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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

THOMAS E. CREECH, JAMES H. HAIRSTON, RICHARD A. LEAVITT, GENE F. STUART, Plaintiffs, v. **BRENT REINKE**, in his official capacity as Director, Idaho Department of Corrections; **KEVIN KEMPF**, in his official capacity as Chief, Operations Division, Idaho Department of Corrections; **JEFF ZMUDA**, in his official capacity as Deputy Chief, Bureau of Prisons, Idaho Department of Corrections; and **RANDY BLADES**, in his official capacity as Warden, Idaho Maximum Security Institution, Idaho Department of Corrections Defendants.	Case No. 12-00173-S-EJL **CAPITAL CASE** Civil Action **PLAINTIFF LEAVITT'S REPLY TO DEFENDANTS' RESPONSE AND OBJECTION TO PLAINTIFF'S EMERGENCY MOTION FOR PRELIMINARY INJUNCTION OR STAY OF EXECUTION** Expedited Oral Argument and Evidentiary Hearing Requested **Execution Scheduled June 12, 2012**

Two of the grounds articulated in Plaintiff Leavitt's ("Plaintiff's") Emergency Motion For Preliminary Injunction Or Stay of Execution ("Emergency Motion") [Dkt. 16] were that (1)

the 2012 Protocol expressly allows Idaho Department of Corrections personnel—specifically, Defendants Reinke and Kempf—to revise the protocol at any time, for any reason and at their sole discretion, and (2) the 2012 Protocol clearly creates a demonstrated risk of severe pain. Dkt. 16-1 at 3 (citing to Dkt. 1-7, Exh. 1 at 1) and at 8. Defendants recently made two material representations in their IDOC Notice Of Intent To Use One-Drug Protocol In The Execution Of Richard Leavitt ("Notice"). Dkt. 18. They state that they "will be proceeding with implementing the one-drug pentobarbital protocol (method 4) outlined in SOP 135 for the execution of Richard Leavitt on June 12, 2012." *Id.* at 2. They also state that they "will not invoke [their] authority to deviate from the one-drug pentobarbital protocol outlined in SOP 135 for the execution of Richard Leavitt on June 12, 2012."[1] *Id.* This Court should find the Notice binding on the Idaho Department of Corrections ("IDOC"), including Defendants. *See Towery v. Brewer*, 672 F.3d 650, 658 (9th Cir. 2012). Should the Court decline to find the Notice binding, Mr. Leavitt requests leave to supplement this Reply.

Defendants' Notice, assuming it is binding, appears to moot out several issues material to Plaintiff's motion for a preliminary injunction or stay of execution. It appears to render moot the first ground cited above for a preliminary injunction or stay of execution, that the IDOC has unfettered discretion to change the 2012 Protocol at any time, for any reason and at their sole discretion. The Notice also appears to render moot two bases for Plaintiff's second contention, that the 2012 Protocol clearly creates a demonstrated risk of severe pain: its lack of a meaningful consciousness check in violation of *Baze v. Rees*, 533 U.S. 35 (2008) and its failure to address

[1] Throughout this Reply, Plaintiff refers to the SOP 135 adopted in mid-October, 2011, as the "2011 Protocol" and to the superceding SOP 135, adopted in January, 2012, as the "2012 Protocol."

what measures will be taken if the offender regains consciousness after or during the administration of potassium chloride.

The remainder of this Reply addresses those issues which the Notice, if binding, does not render moot.

A. The 2012 Protocol Clearly Creates A Demonstrated Risk of Severe Pain.

Contrary to Defendants' assertion, the 2012 Protocol is not substantially similar to the protocol approved in *Baze*. Dkt. 22 (Opposition) at 14. The Supreme Court characterized as "safeguards" against severe pain those measures required by the Kentucky protocol. *Baze*, 553 U.S. at 56. It was these "safeguards" upon which the Court relied in upholding that protocol. *Id.* The most basic criterion by which to discern a protocol's similarity to the *Baze* protocol is whether it contains materially similar "safeguards" against severe pain. If a required measure of an execution protocol does not act as a safeguard against the otherwise present risk of severe pain, then it cannot be relied on to find that the protocol is materially similar to that upheld in *Baze*.

