IN THE COURT OF COMMON PLEAS OF
SUMMIT COUNTY, OH
CIVIL DIVISION
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MICHAEL GRIMM, *
et al., *
Plaintiffs *
vs. *
ARDESHIR AZAR, M.D., *
et al., *
Defendants *
* * * * * * *

No. CV 96030894

VIDEOTAPE DEPOSITION OF
JOHN S. ANASTASI, M.D.
MARCH 31, 1999

VIDEOTAPE DEPOSITION

OF

JOHN S. ANASTASI, M.D., was taken on behalf of the Defendants 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 Altoona Hospital, 620 Howard Avenue, 7th Floor, F Building, Altoona, Pennsylvania, on Wednesday, March 31, 1999, at 4:42 p.m.

A P P E A R A N C E S

ROBERT C. MEEKER, ESQUIRE
MICHAEL BOWLER, ESQUIRE
Suite 200
80 South Summit Street
Akron, OH 44308
COUNSEL FOR PLAINTIFFS

MICHAEL OCKERMAN, ESQUIRE
Buckingham, Doolittle, Burroughs,
LLP
4518 Fulton Drive, N.W.
P.O. Box 35548
Canton, OH 44735-5548
COUNSEL FOR DEFENDANTS

I N D E X

WITNESS: JOHN S. ANASTASI, M.D.

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VIDEOGRAPHER:

My name is Stacey Commers, a Certified Legal Video Specialist and my address is 557 Russell Avenue, Johnstown, Pennsylvania. I'm employed by Sara Ann Sargent Court Reporting Service, 210 Main Street, Johnstown, Pennsylvania. The date today is March the 31st, 1999, and the time is approximately 4:42 p.m.

This deposition is being held at the office of John Anastasi, M.D., Altoona Hospital, 7th Floor, Altoona, Pennsylvania.

The caption of the case is: In the Court of

Common Pleas of Summit County, Ohio. Case number CV 96030894, Michael Grimm, et al., Plaintiffs, versus Ardeshir Azar, M.D., et al., Defendant.

The name of the witness is John Anastasi, M.D. The deposition of. Doctor Anastasi is being taken on behalf of the Defendant. Attorney Meeker and Attorney Bowler are present on behalf of the Plaintiffs. Attorney Ockerman is present en

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EXAMINATION ON QUALIFICATIONS

BY ATTORNEY OCKERMAN:

Q. Good afternoon, Doctor Anastasi. We're here in your office in Altoona, Pennsylvania at Altoona Hospital. My name is Michael Ockerman. I'm here on behalf of Doctor Azar, the Defendant in this case. Would you please state your name for the Jury?

A. John Anastasi.

Q. And what is your business address?

A. 620 Howard Avenue, Altoona, Pennsylvania.

Q. And Doctor, can you --- we're here on March 31st, 1999. We're scheduled to start trial on April 5th, 1999. You were scheduled to come in and appear live at trial. Can you explain to the Jury why you're unable to do that?

A. I recently began in January to take on increased clinical responsibilities by

starting a new practice in Johnstown. Unfortunately with only three surgeons it's made it very difficult to cover two busy practices, so I'm unable to leave.

Q Doctor, can you tell us what your occupation is?

A. I'm a cardiothoracic and vascular surgeon.

Q. Are you licensed?

A. I am.

Q. Where are you licensed at?

A. Currently in the State of Pennsylvania.

Q. Do you spend more th'an 50 percent of your time in the active clinical practice of medicine?

A. Ninety-eight (98) percent of the time, 99 percent of the time, clinical practice of medicine.

Q. Doctor, can you briefly describe to the Jury the type of practice that you have?

A. My practice is made up of the surgical diseases of the

cardiac, thoracic and vascular structures. We do all phases of open heart surgery, with the exception of transplant and congenital heart disease. We do thoracic surgery, lung resections, aneurisms, esophageal work. And we do all phases of vascular surgery involving the head and neck, the upper extremity and the lower extremity as well as intra-abdominal aneurisms and the like.

Q. Doctor, do you perform surgery involving the arteries of the lower extremities?

A. Yes.

Q. And can you give the Jury an approximate number of those surgeries of the arteries of the lower extremities you perform per year?

A. In the last --- practice has been here for approximately nine years now and we do between 300 and 450 major vascular procedures a

year.
Q. And you participate in some or all of those?
A. In the first eight years approximately 75 to 80 percent of them was done by myself.
Q. And you've been here in Altoona running this practice for how long now?
A. Beginning ten years. Since September of 1989.
Q. Do you feel you're qualified to give opinions to this Jury about the care rendered by Doctor Azar to Michael Grimm
A. Absolutely.
DIRECT EXAMINATION
BY ATTORNEY OCKERMAN:
Q. Doctor, have you had the opportunity to review medical records in this case?
A. I have.
Q. Have you had the opportunity to review Suma Hospital records of 1993 and 1994?

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2 Q. Xave yo3 h-a the
3 opaortunit- to re3ie3 a Doaa-r
4 stuah aerforEea on Mr Grimm in
5 1993?
6 A. I have.
7 Q. Have you reviewed
8 arteriograms or angiograms taken of
9 Mr. Grimm in 1993 and 1994?
10 A. I have.
11 Q. Have you --- have you
12 reviewed Doctor Azar's office notes?
13 A. I have.
14 D aoctor, based upon your
15 training and experience as a
16 vascular surgeon, do you have an
17 opinion based upon reasonable
18 medical certainty about the care
19 pro3iaea Hy Doctor Azar to r.
20 Grimm?
21 A. After reviewing the charts
22 I believe that the care was --- met
23 the Hanar a of care, aaaeptaHle
24 stanaard of care
25 Q Doctor, 3hat is the Hasis

of that opinion? What I'm saying is, can you briefly tell the Jury why you're saying that?

