

1 IN THE COURT OF COMMON PLEAS

2 OF CUYAHOGA COUNTY, OHIO

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4 CHRISTOPHER S. LONG, etc.

5 Plaintiffs,

6 vs Case No. 321518

7 CLEVELAND CLINIC FOUNDATION,

8 Defendant.

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10 DEPOSITION OF MARY ANNE BELANGER, R.N.

11 WEDNESDAY, APRIL 24, 2002

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13 Deposition of MARY ANNE BELANGER, R.N., a
14 Witness herein, called by counsel on behalf of
15 the Plaintiff for examination under the statute,
16 taken before me, Vivian L. Gordon, a Registered
17 Diplomate Reporter and Notary Public in and for
18 the State of Ohio, pursuant to agreement of
19 counsel, at the offices of Roetzel & Andress,
20 One Cleveland Center, Cleveland, Ohio,
21 commencing at 2:30 o'clock p.m. on the day and
22 date above set forth.

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1 APPEARANCES:

2 On behalf of the Plaintiff

3 Becker & Mishkind

4 JEANNE M. TOSTI, ESQ.

5 Skylight Office Tower Suite 660

6 Cleveland, Ohio 44113

7 216-241-2600

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10 On behalf of the Defendant

11 Roetzel & Andress

12 JOHN V. JACKSON, II, ESQ.

13 DAVID J. HUDAK, ESQ.

14 One Cleveland Center 10th Floor

15 Cleveland, Ohio 44115

16 216-623-0150

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1 MR. JACKSON: Ms. Belanger was asked to
2 bring with her her entire file relative to this
3 case, and she has done that, including
4 correspondence between our office and her.

5 In the past in dealing with Ms.
6 Tosti's office, they have taken the position on
7 occasion that any correspondence between counsel
8 and experts is not discoverable, although that
9 correspondence is a part of any expert's file.

10 Ms. Tosti has been provided the
11 correspondence that Ms. Belanger had in her file
12 and Ms. Tosti has requested copies of those
13 documents, which I will provide for her.

14 I just wanted to make a record that
15 they were requested and provided, and I assume
16 that in the future if they believe that they are
17 entitled to discover these, that they can't take
18 the argument on one side that they are entitled
19 to them and on the other side that we are not.
20 So I just wanted to put that on the record.

21 MS. TOSTI: I also would like to
22 respond to what Mr. Jackson has said. He has
23 exerted no attorney work product privilege in
24 regard to these documents. These documents were
25 contained in the witness' file, and as such, I

1 had asked for a copy of it. And as to what we
2 may assert in regard to future depositions, I
3 would reserve any right to object to the
4 production of correspondence based on an
5 attorney work product privilege.

6 - - - - -

7 MARY ANNE BELANGER, R.N., a witness herein,
8 called for examination, as provided by the Ohio
9 Rules of Civil Procedure, being by me first duly
10 sworn, as hereinafter certified, was deposed and
11 said as follows:

12 EXAMINATION OF MARY ANNE BELANGER, R.N.

13 BY MS. TOSTI:

14 Q. Would you please state your full name
15 for me.

16 A. Mary Anne Belanger.

17 Q. And your business address.

18 A. 115 West Liberty Street, Wooster,
19 44691.

20 Q. Have you ever had your deposition
21 taken before?

22 A. Yes.

23 Q. How many times?

24 A. Perhaps six to eight times.

25 Q. I'm sure that defense counsel has had

1 an opportunity to speak with you. I'm just
2 going to go over a few of the ground rules.

3 This is a question and answer
4 session. It's under oath. It's important that
5 you understand my questions. If you don't
6 understand my questions, let me know and I'll be
7 happy to rephrase the question or to repeat the
8 question. Otherwise I'm going to assume you
9 understood my question and that you are able to
10 answer it,

11 If at any point in time you would
12 like to refer to the medical records that have
13 been provided to you by defense counsel, please
14 feel free to do so. It's important that you
15 give all of your answers verbally, because our
16 court reporter can't take down head nods or hand
17 motions.

18 At some point Mr. Jackson may choose
19 to enter an objection for the record. You are
20 still required to answer my questions, unless he
21 feels he has grounds to instruct you not to.

22 Do you understand those directions?

23 A. Yes.

24 Q. The file that *is* on the table before
25 you, is that your entire file on this case?

1 A. Yes.

2 Q. Has anything been removed from your
3 file?

4 A. No.

5 Q. And is there anything that you did
6 not bring with you today that you reviewed and
7 considered in connection with this case?

8 A. No.

9 Q. I would like you to tell me a little
10 bit about your experience in medical/legal
11 matters. When is the first time that you
12 offered your service as an expert nursing
13 consultant in a medical negligence case?

14 A. I started doing nurse consulting in
15 1997, August.

16 Q. How did you happen to become a legal
17 nurse consultant?

18 A. I decided that this is what I wanted
19 to do. I looked into what I needed to do to
20 pursue this goal and kind of took it upon myself
21 and did it.

22 Q. And what did you find you needed to
23 do to be a legal nurse consultant?

24 A. I found that you had to have
25 experience in a particular field that the legal

1 people would want so that I could be used as an
2 expert in medical malpractice suits. I felt
3 because I had the experience that I did, that I
4 would have a good background to get into the
5 field.

6 Q. How many medical/legal matters have
7 you consulted on?

8 A. I just counted that last night
9 anticipating that question. In the past three
10 years I have done 28 cases. Actually, it's
11 since '97, so almost five years.

12 Q. And how many of those have been in
13 the last year?

14 A. Perhaps three. And that's a
15 guesstimate.

16 Q. And what proportion of the
17 medical/legal matters on which you consulted
18 have been for plaintiff and what proportion have
19 been for defendant?

20 A. A third has been for plaintiff and
21 two-thirds has been defense.

22 Q. In the cases that you have consulted
23 on for plaintiff, what percentage of those cases
24 have you found that there was substandard care?

25 A. Oh, boy. Actually a small percent.

1 Q. Can you give me a reasonable
2 approximation?

3 A. Maybe ten percent of them.

4 Q. How many times have you had your
5 deposition taken as an expert in a medical/legal
6 matter?

7 MR. JACKSON: You asked that before.

8 A. Six to eight times.

9 MS. TOSTI: I think I asked how many
10 times you had served as a -- you are correct, I
11 did.

12 Q. Have you testified at trial before?

13 A. No.

14 Q. Have you ever acted an as an expert
15 in a case involving issues of postoperative
16 bleeding?

17 A. No.

18 Q. Cardiac tamponade?

19 A. No.

20 Q. Any involving issues dealing with
21 complications following aortic valve surgery?

22 A. No.

23 Q. What is your charge for consultation
24 on medical/legal matters?

25 A. To review the records, I charge \$80

1 an hour. For a deposition it's \$95.

2 Q. Is the same for your trial testimony?

3 A. Trial is \$110.

4 Q. Have you ever provided your name to a
5 professional service or medical/legal consulting
6 firm indicating that you were available to do
7 medical/legal consultations?

8 A. No.

9 Q. Other than this case, have you ever
10 been consulted on a medical/legal matter by
11 Mr. Jackson or his law firm?

12 A. I have worked for Roetzel & Andress
13 in Akron, but this is my first experience with
14 the Cleveland office.

15 Q. How many times have you worked with
16 Roetzel & Andress in Akron?

17 A. I'm not sure I can give you --

18 Q. Approximately.

19 A. Maybe 12 or 15 times.

20 Q. Do you know how it is that you came
21 to be contacted in this case?

22 A. My understanding is that it was
23 through their office in Akron.

24 Q. Do you know when you were first
25 contacted in regard to this case?

1 A. I would have to look at the first
2 correspondence. I want to say it's almost a
3 year ago. June of 2001. Actually, it probably
4 was before that, because that's -- it's easily a
5 year ago.

6 Q. Have you ever been named as a
7 defendant in a medical negligence case?

8 A. No.

9 Q. Do you know when this case is set for
10 trial?

11 A. My understanding is the end of June.

12 Q. And have you been asked to come to
13 Cleveland to provide testimony in this matter in
14 June?

15 A. I was told when the date was and I
16 haven't had a formal invitation to come.

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18 (Thereupon, BELANGER Deposition
19 Exhibit 1 was marked for
20 purposes of identification.)

21 - - - - -

22 Q. I'm going to hand you what's been
23 identified as Plaintiff's Exhibit 1. I'm going
24 to ask you if you just would identify what that
25 document is for me.

1 A. This is my most recent CV.

2 Q. Is it current and up to date?

3 A. Yes.

4 Q. Any additions or corrections that you
5 would like to make to it?

6 A. No.

7 Q. Where did you complete your basic
8 nurses training?

9 A. St. Joseph's Hospital in Syracuse,
10 New York.

11 Q. How long was that program?

12 A. Three year program.

13 Q. And what year did you complete your
14 basic nursing program?

15 A. 1967.

16 Q. Were you awarded any type of an
17 academic degree, such as an associate degree,
18 bachelor's degree?

19 A. No.

20 Q. You have to wait until I finish my
21 question and then answer, because she will have
22 difficulty taking us both down.

23 A. Sorry.

24 Q. Since completing your diploma nursing
25 program, have you completed any academic degree

1 programs in nursing?

2 A. No.

3 Q. Do you have any other academic
4 degrees?

5 A. No.

6 Q. Do you hold any academic appointments
7 with a college or a university?

8 A. No.

9 Q. Now, I see on your CV that you
10 attended -- I don't know if I will pronounce
11 this correctly -- LeMoyne College.

12 A. Yes.

13 Q. When did you attend there?

14 A. You did it at the same time that you
15 were going through St. Joe's.

16 Q. So some of your sciences and that
17 were taken at the college?

18 A. Yes. Our whole first year was at the
19 college.

20 Q. And that was part of your diploma
21 school program; is that correct?

22 A. Yes.

23 Q. And that the clinical component was
24 then done at the hospital?

25 A. Yes.

1 Q. I also see that you went to
2 University College in Syracuse, New York.

3 A. Yes.

4 Q. When did you attend there?

5 A. After I graduated from St. Joe's, so
6 it probably would have been 1968 or '69.

7 Q. And the course work that you took,
8 was it in relation to any particular subject
9 matter?

10 A. Yes.

11 Q. What area?

12 A. English.

13 Q. Mercy College, I see that you
14 attended there. When did you attend there?

15 A. The early 1970s.

16 Q. And the course work that you took
17 there, was that in relation to any particular
18 subject?

19 A. Yes.

20 Q. What?

21 A. English.

22 Q. Now, do you hold a professional
23 nursing license?

24 A. Yes, I do.

25 Q. What state or states?

1 A. The State of Ohio.

2 Q. When did you receive that?

3 A. 1981 or '82 when we moved here.

4 Q. Did you pass your nursing boards on
5 the first attempt?

6 A. Yes, I did.

7 Q. Has your nursing license ever been
8 suspended, revoked or called into question?

9 A. No.

10 Q. Now, you hold several professional
11 certifications. Would you tell me what
12 certifications you hold?

13 A. I'm certified in emergency nursing.
14 I also hold an advanced cardiac life support
15 affiliation and I have a pediatric component of
16 that also. I'm also a sexual assault nurse
17 examiner.

18 Q. When did you receive your
19 certification as an emergency nurse?

20 A. I renewed it four times and it's a
21 four year period, so -- and I just renewed it.
22 So probably back 12, 14, 15 years ago.

23 Q. The recertification process, what do
24 you have to do in order to be recertified?

25 A. It's an exam.

1 Q. Is there any clinical component
2 required as far as the recertification?

3 A. Yes. You are required to have so
4 many hours in the clinical field before you can
5 sit for the exam.

6 Q. And you have to do that each
7 certification period?

8 A. That's correct.

9 Q. Tell me what a sexual assault
10 examiner is.

11 A. A sexual assault nursing examiner is
12 a person who has been trained in forensics, who
13 does a medical forensic exam on sexual assault
14 victims.

15 Q. Did you complete any type of program
16 or course work in order to obtain that
17 certification?

18 A. Yes.

19 Q. How long was that?

20 A. I attended a 40 hour session on it in
21 Fort Wayne, Indiana and I had to go into my own
22 county and do 60 hours of preceptorship and an
23 additional 200 forensic CEU's.

24 Q. When did you receive your
25 certification?

1 A. January of '99.

2 Q. Do you currently utilize your
3 certification in this area in your current
4 clinical practice?

5 A. Yes. I'm the coordinator of the
6 program at our hospital and in our county,
7 actually.

8 Q. Who is your current employer?

9 A. The Prosecutor of Wayne County.

10 Q. When did you first become employed
11 there?

12 A. November 1st of 2001.

13 Q. What are your duties and
14 responsibilities with the prosecutor?

15 A. I am director of his county program,
16 Victim Witness Assistance, which is a program
17 that deals with victims of all crimes, and we
18 act as a liaison, if you will, between the
19 victim and the judicial system. I have five
20 advocates under me.

21 Q. Are you doing any type of hospital
22 practice at this time?

23 A. Sexual assault practice.

24 Q. And what do you do in regard to your
25 sexual assault practice?

1 A. I'm the coordinator of the program,
2 so I take my share of on-call time, which at the
3 present time is about 50 percent of the time per
4 month, because we are down to two. I also do
5 four hours a week in the office, and then
6 obviously any cases that I would be called in
7 on.

8 Q. How many hours a week, approximately,
9 do you spend in the clinical area?

10 A. It would depend on the week. Because
11 the only time I'm in the clinical area is when
12 there is a victim, and we average a victim about
13 once every two weeks.

14 Q. And when you are there with a victim,
15 can you approximate how much time you are
16 usually in the hospital?

17 A. The exam takes anywhere from four to
18 six hours, depending on the case.

19 Q. And so these exams would be normally
20 conducted in a hospital setting?

21 A. I'm not sure I understand your term
22 normally.

23 Q. Is that the site where you would
24 usually conduct your examination in a hospital
25 setting?

1 A. That is the site where I always
2 conduct it.

3 Q. Now, I see that you were also
4 employed at Wooster Community Hospital; is that
5 correct?

6 A. That's correct.

7 Q. What was your term of employment with
8 Wooster Community Hospital?

9 A. In years?

10 Q. When did you start and when did you
11 end your employment there?

12 A. I was there for 18 years. I started
13 in 1982 and I left in November from the
14 emergency room.

15 Q. How large a hospital -- and by that I
16 mean, approximately how many beds does Wooster
17 Community Hospital have?

18 A. 100.

19 Q. The last title and position that you
20 had with Wooster, what was it?

21 A. Staff nurse.

22 Q. And in what area were you working as
23 a staff nurse?

24 A. Emergency department.

25 Q. How long a term were you in the

1 emergency department? When did you start?

2 A. I started in the beginning when I
3 came to Wooster Hospital. I went between CCU,
4 ICU and ER, and then I went full time in the ER
5 in 1969.

6 Q. Did you remain full time in the
7 emergency room from 1969 until you ended your
8 employment at Wooster Community Hospital?

9 A. I was full time up until a year
10 before I left and I went to two, 12's a week.

11 Q. Still in the emergency department
12 though?

13 A. Yes.

14 Q. Were you ever a full-time staff
15 person in the intensive care unit at Wooster?

16 A. At Wooster, no.

17 Q. When you were working at Wooster,
18 were you working 40 hours a week up until that
19 last year when you were doing two, 12 hour
20 sessions?

21 A. We did three, 12's, so it was 36.

22 Q. But prior to that, were you full time
23 40 hours a week?

24 A. Full time is 36 hours.

25 Q. Tell me what the difference was in

1 your employment before you went on the three, 12
2 hour shifts. What did you do before that period
3 of time?

4 A. I'm not sure I understand your
5 question.

6 Q. You said that a year before you left
7 Wooster, you went to three, 12 hour shifts.

8 A. No.

9 Q. Well, then I misunderstood what you
10 said. Would you please tell me again what your
11 work schedule was at Wooster.

12 A. My full time that we started out with
13 was actually five, 8's a week, 40 hours. The
14 hospital then went to 12 hour shifts and I
15 worked three, 12's, up until a year ago when I
16 worked two, 12's.

17 Q. Were all the nursing staff doing 12
18 hour shifts when they made the switch?

19 A. No.

20 Q. Just a portion of the staff?

21 A. Yes.

22 Q. Do you currently provide any
23 professional services for anyone besides the
24 Wayne County Prosecutor's Office? Anyone else
25 at this time that you provide professional

1 services for?

2 A. Do you mean am I employed by anyone
3 else?

4 Q. Well, let's start with that. Do you
5 have employment with anyone besides the Wayne
6 County Prosecutor's Office?

7 A. Other than my sexual assault position
8 at the hospital, no.

9 Q. Is that an employed position at the
10 hospital where you receive some type of
11 remuneration?

12 A. Yes.

13 Q. What percentage of your income is
14 from the hospital?

15 A. You want an exact percentage?

16 Q. I'm asking for an approximation, just
17 so I have an idea as to how you divide your
18 professional time.

19 MR. JACKSON: Why don't you tell her
20 what percentage of your time is spent at the
21 hospital rather than your income then.

22 A. I spend a minimum of four hours a
23 week at the hospital.

24 Q. How much time do you spend with Wayne
25 County Prosecutor's Office responsibilities?

1 A. Forty hours a week.

2 Q. So the last time that you worked as
3 an emergency room nurse or as a hospital staff
4 person was in November of 2000; is that correct?

5 A. 2001.

6 Q. 2001, okay. When you worked in the
7 emergency room, did you work a particular shift?

8 A. Yes.

9 Q. Which shift did you work?

10 A. 7-A to 7-P.

11 Q. And during the last year that you
12 worked in the emergency room, you were working
13 two, 12 hour shifts a week; is that correct?

14 A. Yes.

15 Q. How many nurses normally would staff
16 the emergency room on the shift that you worked?

17 A. Do you want to know how many are
18 supposed to or how many did you have?

19 Q. How many did you have?

20 A. From 7-A until 9:30 there would be
21 two RNs. From 9:30 until 11:00 there would be
22 three. At 11:00 we have another one. That
23 would be the number until we got to 7:00 p.m.

24 Q. How many physicians routinely staff
25 the emergency room during the time that you were

1 there?

2 A. One physician and one PA.

3 Q. Now, your curriculum vitae also
4 mentions that you worked in the coronary care
5 department at Wooster. Were you working in a
6 critical care coronary care area?

7 A. Yes.

8 Q. What were your duties and
9 responsibilities in that unit?

10 A. I worked both as a staff nurse and a
11 charge nurse, so depending on shift, either I
12 was doing hands-on patient care where that was
13 my only responsibility, or if I was in charge, I
14 also had to handle the administrative aspect of
15 the shift.

16 Q. And when did you work in the coronary
17 care area?

18 A. When I first went to Wooster Hospital
19 until I went full time in the emergency room, so
20 it would have been from, whatever the years, up
21 until I went full time I think I said 19 -- when
22 did I tell you?

23 Q. I believe you said something like
24 1969.

25 A. '69, yes.

1 Q. 1969?

2 A. Went full time in just the emergency
3 room.

4 Q. Into the emergency room. And so
5 prior to that, how long were you working in the
6 coronary care unit?

7 A. I rotated between the three units
8 from the time I got to the Wooster Hospital,
9 which was 1983 or wherever, until I left for the
10 ER in 1969. Sorry. '89, I'm sorry.

