IN THE COURT OF COMMON PLEAS OF BLAIR COUNTY, PA

CIVIL DIVISION

* * * * * * * ORIGINAL

ALFRED VELOZ, *

Plaintiff * No. 1996 CP 747

vs. *

JOHN ANASTASI, M.D., and *

THE ALTOONA HOSPITAL, *

Defendants *

* * * * * * *

DEPOSITION OF

JOHN S. ANASTASI, M.D.

FEBRUARY 18, 1997

DEPOSITION

OF

JOHN S. ANASTASI, M.D., taken on behalf of the Plaintiff herein, pursuant to the Rules of Civil Procedure, taken before me, the undersigned, Denise J. Khorey-Harriman, a Registered Merit Reporter and Commissioner of Deeds in and for the Commonwealth of Pennsylvania, at the law offices of Pfaff, McIntyre, Dugas & Hartye, 1816 Old Route 220 North Business, Duncansville, Pennsylvania, on Tuesday, February 18, 1997, at 12:35 p.m.

APPEARANCES

WILLIAM S. SCHWEERS, JR., ESQUIRE
Harrington, Schweers, Dattilo & McClelland, P.C.
100 Ross Street
Pittsburgh, PA 15219
COUNSEL FOR PLAINTIFF

GILES J. GACA, ESQUIRE
Gaca, Matis & Baum
300 Four PPG Place
Pittsburgh, PA 15222
COUNSEL FOR DEFENDANT, JOHN ANASTASI, M.D.

FRANK J. HARTYE, ESQUIRE
Pfaff, McIntyre, Dugas & Hartye
P.O. Box 533
Hollidaysburg, PA 16648
COUNSEL FOR DEFENDANT, ALTOONA HOSPITAL

I N D E X

EXHIBITS:

NUMBER	IDENTIFICATION	PAGE IDENTIFIED
One	Curriculum Vitae	7

OBJECTION PAGE

ATTORNEY	PAGE

NONE MADE

P R O C E E D I N G S

- -

JOHN ANASTASI, M.D., HAVING FIRST BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

- -

EXAMINATION

BY ATTORNEY SCHWEERS:

Q. Good morning, Doctor. Good afternoon, I guess.

A. Yeah.

Q. Would you state your name for the record?

A. John M. Anastasi.

Q. Okay. I have been provided with a copy of your CV by Mr. Gaca, and I take it that it is an accurate and current CV; is that correct?

A. That's correct.

ATTORNEY SCHWEERS:

I'd like to have it attached to the deposition as an exhibit.

(Deposition Exhibit A marked for identification).

BY ATTORNEY SCHWEERS:

Q. Do you know a Doctor James R. Elmore?

A, Yeah.

Q. Prior to the time that you made a

recommendation for surgery for Mr. Veloz, you would have reviewed yourself the angiograms performed at Altoona Hospital?

A. Correct.

Q. What is a string sign?

A. What is a string sign?

Q. Yes.

A. Related to what?

Q. To a finding on angiogram of the carotid artery.

A. The term string sign is an anatomical one. It's a term used by some radiologists and others not.

Q. Okay.

A. So I don't really know what one would mean and what another --- it means different things to different people.

Q. Oh. On your review of the angiography, and feel free to review whatever papers you need to ---

A. Uh-huh (yes).

Q. --- if you'd like, did the left internal carotid artery appear to be very diseased?

A. Yes, very diseased.

Q. And did this disease process go all the way up into the carotid siphon on the left side?

A. Yes, there was a very severe blockage of

the carotid artery, and it appeared to be a trickle of blood flow going up towards the brain.

Q. **Did** the disease process, however, go all the way up into the carotid siphon?

A. I have no way of knowing that.

Q. The angiogram would not reveal that?

A. You can only see what the dye fills, and the dye was not completely filling above the bifurcation. So I don't really have any idea of what the carotid siphon looked like.

Q. Okay. Would a carotid artery that was diseased to the extent that the disease process went up into the carotid siphon be one which is amenable to carotid endarterectomy?

A. I'm not certain what you mean by the question.

Q. Well, there are indications for carotid endarterectomy; are there not?

A. Uh-huh (yes). Yes.

Q. And there are relative and absolute possible limitations to carotid endarterectomy?

A. Uh-huh (yes).

Q. In some patients the disease may be located in or in a location in the carotid artery that would make it appropriate to intervene surgically; correct?

A. Correct.

Q. Now, are there conditions concerning the location of the disease that could be described as a condition which would make the carotid not amenable to endarterectomy?

A. Yes.

Q. Okay. What would those include?

A. If it was totally occluded.

Q. And what if the disease process went up into the carotid siphon?

A. Again, there's no way you can tell that if you can't see it.

Q. Okay. Well, what if you could see it? What would that indicate *to* you?

A. I'd be guessing. I'd have to take a look at the arteriogram. There's a lot more that goes to it than just a picture.

Q. Okay. In 1994 was carotid endarterectomy for any patient, no matter where the disease was located, somewhat controversial concerning its efficacy?

A. Was there any question that a carotid endarterectomy was helpful in patients, is that what you're asking me?

Q. Yes.

A. With specific indications, no, I don't think there was any controversy there.
Q. Okay. Now, do you have your office notes?
A. Uh-huh (yes), which are you referring to?
Q. You saw Mr. Veloz for the first time on April 25, 1994?
A. Correct.
Q. And at that time you wrote a letter to Doctor Hommer?
A. Uh-huh (yes).
Q. Was it your understanding that Doctor Hommer had referred Mr. Veloz to you?
A. That's correct.
Q. And did you indicate in your letter of April 25 to Doctor Hommer that you were concerned that the vessel could not be endarterectomized?
A. I did at that time.
Q. And that there was a possibility that surgery could not be done after the artery was physically examined?
A. Uh-huh (yes), that's correct.
Q. All right. Now, during the course of this surgery, you physically examined the artery, obviously, and did you determine that endarterectomy could be performed?

