

THE STATE of OHIO .
COUNTY of CUYAHOGA. - - - - -

Doc. 81

IN THE COURT OF COMMON PLEAS
- - - - -

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

vs.

: Case no.
: 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.



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I N D E X

WITNESS: CAROLE M. BUCHTER, M.D.

	PAGE
Cross-examination by Mr. Kampinski	5
Cross-examination by Mr. Fulton	81
Cross-examination by Mr. Seibel	82
Recross-examination by Mr. Fulton	88
Recross-examination by Mr. Kampinski	91
Further recross-examination by Mr. Fulton	113
Cross-examination by Mr. Knopp	117
Further recross-examination by Mr. Fulton	124
Further recross-examination by Mr. Kampinski	125

(NO EXHIBITS MARKED)

(FOR KEYWORD AND OBJECTION INDEX, SEE APPENDIX)

1
2
3
4
5
6
7
8
9
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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 afternooon. 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.

1 Q. That's been for how long?

2 A. On staff since 1983.

3 Q. And you were the acting chief for a year,

4 July, '88 to June of '89?

5 A. At the VA Hospital I was acting chief for one

6 year.

7 Q. I see. Have you published at all, Doctor?

8 A. A little bit, yes. They may not be on my CV.

9 Q. That's why I am asking because they're not.

10 Would you tell us what you have

11 published?

12 A. I think this is the same copy, yeah.

13 Recently I co-authored a book chapter on anesthesia

14 for transplant patients, and I have written

15 two review articles concerning heart failure.

16 Q. Is that your specialty, heart failure?

17 A. Yes, it's a special interest.

18 Q. As a matter of fact, on this stationery you

19 wrote the report on, that's what listed under your

20 name is heart failure?

21 A. Everybody gets kind of one special interest

22 that they list.

23 Q. I see. I assume that doesn't mean that you

24 don't deal with other aspects of cardiology?

25 A. Right. Right. It's not an inclusive list.

1 Q. Have you testified before, Doctor?

2 A. Yes, I have.

3 Q. How many times?

4 A. In deposition, is that what you mean? Giving
5 depositions?

6 Q. We'll start with that.

7 A. Three or four, somewhere in that
8 neighborhood.

9 Q. For whom did you testify?

10 A. I have given previously one deposition for
11 Mr. Coyne or his office, and one or two or -- for
12 other firms.

13 Q. Who?

14 A. Jacobson, Maynard.

15 Q. Who at Jacobson, Maynard?

16 A. Who at Jacobson, Maynard?

17 Q. Yes.

18 A. One was Steve Charms. That's the only one I
19 can recall.

20 Q. Anybody else, any other depositions?

21 A. No.

22 Q. What was the name of the case that you
23 testified for Mr. Coyne in?

24 A. I don't remember the name of the case.

25 Q. What was the nature of the case?

1 A. The nature of the case was an automobile
2 accident and a woman with pre-existing heart
3 disease, and nature of the case was whether her
4 heart disease had been worsened by her accident.

5 Q. And was he defending?

6 A. Yes.

7 Q. You don't remember the name of the case?

8 A. No, I don't.

9 Q. Is it still pending?

10 A. Quite a number of years ago. I don't believe
11 so, but I am not sure. It was several years ago.

12 Q. Did you testify at trial in that case?

13 A. No, I did not.

14 Q. What was the name of the case that you
15 testified for Mr. Charms?

16 A. I don't remember the case.

17 Q. What was the nature of the case?

18 A. It is a medical malpractice case regarding a
19 balloon pump insertion and a complication from
20 that.

21 Q. Is that still pending?

22 A. I believe it is.

23 Q. You don't recall the other members at
24 Jacobson, Maynard, Tuschman & Kalur that you
25 testified for?

1 A. I don't.

2 Q. Do you have any other pending cases with them
3 currently?

4 A. No.

5 Q. Just this one that you just mentioned?

6 A. Yes.

7 Q. Are there other people that you testified
8 for?

9 A. Give me one minute to think.

10 Q. Sure.

11 A. One other.

12 Q. Who was that?

13 A. I am having trouble coming up with the name,
14 having trouble coming up with the names.

15 Q. But was it at Jacobson, Maynard, Tuschman &
16 Kalur?

17 A. Yes. Cup, Steve.

18 Q. Steve Hupp?

19 A. Yes. Yes.

20 Q. What is the name of that case?

21 A. That is Rubin versus -- blocking out the
22 name. I should know. Barnett.

23 Q. What were the allegations in that case?

24 A. That is a medical malpractice, wrongful death
25 case following vascular surgery.

1 Q. What were the allegations of it?

2 A. The allegations, it's a woman who had
3 peripheral vascular surgery performed and who died
4 following hospital discharge and re-admission.

5 Specific allegations, I don't know
6 how to quite answer that.

7 Q. What was your involvement in the case? What
8 were you called to comment about?

9 A. I was a treating physician, so.

10 Q. Subsequent treating?

11 A. Concurrent treating.

12 Q. Well, I mean, were you involved as an expert
13 as well?

14 A. No. I think I was just -- I was involved as
15 a treating physician.

16 Q. Factual testimony as opposed to opinion
17 testimony?

18 A. No, they asked me opinions, so.

19 Q. Was it with respect to life expectancy?

20 A. Partially that, yes.

21 Q. Who was the plaintiff's attorney in that
22 case?

23 A. I do not know.

24 Q. Who was the plaintiff's attorney in
25 Mr. Charms' case?

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

3 It's not coming to me.

4 Q. How about Mr. Coyne's case?

5 A. You mean as in your name?

6 Q. How about Mr. Coyne's case?

7 A. The previous one?

8 Q. What did you think I said?

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

12 The previous case, I don't know.

13 Q. Any others that you can think of?

14 A. No. I think that's it.

15 Q. Have you ever testified in court before?

16 A. Once.

17 Q. Who did you testify for?

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

20 Q. When was that?

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

23 Q. That case involving Jeff Rubin?

24 A. Yes.

25 Q. So it's Barnett versus Rubin?

1 A. Yes. Sorry.

2 Q. Have you been retained by anybody to review
3 records and to render opinions that have not
4 resulted in either deposition testimony or
5 courtroom testimony?

