over the last two years, the cardiac anesthesiologist uses it on every case.

Q. Every open heart case?

A. Yeah. Is it necessary, probably not.

Q. Have you voiced that opinion?

A. I do. Because I think it's very helpful when you're doing valvular surgery. If you have a sick patient with a low injection fraction, it can help you. But it's not really used -- should be used to every case.

Q. What is the response that your opinion is met with?

A. We're doing it. Because the cardiac anesthesiologist does it and they want to bill for it.

Q. Prior to the last two years, how often was it

used?

A. Mostly for valve cases, particularly when we're doing a mitral valve repair.

Q. Have you ever passed a probe intraoperatively?

A. Not in the operating room, but in the ICU.

Q. And what was the circumstances?

A. The surgical critical care guy couldn't pass the probe, so I passed it. Most of the probes are now passed by techs.

Q. In your experience, they're passed by techs in the operating room?

A. Either the anesthesia tech or the anesthesiologist. If they're done preoperatively, they're done by the cardiologist or the cardiologist tech.

Q. But when they're done intraoperatively, they're done by somebody on the anesthesia team.

A. Correct.

Q. You are not an anesthesiologist.

A. That's correct.

Q. You have never practiced as an anesthesiologist.

A. That's correct.

Q. You're not Board Certified in anesthesia.

A. That's correct.

Q. And as I understand your testimony, you have passed an echo probe once in an ICU setting.

A. Correct.

Q. And you did that because the intensivist could not?

A. Correct.

Q. What was it that was preventing the intensivist from doing so?

A. The patient was also orally intubated, so it was difficult for him to pass the probe around the endotracheal tube.

Q. Did you have any difficulty?

A. No.

Q. What did you do that allowed you to pass it and the intensivist didn't do that prevented him or her from passing it?

A. Xylocaine Jelly.

Q. In light of the difficulty that was encountered passing it when the intensivist attempted, was there any consultation with thoracic surgery or gastroenterology or any other specialist to evaluate the esophagus?

A. No. It was a postop heart patient and we had a concern for pericardial fluid collection, so we didn't consult. It was one of our patients, a thoracic surgery patient.

Q. My question probably wasn't a good one. Based upon the fact that the intensivist couldn't pass the probe and you had to pass the probe on a subsequent attempt --

A. Um-hmm.

Q. -- based upon that fact alone, did you evaluate the esophagus to determine whether or not there was any perforation or pathology?

A. No, I did not.

Q. If you had to estimate for me how many times you've been in the operating room when a TEE probe was passed, what number would you give?

A. Well, over the last probably seven years since we've been using it, a thousand plus cases, not only me as the surgeon but being a co-surgeon.

Q. Has there ever been an occasion in the operating room where whoever was attempting to pass the probe made you aware of difficulties encountered in doing so?

A. No.

Q. Was there ever an occasion when the plan was to use a transesophageal echo probe but for whatever reason a conversion to an echocardial probe was utilized?

A. No.

Q. Do you know of any instance in those thousand

cases where injury to the esophagus occurred as a consequence of passing a probe?

A. Not to my knowledge.

Q. Prior to this case, had you ever heard or read about the risk of perforation to the esophagus by virtue of passing a TEE probe?

A. I have heard of it. It's very rare.

Q. How had you heard of it? Where did you hear it from?

A. For recertification. It's one of the questions in our recertification test booklet.

Q. Do you still have that?

A. It's CSAT, so it's on the computer. It's the thoracic surgery --

Q. What did it ask?

A. Basically what symptoms from esophageal perforation after a patient has been instrumented.

Q. And by instrumented, is it limited to a TEE probe or is it any instrumentation that's passed through the esophagus?

A. It was a TEE probe.

Q. Let me back up for a moment and ask you whether or not you've contributed to the literature on any issues that you think are relevant in this case.

A. No, I have not.

Q. Have you given any presentations or lectures on issues that you think are relevant to this case?

A. I've given some talks in the ICU, but not, you know, about esophageal perforation. But not specifically with a TEE probe. You know, as a thoracic surgeon, we get called for other instrumentation EGD rigid esophagoscopy, rigid bronchoscopy where there's a perforation.

Q. Have you reduced any of those talks to writing?

A. No.

Q. In other words, a power point or anything like that?

A. No, I haven't given many talks in the last three years because predominantly we're busy doing our heart program at St. Joe's.

Q. When is the last time you contributed to the medical literature?

A. Ooh. I'd have to look at my CV, but it's been a long time ago.

Q. I thought I saw 1996.

A. Yeah. I'm out of the publications mode after 28 years of doing this.

Q. What was the nature of your practice in Hawaii?

A. It was a very busy cardiac, vascular, thoracic, trauma, general surgery -- as my partner called it,

anything that had blood in it surgery. We covered five hospitals on the island and covered Maui Memorial and Kauai Wilcox Hospital.

Q. And you were there from '92 to 2001?

A. Correct. After Desert Storm, I returned and was released from the Army and went into private practice to Honolulu Medical Group.

Q. Where were you stationed during Desert Storm?

A. I was actually in Iraq.

Q. For how long?

A. A year. Not exclusively in Iraq but in Damon and then Bahrain.

Q. So you left the Army in 1992 and went into private practice. And then were you in the Reserves after that?

A. No. I resigned my commission and they called me back in three years ago, so I'm in the Reserve now.

Q. How does that work in terms of getting called back in? What's the mechanism or criteria for being called back in once you've resigned your commission?

A. Because I was a Barry planner, which was a scholarship program, and took a regular Army commission. The fine print is that you have to serve -- they can call you back up until 20 years if you haven't completed 20 years of service. And I served 17 years and 9

months, so I got the fateful letter from the War Powers Act in 2008.

Q. So what have been your obligations since then relative to the Army?

A. Doing a weekend at Fort Carson, teaching the trauma ATLS course at Fort Sam Houston in San Antonio, Texas. And they want me to do a deployment, but we'll see.

Q. When does that happen, or how does that happen?

A. Negotiation.

Q. What are the possibilities?

A. High.

Q. And where might you go?

A. Well, I'm assigned to Fort Carson, so they have an ongoing operation in Afghanistan, Somalia, and in Kenya. They're part of what's called Africa Command. So if I'm going to do something, it has to be short term because I have my commitment at St. Joe's, so a six-week to eight-week commitment.

Q. When are you finally done?

A. Next May.

Q. Okay.

A. Unless we go to some other nice place.

Q. So when you're spending your 190 days back in Durango, how do you spend your time?

A. I do expert consulting work. I travel and go to South Africa four times a year and I play golf and scuba dive.

Q. So you have -- you enjoy life.

A. Trying to, correct. Yeah. Yeah. After 28 years of being on call.

Q. Four times to Africa. What do you do there?

A. There's a charity, Richard Branson's Pride and Purpose, which is in Ulusaba, so we have a hospital there and I bring back supplies that are expired and help them do things in Ulusaba, which is in South Africa. And then in Tanzania, we have a program at the Heart Institute there helping them do some pediatric heart stuff -- ASD closures, simple things.

Q. How long do you stay there?

A. Two weeks at a time if I'm lucky enough. If I work three weeks and then I have three weeks off, so then I can plan that -- you know, to be gone a little bit longer.

Q. You've been reviewing medical legal cases for how long?

A. I did my first one in 2001, so coming up on 10 years.

Q. How many have you done over that span?

A. In the beginning I was probably doing maybe

four or five a year, but in the last five years I think I've probably reviewed 10 cases a month.

Q. So about 120 a year.

A. Correct, um-hmm.

Q. And that's been for about five years?

A. Correct. It's reviews for attorneys and then I'm an expert reviewer on the Medical Board for California, so I do reviews for the Medical Board.

Q. And that's based upon their system of panel of physicians that review cases before the cases are filed or --

A. If there's a complaint against a physician or they're tracking a physician or there's a hospital that has issues, then it's referred to the Quality Assurance Division of the Medical Board and we're sent the cases as a panel to review them.

Q. Of the 120 approximately on average a year that you do, how many are from lawyers with regard to a pending or potential lawsuit?

A. Probably about a hundred. Probably -- maybe fair enough to say 15 to 20 a year from the Medical Board.

Q. And do you list your name with any services?

A. No, I do not.

Q. Have you in the past?

A. No, I do not.

Q. Have you ever advertised your services as an expert?

A. No, hm-umm. We're bound by the Society of Thoracic Surgeons and the College of Surgeons not to do that, so I do not do that.

Q. How much do you charge?

A. I charge $500 per hour for review of medical records and a written report, and I charge $700 per hour for deposition testimony with a four-hour minimum. And I charge $8,000 a day for trial testimony. That's inclusive -- exclusive of travel. But I don't charge travel charges or anything like that.

Q. So if you have to come in the day before and wait around and go on the next day, is it 16,000?

A. No, it's 8,000. I charge for a day.

Q. How much did you earn doing medical legal work or doing expert reviews in 2010?

A. Between 85 to $100,000 I think is a fair estimate.

Q. And has that been the range in terms of what you've earned over the last five years?

A. That's fair.

Q. How does it break down between cases that you're sent on behalf of plaintiffs versus defense?

A. That's a good question. When I get cases, some are defense and some are plaintiff. Usually if I write a good strong defense letter, they go away. Most of the cases I do are plaintiff because somehow they go to fruition, they go through the process. So the majority of my cases are plaintiff and then product liability and some insurance things.

Q. I think I read some prior testimony where you said about 70, 80 percent of your reviews are plaintiffs. Does that sound right?

A. Of what comes to either deposition testimony or trial.

Q. How about just what's sent to you?

A. It would be fair to say that most of them are plaintiff, um-hmm.

Q. I mean, is that 70, 80 percent range still accurate?

A. I would say it's between 60 percent plaintiff, 30 percent defendant, and about 10 percent insurance things, products liability things.