A. When I felt the vessel, it felt pretty hard to me. I did find one area above an internal that did feel soft, and there was an idea in my mind that it could possibly be opened to improve flow.

Q. Okay. Your operative note ---

A. Uh-huh (yes). Okay.

Q. --- indicates that the internal carotid was small and very fibrodiseased?

A. No, that's fibromuscular, is what it --- the dictation is not correct.

Q. It indicates after endarterectomy was completed and all debris removed a vein pack was summoned?

A. Uh-huh (yes), vein patch it should say.

Q. Vein patch. An endarterectomy then was performed and completed?

A. Uh-huh (yes). That's correct.

Q. So that this was a vessel that you felt intraoperatively could be endarterectomized?

A. That's correct.

Q. Now, in your May 9th letter to Doctor Poon, ---?

A. I don't have it. Do you have it ---?

Q. Here, take my copy.

A. Okay.

Q. In the second paragraph of that letter, you wrote that the endarterectomy was unsuccessful, the carotid was totally occluded. When did you determine that the carotid was totally occluded?

A. On the first day post-op when I completed the non-invasive study.

Q. And was it also at that time that you determined that the endarterectomy was unsuccessful?

A. If it was totally occluded, it wasn't open.

Q. Right. And that was based on a Doppler that was done?

A. Correct.

Q. On post-operative day number one?

A. Correct.

Q. Now, as earlier indicated, you saw Mr. Veloz for the first time on April 25 and surgery was performed three days later on the 28th.

A. Uh-huh (yes).

Q. With regard to the carotid endarterectomy, did you feel that this was urgent surgery?

A. I felt that he had a 99 percent blockage of his carotid and that if the carotid was open, that he had only one percent of flow going up there. If it closed, he'd have a major stroke. So in that case, it might be urgent.

Q. If his carotid was totally occluded, was he guaranteed to have a stroke or was he at risk for having a stroke?

A. At which ---?

Q. If the carotid, the left carotid became totally occluded?

A. If it became totally occluded?

Q. Yes.

A. Most individuals who occlude, totally occlude a carotid, will have a stroke. Some do not. It depends on what period of time it occurs over ---

Q. I see.

A. --- and the development of the collaterals.

Q. All right. You had indicated earlier that one of the contraindications to doing carotid endarterectomy was total occlusion?

A. Correct.

Q. All right. Why is that a contraindication?

A. Because if the vessel is totally occluded at the internal, one presumes the disease goes all the way up to the brain, and there's no way you can endarterectomize everything up to the brain.

Q. I see. And wouldn't that be true of someone who is 99 percent occluded?

A. That's absolutely not true.

Q. Okay. Now, there are certain risks attendant to the performance of this procedure.
A. Uh-huh (yes).
Q. And did you feel that the possible benefits of this procedure outweigh those risks?
A. I wouldn't have operated on him if I didn't think that.
Q. Now, Mr. Veloz had an echocardiogram done prior to surgery, did you order that test?
A. I did.
Q. And why did you order that test?
A. I routinely order echocardiograms on my vascular patients.
Q. Okay. And you were told that the echo was abnormal?
A. Correct.
Q. And by whom were you told that?
A. By Doctor Brandt, who read the echo.
Q. And did you read the echo?
A. I personally? Did I personally read the echo?
Q. Yes.
A. I read the report. I did not personally read the echo.
Q. And Doctor Brandt felt that there was a

mass in the right atrial chamber ---
A. Correct.
Q. --- and recommended further evaluation with MRI and TEE?
A. Correct.
Q. And both of those tests were performed?
A. Correct.
Q. The MRI was negative?
A. That's correct.
Q. And the TEE demonstrated an abnormality?
A. A mass.
Q. Now, during surgery, the heart was explored?
A. Uh-huh (yes).
Q. The atrium was examined, and there was no mass.
A. Uh-huh (yes).
Q. Subsequent to surgery, an echocardiogram was performed ---
A Uh-huh (yes).
Q. --- and did not show the mass?
A. I'm not certain if an echo was done post-operatively or not.
Q. Okay. Well, let me see if I can find it. During your surgery, did you find anything in the

chest, in the area of the heart, which could account for the findings on echo and transesophageal echo ---?

A. I did not find a large tumor or mass there.

Q. I understand that.

A. Uh-huh (yes).

Q. But did you find anything that could account for the echocardiogram ---?

A. I'm not a specialist in echo, so I don't know what the --- you know, what their signals are and what they see. I did not find anything. I do remember, and I'm only reminded of this by what Mr. Veloz said, I do remember that one of the atrial walls appeared to be thickened to me, and that might explain what they saw, but that was it.

Q. Let's see. Here's a report dated May 4, 1994, an echo Doppler report (indicating .

A. Okay.

Q. And it indicates that you were the ordering doctor.

A. Uh-huh (yes).

Q. And here's another one done May 6th (indicating). Now, do those reports demonstrate any finding that would be consistent with a mass on the atrium?

A. No, I don't see it here.
Q. Okay. Can you explain how or why the pre-operative echo demonstrated a mass and the post-operative echo no mass?
A. I can't explain.
Q. After your surgery and it was determined that no mass was present, did you discuss that finding with Doctor Brandt?
A. I don't recall if we discussed it or not.
Q. Did anyone, to your knowledge, go back and take a second look at the echo that was done on 4/25?
A. I remember Doctor Poon and Doctor Brandt both looking at both the TEE and the transthoracic even after the other echos and saying it is definitely here.
Q. Did you speak to Doctor Poon about his findings, his pre-operative findings?
A. Before the surgery?
Q. After the surgery.
A. I don't recall if we had any discussion about that. I know I called him and told him I didn't find a tumor.
Q. Well, now, when did this incident occur you just described where Doctor Brandt and Doctor Poon said that something was definitely there?

A. I remember when I told him that there was no tumor, I remember the two of them getting together and relooking at the echos and saying that they definitely --- that there was no question, that there was something there.

