Case: Rebecca T. Dunn vs. Henley Hospital
Summary of the Deposition of: Steven Packard, M.D.
Date of Deposition: September 2, 2004

PAGES/LINE	TOPIC	SUMMARY
3:15-16	Location	Henley Hospital, 85 Palm Street, Reno, Nevada
3:24-4:2	Appearances	Wendy Adams, Adams, Smith, & Adams, LLP- Attorney for plantiff Jack Daley, Slater, Dunn, and Metcalf– Attorney for defendant
4:9-19	Name and profession of witness	**Examination by Ms. Adams** Witness' name is Steven L. Packard. He is a doctor of osteopathy at Henley Hospital.
4:20-21	Exhibit 1	**Exhibit 1** A copy of witness' curriculum vitae was marked for identification.
5:5-12	Previous deposition	Witness testified at trial once approximately five years ago.
5:13-6:17	Admonitions	Admonitions were reviewed.
6:18-7:8	Educational details	Witness graduated from University of Nevada in 1975. In 1986 he completed a Doctorate of Osteopathy from Health Science University. He completed his residency at the County Medical Center in 7/1990. He worked his entire professional career since his residency for Henley Hospital.
7:9-8:1	Witness' medical specialty	Witness' medical specialty has always been internal medicine. He was Board certified in internal medicine in 1990. He is a hospital-based services doctor at Henley Hospital, which means that he sees only in-patients and not outpatients.
8:2-9:10	Treatment of James	Witness had been a treating physician for James many times in the past. No treatment was rendered before 8/10/2002 as that was the first day he saw James. He saw James as an inpatient during his hospitalization that ended in 2002. Witness reviewed the medical charts for James very briefly earlier that day before this deposition. Apart from the records he also had an independent recollection of the treatment given to James in August and September of 2002.
9:18-23	Exhibit 2	**Exhibit 2**

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		Henley Hospital Medical Records were marked for identification.
9:24-12:23	Details of 8/10/2002	Witness was working on his own patient in the emergency room on 8/10/2002 when Dr. Ramirez called him to see James. Witness DNR explicitly what Dr. Ramirez wanted him to do but he examined James with Dr. Ramirez. Witness DNK what time he first saw James in the ER on that date. The nurse had mentioned witness' name on page 43 of Exhibit 2 after the 18:20 time. He recalls having looked at James on 8/10/2002 and reviewing his ER order sheet, which is page 44 of Exhibit 2. He wrote a couple of orders for medications and fluids as shown on page 44 of Exhibit 2. He noted dopamine, 10 milligrams per kilogram per minute and normal saline at 250 cc's per hour on the right hand column of the page. James did not become witness' patient on 8/10/2002. Witness wrote the medication orders perhaps because Dr. Ramirez could have been busy, or witness' advice was needed, or he and Dr. Ramirez discussed it and decided it was the appropriate thing to do.
12:24-15:7	Dopamine medication given to James	Witness ordered dopamine for James because his blood pressure was low and the dopamine would be a pressor. He DNR specifically reviewing any medical records of James for the emergency room for that day. Witness would have focused on James' blood pressure before starting him on dopamine. According to the 18:20 nursing notes on page 42, James' blood pressure was noted as 85 over 25, which would be characterized as low. Witness DNR any discussion with Dr. Ramirez prior to administering the dopamine to James. He recalled not necessarily reviewing the chart in the nursing notes at the time he wrote the order for the dopamine, to find out how long James' blood pressure had been low prior to that time. At 17:10 the blood pressure was recorded as 80 over 30, which was low. Per witness' knowledge, a man in James' condition and at his age would have a normal blood pressure in the neighborhood of 110 over 60 or 70. It was not necessary for witness to look at the nurse's notes to find out James' blood pressure when he first came in the emergency room.