The 2012 Protocol measures, as supplemented by the facts to which Defendant Zmuda testifies in his affidavit, and on which Defendants rely in opposing Plaintiff's motion, do not constitute safeguards against severe pain. Dkts. 22 & 22-1.

1. The 2012 Protocol's Requirement of Three Years Medical Experience Is Not A Safeguard Because It Fails To Require That The Experience Include Initiating And Delivering Drugs By IVs or Central Lines.

Defendants contend that the 2012 Protocol's requirement that each Medical Team member have at least three years medical experience exceeds the *Baze* requirement of one year experience. Dkt. 22 at 15. However, as Plaintiff notes in his memorandum supporting his Emergency Motion, the 2012 Protocol does not require that Medical Team members have

adequate training and experience respecting their duties under the 2012 Protocol. Dkt. 16-1 at 17.

a. The Qualifying Credentials do not Receive Adequate Training and Experience.

Some of the credentials that qualify an individual for Medical Team membership do not require any training or experience in initiating or administering drugs by IV. Specifically, Licensed Practical Nurses, phlebotomists, basic (as opposed to Advanced) EMTs, and some military corpsmen need not have any training or experience in these matters. Dkt. 16-1 at 17-18, Dkt. 1 at paras. 105-116. Further, the "other medically trained personnel" qualifying credential is sufficiently vague that it does not require that the training or three years medical experience include initiating or administering drugs through IVs. Dkt. 16-1 at 18-19, Dkt. 1 at paras 119-120. For example, as Plaintiff notes in his Emergency Motion and Complaint, a Certified Medical Assistant ("CMA") may fall within the "other medically trained personnel" qualification, yet IV medication administration is outside the scope of the CMA's practice and certification. *Id.* Thus, while the 2012 Protocol provides that Medical Team members have at least three years medical experience in the area of their qualifying credential, that experience may not include initiating and administering drugs through IVs. Consequently, the qualifying credential plus at least three years medical experience required by the 2012 Protocol do not serve as safeguards against severe pain.

Defendants counter that the plain language of the 2012 Protocol is to the contrary, citing to the requirement that the "Medical Team shall consist of volunteers whose training and experience include administering intravenous (IV) drips." Dkt. 1-7 at 12. As just seen, however, this requirement squarely contradicts the list of qualifying credentials, which includes credentials for which training or experience in initiating or delivering drugs via IVs is not required. In the

face of such a clear contradiction, it cannot fairly be said that the 2012 Protocol requires that the Medical Team members must have training and experience in administering IV drips.

Even assuming that the training and administration of IV drips "requirement" trumps the qualifying credentials list, the 2012 Protocol still does not require any training or experience in *initiating* IVs. It is only after an IV is initiated that an IV bag is attached to administer a "drip." After an IV is properly initiated with the fluid flowing into the blood vessel, the IV can shift so that the fluid flow is redirected from the blood vessel into the surrounding soft tissue. Exhibit 1 at page 5 (Testimony of David Waisel, M.D., *Blankenship v. Owens et al.*, No. 11-CV-202236 (Super.Ct., Fulton County Ga.)). Under these conditions, the IV is said to be infiltrated. *Id.* Infiltration stretches the tissue, including the skin, which can be "excruciating[ly] painful." *Id.* The same excruciating pain can result if the IV is not properly placed in the blood vessel to start with. Additionally, "some medications, when you go in the soft tissue, burn extremely and rather excessively." *Id.* Pentobarbital is one of those medications. Dkt. 1-8, Exh. 13 at 3 (pentobarbital package insert's caution).