Q. Okay. And you weren't present when that was done?

A. I don't think I was.

Q. You were told that it was done?

A. Right.

Q. Your office note of April 27, '94, describes a conversation that you had with Barbara Veloz.

A. Uh-huh (yes).

Q. Do you know, can you recall why you had a discussion with Mrs. Veloz about various findings and reported that as opposed to any discussion that you may have had with Mr. Veloz?

A. I believe they were both together at the time. I always make a point of making a reference that I discussed it with a family member, that's just my practice.

Q. And the transcriptionist, JKL, ---

A. Uh-huh (yes).

Q. --- who is that?

A. Janet Lee.
Q. She's still a member of your office staff?
A. No.
Q. Why was the endarterectomy unsuccessful?
A. Because the non-invasive study afterwards showed it was totally occluded.
Q. Did that occur after the endarterectomy?
A. It must have.
Q. Now, subsequent to the surgical procedure, Mr. Veloz developed a pericardial fusion ---
A. Uh-huh (yes).
Q. --- that required drainage?
A. Uh-huh (yes).
Q. Do you know what caused the pericardial fusion?
A. Probably the institution of Heparin in the patient about two or three days post-op.
Q. It was on May 2nd of 1994 that Mr. Veloz developed his episode of right-sided weakness and aphasia?
A. I think that's correct. Do you have the office note, do you want me to confirm that?
Q. Yes, that's what the record indicates, ---
A. Okay.
Q. --- you can take my word for that. Do you

know what caused that episode?
A. I believe that he had developed some hypotens --- blood pressure was around 80 or 90 at that time, and I believe I felt it was secondary to the Tenormin that he was given, and I think when his blood pressure dropped, since his collateral circulation wasn't the best, he had symptoms.
Q. And Tenormin was given for what condition?
A. He must have had a tachycardia on day two or three, whenever it was started, his heart rate was fast, so he was placed on some Tenormin to slow it down.
Q. Doctor Lukacs' consultation report ---
A. Uh-huh (yes).
Q. --- indicates that he was consulted by you because of an apparent new stroke. Did you think at the time that that was --- first of all, what is Doctor Lukacs' specialty?
A. Neurology.
Q. Did you think at the time that he was consulted that Mr. Veloz had developed a new stroke?
A. I consulted with him because he was unable to move. He was weak on his right side, and he was having difficulty speaking and that was different from what he had been for the last three days.

Q. At the time of Mr. Veloz' discharge did you feel that he had not had a stroke?
A. That's correct. No CAT Scan showed any evidence of stroke, and clinically he had no manifestations of a stroke.
Q. Okay. So that those symptoms, the right-sided weakness, and his inability to speak, ---
A. Uh-huh (yes).
Q. --- you felt were related to a reaction to medication?
A. I think it was related to his hypotension and his cerebral circulation. I don't think it was a reaction to a medicine --- like a side effect to medication or allergy.
Q. Okay. Perhaps I misunderstood what you said, Doctor. I thought that you had indicated that the Tenormin had influenced what had happened.
A. His blood pressure was lower than what it normally was. He was given Tenormin, Tenormin lowers blood pressure as well as lowers the heart rate. When his blood pressure dropped, I believe it compromised his circulation in his brain, and he had the symptoms that he had. They resolved when his blood pressure was brought up again. That's --- you can call that a TIA or a transient ischemic attack or

a small stroke, but there was no brain damage associated with it, and he came out of it and he had no CAT Scan evidence of any stroke.

Q. Just one more question about your May 9 letter. We know that echocardiogram was ordered post-operatively, and you indicate in your letter to Doctor Poon that should this significant lesion continue to be seen on his right atrium, I would suggest repeating another transesophageal echocardiogram at another facility as well as a repeat MRI for the sake of completeness.

A. Uh-huh (yes).

Q. Why were you suggesting a repeat of those tests in the event that that finding should reappear?

A. Just that I felt that they were so confident that there was something on the TEE and on the transvasic echo. I did not find it, and if it did show up again, if on the repeat echo it showed up again, then I think that it should be done at another facility to make certain that it isn't the testing or whatever else is going on.

Q. And repeat testing was done and was found to be negative for a mass?

A. On the echos that we had, yeah, nothing was seen on those.

Q. When you heard from Doctors Poon and I forget his ---

A. Brandt.

Q. --- Brandt, that they went back and reviewed the pre-operative echos, did they offer any explanation for what it was they saw?

A. No. They were surprised to hear that there was nothing there.

Q. And Doctor Poon is a cardiologist?

A. Correct.

Q. Doctor Brandt?

A. Cardiologist.

Q. Cardiologist.

ATTORNEY SCHWEERS:

Just give me one second here, I'll talk to Mr. Veloz.

OFF RECORD DISCUSSION

ATTORNEY SCHWEERS:

Okay. That's all.

ATTORNEY GACA:

Okay. We want him to read it, please.

* * * * * * *

DEPOSITION CONCLUDED AT 1:12 P.M.

* * * * * * *

COMMONWEALTH OF PENNSYLVANIA:

: SS

COUNTY OF CAMBRIA

C E R T I F I C A T E

I, Denise Jeanne Khorey-Harriman, Notary Public in and for the Commonwealth of Pennsylvania, do hereby certify:

That the witness was hereby first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the foregoing deposition was taken at the time and place stated herein; and that the said deposition was taken in Stenotype by me and reduced to typewriting, and constitutes a true and correct record of the testimony given by the witness.

I further certify that the reading and signing of said deposition were (not) waived by counsel for the respective parties and by the witness.

I further certify that I am not a relative, employee or attorney of any of the parties, nor a relative or employee of counsel, and that I am in no way interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and stamp this 9 day of April, 97.