15:8-16:25	Details of James' blood pressure and appearance	James' blood pressure concerned witness because it was not normal. However in order to take into context the overall clinical picture of the patient the blood pressure alone was insufficient. Witness at the time was also concerned about James' physical appearance, as he appeared to be in a state of severe medical distress. Witness DNR if James was conscious or not. He remembered James being in respiratory distress and diaphoretic. He believed James had a very fast heart rate. He DNK exactly why James' blood pressure was 85 over 25 at 18:20 on 8/10/2002.
17:1-20:7	Medication given to James	Witness suspected a combination of medication and sepsis was responsible for James' low blood pressure at the time. Witness DNK what was the

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		source of the sepsis at the time. According to the chart at page 44 of Exhibit 2, James was being given metoclopramide, an antiemetic. James was also getting metoprolol at some time in the past. Diltiazem and metoprolol were drugs that in witness' opinion could suppress blood pressure, among others like amiodarone and morphine that James was being given. James was given morphine at 17:10 as noted on page 42. The four medications given at 18:20 could conceivably lower James' blood pressure. His blood pressure could have been low also because of the sepsis, which would have been another reason to give him dopamine as well as fluids.
20:8-22:5	Order for fluids	The order for fluids at 18:15 was made by witness to support James' blood pressure. Page 42 mentioned that James was getting some fluids. There were, however, no doctor's orders before 18:15 for fluids. Witness DNK for sure what James was getting in fluids but he was getting IVs. Witness changed James' IV fluids to dextrose five percent with two amps of bicarb because he received a lab result indicating that James was acidotic. There were no other orders that witness wrote on page 44 of Exhibit 2.
22:6-25:9	Discussions on James' condition	Witness DNR specifically any conversations he had with Dr. Ramirez, Dr. Knope, the cardiologist and other doctors or nurses about James' condition while he was at the emergency room on 8/10/2002. Most of the conversations about James were in continuum because witness took care of James so many times after that. He recalled talking with Rebecca Dunn on 8/10/2002. Witness explained to Mrs. Dunn the seriousness of James' condition and that he was concerned about James' survival. Mrs. Dunn was very tearful but witness DNR her response to him. Witness DNR specifically any other conversations with Mrs. Dunn although there were a few more discussions generally about updates on James' condition. On 8/10/2002, while talking to Mrs. Dunn witness had a presumptive diagnosis of sepsis for James. Witness DNK the source of the sepsis although Dr. Ramirez thought it was colicystitis.
25:10-26:2	Friedrich's ataxia	Witness DNR James having Friedrich's ataxia on 8/10/2002. Witness had not treated a patient with Friedrich's ataxia before 8/10/2002. Witness did not have any knowledge that such patients may often have cardiomyopathy.
26:3-31:14	James' responsiveness in the emergency room	Witness DNR any discussions with Dr. Kim or any other doctors on 8/10/2002 on why James was unresponsive in the emergency room. However, while witness was taking care of James in the intensive care unit, he was responsive. After James' CAT scan witness recalled discussing generally the etiology of the stroke findings and at some time discussing sedimentations that James had required during his intubation period. The medications were adjusted to see if James' responsiveness could be improved but that was before the stroke. Witness DNK when James had the stroke. He DNR what caused James to be unresponsive at 16:50 hours in the emergency room.

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31:15-33:8	Details of middle cerebral artery stroke	James' stroke was in the middle cerebral artery on the right side. Based on witness' experience with previous stroke patients, he frequently expected some sort of hemiplegia resulting from the stroke depending on the size of the stroke. Hemiplegia is the partial loss of motor function. In witness' treatment of James since 8/10/2002, James exhibited some signs of hemiplegia, on the left side. James had dysreflexia and he does not have volitional motion, so it was difficult to assess hemiparesis, hemiplegia or dysreflexia.
33:9-34:16	Details of dysreflexia	Dysreflexia is the loss of deep tendon reflexes to stimulation. James also occasionally had extensive posturing. Witness determined that James had all four limb dysreflexia secondary to the Friedrich's ataxia. James could have had the dysreflexia even before 8/10/2002, as he was wheel chair bound. When witness last saw James, James had problems on his right side in addition to the left side.