Q. How many depositions have you given?

A. In --

Q. This period. I mean, how many depositions have you given?

A. I generally do between six to ten depositions a

year and maybe four trial testimonies a year. And it varies from year to year. This year I think I've done eleven-plus depositions.

Q. I saw testimony where you had kept a list of cases that you had testified in both in deposition. Do you still maintain that list?

A. I do.

Q. Did you bring a copy with you today.

A. I do have a copy of it, um-hmm.

Q. May I see that?

A. (Witness complies.)

Q. Obviously, the copy that was just handed to me came from counsel for the plaintiffs. Why is it that a counsel for the plaintiff had your copy?

A. I gave it to him last night.

Q. Okay. Did you give him anything else out of your file?

MR. DOLESH: Objection.

A. No.

Q. Has anything been removed from your file?

A. No.

Q. Did counsel go through your file last night?

A. He looked at it, correct.

Q. How long did you meet with counsel?

A. We had dinner probably an hour and a half, two

hours. Told me what a great guy you were.

MR. MEADOWS: Now you've lost all credibility.

Q. Had you previously conferenced with Jonathan Tsilimos in preparation for today?

A. I talked to him about a month ago, tried to organize the deposition time and dates and whether he was going to come or Jonathan was going to come.

Q. For what purpose did you prepare this?

A. I'm required to by the Society for Thoracic Surgeons and the American College of Surgeons to maintain a list of deposition testimony. I've been asked in a federal court to provide one, so I started keeping it since 2004.

Q. Obviously, I was just handed this, but do you know whether you've ever reviewed a case, regardless of whether it came to deposition or trial, where the issue was perforation of the esophagus?

A. I did in Hawaii back in 2004. I think it's the Kumar case. It was a perforation of the esophagus.

Q. And what was the issue there?

A. Basically a thoracic surgeon perforated her esophagus through the scope, failed to recognize it in a timely fashion, and she died. That's the Kumar case, I think it's on there, Kumar versus Morris.

Q. You were retained by the plaintiffs?

A. Correct, Dr. Kumar. He was the doctor. It was his wife against Dr. Morris.

Q. Oh. And what happened with the case?

A. They settled before we -- before the jury had a verdict, I believe.

Q. You gave trial testimony?

A. I did. Deposition and trial testimony.

Q. Do you keep that? Do you keep the transcripts?

A. I do not.

Q. What did you say that they should have done that they didn't do?

A. Well, basically, the perforation occurred and Dr. Morris, the thoracic surgeon, let her smolder and she developed all the complications -- mediastinitis, pleural effusion, and subsequently died from sepsis.

Q. After it was diagnosed?

A. Correct, um-hmm. It's so long ago I don't know the exact details, but it was nasty.

Q. Any other cases involving esophageal perforation?

A. No. I take that back. I am doing a case of esophageal perforation in Arizona. It was an ENT doctor who did a rigid scope that perforated the esophagus. But I haven't written a report on that yet.

Q. What's the issue there?

A. Exactly misdiagnosis or failure to diagnose esophageal perforation. The ENT physician did a scope on a Friday, the patient immediately complained of pain in her neck, they sent her home, she came back to the Emergency Room with an abscess in her neck.

Q. Over your career, have you surgically treated perforated esophagus?

A. Unfortunately, yes.

Q. On how many occasions?

A. From trauma, probably 20 cases. And I mean by trauma, car accidents, gunshot wounds.

Q. Um-hmm.

A. Most of the cases that we get as thoracic surgeons are iatrogenic perforations from patients that have cancer, so my last one that I did was in 2008 was a traumatic esophageal perforation from a rigid bronchoscopy.

Q. The last one you did was in 2008?

A. Yeah, the total esophagus that I had to do, um-hmm.

Q. And when you say total esophagus, is that different than an esophagectomy?

A. Correct.

Q. How is it different?

A. Total esophagus is doing a complete resection from below the crycoid and then doing like an Ivor Lewis procedure and bringing up the stomach, whereas some of the short segments that I've done in the last three years have been with a stent coverage or doing just an I&D and drainage. In other words -- maybe the answer was confusing, but we really don't do total esophagectomies any more. The last three years we probably do more stenting and local I&D with diversion, particularly in a trauma setting.

Q. And when you say trauma, you're including iatrogenic?

A. No. What I call trauma is gunshot wound, car accident. Iatrogenic is the GI doctor calling you at 2:00 in the morning saying I have a lady that has air in her chest.

Q. Okay. So let's stick with iatrogenic for a moment.

A. Okay, um-hmm.

Q. When was the last time you treated a perforation that was thought to be iatrogenic?

A. About two years ago.

Q. And what was the circumstances?

A. That was a postendoscopy for an esophageal stricture, and the patient had mediastinitis. It was a

drainage procedure. And then the GI doctor put a covered stent over the hole.

Q. And when you say covered stent over the hole, endoscopically inserted the stent?

A. Correct. Did a balloon stent, a wall stent, placed it, then I drained the mediastinum.

Q. At your hospital at St. Joseph's, does the gastroenterologist do the stenting procedures?

A. Dr. Palmer, who is the thoracic surgeon, vascular surgeon, likes to do the stents with the GI doctors there. Since it's a relatively new procedure, they always have us stand by when they do it.

Q. So you haven't -- you don't yourself do the stenting.

A. I've done stenting. I don't prefer stenting. I like to let the GI doctors do the stenting.

Q. And that's because they're more expert in stenting than you?

A. Right. They intubate the esophagus more than we do.

Q. How many stenting procedure have you done yourself where you were the primary physician?

A. Less than three in my entire career.

Q. Do you defer to gastroenterology as to whether stenting is an option?

A. Correct, I do. Once we have a fresh perforation that's identified, the treatment is stenting preferably, and then antibiotics. If we get called late in the game 24 hours plus, then it's us because we have to establish draining. And then it's depending on the tissue friability when they do their endoscopy whether or not it's going to be stenting or surgery.

Q. And after 24 hours, stenting is usually not an option, true?

A. That's a true statement. The thoracic literature is between 24 to 36. But the problem is if you have a small hole in the esophagus and you have spillage and the mediastinum is contaminated, that is a surgical event that you need a drain, to establish drainage.

Q. Even if you can do stenting.

A. Correct. Correct.

Q. So if you can't do stenting, the surgical options are what?

A. You have to establish diversion and drainage.

Q. And within the broader category of diversion and drainage, is esophagectomy within that category?

A. It's rare that we do an emergency esophagectomy because the patients are so critically ill at that point. The key is to go in, do what's called a proximal

diversion either through a neck incision or do a stapling anastomosis in the chest, and then do orogastric tube and then distally staple and then perform a gastrostomy, then drainage of the mediastinum around the area of the perforation, come back another day and do the procedure that you need to do, which is either a colonic pull-through or the stomach.

Q. So eventually do an esophagectomy -- eventually do what Dr. Rice did in this case but initially divert but not necessarily resect.

A. Correct.

Q. And we can agree that more likely than not after 24 hours a diversion and drainage is the option that's available.

A. After 24 hours, a diversion and drainage is required.

Q. Is required. It would be below the standard of care not to do diversion and drainage after 24 hours.

A. Correct.

Q. Is primary repair ever an option?

A. Yes.

Q. When is primary repair an option?

A. We like to think before we call it the 12 hour mark, 12 hours. That's the old thinking. But people are extending that to 24.

Q. What's your thinking?

A. I like to do it earlier than later. The reason I like to do that is because once you have contamination in the space, then even putting sutures in that area, it tends to break down. Again, you always combine the primary closure with a drainage procedure and diversion.

Q. And diversion?

A. Not a total diversion, but a diversion. In other words, you do a gastrostomy feeding tube, depending where the location of the perforation is, and you put drains in the area of your primary repair and keep the patient NPO with a tube above the level of perforation to suck on it. So that's a partial diversion.

Q. So there's not an actual diversion --

A. Correct. It's a physiological diversion.

Q. Is ability to perform a primary repair correlated to the size of the defect?

A. Well, that makes common sense. I mean, if you have a large rent, it's probably greater than two-thirds of the circumference of the esophagus, you're not going to get a good primary repair.

Q. What is that distance?

A. It's probably a centimeter and a half. If the esophagus is, of course, torn in half, certainly you can

resect proximally and distally you can do a primary anastomosis and then wrap it with a piece of plura.

Q. But generally speaking, if the hole in the esophagus is greater than or equal to a centimeter and a half, primary repair is not going to be a reasonable option.

A. No. No.

Q. What is the failure rate of primary repair?

A. It depends on the stage at which you attack the esophagus when you're involved in it.

Q. How about up till 12 hours?

A. Yeah. The sooner the better. And the sooner before the mediastinum becomes contaminated.

Q. Is there any percentage that you're aware of in the literature or from your own experience that you associate with the failure rate of a primary repair of up to 12 hours?

A. Well, it depends on the situation. If we're going to just keep it to iatrogenic perforations, usually those patients are already prepped, so you have a better chance of having a successful primary repair as to a trauma case, where someone just had a bag of Fritos, you know, some beer, and their esophagus gets torn in half.

Q. Setting aside the trauma cases, is there a

number or percentage that you're aware of that you associate with a failure rate for primary repair up to 12 hours?

A. No, I don't have a solid number.

Q. Is there a range?

A. I would say that you probably have a greater than 80 to 90 percent chance of success with an isolated perforation within 12 to 24 hours. I did bring a landmark article back that was published in the Annals of Surgery in 1964 that pretty much still is the standard for today.

Q. We'll get to that in a moment.

A. Yeah. It has the numbers that, you know, earlier is better than later.

Q. Do you know what the failure rate is for stenting?

A. It depends on who you believe. I mean, the stenters say that they have a 90-plus success rate depending on the size and location of the perforation.