Denise Jeanne Khorey-Harriman

NOTARIAL SEAL
Denise Jeanne Khorey-Harriman, Notary Public
Cambria County, Pennsylvania
My Commission Expires Mar. 5, 2001

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Sargent's Correction Page

Page Number	Line Number	Error	Correction	Reason
7	24A	Vlatt	no	I Do not Know Him
20	15	fusion	effusion	spelling error
~~12A~~				
			I believe I said	
			no to the Disputa	
7	12A	M	S	Mediterranean -
				salvadore

I HAVE READ THE TRANSCRIPT OF MY TESTIMONY AND CERTIFY IT IS ACCURATE WITH THE ABOVE CORRECTIONS

John Anastasi, Deposition on 2/18/97

H. Barton Hall

Notary Public

H. Barton Hall, Notary Public
Altoona, Blair County
My Commission Expires May 31, 1997
Member, Pennsylvania Association of Notaries

IN THE COURT OF COMMON PLEAS OF BLAIR COUNTY, PA

CIVIL DIVISION

* * * * * * *

MARY FORR, Administratrix *
of the Estate of RALPH T. *
FORR, SR., Deceased, * NO. 95-CA-1115
Plaintiff *
vs. *
BERNARD FAZI, M.D.; JOHN *
S. ANASTASI, M.D.; *
CARDIOVASCULAR THORACIC *
ASSOCIATES, INC.; JOHN M. *
DINGER, M.D.; ALTOONA *
ANESTHESIA ASSOCIATES; *
GLORIA KOLONICH, C.R.N.A., *
and ALTOONA HOSPITAL, *
Defendants *

* * * * * * *

Deposition of: JOHN S. ANASTASI, M.D.

July 17, 1996

DEPOSITION OF

JOHN S. ANASTASI, **M.D.**

Taken on behalf of the Plaintiff herein, pursuant to the Rules **of** Civil Procedure,'taken before me the undersigned, Tammie B. Elias, a Registered Professional Reporter and Notary Public in and for the Commonwealth of Pennsylvania, at the law offices of Jubelirer, Carothers, Krier & Halpern, 10 Sheraton Drive, Altoona, Pennsylvania, on Wednesday, July **17**, 1996, at 2:10 p.m.

APPEARANCES

COUNSEL FOR PLAINTIFF:	JACK E. FEINBERG, ESQUIRE Feinberg & Silva Suite 1805 2000 Market Street Philadelphia, PA 19102
COUNSEL FOR DEFENDANT: (Dr. Dinger & Altoona Anesthesia Associates)	M. DAVID HALPERN, ESQUIRE Jubelirer, Carothers, Krier & Halpern 10 Sheraton Drive P.O. Box 2024 Altoona, PA 16602
(Gloria Kolonich & Altoona Hospital)	FRANK J. HARTYE, ESQUIRE Pfaff, McIntyre, Dugas & Hartye P.O. Box 533 Hollidaysburg, PA 16648
(Dr. Fazi, Dr. Anastasi & Cardiovascular Thoracic Associates, Inc.)	THOMAS A. MATIS, ESQUIRE 300 Four PPG Place Pittsburgh, PA 15222-5404

I N D E X

EXHIBIT PAGE:

NUMBER	IDENTIFICATION	PAGE IDENTIFIED

NONE OFFERED

OBJECTION PAGE

PROCEEDINGS

- -

JOHN S. ANASTASI, M.D., HAVING FIRST BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

- -

EXAMINATION

BY ATTORNEY FEINBERG:

Q. Good afternoon, Doctor.

A. How are you?

Q. Tell us please your full name and your office address?

A. John S. Anastasi, 620 Howard Avenue, Altoona.

Q. Your Counsel has provided us with your CV and I'll have a few questions to ask you beyond the information contained in that form. It indicates you're the Chairman of Cardiovascular Thoracic Surgery of Altoona, Inc.?

A. Uh-huh (yes).

Q. And I gather you're a shareholder then?

A. Uh-huh (yes).

Q. If you would say yes, no.

A. Yes, I'm sorry. I own 51 percent and Doctor Fazi owns 49.

Q. And that's still true to today?

A. Correct.
Q. What, if anything, is your relationship to the ---?

ATTORNEY MATIS:

Jack, I know you're going --- don't get upset with me, but I think your question to that is still true today, it wasn't at the time, I don't want there to be a misstatement on the record.

ATTORNEY FEINBERG:

Okay.

ATTORNEY MATIS:

Doctor, this was just recently and I think he may have been misunderstood.

BY ATTORNEY FEINBERG:

Q. Back in June of 1993, were you ---?
A. I was a sole shareholder in '93.
Q. Okay. But you were still the Chairman?
A. Correct.
Q. And you're still 'boarded by the American Board of Surgery and Thoracic Surgeons?
A. Correct.
Q. Have you published at all?
A. No.

Q. Have any teaching positions?
A. No.
Q. Let's talk about Mr. Forr. You were here when your associate, Doctor Fazi, testified?
A. Uh-huh (yes).

indicated that you were not there at the beginning of the procedure; is that correct?
A. That's correct.
Q. And that you came on just before the CPS unit was inserted?
A. That's not accurate. I came in before the pacemaker was inserted.
Q. And how did you happen to be called in there; do you know that?
I was in the other room doing a case and the nurse came in and told me that Doctor Fazi was having difficulty with the patient and that he was unstable and was I free to give him a hand.
Q. And did you then go immediately to the next room?
A Immediately.
Q And did you determine what was going on when you got there?
A Sure. I had some conversation with Doctor

Fazi at the time, I don't remember the specifics of it, but the patient, he did tell me that he encountered bleeding when trying to put in the introducer sheath and the patient had hemidynamic instability and his blood pressure was low at the time when I arrived in the room.

Q. One thing, we're not going to be here forever, so you're supposed to talk fast and that potentially increases the risk of errors creeping into the record, so if you just try to stop ---.

A. I'm from New York, it's a hereditary thing. Sorry.

Q. Someone somewhere requested please do this or please do that or, in other words, when you got there to the OR what were you supposed to do, how did you find out what you were supposed to do?