6 A. A few.

7 Q. By whom have you been retained?

8 A. Once by Mr. Coyne's office.

9 Q. You mean another time other than what you
10 told me?

11 A. Yes.

12 Q. When you say "His office," someone else
13 within his office?

14 A. Yes.

15 Q. Who?

16 A. Marty Franey.

17 Q. What was the type of case?

18 A. Actually maybe that was the malpractice case
19 I told you. These are a number of years ago. It's
20 hard for me to remember with details.

21 Q. You are confusing me now.

22 A. I am confused myself.

23 There were -- this is the third
24 case for Mr. Coyne's office that I have done.

25 Q. Okay.

1 A. One was an automobile accident case, another
2 was malpractice case, and I believe the malpractice
3 case was with Mr. Franey. I am not sure.

4 Q. What was the nature of that case?

5 A. I don't recall. It's a number of years ago.
6 I honestly don't recall.

7 Q. What was the nature of your involvement?
8 What is it that you were being asked to comment
9 upon; was it a cardiology involvement?

10 A. In some area it would have been a cardiology
11 case. It would have been cardiology.

12 Q. Was it based on life expectancy?

13 A. In part, I believe.

14 Q. Do you remember the name of that case?

15 A. No.

16 Q. You said that you have been retained by his
17 office three times. I now know about two, what is
18 the third?

19 A. Automobile accident case.

20 Q. Yes.

21 A. A previous malpractice case, that I do not
22 remember the details, and this one.

23 Q. Any other people?

24 A. I don't believe so.

25 Q. So a couple for Jacobson, Maynard, Tuschman &

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

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

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

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

12 Q. What is the name of that case?

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

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

18 Did I give you a name on it?

19 Q. No, you didn't.

20 A. I didn't give you a name?

21 Q. No.

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

24 Sweeney.

25 Q. That was the name of the patient?

1 A. Yes.

2 Q. You are one of the defendants?

3 A. I think I am at this point the only
4 defendant.

5 Q. What are the allegations against you?

6 A. Concerning an intra-aortic balloon pump that
7 was inserted in an emergency manner following a
8 cardiac catheterization allowing the patient to go
9 to bypass surgery, with a complication of the
10 potentially -- a potential complication of the
11 balloon pump insertion causing neurologic damage to
12 his leg.

13 Q. That remains pending?

14 A. Correct.

15 Q. Is it Mr. Charms that's representing you in
16 that case?

17 A. No. Presently I am being represented by --

18 Q. Mr. Jackson?

19 A. No.

20 Q. Mr. Hupp?

21 A. No.

22 Q. Mr. Seibel, Mr. Bonezzi, Mr. Djordjevic,
23 Mr. Kalur?

24 A. Sweeney came to my head. The other will
25 come, too.

1 MR. SEIBEL: Susan Reinker.
2 Q. Somebody at Jacobson, Maynard, Tuschman &
3 Kalur?
4 A. Yes. I don't remember his name.
5 Q. If you think of it, let me know.
6 A. I will.
7 Q. All right. Any others?
8 A. No.
9 Q. You mentioned that you had a couple other
10 articles, what are those?
11 A. I have written a review article on reflex
12 control in heart failure.
13 Q. Has that been published?
14 A. Yes.
15 Q. Where at?
16 A. It is a journal called Hospital Practice, and
17 I believe 1991, I think.
18 Then one that is in press right now
19 for a journal called Cardio, on the use of
20 vasodilators in mild to moderate heart failure.
21 Q. The name of your article is?
22 A. The "Use of Vasodilators in Mild to Moderate
23 Heart Failure."
24 Q. That's in press now?
25 A. Yes.

1 Q. Any others?

2 A. No.

3 Q. Have you reviewed anything in connection with
4 this case after you wrote your report this year?

5 A. I reviewed no new documents after I wrote my
6 report.

7 Q. You haven't looked at deposition?

8 A. No.

9 Q. Or any other testimony?

10 A. No.

11 Q. Have you spoken with any of the other experts
12 or have you been provided with any testimony by
13 Mr. Coyne or anybody else in his firm of what the
14 experts have said?

15 A. No.

16 Q. Is there some --

17 A. I thought of my lawyer's name if you want to
18 know --

19 Q. Yes.

20 A. -- before I forget.

21 John Polito.

22 MR. FULTON: Don't tell

23 John.

24 Q. Is there some specialty within medicine that
25 provides for the ability to determine how long

1 someone will live?

2 A. There is no specialty within medicine that
3 lets you know precisely how long people will live.
4 There are special --

5 Q. You stressed the word "precisely," Doctor?

6 A. I think all specialties in medicine to some
7 degree or another allow you to make an assessment
8 regarding possibility of survival. It depends I
9 guess what's limiting your survival.

10 If you have a cancer, then it's the
11 oncologist who's best able to tell you that. So
12 it's probably all specialties within medicine to
13 some degree.

14 Q. I see. So as a cardiologist then you would
15 be able to assist us in telling us within your
16 specialty to what extent people would live with any
17 type of heart problem, heart disease?

18 A. With any kind of heart problems. Also with
19 general medical problems, yes.

20 Q. That's because you're also an internal
21 medicine specialist?

22 A. Correct.

23 Q. How much time in your practice is spent
24 dealing with neurologic deficit?

25 A. Percentage of time-wise? I spend a fair

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

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

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

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

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

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

1 of record for those doctors -- for those patients.

2 Q. For all the patients going through?

3 A. Yes.

4 Q. That doesn't mean you treat all the patients
5 going through, does it?

6 A. Yes, it does.

7 Q. Does it?

8 A. Yes. Yes, I take care of them.

9 Q. Take care of all of them?

10 A. Yes.

11 Q. Do they have other cardiologists who take
12 care of them as well as you or do you take --

13 A. No, I take care of them.

14 Q. -- all of them?

15 A. During my months they may have cardiologists
16 who have cared for them in the past who offer
17 opinions or see the patient, but I am primarily
18 responsible for all of them.