34:17-36:10	Details of hemiparesis	James had hemiparesis on the left side, which could be related to the stroke. Hemiplegia was complete and hemiparesis was incomplete loss of motor function. On witness' last visit James was blind and non-verbal. It was possible that James could develop a bladder dysfunction and occasionally spastic colon. The blindness was likely to be an effect of Friedrich's ataxia. Witness DNK if James became non-verbal due to Friedrich's ataxia. In talking to James' mother witness learned that James was verbal before. It was possible to relate the non-verbal problem to the stroke. Witness entertained bulbar degeneration secondary to Friedrich's ataxia leading to brain stem dysfunction, respiratory vocalization and swallow impairment.
36:11-37.6	Bladder dysfunction	The bladder dysfunction could also due to Friedrich's ataxia. James has bladder function but had an episode of urinary retention during his most recent hospitalization. Dyspascicity is multifactorial and could be caused due to both Friedrich's ataxia and the stroke.
37:7-38.23	Details of Exhibit 2	According to page 65 of Exhibit 2, there was an emergency room visit on 8/12. Page 65 also stated the plan for the day. On page 64 witness wrote that cardiomyopathy was secondary to exacerbated sepsis with 25 percent ejection fraction on echocardiogram at 711 and it was related to Friedrich's ataxia. Oliguria was related to low urine output. After that sepsis versus dehydration versus hypoperfusion secondary to cardiomyopathy was written.
38:24-42:3	Witness resumed being James' attending	The next note in the chart was on page 67 dated 8/13/2002 when James was in ICU. Witness increased Mr. Dunn's beta blockers, which would be low pressor. He discussed with cardiology that calcium channel blocker might

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		be more beneficial in the setting of a restrictive cardiomyopathy. He transferred Mr. Dunn to the transitional care unit and did urinalysis, chest x-ray and a.m. labs.
42:4-44:7	Interim discharge summary of 8/13/2002	Pages 13, 14 and 15 of witness' notes were an interim discharge summary. 8/13/2002 was the last day witness saw Mr. Dunn for about a month. He summarized Mr. Dunn's current diagnoses on page 13 and referenced an echocardiogram revealing significant cardiomyopathy and decreased ejection fraction of 25 percent on page 14. He DNK the ejection fraction on or before 8/10/2002. Historically, echocardiograms would be either in the computer or in the outpatient chart.
44:8-45-7	Acute renal failure	Page 14 of Exhibit 2 mentioned acute renal failure, acute tubular necrosis secondary to hypotension and acute interstitial nephritis secondary to medication. Secondary to hypotension means that the kidneys would be sensitive to blood flow if the blood pressure is very low because their function is dependent upon adequate blood flow. If kidneys have an interruption or diminution of blood flow, acute renal failure could occur. Witness DNK whether it was hypotension versus the medication that caused the acute renal failure on 8/13. He DNR if he made a diagnosis of acute renal failure at any later time.
45:8-46:15	Aspiration versus CNS	On page 14 of Exhibit 2, under septic shock, it was written that the source is unclear, possibly aspiration versus CNS. It meant James had aspirated the vomitus into his lungs while he was very ill, rather than some sort of cerebral central nervous system infection. He DNK whether Mr. Dunn had any cerebral central nervous system incident including a stroke on 8/13/2002. Mr. Dunn was unresponsive on 8/13/2002, which might be secondary to a CNS infection or septic shock.
46:16-50:4	Cardiomyopathy secondary to Friedrich's ataxia exacerbated by sepsis	Under No. 3 on page 25 of Exhibit 2, cardiomyopathy was secondary to Mr. Dunn's Friedrich's ataxia exacerbated by his sepsis. Witness knew that cardiomyopathy could be exacerbated by sepsis the first time he saw Mr. Dunn. He DNK whether Mr. Dunn had cardiomyopathy on 8/10/2002. Per page 25, ejection fraction returned to 40 percent after Mr. Dunn's sepsis has resolved.
