Doc. 81

THE STATE of OHIO :
:
COUNTY of CUYAHOGA. :

IN THE COURT OF COMMON PLEAS

LESTER WEITZEL, executrix of the ESTATE of SHARON WEITZEL, deceased, and LESTER WEITZEL,
plaintiffs,

: Case no.
vs. : 226946

SAINT VINCENT CHARITY HOSPITAL, et al., :
defendants.

Deposition of CAROL M. BUCHTER, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, a Registered Professional Reporter, a Certified Legal Video Specialist, a Notary Public within and for the State of Ohio, taken at the offices of Flowers & Versagi Court Reporters, The 113 Saint Clair Building, Cleveland, Ohio, on Monday, the 3rd day of May, 1993, commencing at 1:40 p.m., pursuant to notice.

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

Charles Kampinski, Esq.
Christopher M. Mellino, Esq.
Charles Kampinski Co., L.P.A.,
1530 Standard Building
Cleveland, Ohio 44113.

- - - - -

ON BEHALF OF THE DEFENDANTS CENTRAL ANESTHESIA OF CLEVELAND, INC., AND DRS. SOPKO, MOASIS, STEFFEE:

Robert C. Seibel, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

ON BEHALF OF THE DEFENDANT CLEVELAND CLINIC FOUNDATION:

Albert J. Knopp, Esq.
Baker & Hostetler
3200 National City Bank Building
Cleveland, Ohio 44114.

APPEARANCES: (continued)

ON BEHALF OF THE DEFENDANTS RADIOLOGY CONSULTANTS, INC., AND DRS J. PORTER, SMITH, WIRTZ:

Robert D. Warner, Esq.
Reminger & Reminger
The 113 Saint Clair Building
Cleveland, Ohio 44114-1273.

- - - - -

ON BEHALF OF THE DEFENDANT SAINT VINCENT CHARITY HOSPITAL:

William J. Coyne, Esq.
William J. Coyne Co., L.P.A.,
1240 Standard Building
Cleveland, Ohio 44113.

- - - - -

ON BEHALF OF THE DEFENDANTS DRS. ROLLINS, KITCHEN, STEELE, KHADDAM:

(NOT PRESENT)

John V. Jackson, II, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

APPEARANCES: (continued)

ON BEHALF OF THE DEFENDANT PREM VARMA, M.D.

Burton J. Fulton, Esq.

Lynn A. Moore, Esq.

Gallagher, Sharp, Fulton & Norman

Seventh Floor - Bulkley Building

Cleveland, Ohio 44115.

- - - - -

I N D E X

(NO EXHIBITS MARKED)

(FOR KEYWORD AND OBJECTION INDEX, SEE APPENDIX)

CAROL M. BUCHTER, M.D.

of lawful age, a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined, and testified as follows:

- - - - -

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your name, please?

A. Carol Michelson Buchter.

Q. You are a resident of Cleveland Heights, Doctor?

A. Yes, I am.

Q. I am going to be asking you a number of question afternoon. If you don't understand any of them, tell me and I'll be happy to rephrase any questions you don't understand.

When you respond to my questions, please do so verbally. He is going to be taking down everything that's said. He can't take nods of your head.

A. Okay. Yes.

Q. Doctor, you practice at University Hospitals?

A. Yes, I do.

Q. That's been for how long?
A. On staff since 1983.
Q. And you were the acting chief for a year, July, '88 to June of '89?
A. At the VA Hospital I was acting chief for one year.
Q. I see. Have you published at all, Doctor?
A. A little bit, yes. They may not be on my CV.
Q. That's why I am asking because they're not. Would you tell us what you have published?
A. I think this is the same copy, yeah. Recently I co-authored a book chapter on anesthesia for transplant patients, and I have written two review articles concerning heart failure.
Q. Is that your specialty, heart failure?
A. Yes, it's a special interest.
Q. As a matter of fact, on this stationery you wrote the report on, that's what listed under your name is heart failure?
A. Everybody gets kind of one special interest that they list.
Q. I see. I assume that doesn't mean that you don't deal with other aspects of cardiology?
A. Right. Right. It's not an inclusive list.

Q. Have you testified before, Doctor?
A. Yes, I have.
Q. How many times?
A. In deposition, is that what you mean? Giving depositions?
Q. We'll start with that.
A. Three or four, somewhere in that neighborhood.
Q. For whom did you testify?
A. I have given previously one deposition for Mr. Coyne or his office, and one or two or -- for other firms.
Q. Who?
A. Jacobson, Maynard.
Q. Who at Jacobson, Maynard?
A. Who at Jacobson, Maynard?
Q. Yes.
A. One was Steve Charms. That's the only one I can recall.
Q. Anybody else, any other depositions?
A. No.
Q. What was the name of the case that you testified for Mr. Coyne in?
A. I don't remember the name of the case.
Q. What was the nature of the case?

A. The nature of the case was an automobile accident and a woman with pre-existing heart disease, and nature of the case was whether her heart disease had been worsened by her accident.
Q. And was he defending?
A. Yes.
Q. You don't remember the name of the case?
A. No, I don't.
Q. Is it still pending?
A. Quite a number of years ago. I don't believe so, but I am not sure. It was several years ago.
Q. Did you testify at trial in that case?
A. No, I did not.
Q. What was the name of the case that you testified for Mr. Charms?
A. I don't remember the case.
Q. What was the nature of the case?
A. It is a medical malpractice case regarding a balloon pump insertion and a complication from that.
Q. Is that still pending?
A. I believe it is.
Q. You don't recall the other members at Jacobson, Maynard, Tuschman & Kalur that you testified for?

A. I don't.
Q. Do you have any other pending cases with them currently?
A. No.
Q. Just this one that you just mentioned?
A. Yes.
Q. Are there other people that you testified for?
A. Give me one minute to think.
Q. Sure.
A. One other.
Q. Who was that?
A. I am having trouble coming up with the name, having trouble coming up with the names.
Q. But was it at Jacobson, Maynard, Tuschman & Kalur?
A. Yes. Cup, Steve.
Q. Steve Hupp?
A. Yes. Yes.
Q. What is the name of that case?
A. That is Rubin versus -- blocking out the name. I should know. Barnett.
Q. What were the allegations in that case?
A. That is a medical malpractice, wrongful death case following vascular surgery.

Q. What were the allegations of it?
A. The allegations, it's a woman who had peripheral vascular surgery performed and who died following hospital discharge and re-admission.
Specific allegations, I don't know how to quite answer that.
Q. What was your involvement in the case? What were you called to comment about?
A. I was a treating physician, *so.*
Q. Subsequent treating?
A. Concurrent treating.
Q. Well, I mean, were you involved as an expert as well?
A. No. I think I was just -- I was involved as a treating physician.
Q. Factual testimony as opposed to opinion testimony?
A. No, they asked me opinions, *so.*
Q. Was it with respect to life expectancy?
A. Partially that, yes.
Q. Who was the plaintiff's attorney in that case?
A. I do not know.
Q. Who was the plaintiff's attorney in Mr. Charms' case?

A. Boy, you're asking me a lot of hard questions on names that I am not good on.

It's not coming to me.

Q. How about Mr. Coyne's case?

A. You mean as in your name?

Q. How about Mr. Coyne's case?

A. The previous one?

Q. What did you think I said?

A. Isn't this Mr. Coyne's case? I thought you were questioning me on your name, which I was going to be able to answer.

The previous case, I don't know.

Q. Any others that you can think of?

A. No. I think that's it.

Q. Have you ever testified in court before?

A. Once.

Q. Who did you testify for?

A. That was the case I just mentioned, the Rubin versus Barnett.

Q. When was that?

A. This morning. One reason I am having a little trouble keeping names straight.

Q. That case involving Jeff Rubin?

A. Yes.

Q. So it's Barnett versus Rubin?

A. Yes. Sorry.
Q. Have you been retained by anybody to review records and to render opinions that have not resulted in either deposition testimony or courtroom testimony?
A. A few.
Q. By whom have you been retained?
A. Once by Mr. Coyne's office.
Q. You mean another time other than what you told me?
A. Yes.
Q. When you say "His office," someone else within his office?
A. Yes.
Q. Who?
A. Marty Franey.
Q. What was the type of case?
A. Actually maybe that was the malpractice case I told you. These are a number of years ago. It's hard for me to remember with details.
Q. You are confusing me now.
A. I am confused myself.
There were -- this is the third case for Mr. Coyne's office that I have done.
Q. Okay.

A. One was an automobile accident case, another was malpractice case, and I believe the malpractice case was with Mr. Franey. I am not sure.
Q. What was the nature of that case?
A. I don't recall. It's a number of years ago. I honestly don't recall.
Q. What was the nature of your involvement? What is it that you were being asked to comment upon; was it a cardiology involvement?
A. In some area it would have been a cardiology case. It would have been cardiology.
Q. Was it based on life expectancy?
A. In part, I believe.
Q. Do you remember the name of that case?
A. No.
Q. You said that you have been retained by his office three times. I now know about two, what is the third?
A. Automobile accident case.
Q. Yes.
A. A previous malpractice case, that I do not remember the details, and this one.
Q. Any other people?
A. I don't believe so.
Q. So a couple for Jacobson, Maynard, Tuschman &

Kalur, and three for Mr. Coyne's office, and that's it?

A. To the best of my recollection, yes. There may have been in the distant past other cases that did not go to deposition or trial that I wouldn't remember that, charts I would have reviewed. There might have been one or two but --

Q. Have you yourself ever been a defendant in a case?

A. I am presently a defendant in a not yet tried case.

Q. What is the name of that case?

MR. COYNE: Show an objection on this. You can answer. Continuing objection.

A. That was the one that I had previously mentioned to you with the balloon pump.

Did I give you a name on it?

Q. No, you didn't.

A. I didn't give you a name?

Q. No.

A. It's in there, if you want to wait for a minute it will come out.

Sweeney.

Q. That was the name of the patient?

A. Yes.
Q. You are one of the defendants?
A. I think I am at this point the only defendant.
Q. What are the allegations against you?
A. Concerning an intra-aortic balloon pump that was inserted in an emergency manner following a cardiac catheterization allowing the patient to go to bypass surgery, with a complication of the potentially -- a potential complication of the balloon pump insertion causing neurologic damage to his leg.
Q. That remains pending?
A. Correct.
Q. Is it Mr. Charms that's representing you in that case?
A. No. Presently I am being represented by --
Q. Mr. Jackson?
A. No.
Q. Mr. Hupp?
A. No.
Q. Mr. Seibel, Mr. Bonezzi, Mr. Djordjevic, Mr. Kalur?
A. Sweeney came to my head. The other will come, too.

MR. SEIBEL: Susan Reinker.

Q. Somebody at Jacobson, Maynard, Tuschman & Kalur?

A. Yes. I don't remember his name.

Q. If you think of it, let me know.

A. I will.

Q. All right. Any others?

A. No.

Q. You mentioned that you had a couple other articles, what are those?

A. I have written a review article on reflex control in heart failure.

Q. Has that been published?

A. Yes.

Q. Where at?

A. It is a journal called Hospital Practice, and I believe 1991, I think.

Then one that is in press right now for a journal called Cardio, on the use of vasodilators in mild to moderate heart failure.

Q. The name of your article is?

A. The "Use of Vasodilators in Mild to Moderate Heart Failure."

Q. That's in press now?

A. Yes.

Q. Any others?
A. No.
Q. Have you reviewed anything in connection with this case after you wrote your report this year?
A. I reviewed no new documents after I wrote my report.
Q. You haven't looked at deposition?
A. No.
Q. Or any other testimony?
A. No.
Q. Have you spoken with any of the other experts or have you been provided with any testimony by Mr. Coyne or anybody else in his firm of what the experts have said?
A. No.
Q. Is there some --
A. I thought of my lawyer's name if you want to know --
Q. Yes.
A. __ before I forget.
John Polito.
MR. FULTON: Don't tell John.
Q. Is there some specialty within medicine that provides for the ability to determine how long

someone will live?
A. There is no specialty within medicine that lets you know precisely how long people will live. There are special --
Q. You stressed the word "precisely," Doctor?
A. I think all specialties in medicine to some degree or another allow you to make an assessment regarding possibility of survival. It depends I guess what's limiting your survival.
If you have a cancer, then it's the oncologist who's best able to tell you that. So it's probably all specialties within medicine to some degree.
Q. I see. So as a cardiologist then you would be able to assist us in telling us within your specialty to what extent people would live with any type of heart problem, heart disease?
A. With any kind of heart problems. Also with general medical problems, yes.
Q. That's because you're also an internal medicine specialist?
A. Correct.
Q. How much time in your practice is spent dealing with neurologic deficit?
A. Percentage of time-wise? I spend a fair

amount of time working in the intensive care unit. In the intensive care unit a percentage of the patients, not a majority, but a sizeable percentage of the patients will have neurological deficit usually secondary to cardiac disease, sometimes from other disease that would get them into the intensive care units.

Q. Do you treat them for that or do you get -- when you say large amount of time spent in I.C.U., is that in conjunction with primary duties to the I.C.U. or as a consultant to people within the I.C.U. that have a heart condition?

A. More often as a primary physician in the I.C.U., but both.

Q. What are your duties in the I.C.U., do you hold a position there?

A. Well, one or two months of the year I would -- 1 am the physician of record in the intensive care units, such that in the cardiac intensive care unit such that I assume primary responsibility for every patient that is admitted there.