A. Mr. Grimm presented to Doctor Azar with complaints of pain when he was walking. A noninvasive Doppler study showed that he had severe blockage of one of the major arteries going to his lower leg. A very acceptable treatment for that condition to relieve the pain and give the patient a better quality of life is a bypass, a vascular bypass. And that's what was done in this case.

Q. Now, Doctor, there were some complications from that surgery. Can you discuss those briefly?

A. The initial operation that was done was a femoral popliteal bypass with the use of a vein from the --- the patient's own vein. It worked initially very well,. And I think 24 days later, the patient's

graft closed. He was taken back to the operating room, the clot was removed from the vein and I believe a segment of vein, which Doctor Azar felt to be the culprit problem, was removed and the vein put back together again, re-establishing good flow to his lower leg.

Q. Is that something that you have done in the past treating your patients?

A. With in situ veins, meaning a vein that is left in the normal anatomical position of the leg, you have to destroy the valves in order to get the blood to flow in the proper direction. There is times that you can get a retained valve, a vein that is --- a valve that is not destroyed. That valve can lead to a blockage in the graft or an occluded graft. And you would have to require taking out that segment of vein in order to get rid of the problem. And yes, I have had

that come up from time to time.

Q. Doctor, if I can stop you for just a second. One of the things that is in the operative record from the initial surgery of 8/26/93 is that Doctor Azar had good flow from the in situ vein graft. Is that one way to check whether you have gotten the retained valves or not?

A. In the initial operation?

Q. Yes, sir.

A. It absolutely is a very good way to check. But it doesn't guarantee you 100 percent. And I have had situations where I have measured the pressure at the end of the vein and it noted to be perfectly fine, normal compared to the brachial pressure that the --- the radial pressure that they were also checking. They would be equal. And yet in a month or two months later have a patient come back, the pulse isn't as good and we

check it out and there would be a retained valve there. I've even done arteriograms in the operating room immediately after finishing a case and appearance to be perfectly normal only to get a repeat arteriogram two months down the line seeing a retained valve.

Q. Doctor, one of the criticisms of Plaintiff's expert is that Doctor Anastasi did not get arteriograms ---

A. Doctor Azar.

Q. --- Doctor Azar did not get arteriograms after the surgery. Is that something that's required by the standard of care?

A. It is not. Not all vascular surgeons do arteriograms after every operation. I think --- I do not do them after every operation. There are risks involved with giving arteriogram dyes, especially to patients with dye allergies or renal kidney

insufficiency. I only do them if I believe I have a technical problem or if I'm not satisfied with the pulse that I'm hearing beyond my graft or that I could feel beyond my graft.

Q. I believe that the surgery that Doctor Azar performed in September of 1993 was shown to be successful but later on the graft occluded again?

A. That's correct.

Q. Can you explain that to us?

A. On reviewing the arteriograms that I saw that were done approximately 10 or 11 months after the second operation, after the revision of the in situ graft, this patient had a very remarkable progression of his disease. And by that I meant on the first arteriogram that I saw, he had one blockage in the popliteal artery, complete 100 percent blockage and

then had some small blood vessels going around the knee, vessels we call collaterals which gave some flow to outline the blood vessels in the lower leg.

On the arteriogram I saw 11 months later, there was not only a progression of disease, meaning more blockage in the artery up in the groin in the femoral region, but there was also marked progression disease in the three blood vessels that normally go from the knee to the foot. Instead of being three there was only one dominant vessel now. So in just 11 months' time he had pretty significant progression of disease.

Q. Doctor, I believe that the arteriogram you're speaking of was taken on 8/9/94. Did you have the opportunity to review that some time ago?

A. I did. It was a while ago. That's what I'm referring to.

Q. Okay. Doctor, I believe then the patient again had a failure of that graft. Can you explain what occurred after that surgery of 8/11 and 8/12/94?

A. You mean after the second arteriogram was done?

Q. Yes.

A. He was taken back to the ---

ATTORNEY MEEKER:

No. No. The second arteriogram was September '93. You're now into August of '94, the third arteriogram.

ATTORNEY OCKERMAN:

Off the record.

VIDEOGRAPHER:

At this time we're going off the record. It's 4:52.

OFF RECORD DISCUSSION

VIDEOGRAPHER:

At this time we're

back on the record. It's 4:53.

BY ATTORNEY OCKERMAN:

Q. Doctor, when you were talking about progression of his disease which you saw on the arteriogram, you were speaking of the 8/9/94 arteriogram?

A. I'm speaking of the arteriogram that was done approximately 10 or 11 months after the second operation.

Q. Okay. Approximately a month later the graft clotted again and Doctor Azar took the patient back to surgery. Was that a reasonable thing to do?

A. Absolutely.

Q. And do you know what occurred as a result of the 9/3/94 surgery?

A. I believe at that operation he did the femoral to posterior tibial bypass with gortex. And after that operation,

the graft remained open, I believe, for one day and then closed the following day. At that point I believe he was sent to another institution.

Q. And do you know what institution he was sent to?

A. I believe he went to Cleveland Clinic.

Q. Do you know what occurred there?

A. I believe that they attempted --- they removed a lot of the grafting material that was done at previous operations. They looked for a vein in the patient's arms and in the other leg, did not find anything satisfactory. I believe they then used gortex again down to the same blood vessel that Doctor Azar had in his final operation. That graft did not --- did not work initially, they had to use some Urokinase infusions to break up clots in the distal vessels in the

feet.
Q. And you're saying vessels that were further away from where?
A. Further away from their bypass, correct.
Q. And did anything that Doctor Azar do prevent the Cleveland Clinic from getting a good result?
A. I don't believe so, no.
Q. And why do you say that?
A. They were starting from scratch basically. They could not find --- the best conduit to use --- the further you go down in the leg the best thing to use is the patient's own vein because that stays open the longest. If you don't have the patient's own vein, then you have to use a prosthetic material. There are two types you can use. You can use cadaver vein, which is in some patients very good, it's a dead person's vein that they've donated
, or you could use plastic.