11 Q. Let's back up here.

12 When did you first start at Wooster
13 Hospital?

14 A. 1983 or '84.

15 Q. And then from 1983 or '84, until
16 1989, you were rotating through the emergency
17 room, the coronary care unit --

18 A. And ICU.

19 Q. -- and ICU?

20 A. Yes.

21 Q. And then in 1989, you then went to
22 the emergency room and were a full-time staff
23 person in the emergency room?

24 A. That's correct.

25 Q. So does Wooster Hospital have a

1 separate coronary care unit from their intensive
2 care unit?

3 A. They did at that time.

4 Q. How many beds was it?

5 A. The intensive care or the coronary
6 care?

7 Q. The coronary care.

8 A. The coronary care had eight.

9 Q. How many in the intensive care?

10 A. Ten.

11 Q. And since that time, have they done
12 something else rather than have two independent
13 units?

14 A. They have combined the two units.

15 Q. How many beds is it currently?

16 A. Ten.

17 Q. And the last time you would have
18 worked as a staff nurse in the intensive care
19 unit or coronary care unit was 1989; correct?

20 A. Sometime before 1989, yes.

21 Q. The last time that you worked in the
22 intensive care unit also would have been 1989?

23 A. Yes, because I rotated between the
24 three units.

25 Q. In the time that you worked in the

1 intensive care unit or the coronary care unit at
2 any point in time, were you caring for immediate
3 post-op patients?

4 A. No.

5 Q. Did those patients go to a recovery
6 room?

7 A. Wooster Hospital doesn't do cardiac
8 surgery.

9 Q. Well, my question was, postoperative
10 patients. Did the ICU get just postoperative
11 patients from whatever surgery Wooster Hospital
12 does?

13 A. Only on an overflow on weekends.

14 Q. So it wasn't routine for them to come
15 directly to the ICU or the coronary care unit
16 after surgery?

17 A. No.

18 Q. Now, you have indicated that Wooster
19 Hospital doesn't do cardiothoracic surgery;
20 correct?

21 A. That's correct.

22 Q. Do they do thoracic surgery?

23 A. Yes.

24 Q. Do they have thoracic surgeons on
25 staff there?

1 A. Yes.

2 Q. Can you tell me the name of any of
3 them?

4 A. Yes. Dr. Stern and Dr. Dick Davis.

5 Q. And at the time that you were working
6 in the ICU or the coronary care, did you have an
7 opportunity to care for immediate post-op
8 patients that had undergone thoracic surgery?

9 A. Probably not, because neither of
10 those physicians were there at that time.

11 Q. Since the time that you started at
12 Wooster Hospital, which was around 1983 or '84,
13 did you ever have an opportunity to care for any
14 immediate post-op thoracic or cardiothoracic
15 patients?

16 A. No.

17 Q. In any environment?

18 A. No.

19 Q. Does your absence of experience in
20 regard to postoperative care of thoracic or
21 cardiothoracic patients limit your opinions in
22 this case in any way?

23 A. I don't feel that they do.

24 Q. Why do you believe you're qualified
25 to render opinions regarding the standard of

1 nursing care for cardiothoracic surgery

2 intensive care nurses in this case?

3 A. I feel that taking care of critical
4 care patients is pretty much the same across the
5 board. The standard is the same. In my
6 experience I have taken care of patients with
7 chest tubes. I have taken care of patients that
8 had the same medications that this patient in
9 the case did. I feel that the principles are
10 the same in critical care nursing whether in a
11 fresh post-op unit or in a trauma room in an ER.

12 Q. When is the last time that you have
13 cared for an immediate postoperative patient?

14 A. A long time.

15 Q. Approximately.

16 A. When I went into the ER.

17 Q. 1989?

18 A. So before that, yes.

19 Q. Do you believe that the standard of
20 care for nursing practice has remained the same
21 since 1989 for patients that have undergone
22 surgery?

23 A. I think the surgery that is being
24 done to the patient has dramatically changed,
25 but I feel the standard of care with any prudent

1 nurses keeping up with the changes in the field,
2 I think that would be the same.

3 Q. Tell me how you have kept up with the
4 changes in the field in regard to immediate
5 postoperative care.

6 A. I have not. Because that was not my
7 field. What I have kept up with is the field
8 with which I work, and I work with critical care
9 patients. So I have kept up with the changes
10 given to a critical care patient.

11 Q. You said that you work with patients
12 in an emergency room setting; correct?

13 A. That's correct.

14 Q. Critical care from a nursing
15 perspective usually has a different connotation,
16 wouldn't you agree?

17 A. Having worked in CCU, ICU and ER, I
18 think all three of those fields are critical
19 care nursing. If you mean to dub someone a
20 critical care nurse because she works in a
21 critical care unit, of course then there would
22 be a difference geographically, but I think the
23 same standards or the same assessment skills
24 really don't vary between those three units.

25 Q. Do you routinely have patients on

1 ventilators in the emergency room?

2 A. Routinely is a word that isn't
3 synonymous with ER, but we have patients in the
4 ER on ventilators.

5 Q. Not routinely?

6 A. No.

7 Q. Do you routinely have patients in the
8 emergency room receiving hemodynamic monitoring?

9 A. No.

10 Q. You have one publication on your
11 curriculum vitae. Does this publication have
12 any inference as to your opinions in this case?

13 A. No.

14 Q. Do you have any publications that are
15 not listed on your curriculum vitae?

16 A. No.

17 Q. Have you ever lectured on or taught
18 on the subject matter of postoperative bleeding
19 complications?

20 A. No.

21 Q. How about on cardiac tamponade?

22 A. No.

23 Q. Hemodynamic monitoring?

24 A. No.

25 Q. Are you proficient in hemodynamic

1 monitoring?

2 A. No.

3 Q. Have you ever received any type of
4 training in hemodynamic monitoring?

5 A. We had an in-service many years ago
6 when they were going to start using balloon
7 pumps at the hospital and they wanted ER nurses
8 to go through it and we went through a minimal
9 training in balloon pumps. That's all I can
10 profess to.

11 Q. Have you ever been responsible for
12 doing hemodynamic monitoring assessments on
13 patients?

14 A. Using invasive hemodynamic monitors?

15 Q. Yes.

16 A. No.

17 Q. Now, your report, I believe,
18 indicates a number of materials that you
19 reviewed in this case, and I had an opportunity
20 to look through the pile that you have in front
21 of you. Is this a comprehensive list as far as
22 you know?

23 A. Yes.

24 Q. As to all the materials that you
25 looked at?

1 A. Yes.

2 Q. Have you since the time of rendering
3 your report received any additional materials?

4 A. I just received the most recent one.

5 Q. Perhaps the deposition of Mary Jane
6 Smith?

7 A. Is that not on that?

8 MR. JACKSON: It's in the
9 correspondence, Jeanne. You can see in the
10 correspondence.

11 MS. TOSTI: I'm just asking if she
12 knows, because I didn't go through and check the
13 two.

14 MR. JACKSON: There are additional
15 things listed in the correspondence.

16 Q. Have all of the materials that you
17 have been provided in regard to the depositions
18 -- have you read all the depositions?

19 A. Yes.

20 Q. And have you had an opportunity to
21 read the deposition of the plaintiff's expert,
22 Mary Jane Smith?

23 A. Yes.

24 Q. And you also have a copy of her
25 report, I believe, in your file; is that

1 correct?

2 A. Yes.

3 Q. Now, you were given certain portions
4 of The Cleveland Clinic records, and from what I
5 can see in reviewing your file, it appears that
6 you were given the first several days of that
7 admission. The aortic valve surgery admission
8 to Cleveland Clinic, you were given the first
9 several days records from that admission?

10 A. 8-20 through 9-13.

11 Q. Obviously, you don't have a complete
12 record through September 19th. I would imagine
13 the records that you have in front of you are
14 about three-quarters of an inch thick. If that
15 was a complete record from August 20th through
16 September 19th, I would imagine that they would
17 considerably more voluminous than that. From
18 what I can see in the nursing records as well as
19 the doctor's orders, it appears that you have
20 about three days worth of records?

21 A. Well, I was reading what was on the
22 front of the book.

23 Q. Well, I'm asking what you actually
24 reviewed.

25 A. I reviewed from 8-20 through 8-23.

1 Q. So that's about three days worth.
2 You have not seen any records after James Long's
3 discharge from Cleveland Clinic; correct?

4 A. No.

5 Q. And you have not, at least from what
6 I have reviewed, seen any of the depositions of
7 any of the lay witnesses in this case, have you?

8 A. No.

9 Q. At any time when you were reviewing
10 this case, did you ever request from defense
11 counsel that they send you some additional
12 materials?

13 A. No.

14 Q. And in formulating your opinions in
15 this case, did you refer to any journal
16 articles, medical literature, textbooks?

17 A. No.

18 Q. And as you sit here today, are there
19 any publications that you believe have
20 particular relevance to the issues in this case
21 as you understand them?

22 A. No.

23 Q. At any time after you received this
24 case for review, did you consult with any
25 physicians or any nurses?

1 A. No.

2 Q. Have you ever met or had any contact
3 with any of the health care providers that are
4 identified in James Long's medical records?

5 A. No.

6 Q. Have you had any contact with any of
7 the experts that have been identified in this
8 case, either for plaintiff or for defense?

9 A. No.

10 Q. Have you ever had any professional
11 affiliations with The Cleveland Clinic
12 Foundation?

13 A. No.

14 Q. Have you ever visited their main
15 campus in Cleveland?

16 A. I have been to The Cleveland Clinic
17 Foundation for a seminar.

18 Q. And you have never worked or provided
19 services for any of The Cleveland Clinic's
20 affiliates?

21 A. No.

22 Q. Have you generated any personal notes
23 in this case?

24 A. No.

25 Q. Do you have an opinion as to whether

1 a registered nurse should have practical
2 experience as a nurse before becoming a staff
3 nurse in intensive care cardiothoracic surgical
4 intensive care?

5 A. I'm sorry. Repeat that.

6 Q. It wasn't worded very well.

7 I said, do you have an opinion as to
8 whether a registered nurse should have practical
9 experience before becoming a staff nurse in a
10 cardiothoracic surgical intensive care unit?

11 MR. JACKSON: Objection.

12 A. Yes, I do have an opinion.

13 Q. What is your opinion?

14 A. In my experience, I have found that
15 if a nurse has practical experience that is more
16 general before she goes into any of the critical
17 areas, that it is more beneficial for her.

18 Q. And in your experience, is it common
19 to put inexperienced new nursing graduates in a
20 cardiothoracic surgical intensive care unit?

21 MR. JACKSON: Objection. Go ahead.

22 A. I have really not worked in
23 cardiothoracic surgical intensive care, so I
24 wouldn't be able to answer that question for
25 you.

1 Q. Do you currently participate in the
2 training of any nurses who work in the intensive
3 care unit?

4 A. In the intensive care unit?

5 Q. Yes.

6 A. No.

7 Q. Do you currently participate in
8 training of nurses in some other area?

9 A. Yes.

10 Q. What areas is that?

11 A. Sexual assault.

12 Q. Do you provide classroom instruction
13 or are you direct as a clinical preceptor?

14 A. Both.

15 Q. Have you ever worked as a preceptor
16 for a registered nurse who is new to an
17 intensive care unit setting?

18 A. Yes.

19 Q. When did you do that?

20 A. When I was working in Syracuse, New
21 York, I was a head nurse in intensive care and I
22 was part of the orientation program for new
23 people who came through.

24 Q. And what year was that?

25 A. I was afraid you were going to ask me

1 that. When I graduated from school in '67 I
2 worked in intensive care at Straum Memorial
3 Hospital until probably '69.

4 I came back to the burn unit and
5 worked there a year and then went to Straum
6 Memorial Hospital and worked until 1970 in the
7 intensive care unit as a head nurse. Then I
8 moved to New York near the City of New York and
9 worked in an intensive care unit there where I
10 was part of the orientation program.

11 Q. What is the purpose of having a
12 preceptor oversee a nurse trainee's work?

13 A. What would be the purpose of having a
14 preceptor?

15 Q. Yes.

16 A. That you would be able to guide this
17 new person in the field in which you are
18 teaching her, making sure that she is doing the
19 correct thing and that you can share your
20 experience with her.

21 Q. And how is it determined when a nurse
22 has the appropriate technical skills, assessment
23 skills, expertise, to provide nursing care
24 independently in an ICU setting?

25 A. I would think that would depend on

1 the ICU. Anyone that I have been familiar with
2 has set up parameters as a generality; that in
3 this many weeks you will be ready to go. But
4 that is definitely a generality. And what I
5 have found in my experience is if at the end of
6 that time period the nurse does not feel
7 comfortable in taking that step, then the
8 orientation is extended.

9 Q. Why do nurses write nurse's notes,
10 record assessments, document observations in
11 patient's hospital medical records?

12 A. So they can at a later date tell what
13 happened at that time.

14 Q. Would you agree that documentation of
15 assessments and care are a very important
16 nursing function?

17 A. Yes,

18 Q. And isn't it true that one important
19 reason that nurses record observations and
20 assessments in care is so that caregivers can
21 look back and see if there is any changes that
22 may indicate a problem is developing?

23 A. Well, documentation in itself is a
24 running tally of what is going on, so anyone who
25 would be looking back on it would be able to see

1 a sequence of events, yes.

2 Q. So one of the objectives is to be
3 able to look back to see if there is any type of
4 a trend or any type of indicators of a change
5 that's occurring in a patient; correct?

6 A. Well, documentation is putting down
7 numbers, so, yes, you would be able to look at
8 it retrospectively and see a trend.

9 Q. It's not just putting down numbers,
10 there is also narrative notes that nurses write;
11 correct?

12 A. That's correct.

13 Q. And would you agree that when routine
14 assessments go uncharted or incomplete, that
15 there is a risk that it may delay the
16 recognition of a problem in a patient?

17 MR. JACKSON: Objection. Go ahead.

18 A. You know, I live in the real world
19 and I would love to say to you that if I haven't
20 documented it I haven't done it, but I know
21 better than that; therefore, I guess I would
22 have to answer your question if the patient is
23 in need of my attention at that time, giving
24 nursing care, probably that's where my priority
25 is going to be and perhaps my documentation

1 isn't going to be done at that specific time.

2 Q Well, I don't think that you have
3 addressed the question that I asked.

4 A Then please reask the question.

5 MS. TOSTI: Would you read my
6 question back.

7 (Record read.)

8 MS. GORDON: QUESTION: And would you
9 agree that when routine assessments go uncharted
10 or incomplete, that there is a risk that it may
11 delay the recognition of a problem in a patient?

12 MR. JACKSON: Same objection.

13 A So you are asking me that if in an
14 assessment situation if I am not writing it down
15 that there is a risk?

16 Q. Yes.

17 A That it won't be there for future
18 reference?

19 Q. Yes.

20 A. Yes.

21 Q Have you utilized ICU flowsheets for
22 charting?

23 A. Yes.

24 Q Would you tell me what a flowsheet
25 is.

1 A. It's a piece of paper, in most cases
2 it's a fold out piece of paper, sometimes it's a
3 flipping type situation where you are able to
4 see the whole picture of a day, usually it's a
5 24 hour period, and everything that would be
6 pertinent to that patient is on that sheet of
7 paper.

8 Q. And would you agree that flowsheets
9 are specifically designed so that values such as
10 blood pressures, temperatures, urine outputs,
11 hemodynamic values, et cetera, can be recorded
12 in a series and evaluated for any trends that
13 may indicate a change in the patient's
14 condition?

15 A. Yes, just by the nature of the
16 flowsheet.

17 Q. And have you on occasion when you
18 have worked at an ICU utilizing flowsheets
19 identified trends that you have recorded that
20 later turned out to be indicative of a problem
21 that a patient was developing?

22 A. You mean as I look at something
23 retrospectively?

24 Q. I'm asking in your experience, have
25 you ever recorded a series of evaluations on the

1 patient on an ICU flowsheet and then have
2 identified a trend that later turned out to be a
3 developing problem for a patient?

4 A. Yes.

5 Q. And would you agree that an intensive
6 care nurse caring for a patient in the immediate
7 postoperative period has a duty to watch for
8 trends in their assessments that may indicate
9 early signs of complications?

10 A. Yes.

11 Q. In fact, because the nurses are with
12 the postoperative patients constantly and the
13 surgeons are not, the surgeons rely on the
14 nurses to keep them informed of any trends that
15 may indicate a significant change in the
16 patient's condition; correct?

17 A. Yes.

18 Q. Does the position of staff nurse in a
19 cardiothoracic surgical intensive care require
20 any specialized training beyond that of a
21 primary nursing program?

22 A. I would hope that it would.

23 Q. Do you know if it does or not?

24 A. I have not worked there, so I don't
25 know that that would be a specific.

1 Q. So do you know of any specialized
2 nursing skills that are required to work in a
3 cardiothoracic surgical intensive care unit?

4 A. I would feel that they would have to
5 know hemodynamic monitoring. I would feel they
6 would have to know specific medications that
7 these patients would be on. Yes, I feel there
8 are.

9 Q. And do you know whether nurses
10 trained in hemodynamic monitoring are taught to
11 recognize abnormal parameters and to recognize
12 significant trends in those parameters?

13 A. Yes, that would be part of the
14 training, I would feel.

15 Q. And to recognize trends, it requires
16 that the nurses record the hemodynamic values in
17 a series to determine if they are going up,
18 going down, or staying the same; correct?

19 A. Correct.

20 Q. Now, in your opinion, what are the
21 duties and the responsibilities of a
22 cardiothoracic ICU nurse caring for an aortic
23 valve replacement patient in the immediate
24 postoperative period?

25 A. Never having done that, I would have

1 to make this a generalization and I would have
2 to say it would be assessing frequently this
3 patient, acting upon those assessments with
4 interventions, and then based on the
5 interventions, whether they worked or not to
6 continue your care.

7 Q. And do you know or do you have an
8 opinion what the most important nursing
9 assessments would be for a patient with an
10 aortic valve replacement in the immediate
11 postoperative period?

12 A. I don't know that you could single
13 anything out as the most important. I think you
14 are looking at this whole patient as a totality
15 and you are looking at all of the pieces and
16 parts of the puzzle. So I would think if I had
17 to tell you the most important thing, I would
18 think it would be to be able to assess this
19 patient correctly and then act upon that
20 assessment.

21 Q. Can you tell me what the nurses'
22 responsibilities are regarding hemodynamic
23 monitoring in a cardiothoracic surgical
24 intensive care for a patient that has undergone
25 aortic valve replacement?

1 A. What the responsibilities would be?

2 Q. Yes. Regarding the hemodynamic
3 monitoring.

4 A. I would assume that they would have
5 to be monitoring this in a timely manner,
6 recording those and then acting upon their
7 findings and correlating at all times the
8 findings that they have with the patient that
9 they are looking at.

10 Q. Would you agree that a nurse in that
11 environment should be trained to watch
12 postoperative patients for signs and symptoms of
13 excessive bleeding?

14 A. Yes.

15 Q. And what would be the signs or the
16 trends that would raise a suspicion that a
17 postoperative aortic valve replacement patient
18 may be having excessive bleeding?

19 A. Well, I think any patient having
20 excessive bleeding, there would be some red
21 flags, and among those flags I would consider
22 increase in their pulse, decrease in their blood
23 pressure, decrease in sensorium.