The remainder of the year I might go in there and see cardiology consultations, but one or two months a year I am the primary physician

of record for those doctors -- for those patients.
Q. For all the patients going through?
A. Yes.
Q. That doesn't mean you treat all the patients going through, does it?
A. Yes, it does.
Q. Does it?
A. Yes. Yes, I take care of them.
Q. Take care of all of them?
A. Yes.
Q. Do they have other cardiologists who take care of them as well as you or do you take --
A. No, I take care of them.
Q. -- all of them?
A. During my months they may have cardiologists who have cared for them in the past who offer opinions or see the patient, but I am primarily responsible for all of them.
Q. When the two months are done, do you continue to care for them or does the next doctor of record take over?
A. Either way. Either way, depending if they are likely to be in the hospital for another full month, I guess if they're going to be there, then in general you would transfer that care to someone

else; if they are likely to be there several days, a week, then you would continue their care.

Q. Would that be for three shifts or would there be three separate doctors, how would that work?

A. No, this would be 24 hours a day that you are responsible.

Q. Well, you may be responsible, but who cares for them?

A. I'm not there 24 hours a day, no.

Q. Who is, residents?

A. Fellows, specialty trainees in cardiology.

Q. So you as the attending then is responsible for the conduct of the residents even though you may not be there?

A. Yes.

Q. That would be true I take it of any attending who has got residents underneath him; would that be a fair statement?

A. I think the attending is responsible for the overall care of the patient, the decisions that are made, and how to take care of that patient.

Q. Is that answer different than the previous "yes" you gave me to that question?

A. The resident is not my employee, *so;* but I am responsible for the patient when the decisions are

made.
Q. If the resident does something inappropriate as it pertains to the patient, are you responsible for the resident's conduct in that regard?
A. I don't know in a, you know, hierarchal sense or a management structure sense whether the resident is responsible to me or to the hospital.
Q. If I am a patient and I am in the C.I.C.U., okay, is that what it is?
A. Yes.
Q. And you leave me in the care of one of the residents there?
A. Yes.
Q. You go home, he does something wrong towards me, are you responsible for that?
A. I believe I am.
Q. So I mean, can we agree that Dr. Steele would have been responsible for the conduct of Dr. Varma as it pertained to Mrs. Weitzel?
A. I think that's perhaps more legal questions than a medical question. I can't really answer.
Q. I'm asking from a medical standpoint, you as a physician, we'll work out the legalities.
MR. FULTON: Hopefully.
MR. KAMPINSKI: We will.

A. As the attending I am -- would be responsible for the patient. I think that's as kind of a broad statement as I can make about it.

Q. Did Mrs. Weitzel die because of sequelae of her heart attack that occurred on February llth, 1991?

A. She died from a multitude of factors.

Q. Did she die as a result of any damage done as a result of the heart attack that she sustained on February llth, 1991; was that the cause of her death, Doctor?

A. She sustained a heart attack, was admitted to the hospital, was in the hospital for a month, and a combination of everything that happened after her heart attack contributed to her death; whether everything that happened after her heart attack was a direct relation to that heart attack or whether separate events occurred, I can't say.

Q. So you don't know then, is that your answer?

MR. COYNE: I don't think that was her answer. The answer speaks for itself.

MR. KAMPINSKI: I don't think she did.

Read her answer.

- - - - -

(Answer read.)

- - - - -

Q. Does that mean she did die as a result of the damage due to the heart attack or she didn't?

A. I meant she had a heart attack and other things happened, but I cannot say that everything else that happened, happened because of the heart attack.

Q. Well, for example, did the placement of two guide wires into her arterial system happen because of the heart attack; was that iatrogenic?

MR. FULTON: Objection.

A" If -- if you are asking me did the placement of the guide wires happened because she had a heart attack, that was the first part of your question --

Q. That wasn't any part of my question.

Was the fact that there were two guide wires in her arterial system at all a result of her heart attack or was that because of doctor's inability to know how to place an arterial line, Doctor?

MR. FULTON: That's a different question.

MR. KAMPINSKI: That is not.

Iatrogenic means caused by a doctor.

MR. FULTON: Show an objection.

MR. KAMPINSKI: Sure.

A. The guide wires that were left in her --

Q. Yes?

A. -- were not left in as a direct sequela of her heart attack, that was -- was your phrase.

Q. I think that's what my question was.

A. Yes.

No, they were not a direct result of the heart attack.

Q. And the surgery then to remove the guide wire by Dr. Moasis, was that as a result of the heart attack or was that a result of the leaving of the guide wires in Mrs. Weitzel?

A. Guide wires were removed because of the guide wires were left in, yes.

Q. And the failure of the hospital personnel to attend to Mrs. Weitzel subsequent to the surgery, was that as a result of the heart attack, Doctor, or was that as a result of their inability to understand her worsening condition?

A. I can't say that that hospital did not attend to her.

Q. Let's assume they didn't, was that as a result of the heart attack, assuming that?
A. Assuming that the hospital personnel did not attend to her?
Q. That's right.
A. If I was to assume the hospital personne di(not attend to her, no, that would not be a cause of her heart attack; other than the fact that she's in the hospital because she had a heart attack. That was what admitted her to the hospital, that was the primary admitting diagnosis.
Q. Well, maybe you can help me out: If the guide wires had not been left in Mrs. Weitzel, if surgery had not been done to remove them, under those circumstances we wouldn't be talking about the events that occurred on the evening of March 14th as to whether or not they were appropriate or not in terms of her post surgical care, because they wouldn't have happened, correct?
A. She would not have gotten the surgery on that, correct. So the exact sequence of events that were post surgical would not have happened, correct.
Q. And you would agree with me, would you not, that in terms of definitions, this was a surgical

death, correct, or a operative mortality since it happened within 24 hours of an operation?

A. By definition, yes.

Q. Would you please tell me on what day Mrs. Weitzel would have died had the wires not been left in her?

A. I couldn't give you an exact date.

Q. Would it have been in March of 1991?

A. I can't give you an exact date.

Q. Would she still be alive today?

A. I doubt it.

Q. Would she have died last week?

A. I doubt it.

Q. This week?

A. I don't think she would have survived to leave the hospital.

Q. So she would have died in the hospital, right?

A. In the hospital, I believe.

Q. Sure. Would you tell us the basis of your opinion?

A. There's multitude bases for my opinion.

Q. First of all, is it based on your experience, is it based upon literature, tell us what it's based on first?

A. It's based upon my review of the chart, it's based upon literature, and it's based upon my experience.

Q. What literature do you base it on?

A. I base it on a few textbooks.

Q. Tell me what, please.

A. Braunwald's textbook of cardiology.

Q. Say it slowly.

A. Braunwald is the author, B-r-a-u-n-w-a-1-d. I believe it's just called a textbook of cardiology, or cardiology.

Q. What part of that textbook of cardiology supports that conclusion?

A. I can't cite to you where in the book, but he discusses adult respiratory distress syndrome and multitude organ failure and the sequela of heart attacks.

Q. Any other text or literature?

A. A few other articles that I read, which I cannot quote you names.

Q. Why not?

A. Because I reviewed them quite a while ago. I don't remember the names.

Q. I beg your pardon?
A. Back in January, I think.
Q. You mean a total of three months ago?
A. Yeah.
Q. You say that the syndrome of ARDS carries exceedingly high mortality, and "When three or more organ systems are involved, mortality rate exceeds 80 percent, and if this organ failure persists beyond four days, mortality approaches 100 percent," that sounds like it is out of some literature --
A. Yes.
Q. __ rather than you --
A. Pulling it off the top of my head?
Q. Yes.
A. Right.
Q. Could you tell me what literature it's from?
A. Unfortunately I can't. I don't remember the names. I reviewed several articles on adult respiratory distress syndrome and multiple organ failure. I'm sorry. I don't. I didn't bring the names with me.
Q. I apologize to some extent because, you see, when you put things like this in a report, it is hard for me to determine how accurate they are

without my knowing your reference source; that's true in medicines, isn't it?

A. Yes.

Q. You read an article, you want to know where they got the research material from to determine the validity of what is being said?

A. I agree, yes.

Q. Is there some way that we can agree you can provide me with this?

A. Yes, I will. I would be happy to.

Q. How long would it take you to get this, we have a trial in two weeks here.

A. It wouldn't take me -- about two days. I have to go to my office and I find the articles.

MR. KAMPINSKI: Can we agree that we'll reconvene once she finds the literature to support what she is saying? I quite frankly have a great deal of difficulty questioning her about something that I don't have.

MR. COYNE: It's up to you. We can provide with you the articles in two days and then -- well, it's your deposition.

MR. KAMPINSKI: Okay.

MR. COYNE: As soon as -- I'd ask you to send them to me and then I will get

them to you the same day I receive them.

Q. The next part of your report also appears to refer to some reference material, and that is, "It is known that," which implies that it is written somewhere?

A. Yes.

Q. "The prognosis is exceedingly poor in patients who suffer an out of hospital cardiac arrest secondary to ventricular fib."

Then once again the next sentence you talk about for out of hospital ventricular fibrillation arrests, that refers to a specific article, too; doesn't it, Doctor?

A. Yes. That I believe comes from Braunwald's textbook.

Q. From the text?

A. I believe, but it may have been an article. I think it's the text.

Q. Well, does that text say anything about the survival rates for someone who suffers an out of hospital cardiac arrest and then is maintained within an intensive care unit setting, or does the article or the literature only talk about the survival of those people who suffer an out of hospital arrest without regard to whether or not

they survive to make it to the hospital?
A. No. Data is provided both ways for patients who survived to the hospital, patients who survive to be admitted to the hospital; and patients who survived to be discharged from the hospital.
Q. What are the statistics with respect to patients who are discharged from the hospital in terms of their survival?
A. No. The statistics go to hospital admission and to hospital discharge, but if you are asking me from hospital discharge long term, if that's what you're asking me, that data is not available to me.
Q. You are saying to hospital discharge and that implies they survived sufficiently to be discharged?
A. Correct. But not -- but the data is not there for long term after that.
Q. So it's 100 percent of those who make it to hospital discharge, are discharged I mean?
A. Yes.
Q. I see. So the statistics --
A. But those statistics do not speak to whether -- to how long you live after hospital discharge.
Q. Did she die as a result of her adult

respiratory distress syndrome?
A. That was one factor.
Q. Did she die as a result of that, Doctor?
A. She died as a result of multiple things. I can't isolate one.
Q. That's one of the things that caused her to die?
A. That is one of the things that caused her to die, yes.
Q. Do you agree or disagree with Dr. Holland in terms of it being his opinion that it was as a direct result of the bleed that she sustained intra-operatively and the failure to attend to that bleed postoperatively that caused her death?
MR. FULTON: Objection.
MR. SEIBEL: Objection.
MR. COYNE: I don't think that's his testimony.
MR. KAMPINSKI: I think it is.
Q. Go ahead. Do you agree or disagree?
A. I didn't read Dr. Holland's deposition, so that --
Q. So you don't know?
A. Are you asking me if I think she died as a direct result of a bleed after her operative

surgery?

Q. And sequelae of a bleed?

A. Of the bleed?

Q. Yes, ma'am.

A. I think that's a part. I think that's a relative large part. It's not -- I wouldn't say it's the sole event. She had a relatively -- she had a moderate amount of blood, I think three to 400 cc's.

Q. 500.

A. I think the autopsy said three to 400 in the body of it.

Three to 400.

MR. COYNE: For the record, it says three to 400 in the autopsy report.

MR. KAMPINSKI: Okay.

A. Which is **10** to **12** ounces of blood, and I think that a blood loss even if it's very acute, very sudden of **10** to **12** ounces of blood in an otherwise healthy person would not cause her death, *so* I think it's part; but if you lose **10** ounces of blood you wouldn't die.

Q. She wasn't an otherwise healthy person.

A. That's my point.

So yes, that a part. It's not a

whole answer. It's part of it.

If you lose 10 ounces of blood, you wouldn't --

Q. Why do you keep talking about me. We're talking about Sharon Weitzel.

I'm asking if the blood loss that she sustained and the sequelae as a result of that is what probably caused her to die, is it?

MR. COYNE: I think she answered. She said it's part of it.

MR. KAMPINSKI: She keeps talking about me or an otherwise healthy person. Let's talk about Sharon Weitzel.

Q. She was in the hospital because she wasn't a well person, right?

A. It is part of the reason that she died. It is a contributing factor to her death.

Q. It's your belief that even absent that blood loss she would have died in the hospital anyhow, and you base that on literature?

A. Yes. Yes. That is my belief.

MR. COYNE: Not solely because of the literature, though.

MR. KAMPINSKI: You can ask questions whenever you --

MR. COYNE: You added solely because of literature.

MR. KAMPINSKI: I didn't ask you. I asked her.

MR. COYNE: Earlier she said of her own experience and her own training.

Q. You have a lot of people that get wires put into their arterial systems in your cardiac intensive care unit, Doctor --

A. Yes.

Q. -- that nobody tells you about them?

A. Put -- I had lots of people that wires were put in. That was put in and left in, it's not the same.

Q. How about left in?

A. No.

Q. Any?

A. Patient under my care?

Q. Yes.

A. None.

Q. So your experience doesn't include anybody like Sharon Weitzel, does it?

A. My experience does not include patients that have wires inadvertently left in arterial systems, it does not.

Q. In terms of dealing with their ARDS condition, is that dealt with primarily by a pulmonologist specialist?
A. It's dealt with by pulmonologist specialists in conjunction with intensive care unit attendants.
Q. Who determines the various settings on ventilators with somebody who has ARDS, the pulmonologist?
A. Again, it's a combination of the pulmonologist and intensive care unit attending.
Q. Who determines whether or not somebody is to be weaned off of a ventilator?
A. The same.
Q. Combination?
A. Yeah.
Q. Did you read Dr. Sopko's testimony in this case?
A. No, I did not.
Q. Didn't you think it was important to read the pulmonologist's testimony?
A. In regard to what?
Q. In regards to whether or not she was about to be weaned off the ventilator?
A. No. I read the chart and the data in the chart and I can form an opinion based on what I see

in the chart.