Q. What other numbers have you seen in the literature?

A. For carcinoma with perforation, it's miserable, 50/50 chance of sealing that. And that's palliative only.

Q. Do you know Dr. Thomas Watson?

A. No. Just by reading his deposition.

Q. I think in his deposition he said there's an 18 percent failure rate associated with -- and I'm going from memory, we can look at it -- with stenting.

A. That's reasonable, depending on location, size of the perforation.

Q. Did you read Dr. Watson's deposition before you authored your report?

A. No. I just read it this last week.

Q. Did you know of Dr. Watson before this case?

A. No, I did not.

Q. Do you agree that stenting is not an option if the hole is in the area of tortuosity?

A. I would agree with that. Most stents don't work in areas that have a large annular division, whether esophagus or a vessel.

Q. Did you see any evidence of tortuosity with regards to the esophagus in Mr. Meeker's case?

A. Only by the reports. I haven't seen the images, but just by report. There was some deviation of the left carina.

Q. And it was in the area of the perforation?

A. Correct.

Q. And does that lead you to conclude that in all probability stenting would not be an option in light of

that deviation to the left?

A. Without actually looking at it, I can't make that statement.

Q. By the same token, you can't say that stenting could have been performed in that area in light of that angulation as described in the report, correct?

A. Well, based upon Dr. Rice's operative note, I would that think that stenting may have been an option to go.

Q. Isn't it his report that mentions the deviations in the left?

A. Right, it does. But I don't know the degree of angulation, but a carina usually -- that's a good place for stenting, but esophageal is a good place for a stent.

Q. Is it a good place for a stent if there happens to be a deviation in the esophagus at that point in the hole?

A. Well, it depends on the degree of angulation.

Q. Have you looked at any imaging in this case?

A. Just the reports.

Q. Do you intend to?

A. Yes. If asked, I will. And I particularly would like to see the chest x-rays, the actual hard copies.

Q. Why?

A. Well, it's important. Because when I reviewed the case, looking at the imaging studies, at what point would there be classic findings on a chest x-ray to suggest an injury to the esophagus. And on postoperative Day Number 2, there is significant change in the patient's chest x-ray. The radiologist states a large rapid accumulation of a right pleural fluid accumulation that wasn't present the day before. It's unusual for heart surgery.

Q. The radiologist doesn't say rapid accumulation, those are your words?

A. Correct.

Q. When making decisions to what surgical option is best for a patient with an iatrogenic esophageal tear, are the patient's comorbidities important to consider?

A. Absolutely.

Q. And is that because if there is a re-leak, the mortality rate increases even in the absence of comorbidities?

A. It depends. You re-leak if you've done what?

Q. Well, regardless of what you've done, can we agree that the morbidity and mortality associated with a re-leak is greater than the initial tear?

A. Sure.

Q. And so can we agree that you would want to minimize the risk of a re-leak under any circumstance.

A. Absolutely.

Q. And if a patient has comorbidities that puts him or her at increased risk for a re-leak, you would want to give that patient the option that most -- that minimizes that risk the most.

MR. DOLESH: Objection.

A. That's complex.

Q. I'm not sure it's a very good question at all.

A. I think what you're asking me, you would -- you would ensure that the procedure that you're going to perform had the lowest incidence of a re-leak. You'd back it up with diversion and make sure that it's tailored to the patient's condition at the time that you fix it.

Q. Maybe I've overcomplicated it. You've got a patient like Mr. Meeker who's got heart disease, just had surgery and may -- or probably would not survive a re-leak. Wouldn't you want to take the safest course of action to make sure that that re-leak doesn't occur?

A. Sure. The key is early identification of the leak.

Q. In other words, you wouldn't want to risk the

failure rate associated with the primary repair in somebody with comorbidities like Mr. Meeker.

A. That's all predicated at the time in which you make the diagnosis.

Q. Well, regardless of when you make the diagnosis, there is a risk of re-leak with a primary repair and stenting that is greater than the risk of re-leak with a diversion and drainage, true?

MR. DOLESH: Objection.

A. Again, it's all predicated at the time you make the diagnosis. As we said earlier, if you make the diagnosis sooner than later, a primary repair with wide drainage has a higher success rate than doing it 40 hours or 72 hours later.

Q. But everything being equal, the risk of re-leak is greater with a primary repair in stenting than it is with diversion, no matter when the intervention is pursued.

A. That's absolutely a true statement.

MR. DOLESH: Objection.

Q. So regardless of time of diagnosis, if you wanted to give the patient the best chance to avoid re-leak, you would do the diversion and drainage.

MR. DOLESH: Objection.

Q. Correct?

A. I would disagree. It's all predicated on time.

Q. I thought we established, though, that regardless of time, the patient has the best chance of avoiding re-leak if there is a diversion and drainage.

A. Right. Because you haven't repaired the leak. Correct? I mean, if you're comparing a primary division to a primary repair, with a primary repair, you also do a diversion, whether it's a physiological diversion or anatomical diversion, and do wide drainage. If that's done earlier than later, you have a higher success rate at that point than you do at 24, 48, 72.

Q. Compared to a primary repair done later.

A. Correct. Correct. Because the way we would attack in this case specifically would be to get a rapid diagnosis, do a staple dissolvable suture closure of the proximal esophagus and distal esophagus, do a primary repair, wide drainage gastrostomy. Over seven days those dissolvable sutures that open -- and you can actually open with a bougie, you've isolated that segment that has the hole in it and you've done wide drainage.

Q. But you still have a risk of a re-leak.

A. You do, but it's very, very small in seven days.

Q. What is it?

A. God, less than one percent.

Q. But if you do have that re-leak in somebody with comorbidities, the likelihood is they're not going to survive that --

A. It depends on how big the leak is. And if you've left your tubes in and established drainage, then sometimes a leak will heal on its own. The key is to attack it surgically earlier than later.

Q. Have you done a primary repair that has failed?

A. Not in an iatrogenic perforation. In a trauma perforation, I have.

Q. On how many occasions?

A. I've had about two to three leaks in my career. But I've had established drainage so we let them heal by their own secondary closure. I've never had to take anyone back for a reclosure of an esophageal injury. Because I was trained the old-fashioned way.

Q. What does that mean?

A. Basically, you do the primary closure and you put a large Jackson-Pratt drain or a large drain in that area, bring it out through the abdomen in your chest tube drains, and you don't remove that drain until you have confirmation by an esophagram that that has been sealed. And the way you get a leak after a primary closure is someone pulls that drain prematurely and then

that seal tract doesn't close.

Q. Have you ever had a patient of yours, whether you're following as a cophysician or not, where they get stenting that had failed?

A. No, I have not. No.

Q. Have you ever had a patient die as a consequence of an iatrogenic perforated esophagus?

A. I have when I was a resident.

Q. Tell me the circumstances of that.

A. It was a patient who was getting a rigid bronchoscopy. And not only did they perforate the bronchus, but they also perforated the esophagus because the posterior wall of the bronchus is very soft. When I recognized by that service -- I was on the pulmonary service, and they consulted us, and it was, you know, an older fellow that had esophageal carcinoma and lung cancer and it was sepsis and death, even in the presence of a surgical procedure.

Q. Do you know how the plaintiffs got your name in this case?

A. I'm not sure, but it may have been American Medical Experts.

Q. What is that?

A. It is a referral service that's located in Virginia.

Q. I asked you earlier whether you were listed with any services and I thought you said no.

A. I'm not listed, no.

Q. How does that work?

A. They may know who I am and they've connected me with them.

Q. What's the difference? I'm losing --

A. Well, I'm not published on a web site or in a book.

Q. What other services are you associated with?

A. The only other one right now is TASA.

Q. What others have you been associated with in the past?

A. Medical Review Foundation and Consolidated Consultants. I don't work with the last two any more.

Q. Why not?

A. I don't like the system that they have.

Q. What about the system do you not like?

A. Limited medical records, opinions without getting all the facts, premature letters.

Q. They ask you for premature letters?

A. Well, they send you limited medical records. And as an expert, I take this very seriously and I want to have all the documents to formulate my opinion. If it takes weeks or months to get them, I have little

tolerance for that.

Q. Did you formally disassociate with them?

A. Yes, um-hmm.

Q. And did you give them reasons why?

A. I did.

Q. Of all the cases you reviewed, where did most of them come from?

A. Basically, primary attorney referrals to me.

Q. How many do you get from the American Medical Experts out of Virginia?

A. Maybe twenty plus a year.

Q. How many do you get from TASA?

A. Five to ten a year.

Q. Can we agree that those services work primarily with plaintiff lawyers and personal injury lawyers?

A. I'm not familiar with their business practice, I don't know. I think TASA does everything, because I've gotten called for product liability and insurance issues from TASA.

Q. How does it work with American Medical Experts?

A. Generally -- the person that runs it, his name is Eric Jacobs. He will give me a call and he'll say that he has a case that needs to be reviewed. So I don't know who the attorney is or what volume of documents, but he'll send it to me and I'll review it.

If I need more information, I'll call him. Generally, he's very good about getting that information to me.

Q. Is that what happened in this case?

A. I believe it was Eric that called me about this case.

Q. And at what point, then, are you put in touch with the lawyer?

A. I think after I do my review the way it works is I do a letter. It's not address to an attorney, it's addressed to whom it may concern, and I send it to Eric and --

Q. So in this case the letter was to whom it may concern. So that went to Eric?

A. Correct. Correct.

Q. And then are you paid through Eric?

A. Eric -- I do $500 for the initial review from Eric.

Q. So Eric pays you that?

A. Correct.

Q. And how does Eric get paid?

A. Hopefully directly from the attorneys. I don't know.

Q. Well, does the payment that's ongoing in this case go through Eric?

A. Once the attorney contacts me, then I request a

retainer fee. And if I need any additional records, we have conferences, then I specifically bill for that.