Zmuda's assurance of regarding the quality credentials of the actual Medical Team members in place for Mr. Leavitt's execution establish that Defendants meet the *Baze* mandate for safeguards as to his execution. Medical Team member M-2 and/or M-3 will initiate the IVs. Dkt. 22-1 at Exhibit B. However, the qualifying credential of

is ambiguous. *Id.* As set out in

Idaho law does not provide

Id. It is unclear whether the individuals who will be responsible for initiating and administering drugs through an IV are

disciplines required training and competence in initiating and administering medication via IVs. But, as set out in the last subsection, they do not.

Defendant Zmuda's affidavit does not represent that the actual executioners responsible for initiating the IVs (M-2 and/or M-3) have recent experience and competence in initiating IVs. Nor does it represent that the actual executioners responsible for administering the drugs through the IV(s) (M-4 and/or M-5) have recent experience and competence in IV drug administration. While Exhibit B to Defendant Zmuda's affidavit does state that each of these executioners (M-2 – M-5) has "current" and "routine" "venous access currency," the meaning of these statements is needlessly opaque. Defendant Zmuda could have but did not write that each of these Medical Team members has recent and regular experience and competence in completing their respective duties, initiating IVs and administering drugs through IVs. Instead, we are left to wonder whether that is what "venous access currency" means. It could equally well mean that the individual has currency (whatever that means) in accessing veins with a syringe, a very different procedure than initiating an IV. And because "access" is very different from "delivery", or "administration" we are left to wonder whether "venous access currency" speaks in any way to whether one is experienced and competent in the administration of drugs through IVs.

2. Competency Is Not Required, Even If The Medical Team Members Have Otherwise Relevant Training And Experience.

Plaintiff alleges in his Emergency Motion that despite whatever else it may require, the 2012 Protocol does not require that team members, or any other participant in the mandated training or rehearsals, perform with any minimal competency at the assigned task. Dkt. 16-1 at 19. Defendant Zmuda's affidavit provides no assurance that the Medical Team members responsible for initiating the IVs are certified or licensed in occupations requiring competency in initiating IVs or hold a credential whose acquisition required that competency. Defendant

Defendant Zmuda's affidavit states that the Medical Team members who will inject the drugs are no

However, only

The cited qualifying credential does not show that the individual(s) initiating and delivering drugs through the IV into Mr. Leavitt will have relevant experience and training.

Similarly. , may place, monitor and maintain a central line. According to Defendant Zmuda's affidavit, M-3 is the Medical Team member who will initiate a central line, if necessary. Because of the ambiguity cited above he or she may have no relevant experience and training.

b. The Actual Executioners May Not Have Experienced Incompetence Respecting Their Duties Under the 2012 Protocol.

Zmuda's assurances regarding the qualifications of the Medical Team members in place for Plaintiff's execution do not establish that the 2012 Protocol meets the *Baze* mandate for safeguards. He makes much of the so-called "significant change" in the 2012 Protocol requiring that each Medical Team member have three years of "medical experiences [sic] as [sic] one of the identified disciplines." Dkt. 22-1 at 4. This might be a significant change if the identified

[2] It may be theoretically possible for one person to be . However, since a this seems the least plausible meaning Mr. Zmuda intended to assign the ,

Zmuda asserts that the Medical Team in place has participated in 10 training sessions this year "involving live sticks." Dkt. 22-1 at 9. Significantly, though, Zmuda does not state how many of these "sticks" were successful. The point is not the stick, but the insertion of an IV into a blood vessel and the maintenance of that IV in the blood vessel. Zmuda's highly ambiguous language fails to provide any assurance that safeguards substantially similar to those in *Baze* are in place.

3. Inadequate On-Site Training.

Plaintiff does not dispute Defendants' statement that the 2012 Protocol "articulates an annual training schedule and periodic on-site rehearsal sessions." Dkt. 22 at 18. But neither this statement nor any other in Defendants' Opposition addresses the factual basis for Plaintiff's assertion that the 2012 Protocol's on-site training requirement is deficient. In the Motion, Plaintiff stated:

> The 2012 Protocol's in-house training provision does not require that the training sessions involve anyone other than Medical Team members. Consequently, there is no requirement that the training be conducted by someone with the necessary skills which, in accord with the 2012 Protocol, every Medical Team member may lack.