Q. Would it matter to you as to what the pulmonologist said with respect to when he anticipated she would be weaned from the ventilator; would that matter to you at all?

A. I wouldn't alter my opinion, no.

Q. So that's not something that would affect what you have to say?

A. No, it wouldn't.

Q. Was she improving from a ventilatory standpoint?

A. In some small ways she was improving, in some ways she was not.

Q. Was she stable from a cardiac statement?

A. She was stable from a cardiac statement, yes.

Q. Would you point out to me in the record where you derive the information that she had a profound neurologic deficit, ma'am?

A. Yeah. Let me find out how the chart is arranged.

Progress notes. These are the notes, I can find it in here. I would -- could look at them front and back all through her chart. I would start with the latter part of her hospitalization, because I think that's

prognostically more important than when she came into the hospital.

Q. Whatever.

A. I would go backwards.

On 14th of March there is a junior medical resident's note that -- this is one of the many, this is not the most important one.

Q. We'll find it along with you, okay?

A. Okay. That might be it. That looks like it.

3-14, JMR, top of the page starts renal.

Q. That's the third page of the note.

A. Okay. At the very end of the note when it gets to neurology he says continue to watch for awakening, I believe, which again is kind of a minor point; implies to me that she was not awake.

Slowly resolving neuromuscular blockade means she was -- had been off of the medication that will paralyze her for three days; no advances for three days.

That was his neurologic note on that day when he is still waiting for her to wake up.

Q. Who is the junior medical resident?

A. I cannot read that signature.
Q. How long has he been on --
A. If he was a junior medical resident in March, that means he graduated from medical school approximately a few months shy of two years previous.
Q. You didn't let me finish the question.
A. Go ahead.
Q. How long has he been seeing Mrs. Weitzel, how long has he been at Charity prior to writing this note?
A. I have no way of knowing how long he had been at Charity. I can go back through and see approximately when his first note was written. I am not sure this pertains to physically walking in and seeing her for the first day and can tell if she was awake or not; but to answer, I don't know.
Q. You are not a junior medical resident, or do you equate your capabilities to that of a junior medical resident?
A. No, I don't, but I think a junior medical resident or a first year medical or a medical student could tell -- tell whether or not someone was awake, or a lawyer.
Q. How about a husband, could he tell?

A. No, I think it's difficult for family members to tell. I think you need medical training.
Q. Lawyers don't have medical training.
A. That was a facetious comment. I'm aware lawyers don't have medical training.
It's a little hard for me to find things here quickly. When I looked at the chart it was not put together in this order, so I have to be --
Q. Take your time.
A. On the 12th there is a JMR note. Again it starts GI nutrition on the top line.
MR. COYNE: For clarification, it's March 12.
A. I'm sorry. March 12th.
Q. Just give me a minute to find it.
A. Fine.
Q. Is this the same junior medical resident or is this someone different?
A. I think it's the same.
Q. Writing looks the same?
A. Yes.
Q. All right. What part of --
A. Under neuro again, halfway down the page, as above requiring prolonged recovery time from

sedation, neuromuscular blockade.

Q. I'm sorry?

A. Half way down it says neuro, the page starts with GI/nutrition. Then almost halfway down it says as above requiring prolonged recovery time from sedation, neuromuscular blockade, no focal changes apparent.

Q. Nurse would be able to observe this too then, right?

A. Yes.

Q. All right. Go ahead.

A. On the 12th, which I think is just two pages previous, there's a note by cardiology, got a little -- you just had it; has a little heart on the side, there's a cardiology note.

Patient given 0.4 milligrams Robinul and 4 milligrams Neostigmine over a five-minute period. That's an attempt to reverse the medication that may be keeping her neurologically depressed; patient demonstrated positive Doll's eyes and blink reflex and moved left arm apparently on command.

Those are very simple, basement low level neurologic functions. She did not wake up and purposefully look, she had very -- I would

interpret that as being very minimally neurologic function.

MR. FULTON: Are we looking at the progress notes?

MR. COYNE: Doctor's progress notes.

Q. What does it say right after that?

A. Discuss with medical residents and will restart Versed drip for sedation until -- I'm not sure what that is -- is worn off.

Q. Didn't you just testify under oath based on careful review of the chart that the junior medical resident, I think you said on the 14th, was looking at someone who had had the neuromuscular block removed for three days?

A. I am reading backwards in time.

Q. If they started the Versed -- if it was still going on the 14th, then --

A. Versed is not a neuromuscular blockade. A neuromuscular blockade is specifically a paralyzing agent.

Q. What does Versed do?

A. Versed is an anti-anxiety or a sedation. It doesn't paralyze.

Q. It sedates?

A. Yes. Anti-anxiety.
Q. What does it do to your neurologic status?
A. It doesn't do anything to your muscular strength. It would sedate, make you sleepy.
Q. Drowsy?
A. Drowsy, but not paralyze you.
Q. But would it make it difficult for you to respond?
A. It might. I would need to look in the orders to see. I believe that was discontinued as well, the Versed.
Q. Do you?
A. I believe *so,* but I have to look in the order.
Q. Why don't you take a look.

Would that matter with respect to your opinion about her neurologic status?
A. It wouldn't reverse my opinion completely, no.

Then I can also go to the beginning parts of the doctor's progress notes.
Q. Let's go slow.

Are you done with the back part? Have you now shown me --
A. I was working backwards and I got to

the 12th. The orders I think are on this part. I'm looking at her routine medication orders for a week, that begins on March 14th, that list that begins on March 14th -- March 13th, I'm sorry.

Her medication includes Carafate, Amantadine, Nitroglycerin patch, Heparin, Solu-Medrol, aspirin, Verapamil, Dig, Reglan, Fortaz, Vancomycin, Tobramycin, Verapamil and Solu-Medrol, *so* there is a -- appears by that list at least routine medication orders that no Versed was given.

Q. Up until on the 13th, Doctor, there is an order that says discontinue Versed; do you see that, it's at 9:00 p.m.?

A. I'm looking at the medication record to see what she --

Q. Doctor --

A. Do I see that order, the 13th, yes, which was I believe four days before she die.

Q. How many days?

A. Four.

Q. Based on your careful review of the record; is that correct?

Is that the same day of the junior medical resident's note that you read to us before?

A. I don't remember.

The junior medical resident note was on the 13th?

Q. Yes.

MR. COYNE: That was a question now?

MR. KAMPINSKI: Well, I'm just trying to figure out what the Doctor is trying to tell me.

A. Her Versed was discontinued per the order you showed me on the 13th.

Q. Yes, ma'am. Appears to be at nine o'clock, it looks to me. I could be wrong.

What time was the junior medical resident's note?

A. It is not timed; but again, the junior medical resident's note speaks of neuromuscular blockade, not of sedation. That is -- those are two different things.

Q. And is it your opinion then you can determine whether someone has sustained brain damage by virtue of a junior medical resident note looking for awakening from a neuromuscular blockade?

A. Well, I think there are many other notes in the charts.

Q. Point them out to me. You showed me two junior medical resident notes. Anything else in the record that --

A. Here is notes.

Q. __ that supports your conclusion?

A. Here, February 12.

Q. We're going now from working backwards, you've just gone now --

A. I can work either way.

Q. I want to know each and every note that you suggest --

A. Yes.

Q. __ supports your conclusion.

A. Okay.

Q. You started backwards, you now want to go forward?

A. Yes.

Q. From the day she was admitted you now want to *go* to?

A. Yes.

Q. Didn't you testify earlier it's much more important for you to know what she was like near the end?

A. It's easier for me to flip the pages going forward, but I can --

Q. You are the one that started going backwards.
A. I can continue.
Q. Whatever you want to do.
A. Whatever you want to do.
Q. Knock yourself out.
A. Thank you.
A cardiology note on the 12th.
Q. By the way, you wouldn't just point out those things that support your conclusion as opposed to factors that go the other way, would you, Doctor?
A. I'm looking for everything that says neurology.
Here's a neurology note from the llth from a junior medical --
MR. COYNE: March?
A. llth, yeah. Neuromuscular blockade and a word I can't read, and --
Q. Sedate?
A. -- Sedatol or -- sedated, maybe, will D/C Vecuronium and Versed to help with another word I can't read. I don't think -- that is not a helpful note.
Q. Helpful?
A. I said it's not a helpful note.

On March llth, a JMR note, neurology, responds minimally to noxious stimuli.

Q. Does that tell you anything one way or the other?

A. Yes. It is my opinion that even if someone is on Versed they should be able to do more than respond minimally to noxious stimuli. That was of concern to me.

Q. Was she on anything else at that time?

A. I could *go* back to the orders and look.

MR. COYNE: Do you want her to go back to the orders and look?

MR. KAMPINSKI: Anything that helps her support her conclusion.

A. Let me go through all the notes first, then I can look at the orders.

Q. Didn't you do all this before you wrote your report, Doctor?

A. Yes, I did. This is a pretty thick chart, a couple hundred pages. I can't remember every detail of the chart.

Q. Did you review it before coming here today?

A. I reviewed it briefly, yes.

Q. When?

A. A little bit last night and more this

morning, but I didn't review it in such detail as to find every neurology note.

Neurology note on the 9th by junior medical resident says neuromuscular unchanged, heavily sedated. I think there's many pages of notes without neurological comments.

On the 8th says neurology unchanged, neuro unchanged. Then there are several more pages with no neurologic notes.

I am back now to I believe the 7th of March, which again simply says neuro, heavily sedated.

On the 6th, neuro, no change. There's a long period in the middle where there really isn't much information, but I am trying to find every neuro note for you.

On the 5th again, neuro unchanged.

On the 4th, the same, unchanged. A word I can't read. Excuse me. Unchanged, heavily sedated.

On the 3rd, neuro unchanged, which is really not any progress or any change.

On the lst, neuro, heavily sedated.

Again, several days with no

neurologic comments.

On the 27th of February, heavily sedated with Versed.

Several more notes without neurologic comment.

2-24 -- no. Let me find a date. 2-24, yes. Neuro unchanged, grossly intact.

2-23, patient lethargic.

2-22, unchanged, still follows commands. Well, I am sorry. 2-25 --

Q. Still follows commands you said?

A. Yes.

Q. What does that mean?

A. Well, I don't know specifically what it means, but I assume it's a -- they tell her to open her eyes, she opens her eyes. That's the kind of usual command you give people.

Q. What does that mean to you as a physician trying to analyze her neurological status if she is able to follow commands then, does that mean she understands what is being said to her?

A. Means to me she is not completely brain dead.

Q. Were a number of neurological consultants involved in this patient, Doctor?

A. I am almost to the end. Just hold on.
Neuro, unchanged on 19th of February.
Q. Wait. The one you read, the 22nd, does it say "Still follows commands well" or just "Still follows commands"; it seems that you left something out?
A. What's the first line of the page?
Q. Junior medical resident.
A. Can you read me the first line of the page so you can -- I can find it.
Q. That's the one you just read to me a minute ago.
A. Yes.
Q. You left the word "well" out. I wondered why you did that.
A. I think you're right. I think it says "Still follows commands well," I think.
Q. Does that make any difference to you?
A. Well, if the command is open your eyes and she opened her eyes, I am not sure that "well" means very much to me, honestly.
Q. Let me, hypothetically, Doctor, we'll continue on, I know you're near the beginning, but let's just assume for the sake of argument that she

was able to communicate to the point of actually writing in the air letters to respond to people since she couldn't verbally speak to them because she had a ventilator in?

A. Writing letters with her finger?

Q. Yes. Writing letters on someone's back and was able to make herself understood in that fashion, would that affect you at all?

A. If she could truly do **a** -- first of all, have you ever tried to read someone else's air writing, it's almost completely impossible, but I have tried.

Q. Do you want to answer my question?

A. If she could truly do it, and I saw her do it, and believed that she did, it might change my mind.

Q. How would it change your mind, would it make her totally brain dead or would it --

A. No. I have decided she's not totally brain dead. That takes it to a higher level of neurologic function to be able to communicate.

Q. Well, how high a level?

A. There is no answer to that question. It's a higher level function.

Q. Well, how would it affect your opinion as set

forth in your letter saying all these problems of neurologic dysfunction was the greatest concern with regard to the possibility of meaningful survival; would that affect that opinion?

A. If I saw her communicating by writing on a piece of paper or legibly writing letters in the air?

Q. Yes.

A. If I saw that yes, it would.

Q. How would that affect your opinion?

A. I will have some more hope for her neurologic status.

Q. What do you mean "hope."

You preface many of your opinions in terms of "probabilities" or "possibilities" and I guess I'm asking you to quantify that?

A. I will not say that someone who is able to communicate by writing in the air -- I will not say that that assures a probability of a meaningful survival.

Q. Assures a probability?

Does it mean that it's probable that she will have a meaningful survival?

A. No.

Q. So it's probably that she won't?

A. Yes. Given everything else.
Q. Beg your pardon?
A. Given everything else.
Q. We're talking about the neurological status, Doctor.
A. Given her other neurologic findings.
Q. What other neurologic findings?
A. 2-12, neurology, eyes wander and --
Q. You left me off back at 2-20, is there nothing else between that and 2-12, the day she came in?
A. I didn't find anything.
Q. Nothing else?
A. I can look again.
Q. If there is nothing else, that's fine.
A. No. Let me look again. You know, there's a neuro unchanged on the 21st; there's a neuro unchanged on the 20th, there's a neuro unchanged on the 19th, a neuro unchanged on the 18th. There was nothing else of substance there.