A. When you walked in the operating room the patient was unstable, he had very little cardiac rhythm. He had very little blood pressure. Doctor Fazi had already inserted a chest tube. He was holding pressure on the subclavian site. We quickly talked, we decided that the first thing we needed to do was get this patient hemidynamically stable. There was no active site of bleeding coming from either his operative site or the chest tube when I

arrived. I told him I felt the best thing we should do is get the pacemaker inserted to see if that would help with his rhythm and that's the first thing that was done. Doctor Fazi was continuing to hold pressure and start working on the groins for more IV access.

Q. Let me just back up a step. I have a picture from what you're saying. He's holding his hands there, applying manual pressure to try to prevent blood and stop blood.

A. Uh-huh (yes).

Q. Who is going to then put in --- insert the pacemaker?

A. I put the pacemaker in.

Q. And at the time you inserted the pacemaker, he was still applying manual pressure?

A. Off and on.

Q. In other words, there would come a time he would have to go off so you could do what you were trying to do?

A. No, I was able to work around his hands.

Q. And did you have any difficulty or problem in the actual insertion ---

A. No.

Q. --- of the pacemaker?

A. No.
Q. Then when you got it inserted, about how long did that take?
A. I don't recall, but probably under five minutes.
Q. By the way, before the time that you come into the operating room, had you had anything to do with Mr. Forr?
A. I operated on him I think back in 1990.
Q. And then what was that for?
A. He had aortic insufficiency, a leaking of an aortic valve. He had severe triple vessel zoronary artery disease, blockage of his coronary arteries and he had a very large heart and I did four bypasses on him and replaced his aortic valve.
Q. Cabbage surgery?
A. And valve combined.
Q. And he recovered well from that?
A. Went home about five, six days after the operation and had done well up to his problem with his rhythm.
Q. Had you had any contact with him from the time after he went home from that cabbage and valve replacement surgery and up until the time we get into the operating room for the ---?

A. I saw him two weeks after the operation, the initial cabbage and valve surgery, and then after that I did not see him again until I walked into the operating room.

Q. And at the time you last saw him several weeks after the original cabbage and valve surgery he was doing well?

A. From the surgical standpoint his wounds were healing and he was doing well, yes, from the surgical standpoint.

Q. There was no reason for him to see you further about that problem as of that time?

A. We routinely don't see patients more than two weeks after the operation.

Q. Go back to whoever was treating him generally?

A. Correct.

Q. And then the next time you have to do with him is on June 15th, '93?

A. That's correct.

Q. Now, I sort of diverted a moment for a moment and that is, you inserted the pacemaker?

A. Uh-huh (yes).

Q. And that was uneventful, I gather?

A. Uh-huh (yes).

Q. What did you do next?
A. We connected it to the battery and we tried to see if with a better rhythm if we were going to be able to maintain a blood pressure and maintain a more stable rhythm, because looking down there was no active bleeding coming from the chest tube, none coming from the site and yet this patient was in an arrested state.
Q. And when you say in an arrested state you mean what?
A. The CPR was proceeding by that point I did not have a blood pressure or a good rhythm on is own
Q. You say no blood pressure or good rhythm on his own. I think he had some rhythm and ---?
A. His rhythm was paced but it was not capturing his heart so that his heart would produce a blood pressure.
Q. So what did you do then?
A. At that point Doctor Fazi and I determined that this patient was not going to survive unless we did something even more heroic than we had already done and that was to place him on the bypass, portable bypass machine.
Q. And the purpose for that?

A. Is to take complete control over his heart and circulation.
Q. And what happened then? Were you able to get him on the machine?
A. Uh-huh (yes). Cannules were inserted in his groins and he went on bypass, yes.
Q. And then what happened?
WITNESS AND COUNSEL CONFER
A. Initially he was put on at approximately 11:30 in the morning and when he was initially put on his flows were excellent. Well, not excellent but were adequate at four liters giving him a cardiac index that was compatible with life, which would have been at least two liters and a mean blood pressure that was adequate also.
Q. And what was the mean blood pressure then?
A. Forty (40) to 50 during the whole time he was on the machine.
Q. And then what happened?
A. We had decided that he was fairly stable at that point. Looked down at the chest tube, there was no more significant bleeding. Doctor Fazi had closed the wound at that point and we were making plans to take him up to the intensive care unit on the CPS unit.

Q. And then what happened?
A. Approximately, probably around 12:30 or actually 12:15 his flows on the machine were dropping down below a two liter cardiac index. And despite the fact that he had gotten a massive amount of volume it still wasn't maintaining his flows. At this point I had already left the room, so what I'm telling you I just got from my conversations with Doctor Fazi.
Q. And then what happened?
A. Doctor Fazi felt that he might have continued bleeding in his chest and for that reason he opened up his right chest.
Q. And then what?
A. At that time I came back into the room, there was only about 300, 400 cc's of blood that I saw in the chest. We both inspected the subclavian area. We saw some hematoma there in the tissues but we saw no active source of bleeding.
Q. And then what happened?
A. At that point we again at the full inspection of the situation, we kept watching and the flows continued to be below two liters and at that point we decided that he had had flows that were not acceptable with any type of good quality of life even

if he had a chance to recover so we decided to discontinue the machine.

Q. And then death occurred?

A. Uh-huh (yes).

Q. I didn't make a note, you had told us you had come into the OR, you had done certain things and then there was a point at which you left?

A. Uh-huh (yes).

Q. What was that point again?

A. After the patient was on the CPS and he had stable flows and there did not appear to be any more bleeding from the chest tubes, Doctor Fazi had both his hands free and was able to take care of the situation. I left to go back to my case.

Q. And then when you returned the second time to the OR was that pursuant a call or ---?

A. No. I was done with my case and I went back over to check what was going on.

Q. There are two operative records here, the first operative record shows Doctor Fazi as the surgeon and it doesn't speak in terms of an assistant surgeon; is that correct?

ATTORNEY MATIS:

The first one?

ATTORNEY HALPERN:

The first one does.