19 Q. When the two months are done, do you continue
20 to care for them or does the next doctor of record
21 take over?

22 A. Either way. Either way, depending if they
23 are likely to be in the hospital for another full
24 month, I guess if they're going to be there, then
25 in general you would transfer that care to someone

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

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

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

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

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

10 Q. Who is, residents?

11 A. Fellows, specialty trainees in cardiology.

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

15 A. Yes.

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

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

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

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

1 made.

2 Q. If the resident does something inappropriate
3 as it pertains to the patient, are you responsible
4 for the resident's conduct in that regard?

5 A. I don't know in a, you know, hierarchal sense
6 or a management structure sense whether the
7 resident is responsible to me or to the hospital.

8 Q. If I am a patient and I am in the C.I.C.U.,
9 okay, is that what it is?

10 A. Yes.

11 Q. And you leave me in the care of one of the
12 residents there?

13 A. Yes.

14 Q. You go home, he does something wrong towards
15 me, are you responsible for that?

16 A. I believe I am.

17 Q. So I mean, can we agree that Dr. Steele would
18 have been responsible for the conduct of Dr. Varma
19 as it pertained to Mrs. Weitzel?

20 A. I think that's perhaps more legal questions
21 than a medical question. I can't really answer.

22 Q. I'm asking from a medical standpoint, you as
23 a physician, we'll work out the legalities.

24 MR. FULTON: Hopefully.

25 MR. KAMPINSKI: We will.

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

4 Q. Did Mrs. Weitzel die because of sequelae of
5 her heart attack that occurred on February 11th,
6 1991?

7 A. She died from a multitude of factors.

8 Q. Did she die as a result of any damage done as
9 a result of the heart attack that she sustained on
10 February 11th, 1991; was that the cause of her
11 death, Doctor?

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

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

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

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

25 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.

1 Iatrogenic means caused by a doctor.

2 MR. FULTON: Show an
3 objection.

4 MR. KAMPINSKI: Sure.

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

6 Q. Yes?

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

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

10 A. Yes.

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

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

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

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

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

1 Q. Let's assume they didn't, was that as a
2 result of the heart attack, assuming that?

3 A. Assuming that the hospital personnel did not
4 attend to her?

5 Q. That's right.

6 A. If I was to assume the hospital personnel did
7 not attend to her, no, that would not be a cause of
8 her heart attack; other than the fact that she's in
9 the hospital because she had a heart attack. That
10 was what admitted her to the hospital, that was the
11 primary admitting diagnosis.

12 Q. Well, maybe you can help me out: If the
13 guide wires had not been left in Mrs. Weitzel, if
14 surgery had not been done to remove them, under
15 those circumstances we wouldn't be talking about
16 the events that occurred on the evening of March
17 14th as to whether or not they were appropriate or
18 not in terms of her post surgical care, because
19 they wouldn't have happened, correct?

20 A. She would not have gotten the surgery on
21 that, correct. So the exact sequence of events
22 that were post surgical would not have happened,
23 correct.

24 Q. And you would agree with me, would you not,
25 that in terms of definitions, this was a surgical

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

3 A. By definition, yes.

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

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

8 Q. Would it have been in March of 1991?

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

10 Q. Would she still be alive today?

11 A. I doubt it.

12 Q. Would she have died last week?

13 A. I doubt it.

14 Q. This week?

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

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

19 A. In the hospital, I believe.

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

22 A. There's multitude bases for my opinion.

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

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

4 Q. What literature do you base it on?

5 A. I base it on a few textbooks.

6 Q. Tell me what, please.

7 A. Braunwald's textbook of cardiology.

8 Q. Say it slowly.

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

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

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

18 Q. Any other text or literature?

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

21 Q. Why not?

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

24

25

1 Q. I beg your pardon?

2 A. Back in January, I think.

3 Q. You mean a total of three months ago?

4 A. Yeah.

5 Q. You say that the syndrome of ARDS carries
6 exceedingly high mortality, and "When three or more
7 organ systems are involved, mortality rate exceeds
8 80 percent, and if this organ failure persists
9 beyond four days, mortality approaches
10 100 percent," that sounds like it is out of some
11 literature --

12 A. Yes.

13 Q. -- rather than you --

14 A. Pulling it off the top of my head?

15 Q. Yes.

16 A. Right.

17 Q. Could you tell me what literature it's from?

18 A. Unfortunately I can't. I don't remember the
19 names. I reviewed several articles on adult
20 respiratory distress syndrome and multiple organ
21 failure. I'm sorry. I don't. I didn't bring the
22 names with me.

23 Q. I apologize to some extent because, you see,
24 when you put things like this in a report, it is
25 hard for me to determine how accurate they are

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

3 A. Yes.

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

7 A. I agree, yes.

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

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

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

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

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

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

23 MR. KAMPINSKI: Okay.

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

1 them to you the same day I receive them.

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

6 A. Yes.

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

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

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

16 Q. From the text?

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

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

1 they survive to make it to the hospital?

2 A. No. Data is provided both ways for patients
3 who survived to the hospital, patients who survive
4 to be admitted to the hospital; and patients who
5 survived to be discharged from the hospital.

6 Q. What are the statistics with respect to
7 patients who are discharged from the hospital in
8 terms of their survival?

9 A. No. The statistics go to hospital admission
10 and to hospital discharge, but if you are asking me
11 from hospital discharge long term, if that's what
12 you're asking me, that data is not available to me.

13 Q. You are saying to hospital discharge and that
14 implies they survived sufficiently to be
15 discharged?

16 A. Correct. But not -- but the data is not
17 there for long term after that.

18 Q. So it's 100 percent of those who make it to
19 hospital discharge, are discharged I mean?

20 A. Yes.

21 Q. I see. So the statistics --

22 A. But those statistics do not speak to
23 whether -- to how long you live after hospital
24 discharge.

25 Q. Did she die as a result of her adult

1 respiratory distress syndrome?