There's a neuro unchanged on the 17th.

On the 16th says awake, follows commands.

Q. What date?

A. On the 16th. Junior medical resident, awake, follows commands, neuro unchanged.

Q. What date was that? I'm sorry.

A. 16.

Q. 16th?

A. Yes.

On the 15th there was awake, moves extremities.

Q. Is that good?

A. Not necessarily.

Q. Is that bad?

A. Brain stem --

Q. Is that bad?

A. __ function can be sufficient to have -- to have you move your extremity, so it's not --

Q. So that's a neither?

A. Exactly.

On the 14th there is a pupils equal, reactive, equal, round, reactive to light.

Q. Is that good?

A. Again, it's a neither here nor there.

Follows commands --

Q. Anything else?

A. Yes. That was the one I was back to.

Q. I know you desperately want to get back to

the 12th.

A. I want to go back to the beginning.

On the 13th a neuro, withdraws to pain, moves extremities.

Q. Is that good?

A. That's a minor sign. It's not enough.

Q. Minor sign of what?

A. That you're not completely brain dead. I don't think anybody is saying she's completely brain dead. I don't want to be arguing about that.

MR. COYNE: We're not here to argue. You are here to render opinions based on -- based on records.

Q. What are you here to do?

A. Let me --

MR. COYNE: She's here to answer your questions --

MR. KAMPINSKI: No.

MR. COYNE: -- in a deposition.

MR. KAMPINSKI: That's not the only --

MR. COYNE: That's why she's here.

MR. KAMPINSKI: Is she? I

thought maybe she was on a mission here. Just trying to figure it out myself.

MR. COYNE: There is no question. Wait for the next question. This is just editorial comments.

MR. KAMPINSKI: Is it?

MR. COYNE: You are talking about being on a mission. I don't think that's a question.

MR. KAMPINSKI: All right.

BY MR. KAMPINSKI:

Q. Any other neurological findings of any substance that assist you if formulating your opinion in this case, ma'am?

A. On 2-12 a note by the neurologist, patient eyes wander, patient doesn't follow command, blinks to clap, positive corneal reflex, positive reflex to suctioning.

Q. Is that on admission?

A. **2-12**, by the neurologist. That's the only note going backwards, at least that I have seen from the neurology.

Q. The day she was admitted?

A. Yes.

Q. Well, based upon the other notes that you

looked at, did she then get better, did she get worse?

A. I don't think she got worse.

Q. Did she get better?

A. I don't think there is sufficient evidence to say that she got substantially better.

Q. On the 12th she didn't follow commands, right?

A. I would place more weight on the neurologist's notes. That's the -- the problem, these are not the same people making comparisons, and I would place more weight on the neurologist's note saying she didn't follow commands than on a junior medical saying she did. We're stuck with the fact there's two people seeing her at two different levels so there's no longitudinal comparison.

Q. Is there anything else that led you -- any other notes, Doctor, that led you to your conclusion if your quotes "expert" report?

A. In her Life Flight sheets -- excuse me. It's not Life Flight.

The division of fire emergency medical service reports from the City of Ashland, I think it's the EMS that responded to the call when

she had her cardiac arrest.

Q. I'm listening.

A. I thought you were looking for another copy.

At 8:59, which is when they begin recording vital signs, until when -- I believe says 9:30, for 31 minutes she was without pulse, without respiration, without blood pressure. In my mind that is a -- a very serious neurologic insult that would cause me great concern, if essentially 30 days later, 32 days later -- 13th of March, if 32 days later -- by 30 days, February is a short month -- if 30 days later we are still at the minutiae level of, is she opening her eyes when I tell her to, is she moving her extremities purposely, 30 days after a documented 30-minute episode of no blood pressure, no pulse, meaning no blood flow to her brain, I think that she -- my opinion is that she is in very serious neurological straits.

Q. How serious?

A. I don't think she will recover from it.

Q. Will she be a vegetable then?

A. A vegetable is a nonmedical term. I can't say yes to that, or no.

Q. How would you put it in medical terminology?

A. I think she will have severally impaired cognitive function. I think she will be unable to to work, I think she will be unable on some levels to enjoy life, although on some levels she could; I don't think she is going to be -- to be able to interact with her environment in large measure because of that insult.

I don't think there is any way around the fact that she had 30 minutes of no blood pressure, no heart rate, and 30 days later is maybe opening her eyes, maybe moving purposely. That is very minute recovery.

Q. Did you review the nurses' notes in this?

A. Yes, I did.

Q. Before you decided to write an expert's report?

A. Yes, I did.

Q. Is everything you are testifying here consistent with what the nurses found out?

A. Again, I don't remember at this point in time the details of the nurses' notes, which as you know are voluminous.

You know, there are, as I recall, some reports that she is following commands, some that she is not following commands, and some that

she was moving extremities, some that she is not. I didn't -- I did read them, yes.

Q. Is that inconsistent with what you are telling us here?

A. I think she had changing neurologic status. I can believe that on some days she will follow commands, some days she wouldn't.

I am just saying that's -- we're arguing over fine points of a very low neurologic status. If she opened her eyes one day, fine, but the next day she didn't, not fine. If that's the level we're arguing at, you know, that's a very low level of functioning.

Q. Doctor --

A. We're not discussing whether or not she was reading a book one day.

Q. Go ahead. Were you going to look at the orders to see about her capability of responding?

A. I was going to look at the order to see the medication that she was on.

MR. COYNE: In regard to the medication, is this at any point in time or do you want to know the medication she was on over the whole period of time? We're talking a long period of time here.

What is the question?

MR. KAMPINSKI: Well, I guess there's a couple questions.

If in fact she was medicated to the point where she couldn't respond, then certainly I'd like to know that, and I assume the doctor looked at that to try to analyze whether or not the lack of response was due to medication or whether it was due to brain damage.

A. I think the most important point in that regard is the note where she was given medication to temporarily reverse everything that she was given, *so* they wouldn't have to wait a period of time for it to wear off on its own.

Q. Are you talking the junior medical resident notes that you referred us to on the 13th and the llth?

A. I don't think that's what it was.

Q. You don't?

A. But I think I can find it real quick. I thought I was in the right volume here.

Where is the notes?

MR. COYNE: Progress?

A. I can't recall who wrote that note. Let me find it for you.

No, it doesn't say. It just is cardiology. It is co-signed. I can read Dr. Rollins, who was the attending.

Who wrote the note, I don't know. It doesn't say.

Q. What day is that?

A. 3-12.

Q. Is that where you saw the order on the 13th?

A. No. This is when the two physicians are at the bedside and they gave her medication to reverse the neuromuscular blockade, which is very short term. It's a test -- a test for very short term: give her a medicine, take away all that blockade, see what she can do, *so* that would not necessarily be reflected in the order. This is not something the nurse did, this is -- the physician gave this medication and observed her response.

That was the one where she had what I would interpret as minimal response to Doll's eyes, a blink reflex, and left arm moved apparently on command.

Q. So that's not good?

A. That's not good.

Q. How long does it take for the body to metabolize this medication that they gave her, how

does that work?

A. The medication that they gave her briefly to --

Q. No. The neuromuscular --

A. The long term?

Q. Yes.

A. Does the body metabolize it, yes.

Q. The long lasting drug or short, how do you reverse it?

A. Well, reversing it does not depend upon metabolism.

Q. I'm sorry.

A. Reversing it, you give an antagonistic medication that blocks the effect, its effect transiently. The blocker will go away, then if you want it to wash out, to metabolize, that will take a while.

This does not require you to metabolize or get rid of the blocking medicine in your blood because this temporarily unblocks the block, reverses the block, allows you to see what she is doing under there.

Then the reversal wears off very quickly, very short acting medicine, then you are back where you were right before you gave it, and

you wait for the medicine to wear off.

So there's two different ways of getting rid of the effect of the medicine.

Q. This was over a five-minute period they did this?

A. Gave the medicine over a five-minute period.

Q. She demonstrated positive Doll's eyes?

A. Yes.

Q. What is that?

A. That's when you passively turn someone's head, their eyes will -- you know how dolls do, they have movable eyes -- if you had someone look this way, the eyes go that way. A brain stem reflex, it's a minimal neurological finding.

Q. Is it a good minimal neurologic finding?

A. It's better to have it than not to have it.

Q. That's the positive Doll's eye, what about the blink reflex, is that good or bad?

A. Again, it is minimal, but it's good, better to have it than not to have it, but it's not much. That's things like if you startle somebody, they will blink.

Q. How about moving the left arm apparently on command, is that good?

A. I am concerned when he says "apparently"

because I think that's a big qualifier. That's clearly distinct than somebody saying "Moved left arm on command."

It's that left arm, and you move left arms, she goes like this. This is a move your arm, blink your eyes, then she moves her left arm. It's a -- to me it's a big qualifier. They're not sure if she moved it in a spontaneous motion or nonpurposeful motion, which is as -- not as good a sign, *so* I don't know.

Q. Does it say she did not move left arm when commanded to do *so?*

A. No. It's says "Move left arm apparently on command," which to me is a qualifier. It is not as strong as saying "Move left arm on command"; that would be a good sign; didn't move left arm would be a bad sign, this is somewhere in the middle.

Q. Could you show me in that paragraph any bad signs then?

A. The bad signs is inferred. This is all she had.

Q. Could you show me in the paragraph anywhere there something that says "Well, she didn't respond to this five minutes of medication, she is brain dead like Dr. Buchter says she is"?

A. I did not say she was brain dead.
Q. Whatever you are saying, could you show me where it says it in this paragraph?
A. That is to my reading and to what I believe would be a trained medical person's reading. That is implied. They don't list all the negatives that she doesn't -- it doesn't say she gets out of bed or it doesn't say she's breathing on her own. He didn't ask for the numerous -- they listed the things that she did which are minimal, and to me from that I infer that she did not have a higher order of response or that would have been listed. You list what happens, not the thousand things that don't happen.

No, it's not written in there that she didn't ask for the newspaper.

Q. So you're inferring it?
A. Yes, I am.
Q. So there's nothing written in the chart that causes you to conclude what you concluded; it's what's not written in the chart that causes you to conclude that?

MR. COYNE: Show an objection. It's her interpretation of the chart.

A. They write in the chart the responses that

she had. I assume that to be an inclusive list.
Q. You do?
A. Yes, I do.
Q. It doesn't say she jumped out of bed and ran around the I.C.U., so that's not a good sign, right?
A. Correct. If I understand your question. I take this to be an inclusive list of her responses to the medication, and I will call it a minimal response.
Q. What's the rest of that note -- by the way, when it says "discussed with medical resident'' --
A. Just a minute.
Q. __ "will restart Versed drip for sedation until Nocuron is worn off" --
A. Yes.
Q. __ what were they doing, like teaching the medical residents and students on her and --
A. No.
Q. No?
A. No. Oh, contrar. I think what he's doing is making her more comfortable. At that time they were giving her sedation to keep her calm, to keep her comfortable. They had done this diagnostic test. They learned what they needed to learn and

then could re-assess at another time.

Once they've give her this medicine to reverse the blockade, she is a -- she has improvement with her Doll's eye, blink reflex, and moving her arm apparently on command, they learned what they needed to know €or her status. At that point there is no benefit to leaving her off the Versed. So they are giving it back to her as what I would call a partial comfort measure.

Q. So in other words, they took her off the Versed to do the test?

A. You don't need to take medicine -- people off medicine to do the test.

Q. Why did they do it?

A. I don't interpret that note saying that they did, but I don't know without going back to the orders.

Q. Which is where you were before?

A. Right. What is the date of that? I just looked at it.

MR. COYNE: 12th.

A. But again, 1 don't think -- I'll look and find out -- but I don't think it is germane.

Q. Well, humor me.

A. I'm learning.

The question was regarding the Versed.

Q. Or the --

A. When she was on it, when she was off it.

Q. Yes. That, plus the neuromuscular blocks, what medication would those be?

A. Pavulon is one, that appears that she was given that, at least on this page, only on the 26th of February. We're talking --

MR. COYNE: 28th?

A. Ahead here. It was ordered as p.r.n., as needed, and given on the 26th. That's not the time we're talking about. Kind of old treatment records here. Let me get up-to-date.

Q. Look, Doctor, let me make it easy.

A. Yes.

Q. She came in on the 12th?

A. Yes.

Q. At what point in time after she came in did they provide her with any medication that would have altered her mental status and/or her neurological function in terms of neuromuscularly?

A. They gave her Pavulon. It's a very exhaustive list. Some of the medications are very short acting.

They gave her Pavulon in late February, which is not germane at all to her condition.

Q. Did you understand my question?

A. Yes. You asked me every medication that would have sedated or given her neuromuscular blockage following her admission on the 12th of February.

Q. Reason I am asking you that is, would it not affect your ability to render an opinion as to her neurological status depending upon what medication she was on at what time?