24 Q. Anything else?

25 A. I'm sure there are, but that's what

1 comes to mind right now.

2 Q. How about increased chest tube
3 drainage?

4 A. Would that be a sign of loss of
5 volume?

6 Q. Excessive bleeding.

7 A. If I am seeing a large amount of
8 bloody drainage come from a chest tube,
9 certainly.

10 Q. How about a drop in a hematocrit?

11 A. Just a single drop?

12 Q. A progressive drop in the hematocrit.

13 A. To look at a hematocrit, you are
14 going to watch and oftentimes -- I'm sure you
15 know this -- in a fresh post-op, a hematocrit
16 doesn't drop right away, it's down the line. So
17 I guess you would have to look at several
18 hematocrits to say what was going on.

19 Q. And if serial hematocrits are done
20 and there is a progressive drop in the
21 hematocrit, would that be one red flag that
22 there may be excessive bleeding?

23 A. A hematocrit is definitely going to
24 be an indicator of bleeding. Again, it's a
25 piece of a puzzle. You are looking at all of

1 it.

2 Q. Now, if a patient had bleeding at a
3 suture line in surgery that required return to
4 bypass for repair, should that cause the nurse
5 in the cardiothoracic postoperative intensive
6 care unit to have a higher vigilance for signs
7 and symptoms of excessive bleeding?

8 A. If a patient experienced that in OR,
9 I'm assuming that was verbalized to her, to the
10 nurse when she received this patient. And like
11 any other piece of information that should have
12 been given to that nurse, that's something in
13 the back of your mind that you are keeping there
14 to kind of have again a whole scope. I mean,
15 that's obviously something important to know.

16 Q. And why would that be important to
17 know?

18 A. Because that was something that
19 happened in surgery. Just like anything that
20 could happen in surgery, I think it's that
21 transference of information from surgical nurse
22 to the intensive care nurse that has to be
23 transmitted.

24 Q. Would that increase the level of
25 vigilance for excessive bleeding in the

1 intensive care unit?

2 A. It probably would enter into their
3 assessment, sure.

4 Q. What hemodynamic parameters or values
5 does a swan line provide?

6 A. I have not worked with a swan line,
7 so I would not be able to answer that for you.

8 Q. So you don't know whether a swan
9 produces continuous readouts of certain values
10 or not?

11 A. My understanding is that it does.
12 But again, I have not worked with one.

13 Q. Do you know how to calculate a
14 cardiac output or a cardiac index or how that is
15 done?

16 A. No, I do not.

17 Q. Do you know what hemodynamic values
18 an arterial line provides?

19 A. No, I don't.

20 Q. Do you have an opinion whether it's
21 important in a cardiothoracic intensive care
22 unit that has postoperative patients for the
23 nurses to periodically record the hemodynamic
24 values so that trends can be observed?

25 MR. JACKSON: Asked and answered.

1 Objection.

2 A. I think that's important in any line
3 of nursing, but yes, in your unit.

4 Q. Do you know whether nurses have the
5 discretion to do cardiac outputs or cardiac
6 indexes on a more frequent schedule if they feel
7 it's indicated?

8 A. I think that would be part of working
9 in a unit like that, that you would have the
10 autonomy to do that.

11 Q. Can you tell me what a cardiac
12 tamponade is?

13 A. Very simply, it's blood that has
14 gathered in a specific area that has increased
15 in size so that the capability or the function
16 of the heart has been impaired.

17 Q. And from a nursing perspective, can
18 you tell me what assessment findings would raise
19 a suspicion for cardiac tamponade?

20 A. Probably the biggest one is history.
21 Depending on why the patient is laying there in
22 front of you would be a big one. Cardiac
23 tamponade, on x-ray you are going to see a
24 mediastinal check, jugular vein distention. Off
25 the top of my head, those are things I would be

1 looking for.

2 Q. Are you aware of any hemodynamic
3 parameter changes that would be consistent with
4 cardiac tamponade?

5 A. As far as like say blood pressure or
6 something? Is that where you are going?

7 Q. Hemodynamic parameters, yes. Is
8 there any particular hemodynamic parameter
9 changes that would be consistent with cardiac
10 tamponade?

11 A. There would be hemodynamic changes
12 probably in the pressure and the pulse.

13 Q. In what respect?

14 A. Pulse could probably go down,
15 pressure would probably fall, but you could see
16 those in many chest involvements.

17 Q. And in a surgical cardiothoracic ICU,
18 should the nurses be alert to signs and symptoms
19 that may be suspicious for cardiac tamponade?

20 A. Yes.

21 Q. And in regard to cardiac function, do
22 you know what effect cardiac tamponade may have?

23 A. Cardiac tamponade is going to
24 decrease your heart rate, so therefore it's
25 going to decrease your cardiac output.

1 Q. Have you ever cared for a patient
2 that developed cardiac tamponade after surgery?

3 A. Not after surgery.

4 Q. Have you cared for patients that have
5 developed cardiac tamponade for other reasons in
6 the emergency room?

7 A. Trauma.

8 Q. And in your experience, have you ever
9 seen an echocardiogram ordered to assist in the
10 diagnosis of tamponade?

11 A. Not in the diagnosis of tamponade.

12 Q. Any particular diagnostic studies
13 done to assist with the diagnosis?

14 A. Of tamponade?

15 Q. Yes. In your experience.

16 A. No, not in my experience.

17 Q. How is it arrived at, from what your
18 observations have been?

19 A. X-ray. History, again.

20 Q. Do you know whether in a surgical
21 patient postoperative cardiac tamponade is an
22 emergency situation?

23 A. I don't know that I could answer that
24 question.

25 Q. If there is a suspicion for cardiac

1 tamponade, would you agree that nursing
2 assessments should be done at frequent
3 intervals?

4 A. Yes.

5 Q. Now, I have a copy of a letter dated
6 August 5th of 2001 that has been marked as
7 Plaintiff's Exhibit 2. If you would just
8 identify this for the record.

9 - - - - -

10 (Thereupon, BELANGER Deposition
11 Exhibit 2 was marked for
12 purposes of identification.)

13 - - - - -

14 Q. Is that a copy of your report in this
15 case?

16 A. Yes.

17 Q. And is this the only report that you
18 have provided to your counsel?

19 A. Yes.

20 Q. Did you have any drafts of your
21 report prior to rendering this report?

22 A. No.

23 Q. And does your report of August 5th of
24 2000 summarize all of your opinions that you
25 currently hold in this case?

1 A. Yes.

2 Q. And do you still maintain the
3 opinions that you've expressed in your August
4 5th, 2001 report?

5 A. Yes.

6 Q. Do you intend to do any additional
7 work or review any additional materials in this
8 case before the time of trial?

9 A. No.

10 Q. Have you been asked to do any
11 additional work?

12 A. No.

13 Q. Tell me what your assignment was when
14 you were given this case to review.

15 A. They asked me if I would review this
16 case and do it from a standard of care from a
17 nursing perspective.

18 Q. Were you asked to render opinions as
19 to whether certain individuals met the standard
20 of care?

21 A. No, not in particular, no.

22 Q. And when you reviewed this case,
23 whose care -- and I'm speaking of which
24 individual's care -- were you looking at,
25 specifically?

1 A. Because I was rendering an opinion on
2 the nursing care, I looked at the nurses' care.

3 Q. And can you identify those people for
4 me?

5 A. I would have to look at the names.
6 Hrobat, Zilka and Young.

7 Q. Now, at the bottom of page one of
8 your report, you have indicated, I have
9 concluded within a reasonable degree of
10 professional certainty that the nursing care
11 rendered to James Long did not fall below the
12 standard of care.

13 Tell me what the standard of care
14 required the nurses to do in Mr. Long's case.

15 A. The standard of care is any care that
16 any wise and prudent nurse is going to give in
17 the same situation with the same education. In
18 other words, these nurses that were working in
19 intensive care, based on their education and
20 experience, they were going to give the care
21 that was expected of them.

22 Q. Well, that's my question. What was
23 the care that was expected of them?

24 A. Their care should have included
25 assessments, interventions, reassessments and

1 documentation.

2 Q. Who is Nurse Zilka?

3 A. I would have to refer to her
4 deposition. I don't know them by name, but she
5 was one of the nurses who took care. I would
6 have to look up to see if she was the one when
7 the patient came in or the one who took over.
8 Do you want me to do that?

9 Q. Well, we are going to be talking
10 about her care, so I think, yes, I would like
11 you to figure out who she is so we can discuss
12 her care.

13 A. She apparently was the preceptor.

14 Q. And what were Nurse Zilka's
15 responsibilities as a preceptor? Who was she
16 precepting?

17 A. The nurse who was taking care of the
18 patient that she was acting as a preceptor for.

19 Q. Do you know who that was?

20 A. Not off the top of my head. I'm not
21 sure which one was which, I'm sorry.

22 Q. What were Nurse Zilka's
23 responsibilities as a preceptor?

24 A. A preceptor is to watch them, carry
25 out the care, make sure that they are doing that

1 correctly and kind of overseeing the whole
2 situation.

3 Q. Now, do you recall that she was
4 precepting a new nursing graduate named Nurse
5 Young?

6 A. She was precepting a new nurse. I am
7 not sure of the name.

8 Q. Would you agree that Nurse Zilka had
9 a duty to monitor the care being provided by the
10 new nursing graduate that was in her orientation
11 providing care to Mr. Long?

12 A. Yes.

13 Q. And would you agree that one of the
14 jobs of preceptor is to ensure that the standard
15 of care given to the patient is not diminished
16 because the care is being provided by someone
17 that is inexperienced?

18 MR. JACKSON: Objection.

19 A. Yes.

20 Q. And would you agree that Nurse Zilka
21 had a duty to step in and ensure that the
22 standard of care was being met if the person she
23 was precepting, which I'm going to tell you was
24 Nurse Young, was unable to provide standard and
25 appropriate care to James Long?

1 A. If a preceptor is under that
2 impression, then, yes, that is part of the
3 responsibility of precepting.

4 Q. Now, in your review of the records,
5 did you find any evidence that Nurse Zilka
6 stepped in at any point on the evening of August
7 20th in regard to James Long's care?

8 A. Not from my recollections.

9 Q. Now, I would like to talk to you
10 about Nurse Young. And if you need to refer to
11 anything to refresh your memory as to who Nurse
12 Young is, please feel free to do so.

13 A. Nurse Young was the person who was
14 taking care of the patient when he arrived in
15 the unit; correct?

16 Q. That's for you to determine based on
17 your review.

18 A. She was the nurse that was under
19 Nurse Zilka's preceptorship.

20 Q. And how long had Nurse Young been
21 employed at Cleveland Clinic prior to the time
22 that she cared for James Long?

23 A. I think I read July, but let me
24 just -- she first became employed July 8th of
25 1996 and she was taking care of Mr. Long in

1 August.

2 Q. So she was about in her 7th week;
3 correct?

4 A. Yes.

5 Q. Did she have any prior work
6 experience as a registered nurse prior to her
7 employment with The Cleveland Clinic?

8 A. I think that was her first job.

9 Q. What time did she assume care for
10 James Long on the evening of August 20th?

11 A. He came into the unit close to 1900.
12 1730, I'm sorry.

13 Q. And is it your impression that she
14 assumed care for him when he immediately came
15 into the unit?

16 A. Yes.

17 Q. Who is Nurse Hrobat?

18 A. H-R-O?

19 Q. Yes.

20 A. She is the nurse who took over at
21 7:00 p.m. when the shift ended. When these two
22 nurses went off, she was the nurse who came on.

23 Q. And it's your understanding, based on
24 your review, that Nurse Young assumed care for
25 Mr. Long immediately from the operating room?

1 A. You definitely have me confused on
2 the names of the nurses.

3 MR. JACKSON: Hrobat was there first
4 and then Young took over. We don't need to play
5 a silly little game with this.

6 MS. TOSTI: I would prefer that you
7 not provide information to the witness. Let her
8 answer. If she doesn't know, she can tell me
9 that she doesn't know.

10 MR. JACKSON: It's all here, Jeanne.
11 You are here for purposes of asking her
12 opinions.

13 MS. TOSTI: Part of my purpose is to
14 know what facts she was relying upon and what
15 the basis of her opinions are. Part of that has
16 to do with who had what responsibility.

17 MR. JACKSON: What is your next
18 question?

19 Q. You would agree that Mr. Long had a
20 right to expect the same standard of care from
21 Miss Young as he would expect from an
22 experienced cardiothoracic ICU nurse; correct?

23 MR. JACKSON: Objection. Go ahead
24 and answer.

25 A. Yes.

1 Q. And that's why they put an
2 experienced ICU nurse as a preceptor over a
3 person that is in Miss Young's situation as a
4 person learning how to care for patients in the
5 ICU; correct?

6 MR. JACKSON: Objection. Go ahead.

7 A. Correct.

8 Q. And would you agree that if Nurse
9 Young failed to provide nursing care that met
10 the standard of care, that Nurse Zilka, her
11 preceptor, would be equally responsible for any
12 lapse in care?

13 MR. JACKSON: Objection. Go ahead
14 and answer.

15 A. Yes.

16 Q. Now, when Nurse Young did her
17 assessment of James Long at the beginning of her
18 shift, did she find any changes from the
19 previous assessment?

20 A. When the two shifts changed?

21 Q. When Nurse Young took over care for
22 Mr. Long, I believe she testified that she did
23 an assessment. Were there any changes in her
24 assessment that she noted when she did her
25 assessment?

1 A. She zeroed, I think it was the
2 cardiac output, to make sure the numbers were
3 the same. She looked at the cardiac output
4 compared to the previous shift.

5 Q. Do you recall anything in her
6 physical assessment that showed that there was a
7 change in Mr. Long's condition?

8 A. I would have to look.

9 Q. Please feel free to refer to the
10 medical records if that will be helpful to you.

11 A. When Young came on, she said that she
12 looked at breath sounds. She talked about the
13 secretion, she talked about his sinus rate. I'm
14 not sure that she has said that there were any
15 discrepancies from the previous shift.

16 Q. You don't believe there is anything
17 in her deposition either, where she said that
18 there was a change in his condition based on her
19 assessment?

20 A. No, I don't recall.

21 Q. There is a nursing page that is
22 called assessment that's a grid that has various
23 systems on it with some boxes in which the
24 nurses do charting.

25 A. This?

1 Q. Does it say assessment at the top?

2 A. Yes.

3 Q. Yes. You see at the top of the page,
4 it shows that an asterisk says see note?

5 A. Yes.

6 Q. Do you know which of these
7 assessments on this page Nurse Young did or if
8 she did any of them?

9 A. Her signature is at the bottom, so
10 I'm assuming she did them all.

11 Q. You assume she did all of them?

12 A. In her time slot.

13 Q. And based on this page of
14 assessments, do you see any changes that she
15 noted?

16 A. Do you mean by the fact that there is
17 an asterisk there?

18 Q. Yes.

19 A. Yes, I see an asterisk.

20 Q. Where?

21 A. I see them at alert and oriented,
22 speech clear, moves extremities, pain free, and
23 we can go on through the page.

24 Q. Now, would you agree that under the
25 area of cardiorespiratory, she has marked an

1 asterisk under breath sounds, clear bilaterally?

2 A. Yes.

3 Q. Do you recall her testifying in her
4 deposition or making a notation in the chart
5 anywhere that the patient now had bilateral
6 bronchi?

7 A. She has that charted right here.

8 Q. So is that a change from the previous
9 assessment on this patient?

10 A. There was no asterisk in the
11 previous, yes.

12 Q. Also, down under cardiorespiratory
13 where it says peripheral or dependent edema, she
14 has an asterisk there; correct?

15 A. Yes.

16 Q. Do you recall her indicating in her
17 deposition that she found that this patient had
18 peripheral edema and that was a change in the
19 patient's condition?

20 A. I can't say that I remember it from
21 her deposition, no.

22 Q. Well, the previous assessment, there
23 is a check mark in that box; correct?

24 A. That's correct.

25 Q. So that would indicate a change from

1 the previous assessment; correct?

2 A. That's right.

3 Q. Under gastro, which is on the
4 right-hand column at the top of the page, under
5 bowel sounds present, she has an asterisk there;
6 correct?

7 A. That's correct.

8 Q. And that's a change from the previous
9 assessment where there is a check mark; correct?

10 A. That's correct.

11 Q. Would you agree that Nurse Young and
12 Nurse Zilka had a duty to carry out the doctor's
13 orders as they were written?

14 A. Yes.

15 Q. How often were hemodynamic parameters
16 being assessed on Mr. Long?

17 A. Being assessed?

18 Q. Yes.

19 A. It appears to be every 15 to 20
20 minutes from the time line on the flowsheet.

21 Q. Was that how often they were supposed
22 to be observing and reporting the hemodynamic
23 assessments?

24 A. The standing orders were routine
25 vital signs every hour, hourly.

1 Q. Did you find anywhere in the records
2 that you reviewed how often the nurses were
3 supposed to be doing hemodynamic assessments?

4 A. It states routine vital signs, so I'm
5 assuming that there is a policy for the unit
6 that tells them the exact time frame on that.

7 Q. Were you provided in the records a
8 page that shows treatments, nutrition, activity,
9 hygiene, running down the left-hand side of the
10 page with the section indicating hemodynamic
11 assessments? Do you have that page?

12 MR. JACKSON: Why don't you show us
13 the sheet, Jeanne, and she can tell you.

14 Q. Do you have a page that looks like
15 this?

16 A. Yes.

17 Q. And under the section that says
18 treatments, do you see an area that says
19 hemodynamic assessments?

20 A. Yes.

21 Q. And it has the word swan A-line and
22 CVP circled; correct?

23 A. Yes.

24 Q. And it indicates 15 to 20 minutes;
25 correct?

1 A. Correct.

2 Q. Now, under the area of swan, I think
3 you previously told me you don't know what
4 hemodynamic values can be obtained from a swan
5 catheter; correct?

6 A. That's correct.

7 Q. And that you weren't aware
8 specifically of the various types of information
9 that can be obtained from an A-line; correct?

10 A. Correct.

11 Q. But would you agree that whatever
12 values can be obtained from those particular
13 items, they were supposed to be obtained every
14 15 or 20 minutes?

15 A. That's correct.

16 Q. Now, assuming that a pulmonary artery
17 pressure is one of the values that can be
18 obtained from a swan, would you agree that the
19 pulmonary artery pressures should have been
20 assessed and recorded by the nurses every 15 or
21 20 minutes?

22 A. That's how the order reads, yes.

23 Q. And you would agree based on the
24 flowsheet that you have from the ICU that there
25 is no evidence that James Long's pulmonary

1 artery pressures were being continually
2 assessed, or assessed at all during the last two
3 hours and 40 minutes that he was in the ICU;
4 correct?

5 A. There is no documentation there. I
6 can't assume that they weren't being assessed.

7 Q. Do you have any evidence that they
8 were assessed during that period of time?

9 A. I don't have any hard evidence, no.

10 Q. Well, what evidence do you have?

11 A. I guess what I would have to say is I
12 would have to base it on their care of this
13 gentleman up until now. I mean, obviously they
14 are taking good care of him and assessing him,
15 so I can't imagine at that time frame they just
16 chose to stop looking at his pulmonary artery
17 pressures.