Dkt. 16-1 at 20. As shown above, the Medical Team members—theoretical and actual—need not have relevant training and experience. Therefore, the 2012 Protocol's on-site training requirement does provide any assurance that safeguards substantially similar to those in *Baze* are in place.

Defendants make much of the fact that the Medical Team in place for Plaintiff's execution consists of the same individuals who executed Mr. Rhoades in November, 2011. Dkt. 22 at 16; Dkt. 22-1 at para. 32. Presumably, the point is that, as Defendant Zmuda asserts, "no problems relating to the implementation of [the 2011 Protocol] arose during the actual execution

that required any deviation from the" protocol. Dkt. 22-1 at 10. Even interpreting and crediting Zmuda's statement to mean that Mr. Rhoades did not experience severe pain, it does not reduce the clear and substantial *risk* that Mr. Leavitt will experience severe pain if the IVs are initiated and the pentobarbital administered by individuals without training, experience and competency in initiating and administering drugs via IVs. Just as execution botches can be isolated instances which occur even though the protocol does not create a clear risk of severe pain, so too can a non-botched execution occur even though the protocol does create a clear risk of severe pain. *Baze* focuses on the risk, not on isolated outcomes.

4. The 2012 Protocol Lacks Meaningful Redundancy.

Defendants do not address Plaintiff's point that the 2012 Protocol does not require meaningful redundancy. In his Motion, Plaintiff asserted:

> The 2012 Protocol likewise [i.e., like the protocol at issue in *Baze*] requires a backup IV, and backup chemical preparation and readiness as well.[3] Dkt. 1-7, Exh. 1. However, it does not require that the individuals initiating, maintaining, or delivering chemicals through the IV have any relevant training and experience in doing so. Where no such training and experience requirements exist, such as in Idaho, the redundancies do not become a safeguard. Having that same untrained and inexperienced person do the task twice does not materially improve the chances of it being done correctly.

Dkt. 16-1 at 21. In response, Defendants again note that the Medical Team in place for Plaintiff's execution consists of the same individuals who executed Mr. Rhoades last year. But for all the reasons above, this redundancy does not reduce the clear and substantial risk that Mr. Leavitt will experience severe pain if executed by the Medical Team now in place. Medical Team members M-2 through M-5 are responsible for initiating the IVs and administering the

[3] Curiously (and wrongly, as the block quote establishes) Defendants assert that Plaintiff argues that the 2012 Protocol "does not require a backup IV, and backup chemical preparation and readiness[.]" Dkt. 22 at 20.

drugs, but they need not have either the training or experience necessary to ensure their competence in their assigned tasks.

5. The 2012 Protocol Allows For A "Cut Down" To Establish A Central Line.

The 2012 Protocol allows "the Medical Team leader [to] direct Medical Team members to place an IV catheter in a central line for the purpose of administering the chemicals." Dkt.1-7, Exh. 1, appendix A at 7. A central line is "a catheter that would be placed in a much larger vein [, typically] in the groin, the inner thigh of the offender and that's a catheter that reaches up into the upper abdomen and is a much larger catheter than a peripheral IV catheter." Dkt. 1-8, Exh. 7 at 29 (testimony of Mark Heath, M.D.). The 2012 Protocol mandates no specific method(s) for establishing a central line. Instead, there is only one constraint on how the Medical Team may establish a central line: "The Medical Team member will place the central line catheter *utilizing appropriate medical procedures.*" *Id.* at 8 (emphasis added). Defendant Zmuda contends that the 2012 Protocol does not explicitly provide for a cutdown procedure. Dkt. 22-1 at para. 3b. Defendant Zmuda does not hold himself out as having medical expertise. Nor does his affidavit state that any medical expert or member of the Medical Team has advised him that a "cutdown" is not an appropriate medical procedure for establishing a central line. Indeed, as the Court is aware, the Supreme Court addressed using a cutdown to establish a central line, stating that it should "be performed only by a trained physician in a clinical environment with a patient under deep sedation." *Nelson v. Campbell*, 541 U.S. 637, 642 (2004) (paraphrasing affidavit of Mark J.S. Heath, M.D., an anesthesiologist). Clearly, a cutdown may be a medically appropriate way to establish a central line. While Defendant Zmuda is correct that the 2012 Protocol does not explicitly provide for a cutdown procedure, the fact that it does not prohibit the cutdown coupled