Q. To Eric or to the attorney?

A. To the attorney. Eric is sort of like the matchmaker I guess you'd call him.

Q. So once you get your $500 from Eric --

A. Um-hmm.

Q. -- and it gets to the point where the lawyer that contacted Eric contacts you, Eric's out of the picture.

A. Correct. And a lot of times I'll never hear from the attorney again after review of a case.

Q. Do you have a contract with American Medical Experts?

A. No.

Q. Did you have a letter that memorializes your understanding with them?

A. No.

Q. And how long have you been working with them?

A. With Eric, probably five years.

Q. How many different states have you reviewed cases in?

A. Wow. A lot, to include Puerto Rico.

Q. So if you had to estimate out of the 50 states, how many have you been involved in litigation?

A. Maybe 20, 25 states, if not more.

Q. And Puerto Rico?

A. Correct.

Q. Have you done any other cases where the Cleveland Clinic was involved?

A. I'm reviewing one right now.

Q. And what are the facts in that?

A. It's a mitral --

MR. DOLESH: Objection. I don't know what stage this is in, I don't know if he's been retained, I don't know if it's been disclosed. I just don't want him to -- if this is something that's in suit, it's one thing, but before we go down this line of questioning, I want to make sure that he --

Q. Are you retained on behalf of the plaintiff's attorney?

A. Correct. It's in the initial phases of review.

Q. Do you know whether you've been disclosed as an expert?

A. We haven't gotten that far yet.

Q. Any other reviews involving the Cleveland Clinic?

A. Not that I know of, no.

Q. Have you ever been to the Cleveland Clinic?

A. No.

Q. Do you know any of the physicians involved?

A. I do not know any of the physicians involved in this case, no, but I know some physicians at the Cleveland Clinic.

Q. Who do you know?

A. Dr. Cosgrove, Dr. Sundt.

Q. How do you know Dr. Cosgrove?

A. From meetings, STS.

Q. When was the last time you talked to Dr. Cosgrove?

A. God, probably five, six years ago.

Q. What were the circumstances?

A. It was an STS function.

Q. Do you know Dr. Pettersson by reputation?

A. No.

Q. Have you ever read anything that he's written?

A. No.

Q. Do you know Dr. Starr?

A. No.

Q. Not by reputation or any other way?

A. No.

Q. Do you know Dr. Rice?

A. No.

Q. Do you know any of the defense experts?

A. No.

Q. Have you been provided the defense expert reports?

A. No.

Q. Have you been told who the defense experts are?

A. No.

Q. Then how do you know you don't know them?

A. I guess that's true. I don't know who they are, so I've not been told. So since I really don't know who they are --

Q. Do you know Dr. Rafael Bueno, B-u-e-n-o?

A. No.

Q. Michael Cody?

A. No.

Q. Daniel Nyhan?

A. No.

Q. Bruce Rosengard?

A. No.

Q. Stanton Shernan?

A. No.

Q. You said you don't know Dr. Rice? I forget.

A. I do not.

Q. Do you know him by reputation?

A. No.

Q. Let me ask you just some general principles. Can we agree that a physician can act within the

standard of care and still have a bad result?

A. Sure. I agree.

Q. A bad result or unexpected outcome does not necessarily mean the doctor was negligent.

A. That's correct.

Q. Two physicians can disagree as to a diagnosis and/or treatment and yet both can hold views within the standard of care.

A. Correct. I agree.

Q. When you reviewed this case, you knew at a minimum that there was litigation or potential litigation, true?

A. That's correct.

Q. Is it fair to say that you also knew that as a consequence of there being potential litigation at a minimum, there's likely a bad outcome.

A. A bad outcome for?

Q. The litigant, the patient.

A. Sure. The patient had a bad outcome.

MR. DOLESH: Bad medical outcome.

A. Correct.

Q. In other words, you wouldn't be asked to review a case if there wasn't a bad outcome.

A. Correct.

Q. Can we agree that knowing that there's a bad

outcome before you set out to look at records, just by the mere nature of the process of review injects some degree of hindsight bias into the equation.

A. No. I like to think that because there's a bad outcome that once I review the records, I put myself in the shoes of a physician and I try to give an unbiased straightforward opinion.

Q. And I'm not suggesting that you do anything devious --

A. No, no.

Q. I'm just saying that knowing there's a bad outcome, isn't there just by the nature of the review process, some degree of hindsight bias that goes into the review?

A. I would disagree with that. As you do this over a period of time, and for me it's always easy to be the Monday morning quarterback and have a retrospective analysis, but you try to set aside that bias. I agree there probably is some, but just because a patient has a bad outcome does not negate that there's malpractice.

Q. And I think you're agreeing, but let me tease it out a little bit. You'd agree that the nature of the process injects some hindsight bias but you do your best to set that aside.

A. Correct.

Q. All right. Let's take a look at what your file consists of.

A. Sure. I brought all the medical records concerning the preoperative in-patient operative treatments of Mr. Meeker.

Q. Is there any you didn't bring?

A. No.

Q. This is your entire file?

A. Correct. Deposition of Dr. Watson --

Q. Is the August 17th, 2011 report the only report you prepared in this case?

A. Yes.

Q. Did you make any drafts of that report before coming upon the version that's now been exchanged?

A. No.

Q. Do you type it yourself?

A. I did. Well, actually I have Dragon software, so --

Q. In your file we have a report from Dr. Berens and a report from Dr. Watson. Did you have those before you wrote your report?

A. No.

Q. When did you receive those?

A. Shortly after I discussed the case with the law firm. And I think John had mentioned there had been two

previous expert reports, one by a cardiologist and then by a thoracic surgeon.

Q. Your letter reports -- and you have a copy there if you want to take a look at it.

A. Um-hmm.

Q. It talks about on Page 2 in the third full paragraph down, you say, "It is my opinion based upon my training and 27 years of cardiovascular and thoracic experience, my detailed review of the medical records of the Cleveland Clinic, with particular attention to the nursing notes, operative reports, progress notes, consultations, and laboratory studies, that the physicians, Dr. Norman Starr and Pettersson deviated..." In reaching your opinions as set forth in your letter report, did you review anything other than the medical records that are described in that paragraph?

A. No.

Q. Were you provided the deposition testimony of Dr. Starr and/or Dr. Pettersson?

A. No, I was not.

Q. Were you provided the deposition of Mr. Meeker?

A. No.

Q. Were you provided any deposition?

A. The only deposition, Dr. Watson.

Q. Typically, when you review cases, do you expect

that available deposition testimony will be made available to you before you issue your opinions?

A. My practice is to base my opinions on the facts and the medical records entirely.

Q. Is it your policy not to look at the depositions?

A. I'll look at them later on as the cases progress. I always reserve the right to change or modify opinions if new or additional information becomes available.

Q. When you review a case most often to get at your initial opinions that you set forth in your letter report, do you usually have the depositions that are available from the defendant physicians?

A. I generally don't. Do I deem them important? If I have questions, sometimes. Generally, I make my opinion based upon what's in the medical records. And I'll modify that opinion if something occurs later on during the course of the suit.

Q. Well, I'm here to ask you your opinions, and I likely won't have another opportunity until we meet at trial. Do you have any intention between now and trial of reviewing the depositions of Dr. Pettersson, Dr. Starr, or any other physician?

A. Not unless asked.

Q. Up till now you have not asked to look at those depositions?

A. That's correct.

Q. Have you been given any summary, whether verbal or in writing, of what any physician has said under oath?

A. No.

Q. Have you asked for information regarding any such testimony?

A. No.

Q. Is it important for you to know in reaching your opinions in this case what Dr. Pettersson and Dr. Starr testified to about the circumstances surrounding the surgery of Mr. Meeker?

A. It's important that I know information concerning his care. I don't believe that their deposition testimony is going to change my opinion.

Q. How do you know?

A. Because basically the facts of the records speak for themselves what happened to this gentleman.

Q. If you were sued for medical malpractice and you gave a deposition, would you want the reviewing expert to read what you had to say?

MR. DOLESH: Objection.

A. I don't know how to answer that.

Q. Why not?

A. Well, I was sued once, and certainly they made their opinion before they read my deposition.

Q. Do you recall that?

A. I do recall that.

Q. Did that bother you that they didn't wait to hear what you had to say?

A. No.

Q. Did they ultimately review your deposition?

A. I don't know. My case went to the Supreme Court in Hawaii twice. I don't know.

Q. What was the issue in your case?

A. Basically a young woman fell into a hole after being intoxicated and she went to the Emergency Room at Maui Memorial Hospital. And the Emergency Room physician diagnosed as a tibial plateau fracture. Orthopedic surgeon put her leg into a long-leg splint and the third day her toes died. They shipped her to me on a Christmas Eve. She had compartment syndrome that included the popliteal artery. The orthopedic surgeon and I put her knee back together, I thrombectomized her popliteal artery trifurcation vessels, did a short graft. She lost a couple toes, but she sued us for chronic pain. What we didn't know, they had sued the other physicians on Maui and settled with them first, so

we lost our right to a counterclaim. So we settled the case after I think four years of going back and forth to the Supreme Court.

Q. Is that the only case you were sued in?

A. Correct. It was Troyer versus Adams versus Dang versus the Medical Group.

Q. I don't see in your file material any correspondence between you and anybody.

MR. DOLESH: I believe there's a second compartment.

Q. Oh, I'm sorry. I stand corrected. So tell me how this folder file works. It seems to be --

A. Basically, I had my CV and testimony there and I had my letter there. There was two expert reports that I reviewed. There are some selected medical records that I copied of the operation, there is my letter to the office confirming the deposition, two invoices your office paid me, thank you, and there is an e-mail that I downloaded and copied. And then there's the article.

Q. The article that you have here, how did you come about this?

A. It's a classic esophageal injury perforation article.

Q. And this is dated --

A. 1964. I believe it's somewhere there at the top.

Q. Yeah. May, 1965. Did you do an internet search to find this or --

A. Well, basically what I was looking in and reading about esophageal perforation, I always like to go over in my own mind, you know, what you would do. And there's landmark articles about how to treat esophageal perforation. And I did that as a reference point, just for review.