18 Q. You are making an assumption that
19 they did it?

20 A. Based on their previous care.

21 Q. The fact that they previously did
22 them, you are assuming they did them after the
23 point in time when there is no documentation?

24 A. Yes.

25 Q. So what is your understanding as to

1 why the pulmonary artery pressures were recorded
2 every 20 minutes until 2050 hour and then they
3 stopped at the point when his systolic blood
4 pressure is still down in the 80s?

5 A. You are asking me why they stopped
6 doing that?

7 Q. Yes.

8 A. I don't know that I could tell you
9 that. I mean, unless I was there, how would I
10 know?

11 Q. I'm just asking if you have an
12 understanding as to why it stopped at that
13 point?

14 A. Well, again, it would be an
15 assumption, and it would be an assumption that
16 they were taking care of him; that the priority
17 was on something else. I don't know. I wasn't
18 there.

19 Q. Now, the last pulmonary artery
20 pressure was recorded at 2050 hour, which I
21 believe is at letter K on that flowsheet. And
22 at that point in time, his **blood** pressure was 81
23 over 52.

24 A. Uh-huh, yes.

25 Q. Would you agree that it was a

1 deviation from the standard of care for Nurse
2 Zilka and Nurse Young to fail to assess and
3 record the pulmonary artery pressures for the
4 last two hours and 40 minutes that James Long
5 was in the ICU?

6 MR. JACKSON: Objection.

7 A. During that same time period they are
8 looking at all the other parameters. Why it
9 wasn't documented, I am not sure, but I don't
10 feel that they fell below standard of care.

11 Q. In your opinion --

12 A. That's just a piece of the picture.

13 Q. In your opinion, was it prudent to
14 stop assessing Mr. Long's pulmonary artery
15 pressures at 2050 hours?

16 MR. JACKSON: Objection. Go ahead.

17 A. We don't know they stopped it. All
18 it is is not documented.

19 Q. You don't have any evidence that it
20 was done after that point in time; correct?

21 A. Well, that's correct.

22 Q. Would you agree that Nurse Zilka, as
23 Nurse Young's preceptor, should have stepped in
24 and ensured that the pulmonary artery pressures
25 were documented every 15 to 20 minutes so that

1 trends could be observed for this particular
2 patient, particularly because of the hypotension
3 that he had and the unresponsiveness to the
4 vasopressors he was on?

5 MR. JACKSON: Objection. Go ahead.

6 A. The preceptor needs to step in when
7 she sees that there is something that is falling
8 below the standard. At this point, you know,
9 again I'm going to reiterate that this is one
10 piece of the puzzle. They were doing everything
11 else they were supposed to be doing.

12 By eliminating that one reading, is
13 that in any way jeopardizing this man's care? I
14 mean, they should be looking at it, yes. Was it
15 documented? We don't know if they are not
16 looking at it.

17 I guess to answer your question, a
18 preceptor should be teaching her how to
19 document, yes, and it should be being
20 documented.

21 Q. When Mr. Long returned from his
22 reoperation and went back into the intensive
23 care unit, how often were his pulmonary artery
24 pressures assessed?

25 A. He came back like at 3:00 o'clock in

1 the morning, I think, on 8-21. Is this the date
2 we are talking about? Is that what you want to
3 know?

4 Q. When he came back from his surgery,
5 he came into the unit. How often were they
6 doing his pulmonary artery pressures?

7 A. It appears again every 20 minutes.

8 Q. Any gaps in the times there?

9 A. I don't see any there, no.

10 Q. So consistently every 20 minutes;
11 correct?

12 A. That's correct.

13 a. We are back in the unit prior to his
14 reoperation, and you may want to look at that
15 flowsheet because we are going to be talking
16 about it.

17 After James Long had that long period
18 of hypotension followed by the 250 cc chest tube
19 drainage recorded at 2210 hour, which I think is
20 at letter O, would you agree that it would have
21 been prudent for the nurses to do cardiac
22 outputs and cardiac indexes more frequently than
23 every two hours as a nursing measure?

24 MR. JACKSON: Objection. Go ahead.

25 A. Tell me the every two hours again.

1 I'm not sure where you are coming from there.

2 Q. Do you know how often they routinely
3 did cardiac outputs and cardiac indexes in the
4 ICU?

5 A. They were ordered every 20 minutes.

6 Q. Your understanding is that the
7 cardiac outputs and the cardiac indexes were
8 ordered every 20 minutes?

9 A. I would have to go back and look at
10 the order, but I'm not sure I understand your
11 question. Could you rephrase it?

12 Q. Mr. Long had a long period of
13 hypotension that lasted for, I believe, about an
14 hour and 40 minutes, and that was followed by a
15 250 cc drainage over the course of an hour into
16 his chest tubes. Do you recall that?

17 A. Yes, I do.

18 Q. Would you agree that it would be
19 prudent for the nurses following that period of
20 hypotension and the chest tube drainage to be
21 doing frequent cardiac outputs and cardiac
22 indexes on him?

23 A. Yes.

24 MR. JACKSON: Objection.

25 Q. And would you agree that it should be

1 more frequent than every two hours?

2 MR. JACKSON: Objection. Go ahead.

3 A. Yes, I would agree it should be more
4 than every two hours.

5 Q. Every 15 or 20 minutes, would that be
6 appropriate?

7 A. I think I would have to be there with
8 a patient and see what was going on.

9 Q. And the reason why you would want to
10 do more frequent cardiac outputs and cardiac
11 indexes is in order to see if there was a trend
12 downward indicating that this patient was having
13 a problem with his cardiac function; correct?

14 MR. JACKSON: Objection. Go ahead.

15 A. It's a piece of what would be telling
16 you that the patient could be in trouble, sure.

17 Q. From a nursing perspective, does a
18 falling urine output have any significance the
19 first few hours after surgery?

20 A. Depending on the surgery. Just as a
21 general statement?

22 Q. Yes.

23 A. I have seen patients that had a
24 decrease in urinary output as a result of the
25 anesthesia.

1 Q. Can hemorrhaging have any effect on
2 urinary output?

3 A. Yes.

4 Q. When a patient slips into a shock
5 condition, is there generally a decrease in
6 urinary output?

7 A. Yes.

8 Q. Is that one of the indicators that
9 nurses watch the urinary output to determine
10 whether or not this patient may be slipping into
11 a shock type condition?

12 A. Yes, but urine output is usually one
13 of the latter symptoms that you see.

14 Q. Sure, but it's one of things that the
15 nurses should be assessing, particularly in a
16 postoperative patient; correct?

17 A. You are going to assess urine output
18 for many reasons in a post-op, yes.

19 Q. That's one of the reasons?

20 A. That could be one of the reasons,
21 yes.

22 Q. And how often were the nurses
23 supposed to be recording James Long's urine
24 output?

25 A. Again, I would have to look. Hourly.

1 Q. And did you find that his hourly
2 urine outputs were assessed by Nurse Zilka and
3 Nurse Young after 2210 hour?

4 A. After 2210, there is no urinary
5 output after 2210.

6 Q. And given the fact that he had 250
7 cc's of chest tube drainage at 2210, and the
8 hypotension that we discussed a minute ago,
9 would you agree that his urine output should
10 have been monitored closely by Nurse Zilka and
11 Nurse Young?

12 MR. JACKSON: Objection. Go ahead.

13 A. At 2250, this is the same time when
14 this patient is being prepared to go back to
15 surgery; correct? So there are many things
16 going on at this time.

17 You were going to say something?

18 Q. No, I'm listening to your answer.

19 A. At this time, you know, they are
20 getting this patient ready to go back to
21 surgery. I'm not going to sit here and say they
22 weren't looking at urinary output. It just
23 isn't written down.

24 Q. Why is it your impression that at
25 2250 they were getting the patient ready to go

1 back to surgery?

2 A. It was close to the time that they
3 were going back to surgery. This was the time,
4 my understanding is, this is when the physicians
5 were there and decisions were being made to take
6 him back.

7 Q. He went back to surgery at 2330 hour;
8 correct?

9 A. Yes.

10 Q. And what indicated to you at 2250
11 hour that there was reason to believe that he
12 was going back to surgery?

13 A. I was looking at the time frame
14 thinking that that really is a short period of
15 time, and the decisions to take patients back to
16 surgery, you know, there is a time element
17 there. And I guess my assumption was all these
18 people were gathered around making this decision
19 during that time.

20 Q. So you don't have a problem with the
21 fact that the nurses from 2210 until 2330 didn't
22 record any urine output?

23 A. They should have been recording it,
24 yes.

25 Q. They should have been?

1 A. Yes.

2 Q. So that was substandard care that
3 they did not record the hourly urine output as
4 ordered?

5 MR. JACKSON: Objection.

6 A. I'm not sure the standard reads that
7 every hour you should record urinary output.
8 The standard reads that you are doing timely
9 assessments.

10 Q. Didn't you just read me an order
11 written by the doctor that said that he was to
12 have intake and output done every hour?

13 A. Yes, I did.

14 Q. And did he have an intake and output
15 done --

16 A. It's not recorded.

17 Q. Let me finish my question. Did he
18 have an intake and output done the last hour
19 that he was in the intensive care unit?

20 A. I do not know that because it's not
21 recorded.

22 a. Now, on line 2210, there is a
23 systemic vascular resistance that's recorded at
24 a level of 411. Do you see that?

25 A. Yes, I do.

1 Q. Now, you would agree that that's the
2 lowest systemic vascular resistance that was
3 recorded while he was in the intensive care
4 unit; correct?

5 A. That's correct.

6 Q. Would you agree that although this
7 was the lowest systemic vascular resistance
8 recorded, that there is no indication that the
9 nurses were continuing to assess the systemic
10 vascular resistance for the remainder of the
11 time that he was in the intensive care unit
12 before returning to surgery?

13 A. There are no others documented.

14 Q. Would you agree that given this low
15 systemic vascular resistance, the nurses should
16 have repeated the systemic vascular reading in
17 15 or 20 minutes to see if it was continuing to
18 drop, improving, or staying the same?

19 A. Yes.

20 Q. Now, I see that James Long received a
21 unit of packed red blood cells that finished
22 infusing at 2310 hour, which is at the letter R.
23 There is a physician's order that says that
24 there should be a hematocrit done after each
25 unit of packed red blood cells. Did you find

1 that that order was carried out by the nurses;
2 that a hematocrit was done after the infusion of
3 that unit of packed red blood cells?

4 A. No, I did not.

5 Q. Now, given the fact that the
6 hematocrit had fallen from 36 to 35 to 27 while
7 he was in the unit, shouldn't Nurse Young or
8 Nurse Zilka have made sure that that hematocrit
9 was obtained after the packed red blood cells
10 were infused?

11 A. There is a period of, what, 20
12 minutes before the patient leaves, from the time
13 the packed cells were infused until the time the
14 patient goes back to the OR?

15 Q. Yes.

16 A. I'm not sure there is physically time
17 to draw and get a result from the hematocrit
18 then. I think they were getting the patient to
19 the OR just that simple.

20 Q. So you don't have a problem with the
21 fact that that wasn't done?

22 A. I'm not sure at that point in time it
23 was going to make a whole lot of difference.
24 The man was back on his way to the OR.

25 Q. Now, your report indicates that

1 reassessments took place after each intervention
2 and documentation was done. I would like you to
3 tell me what the interventions are that you are
4 referring to, and then point out the
5 documentations to which you are referring to in
6 your report.

7 MR. JACKSON: Would you read that
8 back.

9 (Record read.)

10 A. I saw the nurses evaluating this
11 gentleman -- even let's take an example of blood
12 pressure. Apparently they were working under
13 standard orders where they could, if they did
14 not keep the blood pressure between the
15 parameters that it was ordered, they were able
16 to start various medications, which they did.
17 They were able to give him boluses of fluid,
18 which they did. They assessed the fact that he
19 was becoming restless on the ventilator and he
20 was given medications to relieve some of that
21 anxiety. Those are just some of the things I
22 saw as far as interventions after assessments.

23 Q. So you've referred to the
24 medications. Any other interventions other than
25 the institution of various medications or the

1 change of doses in medications?

2 A. As far as interventions?

3 Q. Yes. I'm trying to discern what you
4 are referring to as far as interventions.

5 A. Right. Medications.

6 Q. You mentioned the medications.

7 A. Right.

8 Q. What else?

9 A. That would be the interventions,
10 because they were monitoring parameters of his
11 vital signs, and based on those vital signs,
12 they were trying to effect the result with the
13 medication.

14 Q. Now, your report also indicates that
15 there was frequent and timely communication with
16 the medical staff; correct?

17 A. Yes.

18 Q. I would like you to point out to me
19 what time those communications occurred and then
20 we will talk a little bit about them.

21 A. Well, we can start with the orders
22 that were given. All of these orders were
23 written from the time the gentleman, Mr. Long,
24 came back. 1730, 1800, 1830, for every one of
25 those orders there was a physician there.

1 Q. So you have mentioned 1730 order, a
2 1830 order. What other communications are you
3 referring to?

4 A. Then in the nurse's notes, they are
5 making note of when doctors were at the bedside
6 under significant events. There are physician's
7 names there.

8 Q. Tell me what time those
9 communications occurred.

10 A. It's easier said than done in these
11 charts. Looks like Dr. Cosgrove at 1830. Well,
12 you can start with the fact that someone was
13 with the physician when he came at 1730, all
14 right? So either PACU or anesthesia or someone.

15 Cosgrove was there at 1830. These
16 orders appear, you can intersperse when they
17 were there to write the orders. The time line
18 would be much easier to do this.

19 I think we established 1730, 1800,
20 1830 and the next two are not timed. You then
21 have a documentation that doctor -- line L,
22 2110. 2215. And then they seem to be at
23 bedside almost consistently after that.

24 Q. What is a reasonable range for chest
25 tube drainage per hour for a person who has

1 undergone an aortic valve replacement surgery?

2 A. As I have told you, I have not taken
3 care of a patient with an aortic valve
4 replacement, but my dealings with chest tube
5 placements is anywhere between 50 cc's and 100
6 cc's an hour, but I have seen that volume
7 increase depending on what is going on.

8 Q. The 50 to 100 an hour would be
9 reasonable for a postoperative patient that has
10 had chest surgery?

11 A. The ones that I have taken care of,
12 that was, yes.

13 Q. Is there any amount of hourly
14 drainage that would raise a concern in your mind
15 that the patient was having excessive bleeding?

16 A. I would have to couple it with other
17 things going on, I have turned a patient and
18 dumped 250 cc's of chest tube drainage but
19 nothing else has gone on at that same point. No
20 drop in his hemodynamic status, nothing like
21 that. I have seen a patient drop a lot when he
22 coughs while on a respirator. I guess that I
23 would be more concerned about consistent large
24 volumes of chest tube drainage.

25 Q. Would you agree that chest tube

1 drainage in a new postoperative patient that
2 increases from 100 to 250 cc's in the first two
3 hours should raise a concern from a nursing
4 perspective that the patient may be having
5 excessive postoperative bleeding?

6 A. I think it's something the nurse
7 should be watching. I don't think you can draw
8 any definite conclusions just from one piece of
9 information.

10 Q. Should it raise a concern for
11 excessive postoperative bleeding?

12 A. It's going to raise a concern, yes.
13 I'm going to watch it.

14 Q. Now, at 2010, James Long's pulse was
15 104. That's tachycardic; correct?

16 A. Where are you?

17 Q. 2010.

18 A. You are telling me 104 is
19 tachycardic?

20 Q. Yes.

21 A. Yeah, barely.

22 Q. It's tachycardic; correct?

23 A. Yes. By four points.

24 Q. And his blood pressure was 72 over
25 42; correct?

1 A. Yes.

2 Q. And his mean arterial pressure, I
3 believe, was 55 at that time?

4 A. Correct.

5 Q. From a nursing perspective, should
6 that have raised a concern for excessive
7 postoperative bleeding?

8 A. The nurses saw that as a change and
9 that's when they hung the Levophed and Epi, so
10 they did see that was a change from how it had
11 been and acted upon that.

12 Q. That's not what I asked you. I asked
13 you in a patient who has -- in James Long's
14 case, with a pulse of 104, a blood pressure of
15 72 over 42, a mean arterial pressure of 55, and
16 having just had a 250 cc drainage from his chest
17 tube, should that have raised a concern from a
18 nursing perspective that he may be having
19 excessive postoperative bleeding?

20 A. It's going to raise a concern. I'm
21 not sure that postoperative bleeding was going
22 to be my answer to that. I mean --

23 Q. What is your understanding as to why
24 James Long was placed on Amicar?

25 A. Amicar is a medication that's going

1 to increase clotting, so obviously it looked to
2 be a standing order. So if I'm remembering from
3 the depositions, they did contact a physician
4 and they were told to start the Amicar.

5 Q. And they started that at the time
6 when his blood pressure was 75 down to, I guess
7 it's 75 over 46. Just after he had that 75
8 blood pressure, they started the Amicar?

9 A. That's correct.

10 Q. And it was also in conjunction with
11 the bleeding that he had of 250 cc's; correct?

12 A. That's correct.

13 Q. So you believe that it was just a
14 standing order; that it had nothing to do with
15 the assessments that the nurses were providing
16 to the doctor?

17 A. No. It was done because of the
18 results that they saw, but it appears to be an
19 order that they have as a routine order to do in
20 those cases.

21 Q. What's your understanding as to why
22 he was placed on Levophed?

23 A. To raise his blood pressure.

24 Q. What's your understanding as to why
25 he required Epinephrine?

1 A. Again, it has to do with his blood
2 pressure and the results that they were getting
3 when they are monitoring his hemodynamic status.

4 Q. You would agree that between the
5 hours of 1950 and 2130 that Nurse Young was
6 unable to maintain James Long's blood pressure
7 at a level of at least 90 systolic as the
8 physicians had ordered; correct?

9 MR. JACKSON: Objection. Go ahead.

10 A. She at that time was trying to
11 titrate the medication to maintain a blood
12 pressure.

13 Q. And she was unable to get the blood
14 pressure up to the level that the doctor wanted
15 with the two drugs running; correct?

16 A. Yes.

17 Q. During that period of time she was
18 also increasing the drips; correct?

19 A. Yes.

20 Q. Both the Epinephrine and the
21 Levophed; correct?

22 A. That's correct.

23 Q. Did you find any evidence that Nurse
24 Young or Nurse Zilka informed the surgical
25 service that James Long was not responding to

1 the vasopressors between 1950 hour and 2130
2 hour?

3 A. 1950, which would be H?

4 Q. Correct. And 2130, which would be M.
5 Did you find that they notified the surgical
6 service at all that they were having difficulty
7 in getting his blood pressure to come up to the
8 90 systolic that the physicians had ordered?

9 A. It says that there was a doctor at
10 the bedside at 2110. I would have to look and
11 see. Again, those orders are not timed.

12 Q. Do you know who Dr. Yared is?

13 A. I would have to look.

14 Q. Do you know whether he is part of the
15 surgical service or not?

16 A. I would have to look at the list.

17 Q. You don't know?

18 A. I don't know names and occupations,
19 no.

20 Q. Well, the doctor that saw the patient
21 at line L, 2110, you don't know what his
22 responsibilities were in regard to the
23 management of Mr. Long, do you?