2 A. That was one factor.

3 Q. Did she die as a result of that, Doctor?

4 A. She died as a result of multiple things. I
5 can't isolate one.

6 Q. That's one of the things that caused her to
7 die?

8 A. That is one of the things that caused her to
9 die, yes.

10 Q. Do you agree or disagree with Dr. Holland in
11 terms of it being his opinion that it was as a
12 direct result of the bleed that she sustained
13 intra-operatively and the failure to attend to that
14 bleed postoperatively that caused her death?

15 MR. FULTON: Objection.

16 MR. SEIBEL: Objection.

17 MR. COYNE: I don't think
18 that's his testimony.

19 MR. KAMPINSKI: I think it is.

20 Q. Go ahead. Do you agree or disagree?

21 A. I didn't read Dr. Holland's deposition, so
22 that --

23 Q. So you don't know?

24 A. Are you asking me if I think she died as a
25 direct result of a bleed after her operative

1 surgery?

2 Q. And sequelae of a bleed?

3 A. Of the bleed?

4 Q. Yes, ma'am.

5 A. I think that's a part. I think that's a
6 relative large part. It's not -- I wouldn't say
7 it's the sole event. She had a relatively -- she
8 had a moderate amount of blood, I think three to
9 400 cc's.

10 Q. 500.

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

13 Three to 400.

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

16 MR. KAMPINSKI: Okay.

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

23 Q. She wasn't an otherwise healthy person.

24 A. That's my point.

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

1 whole answer. It's part of it.

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

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

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

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

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

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

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

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

21 A. Yes. Yes. That is my belief.

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

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

1 MR. COYNE: You added
2 solely because of literature.

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

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

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

10 A. Yes.

11 Q. -- that nobody tells you about them?

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

15 Q. How about left in?

16 A. No.

17 Q. Any?

18 A. Patient under my care?

19 Q. Yes.

20 A. None.

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

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

1 Q. In terms of dealing with their ARDS
2 condition, is that dealt with primarily by a
3 pulmonologist specialist?

4 A. It's dealt with by pulmonologist specialists
5 in conjunction with intensive care unit attendants.

6 Q. Who determines the various settings on
7 ventilators with somebody who has ARDS, the
8 pulmonologist?

9 A. Again, it's a combination of the
10 pulmonologist and intensive care unit attending.

11 Q. Who determines whether or not somebody is to
12 be weaned off of a ventilator?

13 A. The same.

14 Q. Combination?

15 A. Yeah.

16 Q. Did you read Dr. Sopko's testimony in this
17 case?

18 A. No, I did not.

19 Q. Didn't you think it was important to read the
20 pulmonologist's testimony?

21 A. In regard to what?

22 Q. In regards to whether or not she was about to
23 be weaned off the ventilator?

24 A. No. I read the chart and the data in the
25 chart and I can form an opinion based on what I see

1 in the chart.

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

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

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

9 A. No, it wouldn't.

10 Q. Was she improving from a ventilatory
11 standpoint?

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

14 Q. Was she stable from a cardiac statement?

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

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

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

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

1 prognostically more important than when she came
2 into the hospital.

3 Q. Whatever.

4 A. I would go backwards.

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

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

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

11 3-14, JMR, top of the page starts
12 renal.

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

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

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

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

25 Q. Who is the junior medical resident?

1 A. I cannot read that signature.

2 Q. How long has he been on --

3 A. If he was a junior medical resident in March,
4 that means he graduated from medical school
5 approximately a few months shy of two years
6 previous.

7 Q. You didn't let me finish the question.

8 A. Go ahead.

9 Q. How long has he been seeing Mrs. Weitzel, how
10 long has he been at Charity prior to writing this
11 note?

12 A. I have no way of knowing how long he had been
13 at Charity. I can go back through and see
14 approximately when his first note was written. I
15 am not sure this pertains to physically walking in
16 and seeing her for the first day and can tell if
17 she was awake or not; but to answer, I don't know.

18 Q. You are not a junior medical resident, or do
19 you equate your capabilities to that of a junior
20 medical resident?

21 A. No, I don't, but I think a junior medical
22 resident or a first year medical or a medical
23 student could tell -- tell whether or not someone
24 was awake, or a lawyer.

25 Q. How about a husband, could he tell?

1 A. No, I think it's difficult for family members
2 to tell. I think you need medical training.

3 Q. Lawyers don't have medical training.

4 A. That was a facetious comment. I'm aware
5 lawyers don't have medical training.

6 It's a little hard for me to find
7 things here quickly. When I looked at the chart it
8 was not put together in this order, so I have to
9 be --

10 Q. Take your time.

11 A. On the 12th there is a JMR note. Again it
12 starts GI nutrition on the top line.

13 MR. COYNE: For
14 clarification, it's March 12.

15 A. I'm sorry. March 12th.

16 Q. Just give me a minute to find it.

17 A. Fine.

18 Q. Is this the same junior medical resident or
19 is this someone different?

20 A. I think it's the same.

21 Q. Writing looks the same?

22 A. Yes.

23 Q. All right. What part of --

24 A. Under neuro again, halfway down the page, as
25 above requiring prolonged recovery time from

1 sedation, neuromuscular blockade.

2 Q. I'm sorry?

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

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

10 A. Yes.

11 Q. All right. Go ahead.

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

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

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

1 interpret that as being very minimally neurologic
2 function.

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

5 MR. COYNE: Doctor's
6 progress notes.

7 Q. What does it say right after that?

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

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

16 A. I am reading backwards in time.

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

19 A. Versed is not a neuromuscular blockade. A
20 neuromuscular blockade is specifically a paralyzing
21 agent.

22 Q. What does Versed do?

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

25 Q. It sedates?

1 A. Yes. Anti-anxiety.

2 Q. What does it do to your neurologic status?

3 A. It doesn't do anything to your muscular
4 strength. It would sedate, make you sleepy.

5 Q. Drowsy?

6 A. Drowsy, but not paralyze you.

7 Q. But would it make it difficult for you to
8 respond?

9 A. It might. I would need to look in the orders
10 to see. I believe that was discontinued as well,
11 the Versed.

12 Q. Do you?

13 A. I believe so, but I have to look in the
14 order.

15 Q. Why don't you take a look.

16 Would that matter with respect to
17 your opinion about her neurologic status?

18 A. It wouldn't reverse my opinion completely,
19 no.

20 Then I can also go to the beginning
21 parts of the doctor's progress notes.

22 Q. Let's go slow.

23 Are you done with the back part?
24 Have you now shown me --

25 A. I was working backwards and I got to

1 the 12th. The orders I think are on this part.