BY ATTORNEY FEINBERG:

Q. The first one indicates Doctor Fazi as the surgeon and you as the assistant surgeon; is that correct?

A. Correct.

Q. And the anesthesia that's described there is general endotracheal?

A. That's correct.

Q. Now, that wasn't how the procedure was started; is that correct?

A. That's correct.

Q. It was started as a local?

A. With IV sedation.

Q. And then changed?

A. Correct.

Q. Now, in respect to the way in which patients are restrained for this type of a procedure and insertion of the pacemaker, how do they restrain them at this hospital?

A. Generally all the patients that come down, there is a strap placed across their thighs and their arms are tucked at their sides.

Q. What is there to prevent a patient from bucking or lifting up?

A. If the anesthesia, the IV sedation is adequate, they don't lift up, they don't move.
Q. So it's the level of the sedation that keeps them from moving then?
A. That's correct.
Q. And that's something controlled by who?
A. The anesthesiologist, the CRNA.
Q. Now, then there's the second operative note in which Doctor Fazi is listed as the surgeon; correct?
A. Correct.
Q. Do you know why this gave rise to the two operative notes as opposed to one continuous note?
A. Because the first operation was completed, the CPS was inserted, the pacer was inserted, the wounds were closed and I believe Doctor Fazi was dictating that while they were making plans to transfer the patient to the unit. Then when he was notified the flows were not --- were not good, he decided to look further to reprep and drape and look further to see --- to reprep and drape the patient to see if there was further difficulties in the chest, so I assume that's why it's different, or another note.
Q. Actually the patient never left the OR?

A. That's correct.
Q. And during what we'll call the second procedure, you were not there when that began but you came along before it ended?
A. Correct.
Q. So let me just make sure I have the correct sequence. In respect to the first procedure, you came in at a point in time and then when you left the first procedure was still ongoing, or was it completed at that time?
A. It was --- if anything, the skin incision on the pacemaker probably wasn't closed, but the CPS was in and the chest tube was inserted. The pacemaker was inserted. If anything, the skin incision might have been being closed, that would be about the only thing that was left to do.
Q. And then you returned to the other operating room to complete the procedure that you were doing there?
A. Uh-huh (yes).
Q. How did you know that Forr was still in the other operating room then if when you left the first time you took it that he was done, or essentially done?
A. Because I'm constantly aware of everything

that's going on in the two operating rooms.
Q. They just have two of them there?
A. uh-huh (yes).
Q. Or just two of them used for your ---?
A. We have two open heart rooms that ---.
Q. And then they are immediately next to each other or across from each other?
A. Across the scrub sink.
Q. So you're talking about the five or ten feet?
A. Correct.
Q. So that when you were done with yours you could see that something was still going on in the other room?
A. I couldn't see, but I was aware that the patient was still in there.
Q. And that's what caused you to go back in then?
A. Correct. Right.
Q. It wasn't that you were called the second time?
A. Correct.
Q. Was there ever any consideration given to opening the neck and taking a look at the right subclavian?

A. I never gave it any consideration, no.
Q. Were you aware of the amount of volume expanders that were going into the patient?
A. I knew that he was getting a significant amount of fluid, yes.
Q. When you say significant amount that's a relative term.
A. I can't tell you was I aware he got 17 liters during the time of the procedure? I was not aware of that, no. I knew that he was getting fluid and blood to attempt to support his blood pressure.
Q. Had you been aware that 17 liters was being pushed in, would that have been meaningful to you?
A. I probably would have felt at that time had I known it that it might have been too much fluid considering that he wasn't losing that much fluid.
Q. But where would the fluid go then if it wasn't coming out?
Could go into the interstitium, into his tissues.

cardiopulmonary bypass machine, you can lose liters and liters of fluids. Can I confer for one second, please?

Q. Sure.
WITNESS AND COUNSEL CONFER
A. And that is supported by the fact that his weight is 35 pounds greater at autopsy than when he was admitted. In fact, it probably almost breaks down to 15 or 16 kilos of fluid.
Q. Where do you pick up his admitting weight?
A. It's on the nurse's admission note.
Q. What is that, Doctor?
A. It's 215 in one place and 216 in the other, I believe. Right here (indicating).
Q. Just give me a reference.
A. Okay. Where am I here?
ATTORNEY MATIS:
Up here (indicating).
A. 215 pounds is his usual weight but he's weighed in at 216.4, 98 kilos.
BY ATTORNEY FEINBERG:
Q. And what's that sheet you're looking at?
A. It's right here (indicating).
Q. And where do you pick up the examiner's weight, Doctor?
A. If you look in the autopsy.
ATTORNEY MATIS:
Let me see if I can help you

here

A Here, we got the first page of the gross description, the body is well emphasized ---

BY ATTORNEY FEINBERG:

Q Just read the weight

A The body weight is approximately 250 pounds

Q. What's an approximate weight?

A Right.

Q Is the nurse's weight of 216 4 an approximate weight do you know or ---?

A. 216.4 is a weighed weight and the 215, I guess, is what he said his usual weight is.

Q And the examiner's weight is the examiner's approximation ---

A. Right.

Q. --- of weight?

A Right And if I may add also the other reason that I'm well aware of how much fluid can go into the interstitium is that any patient that we do bypass surgery on, even if the operation only takes two hours, when they come out, have a significant amount of fluid in their tissues Their eyes are swollen. And family members always remark how much bigger they appear. And it takes the next two or

three days for that fluid to come out

Q. Are approximated blood losses normally incorporated into the hospital charts at the Altoona Hospital?

A. They are usually recorded by the nurses yes

Q. Do you know why that wasn't done in this case?

A. It's an error. It should have been.

Q. And is that something that normally the surgeon will build into his notes?

A. We usually do not incorporate the blood loss on our procedures, it's usually part of the operative record that the circulating nurse in the operating room records

Q. And the anesthesia people also usually record approximate blood loss

A. I'm not certain whether they do or not

Q. In respect to the operative note of the first procedure, normally an event such as was described by Doctor Fazi where the patient lifts up or attempts to lift up on the table and there's a puncture or laceration of the vessel, is that something you would normally put into your operative note?