A. Yes. As I said --

Q. Did you in fact do that prior to preparing this report?

A. Yes.

Q. You looked at the medication she was on?

A. Absolutely. I have read every page.

Q. You looked at the nurses' notes?

A. Yes.

Q. And if in fact the nurses said that she was appropriately nodding her head to questions, responding well, following commands, alert and oriented, opening eyes to name, responds appropriately, those things really don't have any

impact on you in terms of your opinion, right?
A. I think it's very difficult to assess if someone is oriented when they are on a ventilator, since you can't -- if you cannot communicate with them.
Q. You and I weren't there, the nurses were there, is it --
A. The doctors were there too, though.
Q. But that's why I had you go through their notes, and they really don't say, do they, between the 12th of February and the 13th of March?
A. They make comments on whether she followed commands, they made comments on whether or not her condition changed.
Q. You read me two junior medical resident notes on the 13th, I think is what you did, and --
MR. COYNE: I think she read more than that.
A. There was one almost every day.
Q. All said unchanged?
A. Correct.
Q. And the one that you read on the, I think the 18th, you minimized in terms of his saying that she did follow commands. You said well, that may not mean anything.

Then I asked you whether the nurses would in fact have been capable of seeing her neurological status, I thought you told me yes?

A. Yes.

Q. Now I am asking you questions about whether or not if anything they say would have an impact on you, and you are now telling me they wouldn't know because they couldn't communicate with her and I am trying to --

A. I didn't mean to say that if that's what --

Q. You keep saying things. I guess I am trying to make sure I know what it is you are going to say when we go to trial in two weeks.

Are you saying that the nurses would or would not be the appropriate people that we can rely on to assist us in determining what her neurological status is during her stay at Saint Vincent Charity Hospital, what is your answer to that, Doctor?

A. I would give credence to the nurses' evaluation and I would give credence to the doctors' evaluation. I wouldn't look at the nurses to the exclusion of the doctors, but I will -- would look to both.

Q. Have we exhausted your reliance upon the

physicians in terms of their observation regarding her neurological status?

A. I think we have.

Q. Have we?

A. I think so.

Q. You just don't remember all the nurses' notes because there's too many of them?

A. Yes.

Q. If they said that she was responding appropriately to commands, that she was awake, alert, that she nodded her head appropriately to questions, I mean, would all of these things support what you are saying, or would they be contrary to what you are saying, Doctor?

Ma'am?

A. I am thinking. I am here.

I don't know that they would either support or deny. I mean, I think they're additional pieces of data.

I am not trying to say that she had no neurological function. I am not trying to say that she had nothing.

a. Pick a day in the nurses' notes.

A. I am trying to say that she had a significant neurologic insult and in all probability would have

suffered significant long term neurology data -- damage.

I am not -- if you want to say that she followed simple commands per the nurses, that's fine, she followed simple commands; that's to me not a higher order neurologic functioning, to intermittently follow simple commands.

If the nurses said she did that, then she intermittently followed simple commands.

Q. Intermittently? Did I say intermittently?

A. No, I said intermittently, because the doctors say she did not. So if we were to split the difference, I would say intermittently.

Q. If you want to pick a day, pick any day. I am just leafing through here.

MR. KAMPINSKI: You got the 17th in front of you there, Mr. Coyne?

MR. COYNE: Of which?

MR. KAMPINSKI: February.

MR. COYNE: February.

Q. Pick a day, any day, all right.

"Nods head appropriately to answer questions, opens eyes to name and waved, denied discomfort when asked, follows commands, makes good effort to squeeze fingers on commands"; do you see

all those notes, ma'am?
A. No.
Q. Is that somebody who is neurologically impaired?
A. Let me see.
That may be somebody with a profound neurologic deficit, yes. That is someone who -- whatever you read me, let me find it.
Q. Right at the top.
A. If someone opens their eyes to a name and waves, denies discomforts when asked, follows commands, makes good efforts to squeeze fingers, which is not quite as the same as squeezing finger on command --
Q. Does it say why, because her hands are swollen?
A. Doesn't say why.
Q. What is the next sentence, ma'am?
A. Okay. I'll continue reading, "Action limited RT edema in hands and soft wrists restraint.'' I'm not sure what RT means.
"MAE," whatever that is, "difficult to evaluate, difficult to evaluate strength or potential deficit at this time."
I do not think that this is

inconsistent with severe neurologic damage.
Q. Is it consistent with it? Does it support neurological damage or does it support the fact that the lady could understand, that she did respond, that she didn't have brain damage as a result of the anoxic event?
A. It is -- no. No way says that she did not have brain damage.
Q. I see.
A. There's a lot more to your brain than those sort of activities. Does not in any way tell us she did not have brain damage.
Q. Do you know any of the physicians involved in this case?
A. No, I do not.
Q. Dr. Rollins, Dr. Steele, Dr. Kitchen?
A. I know Dr. Rollins by sight but do not know him. The other doctors I do not know at all.
Q. I think your CV indicated that you were 43 years old?

Q. What is your life expectancy, Doctor?
A. What is my life expectancy? I don't know with a great degree of certainty.
Q. We have to look at actuarial tables to

determine that, probably?
A. I don't think actuarial tables takes into account these risk factors. I don't think every 43 year old woman has the same life expectancy. They're not very sophisticated. That's average for everybody, not everybody is average.
Q. Includes people with brain damage, includes people with heart problems, includes people that don't have any of those, right?
A. Right. I would say it's an average of all 43 year old woman.

MR. KAMPINSKI: That's all I have.

MR. FULTON: That is who don't have to suffer with attorneys.

MR. COYNE: Anybody else have any questions?

MR. SEIBEL: Yes, I do.
Anybody else?

MR. FULTON: Who's named as the -- am I, unfortunately.

MR. COYNE: I don't know if that makes any difference.
Whoever has questions.

MR. FULTON: I have no

questions on behalf of Dr. Varma.

MR. KAMPINSKI: So we don't have to have an argument whether you have a right to ask them?

MR. FULTON: Is that right?

MR. KAMPINSKI: If you don't have any questions.

MR. FULTON: I do have one question.

MR. KAMPINSKI: Wait a minute.

MR. FULTON: The --

MR. KAMPINSKI: I object.

By the way, before he gets started, I do not intend by any means to suggest that this deposition is concluded. It is only to the extent of allowing the doctor a couple days which she can gather up what she needs to provide me with whatever articles she referred to or that she used in support of her opinions set forth in this matter, then at which point I would look to inquire further of her regarding those materials and her opinions based on those materials.

I'm sorry. Mr. Fulton, you can ask the questions now that I am objecting that you ask.

MR. FULTON: Just to clear

up something that you asked.

MR. KAMPINSKI: Sure.

CROSS-EXAMINATION

BY MR. FULTON:

Q. With respect to University Hospitals, there are individuals who are trained out there to remove wires in a percutaneous manner?

A. I think some people there, their training period may have occasion to see that procedure done or to assist with a procedure. I wouldn't call it a formal part of anybody's training.

Q. But there are individuals who are able to retrieve wires at University Hospital?

A. Yes.

Q. They're in the radiology department?

A. I am not aware if radiology does it or not. I know that cardiology does.

Q. And the reason of having that training is because on occasions wires do get inside of a person's system?

A. Absolutely.

Q. They have to be removed?

A. Absolutely.

Q. Of course the way you would hope to remove it

would be through what is called a percutaneous method?

A. Correct. If possible.

MR. FULTON: I have no other questions.

CROSS-EXAMINATION

BY MR. SEIBEL:

Q. Doctor, when Mr. Kampinski was asking you some questions he said that Mrs. Weitzel was stable from the cardiac standpoint, could you us tell when you were referring to, what point in her hospitalization?

A. For her -- I was answering I think in a very general way. During her first few days of hospitalization both at the initial hospital and when she got to Saint Vincent, she was clearly not stable initially. She had been defibrillated I think 17 times. It was clearly very, very, very unstable in the beginning; but over the course of several days her cardiac condition stabilized. It improved only in that she no longer had the arrhythmias which needed to be treated urgently, but she is left with significant heart muscle damage. Her heart didn't normalize. It stabilized

but not normalized. It stabilized after the first perhaps three or four days in the hospital, but it was not normal.

Q. Assume that she had been a candidate for some therapy for the heart muscle damage, what would that have been?

A. At the time of her initial presentation when she had her cardiac arrest?

Q. When she had stabilized, rather, in the hospital?

A. When she had stabilized at the hospital?

MR. KAMPINSKI: I object. I am not sure I understand the question.

If she would have gotten out of the hospital, Bob?

Q. At some point after her cardiac status stabilized and she had become a candidate for some treatment to her heart muscle damage, would there have been treatment available to her?

A. In general it's difficult to treat heart muscle damage too far down the line after it happens. You like to treat it very acutely and within the first two hours. After the first two hours there is still some therapy that can be given to improve short function. It's not as

effective as early bypass surgery, balloon angioplasty, things like that.

Q. And you also said that she was improving in some respects from a pulmonology standpoint; again, is there a time reference that you can place on that?

A. I think the two main things you are looking at from a pulmonologist standpoint are how much oxygenation you require to keep your oxygenation level up in your blood, and how much work the ventilator has to do for you. You and the ventilator can kind of share the work of breathing.

She improved in the degree of oxygenation she needed, although that was very variable. She'd get better one day, worse the next. In general that was improving, but the amount of work the ventilator was doing for her was essentially stable throughout the whole course. She never took over the majority of breathing on her own.

She was better to some degree from her oxygenation requirements, but not from her need for the ventilator to do the mechanical work.

Q. What does assist control mean to you?

A. I cannot tell you the exact details of how

assist control works. There's many kinds of different functions of the ventilator.

Q. Does mean at least the patient is breathing to some extent on their own?

A. Absolutely. Absolutely.

Q. Did the presence of these wires pose a risk to Mrs. Weitzel?

MR. FULTON: Objection.

A. I am not sure if this is answering your question or not, I don't think the wires did her any harm. I think there was a potential risk to them, but that none was realized.

Q. What were those potential risks?

A. I think potentially the wires -- I think the major concern of a wire, could cause a perforation, that it could puncture the blood vessels.

I think other concerns of the wire are that you can develop a thrombus, you can get a blood clot on a wire which my travel elsewhere. The wire could become infected. I think those are potential risks.

Q. Would you agree eventually those wires would have to come out?

A. Yes.

MR. FULTON: I just object

to wires. One wire.
Q. Eventually the foreign body in her circulation would have to be removed, whether they were singular or plural?
A. Yes.
Q. In modern cardiology, is there some sort of hard and fast rule about not doing surgery in the first three to six months after an MI?
MR. KAMPINSKI: I'm going to object to "hard an fast" as opposed to medically indicated or medical appropriate or proper.
A. I think there's clearly a consensus of opinion that purely elective surgery should not be performed shortly after an MI.
MR. KAMPINSKI: I'll withdraw my objection.
A. That during the first six months after a heart attack there is some increases in risk which slowly, steadily decreases during that six-month period of time; but then that's for an elective surgery.
Q. How would you define purely elective surgery?
A. It's probably easiest to define by example.
Q. All right.
A. Purely elective surgery is let's say you need

your knee replaced, your knee is giving you lots of pain, you can't jog, you can't put weight on it, you can live with that pain, that's elective; or you need your back operated on because it's giving you pain. Things that are not life threatening or life shortening, are indicated procedures but elective.

Q. Was the surgery to remove the wire from Mrs. Weitzel on March 14th purely elective surgery?

A. No, I don't believe so.

Q. Do you have any opinion about the appropriateness of the timing of the surgery to remove the wire?

A. I think that's a -- a judgment call as to when the wire should come out. I don't have a specific time when I would say the wire needed to come out.

Q. Doctor, do you hold any opinions about the care given to Mrs. Weitzel postoperatively by any hospital agent or employee?

A. I don't.

Q. Do you have any opinion in this case that any of the attending or consulting physicians failed to meet accepted standard of care?

A. Do I have an opinion? I mean --

Q. Do you have an opinion that any of the attending or consulting physicians in this case were negligent in their involvement with Mrs. Weitzel?

MR. FULTON: I have an objection to consulting.

Q. By that I mean any of the nonresidents?

A. Yes, I do have an opinion.

MR. KAMPINSKI: Objection.

Q. What opinion do you hold?

MR. KAMPINSKI: I'll object to the extent they are not set forth in her report.

Go ahead.

A. I don't think any of them were negligent.

MR. SEIBEL: I don't have any further questions.

MR. FULTON: Well, I have a couple questions now.

RECROSS-EXAMINATION

BY MR. FULTON:

Q. Getting back to these wires, you certainly have known of cases in the cardiology department when wires have been -- have had to be removed from an individual patient?

A. Yes.
Q. Is that done under fluoroscopy?
A. Yes. Always.
Q. When you do something like this under fluoroscopy, I'm talking about at University Center, is there some means of recordation of what the fluorscopy shows?
A. No. Fluoroscopy is just a transient image. You step on the pedal and look at the screen. When you take your foot off the pedal, the imagine is gone. There is no permanent copy. It's not like an x-ray.
Q. Is there some standard of care as to what should be recorded then as to taking out a wire at that single -- I mean if it's a transient type of picture, is there a standard of care what the doctor should place in the medical record?
A. I think he should place in the medical record a note saying that it was done or that it was attempted and unsuccessful, or attempt was successful.

I wouldn't write in there, for instance, I don't know if this is the question, I wouldn't write that it is under fluorscopy because it's done under fluorscopy. The standard of care

is to write a note what you did, probably what approach you used, what vessels you went into, what equipment you used, and the results.

Q. If you found a piece or whole piece or part of a piece?

A. Exactly.

Q. You, of course, saw what was reported in these records?

A. I would need to look at it again, if you want me to.

Q. You don't have to look at it.

A. I'm going to look anyway.

Q. Go ahead and look then.

MR. COYNE: Wait for the next question.