2 I'm looking at her routine medication orders for a
3 week, that begins on March 14th, that list that
4 begins on March 14th -- March 13th, I'm sorry.

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

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

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

17 Q. Doctor --

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

20 Q. How many days?

21 A. Four.

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

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

1 A. I don't remember.

2 The junior medical resident note
3 was on the 13th?

4 Q. Yes.

5 MR. COYNE: That was a
6 question now?

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

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

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

14 What time was the junior medical
15 resident's note?

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

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

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

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

4 A. Here is notes.

5 Q. -- that supports your conclusion?

6 A. Here, February 12.

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

9 A. I can work either way.

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

12 A. Yes.

13 Q. -- supports your conclusion.

14 A. Okay.

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

17 A. Yes.

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

20 A. Yes.

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

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

1 Q. You are the one that started going
2 backwards.

3 A. I can continue.

4 Q. Whatever you want to do.

5 A. Whatever you want to do.

6 Q. Knock yourself out.

7 A. Thank you.

8 A cardiology note on the 12th.

9 Q. By the way, you wouldn't just point out those
10 things that support your conclusion as opposed to
11 factors that go the other way, would you, Doctor?

12 A. I'm looking for everything that says
13 neurology.

14 Here's a neurology note from
15 the 11th from a junior medical --

16 MR. COYNE: March?

17 A. 11th, yeah. Neuromuscular blockade and a
18 word I can't read, and --

19 Q. Sedate?

20 A. -- Sedatol or -- sedated, maybe, will D/C
21 Vecuronium and Versed to help with another word I
22 can't read. I don't think -- that is not a helpful
23 note.

24 Q. Helpful?

25 A. I said it's not a helpful note.

1 On March 11th, a JMR note,
2 neurology, responds minimally to noxious stimuli.

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

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

9 Q. Was she on anything else at that time?

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

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

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

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

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

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

22 Q. Did you review it before coming here today?

23 A. I reviewed it briefly, yes.

24 Q. When?

25 A. A little bit last night and more this

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

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

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

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

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

17 On the 5th again, neuro unchanged.

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

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

23 On the 1st, neuro, heavily
24 sedated.

25 Again, several days with no

1 neurologic comments.

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

4 Several more notes without
5 neurologic comment.

6 2-24 -- no. Let me find a date.
7 2-24, yes. Neuro unchanged, grossly intact.

8 2-23, patient lethargic.

9 2-22, unchanged, still follows
10 commands. Well, I am sorry. 2-25 --

11 Q. Still follows commands you said?

12 A. Yes.

13 Q. What does that mean?

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

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

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

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

1 A. I am almost to the end. Just hold on.

2 Neuro, unchanged on 19th of
3 February.

4 Q. Wait. The one you read, the 22nd, does it
5 say "Still follows commands well" or just "Still
6 follows commands"; it seems that you left something
7 out?

8 A. What's the first line of the page?

9 Q. Junior medical resident.

10 A. Can you read me the first line of the page so
11 you can -- I can find it.

12 Q. That's the one you just read to me a minute
13 ago.

14 A. Yes.

15 Q. You left the word "well" out. I wondered why
16 you did that.

17 A. I think you're right. I think it says "Still
18 follows commands well," I think.

19 Q. Does that make any difference to you?

20 A. Well, if the command is open your eyes and
21 she opened her eyes, I am not sure that "well"
22 means very much to me, honestly.

23 Q. Let me, hypothetically, Doctor, we'll
24 continue on, I know you're near the beginning, but
25 let's just assume for the sake of argument that she

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

5 A. Writing letters with her finger?

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

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

13 Q. Do you want to answer my question?

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

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

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

22 Q. Well, how high a level?

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

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

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

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

8 Q. Yes.

9 A. If I saw that yes, it would.

10 Q. How would that affect your opinion?

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

13 Q. What do you mean "hope."

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

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

21 Q. Assures a probability?

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

24 A. No.

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

1 A. Yes. Given everything else.

2 Q. Beg your pardon?

3 A. Given everything else.

4 Q. We're talking about the neurological status,
5 Doctor.

6 A. Given her other neurologic findings.

7 Q. What other neurologic findings?

8 A. 2-12, neurology, eyes wander and --

9 Q. You left me off back at 2-20, is there
10 nothing else between that and 2-12, the day she
11 came in?

12 A. I didn't find anything.

13 Q. Nothing else?

14 A. I can look again.

15 Q. If there is nothing else, that's fine.

16 A. No. Let me look again. You know, there's a
17 neuro unchanged on the 21st; there's a neuro
18 unchanged on the 20th, there's a neuro unchanged on
19 the 19th, a neuro unchanged on the 18th. There was
20 nothing else of substance there.

21 There's a neuro unchanged on
22 the 17th.

23 On the 16th says awake, follows
24 commands.

25 Q. What date?

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

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

4 A. 16.

5 Q. 16th?

6 A. Yes.

7 On the 15th there was awake, moves
8 extremities.

9 Q. Is that good?

10 A. Not necessarily.

11 Q. Is that bad?

12 A. Brain stem --

13 Q. Is that bad?

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

16 Q. So that's a neither?

17 A. Exactly.

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

20 Q. Is that good?

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

22 Follows commands --

23 Q. Anything else?

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

25 Q. I know you desperately want to get back to

1 the 12th.

2 A. I want to go back to the beginning.

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

5 Q. Is that good?

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

7 Q. Minor sign of what?

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

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

14 Q. What are you here to do?

15 A. Let me --

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

18 MR. KAMPINSKI: No.

19 MR. COYNE: -- in a
20 deposition.

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

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

25 MR. KAMPINSKI: Is she? I

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

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

6 MR. KAMPINSKI: Is it?

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

10 MR. KAMPINSKI: All right.

11 BY MR. KAMPINSKI:

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

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

19 Q. Is that on admission?

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

23 Q. The day she was admitted?

24 A. Yes.

25 Q. Well, based upon the other notes that you

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

3 A. I don't think she got worse.

4 Q. Did she get better?

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

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

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

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

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

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

1 she had her cardiac arrest.