24 A. No.

25 Q. Did you read Dr. Yared's deposition?

1 A. Yes, I did.

2 Q. During that period of time that I
3 just mentioned, between 1950 and 2130, would you
4 agree that it would have been prudent for Nurse
5 Young or Nurse Zilka to request that a physician
6 from a surgical service come to the bedside and
7 evaluate the patient?

8 MR. JACKSON: Objection. Go ahead.

9 A. There were no other physicians
10 around. I mean, that's a difficult question.
11 Yes, someone should have been informed of what
12 was going on with the patient. I don't know
13 that they weren't, though, I guess is what I'm
14 saying to you.

15 Q. Well --

16 A. There is no documentation that they
17 were told that, that's correct.

18 Q. And you don't have any basis to
19 assume or presume that anybody was contacted
20 during that period of time and informed that
21 they were having problems maintaining the blood
22 pressure above 90 systolic, do you?

23 A. No, I don't know that they did that,
24 no.

25 Q. Have you ever requested a physician

1 to come down and see a patient because of
2 changes that you found on an assessment?

3 A. Yes.

4 Q. Do you know whether it's common for a
5 postoperative aortic valve patient to require
6 two vasopressor medications to support the blood
7 pressure?

8 A. I have not taken care of a patient
9 post-op there.

10 Q. Would you agree that it's important
11 for the nurses to keep the chest tubes of a
12 postoperative cardiothoracic patient free from
13 clots by routinely milking the tubes at
14 intervals?

15 A. My experience with chest tubes and
16 how they are to be milked is according to the
17 physician who has the patient.

18 Q. Okay.

19 A. So if the physician tells me to do
20 that, then, yes, I'm going to do that.

21 Q. And nurses working in a
22 cardiothoracic intensive care with surgeons
23 would be aware of what a surgeon wants; correct?

24 A. I would feel so, yes.

25 Q. So if Dr. Cosgrove, who did the

1 surgery, expected the nurse to do it on a
2 routine basis, you would expect that Nurse Zilka
3 and Nurse Young would be doing that on a routine
4 basis; correct?

5 A. If the order was written that they
6 were to do it at a specific time interval, yes.

7 Q. Even if there is not an order, aren't
8 there usually understandings between the
9 surgeons and the nurses in the unit as to
10 whether they are supposed to be doing that or
11 not?

12 A. I will say that there is usually an
13 understanding between the surgeon and the
14 nurses, yes. As to what that is, I couldn't
15 tell you. It depends.

16 Q. Do you have an opinion as to whether
17 Nurse Zilka and Nurse Young had a duty to
18 routinely milk the chest tubes to keep them
19 clear from clots in Mr. Long's case?

20 A. If they didn't see clots in there,
21 then, no. And depending on what the surgeon had
22 told them, you know.

23 Q. Can you have clots in chest tubes
24 that are in the portion of chest tubes that you
25 can't see?

1 A. Yes.

2 Q. And what happens if you get clots in
3 the chest tubes and they block off the drainage
4 of the chest tube?

5 MR. JACKSON: You just answered your
6 own question, didn't you?

7 A. You are going to have a blockage.

8 Q. Does anything happen to the cardiac
9 hemodynamics when you have a blockage in the
10 chest tubes?

11 A. You are going to increase thoracic
12 pressure.

13 Q. Can that cause cardiac tamponade in
14 some instances?

15 A. In some instances, it could, yes.

16 Q. Now, if Nurse Zilka and Nurse Young
17 failed to routinely milk the chest tubes as
18 expected by Dr. Cosgrove in James Long's case,
19 would you agree that that would be a deviation
20 from the standard of care?

21 MR. JACKSON: Objection. Go ahead.

22 A. Is the expectation written? I mean,
23 are you telling me that there is an expectation
24 that was actually documented on chest tubes?
25 The order on the chest tubes, let's check that.

1 Q. Well, let me ask this question.

2 A. Okay.

3 Q. Are nurses only required to routinely
4 milk chest tubes if there is an order written to
5 that effect?

6 A. My dealings with chest tubes has been
7 on a personal basis with the surgeon, and he
8 pretty much told me when he wanted the chest
9 tubes touched or not touched.

10 Q. I'm asking in this case. Are you
11 saying that Miss Zilka and Miss Young required
12 an order to routinely milk chest tubes?

13 A. Again, what they did with the chest
14 tubes has to do with how the surgeon wanted them
15 treated.

16 Q. But does the surgeon have to write an
17 order to that effect in order to have the
18 expectation that the nurses will do it?

19 A. I don't know that I can answer that.
20 I mean, sometimes there is a communication
21 between a doctor and a nurse that isn't written
22 down, so depending on what he told them.

23 Q. Would you expect an experienced ICU
24 nurse to know what the physician's routine was
25 if they had worked with that particular surgeon

1 on a regular continuing basis?

2 A. Oftentimes that's true, yes.

3 Q. Are you critical of any of the
4 nursing care provided by any of the nursing
5 staff while James Long was in the cardiothoracic
6 surgical intensive care unit?

7 A. No.

8 Q. Have I covered all the opinions that
9 you presently intend to offer at trial in this
10 case?

11 A. Yes.

12 Q. Are there any opinions that we
13 haven't discussed that you intend to offer at
14 trial?

15 A. No.

16 Q. If you arrive at any new opinions
17 between now and the time of trial, I would ask
18 that you tell defense counsel, and then I would
19 continue your deposition relative to any new
20 opinions that you should have.

21 MS. TOSTI: With that, I think we are
22 finished.

23 MR. JACKSON: You have to tell Vivian
24 that you want to read it.

25 THE WITNESS: I would like to read.

1 - - - - -

2 (Deposition concluded at 4:30 p.m.)

3 (Signature not waived.)

4 - - - - -

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1 AFFIDAVIT

2 I have read the foregoing transcript from
3 page 1 through 96 and note the following
4 corrections:

5 PAGE LINE REQUESTED CHANGE

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17

MARY ANNE BELANGER, R.N.

18

19

20 Subscribed and sworn to before me this
21 day of , 2002.

22

23 Notary Public

24

25 My commission expires

1 CERTIFICATE

2

3 State of Ohio,

4 SS :

5 County of Cuyahoga.

6

7

8 I, Vivian L. Gordon, a Notary Public within
9 and for the State of Ohio, duly commissioned and
10 qualified, do hereby certify that the within
11 named MARY ANNE BELANGER, R.N. was by me first
12 duly sworn to testify to the truth, the whole
13 truth and nothing but the truth in the cause
14 aforesaid; that the testimony as above set forth
15 was by me reduced to stenotypy, afterwards
16 transcribed, and that the foregoing is a true
17 and correct transcription of the testimony.

18 I do further certify that this deposition
19 was taken at the time and place specified and
20 was completed without adjournment; that I am not
21 a relative or attorney for either party or
22 otherwise interested in the event of this
23 action. I am not, nor is the court reporting
24 firm with which I am affiliated, under a
25 contract as defined in Civil Rule 28 (D).

18 IN WITNESS WHEREOF, I have hereunto set my
19 hand and affixed my seal of office at Cleveland,
20 Ohio, on this 30th day of April, 2002.

20

21

22

Vivian L. Gordon

23

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

24 My commission expires June 8, 2004.

25

1	INDEX	
2	EXAMINATION OF MARY ANNE BELANGER, R.N.	
3		
4	BY MS. TOSTI:.....	4:13
5		
6	Exhibit 1 was marked.....	10:19
7	Exhibit 2 was marked.....	53:11
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

A				
able 5:9 36:24	88:1 89:11 94:13	apparently 56:13	63:1 64:9,22 65:1	63:13 67:23
38:16 39:25 40:3	ago 10:3,5 14:22	81:12	65:9 91:2	68:20 82:11
40:7 42:3 45:18	20:15 31:5 76:8	appear 83:16	assessments 31:12	basic 11:7,14
49:7 81:15,17	agree 29:16 39:14	APPEARANCES	39:10,15,20	basis 60:15 90:18
abnormal 44:11	40:13 41:9 42:8	2:1	40:14 41:9 43:8	92:2,4 94:7 95:1
about 6:10 17:3,12	43:5 46:10 53:1	appears 33:5,19	45:3,9 53:2 55:25	became 58:24
30:21 33:14,20	57:8,13,20 60:19	65:19 72:7 87:18	63:7,14 65:23	Becker 2:3
34:1 47:2,10	61:8 63:24 65:11	appointments 12:6	66:3,11,19 78:9	become 6:16 16:10
56:10 58:10 59:2	67:11,18,23	appropriate 38:22	81:22 87:15	becoming 36:2,9
62:12,13 72:2,16	69:25 70:22	57:25 74:6	assignment 54:13	81:19
73:13 82:20	72:20 73:18,25	approximate 17:15	assist 52:9,13	beds 18:16 25:4,15
84:23	74:3 76:9 79:1,6	approximately	Assistance 16:16	bedside 83:5,23
above 1:22 90:22	79:14 84:25 88:4	9:18 17:8 18:16	associate 11:17	89:10 90:6
98:11	90:4 91:10 93:19	28:15	assume 3:15 5:8	before 1:16 4:21
absence 27:19	agreement 1:18	approximation 8:2	46:4 59:9 63:11	5:24 8:7,12 10:4
academic 11:17,25	ahead 36:21 40:17	21:16	68:6 90:19	15:4 19:10 20:1,2
12:3,6	60:23 61:6,13	April 1:11 98:19	assumed 59:14,24	20:6 25:20 28:18
according 91:16	70:16 71:5 72:24	area 13:11 16:3	assuming 48:9	36:2,9,16 54:8
across 28:4	74:2,14 76:12	17:9,11 18:22	63:10 66:5 67:16	79:12 80:12
act 16:18 45:19	88:9 90:8 93:21	23:6,17 37:8	68:22	97:20
acted 8:14 86:11	Akron 9:13,16,23	50:14 63:25	assumption 68:18	beginning 19:2
acting 45:3 46:6	alert 51:18 63:21	66:18 67:2	69:15,15 77:17	61:17
56:18	almost 7:11 10:2	areas 36:17 37:10	asterisk 63:4,17,19	behalf 1:14 2:2,10
action 98:16	83:23	argument 3:18	64:1,10,14 65:5	being 4:9 28:23
activity 66:8	although 3:8 79:6	around 27:12 77:18	attempt 14:5	57:9,16,22 65:16
actually 7:10,25	always 18:1	90:10	attend 12:13 13:4	65:17 68:1,6
10:3 16:7 20:13	Amicar 86:24,25	arrive 95:16	13:14	71:19 76:14 77:5
33:23 93:24	87:4,8	arrived 52:17 58:14	attended 12:10	Belanger 1:10,13
additional 15:23	among 46:21	arterial 49:18 86:2	13:14 15:20	3:1,11 4:7,12,16
32:3,14 34:11	amount 47:7 84:13	86:15	attention 40:23	10:18 53:10
54:6,7,11	Andress 1:19 2:11	artery 67:16,19	attorney 3:23 4:5	97:17 98:9 99:2
additions 11:4	9:12,16	68:1,16 69:1.19	98:15	believe 3:16 23:23
address 4:17	anesthesia 74:25	70:3,14,24 71:23	August 6:15 33:15	27:24 28:19
addressed 41:3	83:14	72:6	53:6,23 54:3 58:6	31:17 32:25
adjourment 98:14	Anne 1:10,13 4:7	articles 34:16	59:1,10	34:19 61:22
administrative	4:12,16 97:17	asked 3:1 4:1 8:7,9	autonomy 50:10	62:16 69:21
23:14	98:9 99:2	10:12 41:3 49:25	available 9:6	73:13 77:11 86:3
admission 33:7,7,9	another 22:22	54:10,15,18	average 17:12	87:13
advanced 14:14	answer 5:3,10,20	86:12,12	awarded 11:16	below 55:11 70:10
advocates 16:20	11:21 36:24	asking 21:16 32:11	aware 51:2 67:7	71:8
AFFIDAVIT 97:1	40:22 49:7 52:23	33:23 41:13	91:23	beneficial 36:17
affiliated 98:16	60:8,24 61:14	42:24 60:11 69:5	away 47:16	besides 20:23 21:5
affiliates 35:20	71:17 76:18	69:11 94:10	4-line 66:21 67:9	better 40:21
affiliation 14:15	86:22 94:19	aspect 23:14		between 3:4,7
affiliations 35:11	answered 49:25	assault 14:16 15:9	B	16:18 19:3 24:7
affixed 98:18	93:5	15:11,13 16:23	bachelor's 11:18	25:23 29:24
aforesaid 98:11	answers 5:15	16:25 21:7 37:11	back 14:22 24:11	81:14 84:5 88:4
afraid 37:25	anticipating 7:9	assert 4:2	38:4 39:21,25	89:1 90:3 92:8,13
after 13:5 26:16	anxiety 81:21	assess 45:18 70:2	40:3 41:6 48:13	94:21 95:17
34:2,23 52:2,3	anybody 90:19	75:17 79:9	71:22,25 72:4,13	beyond 43:20
68:22 70:20	anyone 20:23,24	assessed 65:16,17	73:9 76:14,20	big 50:22
72:17 74:19 76:3	21:2,5 39:1,24	67:20 68:2,2,6,8	77:1,3,6,7,12,15	biggest 50:20
76:4,5 79:24 80:2	anything 6:2,5	71:24 76:2 81:18	80:14,24 81:8	bilateral 64:5
80:9 81:1,22	45:13 46:24	issessing 45:2	82:24	bilaterally 64:1
83:23 87:7	48:19 58:11 62:5	68:14 70:14	background 7:4	bit 6:10 82:20
afterwards 98:11	62:16 93:8	75:15	balloon 31:6,9	bleeding 8:16 30:18
again 20:10 47:24	anywhere 17:17	assessment 29:23	barely 85:21	46:13,18,20 47:6
48:14 49:12	64:5 66:1 84:5	38:22 41:14	base 68:12	47:22,24 48:2,7
52:19 69:14 71:9	aortic 8:21 33:7	45:20 49:3 50:18	based 4:4 45:4	48:25 84:15 85:5
72:7,25 75:25	44:22 45:10,25	61:17,19,23,24	55:19 58:16	85:11 86:7,19,21
	46:17 84:1,3 91:5	61:25 62:6,19,22	59:23 62:18	87:11

<p>block 93:3 blockage 93:7,9 blood 42:10 46:22 50:13 51:5 69:3 69:22 79:21,25 80:3,9 81:11,14 85:24 86:14 87:6 87:8,23 88:1,6,11 88:13 89:7 90:21 91:6 bloody 47:8 board 28:5 boards 14:4 boluses 81:17 book 33:22 both 11:22 23:10 37:14 88:20 bottom 55:7 63:9 bowel 65:5 box 64:23 boxes 62:23 boy 7:25 breath 62:12 64:1 bring 3:2 6:6 bronchi 64:6 burn 38:4 business 4:17 bypass 48:4</p> <hr/> <p style="text-align: center;">C</p> <p>calculate 49:13 called 1:14 4:8 14:8 17:6 62:22 came 9:20 19:3 37:23 38:4 56:7 59:11,14,22 62:11 71:25 72:4 72:5 82:24 83:13 campus 35:15 capability 50:15 cardiac 8:18 14:14 26:7 30:21 49:14 49:14 50:5,5,11 50:19,22 51:4,9 51:19,21,22,23 51:25 52:2,5,21 52:25 62:2,3 72:21,22 73:3,3,7 73:7,21,21 74:10 74:10,13 93:8,13 cardiorespiratory 63:25 64:12 cardiothoracic 26:19 27:14,21 28:1 36:3,10,20 36:23 43:19 44:3 44:22 45:23 48:5 49:21 51:17 60:22 91:12,22 95:5 care 7:24 19:15</p>	<p>23:4,6,6,12,17 24:6,17 25:1,2,5 25:6,7,8,9,18,19 25:22 26:1,1,15 27:6,7,13,20 28:1 28:2,3,4,6,7,10 28:20,25 29:5,8 29:10,14,19,20 29:21 35:3 36:3,4 36:10,20,23 37:3 37:4,17,21 38:2,7 38:9,23 39:15,20 40:24 43:6,19 44:3 45:6,24 48:6 48:22 49:1,21 54:16,20,23,24 55:2,2,10,12,13 55:15,15,19,20 55:23,24 56:5,10 56:12,17,25 57:9 57:11,15,16,22 57:25 58:7,14,25 59:9,14,24 60:20 61:4,9,10,12,21 68:12,14,20 69:16 70:1,10 71:13,23 78:2,19 79:3,11 84:3,11 91:8,22 93:20 95:4,6 cared 28:13 52:1,4 58:22 caregivers 39:20 caring 26:2 43:6 44:22 carried 80:1 carry 56:24 65:12 case 1:6 3:3 5:25 6:7,13 8:15 9:9 9:21,25 10:7,9 17:18 27:22 28:2 28:9 30:12 31:19 34:7,10,15,20,24 35:8,23 53:15,25 54:8,14,16,22 55:14 86:14 92:19 93:18 94:10 95:10 cases 7:10,22,23 17:6 42:1 87:20 catheter 67:5 cause 48:4 93:13 98:10 cc 72:18 73:15 86:16 CCU 19:3 29:17 cc's 76:7 84:5,6,18 85:2 87:11 cells 79:21,25 80:3 80:9,13 Center 1:20 2:14</p>	<p>certain 33:3 49:9 54:19 certainly 47:9 certainty 55:10 CERTIFICATE 98:1 certification 14:19 15:7,17,25 16:3 certifications 14:11 14:12 certified 4:10 14:13 certify 98:9,13 cetera 42:11 CEU's 15:23 change 40:4 42:13 43:15 62:7,18 64:8,18,25 65:8 82:1 86:8,10 97:5 changed 28:24 61:20 changes 29:1,4,9 39:2 15:1 3,9,11 61:18,23 63:14 91:2 charge 8:23,25 23:11,13 chart 64:4 charted 64:7 charting 41:22 62:24 charts 83:11 check 32:12 50:24 64:23 65:9 93:25 chest 28:7 47:2,8 51:16 72:18 73:16,20 76:7 83:24 84:4,10,18 84:24,25 86:16 91:11,15 92:18 92:23,24 93:3,4 93:10,17,24,25 94:4,6,8,12,13 choose 5:18 chose 68:16 CHRISTOPHER 1:4 circled 66:22 City 38:8 Civil 4:9 98:17 classroom 37:12 clear 63:22 64:1 92:19 Cleveland 1:7,20 1:20 2:6,14,15 9:14 10:13 33:4,8 34:3 35:11,15,16 35:19 58:21 59:7 98:18 Clinic 1:733:4,8 34:3 35:11,16 58:21 59:7</p>	<p>clinical 12:23 15:1 15:4 16:4 17:9,11 37:13 Clinic's 35:19 close 59:11 77:2 closely 76:10 clots 91:13 92:19 92:20,23 93:2 clotting 87:1 college 12:7,11,17 12:19 13:2,13 column 65:4 combined 25:14 come 10:12,16 26:14 47:8 89:7 90:6 91:1 comes 47:1 comfortable 39:7 coming 73:1 commencing 1:2 1 commission 97:25 98:24 commissioned 98:8 common 1:1 36:18 91:4 communication 82:15 94:20 communications 82:19 83:2,9 Community 18:4,8 18:17 19:8 compared 62:4 complete 11:7,13 15:15 33:11,15 completed 11:25 98:14 completing 11:24 complications 8:21 30:19 43:9 component 12:23 14:15 15:1 comprehensive 31:21 concern 84:14 85:3 85:10,12 86:6,17 86:20 concerned 84:23 concluded 55:9 96:2 conclusions 85:8 condition 42:14 43:16 62:7,18 64:19 75:5,11 conduct 17:24 18:2 conducted 17:20 confused 60:1 conjunction 87:10 connection 6:7 connotation 29:15 consider 46:21 considerably 33:17</p>	<p>considered 6:7 consistent 51:3,9 84:23 consistently 72:10 83:23 constantly 43:12 consult 34:24 consultant 6:13,17 6:23 consultation 8:23 consultations 9:7 consulted 7:7,17,22 9:10 consulting 6:14 9:5 contact 35:2,6 87:3 contacted 9:21,25 90:19 contained 3:25 continually 68:1 continue 45:6 95:19 continuing 79:9,17 95:1 continuous 49:9 contract 98:17 coordinator 16:5 17:1 copies 3:12 copy 4:1 32:24 53:5 53:14 coronary 23:4,6,16 24:6,17 25:1,5,7 25:8,19 26:1,15 27:6 correct 8:10 12:21 15:8 18:5,6 22:4 22:13 24:24 25:19 26:20,21 29:12,13 33:1 34:3 38:19 40:5 40:11,12 43:16 44:18,19 58:15 59:3 60:22 61:5,7 64:14,23,24 65:1 65:6,7,9,10 66:22 66:25 67:1,5,6,9 67:10,15 68:4 70:20,21 72:11 72:12 74:13 75:16 76:15 77:8 79:4,5 82:16 85:15,22,25 86:4 87:9,11,12 88:8 88:15,18,21,22 89:4 90:17 91:23 92:4 98:12 corrections 11:4 97:4 correctly 12:11 45:19 57:1 correlating 46:7 correspondence 3:4</p>
--	--	--	---	--