50:5-52:3	Mr. Dunn's condition on 8/19/2002	After 8/13/2002, witness visited Mr. Dunn on 8/19/2002 according to page 206 of Exhibit 2. On 8/19, Mr. Dunn was nonverbal and there were no other acute findings. Witness DNK if there was a time when Mr. Dunn became verbal after 8/10/2002. Mr. Dunn's treatment on 8/19/2002 included holding Mr. Dunn's tube feeds until a discussion with GI regarding a percutaneous placement of a gastrostomy tube and a.m. labs. He considered a tracheostomy, sputum culture and a likely transfer to the medical surgical ward with a skilled nursing facility. He DNK whether or

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		not there had been any cerebrovascular acts as of 8/13/2002. Mr. Dunn had no normal responses as he was sedated and intubated on 8/13/2002.
52:4-53:8	Assessment on 8/20/2002	Per page 208 of Exhibit 2, witness' next visit to Mr. Dunn was on 8/20/2002. He did Mr. Dunn's assessment from 1 through 7. Assessment No. 1 mentions status post middle cerebral artery distribution, cerebrovascular accident with left hemiparesis and stable condition. The left hemiparesis would result in a decreased motor function of both the left upper and lower extremity. Assessment No. 7 mentioned that Mr. Dunn's family had elected a full code for him.
53:9-54:11	Details of 8/21/2002 visit	Per page 210, witness' next visit was on 8/21/2002. At the time, Mr. Dunn was unresponsive due to his middle cerebral artery stroke in combination with his underlying Friedrich's ataxia and his whole hospitalization. Mr. Dunn probably had a thromboembolic stroke secondary to afib.
54:12-56:18	Three-page interim discharges summary written on 8/22/2002	According to page 214, witness next visited Mr. Dunn on 8/22/2002. Mr. Dunn was still nonresponsive but stable. On 8/22, witness wrote a three-page interim discharge summary, which was pages 10, 11, and 12, to cover the period from 8/17 to 8/22. At the bottom of page 10, witness said the cerebrovascular accident of the middle cerebral artery was secondary to an embolic event during atrial fibrillation during Mr. Dunn's early hospitalization in the intensive care unit. On page 11 under number five, it is mentioned that cardiomyopathy was returned to baseline, somewhere in the 40s.
56:19-59:10	Mr. Dunn's condition during witness' visits on 8/28-8/31	Per page 230, the next time witness saw Mr. Dunn was on 8/28/2002. There were no major changes noted on 8/28/2002. Per page 232, Mr. Dunn's condition was stable during witness' next visit on 8/29/2002. According to page 233, Mr. Dunn was more awake with eyes open and nonverbal during witness' next visit on 8/30/2002. Mr. Dunn was getting better. Page 235 states, 24-year-old male status post septic shock with Friedrich's ataxia and middle cerebral arteries, cerebral vascular accident with anoxic versus eschemic encephalopathy on witness' next visit on 8/31/2002.
59:11-60:10	Difference between anoxic and eschemic encephalopathy	The difference between anoxic and eschemic encephalopathy is lack of oxygen versus lack of blood based on the fact that Mr. Dunn was awake and unresponsive with eye movement and nonverbal. Mr. Dunn had a brain injury caused by either a lack of oxygen or blood supply. The lack of blood supply would be because of low blood pressure or a stroke. Mr. Dunn had been intubated and had pneumonia in the early part of his hospital course.
60:11-62:15	Discharge summary on	According to page 235, there were no significant changes in James since witness' last visit. On 9/1/2002, witness had the same assessment of

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	9/1/2002	encephalopathy, eschemic versus anoxic, and no improvement clinically. James had developed an eosinophilia, a type of white blood cell usually seen in allergic reactions. According to pages 34, 35 and 36 witness did another interim discharge summary on 9/1/2002. On page 34, under encephalopathy, there was a reference to eschemic versus hypoxic encephalopathic process. Eschemic refers either to an embolic or a thrombotic stroke, related to James' cardiomyopathy, or atrial fibrillation. The reason behind James' hypoxia was his hospital course during the intensive care unit and intubation.