A. I really can't answer why Doctor Fazi would have or not have put it in his operative note, I'd be guessing.

Q. My question is a little bit different though, is that something normally you would record in an operative note, a patient attempted to get up and bleeding occurred, something of that effect?

A. I guess if it would have ---.

ATTORNEY MATIS:

Don't guess.

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

BY ATTORNEY FEINBERG:

Q. You can either answer it yes, it is or, no, it isn't or I don't know?

A. I have never come across a situation where it's something that I had to record in the past.

Q. If during a surgical procedure involved an untoward or unexpected event occurs, do you normally put that into your note?

A. I probably would have put it in my operative note.

Q. Are you able to rationalize for me why the chest tube was not after a while demonstrating evidence of bleeding and yet the medical examiner found 500 cc's of blood in the right pleural cavity?

A. That could have been after we were done, that could have been from the thoracotomy incision. It didn't necessarily have to be bleeding from the subclavian artery. He opened the chest, could have bleeding from anywhere. And I'm sure that he had a coagulopathy by this time. He had gotten umpteen units of blood. Fluid had been on the bypass machine. He could be bleeding, you know, from a coagulopathy.

Q. You're talking about a DIC?

A. Yes.

Q. Is there any evidence in the chart of a DIC?

A. It would be too early to see it on the pathology. We didn't send off --- you know, this all took place in an hour and a half time. I'm certain we didn't send off coagulation profiles at this point.

Q. But a DIC would normally cause bleeding from all of the body's orifices?

A. If they were traumatically entered, yes. I mean, you wouldn't just normally spontaneously bleed from your nose or your mouth. Now, a lot of patients in DIC have only bled from the operative sites.

Q. Was there any effort here to determine whether or not there was a **DIC?**

A. No, but he was treated as **if** there might be. He was given platelets. He was given FFP. He was given everything that was the usual treatment for

Q. Those things are also the usual treatment to replace blood loss?

A. Not FFP and platelets, that's not what's given to replace blood. You give blood to replace blood.

Q. I think we can agree there's no evidence here that there was bleeding from anyplace else in the body but beside the right subclavian artery or the wounds that you would normally make in doing the surgery?

A. **I** would agree that the only bleeding was found that was in the chest.

Now, I'm looking at Doctor Fazi's operative

first page and runs over onto the other --- you were

bottom of the first page and runs to the second page, the patient was ready to be transferred to the cardiothoracic intensive care unit when he became

unstable and developed significant amount of bleeding in the right pleural chest tubes. What was the significance of that, if any, in respect to the wound or the laceration or puncture that occurred in the right subclavian vein?

ATTORNEY MATIS:

I object. Well, not only that but I don't think the Doctor's testified he was here at that time, he was in the room at that time.

ATTORNEY FEINBERG:

Well, I think he said he wasn't in the room at that time.

ATTORNEY MATIS:

That's exactly the point.

BY ATTORNEY FEINBERG:

Q. The question is, what is the significance of that?

ATTORNEY MATIS:

And that's asking for a pure opinion.

ATTORNEY FEINBERG:

Well, he's a party to the action and he's associated with the Defendant. You know, I think that's a fair question.

ATTORNEY MATIS:

If he had an opinion you can ask him if he had an opinion at that time.

BY ATTORNEY FEINBERG:

Q. What is the meaningfulness?

A. Well, if that is correct and he had more bleeding from the chest tube, that's what prompted him to do the thoracotomy, to look.

Q. That's the second procedure?

A. Right.

Q. And was it determined where that bleeding was coming from in the second procedure?

A. There was no --- there was some hematoma up at the site where the subclavian was, but there was no active bleeding that either of us saw coming down from the subclavian artery or vein at that point.

Q. But that's not set forth again in that second operative note; is it?

A. What specifically are you speaking of?

Q. All it says in that respect is that bleeding was encountered involving the mediastinum in the area of the great vessels?

A. Uh-huh (yes).

Q. The bleeding site could not be localized; is that correct, as to what it says?

A. I know what it says and that is correct, that's what it says. I'm not certain that it's completely accurate.

Q. Do you know why it's not accurate?

A. Because we knew where the bleeding site was. The bleeding site was in the subclavian artery, we knew that. Okay. What I think he's saying here is that there was hematoma over these vessels. The tissue was stained there, but there was no active bleeding coming from any hole that we could see.

Q. But I think we can agree that that language doesn't appear in that note?

A. I agree with you, it doesn't appear in the note.

Q. And you've had occasion to look at the medical examiner's report?

A. Correct.

Q. And in that report you heard as I questioned your associate before ---?

ATTORNEY MATIS:

Hold on a second, Jack.

ATTORNEY FEINBERG:

Sure.

BY ATTORNEY FEINBERG:

Q. If you look on the gross description down

on the category of thoracic cavity mediastinum, the last sentence there which reads, a short portion, paren, about one centimeter, closed paren, of pacemaker is noted on the surface of the right subclavicular area which indicates that the subclavian vein has been lacerated, period. What is the meaningfulness of that sentence?

A. Well, the sentence is poorly done. Because what he's describing is a normal finding. There has to be a hole in the subclavian vein in order to place the pacemaker to go through it. Where we're getting confused is what the term lacerated means.

Q. Let's go to the next --- well, skip the sentence. And then he goes on the intima, referring to the right subclavian artery, shows a longitudinal, small size laceration, which measures 1.2 centimeters in length. What is he referring to there?

A. What he's referring to, again, if he's describing a laceration the same way he is in the first reference to the vein, he's talking about a puncture of 1.2 centimeters through the inside of the vessel.

Q. And he notes several blood clots in that area, the next sentence, several blood clots are noted within this area?

A. Okay.

ATTORNEY MATIS:

That's what it says.

A. Right, he's got some blood clots. Right, which means there's a clot over the hole is what means, which is what was attempted to be accomplished with the pressure.

BY ATTORNEY FEINBERG:

Q. And then down below he finds on the right pleural cavity there's 500 cc's of fresh blood. How do you --- how is that consistent with the fact that no blood was draining out the tube, the chest tube?