2 Q. I'm listening.

3 A. I thought you were looking for another copy.

4 At 8:59, which is when they begin
5 recording vital signs, until when -- I believe says
6 9:30, for 31 minutes she was without pulse, without
7 respiration, without blood pressure. In my mind
8 that is a -- a very serious neurologic insult that
9 would cause me great concern, if essentially
10 30 days later, 32 days later -- 13th of March, if
11 32 days later -- by 30 days, February is a short
12 month -- if 30 days later we are still at the
13 minutiae level of, is she opening her eyes when I
14 tell her to, is she moving her extremities
15 purposely, 30 days after a documented 30-minute
16 episode of no blood pressure, no pulse, meaning no
17 blood flow to her brain, I think that she -- my
18 opinion is that she is in very serious neurological
19 straits.

20 Q. How serious?

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

22 Q. Will she be a vegetable then?

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

25 Q. How would you put it in medical terminology?

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

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

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

14 A. Yes, I did.

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

17 A. Yes, I did.

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

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

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

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

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

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

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

14 Q. Doctor --

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

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

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

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

1 What is the question?

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

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

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

15 **Q.** Are you talking the junior medical resident
16 notes that you referred us to on the 13th and
17 the 11th?

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

19 **Q.** You don't?

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

22 Where is the notes?

23 **MR. COYNE:** Progress?

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

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

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

6 Q. What day is that?

7 A. 3-12.

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

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

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

22 Q. So that's not good?

23 A. That's not good.

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

1 does that work?

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

4 Q. No. The neuromuscular --

5 A. The long term?

6 Q. Yes.

7 A. Does the body metabolize it, yes.

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

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

12 Q. I'm sorry.

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

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

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

1 you wait for the medicine to wear off.

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

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

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

7 Q. She demonstrated positive Doll's eyes?

8 A. Yes.

9 Q. What is that?

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

15 Q. Is it a good minimal neurologic finding?

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

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

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

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

25 A. I am concerned when he says "apparently"

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

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

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

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

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

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

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

1 A. I did not say she was brain dead.

2 Q. Whatever you are saying, could you show me
3 where it says it in this paragraph?

4 A. That is to my reading and to what I believe
5 would be a trained medical person's reading. That
6 is implied. They don't list all the negatives that
7 she doesn't -- it doesn't say she gets out of bed
8 or it doesn't say she's breathing on her own. He
9 didn't ask for the numerous -- they listed the
10 things that she did which are minimal, and to me
11 from that I infer that she did not have a higher
12 order of response or that would have been listed.
13 You list what happens, not the thousand things that
14 don't happen.

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

17 Q. So you're inferring it?

18 A. Yes, I am.

19 Q. So there's nothing written in the chart that
20 causes you to conclude what you concluded; it's
21 what's not written in the chart that causes you to
22 conclude that?

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

25 A. They write in the chart the responses that

1 she had. I assume that to be an inclusive list.

2 Q. You do?

3 A. Yes, I do.

4 Q. It doesn't say she jumped out of bed and ran
5 around the I.C.U., so that's not a good sign,
6 right?

7 A. Correct. If I understand your question. I
8 take this to be an inclusive list of her responses
9 to the medication, and I will call it a minimal
10 response.

11 Q. What's the rest of that note -- by the way,
12 when it says "discussed with medical resident" --

13 A. Just a minute.

14 Q. -- "will restart Versed drip for sedation
15 until Nocuron is worn off" --

16 A. Yes.

17 Q. -- what were they doing, like teaching the
18 medical residents and students on her and --

19 A. No.

20 Q. No?

21 A. No. Oh, contrar. I think what he's doing is
22 making her more comfortable. At that time they
23 were giving her sedation to keep her calm, to keep
24 her comfortable. They had done this diagnostic
25 test. They learned what they needed to learn and

1 then could re-assess at another time.

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

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

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

14 Q. Why did they do it?

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

18 Q. Which is where you were before?

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

21 MR. COYNE: 12th.

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

24 Q. Well, humor me.

25 A. I'm learning.

1 The question was regarding the
2 Versed.

3 Q. Or the --

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

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

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

10 MR. COYNE: 28th?

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

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

16 A. Yes.

17 Q. She came in on the 12th?

18 A. Yes.

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

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

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

4 Q. Did you understand my question?

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

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

13 A. Yes. As I said --

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

16 A. Yes.

17 Q. You looked at the medication she was on?

18 A. Absolutely. I have read every page.

19 Q. You looked at the nurses' notes?

20 A. Yes.

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

1 impact on you in terms of your opinion, right?

2 A. I think it's very difficult to assess if
3 someone is oriented when they are on a ventilator,
4 since you can't -- if you cannot communicate with
5 them.

6 Q. You and I weren't there, the nurses were
7 there, is it --

8 A. The doctors were there too, though.

9 Q. But that's why I had you go through their
10 notes, and they really don't say, do they, between
11 the 12th of February and the 13th of March?

12 A. They make comments on whether she followed
13 commands, they made comments on whether or not her
14 condition changed.

15 Q. You read me two junior medical resident notes
16 on the 13th, I think is what you did, and --

17 MR. COYNE: I think she
18 read more than that.

19 A. There was one almost every day.

20 Q. All said unchanged?

21 A. Correct.

22 Q. And the one that you read on the, I think
23 the 18th, you minimized in terms of his saying that
24 she did follow commands. You said well, that may
25 not mean anything.

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

4 A. Yes.

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

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

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

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

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

25 Q. Have we exhausted your reliance upon the

1 physicians in terms of their observation regarding
2 her neurological status?

3 A. I think we have.

4 Q. Have we?

5 A. I think so.

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

8 A. Yes.

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

15 Ma'am?

16 A. I am thinking. I am here.

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

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

23 a. Pick a day in the nurses' notes.