Q. What I'm asking is did you remember a 1965 article and go find it?

A. I did.

Q. So you didn't do an internet search and type in --

A. No.

Q. -- esophageal injury and repair.

A. No. But I do that because that is the landmark article in my training. When I finished my training, that was the article that I always bring up on the Boards. I just wanted to see how that has changed to the recent CSATs and how much it's changed.

Q. Had you -- where did you go to get this?

A. I think I went on line to the annals.

Q. And what did you type in to pull it up?

A. Esophageal injury, perforation.

Q. And did anything else come up other than this 1965 article?

A. Nothing else specific to the annals article.

Q. And you're talking about a Google search, I'm assuming, Google search?

A. I just put the annals, esophageal perforation.

Q. So in all likelihood, all sorts of articles came up.

A. Probably more recent articles, too, I'm sure.

Q. Did you look at any other articles other than the 1965 article when you Googled esophageal perforation?

A. No. Just that one.

Q. Why not?

A. This is the classic article. It's the one you always bring up in Journal Club, the one the residents here have to read.

(Off the record.)

MR. MEADOWS: So back on the record here.

Q. Your folder file, is this all the medical records?

A. Correct, it is.

Q. Do you make notes as you review the records?

A. Not in the records, but I just have the expert report.

Q. Okay. You have one tab I see.

A. Right, um-hmm.

Q. But otherwise you don't make notes as you go through?

A. No. I don't deface the medical records.

MR. MEADOWS: Okay. So let's do this. Let's mark your folder file as Exhibit 1.

(Exhibit 1 marked for identification.)

Q. I'll hand you what I've marked as Exhibit 1. Is that, in fact, the green folder that you brought here today that includes those items that you've reviewed, including expert reports, your report, some correspondence, and one article from 1965?

A. My invoices and my testimony letter, correct.

Q. Okay. The only other thing that makes up your file is the medical records. Fair to say the medical records you looked at, are those limited to the admission of August 27th, 2009?

A. Correct.

Q. You have not looked at any subsequent medical records?

A. The medical records have some postop clinic visits in them, and that's it.

Q. What's the most recent medical record?

A. There's about 45 days after discharge, so --

Q. Okay, that's good enough.

A. Yeah. That was a cardiology follow-up and thoracic surgery follow-up, Dr. Rice.

Q. So you see no records with regards to the take down of the esophagectomy, the reversal?

A. No.

Q. You see no records with regards to his most recent examinations and his current condition?

A. Correct.

MR. MEADOWS: I'll also mark as Exhibit 2 the case list of depositions.

(Exhibit 2 marked for identification.)

THE WITNESS: Trial arbitration.

Q. Right. Can you just identify that for the record?

A. Correct. That's the case list.

Q. All right. And then, as we said earlier, the only deposition that you reviewed is that of Dr. Thomas Watson, correct?

A. Correct.

Q. And you received that you said in the last week?

A. Correct, last week.

Q. And why was this sent to you?

A. Just for my information only.

Q. Did you ask for it?

A. No, hm-umm.

Q. Did the lawyer give you an explanation as to why he was sending you only Dr. Watson's deposition?

A. No.

Q. Did you make any notes in this?

A. No.

Q. And I'll ask you some questions about your report if you want to get that out in front of you.

A. Sure.

Q. Can we agree that the surgery performed by Dr. Pettersson was indicated based upon the presentation of Mr. Meeker back in August of 2009?

A. Correct.

Q. It was an appropriate procedure to perform?

A. Absolutely.

Q. And in your report, in fact, you stated that there was a technically good cardiovascular result, correct?

A. Correct.

Q. So from the perspective of what they were attempting to achieve relative to the surgery itself, that was a success.

A. Correct.

Q. Can we agree that the use of transesophageal echocardiogram was necessary in conjunction with the surgery that Dr. Pettersson was performing?

A. It's a necessary adjuvant to ensure the repair.

Q. Okay. In other words, it was reasonable to make the decision to use transesophageal echocardiogram.

A. Yes.

Q. There was nothing about Mr. Meeker's history, medical history, that rendered it contraindicated, correct?

A. That's correct.

Q. We can agree that the use of a transesophageal echocardiogram intraoperatively carries with it the risk of perforated esophagus, correct?

A. One of them, correct.

Q. And can you quantify the risk associated with the use of a TEE as relates to an esophageal perforation?

A. Quantify --

Q. What is the risk as reported in the literature?

A. The risk rate?

Q. Yeah.

A. Is less than one percent. It's a very rare complication.

Q. Can we agree that that perforation can occur in the absence of negligence?

A. I would have to qualify that.

Q. Okay.

A. And the way I qualify it is in those patients once resistance is met, then an explanation for the resistance has to be sought. So a blind passing of the TEE probe once a resistance is met should be terminated and then the reasons for the inability to pass a probe need to be investigated promptly.

Q. We'll get to that opinion, but I'm talking about the mere fact that a perforation occurs doesn't mean that the operator did anything wrong.

A. I'd have to disagree with that because most perforations occur with resistance.

Q. Well, let me ask you directly. Do you feel that in this case Dr. Starr or his resident was negligent or were negligent merely by virtue of the fact that perforation occurred or is it your opinion that they were negligent because they didn't pursue a possible perforation once resistance was met?

A. The latter, with the qualification that once the resistance was met, the procedure needed to be terminated and then needed to be reattempted, that the reason for the obstruction needed to be addressed at

that point. And what you would do is go to a flexible pediatric EGD scope and look instead of trying to attempt it, because that perforation occurred more probably than not in the second attempt.

Q. What's your understanding of how many attempts occurred?

A. Two.

Q. Where do you gain that understanding?

A. Well, just logically the resident attempted once, had difficulty. I don't know how many times she went in and out because it's not documented. And then Dr. Starr attempted and could not complete. And just reason to believe that it would be once by the resident intubation and then next by Dr. Starr intubation.

Q. Where do you gain that from the medical record?

A. I can't. It's assuming that's the normal course of once you place the probe you don't withdraw it back and forth, you try to advance it back and forth.

Q. Has any summary of the facts been provided to you?

A. No.

Q. What information did Eric give you when the records were first sent?

A. That he had a case that needed to be reviewed concerning esophageal perforation.

Q. So you're telling me that you have just guessed that the resident tried once and then Dr. Starr tried once?

A. I'm not guessing, I'm postulating that in the normal course of placing a TEE probe, that's what we do. We go in the esophagus and if you can't advance it, you go back and forth. You don't withdraw it and reattempt to place it.

Q. Did you ask anybody for whether or not there was any deposition testimony that spoke to how many attempts and who attempted?

A. No.

Q. Did counsel summarize their view of what they recalled the testimony, what they thought happened?

A. No. It's not logical that you'd take the scope out back and forth several times.

Q. When, along the time line of when the patient got into the operating room, do you feel the first deviation from the standard of care occurred?

A. It would be the attempt by Dr. Starr to do the repeated attempt or trying to pass the obstruction.

Q. Show me where in that record there's anything that suggests the resident attempted and then Dr. Starr attempted.

A. It's not. It's just by what is in the record

that the resident and Dr. Starr worked together.

Q. So how do you know that the resident tried once and Dr. Starr tried once for you to go on record saying Dr. Starr was negligent for trying after the resident had already tried?

A. Well, doesn't it make sense the resident is there to learn how to pass the scope and Dr. Starr, the anesthesiologist who's supervising the resident?

Q. That may, in fact, be exactly what happened, but I'm trying to figure out whether you're just making up the facts as you go along or whether or not you have some reasonable basis in the materials that you reviewed to reach these conclusions.

A. My conclusions are that the resident passed the scope because that's what they're there to learn and if she couldn't do it or he couldn't do it, and then Dr. Starr attempted and couldn't do it.

Q. And, in truth, somebody told you that that's what they think happened.

A. That's what I deduced from the records.

Q. Didn't you talk with counsel, whether it be Jonathan or counsel who's present here today, about what the testimony has been about what happened in the operating room?

A. Not to my knowledge, no, I haven't discussed

it, no.

Q. All right. So despite the fact that you're not an anesthesiologist, you're critical of Dr. Starr for attempting to pass the probe after the resident had passed the probe?

A. I'm critical not as an anesthesiologist but as someone who passes probes that once you meet resistance, you stop and then you search for the reason why you can't pass the probe. Because it's so uncommon not to be able to pass the probe.

Q. Do you have an opinion as to when the perforation occurred?

A. I don't have -- well, prior to them commencing the open heart procedure. Before.

Q. Do you have an opinion as to how big the hole in the esophagus was at that point in time?

A. No. But I would assume it would be the diameter of the probe.

Q. How big is the probe?

A. The tip of the probe is between .7mm and a centimeter.

Q. In the second paragraph of your report, you state, "Unfortunately, even though Dr. Pettersson was advised by Dr. Starr of the extreme difficulty with attempts to intubate the esophagus," what do you draw

upon to reach the conclusion "extreme difficulty"?

A. Because it couldn't be passed. So that is extreme difficulty in my mind, because generally you can pass the probe.

Q. What do you draw upon in the next line to reach the conclusion that there were multiple passes?

A. Because that makes sense. If you can't pass it once, you try to pass it twice. And they abandoned the procedure.

Q. Do you agree that it was reasonable for them to proceed with the planned surgical procedure before further evaluation of the esophagus was performed?

A. I agree.

Q. So, in other words, Dr. Pettersson was reasonable in proceeding with the procedure before he took any steps that you believe necessary to evaluate the esophagus.

A. That's correct. Simply stated, because there was difficulty passing the probe would not make the cardiac surgeon say stop this procedure, we're not doing this. Because we have other ways of evaluating the valves.