with the fact that cutdowns may sometimes be a medically appropriate way to establish a central line in some circumstances shows that Zmuda's assertion does not rebut Plaintiff's argument.

6. If The Court Denies Plaintiff's Emergency Motion Based On The Qualifications Of The Actual Executioners, It Should Order Defendants To Notify Petitioner Of Any Changes To The Medical Team Composition.

For the reasons above and those in the Emergency Motion, the 2012 Protocol is not substantially similar to *Baze*. Defendants argue that the qualifications of the actual executioners assigned to the Medical Team ensures that the actual protocol by which they propose to execute Mr. Leavitt is substantially similar to the protocol approved in *Baze*. Because Defendant's argument is specific to the actual Medical Team in place for Leavitt's execution, it necessarily fails should the Medical Team membership change. For this reason, if the Medical Team membership changes regarding those who will initiate and/or administer the drugs through IV, Mr. Leavitt has a due process right to examine the credentials of the new members and object and be heard in this Court. Changes in team membership may mean that the actual protocol by which Defendants propose to execute Mr. Leavitt is not substantially similar to that approved in *Baze*. Plaintiff, therefore, moves that the Court order Defendants to immediately notify undersigned counsel of any Medical Team membership changes regarding who will initiate and/or administer the drugs through an IV.

B. Defendants Are Not Subjectively Blameless For Eighth Amendment Purposes.

Defendants assert that, "In November 2011, the Idaho [Federal] District Court held that the 2011 SOP 135 substantially complied with the *Baze* standards, which was subsequently affirmed by the Ninth Circuit Court of Appeals." Dkt. 22 at 22. Even Defendants recognize, though, that this statement is wrong. Elsewhere in their Opposition, Defendants note that the District Court held that:

> [The 2011 Protocol] does not state that the Medical Team members have at least one year of professional training and practical experience, however, all Medical Team members selected for the preparation of chemicals have at least one year of professional training and practical experience necessary to prepare the chemicals. [] With Zmuda's testimony in mind, this Court cannot agree with Plaintiff that [the 2011 Protocol's] Medical and Injection Team members do not (or, in the case of replacements, will not) have the requisite medical credentials and experience over time.

Dkt. 22 at 18 (quoting *Rhoades*, 2011 WL 5520446 at 8-9). In *Rhoades*, the IDOC proffered an affidavit from Defendant Zmuda, contending that it established that in light of the actual executioners' credentials and experience, the protocol by which it planned to kill Mr. Rhoades was substantially similar to that approved in *Baze*. Defendants deploy the same strategy here, one which Ninth Circuit Court of Appeals very recently found uniquely frustrating and which seven Ninth Circuit judges criticized with unusually harsh language. *Lopez v. Ryan*, 2012 WL 1693926 (9th Cir. 5/15/2012), Dkt. 16-1 at 4-9. Continuing to deploy this strategy of filing last-minute affidavits to overcome the written protocol's deficiencies is bad faith in action: In January of this year, Defendants chose to implement the 2012 Protocol with the same material deficiencies present in their October, 2011 protocol, apparently intending to file a last-minute curing affidavit. Defendants' failure to implement a constitutionally adequate execution protocol was in bad faith and unquestionably increases the likelihood of a substantial risk of harm to Mr. Leavitt.