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

1 suffered significant long term neurology
2 data -- damage.

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

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

10 Q. Intermittently? Did I say intermittently?

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

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

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

18 MR. COYNE: Of which?

19 MR. KAMPINSKI: February.

20 MR. COYNE: February.

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

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

1 all those notes, ma'am?

2 A. No.

3 Q. Is that somebody who is neurologically
4 impaired?

5 A. Let me see.

6 That may be somebody with a
7 profound neurologic deficit, yes. That is someone
8 who -- whatever you read me, let me find it.

9 Q. Right at the top.

10 A. If someone opens their eyes to a name and
11 waves, denies discomforts when asked, follows
12 commands, makes good efforts to squeeze fingers,
13 which is not quite as the same as squeezing finger
14 on command --

15 Q. Does it say why, because her hands are
16 swollen?

17 A. Doesn't say why.

18 Q. What is the next sentence, ma'am?

19 A. Okay. I'll continue reading, "Action limited
20 RT edema in hands and soft wrists restraint.'" I'm
21 not sure what RT means.

22 "MAE," whatever that
23 is, "difficult to evaluate, difficult to evaluate
24 strength or potential deficit at this time."

25 I do not think that this is

1 inconsistent with severe neurologic damage.

2 Q. Is it consistent with it? Does it support
3 neurological damage or does it support the fact
4 that the lady could understand, that she did
5 respond, that she didn't have brain damage as a
6 result of the anoxic event?

7 A. It is -- no. No way says that she did not
8 have brain damage.

9 Q. I see.

10 A. There's a lot more to your brain than those
11 sort of activities. Does not in any way tell us
12 she did not have brain damage.

13 Q. Do you know any of the physicians involved in
14 this case?

15 A. No, I do not.

16 Q. Dr. Rollins, Dr. Steele, Dr. Kitchen?

17 A. I know Dr. Rollins by sight but do not know
18 him. The other doctors I do not know at all.

19 Q. I think your CV indicated that you were
20 43 years old?

21

22 Q. What is your life expectancy, Doctor?

23 A. What is my life expectancy? I don't know
24 with a great degree of certainty.

25 Q. We have to look at actuarial tables to

1 determine that, probably?

2 A. I don't think actuarial tables takes into
3 account these risk factors. I don't think every
4 43 year old woman has the same life expectancy.
5 They're not very sophisticated. That's average for
6 everybody, not everybody is average.

7 Q. Includes people with brain damage, includes
8 people with heart problems, includes people that
9 don't have any of those, right?

10 A. Right. I would say it's an average of all
11 43 year old woman.

12 MR. KAMPINSKI: That's all I
13 have.

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

16 MR. COYNE: Anybody else
17 have any questions?

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

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

22 MR. COYNE: I don't know if
23 that makes any difference.

24 Whoever has questions.

25 MR. FULTON: I have no

1 questions on behalf of Dr. Varma.

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

5 MR. FULTON: Is that right?

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

8 MR. FULTON: I do have one
9 question.

10 MR. KAMPINSKI: Wait a minute.

11 MR. FULTON: The --

12 MR. KAMPINSKI: I object.

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

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

25 MR. FULTON: Just to clear

1 up something that you asked.

2 MR. KAMPINSKI: Sure.

3 -----

4 CROSS-EXAMINATION

5 BY MR. FULTON:

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

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

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

15 A. Yes.

16 Q. They're in the radiology department?

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

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

22 A. Absolutely.

23 Q. They have to be removed?

24 A. Absolutely.

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

1 would be through what is called a percutaneous
2 method?

3 A. Correct. If possible.

4 MR. FULTON: I have no other
5 questions.

6 -----

7 CROSS-EXAMINATION

8 BY MR. SEIBEL:

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

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

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

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

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

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

11 A. When she had stabilized at the hospital?

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

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

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

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

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

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

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

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

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

24 Q. What does assist control mean to you?

25 A. I cannot tell you the exact details of how

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

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

5 A. Absolutely. Absolutely.

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

8 MR. FULTON: Objection.

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

13 Q. What were those potential risks?

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

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

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

24 A. Yes.

25 MR. FULTON: I just object

1 to wires. One wire.

2 Q. Eventually the foreign body in her
3 circulation would have to be removed, whether they
4 were singular or plural?

5 A. Yes.

6 Q. In modern cardiology, is there some sort of
7 hard and fast rule about not doing surgery in the
8 first three to six months after an MI?

9 MR. KAMPINSKI: I'm going to
10 object to "hard an fast" as opposed to medically
11 indicated or medical appropriate or proper.

12 A. I think there's clearly a consensus of
13 opinion that purely elective surgery should not be
14 performed shortly after an MI.

15 MR. KAMPINSKI: I'll withdraw
16 my objection.

17 A. That during the first six months after a
18 heart attack there is some increases in risk which
19 slowly, steadily decreases during that six-month
20 period of time; but then that's for an elective
21 surgery.

22 Q. How would you define purely elective surgery?

23 A. It's probably easiest to define by example.

24 Q. All right.

25 A. Purely elective surgery is let's say you need

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

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

10 A. No, I don't believe so.

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

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

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

21 A. I don't.

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

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

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

5 MR. FULTON: I have an
6 objection to consulting.

7 Q. By that I mean any of the nonresidents?

8 A. Yes, I do have an opinion.

9 MR. KAMPINSKI: Objection.

10 Q. What opinion do you hold?

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

13 Go ahead.

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

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

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

19 -----

20 RECROSS-EXAMINATION

21 BY MR. FULTON:

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

1 A. Yes.

2 Q. Is that done under fluoroscopy?

3 A. Yes. Always.

4 Q. When you do something like this
5 under fluoroscopy, I'm talking about at University
6 Center, is there some means of recordation of what
7 the fluorscopy shows?

8 A. No. Fluoroscopy is just a transient image.
9 You step on the pedal and look at the screen. When
10 you take your foot off the pedal, the imagine is
11 gone. There is no permanent copy. It's not like
12 an x-ray.