Q. Do you know if it speaks of a piece being found here?

A. I don't recall.

Q. You want to look now.

A. Yes, thank you.

Q. I think it is the 13th.

MR. COYNE: Just for clarification, you are asking her to look at the doctors' notes for March 13th, is that what you want her to look at?

MR. FULTON: I think it's the 13th.

A. A note dated **3-13**, had a wire retrieval.

MR. COYNE: Read it.

A. "Number **8** sheath inserted in left femoral artery, snare using NIH catheter and guide wire was advanced to area of wires. One wire was successfully snared and removed but the other piece could not be snagged, will ask vascular surgeon to see to make sure left femoral artery is okay and to discuss options for retrieval of other piece of wire," and a signature I can't read.

MR. FULTON: Thank you. That's all I have.

MR. KAMPINSKI: You skipped me, Mr. Fulton, when you went after --

MR. SEIBEL: Breach of protocol.

MR. KAMPINSKI: I have a couple questions.

Does anybody have any questions?

RECROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Mr. Seibel asked you about training as it

pertained to the removal of a foreign object when it's left in a person; do you recall?

A. Yes.

MR. FULTON: Did I?

A. I believe the other gentleman, he asked me. It was Mr. Seibel.

MR. COYNE: This fellow.

THE WITNESS: I don't think it was.

MR. KAMPINSKI: I do.

MR. MELLINO: We haven't agreed on anything yet.

A. Someone did ask me that question.

Q. You're right. We can agree on that.

Do you train residents?

A. Yes, I do.

Q. Is it first year or second year or both?

A. All levels.

Q. All levels?

A. Yes, internal medicine residents and cardiology Fellows.

Q. Do you train residents how to place arterial lines?

A. Yes.

Q. At what level would you expect that a

resident would know how to place an arterial line, would that be a second year resident, would you anticipate that he can do that?

A. I would certainly think a second year resident would be able to do that.

Q. Part of his training ought to then show him or provide him with the tools so that he can do it if in fact he was left on his own to do that, correct?

A. Yes.

Q. Do the residents at University have any type of procedure books that they employ with respect to the procedures that they are taught, then they can go over them with their attendings or whoever it is that's teaching them?

MR. KNOPP: Excuse me. Let me show an objection to that for the same reason you raised earlier. It's far afield from her report and purpose of this deposition.

MR. KAMPINSKI: Apparently it doesn't matter to anybody else.

MR. KNOPP: It does to me, that's why I raised the objection.

A. The residents keep procedure books which document the number of procedures they've done in

the specific -- they will keep the patient, hospital number, and the procedure that was done. Not anything more than that, a log.

Q. And is that presented somehow then later on to the attending when they comment upon their qualifications to move onto the next part of the project?

MR. KNOPP: Excuse me. Let me just have a continuing objection to this line of questioning. You can go ahead.

MR. KAMPINSKI: You are excused.

MR. KNOPP: Thank you, Chuck. I've missed doing this for the last five years. I wasn't sure what I was missing.

Q. Go ahead.

A. The procedure lines are not presented to him. My understanding is they present to the chief of cardiology, the chief of the division, but because it is his or her jobs to document or verify that, this -- if we're talking about cardiology Fellows, if we're talking about medicine department, it's the medicine chairman to verify that this individual has done a sufficient number of procedures and is qualified to do this on his

own.

Q. I got you. Okay.

I assume that, correct me if I am wrong, that part of the training of these residents would be to actually be shown how, for example, to place a femoral arterial line, to do one himself in the presence of somebody who knew what they were doing, and for then someone to say fine, you now know how to do it, you can do it on your own; would that be a fair recitation of how this would occur?

A. Yes. First you watch someone who knows what they're doing, do it; maybe more than one time, however many times is deemed necessary.

Q. I see.

A. Then you do it under direct supervision, let him watch you do this, I won't touch; and then on their own, but it's not see one, do one.

Q. I got you.

See one or more?

A. Exactly.

Q. Do one or more --

A. Under supervision.

Q. __ is necessary so that somebody knows you can do it, and then do them yourself?

A. Yes.

Q. And presumably teach it?
A. Exactly. Definitely.
Q. And at least the see one or more and the do one or more ought to be logged in a procedure book, correct?
A. At our hospital we log them in procedure books, yes. I don't know what the standard is. I do not know if that's universal.
Q. I got you.
You said something -- this was in response from a question from Mr. Seibel -- that the major risk you believe from the wire was perforation; was that correct?
A. That would be the most serious risk.
Q. Have you seen the wires in this case?
A. On the chest x-ray, yes.
Q. I mean the actual wires?
A. No.
Q. Do you know what kind of wires they were?
MR. FULTON: You mean manufacturer?
MR. KAMPINSKI: Yes.
A. I know from reading the record and looked at the chest x-ray they're J tipped, had 48 centimeter long wires.

Q. What does J tipped mean?
A. It means the wire, instead of just coming up as a straight tip, is curved like it's the letter J.
Q. And is that significant as it relates to the risk of perforation?
A. It lowers the risk but does not remove it.
Q. What is the end of that wire; is the end of the wire sharp?
A. Well, the end of the wire, if you look at a J, and you are at the end of the wire --
Q. I have seen them.
A. -- it's not sharp. It's a little stiff, but not -- it's not sharp.
Q. And the reason I ask is, Dr. Holland said the risk of perforation is almost nonexistent with that kind of wire?
A. It's much less than with a straight tipped wire, and the straight tipped wires are no longer used because the risk of perforation was too high, but you can still do it.
Q. By the way, you are aware of the fact that there were two wires, right?
MR. KAMPINSKI: Mr. Fulton?
MR. FULTON: Am I under

oath?

MR. KAMPINSKI: You keep objecting to there being two wires. I don't know why.

MR. FULTON: I didn't say anything.

Q. You are aware that --

A. My understanding is there were two wires.

Q. Everybody is aware of that, I think.

And if I understand what you said in terms of your definition of elective surgery as not being life threatening or life shortening, you started to sound like that was this surgery. In other words, the existence of the wires, and a number of people including those retained by the hospital, Dr. Holland, or by the hospital resident I should say --

MR. COYNE: Show an objection. Dr. Varma's expert, it was.

MR. KAMPINSKI: No.

MR. COYNE: It's Varma's.

MR. KAMPINSKI: Dr. Varma was the hospital's resident, he was your employee, he hired an expert.

MR. COYNE: But not our

expert, just for clarification. It's Dr. Varma's expert.

MR. KAMPINSKI: I get very confused by this.

MR. COYNE: I am sure you can figure it out in your own mind.

MR. KAMPINSKI: Your employee hires an expert. I am very confused.

Q. Doctor, do you know who Dr. Holland is?

A. Yes.

Q. Are you on any committees with him?

A. No.

Q. Belong to the same societies?

A. Probably, but societies are big. I don't go to the meetings.

Q. I apologize.

Well, anyhow, he as well as other physicians in this case opined that this was not a surgery that needed to be done for the period of time post MI that she was in. In other words, what you said about the risk being present for approximately six months, with some variation that's what all the other all cardiologists, including Dr. Steele, have said, *so* I don't think we have any disagreement, I don't think with that;

but is it your testimony that the surgery to remove the wires should have been delayed for a period of six months or more to reduce the risks to Mrs. Weitzel or don't you have an opinion one way or the other?

A. I do have an opinion.

Q. What is it?

A. That was not my testimony. My opinion is that those wires needed to be removed, should have been removed well before that six-month period was up.

Q. So they should have been removed at the time they were, in your opinion?

A. I think there is -- is a spectrum of time in which they could be removed, and that's a judgment call. I wouldn't say it has to be removed today as opposed to tomorrow.

Q. When I say "removed," I don't want this to be confusing, but there were attempts to remove it two different ways: one percutaneously, one surgically, and I guess I want you to limit your answer to the surgical removal.

A. Yes.

Q. That was placing her under general anesthesia?

A. Yes. I don't think she could wait the six months. I would not wait the six months. I will not say that it had to be done on the day it was done. That is a judgment call on when in the spectrum of time it's removed.

For instance, I would personally, and other people may vary, I will not send her home with a wire in. In other words, if she was ready to *go* home, I wouldn't keep her six months in the hospital for that, but I would take it out within a relatively short time.

Q. When you say "you"?

A. I would have the surgeon take it.

Q. You wouldn't try to remove it percutaneously?

A. It was tried and failed.

Q. Do you know why?

A. No, I don't.

Q. Would you have tried somebody else to remove it percutaneously before subjecting her to general anesthesia and surgery?

A. Not having been there, I really can't say.

Q. You responded to a question that's not in your report, and I guess I am little curious as to why you didn't put anything in your report regarding the standard of care as it pertained to

the various doctors, were you asked to comment on that?

A. Specifically I was not asked to comment on it. I answered a lot of questions today that aren't in the report, a whole lot.

Q. That's why they call it discovery.

A. Right.

Q. Well, do you think Dr. Varma did a pretty good job in putting in the catheter on February 26, 1991?

MR. FULTON: Objection. The catheter, did it show up there?

MR. KAMPINSKI: Will you let her answer the question.

MR. FULTON: I just wanted to advise the catheter was --

MR. KAMPINSKI: We don't want your opinion on that.

MR. FULTON: It showed up on the monitor, so --

A. The question again.

Q. The placement of a catheter in Mrs. Weitzel on February 26, 1991, did Dr. Varma in your opinion do a good job doing that?

MR. FULTON: Objection.

A. I think the order shows she has had complications from that.
Q. You mean the record shows that?
A. Yes. He said no complication, actually; and I think subsequent notes in the charts were he had a complication from it.
Q. Well, when you say a complication --
A. Of the wire being retained.
Q. The wire or two wires?
A. Two wires.
Q. Is that good medical practice?
MR. FULTON: Objection.
Q. In your opinion, your expert opinion?
A. You never like to have in medical practice complications, but complications happen. I don't know.
Q. How about a deviation from acceptable standard of practice, is that?
A. To lose two wires?
Q. You got it.
A. Yes.
Q. How about covering it up, is that --
MR. FULTON: Objection.
Q. -- good medical practice not telling anybody?
MR. FULTON: That's not

true. He indicated they were there on the 8th.
Q. Is that good medical practice there?
A. To cover up the fact that wires were left behind is not good medical practice.
Q. And I think you told me really very early-on in the beginning of this deposition that you as an attending are responsible for what occurs to your patient when it's done by residents, so your response to Mr. Seibel about Dr. Steele, I assume if asked in the correct context would be that he is responsible for that?
A. Right. And I think my answer had something to do with the same sort of confusion that you admitted about Dr. Varma being the hospital resident, and it is, you know, the -- I don't like -- I didn't write the guy's paycheck. He is not in my employ. He's an employee of the hospital. That's what -- what I had mentioned before with being responsible for patients.
Q. So what happened to her in relation to what Dr. Varma did is Dr. Steele's responsibility, isn't it?
A. I am not able to answer that.
Q. Why not?
A. Again, because I told you I don't -- the

contractual agreement between the residents and hospital is something I don't understand.

Q. I am not asking contractually. I'm asking it in the same context I asked the first question I asked you today, that is: Are you responsible for the care of your patients when something is done to them by the residents, your answer was?

A. Yes.

Q. Right.

So isn't Dr. Steele similarly responsible for what happens to Mrs. Weitzel as relates to Dr. Varma's care of her?

A. He's responsible for the care of that patient, yes.

Q. You said something a little confusing to me, Doctor, and this is not in your report either one way or the other -- by the way, let me ask you this this way: If Dr. Steele chose to have her undergo surgery for the removal of the wire that he couldn't get, should he in your opinion have followed up on her post surgically in light of her condition in the I.C.U.?

A. What specific way do you mean "follow-up"?

Q. Call, gone to see her, see how she was?

He's subjecting her to surgery,

shouldn't he go see what condition she is in after surgery?

A. I don't think the standard of care would be for the attending.

Q. How about standard of humanity?

A. Both ways, absolutely both ways. Wouldn't be necessary to see the patient immediately after the surgery but --

Q. How about sometime afterwards?

A. Attending physicians generally make daily rounds. She would -- it would be humanitarian care and medical care to see her every day.

Q. Should a physician have seen her postoperatively when her vital signs started to change?

A. Yes. If they change in a significant manner she should be evaluated by a physician.

Q. They did change in a significant manner, didn't they, Doctor?

A. Her heart rate went up, there's some blood measurements that are missing *so* you don't know. She became markedly tachycardic, she should have been evaluated.

Q. Her blood pressure, at least what I see there, definitely changed, didn't it?

A. There were -- was, I believe -- I don't know where you find it. There was a change in her blood pressure from approximately 10 or 15 points, it decreased, I think; they were changes.

Q. Those were all changes that needed to be evaluated by a physician?

A. Yes.

Q. And would you agree with me that the failure to do that was a deviation from the appropriate standard of care required of both residents and/or house physicians and/or the nursing staff?

A. I don't know for certain from looking through the charts whether or not a physician evaluated her.

Q. Is there any notes by a physician?

A. There is no notes.

Q. Doctor, that is the way the physician communicates is through their notes through the chart, isn't it?

A. That is the way they communicate, yes.

Q. That's the way that we know that they were or weren't there, isn't it?

A. It's the way we know they were there. I don't know that it's contra-implied.

Q. You don't?

A. Not always.
Q. Was there a doctor there?
A. I don't know. I have no way of knowing.
Q. What do you think?
A. I have no way of knowing.
Q. Well then, what do you assume?
A. There is nothing that I can assume. There is no note there *so* I do not know a physician saw her or not.
Q. So the absence of a note in your expert review of the chart doesn't tell you anything, right; it doesn't allow you to evaluate whether or not appropriate care was given to the patient?
A. Correct.
Q. Well, let's assume that he saw her, was anything done for her condition?
A. For that then I would like to look at the order to see if any orders were written. I think that would be the most reliable way of telling that.