<p>3:7,9,11 4:4 10:2 32:9,10,15 Cosgrove 83:11,15 91:25 93:18 coughs 84:22 counsel 1:14,19 3:7 4:25 5:13 34:11 53:18 95:18 counted 7:8 county 1:2 15:22 16:6,9,15 20:24 21:6,25 98:5 couple 84:16 course 13:7,16 15:16 29:21 73:15 court 1:1 5:16 98:16 covered 95:8 crimes 16:17 critical 23:6 28:3 28:10 29:8,10,14 29:18,20,21 36:16 95:3 current 11:2 16:3,8 currently 16:2 20:22 25:15 37:1 37:7 53:25 curriculum 23:3 30:11,15 Cuyahoga 1:2 98:5 CV 11:1 12:9 CVP 66:22</p> <hr/> <p>D</p> <p>D 98:17 date 1:22 10:15 11:2 39:12 72:1 dated 53:5 DAVID 2:13 Davis 27:4 day 1:21 42:4 97:21 98:19 days 33:6,9,20 34:1 dealing 3:5 8:20 dealings 84:4 94:6 deals 16:17 decided 6:18 decision 77:18 decisions 77:5,15 decrease 46:22,23 51:24,25 74:24 75:5 defendant 1:8 2:10 7:19 10:7 defense 4:25 5:13 7:21 34:10 35:8 95:18 defined 98:17 definite 85:8 definitely 39:4</p>	<p>47:23 60:1 degree 11:17,17,18 11:25 55:9 degrees 12:4 delay 40:15 41:11 department 18:24 19:1,11 23:5 depend 17:10 38:25 dependent 64:13 depending 17:18 23:11 50:21 74:20 84:7 92:21 94:22 depends 92:15 deposed 4:10 deposition 1:10,13 4:20 8:5 9:1 10:18 32:5,21 53:10 56:4 62:17 64:4,17,21 89:25 95:19 96:2 98:13 depositions 4:2 32:17,18 34:6 87:3 designed 42:9 determine 44:17 58:16 75:9 determined 38:21 developed 52:2,5 developing 39:22 42:21 43:3 deviation 70:1 93:19 diagnosis 52:10,11 52:13 diagnostic 52:12 Dick 27:4 difference 19:25 29:22 80:23 different 29:15 difficult 90:10 difficulty 11:22 89:6 diminished 57:15 diploma 11:24 12:20 Diplomate 1:17 direct 37:13 directions 5:22 directly 26:15 director 16:15 discern 82:3 discharge 34:3 discover 3:17 discoverable 3:8 discrepancies 62:15 discretion 50:5 discuss 56:11 discussed 76:8 95:13 distention 50:24</p>	<p>divide 21:17 doctor 78:11 83:21 87:16 88:14 89:9 89:20 94:21 doctors 83:5 doctor's 33:19 65:12 document 10:25 39:10 71:19 documentation 39:14,23 40:6,25 56:1 68:5,23 81:2 83:21 90:16 documentations 81:5 documented 40:20 70:9,18,25 71:15 71:20 79:13 93:24 documents 3:13,24 3:24 doing 6:14 16:21 19:19 20:17 23:12 31:12 38:18 56:25 66:3 69:6 71:10,11 72:6 73:21 78:8 92:3,10 done 3:3 7:10 12:24 25:11 28:24 40:20 41:1 44:25 47:19 49:15 52:13 53:2 70:20 78:12,15,18 79:24 80:2,21 81:2 83:10 87:17 doses 82:1 down 5:16 11:22 17:4 40:6,9 41:14 44:18 47:16 51:14 64:12 66:9 69:4 76:23 87:6 91:1 94:22 downward 74:12 Dr 27:4,4 83:11 89:12,25 91:25 93:18 drafts 53:20 drainage 47:3,8 72:19 73:15,20 76:7 83:25 84:14 84:18,24 85:1 86:16 93:3 dramatically 28:24 draw 80:17 85:7 drips 88:18 drop 47:10,11,12 47:16,20 79:18 84:20,21 drugs 88:15 dub 29:19</p>	<p>duly 4:9 98:8,10 dumped 84:18 during 22:11,25 68:2,8 70:7 77:19 88:17 90:2,20 duties 16:13 23:8 44:21 duty 43:7 57:9,21 65:12 92:17</p> <hr/> <p>E</p> <p>each 15:6 79:24 81:1 early 13:15 43:9 easier 83:10,18 easily 10:4 echocardiogram 52:9 edema 64:13,18 education 55:17,19 effect 51:22 75:1 82:12 94:5,17 eight 4:24 8:8 25:8 either 23:11 35:8 62:17 83:14 98:15 element 77:16 eliminating 71:12 emergency 14:13 14:19 18:14,24 19:1,7,11 22:3,7 22:12,16,25 23:19 24:2,4,16 24:22,23 29:12 30:1,8 52:6,22 employed 16:10 18:4 21:2,9 58:21 58:24 employer 16:8 employment 18:7 18:11 19:8 20:1 21:5 59:7 end 10:11 18:11 39:5 ended 19:7 59:21 English 13:12,21 ensure 57:14,21 ensured 70:24 enter 5:19 49:2 entire 3:2 5:25 entitled 3:17,18 environment 27:17 46:11 Epi 86:9 Epinephrine 87:25 88:20 equally 61:11 ER 19:4,4 24:10 28:11,16 29:17 30:3,4 31:7 ESQ 2:4,12,13</p>	<p>established 83:19 et 42:11 etc 1:4 evaluate 90:7 evaluated 42:12 evaluating 81:10 evaluations 42:25 even 81:11 92:7 evening 58:6 59:10 event 98:15 events 40:1 83:6 ever 4:20 8:14 9:4,9 10:6 14:7 19:14 27:13 30:17 31:3 31:11 34:10 35:2 35:10,14 37:15 42:25 52:1,8 90:25 every 17:13 65:19 65:25 67:13,20 69:2 70:25 72:7 72:10,23,25 73:5 73:8 74:1,4,5 78:7,12 82:24 everything 42:5 71:10 evidence 58:5 67:25 68:7,9,10 70:19 88:23 exact 21:15 66:6 exam 14:25 15:5,13 17:17 examination 1:15 4:8,12 17:24 99:2 examiner 14:17 15:10,11 example 81:11 exams 17:19 excessive 46:13,18 46:20 47:6,22 48:7,25 84:15 85:5,11 86:6,19 exerted 3:23 Exhibit 10:19,23 53:7,11 99:6,7 expect 60:20,21 92:2 94:23 expectation 93:22 93:23 94:18 expected 55:21,23 92:1 93:18 experience 6:10,25 7:3 9:13 27:19 28:6 36:2,9,14,15 36:18 38:20 39:5 42:24 52:8,15,16 55:20 59:6 91:15 experienced 48:8 60:22 61:2 94:23 expert 6:12 7:2 8:5 8:14 32:21</p>
--	--	---	---	--

<p>expertise 38:23 experts 3:8 35:7 expert's 3:9 expires 97:25 98:24 expressed 54:3 extended 39:8 extremities 63:22</p> <hr/> <p>F</p> <p>fact 43:11 63:16 68:21 76:6 77:21 80:5,21 81:18 83:12 facts 60:14 fail 70:2 failed 61:9 93:17 fall 51:15 55:11 fallen 80:6 falling 71:7 74:18 familiar 39:1 far 15:2 31:21 51:5 81:22 82:2,4 feel 5:14 27:23 28:3 28:9,25 39:6 44:4 44:5,7,14 50:6 58:12 62:9 70:10 91:24 feels 5:21 fell 70:10 felt 7:2 few 5:2 74:19 field 6:25 7:5 15:4 29:1,4,7,7 38:17 fields 29:18 figure 56:11 file 3:2,9,11,25 5:24 5:25 6:3 32:25 33:5 find 6:22 58:5 61:18 66:1 76:1 79:25 88:23 89:5 findings 46:7,8 50:18 finish 11:20 78:17 finished 79:21 95:22 firm 9:6,11 98:16 first 4:9 6:11 9:13 9:24 10:1 12:18 14:5 16:10 23:18 24:12 33:6,8 58:24 59:8 60:3 74:19 85:2 98:9 five 7:11 16:19 20:13 flag 47:21 flags 46:21,21 flipping 42:3 Floor 2:14 flowsheet 41:24 42:16 43:1 65:20</p>	<p>67:24 69:21 72:15 flowsheets 41:21 42:8,18 fluid 81:17 fold 42:2 followed 72:18 73:14 following 8:21 73:19 97:3 follows 4:11 foregoing 97:2 98:12 forensic 15:13,23 forensics 15:12 formal 10:16 formulating 34:14 Fort 15:21 forth 1:22 98:11 Forty 22:1 found 6:24 7:24 36:14 39:5 64:17 91:2 Foundation 1:7 35:12,17 four 14:20,21 17:5 17:17 21:22 85:23 frame 66:6 68:15 77:13 free 5:14 58:12 62:9 63:22 91:12 frequent 50:6 53:2 73:21 74:1,10 82:15 frequently 45:2 72:22 fresh 28:11 47:15 from 6:2 13:5 17:17 18:13 19:7 21:14 22:20,21 23:20 24:8,15 25:1 26:11 29:14 33:4 33:9,15,17,25 34:3,5,10 38:1 47:8 48:21 50:17 52:17 54:16,16 58:8 59:25 60:20 60:21 61:18 62:15 64:8,20,25 65:8,20 67:4,9,12 67:18,24 70:1 71:21 72:4 73:1 74:17 77:21 80:6 80:12,17 82:23 85:2,3,8 86:5,10 86:16,17 87:2 90:6 91:12 92:19 93:20 97:2 front 31:20 33:13 33:22 50:22</p>	<p>full 4:14 19:4,6,9 19:22,24 20:12 23:19,21 24:2 full-time 19:14 24:22 function 39:16 50:15 51:21 74:13 further 98:13 future 3:16 4:2 41:17</p> <hr/> <p>G</p> <p>game 60:5 gaps 72:8 gastro 65:3 gathered 50:14 77:18 general 36:16 74:21 generality 39:2,4 generalization 45:1 generally 75:5 generated 35:22 gentleman 68:13 81:11 82:23 geographically 29:22 getting 76:20,25 80:18 88:2 89:7 give 5:15 8:1 9:17 55:16,20 81:17 given 29:10 33:3,6 33:8 48:12 54:14 57:15 76:6 79:14 80:5 81:20 82:22 giving 40:23 go 5:2 15:21 26:5 31:8 32:12 36:21 39:3 40:14,17 41:9 51:14 60:23 61:6,13 63:23 70:16 71:5 72:24 73:9 74:2,14 76:12,14,20,25 88:9 90:8 93:21 goal 6:20 goes 36:16 80:14 going 5:2,8 10:22 10:23 12:15 31:6 37:25 39:24 40:25 41:1 44:17 44:18 47:14,18 47:23 50:23 51:6 51:23,25 55:16 55:20 56:9 57:23 71:9 72:15 74:8 75:17 76:16,17 76:2 177:3,12 80:23 84:7,17 85:12,13 86:20 86:21,25 90:12</p>	<p>91:20 93:7,11 gone 84:19 good 7:4 68:14 Gordon 1:16 41:8 98:8,22 graduate 57:4,10 graduated 13:5 38:1 graduates 36:19 grid 62:22 ground 5:2 grounds 5:21 guess 40:21 47:17 68:11 71:17 77:17 84:22 87:6 90:13 guesstimate 7:15 guide 38:16</p> <hr/> <p>H</p> <p>H 89:3 hand 5:16 10:22 98:18 handle 23:14 hands-on 23:12 happen 6:16 48:20 93:8 happened 39:13 48:19 happens 93:2 happy 5:7 hard 68:9 having 29:17 38:11 38:13 44:25 46:18,19 74:12 84:15 85:4 86:16 86:18 89:6 90:21 head 5:16 37:21 38:7 50:25 56:20 health 35:3 heart 50:16 51:24 helpful 62:10 hematocrit 47:10 47:12,13,15,21 47:23 79:24 80:2 80:6,8,17 hematocrits 47:18 47:19 hemodynamic 30:8 30:23,25 31:4,12 31:14 42:11 44:5 44:10,16 45:22 46:2 49:4,17,23 51:2,7,8,11 65:15 65:22 66:3,10,19 67:4 84:20 88:3 hemodynamics 93:9 hemorrhaging 75:1 her 3:2,2,4,11,13 21:19 32:24</p>	<p>36:17 38:18,20 48:9 56:3,10,12 57:10 59:2,6,8 60:7,11,15 61:10 61:16,17,23,24 62:5,17,18 63:9 63:12 64:3,3,16 64:16,21 71:18 hereinafter 4:10 hereunto 98:18 higher 48:6 him 59:14 68:14,14 69:16 73:22 77:6 81:17 history 50:20 52:19 hold 12:6 13:22 14:10,12,14 53:25 hope 43:22 hospital 11:9 12:24 16:6,21 17:16,20 17:24 18:4,8,15 18:17 19:3,8 20:14 21:8,10,14 21:21,23 22:3 23:18 24:8,13,25 26:7,11,19 27:12 31:7 38:3,6 39:11 hour 9:1 15:20 19:19 20:2,7,14 20:18 22:13 42:5 65:25 69:2,20 72:19 73:14,15 76:3 77:7,11 78:7 78:12,18 79:22 83:25 84:6,8 89:1 89:2 hourly 65:25 75:25 76:1 78:3 84:13 hours 15:4,22 17:5 17:8,18 19:18,23 19:24 20:13 21:22 22:1 68:3 70:4,15 72:23,25 74:1,4,19 85:3 88:5 Brobart 55:6 59:17 60:3 HUDAK 2:13 lung 86:9 hygiene 66:9 hypotension 71:2 72:18 73:13,20 76:8 H-R-O 59:18</p> <hr/> <p>I</p> <p>ICU 19:4 24:18,19 26:10,15 27:6 29:17 38:24 39:1 41:21 42:18 43:1</p>
--	--	--	---	--

44:22 51:17 60:22 61:2,5 67:24 68:3 70:5 73:4 94:23 idea 21:17 identification 10:20 53:12 identified 10:23 35:4,7 42:19 43:2 identify 10:24 53:8 55:3 II 2:12 imagine 33:12,16 68:15 immediate 26:2 27:7,14 28:13 29:4 43:6 44:23 45:10 immediately 59:14 59:25 impaired 50:16 important 5:4,14 39:15,18 45:8,13 45:17 48:15,16 49:21 50:2 91:10 impression 58:2 59:13 76:24 improving 79:18 inch 33:14 included 55:24 including 3:3 income 21:13,21 incomplete 40:14 41:10 increase 46:22 48:24 84:7 87:1 93:11 increased 47:2 50:14 increases 85:2 increasing 88:18 independent 25:12 independently 38:24 index 49:14 99:1 indexes 50:6 72:22 73:3,7,22 74:11 Indiana 15:21 indicate 39:22 42:13 43:8,15 64:25 indicated 26:18 50:7 55:8 77:10 indicates 31:18 66:24 80:25 82:14 indicating 9:6 64:16 66:10 74:12 indication 79:8 indicative 42:20	indicator 47:24 indicators 40:4 75:8 individuals 54:19 individual's 54:24 inexperienced 36:19 57:17 inference 30:12 information 48:11 48:21 60:7 67:8 85:9 informed 43:14 88:24 90:11,20 infused 80:10,13 infusing 79:22 infusion 80:2 instances 93:14,15 institution 81:25 instruct 5:21 instruction 37:12 intake 78:12,14,18 intend 54:6 95:9,13 intensive 19:15 25:1,5,9,18,22 26:1 28:2 36:3,4 36:10,20,23 37:2 37:4,17,21 38:2,7 38:9 43:5,19 44:3 45:24 48:5,22 49:1,21 55:19 71:22 78:19 79:3 79:11 91:22 95:6 interested 98:15 intersperse 83:16 interval 92:6 intervals 53:3 91:14 intervention 81:1 interventions 45:4 45:5 55:25 81:3 81:22,24 82:2,4,9 invasive 31:14 invitation 10:16 involvements 51:16 involving 8:15,20 in-service 31:5 issues 8:15,20 34:20 items 67:13 J J 2:13 Jackson 2:12 3:1 3:22 5:18 8:7 9:11 21:19 32:8 32:14 36:11,21 40:17 41:12 49:25 57:18 60:3 60:10,17,23 61:6 61:13 66:12 70:6 70:16 71:5 72:24	73:24 74:2,14 76:12 78:5 81:7 88:9 90:8 93:5,21 95:23 James 34:2 35:4 55:11 57:25 58:7 58:22 59:10 61:17 67:25 70:4 72:17 75:23 79:20 85:14 86:13,24 88:6,25 93:18 95:5 Jane 32:5,22 January 16:1 Jeanne 2:4 32:9 60:10 66:13 jeopardizing 71:13 job 59:8 jobs 57:14 Joe's 12:15 13:5 JOHN 2:12 Joseph's 11:9 journal 34:15 judicial 16:19 jugular 50:24 July 58:23,24 June 10:3,11,14 98:24 just 3:14,20 5:1 7:8 10:24 14:21 20:20 21:16 24:2 26:10 32:4,11 40:9 42:15 47:11 48:19 53:7 58:24 68:15 69:11 70:12 74:20 76:22 78:10 80:19 81:21 85:8 86:16 87:7,13 90:3 93:5 K K 69:21 keep 43:14 81:14 91:11 92:18 keeping 29:1 48:13 kept 29:3,7,9 kind 6:20 48:14 57:1 know 5:6 9:20,24 10:9 12:10 22:17 31:22 40:18,20 43:23,25 44:1,5,6 44:9 45:7,12 47:15 48:15,17 49:8,13,17 50:4 51:22 52:20,23 56:4,19 60:8,9,14 63:6 67:3 69:8,10 69:17 70:17 71:8 71:15 72:3 73:2	76:19 77:16 78:20 89:12,14 89:17,18,21 90:12,23 91:4 92:22 94:19,24 knows 32:12 L L 1:16 83:21 89:21 98:8,22 lapse 61:12 large 18:15 47:7 84:23 last 7:8,13 18:19 19:19 22:2,11 25:17,21 28:12 68:2 69:19 70:4 78:18 lasted 73:13 later 39:12 42:20 43:2 latter 75:13 law 9:11 lay 34:7 laying 50:21 learning 61:4 least 34:5 88:7 leaves 80:12 lectured 30:17 left 18:13 19:10 20:6 24:9 left-hand 66:9 legal 6:16,23,25 LeMoyné 12:11 let 5:6 58:23 60:7 78:17 94:1 letter 53:5 69:21 72:20 79:22 let's 21:4 24:11 81:11 93:25 level 48:24 78:24 88:7,14 Levophed 86:9 87:22 88:21 liaison 16:18 Liberty 4:18 license 13:23 14:7 life 14:14 like 3:21 5:12 6:9 11:5 23:23 48:10 48:19 50:9 51:5 56:10 58:9 66:14 71:25 81:2 82:18 83:11 84:20 95:25 limit 27:21 line 47:16 48:3 49:5 49:6,18 50:2 65:20 78:22 83:17,21 89:21 97:5	list 31:21 89:16 listed 30:15 32:15 listening 76:18 literature 34:16 little 6:9 60:5 82:20 live 40:18 long 1:4 11:11 15:19 18:25 24:5 28:14 55:11 57:11,25 58:20 58:22,25 59:10 59:25 60:19 61:17,22 65:16 70:4 71:21 72:17 72:17 73:12,12 79:20 82:23 86:24 88:25 89:23 95:5 Long's 34:2 35:4 55:14 58:7 62:7 67:25 70:14 75:23 85:14 86:13 88:6 92:19 93:18 look 10:1 31:20 39:21 40:3,7 42:22 47:13,17 55:5 56:6 62:8 72:14 73:9 75:25 89:10,13,16 looked 6:19 31:25 55:2 62:3,12 87:1 looking 39:25 45:14 45:15 46:9 47:25 51:1 54:24 68:16 70:8 71:14,16 76:22 77:13 looks 66:14 83:11 loss 47:4 lot 80:23 84:21 love 40:19 low 79:14 lowest 79:2,7 TI - - - - M 2:4 89:4 made 20:18 77:5 80:8 main 35:14 maintain 54:2 88:6 88:11 maintaining 90:21 make 3:14 11:5 45:1 56:25 62:2 80:23 making 38:18 64:4 68:18 77:18 83:5 malpractice 7:2 man 80:24 management 89:23 manner 46:5
--	--	---	--	--