Q. But any evaluation of the valve, in your opinion, could have occurred after Dr. Pettersson completed his repair of the valves in the maze

procedure.

A. Correct.

Q. Do you know at what time the maze -- strike that. Do you know at what time the operation was complete?

A. Not exactly, no.

Q. Do you know generally?

A. In the afternoon.

Q. In your report under commentary on the standard of care, you say, "The incidence of esophageal perforation appears to be increasing in frequency." Where do you get that?

A. From the medical -- our medical conferences that we have. With the advent of multiple devices used for instrumentation, it's logical that the incidence of esophageal perforations are becoming higher.

Q. Did you reiterate anything that you found in the literature in your report here?

A. Basically that article, I took out some of the high notes that, you know, an earlier surgery is better. It shows surgical emergency for perforation.

Q. And, in fact, you reiterated verbatim some statements that were made in the article.

A. Correct.

Q. Can you tell me which parts of your report you

lifted verbatim from the article?

MR. DOLESH: Objection.

A. I think with prompt aggressive surgical treatment, perforated esophaguses are treated surgically.

Q. I'm sorry, where are you at?

A. Second page.

Q. So can we agree that the first page at the bottom under commentary on the standard of care, you lifted from the article?

A. Correct, um-hmm.

Q. And then on the second page --

A. Not lifted, but rather --

Q. Well, it's verbatim, isn't it?

A. Verbatim, correct.

Q. And then the balance of the first paragraph there on Page 2, is that right out of the article?

A. Correct, um-hmm.

Q. And then what about the next paragraph that begins with "prompt"?

A. Correct.

Q. How far down does it go?

A. I can't tell you exactly without comparing the two, but I know I took that from the article and put this into the base of my report.

Q. And then what about next paragraph, perforations of the esophagus. Is that lifted from the article?

MR. DOLESH: Objection.

A. I don't know lifted word for word, but it's basically what the article states.

Q. And that's the 1965 article.

A. Correct.

Q. Was it reasonable for Dr. Starr to allow the resident to attempt to pass the probe?

A. Sure.

Q. Can we agree that once the mediastinum is contaminated, primary repair is not an option?

A. Disagree.

Q. Under what circumstances can primary repair be pursued if the mediastinum is contaminated?

A. Well, once you get the perforation, by definition the mediastinum is contaminated. I mean, the minute you put a hole through it, you get saliva and contents. So to qualify, the difference between contamination and infection. So once contamination occurs, the key is to close the hole rapidly, establish wide drainage. Once you have an established infection, which occurs 12, 24 hours afterwards, it's less likely that you're going to get a good closure with a primary

repair.

Q. After 12 hours, primary repair is not an option.

A. Well, 12 to 24 is what generally we accept, depending on the mechanism.

Q. Is it your belief that the right pleural effusion as seen on chest x-ray on August 29th is a manifestation radiographically of what was flowing from the hole in the esophagus into the right chest?

A. Yes, it is.

Q. The right chest was contaminated at that point in your opinion?

A. The mediastinum and the pleura is contaminated, correct.

Q. Certainly by that point, even in your opinion, a primary repair was no longer an option.

A. At that point, correct.

Q. In your opinion, some point between 12 and 24 hours after the surgery was commenced, primary repair was no longer an option.

A. Primary repair with diversion is acceptable in this case, not a stand-alone primary repair.

Q. What diversion are you envisioning?

A. We use the absorbable sutures above and below, seven days.

Q. At what point in time do you believe an actual resection of the esophagus would have been necessary?

A. A resection? Are we talking about a partial or a complete?

Q. Either one.

A. Well, certainly after 48 hours, the chances of you having the ability to sterilize that area without resecting the esophagus is high. So you need to resect probably at 48 hours, greater than 48 hours.

Q. So you believe that after 48 hours from the point in time the surgery was commenced, what Dr. Rice ultimately had to do would have been necessary.

A. Correct, um-hmm.

Q. Although you believe that a primary repair with diversion with these absorbable sutures above and below the perforation could have been accomplished within 12 to 24 hours, can we agree that others may differ and it would have been reasonable for them to approach it more aggressively at that time and do the surgery that Dr. Rice did later.

A. Your question -- the key is the time from contamination, so within 24 hours, a primary repair has the highest success rate for stenting. And then certainly after 48 hours, you need to do what Dr. Rice did.

Q. Would it have been reasonable for Dr. Rice to make the decision to do what he did ultimately sooner if he had been involved in order to give the patient the best chance at not experiencing a re-leak?

A. You're talking about the last surgery or the second-to-last surgery? Dr. Rice's ultimate procedure or Dr. Rice's procedure where he did the drain in the mediastinum? Because, remember, Dr. Rice did a thoracoscopic examination and found the pleura was contaminated.

Q. Right.

A. Then he did a formal thoracotomy and he did a diversion in the neck and did a gastrostomy feeding and resected that section of the esophagus.

Q. Can we agree it would have been reasonable for Dr. Rice to have done that diversion even if he was involved after the surgery on Day 1 or Day 2?

A. Not Day 1, you wouldn't want to do that.

Q. What about Day 2?

A. Day 2, sure. Once the chest x-ray showed that there was contamination of the pleural space, then you're behind the eight-ball.

Q. At what point in time along the time line would it not have been reasonable for Dr. Rice to have done the diversion that he did?

A. It's always reasonable to do what he did.

Q. Okay. That's my question. It would have been reasonable if he had been involved right after surgery to do what he did. It's just not what you would have done.

A. Well, within 12 hours if the patient has gone to the ICU after his open heart surgical procedure and they would have done an EGD or a gastrograph and insufflation if the patient wasn't awake and found the leak, then what Dr. Rice would have more probably than not done is establish drainage at that point, either done a primary closure and put two large chest tubes or Jackson-Pratt in the area of the hole, and that would have been it.

Q. Would it have been reasonable for him to do the diversion that he ultimately did even if he was involved at that early point in time?

A. Not at that point.

Q. When along the time line would it have become unreasonable -- strike that. When along the time line does it become reasonable for him to do the diversion that he ultimately did?

A. That's at the 48-hour mark, generally speaking.

Q. I thought you told me a moment ago at Day 2 it would have been reasonable, so at 24 hours --

A. No, at the 48 hour mark it's reasonable to do what Dr. Rice did. You know, that 24- to 48-hour period depends on the amount of the contamination. The chest x-ray taken at Postop Day Number 2 -- Postop Day Number 1 shows no right pleural effusion. Chest x-ray on Postop Day Number 2 shows a large new right pleural effusion. And that is at the point in which there's mediastinal contamination.

Q. Within the first 12 hours, you think it would be unreasonable for Dr. Rice to have done the diversion that he did.

A. Correct.

Q. Between 12 and 24 hours, would it have been unreasonable?

A. Yes.

Q. Between 24 and 36, would it have been unreasonable?

A. Within accepted standard of care.

Q. In your report, you list symptoms of perforation and you include chest pain, upper abdominal pain, cervical pain, dyspnea, temperature elevation, evidence of crepitus in the neck as classic findings, correct?

A. Correct.

Q. Which of those, if any, did Mr. Meeker

experience in the days following his surgery?

A. None. Remarkably he was afebrile and had a white count less than 10.

Q. You also in your report say that other classic findings include subcutaneous emphysema. He did not have that, correct?

A. Correct.

Q. When did the radiologist first describe a hydropneumothorax?

A. It was on the third postoperative day.

Q. Do you believe that the report from the radiologist described the hydropneumothorax on the third postoperative day?

A. On Postop Day Number 3. Postop Day Number 2 the chest x-ray, according to the report, demonstrates the patient has a new right pleural effusion with compression of the right lower lobe.

Q. Does the radiologist use the word hydropneumothorax in Postop Day 3?

A. No.

Q. Well, then, why did you just say that --

A. He describes air with a fluid. He doesn't say hydropneumothorax. He describes pleural effusion with air.

Q. Can you find that?

A. It's my mistake, it was Postop Day Number 4.

Q. Let me see what you pulled up.

A. Here's the first notation August 29th, which Is Postop Day Number 2. This is Postoperative Day Number 4.

Q. So the Postop Day Number 2, August 29th, says new pleural effusion with significant compressed with atelectasis right lung, no other change, correct?

A. Correct.

Q. And that led to the placement of a chest tube.

A. Correct.

Q. What would you have expected to drain from the chest tube as they placed it?

A. Serosanguinous fluid. But it's very unusual. You know, as a cardiac surgeon, you've done your surgical procedure and the patient has a normal chest x-ray on the first postoperative day with all the lines and tubes being in place. And then on the second day have a new accumulation of new pleural fluid collection on the right side.

Q. Serosanguinous is a normal finding postoperative, true?

A. Well, serosanguinous means pleural reaction. Because you're not going to have pus yet.

Q. So your answer to my question is that's

correct. Serosanguinous -- the finding of serosanguinous fluid after placement of the chest tube is a normal postop finding, is it not, indicative of infection.

A. Correct. But it's indicative of an inflammation reaction.

Q. Which can occur many times after any open heart surgery, correct?

A. Not a large volume after surgery in a previously clean chest.

Q. Can it ever happen in the absence of a perforated esophagus?

A. It can happen in the absence of a perforated esophagus. It can also occur in the presence of transudation of fluid from a pulmonary artery rupture or of loss of fluid into the chest.

Q. Can it happen as a normal postop reaction without--

A. Not a normal, no.

Q. Can it happen postoperatively without a ruptured vessel and without a perforated esophagus?

A. No. You wouldn't expect a new collection of a right pleural effusion in a previously clean chest x-ray after open heart surgical procedure.

Q. Is there any explanation for it other than

perforation or a ruptured vessel?