Back to the orders late on the night of the 14th, do you have it handy or --
Q. You know what, you can look for it between now and the time of trial or when we come back next time, okay.

You will get me those reports within the next couple days, Doctor?

A. Yes, I will.

MR. COYNE: She will give them to me, I'll transfer them to you.

MR. KAMPINSKI: What are we going to do --

MR. KNOPP: Let's not conclude. I have got some questions.

MR. KAMPINSKI: -- about setting up another date in terms of follow-up?

MR. COYNE: I will get you the reports that you asked for, then I'll talk to the doctor regarding availability, and if there is another deposition, it would be restricted only to the matters that she produces in those documents.

MR. KAMPINSKI: Whatever questions that those documents lead to.

MR. COYNE: Within some confinement. I don't think any expert has been asked to bring in authoritative records that they reviewed up until today.

MR. KAMPINSKI: So what. I'm not sure I understand.

MR. COYNE: We're not

compelled to bring her back after she gets these sources. You are entitled to get the sources, whether you are entitled to continue the depo, I don't know. You'll get the authoritative sources that she has. I am not sure --

MR. KAMPINSKI: A large portion of what she's saying is based upon what is in these sources.

MR. COYNE: She told you her opinions based on her education, training, and background. She did verify it with written sources and --

MR. KAMPINSKI: That's what you have said.

MR. COYNE: -- the same as the other doctors have in their testimony in this case.

MR. KAMPINSKI: Just one more thing.

Q. The failure to appropriately train a resident in the placement of an arterial line, that would be negligence on the part of the institution training them?

MR. KNOPP: Objection.

MR. COYNE: Show an

objection.
A. I would not say that necessarily this resident was having -- was failed to be trained.
Q. Do you mean --
MR. COYNE: Is this a hypothetical?
A. Are you asking a hypothetical rather than --
Q. Absolutely. Sure.
MR. COYNE: What's the question?
- - - - -
(Question read.)
- - - - -
MR. KAMPINSKI: See, she hasn't rendered an opinion on that yet.
MR. COYNE: Well, I think it's the jury who will determine the competence in this particular case.
All I was asking, I think the Doctor was wondering if you were talking about this case or a hypothetical.
MR. KAMPINSKI: This case we know that he had no idea what he was doing.
MR. FULTON: Objection.
MR. KNOPP: Objection.

Move that be stricken.

BY MR. KAMPINSKI:

Q. Let's talk about whether or not in the abstract if someone doesn't know how to appropriately place an arterial line, whether or not the institution required to train him in doing so would be remiss in having failed to train him?

MR. KNOPP: Objection.

MR. COYNE: Hypothetically.

A. In that hypothetical the institution would be remiss if they had not adequately trained him to perform this procedure, shouldn't have allowed him to do it without supervision.

MR. KAMPINSKI: Thank you.

MR. FULTON: All right. Going back to the wires again here.

MR. KAMPINSKI: This is the third time you're asking questions. I'm going to object again to the third time like I did the second time, because you know, somebody who is employed by the defendant, who retained this doctor, I don't believe number one, you got a right to ask questions at all; number two, that you certainly don't in this context.

MR. FULTON: I can't just

sit here and get paid for doing nothing.

MR. COYNE: Why don't we get on with it instead of taking up time arguing back and forth.

If you have a question, let's ask it and get an answer.

MR. KAMPINSKI: I object. Go ahead.

MR. COYNE: Your objection is noted. There's nothing more we can do.

FURTHER RECROSS EXAMINATION

BY MR. FULTON:

Q. At University do you employ medical technologists to insert femoral arterial lines?

A. I do not employ. That's an institutional question that-- a technologist to insert femoral arterial lines? No, done by physicians, physicians in training.

Q. So you understand my question: At University Hospital do you have medical technologist who insert femoral arterial lines?

MR. KAMPINSKI: Asked and answered. Objection.

A. Is the question does University Hospital have

technologists or do I --

Q. University Hospital.

MR. COYNE: If you know.

A. To the best of my knowledge, they do not.

Q. Are you aware of any institutions which employ medical technologists to insert such arterial lines when it involves the femoral artery?

A. I have no knowledge one way or the other.

Q. Are you aware that there are -- you are aware there are different kits for say a radial line or femoral arterial line?

A. Yes.

Q. Are you aware of the fact that even today that the manufacturers send out to individual utilizing these lines a straight type of wire, are you aware of that?

A. I think I have seen some kits with straight wires, yes.

Q. The principal manufacturers are what, Cook and Arrow?

MR. COYNE: If you know.

A. I don't know. There are many different manufacturers and I do not know.

Q. From your experience I take it you yourself have inserted arterial lines?

A. Yes, sir.
Q. Have you inserted them in the radial line?
A. Yes.
Q. How about the femoral line?
A. Yes.
Q. A femoral line, what is the degree of difficulty between a radial and a femoral insertion?
A. I don't think I could prioritize as one more difficult than the other.
Q. Do they use a different type of wire in each instance?
A. The wires are longer in the femoral, but other than length, I think in general it would be the same.
Q. Why is it longer?
A. I think partially they're longer to be certain that the path is clear for getting in the sheath, which is what remains behind when the wire is removed. The sheath is also longer. It is so that it is more securely anchored.

In the radial artery there is less extraneous motion that goes on, you are less likely to dislodge the catheter.

In the femoral you can move and

dislodge it. The catheter is longer, therefore the wires will be longer to get it over.

Q. When one inserts a guide wire into a femoral artery, they're getting blood running against the wire towards the insertion point?

A. Right. What you first do is insert a hollow needle into the artery, through that needle the flow is coming backwards, out; and then through that needle the wire is inserted against blood flow.

Q. Then the catheter is inserted over the guide wire?

A. Over the guide wire. The needle is removed and the catheter goes in over the guide wire.

Q. You have not -- I think this was asked -- you have not seen the actual wires that remained that are somewhere in this case?

A. I have not seen these particular wires, no.

MR. COYNE: Except on x-rays she said.

A. Yes, on x-ray.

Q. You don't know as you look at them, when you saw them whether one was a J end or one has a straight end?

A. I would -- wouldn't be able to tell that from

an x-ray.

MR. FULTON: No further questions.

MR. KNOPP: Doctor, my name is Al Knopp. I represent the Cleveland Clinic. I just have a couple questions to ask of you.

CROSS-EXAMINATION

BY MR. KNOPP:

Q. From what you testified just over the last several minutes dealing with the insertion of femoral arterial lines, I gather not only have you done that but you have trained people as to how to do them?

A. Yes.

Q. First of all, there's -- with each of these kits are there any warnings or instructions that the manufacturer provides?

A. There is certainly printed material that comes in every kit, yes.

Q. Are you familiar with any of these instructions?

A. No, I am not. It's been a long time since I read --

Q. But you would anticipate that anyone doing

this procedure would follow the instructions of the manufacturer?

A. Yes.

Q. Just very briefly, would you tell us how you -- what the process is when you teach someone how to insert a femoral arterial line? What do you tell them?

A. Are you talking about I'm doing one and they are watching?

Q. Yes. Very beginning?

A. At the very beginning when they're watching --

Q. When normally would be the very first one they would see?

A. Most likely as a medical student, as a third and fourth year medical student.

Q. Then you see them also as a first year --

A. As a first year resident or intern, as a second year resident.

Q. When would they start doing them, assuming you had average abilities and average opportunity?

A. If you had average ability and average opportunities I will say after you have -- had watched two, maybe three, is plenty enough to watch that you would put them in under supervision; and

with an average opportunity I would say that the majority of people would have their first experience putting one in under supervision probably while they were a medical student.

Q. Now, **I** interrupted you on the procedure.

A. I would first instruct them in a sterile technique, **I** would show them how to wash and prep the area, put a sterile towel over it *so* no infection is introduced.

Q. **Is** there anything unique about that procedure?

MR. KAMPINSKI: Unique to whom?

Q. To that particular procedure?

A. It shares in common putting in -- anytime you are doing a certain procedure, it's normal sterile procedure, for instance, putting in a simple intravenous -- putting in a simple **I.V.**, but it shares in common sort of all operative procedures.

I would show them how to palpate an artery, how to feel the arteries, and then how to use the needle to *go* into the artery, how to assure they have adequate blood flow, which the arterial surge is quite vigorous coming out the end of the needle; to be sure you are in good position.

Then I will instruct them how to put the wire through the needle, make sure that the wire goes smoothly and easily, does not meet any resistance.

Q. Would you explain what the purpose of the wire was?

A. Yes, I would explain the purpose of the wire is to maintain position within the blood vessel because the next thing I am going to do is take the needle out, then I would tell them to put pressure over the puncture site, that just the wire remains; and then at the end of the wire I would show them how to put the catheter on, put the catheter to the skin, where it usually takes a little bit -- a minor degree of pushing or force to kind of pop it through the skin, then it slides smoothly and --

Q. Let me back up, if I may.

I think most of the instructions that I have had an opportunity to look at make mention, in fact most of the ones I've read, to hold onto the wire at all times?

A. Yes.

Q. Do you teach that as well?

A. Yes. What I do when I say to put pressure over the puncture site, that does two things: it

keeps you from bleeding, keeps your hand on the wire, *so* it kind of keeps every wire -- then usually with your other hand you put the sheath over the wire, being sure that some of the wire is sticking out the end of the sheath. If you put too much wire into the patient, then you inch the wire back a little bit until you see it coming out.

Q. You teach that?

A. Absolutely.

Then you insert the sheath and pull the guide wire out.

Q. Is there anything tricky or unusual about any part of that procedure?

A. It's not a difficult procedure to do. It is like anything else, it may seem tricky if you don't know how to do it. Actually it's a series of relatively simple steps. I think the hardest part is probably getting the steps in order, putting your hand on the right piece of equipment. It's not the equipment.

Q. Is there anything that would make it *so* that the person doing this procedure wouldn't know that a wire was gone?

MR. KAMPINSKI: You mean somebody who is properly trained?

I object.

MR. KNOPP: You may ask your questions later.

MR. KAMPINSKI: I object.

- - - - -

(Question read.)

- - - - -

Q. Do you want me to rephrase that?

A. I think I have it.

You would know when the wire is gone. It doesn't vanish from your sight.

Q. Is there any way that you -- you've already taught a person who is going to do this procedure to hold onto the wire. If they read the warning that goes along with the kits, they're told to hold onto the wire?

A. Yes.

Q. Is there anything more than that you would teach them about the importance of holding onto that wire?

A. Again, to make sure a wire is coming out the end of the catheter *so* -- when I work I always see a piece of the wire, *so* I know I have it, and I will warn them specifically don't lose that wire. You have to keep your eyes on it.

Q. If all those things happened, you believe someone would have been properly trained as long as they have the mechanical ability then to do it?
A. Yes.
Q. There's some of talk here about whether or not the appropriate medical standard would have been met if someone didn't report this.

Is it fair to say that in the absence of any evidence to the contrary, that you as an individual teaching residents, unless you have reason to believe from past experience that the person you're training is apt to do something improbable like that, you have no way of knowing that, would you?

That's a convoluted question.

A. Yeah. I had most of that.
Q. Well, how would you -- if someone's training a physician -- be able to tell whether or not he or she is the kind of person that wouldn't -- that would lose two wires and not report them?
A. I don't know that there is any way to predict that. I think human nature, you evaluate people as best you can.

MR. KNOPP: Thank you.

MR. COYNE: Are we through?

MR. FULTON: I have a question.

MR. KAMPINSKI: Go ahead, Burt. I object, but go ahead.

MR. FULTON: You may objec .

FURTHER RECROSS-EXAMINATION

BY MR. FULTON:

Q. Do you know that, whether or not the Cleveland Clinic Foundation utilized medical technologists in the insertion of femoral arterial lines?

A. I have no idea.

Q. Do you know whether the Cleveland Clinic uses anyone else besides medical technologists to insert femoral arterial lines?

A. I don't know who puts the lines in, in the Clinic.

MR. FULTON: No further questions.

FURTHER RECROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. When you get a kit to put the lines in, who

gives it to you?
A. Often you go to the supply cabinet yourself and pick it out, or there's a nurse who's being nice to you who might bring it.
Q. So the nurse brings them to you, then how would they give them to you, is the kit closed, or would it be opened, would they hand it to you?
A. They need to open it and expose the sterile part that's inside for you to take out.
Q. So you as a physician, if that's what you do, you don't stop to read the labels on the kit, do you?
A. No. What I would do is look at the outside of the kit to make sure they're opening the right one, not the wrong one and wasted it. You can read the headline. That's all I would read.
MR. KAMPINSKI: Thanks.
MR. COYNE: She'll read it rather than waive signature.

- - - - -

(Deposition concluded; signature not waived.)

- - - - -

ERRATA SHEET

PAGE LINE

I have read the foregoing transcript and the same is true and accurate.

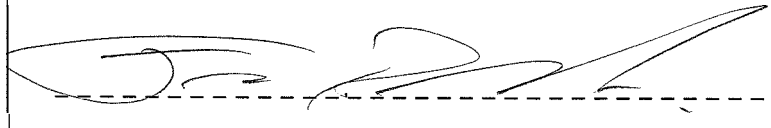
_____

CAROL M. BUCHTER, M.D.