<p>many 4:23 7:6,12 8:4,9 9:15 15:4 17:8 18:16 22:15 22:17,18,19,24 25:4,9,15 31:5 39:3 51:16 75:18 76:15 man's 71:13 mark 64:23 65:9 marked 10:19 53:6 53:11 63:25 99:6 99:7 Mary 1:10,13 4:7 4:12,16 32:5,22 97:17 98:9 99:2 materials 31:18,24 32:3,16 34:12 54:7 matter 8:6,9:10 10:13 13:9 30:18 matters 6:11 7:6,17 8:24 may 4:2 5:18 39:22 40:15 41:10 42:13 43:8,15 46:18 47:22 51:19,22 72:14 75:10 85:4 86:18 Maybe 8:3 9:19 mean 18:16 21:2 29:19 42:22 48:14 63:16 68:13 69:9 71:14 86:2,15,22 90:10 93:22 94:20 measure 72:23 mediastinal 50:24 medical 5:12 6:13 7:2 10:7 15:13 34:16 35:4 39:11 62:10 82:16 medical/legal 6:10 7:6,17 8:5,24 9:5 9:7,10 medication 82:13 86:25 88:11 medications 28:8 44:6 81:16,20,24 81:25 82:1,5,6 91:6 Memorial 38:2,6 memory 58:11 mentioned 82:6 83:1 90:3 mentions 23:4 Mercy 13:13 met 35:2 54:19 57:22 61:9 milk 92:18 93:17 94:4,12 milked 91:16</p>	<p>milking 91:13 mind 47:1 48:13 84:14 minimal 31:8 minimum 21:22 minute 76:8 minutes 65:20 66:24 67:14,21 68:3 69:2 70:4,25 72:7,10 73:5,8,14 74:5 79:17 80:12 Mishkind 2:3 Miss 60:21 61:3 94:11,11 misunderstood 20:9 monitor 57:9 monitored 76:10 monitoring 30:8,23 31:1,4,12 44:5,10 45:23 46:3,5 82:10 88:3 monitors 31:14 month 17:4 more 33:17 36:15 36:17 50:6 72:22 74:1,3,10 84:23 morning 72:1 most 11:1 32:4 42:1 45:8,13,17 motions 5:17 moved 14:3 38:8 moves 63:22 much 17:15 21:24 28:4 83:18 94:8 myself 6:20</p>	<p>night 7:8 nods 5:16 normally 17:19,22 22:15 Notary 1:17 97:23 98:8,22 notation 64:4 note 63:4 83:5 97:3 noted 61:24 63:15 notes 35:22 39:9 40:10 83:4 nothing 84:19,20 87:14 98:10 notified 89:5 November 16:12 18:13 22:4 number 22:23 31:18 numbers 40:7,9 62:2 nurse 6:14,17,23 14:16,19 18:21 18:23 22:3 23:10 23:11 25:18 29:20 36:1,2,3,8 36:9,15 37:16,21 38:7,12,21 39:6 43:6,18 44:22 46:10 48:4,10,12 48:21,22 55:16 56:2,14,17,22 57:4,6,8,20,24 58:5,10,11,13,18 58:19,20 59:6,17 59:20,22,24 60:22 61:2,8,10 61:16,21 63:7 65:11,12 70:1,2 70:22,23 76:2,3 76:10,11 80:7,8 85:6 88:5,23,24 90:4,5 92:1,2,3 92:17,17 93:16 93:16 94:21,24 nurses 11:8 22:15 28:2 29:1 31:7 34:25 37:2,8 39:9 39:19 40:10 43:11,14 44:9,16 45:21 49:23 50:4 51:18 55:2,14,18 56:5 59:22 60:2 62:24 66:2 67:20 72:21 73:19 75:9 75:15,22 77:21 79:9,15 80:1 81:10 86:8 87:15 91:11,21 92:9,14 94:3,18 nurse's 39:9 83:4 nursing 6:12 11:14</p>	<p>11:24 12:1 13:23 14:4,7,13 15:11 20:17 28:1,10,20 29:14,19 33:18 36:19 38:23 39:16 40:24 43:21 44:2 45:8 50:3,17 53:1 54:17 55:2,10 57:4,10 61:9 62:21 72:23 74:17 85:3 86:5 86:18 95:4,4 nutrition 66:8</p>	<p>okay 22:6 91:18 94:2 once 17:13 one 1:20 2:14 3:18 22:22 23:2,2 30:10 32:4 39:18 40:2 47:21 49:12 50:20,22 55:7 56:5,6,7,21 57:13 67:17 71:9,12 75:8,12,14,19,20 82:24 85:8 ones 84:11 only 17:11 23:13 26:13 53:17 94:3 on-call 17:2 operating 59:25 opinion 35:25 36:7 36:12,13 44:20 45:8 49:20 55:1 70:11,13 92:16 opinions 27:21,25 30:12 34:14 53:24 54:3,18 60:12,15 95:8,12 95:16,20 opportunity 5:1 27:7,13 31:19 32:20 order 14:24 15:16 67:22 73:10 74:11 78:10 79:23 80:1 83:1,2 87:2,14,19,19 92:5,7 93:25 94:4 94:12,17,17 ordered 52:9 73:5,8 78:4 81:15 88:8 89:8 orders 33:19 65:13 65:24 81:13 82:21,22,25 83:16,17 89:11 orientation 37:22 38:10 39:8 57:10 oriented 63:21 other 3:19 9:9 12:3 21:7 37:8 48:11 52:5 55:18 70:8 81:24,24 83:2 84:16 90:9 others 79:13 otherwise 5:8 98:15 out 20:12 42:2,20 43:2 45:13 56:11 56:25 65:12 80:1 81:4 82:18 output 49:14 51:25 62:2,3 74:18,24 75:2,6,9,12,17,24 76:5,9,22 77:22</p>
---	--	---	---	--

78:3,7,12,14,18 outputs 42:10 50:5 72:22 73:3,7,21 74:10 76:2 over 5:2 56:7 59:20 60:4 61:2,21 69:23 73:15 85:24 86:15 87:7 overflow 26:13 oversee 38:12 overseeing 57:1 own 15:21 93:6 o'clock 1:21 71:25	85:4 86:13 89:20 90:7,12 91:1,5,8 91:12,17 patients 26:3,5,10 26:11 27:8,15,21 28:4,6,7,21 29:9 29:11,25 30:3,7 31:13 43:12 44:7 46:12 49:22 52:4 61:4 74:23 77:15 patient's 39:11 42:13 43:16 64:19 pediatric 14:15 people 7:1 37:23 55:3 77:18 per 17:3 83:25 percent 7:25 8:3 17:3 percentage 7:23 21:13,15,20 perhaps 4:24 7:14 32:5 40:25 period 14:21 15:7 20:2 39:6 42:5 43:7 44:24 45:11 68:8 70:7 72:17 73:12,19 77:14 80:11 88:17 90:2 90:20 periodically 49:23 peripheral 64:13 64:18 person 15:12 19:15 22:4 24:23 38:17 57:22 58:13 61:3 61:4 83:25 personal 35:22 94:7 perspective 29:15 50:17 54:17 74:17 85:4 86:5 86:18 pertinent 42:6 physical 62:6 physically 80:16 physician 23:2 82:25 83:13 87:3 90:5,25 91:17,19 physicians 22:24 27:10 34:25 77:4 88:8 89:8 90:9 physician's 79:23 83:6 94:24 picture 42:4 70:12 piece 42:1,2 47:25 48:11 70:12 71:10 74:15 85:8 pieces 45:15 pile 31:20 place 81:1 98:14 placed 86:24 87:22	placements 84:5 plaintiff 1:15 2:2 7:18,20,23 35:8 Plaintiffs 1:5 plaintiff's 10:23 32:21 53:7 play 60:4 PLEAS 1:1 please 4:14 5:13 20:10 41:4 58:12 62:9 point 5:11,18 26:2 58:6 68:23 69:3 69:13,22 70:20 71:8 80:22 81:4 82:18 84:19 points 85:23 policy 66:5 portion 20:20 92:24 portions 33:3 position 3:6 18:19 21:7,9 43:18 postoperative 8:15 26:9,10 27:20 28:13 29:5 30:18 43:7,12 44:24 45:11 46:12,17 48:5 49:22 52:21 75:16 84:9 85:1,5 85:11 86:7,19,21 91:5,12 post-op 26:3 27:7 27:14 28:11 47:15 75:18 91:9 practical 36:1,8,15 practice 16:4,22,23 16:25 28:20 precepting 56:16 57:4,6,23 58:3 preceptor 37:13,15 38:12,14 56:13 56:15,18,23,24 57:14 58:1 61:2 61:11 70:23 71:6 71:18 preceptorship 15:22 58:19 prefer 60:6 prepared 76:14 present 17:3 65:5 presently 95:9 pressure 46:23 51:5 51:12,15 67:17 69:4,20,22 81:12 81:14 85:24 86:2 86:14,15 87:6,8 87:23 88:2,6,12 88:14 89:7 90:22 91:7 93:12 pressures 42:10 67:19 68:1,17	69:1 70:3,15,24 71:24 72:6 presume 90:19 pretty 28:4 94:8 previous 61:19 62:4 62:15 64:8,11,22 65:1,8 68:20 previously 67:3 68:21 primary 43:21 principles 28:9 prior 19:22 24:5 53:21 58:21 59:5 59:6 72:13 priority 40:24 69:16 privilege 3:23 4:5 probably 10:3 13:6 14:22 27:9 38:3 40:24 49:2 50:20 51:12,14,15 problem 39:22 40:16 41:11 42:20 43:3 74:13 77:20 80:20 problems 90:21 Procedure 4:9 process 14:23 produces 49:9 product 3:23 4:5 production 4:4 profess 31:10 professional 9:5 13:22 14:10 20:23,25 21:18 35:10 55:10 proficient 30:25 program 11:11,12 11:14,25 12:21 15:15 16:6,15,16 17:1 37:22 38:10 43:21 programs 12:1 progressive 47:12 47:20 pronounce 12:10 proportion 7:16,18 prosecutor 16:9,14 Prosecutor's 20:24 21:6,25 provide 3:13 10:13 20:22,25 37:12 38:23 49:5 57:24 60:7 61:9 provided 3:10,15 4:8 5:13 9:4 32:17 35:18 53:18 57:9,16 66:7 95:4 providers 35:3 provides 49:18	providing 57:11 87:15 prudent 28:25 55:16 70:13 72:21 73:19 90:4 Public 1:17 97:23 98:8,22 publication 30:10 30:11 publications 30:14 34:19 pulmonary 67:16 67:19,25 68:16 69:1,19 70:3,14 70:24 71:23 72:6 pulse 46:22 51:12 51:14 85:14 86:14 pumps 31:7,9 purpose 38:11,13 60:13 purposes 10:20 53:12 60:11 pursuant 1:18 pursue 6:20 put 3:20 36:19 61:1 putting 40:6,9 puzzle 45:16 47:25 71:10 p.m. 1:21 22:23 59:21 96:2
P PA 23:2 packed 79:21,25 80:3,9,13 PACU 83:14 page 55:7 62:21 63:3,7,13,23 65:4 66:8,10,11,14 97:3,5 pain 63:22 paper 42:1,2,7 parameter 51:3,8 parameters 39:2 44:11,12 49:4 51:7 65:15 70:8 81:15 82:10 part 3:9 12:20 37:22 38:10 44:13 50:8 58:2 60:13,15 89:14 participate 37:1,7 particular 6:25 13:8,17 22:7 34:20 51:8 52:12 54:21 67:12 71:1 94:25 particularly 71:2 75:15 parts 45:16 party 98:15 pass 14:4 past 3:5 7:9 patient 23:12 28:8 28:13,24 29:10 40:5,16,22 41:11 42:6,21 43:1,3,6 44:23 45:3,9,14 45:19,24 46:8,17 46:19 48:2,8,10 50:21 52:1,21 56:7,18 57:15 58:14 64:5,9,17 71:2 74:8,12,16 75:4,10,16 76:14 76:20,25 80:12 80:14,18 84:3,9 84:15,17,21 85:1	Q qualified 27:24 98:9 question 5:3,7,8,9 7:9 11:21 14:8 20:5 26:9 36:24 40:22 41:3,4,6,8 52:24 55:22 60:18 71:17 73:11 78:17 90:10 93:6 94:1 questions 5:5,6,20			
R R 79:22 raise 46:16 50:18 84:14 85:3,10,12 86:20 87:23 raised 86:6,17 range 83:24 rate 51:24 62:13 rather 21:21 25:12 read 32:18,21 41:5 41:7 58:23 78:10 81:7,9 89:25 95:24,25 97:2 reading 33:21 71:12 79:16 readouts 49:9				

<p>reads 67:22 78:6,8 ready 39:3 76:20 76:25 real 40:18 really 29:24 36:22 77:14 reask 4:1,4 reason 39:19 74:9 77:11 reasonable 8:1 55:9 83:24 84:9 reasons 52:5 75:18 75:19,20 reassessments 55:25 81:1 recall 57:3 62:5,20 64:3,16 73:16 receive 14:2,18 15:24 21:10 received 3:1,3 32:3 32:4 34:23 48:10 79:20 receiving 30:8 recent 11:1 32:4 recertification 14:23 15:2 recertified 14:24 recognition 40:16 41:11 recognize 44:11,11 44:15 recollections 58:8 record 3:14,20 5:19 33:12,15 39:10 39:19 41:7 44:16 49:23 53:8 70:3 77:22 78:3,7 81:9 recorded 42:11,19 42:25 67:20 69:1 69:20 72:19 78:16,21,23 79:3 79:8 recording 46:6 75:23 77:23 records 5:12 8:25 33:4,9,13,18,20 34:2 35:4 39:11 58:4 62:10 66:1,7 recovery 26:5 red 46:20 47:21 79:21,25 80:3,9 reduced 98:11 refer 5:12 34:15 56:3 58:10 62:9 reference 4:1,18 referred 8:1,23 referring 8:1,4,5 82:4 83:3 refresh 58:11 regard 3:24 4:2 9:25 16:24 27:20</p>	<p>29:4 32:17 51:21 58:7 89:22 regarding 27:25 45:22 46:2 registered 1:16 36:1,8 37:16 59:6 regular 95:1 reiterate 71:9 relation 13:8,17 relative 3:2 95:19 98:15 relevance 34:20 relieve 81:20 rely 43:13 relying 60:14 remain 19:6 remainder 79:10 remained 28:20 remember 64:20 remembering 87:2 removed 6:2 remuneration 21:11 render 27:25 54:18 rendered 55:11 rendering 32:2 53:21 55:1 renewed 14:20,21 reoperation 71:22 72:14 repair 48:4 repeat 5:7 36:5 repeated 79:16 rephrase 5:7 73:11 replacement 44:23 45:10,25 46:17 84:1,4 report 31:17 32:3 32:25 53:14,17 53:21,21,23 54:4 55:8 80:25 81:6 82:14 reporter 1:17 5:16 reporting 65:22 98:16 request 34:10 90:5 requested 3:12,15 90:25 97:5 require 43:19 91:5 required 5:20 15:2 15:3 44:2 48:3 55:14 87:25 94:3 94:11 requires 44:15 reserve 4:3 resistance 78:23 79:2,7,10,15 respect 51:13 respirator 84:22 respond 3:22 responding 88:25</p>	<p>responsibilities 16:14 21:25 23:9 44:21 45:22 46:1 56:15,23 89:22 responsibility 23:13 58:3 60:16 responsible 31:11 61:11 restless 81:19 result 74:24 80:17 82:12 results 87:18 88:2 retrospectively 40:8 42:23 return 48:3 returned 71:21 returning 79:12 review 8:25 34:24 54:7,14,15 58:4 58:17 59:24 reviewed 6:6 31:19 33:24,25 34:6 54:22 66:2 reviewing 33:5 34:9 revoked 14:8 right 4:3 47:1,16 60:20 64:7 65:2 82:5,7 83:14 right-hand 65:4 risk 40:15 41:10,15 RNs 22:21 Roetzel 1:19 2:11 9:12,16 room 18:14 19:7 22:3,7,12,16,25 23:19 24:3,4,17 24:22,23 26:6 28:11 29:12 30:1 30:8 52:6 59:25 rotated 24:7 25:23 rotating 24:16 routine 26:14 40:13 41:9 65:24 66:4 87:19 92:2,3 94:24 rotinely 22:24 29:25 30:2,5,7 73:2 91:13 92:18 93:17 94:3,12 Rule 98:17 rules 4:9 5:2 running 39:24 66:9 88:15 R.N 1:10,13 4:7,12 97:17 98:9 99:2</p>	<p>44:18 55:17,17 60:20 62:3 70:7 76:13 79:18 84:19 saw 81:10,22 86:8 87:18 89:20 saying 90:14 94:11 says 63:4 64:13 66:17,18 79:23 89:9 schedule 20:11 50:6 school 12:21 38:1 sciences 12:16 scope 48:14 seal 98:18 secretion 62:13 section 66:10,17 see 12:9 13:1,13 18:3 32:9 33:5,18 39:21,25 40:3,8 42:4 50:23 51:15 56:6 63:3,4,14,19 63:21 66:18 72:9 74:8,11 75:13 78:24 79:17,20 86:10 89:11 91:1 92:20,25 seeing 47:7 seem 83:22 seen 34:2,6 52:9 74:23 84:6,21 sees 71:7 seminar 35:17 send 34:11 sensorium 46:23 separate 25:1 September 33:12 33:16 sequence 40:1 serial 47:19 series 42:12,25 44:17 served 8:10 service 6:12 9:5 88:25 89:6,15 90:6 services 20:23 21:1 35:19 session 5:4 15:20 sessions 19:20 set 1:22 10:9 39:2 98:11,18 setting 17:20,25 29:12 37:17 38:24 several 14:10 33:6 33:9 47:17 sexual 14:16 15:9 15:11,13 16:23 16:25 21:7 37:11 share 17:2 38:19</p>	<p>sheet 42:6 66:13 shift 22:7,9,16 23:11,15 59:21 61:18 62:4,15 shifts 20:2,7,14,18 22:13 61:20 shock 75:4,11 short 77:14 show 66:12 showed 62:6 shows 63:4 66:8 side 3:18,19 66:9 sign 47:4 signature 63:9 96:3 significance 74:18 significant 43:15 44:12 83:6 signs 43:9 46:12,15 48:6 51:18 65:25 66:4 82:11,11 silly 60:5 simple 80:19 simply 50:13 since 7:11 11:24 25:11 27:11 28:21 32:2 single 45:12 47:11 sinus 62:13 sit 15:5 34:18 76:21 site 17:23 18:1 situation 41:14 42:3 52:22 55:17 57:2 61:3 six 4:24 8:8 17:18 size 50:15 skills 29:23 38:22 38:23 44:2 Skylight 2:5 slipping 75:10 slips 75:4 slot 63:12 small 7:25 Smith 32:6,22 some 5:18 12:16 21:10 34:11 37:8 46:20 62:23 81:20,21 93:14 93:15 someone 29:19 57:16 83:12,14 90:11 something 23:23 25:12 42:22 48:12,15,18 51:6 69:17 71:7 76:17 85:6 Sometime 25:20 sometimes 42:2 94:20 sorry 11:23 24:10 24:10 36:5 56:21</p>
---	---	---	---	--