A. Or transudation of fluid from a lymphatic injury.

Q. Any other explanation?

A. Heart failure.

Q. Any other explanation?

A. No.

Q. So you pulled out now September -- an exam from September 1st.

A. Correct.

Q. That's more than four days, is it not?

A. Postop Day 4-1/2.

Q. Well, isn't this the chest x-ray that led to Dr. Rice's involvement?

A. Correct, um-hmm.

Q. So to be clear, on Postop Day 2, there was no finding of hydropneumothorax.

A. That's right. There was a finding of a new pleural fluid.

Q. So when you said that in your report, that was wrong. The last paragraph on Page 2.

A. Right. Rapid accumulation of a right pleural effusion. I termed it a hydropneumothorax. In reality, I should not call it that until the Postop Day 4-1/2.

Q. Right.

A. Which developed into an empyema.

Q. Okay. But you were wrong when you called what was found on Day 2 a hydropneumothorax.

A. Well, I don't think I'm wrong, I haven't seen the chest x-ray. But I believe it's a hydropneumothorax.

Q. Even then?

A. I do.

Q. So you think that the radiologist got it wrong?

A. I do.

Q. So you're critical of the radiologist's report?

A. You know why? I'll tell you why. Because in his report he says that there's a new right pleural effusion with consolidation of the right lower lobe. Usually when you use a chest x-ray, pleural effusions are not loculated above the lung. They contain the whole space. So if you see a lung volume below, that means you have a loculation of a pleural effusion. There's got to be an air space in there so you can see the compression on the bottom.

Q. So you reached that conclusion without looking at the film?

A. By looking at the chest x-ray and what the radiologist says but doesn't interpret to what is actually happening. I'm not critical of what the

radiologist said, but being a critical care doctor, when I look at a chest x-ray and someone says there's a new right pleural effusion with atelectasis of the right lower lobe, that means that there's fluid above the right lower lobe fissure pressing down. So there has to be an air fluid level. Because either the chest is filled with fluid or it's not.

Q. When you wrote your report, did you attempt to include all significant opinions that you held at that time?

A. My report has all my opinions that I stand by.

Q. Where in your report with regards to Dr. Starr do you say that it was below the standard of care for him to make an attempt after the resident did so?

MR. DOLESH: Objection.

A. Well, I didn't say it in the report, but it makes sense. I mean, that's -- you know.

MR. MEADOWS: I don't know.

MR. DOLESH: Objection. You asked him.

MR. MEADOWS: And he said you know, and I'm telling him I don't know.

MR. DOLESH: No, I meant you asked him about whether or not he believed Dr. Starr had fallen below the standard of care. And he answered your question.

MR. MEADOWS: And your point is?

MR. DOLESH: You're asking what was in his report.

MR. MEADOWS: Right, I am. So what's your point? Seriously, I have no idea what you're talking about.

MR. DOLESH: You asked him whether or not the opinion was contained in the report.

MR. MEADOWS: I did. I'm still trying to understand where you're coming from.

MR. DOLESH: Well, the inference was that it should have been.

MR. MEADOWS: Exactly. So now what's your point?

MR. DOLESH: But you had asked him earlier whether or not he had a criticism.

MR. MEADOWS: Okay. So still where are you going?

MR. DOLESH: I put the objection on the record.

MR. MEADOWS: You put more than the objection on the record and that's why I'm going through this with you. Just object and let me ask my questions. Because I'm allowed to ask him why he didn't put what he appears to think is a significant opinion in a report

that he said just a moment ago said includes all of his opinions. So just object and let me ask my questions.

MR. DOLESH: Okay.

Q. So can we agree nowhere in your report did you include that opinion relative to Dr. Starr.

A. That's correct. I did not.

Q. When did you come up with that?

A. From what I -- you asked me the question what is my thought process in forming my opinion that is below the standard of care. Generally speaking, if you can't pass a probe, to stop.

Q. How do you know?

A. Do I know what?

Q. If that's the standard of care.

A. Well, it's common sense.

Q. Is that what you draw upon, common sense?

A. Well, you know, I'm not going to argue about it, but if you have the inability to pass the probe --

Q. You can argue.

A. If you have the inability to pass the probe, then you have to worry about the presence of an esophageal carcinoma, an obstructing esophageal lesion. You're a doctor, you have to find out why the probe wouldn't pass.

Q. That's a different point. You said that it was

negligent for him to manipulate the probe after the resident attempted to pass the probe and met resistance. And I want to know --

A. No, no, no, maybe that's a misunderstanding. It's not --

Q. Maybe it's not negligent --

A. It's not negligent for him to try to pass the probe, it's negligent for him not to follow up on a further study.

Q. We're not communicating. Because I thought earlier you said it was below the standard of care for Dr. Starr to make an attempt after the resident's attempt.

A. Oh, no. No.

Q. Okay.

A. My -- my mistake, then. That's a misunderstanding. It's now below the --

Q. I'm glad I pursued it further.

A. It's not below the standard of care for Dr. Starr to try to attempt to pass the probe.

Q. Okay.

A. The standard of care violation as outlined in my report is that once he couldn't pass the probe, not to follow up on the reasons why. Because it's common sense that if you can't pass the probe in a gentleman of

his age group, you're worried about an obstructive carcinoma, esophageal lesion, et cetera.

Q. So there are reasons other than a perforation that you believe require follow-up on the inability to pass the probe.

A. Right. Right.

Q. And some of those don't involve the need for acute intervention.

A. Correct. It is so rare that you can't pass that TEE probe that if you meet resistance, then you have to think about anatomical variation, presence of an obstructing esophageal carcinoma, presence of an esophageal leiomyoma or problems with esophageal junction. And you let the surgeon know you can't pass the probe. Common sense would say let's work this thing up, find out why.

Q. And then the question becomes how quickly does it need to be worked up.

A. Right.

Q. And, in your opinion, how quickly does that need to occur?

A. Immediately.

Q. Immediately after the surgery?

A. Correct.

Q. And in terms of hours, how soon after the

surgery is immediately?

A. Well, once the patient, after open heart surgery, demonstrate vital -- stable vital signs and stable hemodynamics, then you have the ability to do your test. Call the GI doctor and have him come in and do, you know, an EGD while the patient's still intubated after his heart surgery.

Q. When was that -- when did that occur in this case?

A. When did what occur?

Q. When the hemodynamic stability was achieved so as it would have been reasonable to call somebody in to evaluate.

A. Well, that afternoon -- that evening, the patient was doing very well hemodynamically. He wasn't doing very well respiratory-wise, but the hemodynamics were very good.

Q. So when do you believe the evaluation should have first been considered or occurred?

A. That postop evening or Postop Day Number 1.

Q. Can you be more specific in terms of hours after surgery?

A. No. I mean, just, you know --

Q. Okay. So it would have been reasonable --

A. Let me just say that we don't do a lot of

interventions to our heart patients right after surgery. We like to give them a couple hours to get the effects of the anesthesia to calm down, to get stable hemodynamics. So according to the PACU, the ICU report, he was doing very well from a cardiovascular standpoint but he wasn't doing very well from an oxygenation standpoint.

Q. So you wouldn't want to work the esophagus up while he's still having problems from a respiratory standpoint, correct?

A. No, from a cardiac standpoint. Respiration standpoint, since he's ventilated, intubated, we can manipulate that. When the patient's intubated and asleep, you can certainly slip a scope down, an EGD scope.

Q. Can we agree that it would have been reasonable for them to first evaluate the esophagus first thing the following morning on the 28th?

A. I would agree with that completely.

Q. Would it have been reasonable to evaluate the esophagus first after the patient was first extubated?

A. I would disagree with that because actually you get a good examination while the patient is asleep. I mean, Mr. Meeker didn't have a good respiratory effort after his surgery, he had difficulties.

Q. When is the latest point along the time line on the 28th that it would have been still reasonable to evaluate the esophagus?

A. The latest point?

Q. Yeah.

A. I don't understand. Certainly --

Q. You said it would have been reasonable to evaluate it first in the morning. When -- by noon, mid afternoon --

A. I don't know. I mean --

Q. Can we agree that it would have been reasonable to evaluate that esophagus for the first time sometime during that first postop day on the 28th?

A. I would certainly do it within the first 12 to 24 hours. And the reason being is because he couldn't pass the scope. And you have a patient that's intubated, that's probably the best time to evaluate him with an EGD or do a squirt and then take a chest x-ray on him. Your concern is always there that, you know, I couldn't pass the scope. Like I said, I wasn't there, I don't know how much difficulty the resident or Dr. Starr had passing the scope, because it is a matter of resistance with the operator who passes the scope.

Q. Is the --

A. If he leans over to me and says, hey, Carl, you

know, get a swallow after this because I had a hard time getting that scope down, I'd do it that evening in the ICU.

Q. Has that ever happened to you where you've evaluated the esophagus because of concern over perforation?

A. No. Not personally, no.

Q. If your cardiac anesthesiologist said I had some -- met some resistance passing the probe, probably something you should consider is evaluating the esophagus at some point into the future, particularly if you think you might have to do another TEE, would that sense of urgency necessarily require that you do it within 12 to 24 hours?

A. I would.

Q. Again, it would be reasonable to do it up to 24 hours under those circumstances?

A. Sure. All predicated on the patient's hemodynamic stability.

Q. And one of the reasons that you would want to wait 12 to 24 hours is, one, to make sure the patient is stable to undergo that evaluation.

A. Right.

Q. And, again, many of the things that you're concerned about relative to the resistance are things

that don't necessarily need acute or immediate intervention. You're worried about obstruction from carcinomas and other things, correct?

A. True. But the biggest thing is once a patient passes that 12-hour point on the ventilator, you have decompressive stomach, so you've got to pass an NG tube. So you'd be concerned that your nurses who are passing the NG tube, if they had a hard time getting a TEE probe in, you know, certainly passing an NG tube for decompression is going to be a concern.

Q. We can agree that other than the accumulation of fluid in the right chest, Mr. Meeker showed no other signs or symptoms of a perforation.