The State of Ohio,

County of Cuyahoga. CERTIFICATE:

I, Frank P. Versagi, Registered Professional Reporter, Certified Legal Video Specialist, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, CAROL M. BUCHTER, M.D., was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid. I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 10th day of May, 1993.



Frank P. Versagi, RPR, CLVS, Notary Public/State of Ohio. Commission expiration: 2-24-98.

Look-See Concordance Report

- - -

1,818 UNIQUE WORDS
386 NOISE WORDS
19,946 TOTAL WORDS

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

EXCLUDES OCCURRENCES IN FIRST 3 PAGES

- - -

WORD RANGES @ BOTTOM **0F** PAGE

* 0 * *

0.4 [1] *42:16*

* 1 *

10 [5]*34:17, **19, 21;** 35:2; 107:3*
100 [2]*29:10; 32:18*
10th [1] *127:20*
113 [1] *4:17*
117 [1] *4:18*
11th [6] *23:5, 10; 48:15, **17;** 49:1; 63:17*
12 [4]*34:17, **19;** 41:14; 47:6*
124 [1] *4:19*
125 [1] *4:20*
12th [11] *41:11, **15;** 42:12; 45:1; 48:8; 57:1; 59:7; 70:21; 71:17; 72:7; 73:11*
13th [14] *45:4, **12, 18;** 46:3, 11; 57:3; 60:10; 63:16; 64:8; 73:11, **16;** 90:21, **24;** 91:2*
14th [9] *26:17; 39:5; 43:13, **18;** 45:3, **4;** 56:18; 87:9; 108:22*
15 [1] *107:3*
15th [1] *56:7*
16 [1] *56:4*
16th [3]*55:23; 56:1, **5***
17 [1] *82:19*
17th [2]*55:22; **76:17***
18th [2]*55:19; 73:23*
1983 [1] ***6:2***
1991 [6] *16:17; 23:6, 10; 27:8; 102:10, **23***
1993 [1] *127:21*
19th [2]*52:2; 55:19*
1st [1] *50:23*

* 2 *

2-12 [4]*55:8, 10; 58:15, **20***
2-20 [1] *55:9*
2-22 [1] *51:9*
2-23 [1] *51:8*
2-24 [2]*51:6, **7***
2-24-98 [1] *127:25*
2-25 [1] *51:10*
20th [1] *55:18*
21st [1] *55:17*
22nd [1] *52:4*
24 [3]*21:5, **9;** 27:2*
26 [2]*102:9, **23***
26th [2]*71:8, **12***
27th [1] *51:2*
28th [1] *71:10*

* * 3 * *

3-12 [1] *64:7*
3-13 [1] *91:3*
3-14 [1] *39:11*
30 [6]*60:10, 11, **12, 15;** 61:9, **10***
30-minute [1] *60:15*
31 [1] *60:6*
32 [2]*60:10,* 11
3rd [1] *50:21*

* * 4 * *

4 [1] *42:17*
400 [4]*34:9, 11, **13, 15***
43 [3]*78:20; 79:4,* 11
44115 [1] ***4:7***
48 [1] *96:24*
4th [1] *50:18*

* * 5 * *

5 [1] *4:12*
500 [1] *34:10*
5th [1] *50:17*

* * 6 * *

6th [1] *50:13*

* * 7 * *

7th [1] *50:10*

* * 8 * *

8 [1] *91:5*
80 [1] *29:8*
81 [1] *4:13*
82 [1] *4:14*
88 [2]*4:15; **6:4***
89 [1] ***6:4***
8:59 [1] *60:4*
8th [2]*50:7; 104:1*

* * 9 * *

91 [1] *4:16*
9:00 [1] *45:14*
9:30 [1] *60:6*
9th [1] *50:3*

* * A * *

abilities [1] *118:21*
ability [4]*17:25; 72:10; 118:22; 123:3*
able [16] *11:11; 18:11, **15;** 42:8; 49:6; 51:20; 53:1, **7,21;** 54:17; 61:5; 81:13; 93:5; 104:23; 116:25; 123:18*
absence [2]*108:10; 123:9*
absent [1] *35:18*
Absolutely [7] *72:18; 81:22, **24;** 85:5; 111:8; 121:9*
absolutely [1] *106:6*
abstract [1] *112:4*
acceptable [1] *103:17*
accepted [1] *87:24*
accident [4]*8:2, **4;** 13:1, **19***
account [1] *79:3*
accurate [2]*29:25; 126:22*
acting [4]*6:3, **5;** 65:24; 71:25*
Action [1] *77:19*
action [1] *127:18*
activities [1] *78:11*
actual [2]*96:17; 116:16*
actuarial [2]*78:25; 79:2*
acute [1] *34:18*
acutely [1] *83:22*
added [1] *36:1*
additional [1] *75:19*
adequate [1] *119:23*
adequately [1] *112:11*
admission [3]*32:9; 58:19; 72:7*
admitted [7] *19:21; 23:12; 26:10; 32:4; 47:18; 58:23; 104:14*
admitting [1] *26:11*
adult [3] *28:15; 29:19; 32:25*
advanced [1] *91:7*
advances [1] *39:21*
advise [1] *102:16*
affect [6] *38:7; 53:8, **25;** 54:4, 10; 72:10*
affixed [1] *127:19*
afield [1] *93:18*
aforesaid [2]*127:8, **13***
afternoon [1] *5:16*
afterwards [1] *106:9*
age [1] ***5:2***
agent [2]*43:21; 87:20*
agree [10] *22:17; 26:24; 30:7, **8, 15;** 33:10, **20;** 85:22; 92:14; 107:8*
agreed [1] *92:12*
agreement [1] *105:1*
air [4]*53:2, 10; 54:7, **18***
Al [1] *117:5*
alert [2]*72:23; 75:11*
alive [1] *27:10*
allegations [5]*9:23; 10:1, **2, 5;** 15:5*
allow [2] *18:7; 108:12*
allowed [1] *112:12*
allowing [2] *15:8; 80:16*
allows [1] *65:21*
alter [1] *38:6*
altered [1] *71:21*
Amantadine [1] *45:6*
amount [4]*19:1, **9;** 34:8; 84:17*
analyze [2]*51:19; 63:7*
anchored [1] *115:21*
anesthesia [3]*6:13; 100:25; 101:20*
angioplasty [1] *84:2*
anoxic [1] *78:6*
Answer [1] *24:2*
answer [22] *10:6; 11:11; 14:14; 21:22; 22:21; 23:19, **21, 25;** 35:1; 40:17; 53:13, **23;** 57:17; 74:18; 76:22; 100:22; **10214;** 104:12, 23; 105:7; 113:6*
answered [3]*35:10; 102:4; 113:24*
answering [2]*82:14; 85:9*
antagonistic [1] *65:13*
Anti-anxiety [1] *44:1*
anti-anxiety [1] *43:23*
anticipate [2]*93:3; 117:25*
anticipated [1] *38:4*
Anybody [3]*7:20; 79:16, **19***
anybody [8] *12:2; 17:13; 36:21; 57:9; 81:12; 91:21; 93:21; 103:24*
anyhow [2]*35:19; 99:17*
anytime [1] *119:15*
anyway [1] *90:12*
anywhere [1] *67:22*
apologize [2]*29:23; 99:16*
apparent [1] *42:7*
Apparently [1] *93:20*
apparently [6] *42:22; 64:20; 66:23, **25;** 67:13; 70:5*
APPEARANCES [1] ***4:1***
Appears [1] *46:12*
appears [3]*31:2; 45:9; 71:7*
APPENDIX [1] *4:24*
approach [1] *90:2*
approaches [1] *29:9*

* * B * *

* * C * *

* * E * *

* * F * *

* N * *

* * O * *

* * p * *

* * Q * *

* * R * *

CAROL BUCHTER, M.D. - Deposition Index - **5/3/93**

06/02 On staff at UH since **1983.**

06/12 Limited publications, co-author of a chapter on anesthesia re: heart failure.

07/10 Has testified three/four time for Coyne and Jacobson.

10/20 Testified in Rubin vs. Barnett; as a concurrent treating: rendered life expectency testimony.

11/21 She had testified that morning.

12/06 Other than testifying she has been retained to look at records.

14/10 She is presently a defendant.

15/06 Case involves intra aortic balloon pump.

16/11 Has also written article on reflex control in heart failure, (Hospital Practice, **1991).**

16/22 Also "use of vasodilator in mild to moderate heart failure", (Cardio - not yet in print).

17/07 She did not look at any depositions.

18/02 No specialty in medicine that lets you know how long someone will live.

20/08 She treats all the patients going thru ICU, one or two months a year.

21/19 Attendings are responsible for the overall care of patients, the decisions made (even if not theirs - **21/15)**

23/07 Mrs. W. died from a multitude of factors.

23/14 A combination of everything that happened to her after her heart attack contributed to her death.

24/08 I cannot say that everything else that happened to her happened because of her heart attack.

25/12 Wires being left in her were not as a result of a heart attack.

25/17 Guidewire removal was not as a result of a heart attack.

27/03 By definition, she agrees this was a surgical death.

27/15 She cannot give us an exact date of death had the wires not been left in but believes she would not have survived to leave the hospital.

28/01 Opinion based upon her review of chart, literature, experience.

28/07 Braunwald textbook of cardiology.

29/04 Also based on literature she read in Jan. of **1993.**

32/24 Statistics do not speak to how long people live after discharge.

33/02 Her ARDS was a factor in her death.

34/05 She thinks the intraoperative bleed was a relatively large part of the death.

36/20 No patients under her care had wires left in.

38/06 It would not alter her opinion to know what a pulmonoligist thought Mrs. W's status was.

38/14 Admits she was stable from cardiac **"statement".**

39/01 She thinks looking at the end of chart is more important prognostically from neurologic standpoint.

42/16 Patient given Robinul and Neostigmine to reverse medication that may be keeping her neurologically depressed (Note from **3/12);** Simple, basement low neurological functions, she did not wake up.

43/19 Versed is not a neuromusce block.

43/23 Versed is a sedative.

45/18 I am looking at the 13th which is four days before she died.

46/10 Versed was discontinued on the **13th** at

51/02 heavily sedated with Versed.
(CK- this supports my theory of ↑ versed to buy time with the wire problem. Sorry for the commentary).

52/17 Admit that **2/22** note status **"still** follows commands **"well".**

53/14 If she could truly do it, and I saw her do it, and believed that she did it, it might change my mind (RE: letters in the air).

54/11 I would have more hope for her neurologic function.

59/03 Based on admit note, I don't think she got worse neurologically.

60/03 From **8/59** to 9/30 for **31** minutes, she was without pulse, without respiration, without BP.

61/02 "I think she would have severally impaired mental function."

62/05 I think she had changing neurologic status.

63/10 I think the most important part is where she was given medication to temp. reverse everything.

64/07 Written on **3/12.**

64/09 Written by physicians at bedside.

64/18 She had what I would interpret as minimal responses to Dolls eyes, a blink reflex and left arm apparently moved.

65/15 The medication blocks the affect, the blocker will go away, then it takes a while to metabolize it.

65/23 The reversal wears off very quickly and then you are right back where you were before you gave it.

66/15 Dolls eyes is better than to not have it.

66/19 Blink reflex is better to have it than not.

67/13 No-it says move left arm apparently on command which to me is a qualifier. (She didn't talk to anyone-how the f#@! does she know?)

67/20 The bad signs are inferred.

68/10 They listed things that she did which are minimal, and to me from that I infer that she did not have a high order of response or that would have been listed.

70/02 Once they've given her this medicine to reverse the blockade, she is a --- she has improvement...they learned what they needed to know.

75/24 I am trying to say that she had **s** significant neurologic insult and in all probability would have suffered long term neurology damage.

79/11 Life tables do include as part of the average, people with brain damage, heart problems, etc.

CROSS - FULTON

81/22 People are trained in wire removal because occasionally a wire is lost.

CROSS - SEIBEL

82/22 Her heart improved over the first few days only in that she no longer had arrythmias which needed to be treated urgently, but she is left with a significant heart muscle damage.

85/09 I don't think the wires did her any harm. I think there was a potential risk to them, but that none was realized.

85/24 Agrees that eventually wires had to come out.

86/12 There is a consensus of opinion that purely elective surgery should not be performed shortly after an MI.

86/17 During the first six months after a heart attack, there is some increase in risk which slowly, steadily decreases during that six month period of time; for elective procedures.

87/10 She doesn't believe pro. to remove wires was purely elective.

87/14 When the wire was to come out was a judgment call.

87/17 No opinion on post op care.

88/14 Doesn't believe any of the attendings or consultings were negligent.

FULTON - **RECROSS**

89/03 Wire removal always done under fluoroscopy.

89/11 Fluoroscopy offers no permanent record.

RECROSS - CK

92/24 She trains residents on the placement of arterial line.

93/04 A second year resident should be able to do it.

95/11 The residents should be watched by someone who knows what they're doing.

95/17 It's not see one, do one.

97/07 J - tip lowers the risk of perforation.

100/16 There was a spectrum of time in which the wires should have been removed.

103/21 Losing two wires was a deviation from the standards of care.

105/08 Responsibility to patient from care given by resident is attendings.

106/16 If the vital signs change in a significant manner post operatively, the patient should be seen by a doctor.

106/23 Mrs. W. should have been evaluated.

108/08 There is no note is chart so I do not know if a physician saw her or not.

112/10 The institution would be remiss if they had not adequately trained him to perform this procedure; shouldn't have allowed him to do it without supervision.

RECROSS - FULTON ?

122/23 I will warn them specifically don't lose that wire. You have to keep your eyes on it.

126/18 She doesn't know who puts in the lines at CCF.