C. Absent A Stay, Mr. Leavitt Will Suffer Irreparable Harm.

Irreparable harm absent a stay is incorporated in the *Baze* stay standard. Because the *Baze* safeguards are not incorporated in the 2012 Protocol and because Defendant Zmuda's affidavit does not cure that deficiency, a substantial likelihood exists that Mr. Leavitt will suffer irreparable harm—severe pain and suffering—should his execution move forward.

D. The Balance of Equities Strongly Tips In Mr. Leavitt's Favor.

Defendants' argument here fails for the same reasons that their argument regarding subjective blamelessness fails: Defendants chose to implement the 2012 Protocol with the same material deficiencies present in the October, 2011 protocol, apparently intending to file a last-minute curing affidavit.

E. An Injunction Or Stay Is In The Public Interest.

Plaintiff does not dispute Defendants' contention that the citizens of the State of Idaho and the victim's survivors have a compelling interest in seeing that Idaho's lawful judgment is enforced.[4] Defendants' contention does not contradict Plaintiff's position that, "[T]he public has a fundamental interest in the protection of all people's constitutional rights." *Klein v. City of Laguna Beach*, 381 Fed.Appx. 723, 727 (9th Cir. 2010) (citing to *Sammartano v. First Judicial Dist. Ct.*, 303 F.3d 959, 973 (9th Cir. 2002). The reason there is no contradiction here is that the State of Idaho and the victim's survivors have *no* interest in the unlawful enforcement of Idaho's lawful judgments. If Idaho is to exact the ultimate penalty, it should only do so in a humane manner, without imposing on Mr. Leavitt a clear and substantial risk that his execution will be severely painful. The strong public interest is in an orderly and deliberate decision of the important issues raised in this case.

F. This Is Not A Prisoners Litigation Reform Act Lawsuit, But The Eighth Amendment Trumps The PLRA In Any Event.

Defendants argue that an injunction or stay is not available under the Prisoners Litigation Reform Act ("PLRA"). However, because Plaintiff's claims concern his execution rather than prison conditions, the PLRA has no application. If the PLRA does apply, Plaintiff's Fourteenth

[4] Plaintiff in no way concedes that the judgment against him is lawful. He is now seeking relief from the Court's final judgment. *See Leavitt v. Arave*, Case No. 03-024, Dkt. 318 (D. Idaho 5/11/2012) (Motion for Relief from Judgment Pursuant to Fed.R.Civ.P. 60(b)).

Amendment right to due process and Eighth Amendment right against cruel and unusual punishment trump any preclusion of a stay of execution which the PLRA may purport to create.

G. Conclusion.

Mr. Leavitt meets his burden for an injunction or stay. The 2012 Protocol creates a demonstrated risk of severe pain in violation of the Eighth Amendment. In light of this, the Court should issue a preliminary injunction or stay of execution pending the resolution of this lawsuit.

Respectfully submitted this 1st day of June, 2012.

Samuel Richard Rubin

/s/
Oliver W. Loewy
Teresa A. Hampton
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on the 1st day of June, 2012, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

Krista Howard
khoward@idoc.idaho.gov

/s/
Oliver Loewy

EXHIBIT 1

EXHIBIT 1

IN THE SUPERIOR COURT OF FULTON COUNTY

STATE OF GEORGIA

ROY WILLARD BLANKENSHIP,

PLAINTIFF,

BRIAN OWENS, IN HIS CAPACITY AS COMMISSIONER OF THE GEORGIA DEPARTMENT OF CORRECTIONS; CARL HUMPHREY, IN HIS CAPACITY AS WARDEN OF THE GEORGIA DIAGNOSTIC PRISON; DOES 1-50, UNKNOWN EXECUTIONERS. IN THEIR CAPACITIES AS EMPLOYEES AND/OR AGENTS OF THE GEORGIA DEPT. OF CORRECTIONS.