Plastic, the further you go down the leg in plastic, the worse results anyone will have with the graft staying open. In fact, there have been times when I've used plastic down that far that I have created a fistula between the artery and the vein just in attempt to keep the vein open because they notoriously have a very difficult time staying open.

Q. And at the Cleveland Clinic did they like to use vein?

A. They did apparently, yes.

Q. In all extremities and were unable to find anything useful?

A. Correct. Correct.

Q. Do you have an opinion why the surgery that was done at the Cleveland Clinic failed?

A. You know, I was not there so I don't know what they came in to. I don't know how --- technically what kind of job they had done, what size the artery was,

was it a good vessel for bypass, how good the inflow was. There's a million reasons why grafts can close and I don't know what they were faced with.

Q. If you were to list any of the reasons, what would be at the top of your list?

ATTORNEY MEEKER:

Objection. He's already indicated he doesn't know.

BY ATTORNEY OCRERMAN:

Q. Go ahead, Doctor, you can answer.

A. The reasons that a graft closes are, as I said, poor inflow, the artery above isn't good or poor outflow, the artery that you're bypassing into is very small and the blood doesn't have anywhere to go, so the graft slows down and closes.

Q. Is that called runoff?

A. Runoff, correct.

Q. Doctor, in your treatment

of patients with --- in lower extremity peripheral vascular disease, have you had patients who have ended up with an amputation?

A. Unfortunately, yes.

Q. Despite all the best efforts?

A. Correct.

Q. Doctor, if I can I'd like to go through a couple things in a little organized fashion. One of the things I'd like to talk to you about is the effects of smoking, such as a three to --- three-pack-a-day habit. What can that do to your arteries?

A. Smoking causes a vasoconstriction of the arteries. It narrow --- meaning it narrows the arteries. And it can make a natural cause of atherosclerosis, hardening of the arteries, it can accelerate that. And we have patients that we do bypasses on all the time that will continue to smoke and they will

close their grafts because of the effects of the vasoconstriction.

Q. Doctor Anastasi, one of the studies that was performed on Mr. Grimm was a Doppler study. Can you explain to the Jury what a Doppler study is and when this was performed on Mr. Grimm?

A. This Doppler study --- let me see a date here. It looks like the date of this study was July 21st, 1993. And what a Doppler study --- what this ultrasound study is *is* what we call a noninvasive technique in order to assess how good the blood supply is to any extremity or in the neck. You could basically do it anywhere. And what this study says is that his right leg was normal but on his left side he had a severe blockage in the popliteal artery. And that his ankle brachial index was .38. And I can explain what that means. Would you like me to explain what that

means?

Q. Would you please?

A. Okay. An ankle brachial index means that your blood pressure --- in a normal person your blood pressure at your ankle ought to be the same as your blood pressure in your arm. So if your blood pressure in your arm is 120 millimeters, like if you have a 120 --- 120/80 blood pressure, the blood pressure in your ankle ought to be the same. So if we put 120/120, that ratio is equal to one. As the numerator drops, if you have a blockage in your leg and if your blood pressure in your ankle then goes from 120 down to 100, down to 90, down to 80, that numerator drops and that's going to make this number one go from one to .9 to .8 to .7 to .5. Simply that means if you have an ankle brachial index which is .5, it means that you're only getting 50 percent of the normal blood supply to your ankle.

If you have .38, you're only getting 38 percent of the normal blood supply to your ankle.

And this study shows that he was only getting about 38 percent of the blood supply to his ankle, to his foot.

Q. And Doctor, one of the things that Mr. Grimm complained about at the time of this study was claudication?

A. Correct.

Q. What is claudication?

A. Claudication is pain while walking. Usually in this patient it would be pain in the calf or the foot while walking.

Q. And what is causing the claudication?

A. The blockage in the popliteal artery would not allow blood to go easily down to his calf and to his lower foot. So while you're just sitting there it seems to be enough blood supply going to

your foot, you can get around through these little collaterals that he has developed, small blood vessels that will grow when there's a blockage. But when he walks, the foot or the muscle in the calf yells for more oxygen, for more blood. But they can't get it because even though the heart's pumping the blood down there, with the blockage, it can't get through and so you get pain in your calf.

It's the same way people with heart blockages have angina, have chest pain, they just don't get enough blood supply to their heart when they're doing something. That's how they get chest pain with exertion. Well, this is angina of the leg is what this is.

Q. And I believe that Doctor Azar also ordered an arteriogram that was performed on August 26th, 1993?

A. Correct.

Q. Is that something you do ---

A. Absolutely.

Q. --- prior to doing any bypass surgery?

A. Correct. It gives you a road map of where to put your bypass.

Q. And did that together with the patient's complaints and the Doppler study, are those --- were those indicative for the need for a bypass surgery?

A. Absolutely.

Q. And I think the bypass surgery that Doctor Azar performed was an in situ vein graft?

A. Correct.

Q. Can you explain that to the Jury?

A. Again, in situ means in place. The saphenous vein is a vein that runs from your groin down to your ankle. And veins in our body and our legs is --- the reason we

have veins is that as the blood supply goes down your lower legs from your heart, pushes down all the blood vessel to your ankle, it's got to get back to your heart some way. And the way it gets back is, it gets back through the veins. And as you walk, your muscles pop, it pushes the blood back up to your heart. The reason that our legs don't swell up is because there are one-way valves in these veins. And so the valves prevent the blood from making our legs swell up. And you see patients all the time that got big swollen legs is because they've either had veins stripped or they've got lousy valves in their veins.