<p>59:12 sounds 62:12 64:1 65:5 speak 5:1 speaking 54:23 specialized 43:20 44:1 specific 41:1 43:25 44:6 50:14 92:6 specifically 42:9 54:25 67:8 specified 98:14 speech 63:22 spend 17:9 21:22 21:24 spent 21:20 SS 98:4 St 11:9 12:15 13:5 staff 18:21,23 19:14 20:17,20 22:3,15 22:24 23:10 24:22 25:18 26:25 36:2,9 43:18 82:16 95:5 standard 27:25 28:5,19,25 54:16 54:19 55:12,13 55:15 57:14,22 57:24 60:20 61:10 70:1,10 71:8 78:6,8 81:13 93:20 standards 29:23 standing 65:24 87:2 87:14 start 18:10 19:1 21:4 24:12 31:6 81:16 82:21 83:12 87:4 started 6:14 18:12 19:2 20:12 27:11 87:5,8 state 1:18 4:14 13:25 14:1 98:3,8 98:23 statement 74:21 states 13:25 66:4 status 84:20 88:3 statute 1:15 staying 44:18 79:18 stenotopy 98:11 step 39:7 57:21 71:6 stepped 58:6 70:23 Stern 27:4 still 5:20 19:11 54:2 69:4 stop 68:16 70:14 stopped 69:3,5,12 70:17 Straum 38:2,5</p>	<p>Street 4:18 studies 52:12 subject 13:8,18 30:18 Subscribed 97:20 substandard 7:24 78:2 Suite 2:5 suits 7:2 summarize 53:24 support 14:14 91:6 supposed 22:18 65:21 66:3 67:13 71:11 75:23 92:10 sure 4:25 9:17 17:21 20:4 38:18 46:25 47:14 49:3 56:21,25 57:7 62:2,14 70:9 73:1 73:10 74:16 75:14 78:6 80:8 80:16,22 86:21 surgeon 91:23 92:13,21 94:7,14 94:16,25 surgeons 26:24 43:13,13 91:22 92:9 surgery 8:21 26:8 26:11,16,19,22 27:8 28:1,22,23 33:7 48:3,19,20 52:2,3 72:4 74:19 74:20 76:15,21 77:1,3,7,12,16 79:12 84:1,10 92:1 surgical 36:3,10,20 36:23 43:19 44:3 45:23 48:21 51:17 52:20 88:24 89:5,15 90:6 95:6 suspended 14:8 suspicion 46:16 50:19 52:25 suspicious 51:19 suture 48:3 swan 49:5,6,8 66:21 67:2,4,18 switch 20:18 sworn 4:10 97:20 98:10 symptoms 46:12 48:7 51:18 75:13 synonymous 30:3 Syracuse 11:9 13:2 37:20 system 16:19 systemic 78:23 79:2</p>	<p>79:7,9,15,16 systems 62:23 systolic 69:3 88:7 89:8 90:22</p> <hr/> <p>T</p> <p>table 5:24 tachycardic 85:15 85:19,22 take 3:17 5:16 17:2 77:5,15 81:11 taken 1:16 3:6 4:21 8:5 12:17 28:6,7 84:2,11 91:8 98:14 takes 17:17 taking 11:22 28:3 39:7 56:17 58:14 58:25 68:14 69:16 talk 58:9 82:20 talked 62:12,13 talking 56:9 72:2 72:15 tally 39:24 tamponade 8:18 30:21 50:12,19 50:23 51:4,10,19 51:22,23 52:2,5 52:10,11,14,21 53:1 93:13 taught 30:17 44:10 teaching 38:18 71:18 technical 38:22 tell 6:9 14:11 15:9 19:25 20:10 21:19 23:22 27:2 29:3 39:12 41:24 45:17,21 50:11 50:18 54:13 55:13 57:23 60:8 66:13 69:8 72:25 81:3 83:8 92:15 95:18,23 telling 74:15 85:18 93:23 tells 66:6 91:19 temperatures 42:10 ten 8:3 25:10,16 term 17:21 18:7,25 testified 8:12 61:22 testify 98:10 testifying 64:3 testimony 9:2 10:13 98:11,12 textbooks 34:16 their 9:23 25:1 35:14 43:8 46:6 46:22,22 49:2 55:19,24 68:12</p>	<p>68:20 thick 33:14 thing 38:19 45:17 things 32:15 50:25 75:14 76:15 81:21 84:17 think 8:9 23:21 28:23 29:2,18,22 38:25 41:2 45:13 45:16,18 46:19 48:20 50:2,8 56:10 58:23 59:8 62:1 67:2 72:1,19 74:7 80:18 83:19 85:6,7 95:21 thinking 77:14 third 7:20 thoracic 26:22,24 27:8,14,20 93:11 though 19:12 90:13 three 7:9,14 11:12 19:21 20:1,7,15 22:22 24:7 25:24 29:18,24 33:20 34:1 three-quarters 33:14 through 9:23 12:15 24:16 31:8,8,20 32:12 33:10,12 33:15,25 37:23 63:23 97:3 time 5:11 6:11 12:14 16:22 17:2 17:3,3,11,15 19:4 19:6,9,22,24 20:3 20:12,25 21:18 21:20,24 22:2,25 23:19,21 24:2,8 25:3,11,17,21,25 26:2 27:5,10,11 28:12,14 32:2 34:9,23 39:6,13 40:23 41:1 54:8 58:21 59:9 63:12 65:20 66:6 68:8 68:15,23 69:22 70:7,20 76:13,16 76:19 77:2,3,13 77:15,16,19 79:11 80:12,13 80:16,22 82:19 82:23 83:8,17 86:3 87:5 88:10 88:17 90:2,20 92:6 95:17 98:14 timed 83:20 89:11 timely 46:5 78:8 82:15 times 4:23,24 8:4,8 8:10 9:15,19</p>	<p>14:20 46:7 72:8 title 18:19 titrate 88:11 today 6:6 34:18 told 10:15 67:3 84:2 87:4 90:17 92:22 94:8,22 top 50:25 56:20 63:1,3 65:4 Tosti 2:4 3:10,12,21 4:13 8:9 32:11 41:5 60:6,13 95:21 99:4 Tosti's 3:6 totality 45:14 touched 94:9,9 Tower 2:5 trained 15:12 44:10 46:11 trainee's 38:12 training 11:8 31:4 31:9 37:2,8 43:20 44:14 transcribed 98:12 transcript 97:2 transcription 98:12 transference 48:21 transmitted 48:23 trauma 28:11 52:7 treated 94:15 treatments 66:8,18 trend 40:4,8 43:2 74:11 trends 42:12,19 43:8,14 44:12,15 46:16 49:24 71:1 trial 8:12 9:2,3 10:10 54:8 95:9 95:14,17 trouble 74:16 true 39:18 95:2 98:12 truth 98:10,10,10 trying 82:3,12 88:10 tube 47:2,8 72:18 73:20 76:7 83:25 84:4,18,24,25 86:17 93:4 tubes 28:7 73:16 91:11,13,15 92:18,23,24 93:3 93:10,17,24,25 94:4,6,9,12,14 turned 42:20 43:2 84:17 two 17:4,13 19:10 19:19 20:16 22:13,21 25:12 25:14 32:13 59:21 61:20 68:2</p>
--	--	---	--	--

70:4 72:23,25 74:1,4 83:20 85:2 88:15 91:6 two-thirds 7:21 type 11:16 15:15 16:21 21:10 31:3 40:3,4 42:3 75:11 types 67:8	75:6,9 76:4,22 78:7 urine 42:10 74:18 75:12,17,23 76:2 76:9 77:22 78:3 used 7:1 using 31:6,14 usually 17:16,24 29:15 42:4 75:12 92:8,12 utilize 16:2 utilized 41:21 utilizing 42:18	wants 91:23 wasn't 26:14 36:6 69:17 70:9 80:21 watch 43:7 46:11 47:14 56:24 75:9 85:13 watching 85:7 way 27:22 71:13 80:24 Wayne 15:21 16:9 20:24 21:5,24 WEDNESDAY 1:11 week 17:5,8,10 19:10,18,23 20:13 21:23 22:1 22:13 59:2 weekends 26:13 weeks 17:13 39:3 well 20:9 21:4 26:9 33:18,21,23 36:6 39:23 40:6 41:2 46:19 55:22 56:9 64:22 68:10 69:14 70:21 82:21 83:11 89:20 90:15 94:1 went 13:1 19:3,4,10 20:1,7,14 23:18 23:19,21 24:2,21 28:16 31:8 38:5 59:22 71:22 77:7 were 3:15,24 9:6,24 11:16 12:15,17 18:3,22,25 19:14 19:17,18,19,22 20:17 22:12,25 23:5,8 24:5,16,22 26:2 27:5,10 31:6 33:3,6,8 34:9 37:25 54:14,18 54:24 55:18,20 56:14,22 61:23 62:2,14 65:13,15 65:21,24 66:2,7 67:13 68:1,8 69:1 69:16 70:25 71:10,11,23 72:5 73:5,7 75:22 76:2 76:17,25 77:3,5,5 77:18 79:9 80:10 80:13,18 81:12 81:15,17 82:10 82:12,22,22 83:5 83:17 87:4,15 88:2 89:6,22 90:9 90:17,21 92:6 weren't 67:7 68:6 76:22 90:13 West 4:18 WHEREOF 98:18	while 79:3 80:6 84:22 95:5 whole 12:18 42:4 45:14 48:14 57:1 80:23 98:10 wise 55:16 witness 1:14 3:25 4:7 16:16 60:7 95:25 98:18 witnesses 34:7 Wooster 4:18 18:4 18:8,16,20 19:3,8 19:15,16,17 20:7 20:11 23:5,18 24:8,12,25 26:7 26:11,18 27:12 word 30:2 66:21 worded 36:6 words 55:18 work 3:23 4:5 13:7 13:16 15:16 20:11 22:7,9 23:16 29:8,8,11 37:2 38:12 44:2 54:7,11 59:5 worked 9:12,15 20:15,16 22:2,6 22:12,16 23:4,10 25:18,21,25 29:17 35:18 36:22 37:15 38:2 38:5,6,9 42:18 43:24 45:5 49:6 49:12 94:25 working 18:22 19:17,18 22:12 23:5 24:5 27:5 37:20 50:8 55:18 81:12 91:21 works 29:20 world 40:18 worth 33:20 34:1 wouldn't 29:16 36:24 write 39:9 40:10 83:17 94:16 writing 41:14 written 65:13 76:23 78:11 82:23 92:5 93:22 94:4,21	20:6,15 22:11 37:24 38:5 years 7:10,11 14:22 18:9,12 23:20 31:5 York 11:10 13:2 37:21 38:8,8 Young 55:6 57:5,24 58:10,12,13,20 59:24 60:4,21 61:9,16,21 62:11 63:7 65:11 70:2 76:3,11 80:7 88:5 88:24 90:5 92:3 92:17 93:16 94:11 Young's 61:3 70:23
U Uh-huh 69:24 unable 57:24 88:6 88:13 uncharted 40:14 41:9 under 1:15 5:4 16:20 58:1,18 63:24 64:1,12 65:3,4 66:17 67:2 81:12 83:6 98:16 undergone 27:8 28:21 45:24 84:1 understand 5:5,6 5:22 17:21 20:4 34:21 73:10 understanding 9:22 10:11 49:11 59:23 68:25 69:12 73:6 77:4 86:23 87:21,24 92:13 understandings 92:8 understood 5:9 unit 19:15 23:9 24:6,17 25:1,2,19 25:19,22 26:1,1 26:15 28:11 29:21 36:10,20 37:3,4,17 38:4,7 38:9 44:3 48:6 49:1,22 50:3,9 58:15 59:11,15 66:5 71:23 72:5 72:13 78:19 79:4 79:11,21,25 80:3 80:7 92:9 95:6 units 24:7 25:13,14 25:24 29:24 university 12:7 13:2 unless 5:20 69:9 unresponsiveness 71:3 until 11:20 19:7,9 19:18 20:15 22:20,21,23 23:19,21 24:9,15 38:3,6 68:13 69:2 77:21 80:13 urinary 74:24 75:2	V V 2:12 values 42:9,11 44:16 49:4,9,17 49:24 67:4,12,17 valve 8:21 33:7 44:23 45:10,25 46:17 84:1,3 91:5 various 62:22 67:8 81:16,25 vary 29:24 vascular 78:23 79:2 79:7,10,15,16 vasopressor 91:6 vasopressors 71:4 89:1 vein 50:24 ventilator 81:19 ventilators 30:1,4 verbalized 48:9 verbally 5:15 very 36:6 39:15 50:13 victim 16:16,19 17:12,12,14 victims 15:14 16:17 vigilance 48:6,25 visited 35:14 vitae 23:3 30:11,15 vital 65:25 66:4 82:11,11 Vivian 1:16 95:23 98:8,22 volume 47:5 84:6 volumes 84:24 voluminous 33:17 vs 1:6	Ti x-ray 50:23 52:19	Z zeroed 62:1 Zilka 55:6 56:2 57:8,20 58:5 61:10 65:12 70:2 70:22 76:2,10 80:8 88:24 90:5 92:2,17 93:16 94:11 Zilka's 56:14,22 58:19	
			S \$110 9:3 \$80 8:25 \$95 9:1	
			1 1 10:19,23 97:3 99:6 1st 16:12 10th 2:14 10:19 99:6 100 18:18 84:5.8 85:2 104 85:15,18 86:14 11:00 22:21,22 115 4:18 129:19 14:22 19:19 20:1,7,14,17 22:13 12's 19:10,21 20:15 20:16 14 14:22 15 9:19 14:22 65:19 66:24 67:14,20 70:25 74:5 79:17 1730 59:12 82:24 83:1,13,19 18 18:12 1800 82:24 83:19 1830 82:24 83:2,11 83:15,20	

1923:21	3:00 71:25			
19th 33:12,16	30th 98:19			
1900 59:11	321518 1:6			
1950 88:5 89:1,3	35 80:6			
90:3	36 19:21,24 80:6			
1967 11:15				
1968 13:6	<u>4</u>			
1969 19:5,7 23:24	4:13 99:4			
24:1,10	4:30 96:2			
1970 38:6	40 15:20 19:18,23			
1970s 13:15	20:13 68:3 70:4			
1981 14:3	73:14			
1982 18:13	411 78:24			
1983 24:9,14,15	42 85:25 86:15			
27:12	44113 2:6			
1989 24:16,21	44115 2:15			
25:19,20,22	44691 4:19			
28:17,21	46 87:7			
1996 58:25				
1997 6:15	<u>5</u>			
<u>2</u>	5th 53:6,23 54:4			
2 53:7,11 99:7	50 17:3 84:5,8			
2:30 1:21	52 69:23			
20 65:19 66:24	53:11 99:7			
67:14,21 69:2	55 86:3,15			
70:25 72:7,10				
73:5,8 74:5 79:17	<u>60</u> 15:22			
80:11	660 2:5			
20th 33:15 58:7	67 38:1			
59:10	69 13:6 23:25 38:3			
200 15:23				
2000 22:4 53:24	<u>7</u>			
2001 10:3 16:12	7th 59:2			
22:5,6 53:6 54:4	7-A 22:10,20			
2002 1:11 97:21	7-P 22:10			
98:19	7:00 22:23 59:21			
2004 98:24	72 85:24 86:15			
2010 85:14,17	75 87:6,7,7			
2050 69:2,20 70:15				
2110 83:22 89:10	<u>8</u>			
89:21	8 98:24			
2130 88:5 89:1,4	8th 58:24			
90:3	8's 20:13			
216-241-2600 2:7	8-20 33:10,25			
216-623-0150 2:16	8-21 72:1			
2210 72:19 76:3,4,5	8-23 33:25			
76:7 77:21 78:22	80s 69:4			
2215 83:22	81 69:22			
2250 76:13,25	82 14:3			
77:10	84 24:14,15 27:12			
2310 79:22	89 24:10			
2330 77:7,21				
24 1:11 42:5	<u>9</u>			
250 72:18 73:15	9-13 33:10			
76:6 84:18 85:2	9:30 22:20,21			
86:16 87:11	90 88:7 89:8 90:22			
27 80:6	96 97:3			
28 7:10 98:17	97 7:11			
<u>3</u>	99 16:1			