DEFENDANTS.

CIVIL ACTION FILE
NO: 2011CV202236

VOL. 1
*****

TRANSCRIPT OF PROCEEDINGS IN THE ABOVE-ENTITLED AND NUMBERED CAUSE, HEARD BEFORE THE HONORABLE WENDY L. SHOOB, FULTON COUNTY, GEORGIA, ON JUNE 21, 2011.

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A P P E A R A N C E S:

ON BEHALF OF THE PLAINTIFF: BRIAN KAMMER, ATTORNEY AT LAW

LYNN PEARSON, ATTORNEY AT LAW

ON BEHALF OF THE DEFENDANTS: JOSEPH DROLET, ATTORNEY AT LAW

BETH A BURTON, ATTORNEY AT LAW

CHRISZANIER D. REID, CCR NO. B-1092
OFFICIAL COURT REPORTER
ATLANTA, FULTON COUNTY, GEORGIA

DR. DAVID WAISEL.

THE SHERIFF: COULD YOU RAISE YOUR RIGHT HAND PLEASE?

THE WITNESS: (COMPLIES WITH REQUEST).

THE SHERIFF: DO YOU SWEAR OR AFFIRM THE TESTIMONY YOU ARE ABOUT TO GIVE TODAY IN COURT IS THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH SO HELP YOU GOD?

THE WITNESS: I AFFIRM.

THE SHERIFF: PLEASE HAVE A SEAT AND STATE YOUR NAME AND SPELLING IT FOR THE RECORD.

THE WITNESS: MY NAME IS DAVID WAISEL. W-A-I-S-E-L.

MR. KAMMER: MAY I APPROACH THE PODIUM, YOUR HONOR?

THE COURT: YES, SIR.

DR. DAVID WAISEL,

HAVING BEEN DULY SWORN, WAS EXAMINED AND TESTIFIED AS FOLLOWS:

DIRECT EXAMINATION

BY MR. KAMMER:

Q. GOOD MORNING.

A. GOOD MORNING.

Q. DR. WAISEL, CAN YOU TELL US WHERE YOU ARE COMING FROM TODAY PLEASE?

ANESTHESIOLOGY. AT TIMES THERE ARE CERTIFIED REGISTERED NURSE ANESTHETISTS, WITH TRAINING AND PRACTICE IN THESE AREAS, WHO ARE RIGHT IN THE FRONT LINE WITH THE PHYSICIAN BEING AVAILABLE FOR CONSULTATION AND FOR COMPLEX MATTERS. HOW TO RESPOND TO THE CASES. OTHER TIMES IT'S A PHYSICIAN. OTHER TIMES IT'S A TRAINEE WHO IS A PHYSICIAN WHO IS LEARNING OF THE SPECIAL EVENTS THAT'S GOING ON.

Q. AND IN THE OPERATING ROOM WHERE ARE THOSE PEOPLE PHYSICALLY IN RELATION TO THE PATIENT?

A. ONE OF US IS ALWAYS A FOOT OR TWO AWAY FROM THE PATIENT. OFTENTIMES BOTH PEOPLE.

Q. DO YOU EVER TOUCH THE PATIENT?

A. FREQUENTLY.

Q. AND WHY DO YOU DO THAT?

A. ASSESSMENT. I MIGHT BE ASSESSING THE PATIENT'S TEMPERATURE. I MIGHT BE ASSESSING A CONCERN WITH THE I.V. AS INFILTRATED. PALPATING THE SITE IS ONE OF THE BEST MECHANISMS WE HAVE FOR HELPING MAKE THAT ASSESSMENT.