So what we have found doing vascular surgery is that the arteries up at the groin are large. And the arteries down at the ankle are small. While, the saphenous vein is the same way, the vein up in the groin is large and the vein down

in the ankle is small. So if you're doing an operation, you like to put the large part to the large part and the small part to the small part.

For many years, we used to take the vein, take it out and reverse it because the flow has got to go in the opposite' direction of the way the valves are. So we would reverse the Vein and we would put it in. But then we would have the large end at the small part of the artery and vice versa the other way. So years ago we developed a technique called in situ vein where you left the vein in place, you didn't turn it around, you put a tool up to rip out all the valves so that you'd have the large end at the large end and the small end at the small end, just anatomically works better.

Q. Now, after you do one of these bypass surgeries, how can you tell if the bypass is working?

A. Several ways. First of all, you open the artery at one end, you open the artery at the other end and you sew the two ends together. It's like plumbing. It's actually kind of simple. After you get done with that, you re-establish the flow. You let the blood pass through the vein. And you can put your finger on the artery beyond where you sewed it in and you can feel a pulse. Now, some people's arteries are very hard, even beyond where you sewed it in. And so you can take a Doppler and you can listen to the pulse either beyond where you went or down at the ankle and hear how the flow is.

Q. In this case, what did Doctor Azar do to ensure that his grafts were working?

A. I believe he palpated it and I believe he listened with a Doppler.

Q. Do you know whether ---

while the patient was in surgery --- or while the patient was in the hospital during his numerous hospitalizations if that was also done by other health care providers?

A. Yes, it was done by the nurses. And they also have, in surgeries, got Doppler flows on it. Can I stop for a second?

VIDEOGRAPHER:

At this time, we're going. It's 5:04.

SHORT BREAK TAKEN

VIDEOGRAPHER:

At the time we're back on the record. It's 5:06.

BY ATTORNEY OCKERMAN:

Q. Doctor, after Doctor Azar did the second operation on Mr. Grimm, he then put him on Coumadin?

A. Correct.

Q. What is that for?

A. Coumadin is a blood thinner. And if you have patients

that you're having problems keeping grafts open, some of these patients can be hypercoagulable. And by putting them on Coumadin, you thin out the blood and you increase your chances of keeping the graft open.

Q. And despite doing that, the patient's graft still closed?

A. Correct.

Q. Doctor, if we can take a few minutes, I'd like to hand you what we'll mark as defendant's Exhibit A.

(Defendant's Exhibit A marked for identification.)

BY ATTORNEY OCKERMAN:

Q. Can you identify that for us?

A. This is my Curriculum Vitae.

Q. And, Doctor, is that up to date?

A. Appears to be, yes.

Q. Doctor, could yau briefly

tell the Jury where you went to medical school at?

A. I went to medical school at the Bowman Gray School of Medicine, Wake Forest University, North Carolina.

Q. Did you then do an internship and residency?

A. I did internship and residency at New York University, Bellevue Medical Center in general surgery and did a cardiac vascular residency at Allegheny General Hospital in Pittsburgh.

Q. Are you Board Certified?

A. Board Certified in general and thoracic surgery.

Q. Doctor, you and I have known each other for some time. Could you just briefly tell the Jury how we know each other?

A. In 1987 I finished my training at Allegheny Hospital and the first job that I took was a cardiovascular thoracic surgeon at

the Aultman Hospital in Canton, Ohio. And at that time Mr. Ockerman was a surgical assistant, had been working at Canton, I guess, several years. And he used to assist me doing open heart surgery and vascular surgery.

Q. Doctor, did you --- are you reviewing this case as a favor to me?

A. No, not necessarily.

Q. Are you --- have you reviewed prior cases for me?

A. I have.

Q. And have you been able to render opinions in those cases that are favorable to the doctors?

A. None that you were happy with.

Q. So this is the only case in which you have been able to defend the standard of care of a physician that I've asked you to review?

A. That's correct.

Q. Are you being paid for your time?

A. I hope so.

Q. Doctor, again, based upon reasonable medical probability and certainty, do you have an opinion whether Doctor Azar met the appropriate standard of care of a surgeon in his treatment of Mr. Grimm? Do you have an opinion?

A. Yes, I do.

Q What is that opinion?

A I believe that he met t[illegible] standard of care [illegible] an indication ---.

ATTORNEY MEEKER:

Objection. He answered the question.

BY ATTORNEY OCKERMAN:

Q. Doctor, why do you believe he met the standard of care?

ATTORNEY MEEKER:

This has been asked and answered I object.

BY ATTORNEY OCKERMAN:

Q. Go ahead, Doctor.
A. He did an indicated operation. He did a perfectly acceptable operation. And although the operation had difficulties, he kept going back and back until he found the satisfactory answer for the patient. He didn't give up on him. And I think that meets the standard of care.

ATTORNEY OCKERMAN:

Thank you, Doctor. I have no further questions.

CROSS EXAMINATION

BY ATTORNEY MEEKER:

Q. Doctor, did I understand you to say that you were Board Certified in general surgery and thoracic surgery?
A. That's correct.
Q. And you are not Board Certified in vascular surgery?
A. Specifically vascular, I am not.
Q. If Mike Grimm had walked

in your office August 17, 1993, explain what you would have done to assess this patient, to examine him and to move forward with the diagnosis?

A. I would have taken a history from him, I would have done a physical exam. And I would have found out what his main symptomatology was, how much discomfort he was in, what his quality of life was like, what his current habits are, what his cigarette smoking level was, what his family history was for cardiovascular disease. And then I would have made an assessment on the basis of all of that.

Q. But you do consider him as he walks in that day as being a serious, serious situation?

A. Absolutely.

Q. And you would have done these things or you would have had a nurse do them?

A. We usually --- our standard practice here is that the patient fills out a lengthy questionnaire regarding what his problem is, medication, past history and this kind of thing. And then we review it on the outside before we walk in to see the patient. We review any Doppler studies they have. And then by the time I get in there with the patient, I have a general idea of what's going on. And then I ask them specific questions.