62:16-64:10	Hypoxemic state	Witness did not give any consideration to Mr. Dunn's low blood pressure in the emergency room as a source of the hypoxia because hypotension does not necessarily mean hypoxemia; it just means a low blood flow. Insufficient supply of blood diminished the oxygen carrying capacity. The period of time the patients were in respiratory distress prior to intubation usually implied a lowered oxygen level. Any course of pneumonia that James had during his hospitalization could create a hypoxemic state. Witness remembers James having pneumonia when he looked at the records in ICU. James was in the intensive care unit and was intubated to protect his airway because he had pulmonary issues. Witness had to review James' lab values to know whether he actually was hypoxemic at the time.
64:11-67:5	Interim discharge summary on 9/21/2002	According to pages 7, 8 and 9, witness did another interim discharge summary on 9/21/2002. Under encephalopathy he mentioned eschemic versus anoxic. He wrote there was very little clinical improvement in the patient's initial presentation. As of 9/21/2002, when witness dictated the particular interim discharge summary, he believed that James was not improving from the stroke because of brain injury in combination with his neurological illness, i.e. the severity of the stroke. A neurologist could classify the severity of the stroke. From witness' point of view, it was a large stroke and he would refer to the neurologist to find out more. As of 9/21/2002, the large stroke, in combination with his preexisting Friedrich's ataxia, created a situation where he was not improving from the stroke. Witness did not consider that the severity of the stroke had exacerbated the Friedrich's ataxia though his overall prolonged illness and the severity of his initial sepsis might have hastened or worsened his underlying neurological problems.
67:6-18	Poor prognosis for future recovery	On page 8, witness stated the poor prognosis for future recovery because of the length of time of James' illness. James had not made the kind of recovery that witness had hoped for.
67:19-69:19	No. 2 on page 8 of Exhibit 2	According to No. 2 on page 8 of Exhibit 2, witness explained the cerebrovascular accident of the right middle cerebral artery distribution. Witness stated that it was secondary to an embolic event during the patient's atrial fibrillation event during the early hospitalization. Between

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		8/10/2002 and early August, when the first CT scan was done, James had a stroke. Thrombotic secondary to poor profusion or hypotension meant that if the patient was hypotensive and sufficient blood was not being moved through the circuit, the blood slows, clots and makes the blood stand still. Witness referred to hypotension as a period of low blood pressure and a septic event. The sepsis contributed to the low blood pressure. Broader involvement of the brain meant that if the patient had a low flow state causing clotting, it would only occur in the middle cerebral artery instead of occurring in both middle cerebral arteries, or vertebral arteries, or any of the other smaller branches of arteries.
69:20-71:19	Responding to voices	Witness described Mr. Dunn's neurological condition as minimally responsive with nonverbal state and spontaneous eye movement and eye openings with a left hemiparesis. Witness observed that Mr. Dunn responded to certain recognized voices but did not respond to witness' voice. Witness has seen Mr. Dunn responding to his mother's voice by turning his eyes towards her when she was speaking. He responds to certain nurse's voices. In Mr. Dunn's initial presentation, witness has tried to inflict pain to see if he would withdraw and he responded.