A. Absolutely, um-hmm. When he got his preoperative antibiotic coverage, he was afebrile and hemodynamically stable. His biggest problem was respiratory.

Q. He had some rising in his creatinine. Can we agree that that can occur as a consequence of going on bypass?

A. Absolutely.

Q. Is that what you attribute it to in this case?

A. Correct.

If I could just say something real quick? I mean, I have -- my basic two opinions are

against the two doctors. The one is that, you know, the perforation occurred during the TEE placement, the probe placement. They couldn't pass it. That's one.

The other issue is that a trained cardiovascular thoracic surgeon, even in a busy practice, gets a patient who he knows has had a problem with intubation and then on the second postoperative day develops a new loculated right pleural effusion, the first thing you got to think of is perforation. That's the only thing that causes it.

Q. But you would agree, then, by that point the likely option available to Dr. Rice or whatever thoracic surgeon was involved was exactly what Dr. Rice ended up doing seven days later.

A. That's -- that's a reasonable assumption. Although Mr. Meeker didn't show signs and symptoms of sepsis, the key would have been to drain that region and then even consider a stent plus-minus. But Dr. Rice's procedure was certainly reasonable at that point.

Q. So, in other words, even if Dr. Pettersson had called in Dr. Rice on Postop Day Number 2 when the right pleural effusion developed, there's a likelihood that the same result would have occurred; that is, he would have performed the surgery that he had performed on the 2nd on the 29th or 30th.

A. Correct. But the key is that because there was a problem -- there was an inability to pass the probe and you had a patient in that setting that you probably should have done a workup on Post Evening 1 or done it the next day before the pleural effusion sets in.

Q. As we move along that time line closer to 24 hours, the likelihood that Dr. Rice is going to do the same thing is -- increases, true?

A. That's reasonable. The key is to save the esophagus, save the patient.

Q. Have you been provided any information as to how he's doing now?

A. No, I have not.

Q. Do you know whether he's alive?

A. I think he's alive. I hope so.

Q. Do you know whether his esophagectomy was taken down?

A. I know in the notes there's plans to do that. I'm sure it was done.

Q. Do you know whether he can eat now?

A. I would hope he could.

Q. Do you know what his cardiovascular status is?

A. No, I do not. No. I can't comment. I haven't seen any records except the notations that that was the plan.

Q. Would you agree that even when a patient's NPO with a perforation, the saliva that leaks out of the hole can cause contamination?

A. Absolutely.

Q. And is there also some retrograde flow of the gastric contents?

A. Correct. Generally, that's where the contamination comes from is the saliva.

Q. Was there anything in Dr. Watson's deposition that you disagreed with?

A. Not really. I mean, he's a younger guy. He finished his training in '96, so they have a different take on what we were taught.

Q. How does that translate into what he testified to?

A. Just that we tend to be more aggressive surgeons that tend to think that they can spend up to, you know, 48, 72 hours and establish percutaneous drainage. But nothing, really. I mean his deposition -- I didn't rely on it for my opinion.

MR. MEADOWS: Let's mark the deposition as Exhibit 3.

(Exhibit 3 marked for identification.)

Q. What is your understanding of any conversation that occurred between Dr. Starr and Dr. Pettersson at

the time of surgery as it relates to the transesophageal echocardiogram probe passage?

A. Just what Jonathan had mentioned to me, that they had talked about it. But I don't -- you know, I don't have -- there isn't a note in the chart.

Q. Okay. So you did get that piece of information from Jonathan.

A. Sure, um-hmm. Um-hmm.

Q. Did he tell you anything about the specifics?

A. No, hm-umm. And that's hearsay, I mean, to me.

Q. Did he say that there's testimony out there about what was said?

A. He told me that the cardiac anesthesiologist, Dr. Starr, told the cardiac surgeon that there was trouble passing the scope and maybe he ought to have the patient looked at. But if it's not documented in the chart, it's not in my report.

Q. So the only source for that information is Jonathan Tsilimos?

A. Correct.

Q. One of the defense experts, Dr. Cody, stated in his report, "Right pleural effusion is a common occurrence after cardiac surgery." Do you agree with that?

A. Disagree.

Q. "Transient renal failure is explained by the fact he was on bypass." I think you've agreed with that.

A. I agreed with that. The thing with the pleural effusion is a new pleural effusion on Postoperative Day Number 2 is not usual during cardiac surgery.

Q. You have no opinions on his life expectancy inasmuch as you haven't seen his most recent records?

A. That's correct.

Q. When was he no longer NPO on the time line?

A. I think they actually fed him after he was extubated on Postop Day Number 3 or 4.

Q. Can we agree that the right pleural effusion manifested before he was fed?

A. Correct.

Q. Where did the fluid come from that represents the pleural effusion?

A. It's a mediastinal reaction from the pleura. And what Dr. Rice dictated in his operative report when he explored him was that it was a well organized pleural peel. So you know it's been there for at least five to seven days.

Q. My question wasn't a very good one. When it first manifested on Day 2, the 29th, did that fluid come from the saliva and from the gastric retrograde flow?

A. In conjunction with pleural reaction. The pleura is the only organ besides the pancreas that when you piss it off, it produces fluid in response. So then the normal absorption of pleural fluid is hindered, so you have more production than you have absorption.

Q. Would you agree that the majority of perforations that are older than 24 hours old are treated with an esophagectomy or similar diversion?

A. Depends on location in the --

Q. Mid esophagus.

A. That would be a reasonable statement.

Q. Do you agree that there may be times when resistance in encountered in passing a probe when consultation or further evaluation of the esophagus is not necessary?

A. Was the probe passed or not? Your question --

Q. Let's assume either way, that resistance was met in the passing of the probe whether the procedure was aborted or whether it was completed.

A. I would say if you have resistance while passing the probe but you pass it, consultation is not indicated. Just keep your radar up. But if you cannot pass the probe, then a consultation is needed for the reasons I mentioned.

Q. In your experience, you've never seen a

situation where the imaging was converted from TEE to epicardial?

A. No.

Q. Do you ever use epicardial imaging?

A. Hardly. It's rare that I use it.

Q. Have you ever?

A. Yeah, when I was little.

Q. How long ago was that?

A. Probably maybe five years ago, seven years ago. We used to use it for looking for plaque in placing our cannulas, but we don't use it that much any more. It's certainly worth -- very much in the standard of care to use it to look at valve function.

Q. So to be clear, you have no criticism of the anesthesia team by virtue of the fact the perforation occurred. Your criticism is that they didn't evaluate in a timely manner the esophagus after resistance was met and they couldn't pass the probe.

A. Correct.

Q. Would you agree that it was reasonable to attribute the hypotension, acidosis, kidney failure in the right pleural effusion to normal postop changes?

A. With exception of the right pleural effusion.

Q. You would agree with it except for the right pleural effusion?

A. Correct, yes.

Q. Would you agree that not all pleural effusions are hydropneumothorax?

A. That's true. The key is loculation and consolidation.

Q. Would you agree that if Dr. Starr did not have concern about a perforation that there was no need to urgently -- and by urgently, I mean within 12 to 24 hours -- evaluate the esophagus?

A. Well, I would disagree with that because of the fact he couldn't pass the probe.

Q. When was the chest tube removed that was placed on August 29th?

A. I think it was taken out on the sixth postoperative day because the fluid reaccumulated. If my memory serves me correctly.

Q. And what's your understanding as to what was draining from the chest tube placed on August 29th through the time it was taken out?

A. Serosanguinous fluid.

Q. Would you have expected that drainage to remain constant if, in fact, there was a perforated esophagus?

A. Well, it depends where the tube was placed. If it's in the periphery, then you're going to get serosanguinous drainage. Only until you're in the area

of the perforation would you get pleural material.

Q. Do you intend to do any further research in the medical literature?

A. I do not.

Q. Do you have plans to come to Cleveland to testify?

A. If you want me to, sure.

Q. Do you know when the trial is?

A. I do not.

Q. So you don't have your flight made yet.

A. No.

(Off the record.)

Q. Dr. Bueno, one of the experts who reviewed the case at the request -- at my request from Brigham and Women's Hospital stated in his report, "I believe it would be risky to operate on the right chest of a patient immediately post open heart surgery, particularly after double valve repair." Do you agree with that?

A. I disagree with that.

Q. Why?

A. Because basically if you have a patient that has a hole in the esophagus, you have to drain it. And you can do it thoracoscopically, which Dr. Rice attempted to do, and reconvert to a thoracotomy. I

mean, we take the patients back to the Operating Room immediately after open heart surgery for bleeding, for ruptured pulmonary arteries. You got to do what you got to do.

Q. He states, "Given that the patient had two prosthetic rings placed within his heart, I believe that the operation chosen by Dr. Rice, diversion and resection, was the operation of choice at any time to prevent potential seeding of the valves with microorganisms."

A. Disagree with that.

Q. Why?

A. Because basically if you could have made the diagnosis sooner than later, drain the space, double antibiotics, you could put a stent or a patch over the esophagus. Again, the longer you wait --

Q. Is a patch the same thing as primary repair?

A. Well, you always do a primary repair and do a pleural patch. That's part of primary repair.

Q. But I think his point is that in light of the failure rate associated with both options you just outlined, the risk of seeding if failure occurs is too great, and therefore diversion and resection is the better course of action. Do you believe that's a reasonable position to take?

A. It's a reasonable position. I disagree with it. And these are rings, not valves.

Q. I think I said rings.

A. Right. I mean, I would be more concerned if he had double valves because the risk of bacterial carditis is double or triple with basic sepsis.

Q. There still is a risk of seeding with the prosthetic ring, true?

A. True. Minimal, though.

Q. Have we covered all the opinions that you intend to give in this case?

A. You have.

MR. MEADOWS: Okay. I think that's all I have. Thank you.

THE WITNESS: Thank you.

MR. DOLESH: That's it.

THE WITNESS: I'll read and sign.