Q. And you make the physical examination?

A. Correct.

Q. Typically, how much time do you spend with a patient under those circumstances that you've just described? You yourself, not your nurse?

A. It really depends on how busy the clinic is, how busy I am and ---.

Q. Well, to meet your standard of care, to have a proper physical, to talk to your patient, to come up with a course of action, how much time minimally is it going to take you?

A. Somewhere between 15 minutes and I've been in there as long as 45 minutes.

Q. And would that --- you say this depends on how busy the clinic is at that time?

A. How busy the clinic is, how busy I am and how many questions the patient has and the family has. There are some people that you can summarize a situation to very quickly and give them their options and they can make a decision. There are other patients that have many questions regarding their alternatives, their expectations. And so it takes a lot more time.

Q. In examining Mike Grimm's note with Doctor Azar on 8/17 ---

you've done that you indicated?
A. Uh-huh (yes).
Q. You can look at it if you need to. But it says essentially referral from Markwert (phonetic), Doctor Markwert, possible fem pop, claudication, pain in left leg upon walking, it says one to 200 hundred feet?
A. Okay.
Q. Did you find anywhere in the record where Mike Grimm said one to 200 feet other than this note? I mean, it was in several places in the record where they were talking about 200 feet some places 200 yards, it's throughout this record?
A. I couldn't tell you exactly. That's the number I remember 100 to 200 feet.
Q. You're interpreting that as meaning 100 to 200 feet?
A. Yes.
Q. It doesn't say that, though, does it?

A No, it doesn't It says one to 200 hundred feet but I thought it was 100 to 200, that he was just abbreviating it but I could be wrong.

Q. Have you talked to Doctor Azar in this case?

A. I have not.

Q. So you really don't know what he intended?

A. I have not. Correct.

Q But as you read it it says one to 200 feet ---

A. Right.

Q. --- which seems to suggest that upon walking as short a distance as a foot that he had claudication and meaning pain in his calf?

A. That's what that says That's not what I assume it to mean.

Q Well, I realize you're assuming it's something different

A. Right

Q. It would help you to know exactly what Mike Grimm was complaining about, wouldn't it? If that one to 200 feet is wrong, you'd certainly want to know that. You'd want that note corrected as far as your evaluation?

A. Correct.

Q. Let's go to the arteriogram from the 26th. That's very important for us to understand how he was when they first did this very important diagnostic test; don't you agree?

A. I'm sorry?

Q. The first arteriogram the day before the first surgery?

A. Right.

Q. August 26th, 1993?

A. Right.

Q. This is a key test for us?

A. Correct.

Q. Perhaps even more important than the Doppler at this point now, just going into surgery?

A. It's a road map, absolutely, yes.
Q. Why don't we review then to see exactly what his status was at that time. Mild plaque formation in the left common femoral artery. The SFA --- which stands for what, Doctor?
A. Superficial femoral artery.
Q. --- and profunda femoris are normal. Now, the superficial femoral feeds into the popliteal; is that true?
A. Correct.
Q. There is a tapered narrowing of the proximal left popliteal with a three centimeter length occlusion of the popliteal artery above the knee joint. That means about an inch; would that be

A. About so far, right.
Q. There's collateral reconstitution. Explain to the Jury

what that means.
A. What it means is that at the superficial femoral artery came down and becomes a popliteal at the knee level, it was 100 percent blocked. And collateral circulation, as I said before, are small blood vessels that respond. As an occlusion occurs, it doesn't occur overnight in chronic patients. It occurs slowly. And as the occlusion narrows, the collaterals grow and they grow to try to feed the blood vessels below the occlusion.
Q. So when it says there is collateral reconstitution, does that mean that there's adequate blood getting to the leg, ---?
A. No.
Q. --- getting to the lower leg?
A. No. It means that this is a means of getting some blood to the lower leg. Collateral flow is not

as good as direct flow.

Q. Well, do we know based on that current situation whether there's been any compromise to the lower leg up to that point?

A. Compromise how? In what way?

Q. Well, is something happening as a result: of not enough blood getting to that lower leg?

A. Yes, he's having pain when he's walks. So he's being compromised.

Q. Other than that, do we see any other compromise up to this point?

A. I did not examine his foot so I don't know.

Q. Well, Doctor Azar, of course, did examine him.

VIDEOGRAPHER:

At this time we're going off the record. It's 5:16.

SHORT BREAK TAKEN

VIDEOGRAPHER:

At this time we're back on the record. It's 5:16.

BY ATTORNEY MEEKER:

Q. Did you find anything in Doctor Azar's record, operative note, discharge summary, office notes, which indicated any kind of compromise to the leg as of that time other than this claudication at one to 200 feet?

A. I did not.

Q. I'm then noting that it says the anterior tibial, comma, posterior tibial, peroneal ---?

A. Peroneal.

Q. Peroneal, I'm sorry. --- arteries are unremarkable. Does that mean he doesn't find any ---?

A. There's no disease in them.

Q. There's no disease in them?

A. Correct.

Q. And those are the three arteries that then feed off of ---?

A. As the popliteal artery comes down below the knee, it breaks into three blood vessels, these three. And they all go down and feed the foot.

Q. So what I see that saying to us then is that those three are fine. We see no disease. The femoral right above the popliteal is fine?

A. Uh-huh (yes).

Q. And the popliteal, a one-inch segment, is occluded and there is collateralization taking blood around that area to get back to those three?

A. That's correct.

Q. And that's his condition at that time?

A. Correct.

Q. Now, if we were to go to the --- to a point 11 months later or a year later, can you go to that

arteriogram for me, please, eight, nine? Let's go to the same left leg. I'd like to know the condition of the left leg arteries at that time?