A. Well, the tube could have been clotted, I mean, and the blood might not have exited that way. But I think that blood could have come from the thoracotomy incision itself on top of the coagulopathy. I'm sure all of those tissues were just oozing and bleeding all over. And 500 cc's of blood, you can lose 500 cc's of blood in 20 minutes and not be as hemidynamically unstable as this patient was.

Q. What was the reason for the patient being as hemidynamically unstable as he was?

A. Do you want me to tell me why I think he died, is that what you're asking me?

Q. Let's take the first question first.
A. Okay.
Q. Why was this patient as hemodynamically unstable as he was during the procedures?
A. Because I think that after he had the injury done to the subclavian artery, I think that he was shortly thereafter intubated, I think that dropped --- that was his first drop in his blood pressure, just from the general anesthetic aqd the intubation. I think then he received a large amount of volume in a very short period of time and I don't think his heart could tolerate it. I think his heart got distended, his rhythm wasn't normal. His heart was not normal. And I think with a combination of a lack of a rhythm and a poor ventricle, I think his heart distended and failed and he was not able to maintain a blood pressure.
Q. Was that all brought on by the fact that there was this wound, whether punctured or laceration to the right subclavian, was that all secondary to that?
A. I don't think it was secondary to that. I think that the wound in the subclavian artery was the inciting cause and then the excessive amount of fluid, the poor ventricle, the crummy rhythm, all of

these things is what added to the fact that the patient couldn't be resuscitated.

Q. ***So*** if the wound did not occur the other things would not have occurred?

ATTORNEY MATIS:

Well, that's pure speculation.\

BY ATTORNEY FEINBERG:

Q. The fluid had to be put in because of the decreased blood pressure which occurred as a result of the wound?

A. There are many different ways to treat decreased blood pressure. If you give only one reason his --- is fluid.

Q. But here that's what they did, they gave a large volume of fluid?

A. And they did other things also.

Q. And it was that fluid that then caused the effect on the heart, the large volume of fluid, ---

A. Uh-huh (yes).

Q. --- which ultimately led to the death?

A. Well, ---.

ATTORNEY MATIS:

Wait a minute. Object to the form of the question because whenever he gave you the answer, which now you're

picking apart at, he referred to other things in terms of his pre-existing condition, Jack, and you're leaving that out of the question.

ATTORNEY FEINBERG:

The record will ---.

ATTORNEY MATIS:

You're leaving it out of your question that's why --- you know, you're saying he said this and he didn't.

ATTORNEY FEINBERG:

On the record will say what he said. We don't have to argue about it.

BY ATTORNEY FEINBERG:

Q. Do you have the last question I have asked?

A. What is it?

COURT REPORTED READS BACK PREVIOUS QUESTION

A. The large amount of fluid was one contributing factor that led to his death.

Q. And what were the other contributing factors?

A. His pre-existing heart function.

Q. Which was doing well, I think, or ---?

A. Well, I don't think we know that.

Q. Let me put it a different way. Do you have

any reason to believe it wasn't doing well?
A. Yes, he came in with a heart rate of 33.
Q. And that's why you were going to insert the pacemaker?
A. Right.
Q. And you certainly wouldn't have thought of inserting the pacemaker if you thought he was going to die?
A. I don't understand the question know.
Q. Well, the purpose of inserting the pacemaker was so that it could permit him to continue to live?
A. Correct.
Q. Now, what are the other factors? You say contributing factors ---?
A. His pre-existing condition, his heart was markedly hypertrophied as showed in the autopsy report. He has got severe triple vessel coronary artery disease. He had aortic valve disease. The fluid, his heart rhythm, he not only was in a rate of

heart. So his cardiac function was at least 30 percent less than normal and that's just on the basis of rhythm.

Q. And the fluid overload certainly didn't help that?
A. Probably not.
Q. The examiner indicates that, as he describes it, that the laceration measured one, two, centimeters in length. What is the diameter of the right subclavian in the area where that laceration was located?
A. It's a different anatomy on everyone. I don't know.
Q. Considering Mr. Forr's age and size and weight, what would be a fair estimate?

ATTORNEY MATIS:

We're not going to --- no, we're not going --- he's already answered that.

A. I have no way of giving that.

ATTORNEY FEINBERG:

That's all I have.

ATTORNEY HALPERN:

Nothing.

ATTORNEY HARTYE:

I just have a question.

EXAMINATION

BY ATTORNEY HARTYE:

Q. Doctor, you said in recording blood losses

that it's your understanding that the circulating nurse usually does that; is that right?

A. Uh-huh (yes).

Q. Where does she get that information?

A. What she records from the chest tubes, what she records from the lap pads.

Q. Does the doctor participate in that?

A. Usually not.

ATTORNEY HARTYE:

That's all I have. Thank you.

ATTORNEY MATIS:

We'll read.

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DEPOSITION CONCLUDED AT 3:00 P.M.

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COMMONWEALTH OF **PENNSYLVANIA:**

COUNTY OF **INDIANA:**

C E R T I F I C A T E

I, Tammie B. Elias, R.P.R., Notary Public in and for the Commonwealth of Pennsylvania, do hereby certify:

That the witness was hereby first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the foregoing deposition was taken at the time and place stated herein; and that the said deposition was taken in Stenotype by me and reduced to typewriting, and constitutes a true and correct record of the testimony given by the witness.

I further certify that the reading and signing of said deposition were (not) waived by counsel for the respective parties and by the witness.

I further certify that I am not a relative, employee or attorney of any of the parties, nor a relative or employee of counsel, and that **I** am in no way interested directly or indirectly in this action.

IN WITNESS WHEREOF, **I** have hereunto set my hand and stamp this 12th day of December, 1999.

NOTARIAL SEAL
TAMMIE B. ELIAS, Notary Public
Indiana, Indiana County, PA
My Commission Expires Dec. 9, 1999

Tammie B. Elias

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