71:20-74:8	Page 9 of Exhibit 2	According to page 9 of Exhibit 2, the patient's family was adamant that the patient would not be placed in a skilled nursing facility and had elected to take him home. Witness DNR if that was something that they have been adamant about. Since 9/2002, during inpatient visits witness assessed the quality of care that James was getting at home to be excellent. Mr. Dunn's primary caregivers were his parents and Ella whom they hired. Witness has met Ella. At the time of the dictation, witness had a discussion with the Dunns that they should not keep their son at home and should put him in a skilled nursing facility. Based upon his experience, witness had strong feelings about people giving 24-hour care to patients at home because it was a tremendous amount of work and required a certain amount of dedication that most people were unable to fulfill and felt guilty about when they were not able to do it well. From witness' point of view, he has not seen anything negative in the results in terms of James' condition but how it affected the parents was not his responsibility.
74:9-75:20	Handwritten note made on 9/20/2002	As of 9/20/2002, the handwritten note on page 298, under cardiomyopathy No. 5 says, "with expected decreased blood pressure, will DC Midodrine." Midodrine, an oral pressor, is a pill to raise people's blood pressure. People who had cardiomyopathy had a low blood pressure. As of 9/20/2002, witness expected James to have a mildly depressed blood pressure, though it was 98 over 56. Witness discontinued the Midodrine and increased James' fluids. He discontinued James' Coreg, which was carvedilol, a beta-blocker, which could also lower blood pressure. The last time witness saw James was within the last six months but note for that would not be in the chart.

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76:2-77:10	James' neurological condition	James' neurological condition has been the same since 9/2002. James was brought into the hospital for pneumonia, acute respiratory distress syndrome, atrial fibrillation, and some respiratory problems.
77:11-79:12	Conversation with Dunns about Tobramycin medication	Since 9/2002, witness had conversations with the Dunns regarding the condition of James but witness DNR if he had any conversations concerning his neurological condition. Witness DNR if James had pneumonia, when he last saw him. Witness remembers that they discussed inhaled Tobramycin, and James' parents elected not to start him on the Tobramycin. James had pulmonary issues at the hospitalization and witness suggested a medication that would have helped him. James' parents were concerned about the side effect, which was tinnitus, or ringing in the ears. Witness indicated to James' parents during the hospitalization and in a prior hospitalization that it was wise to give Tobramycin to James. Witness felt that not taking Tobramycin in any way would subject James to risks of pulmonary complications in the future, and he told the same to his parents. Possibly James has increased pulmonary complications since his parents have not given him Tobramycin.
79:13-80:14	Limited life expectancy	Witness stated that he had discussed a limited life expectancy of James given his Friedrich's ataxia and also the culpabilities that went along with being bed-bound. Witness DNR if he discussed a particular number of years with respect to life expectancy for Friedrich's ataxia with the family. Witness has discussed morbidity issues like pneumonia and other infections like bed sores, aspiration, and malnutrition with Dunns in terms of how that might limit James' life expectancy. James never had bed sores and his skin was in excellent shape. As far as nutritional issues were concerned, James was well fed.
80:15-81:10	G tube	James did not have a stoma because he had a percutaneous placed G tube straight through the skin. Witness had to review the procedure note to know whether it was actually a gastrostomy tube or a jejunostomy tube. Since 2002, the area where the G tube was placed had occasional small amounts of redness and witness expected the same from time to time.
81:11-82:7	More hospitalizations due to the respiratory problems	James had more hospitalizations than average, based on what would be expected from his condition in 9/2002, due to respiratory problems. Witness felt that Tobramycin would have an effect on that. Tobramycin is an inhaled antibiotic. James suffered from a colonization of particular bacteria.
82:8-83:19	Problems James has at present	Besides skin problems, respiratory problems, and bed sore problems, James' Friedrich's ataxia caused him difficulty in his life expectancy. From witness' point of view, since 9/2002, James' Friedrich's ataxia was getting

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		a little worse as he had urinary retention. At present, James has a good cough and a gag, but these things were to be monitored closely because Friedrich's ataxia people also have bulbar degeneration that could lead to difficulties with swallowing and respiratory status. Witness did not have appointments with any patients as he saw them only in the inpatient setting. If James were to be admitted, there was a chance that witness would be assigned to his case if he was working at the time. Witness and James' mother appeared to have a good relationship.