A. This paragraph says the left SFA occludes within three centimeter of its origin.

Q. So now the SFA is now blocked ---

A. Correct.

Q. --- where it wasn't a year before?

A. Much higher up. The profunda femoris is hypertrophied. There seems to be disease in the deep femoral artery as well. There are some collaterals at the thigh. There's reconstitution of the native left SFA in the distal thigh. The popliteal artery is considerably attenuated. So it's really thinned out now above the knee joint measuring two millimeters. There's occlusion now of the anterior tibial

artery which was normal before. And

Q. Doctor, excuse me. I'm sorry. What do you mean by the popliteal is thinned out?
A. It appears to have more disease in it now. It appears normal originally below the blockage. And now its thinned out and narrowed. It means it has disease.
Q. Well, how did it get thinned out and narrowed?
A. The same way his SFA occluded. He's had progression of his atherosclerosis.
Q. Is there any other possibility or probability that caused this to thin out?

ATTORNEY OCKERMAN:

Objection. Can you phrase it in probability or possibility.

ATTORNEY MEEKER:

Probability.

ATTORNEY OCKERMAN:

Okay. Thank you.

BY ATTORNEY MEEKER:

Q. You're not evaluating him on 8/9 after the arteriogram, you notice that the popliteal is thinned out and narrowed?

A. Uh-huh (yes).

Q. Now, what are you looking for, the reasons that cause that particular problem?

A. The only two reasons that I can think off the top of my head is that he's had progression of his atherosclerotic disease or he could have started smoking again. And this represents some vasospasm.

Q. Now, you have now compared the situation in August of '93 compared to August of '94. If you had had this patient walk in, would you have provided him with options for treatment other than just the surgery?

A. At what point are we

talking about?

Q. When you first see him, August 17, 1993?

A. I always give patients options for treatments.

Q. What other option was available to Mr. Grimm other than this in situ bypass?

A. It was a conservative treatment.

Q. What does that mean?

A. It means non-operative and it would mean complete cessation of smoking. It would mean a vigorous exercises program to try to increase his collateralization. It would mean taking a look at his cholesterol and triglycerides and maybe some drugs to affect that. Possibly anticoagulation with Coumadin to improve the flow to his lower leg. And there are some other drugs that are available for people with vascular disease which aren't very successful but some people use.

Q. This is a realistic option for him upon first being seen by you?

A. It can be, yes.

Q. Is there anything you saw in Doctor Azar's record, and I'm going now to his 8/27/93 note, or his operative note or his post-operative note from 8/24 to show that he offered conservative treatment or he suggested that as an option?

A. He might have. But I have no way of knowing that.

Q No my question was did you find anything in the record?

A I don't find anything in the record that ---.

Q And no information has been provided you that he ever did that?

A. That's correct.

Q. Mr. Ockerman has not suggested that and the record has not suggested that; correct?

ATTORNEY OCKERMAN:

Objection. Go ahead.

A. Mr. Ockerman has never suggested anything to me that isn't in the chart.

BY ATTORNEY MEEKER:

Q. Okay. So since it's not in this chart, you have no information that that was ever proposed?

A. Correct. I wasn't there so I don't know whether he discussed it with him or not.

Q. No, I understand. I understand you weren't. Okay. Now, we work our way up to this whole subject of after the 9/24 surgery of '93, the surgery a month later --- excuse me, the 8/27 surgery of '93, the first surgery, ---

A. Okay.

Q. ... second surgery about a month later, ---

A. Right.

Q. ... you explained to us that you do not abide by the concept of using a completion arteriogram. I think I've heard you say --- that's true; is it not?

A. Not in every case.

Q. What percentage of your eases do you do that?

A. Probably 50/50.

Q. And what causes you to choose that?

A. If I'm technically concerned about the operation I have done, if I'm worried that I might not have sewn the artery as perfect as I would like to, if I go very far down the lower leg and the vessel is very small and I want to document that I've got good runoff then I'll do it. But if I do a straightforward femoral popliteal bypass and I'm happy with it, I won't do an arteriogram.

Q. Doctor Azar suggests and the record suggests several places

that Mr. Grimm had particularly small veins. Do you remember reading that?

A. That the vein was small. The arteries, I didn't read about the arteries. Are we talking about the artery or the vein?

Q. No, the vein. And if you're doing an in situ bypass, is that a factdr you would consider that you would want to be particularly careful that it's technically correct and consider ---

A. No.

Q. --- a completion arteriogram?

A. I don't. No, I don't make a decision ---

Q. How can you adequately assess your bypass without a completion arteriogram?

A. First of all, I'm doing distal anastomosis or I'm doing a proximal, I'm sewing it together and I'm looking at every bite. And if

I'm comfortable that I've got a good artery that I'm sewing into and I can see every bite and before I tie the artery down, I put a probe through, a 1.5 or two millimeter probe. If that probe passes through, I know I have a good anastomosis. After I'm done with the bypass, I feel the artery beyond where I sewed it in. I'll listen. And if I've got good sounds and I've got good pulse there, I'm happy I have a good anastomosis.

Q. But in 50 percent of your cases you'll do a completion arteriogram?

A. Correct.

Q. And that's part of your standard of care that you adopt in caring for your patients?

A. Correct.

Q. Now, how about if you do a bypass in August and you have to do it over in September? Has that now raised a red flag for you that you

better do one at the end of that second surgery? Is that not ---?

A. Depends for the reason for the closure.

Q. What do you mean?

A. Well, if I've got a retained valve in the middle of my vein graft and I know that's the reason after I do an embolectomy, if I have great back bleeding coming from where I tied it in below, if I've all of this blood coming back, that means that I'm open below and I've got good runoff. And if I've got great forward bleeding coming down from the thigh and I find an area of retained valve, I'll just cut out the valve and patch it or put it together. And I might not necessarily do an arteriogram.