Q. WHAT DOES THAT MEAN, PALPATING THE SITE?

A. TOUCHING. EXAMINING BOTH VISUALLY AND WITH MY HANDS.

Q. HOW WOULD YOU DO THAT WITH YOUR HANDS?

A. I'M LOOKING FOR SEVERAL THINGS. WELL, LET

ME STEP BACK FOR A MOMENT. WHAT HAPPENS WHEN AN I.V. INFILTRATES IS THE FLUID GOES INTO THE SOFT TISSUE UNDER THE SKIN. DEPENDING ON YOUR SIZE A GREAT DEAL OF FLUID CAN ACCUMULATE IN THERE BEFORE YOU HAVE SIGNIFICANT RESISTANCE. OR BEFORE YOU BURN. SO WHEN I PALPATE I'M LOOKING FOR SEVERAL THINGS. I'M LOOKING FOR A SWELLING IN THAT AREA WHICH CAN BE VERY SUBTLE. I AM FEELING FOR COOLNESS IN THAT AREA WHICH MAY INDICATE DISTRIBUTION OF THE I.V. FLUID RIGHT AT THAT SITE. I AM ASSESSING TO SEE IF I PINCHED THE VEIN -- OBSTRUCTED THE VEIN. PINCH IS NOT THE PROPER TERM -- HIGHER UP. DOES THAT STOP THE I.V. FLOW. WHICH IT SHOULD IF THE I.V. IS IN THE VEIN. AND IF IT'S NOT IF IT'S INFILTRATED AND I THINK MOST ANESTHESIOLOGISTS -- I KNOW MYSELF -- HAVE A VERY LOW THRESHOLD FOR REPLACING THE I.V. BECAUSE INFILTRATED I.V. -- IN ADDITION TO NOT WORKING -- CAN CAUSE A GREAT DEAL OF PAIN.

Q. I WANT TO ASK YOU ABOUT THAT. BUT JUMPING BACK YOU SAID YOU HAVE A VERY LOW THRESHOLD FOR REPLACING THE I.V., CAN YOU EXPLAIN THAT A LITTLE BIT MORE? WHAT DO YOU MEAN BY THAT?

A. EVEN AMONG EXPERIENCED HANDS IT'S SOMETIMES HARD TO TELL. ESPECIALLY IN LARGER PEOPLE. BECAUSE WE KNOW WE CAN'T TELL AND BECAUSE WE KNOW IT IS HARMFUL TO THE PATIENT, WE WOULD RATHER ERR ON THE SIDE OF SAFETY

AND REPLACE IT AND OBTAIN INTRAVENOUS LINE THAT WE ARE MORE CONFIDENT IN.

Q. AND YOU SAID THAT INFILTRATION IS PAINFUL, WHY IS THAT?

A. FOR A NUMBER OF REASONS. THE STRETCHING OF THE TISSUE. WHICH SKIN HAS AN INCREDIBLY AMOUNT OF NERVE ORGANS AND IF YOU STRETCH IT EXCRUCIATING PAINFUL. IN ADDITION SOME MEDICATIONS, WHEN YOU GO IN THE SOFT TISSUE, BURN EXTREMELY AND RATHER EXCESSIVELY. PATIENTS REPORT EXTRAORDINARY PAIN.

Q. AFTER YOU SET THE I.V. IS IT POSSIBLE FOR AN I.V. TO SHIFT AND INJECT CHEMICAL INTO THE ISSUE?

A. YES.

Q. AND IS THAT WHAT YOU'RE LOOKING FOR?

A. YES.

Q. DO YOU KEEP A CONSTANT FLOW OF ANESTHESIA DURING THE SURGERY?

A. YES.

Q. AND WHY IS THAT?

A. WHEN WE EXPLAIN TO PATIENTS HOW THE ANESTHESIA WORKS WE LIKEN IT TO DRIVING A CAR. YOU PUSH ON THE GAS AND THEN WHEN YOU ARE DONE TAKE YOUR FOOT OFF THE GAS AND IT COMES TO A STOP. MANY OF THE AGENTS WE USE, ONE, WORK FOR A SHORT PERIOD OF TIME. SO WE DON'T WANT THE PATIENT TO WAKE UP DURING THE CASE; AND, TWO,