Q. We know that that's something similar to what Doctor Azar did. He cut cut that one inch that was occluded that he saw in September; didn't he?

A. Correct.
Q. And then he pulled the two --- the vein on one end and the artery on the other end and tied them?
A. No, vein to vein.
Q. Vein to vein and tied it?
A. Correct.
Q. Now, if you had that on top of knowing you had to repeat that after only a month, is that not another factor that you would consider in whether to do a completion arteriogram?
A. No, because that was only one factor. The first operation went fine and he had no thoughts or problems about that. He had a good pulse afterwards. Twenty-four (24) days later his graft closed. So this was the first problem we had with the graft. He found the problem in the vein and he took care of it. And again, the back bleeding and the forward bleeding tells him

he's open on top to bottom.

Q. Now, let's go away from the surgery then. We're now at 9/24. Would you not watch carefully how his pulses were doing between that time and when he gets out of the hospital in late September, in fact, September 28th?

A. This is after the second operation?

Q. Yes. Wouldn't that have been important for you *to* know this isn't happening again?

A. Absolutely.

Q. Did you notice that he had pulses --- very weak pulses and there were several finds by the nurses about low pulses during that period of time, before he got out of the hospital?

A. I'd have to see that. I don't remember it.

Q. Well, without making you go into the record, which we can do, although I realize we're very short

of time, let me go forward. Pulses present but not strong. I want to go forward from that point and go to this October 5th visit to the Doctor. Now he's out of the hospital, he's back in to see the Doctor. And they find on October 5th that the left foot was numb on the right side and the great toe was cold to the touch. Are those significant findings?

A. Could be.

Q. Do those raise a red flag for you that there could be a question whether your bypass is failing again?

A. Depends on what the pulses were like.

Q. And does that not call you to consider doing another arteriogram?

A. It might.

Q. You didn't notice that Doctor Azar did anything at that point other than put him on

Coumadin, isn't that true, on October 5th?

A. Again, I'd have to look at his note. I don't have exact memory of what he did at that visit.

Q. I'm happy to have you look at his, Doctor Azar's, note at that point.

A. Left foot numb on right side. Right toe cold to touch. No pain. Short **walk**, doing better. He notes that the foot is numb on the one side and the great toe is cold. But he says the patient doesn't have any pain. And he's walked and he

understand the patient's version of what he was telling the Doctor at those times?

A. It might be. I didn't read it.

Q. You would liked to have known that if it was significantly different than Doctor Azar, I assume?

A. Patients' interpretations of how they are handled on a clinic visit are often very different than the doctor's interpretation. So I don't know how ---.

Q. I can believe that it is.

A. I don't know how important that would be.

Q. But on simple factual matters as to whether he was having pain, that might be significantly different and perhaps one place or the other, either from the patient or from the Doctor, it's not recorded; correct? It's got to be one or the other, right, if there is

a marked difference?
A. It's possible.
Q. At any rate, here we are back on 10/5. We've had to do a bypass. It failed. We had to do a embolectomy and cut out an inch piece. Now he's got some weak pulses in the hospital. Now he's back to see the doctor and he's got a left foot which is numb and a great toe which is cold and can only do short walking without pain, according to the nurse's note. You see those notes; do you not?
A. It says short walk, doing better --- no pain, short walk doing better. I don't know whose note that is.
Q. At any rate, what action would you take at that point to properly assess the status of your bypass?
A. I personally --- if I could feel pulses or hear pulses and I knew the graft was --- I felt the

graft was open, I probably won't do anything further but see him back.

Q. Okay. Let's jump up to that. 1/25/94 he comes back. His next note, 1/25/94, the very first thing on the note, no pulse on exam. Now here he's had --- on Coumadin for three months. He comes back in, there's no pulse.

A. I don't see where it says that. It says one plus pulses, pedal pulses on 1/25/94.

Q. One plus pedal pulses certainly shows a weaker than normal pulse, does it not, Doctor?

A. It depends on what **your** scale is. Two plus is normal for us so **one** plus would be --- it would be a pulse there.

Q. It's not a normal pulse?

A. It's not a normal pulse, no. But it doesn't say that he didn't have any pulse.

Q. If Michael Grimm is back in complaining of pain and

complaining of problem walking and having claudication and he's talking about pain that really is beginning to be worse than his original pain?

A. Uh-huh (yes).

Q. Had Mike Grimm had said that to Doctor Azar or to you as the examining physician, what action would you have taken?

A. I would have probably done a D'oppler, a duplex, another Doppler on him to see what that looked like.

Q. If the Doppler showed some concern or blockage?

A. I would have maybe repeated the arteriogram. I would have discussed it with him and see if he wanted to proceed.

Q. Can you think of any reason in the world had Mike Grimm reported with those symptoms where the doctor would have suggested, we will just wait for a period of time until you can't bear this pain any more and then we will re-operate?

Is there any reason a doctor would say that to a patient under these circumstances?

A. Unless the patient --- unless it wasn't bothering the patient that much, if he wasn't having rest pain, if he was able to get around, if he didn't want to have another operation.

Q. No. Under my scenario I'm suggesting that the patient came in and said he was hurting even more than he was when this all started back in July of '93. Had you heard that under these circumstances, would you have then asked for the Doppler and, had it shown something, asked for the arteriogram?

A. If the patient was uncomfortable and wanted something done, I would have proceeded.

Q. And had it shown the blockage, would you have then gone in for another surgery right then?

A. Probably.

Q. And if the patient had complained back on October 5th to that extent, would you have considered another procedure way back on October 5th had the Doppler and arteriogram verified what the patient was complaining about?

A. I might have, yes.

Q. These are actions you would take if you heard this from your patient, got the confirmation from those tests?

A. Correct.

Q. Of course, the doctor is the expert, right, the patient doesn't know when he needs surgery, when he needs anything. All he says is, Doctor, I'm hurting and here's where I'm hurting. Then you have to tell him what needs done?

A. Correct.

Q. So we get down to the next summer then --- we get down to the next summer and you've now described in August 9th what the arteriogram

showed. And now we find his entire arterial system of his left leg deeply compromised?

A. Much different than it was a year ago.

Q. Much different. And can we assume that he's now had some damage to his lower leg, his other organs or muscle tissue ---

A. No, we can't assume that.

Q. --- as a result of this?

A. We can't assume that at all.

Q. Why not?

A. Because I have a lot of patients that have 100 percent occlusion of all vessels and the foot looks totally normal.

Q. What is ischemia?

A. Lack of blood supply.

Q. And lack of blood supply ultimately does what to your foot and lower leg?

A. Depends on the degree of ischemia. It can be somewhere to no

effect at all to losing hair on your foot to hawing keratinization of your --- of your toenails

Q Well, Doctor, we know with this a few months after this, this man loses his leg, he has a below the knee amputation?

A. Uh-huh (yes).

Q Now, you're not sitting here today, are you, and suggesting that the Cleveland Clinic is responsible for this amputation?

A I don't know I don't know what they did

Q You don't know anything about that And the Cleveland Clinic records weren't supplied for your review?

A. They were, but I'm saying is I don't know what they technically came up against I don't know what the vessels were like.

Q. Well, now, Doctor, ---?

A You're asking me that

prior to this just because he had this progression of his arteriogram that his foot would have been in worse shape. There are no notes to suggest that he had any ulcers or gangrene to his feet. That is advanced ischemia. Ischemia is just a word, without ---.

Q. You answered my question, Doctor. I'm now asking you, I want to get this real clear, you are not saying to this Jury that the reason this leg had to be removed is the Cleveland Clinic did anything below the standard of care? You're not saying that?

A. I am saying that the leg got amputat'ed after they operated on him.

Q. I understand.

A. I don't know what they did. I don't know ---.

Q. Well, you know what they did as well as you know what Azar did. You had their records. You

indicate that you read them. They were very extensive, weren't they? There were two full notebooks full

---

A. Correct.

Q. --- of my records, anyway, of the Cleveland Clinic. At first they did this turn around and eventually came back three months. later and then had to take his leg off. Why do you take a leg off?

A. Because there's no blood supply to a lower extremity and the foot is getting cold and mottled and they can't move it and it's painful.

Q. And does the record show that's why they had to finally take his leg off?

A. I believe it did, yes.

Q. Doctor, you met Mr. Ockerman back in 1985?

A. '87.

Q. And you left the Akron area in what year?

A. '89.

Q. Or excuse me, the Canton area?
A. '89.
Q. So you worked with him as your surgical assistant for two years?
A. Not my personal. He worked for the hospital.
Q. He didn't work for your medical group?
A. Uh-uh (no).
Q. He worked for the hospital?
A. Correct.
Q. How many times did he act as your surgical assistant in that two years?
A. I have no idea.
Q. Was it on a weekly basis?
A. There were 12, 15 surgical assistants. They rotated through the rooms.
Q. Can you estimate it for us?
A. I couldn't even guess.

Q. Did he act as your surgical assistant for over 100 operations?
A. I doubt it.
Q. I notice in your deposition you indicate you had a personal relationship with Mr. Ockerman?
A. Only the fact that we worked together.
Q. Well, did you have a social relationship?
A. The only thing, I went to his father's funeral. I don't think we ever went out to dinner together.
Q. Didn't play golf?
A. Didn't play golf, never went to the movies. I know I went to his dad's wake.
Q. You consider him your friend?
A. Not Thoreau's definition of a friend. He's an acquaintance. I know him. I like him.
Q. You're over here in

Pennsylvania and he brings a case for you to review?

A. Right.

Q. That's unusual for you; is it not?

A. Yes, I don't do this.

Q. Have you done other reviews for his office other than the ones you've done for him, for other attorneys in his office?

A. They have always been together.

Q. He's been involved in those?

A. Right.

Q. So if he brings a case to you or if his office brings a case, he'll always be the one bringing it in to you?

A. Right. Usually.

Q. And does he call you to discuss medical issues where he needs assistance on beyond reviewing whole case?

A. He's called me to ask me

questions about different cases from time to time.

ATTORNEY MEEKER:

That's all I have. Thank you.

REDIRECT EXAMINATION

BY ATTORNEY OCKERMAN:

Q. Doctor, just a couple follow-up questions. When you talk with the pat-ient, do you take what the patient wants to do into account to what you're going to do with the patient?

A. Absolutely.

Q. And, Doctor, getting back to our relationship, I mean, you didn't review this case or you're not testifying today just because it's Mike Ockerman; are you?

A. No.

ATTORNEY OCKERMAN:

Thank you. No further questions.

RECROSS EXAMINATION

BY ATTORNEY MEEKER:

Q. Do you have any cases from any other attorney from Ohio other than Mr. Ockerman that you're reviewing?

A. Not from Ohio, no.

Q. Have you ever had one from Ohio other than Mr. Ockerman?

A. No.

ATTORNEY MEEKER:

That's all I have.

REDIRECT EXAMINATION

BY ATTORNEY OCKERMAN:

Q. Doctor, just one other questions. Have you reviewed cases for other attorneys?

A. I have.

ATTORNEY OCKERMAN:

'Thank you. No further questions.

VIDEOGRAPHER:

There being no further questions at this time, the deposition is now concluded. It's 5:38.

* * * * * * *

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 an, ror 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 31st day of March, 1999.

Tammie Elias

Tammie B. Elias, R.P.R.,
Notary Public

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