13 Q. Is there some standard of care as to what
14 should be recorded then as to taking out a wire at
15 that single -- I mean if it's a transient type of
16 picture, is there a standard of care what the
17 doctor should place in the medical record?

18 A. I think he should place in the medical record
19 a note saying that it was done or that it was
20 attempted and unsuccessful, or attempt was
21 successful.

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

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

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

6 A. Exactly.

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

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

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

12 A. I'm going to look anyway.

13 Q. Go ahead and look then.

14 MR. COYNE: Wait for the
15 next question.

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

18 A. I don't recall.

19 Q. You want to look now.

20 A. Yes, thank you.

21 Q. I think it is the 13th.

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

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

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

4 MR. COYNE: Read it.

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

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

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

17 MR. SEIBEL: Breach of
18 protocol.

19 MR. KAMPINSKI: I have a couple
20 questions.

21 Does anybody have any questions?

22 -----

23 RECROSS-EXAMINATION

24 BY MR. KAMPINSKI:

25 Q. Mr. Seibel asked you about training as it

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

3 A. Yes.

4 MR. FULTON: Did I?

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

7 MR. COYNE: This fellow.

8 THE WITNESS: I don't think
9 it was.

10 MR. KAMPINSKI: I do.

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

13 A. Someone did ask me that question.

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

15 Do you train residents?

16 A. Yes, I do.

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

18 A. All levels.

19 Q. All levels?

20 A. Yes, internal medicine residents and
21 cardiology Fellows.

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

24 A. Yes.

25 Q. At what level would you expect that a

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

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

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

10 A. Yes.

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

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

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

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

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

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

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

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

11 MR. KAMPINSKI: You are
12 excused.

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

16 Q. Go ahead.

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

1 own.

2 Q. I got you. Okay.

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

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

14 Q. I see.

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

18 Q. I got you.

19 See one or more?

20 A. Exactly.

21 Q. Do one or more --

22 A. Under supervision.

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

25 A. Yes.

1 Q. And presumably teach it?

2 A. Exactly. Definitely.

3 Q. And at least the see one or more and the do
4 one or more ought to be logged in a procedure book,
5 correct?

6 A. At our hospital we log them in procedure
7 books, yes. I don't know what the standard is. I
8 do not know if that's universal.

9 Q. I got you.

10 You said something -- this was in
11 response from a question from Mr. Seibel -- that
12 the major risk you believe from the wire was
13 perforation; was that correct?

14 A. That would be the most serious risk.

15 Q. Have you seen the wires in this case?

16 A. On the chest x-ray, yes.

17 Q. I mean the actual wires?

18 A. No.

19 Q. Do you know what kind of wires they were?

20 MR. FULTON: You mean
21 manufacturer?

22 MR. KAMPINSKI: Yes.

23 A. I know from reading the record and looked at
24 the chest x-ray they're J tipped, had 48 centimeter
25 long wires.

1 Q. What does J tipped mean?

2 A. It means the wire, instead of just coming up
3 as a straight tip, is curved like it's the
4 letter J.

5 Q. And is that significant as it relates to the
6 risk of perforation?

7 A. It lowers the risk but does not remove it.

8 Q. What is the end of that wire; is the end of
9 the wire sharp?

10 A. Well, the end of the wire, if you look at
11 a J, and you are at the end of the wire --

12 Q. I have seen them.

13 A. -- it's not sharp. It's a little stiff, but
14 not -- it's not sharp.

15 Q. And the reason I ask is, Dr. Holland said the
16 risk of perforation is almost nonexistent with that
17 kind of wire?

18 A. It's much less than with a straight tipped
19 wire, and the straight tipped wires are no longer
20 used because the risk of perforation was too high,
21 but you can still do it.

22 Q. By the way, you are aware of the fact that
23 there were two wires, right?

24 MR. KAMPINSKI: Mr. Fulton?

25 MR. FULTON: Am I under

1 oath?

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

5 MR. FULTON: I didn't say
6 anything.

7 Q. You are aware that --

8 A. My understanding is there were two wires.

9 Q. Everybody is aware of that, I think.

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

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

20 MR. KAMPINSKI: No.

21 MR. COYNE: It's Varma's.

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

25 MR. COYNE: But not our

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

3 MR. KAMPINSKI: I get very
4 confused by this.

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

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

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

10 A. Yes.

11 Q. Are you on any committees with him?

12 A. No.

13 Q. Belong to the same societies?

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

16 Q. I apologize.

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

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

6 A. I do have an opinion.

7 Q. What is it?

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

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

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

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

23 A. Yes.

24 Q. That was placing her under general
25 anesthesia?

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

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

12 Q. When you say "you"?

13 A. I would have the surgeon take it.

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

15 A. It was tried and failed.

16 Q. Do you know why?

17 A. No, I don't.

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

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

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

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

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

6 Q. That's why they call it discovery.

7 A. Right.

8 Q. Well, do you think Dr. Varma did a pretty
9 good job in putting in the catheter on February 26,
10 1991?

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

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

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

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

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

21 A. The question again.

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

25 MR. FULTON: Objection.

1 A. I think the order shows she has had
2 complications from that.

3 Q. You mean the record shows that?

4 A. Yes. He said no complication, actually; and
5 I think subsequent notes in the charts were he had
6 a complication from it.

7 Q. Well, when you say a complication --

8 A. Of the wire being retained.

9 Q. The wire or two wires?

10 A. Two wires.

11 Q. Is that good medical practice?

12 MR. FULTON: Objection.

13 Q. In your opinion, your expert opinion?

14 A. You never like to have in medical practice
15 complications, but complications happen. I don't
16 know.

17 Q. How about a deviation from acceptable
18 standard of practice, is that?

19 A. To lose two wires?

20 Q. You got it.

21 A. Yes.

22 Q. How about covering it up, is that --

23 MR. FULTON: Objection.

24 Q. -- good medical practice not telling anybody?

25 MR. FULTON: That's not

1 true. He indicated they were there on the 8th.

2 Q. Is that good medical practice there?

3 A. To cover up the fact that wires were left
4 behind is not good medical practice.

5 Q. And I think you told me really very early-on
6 in the beginning of this deposition that you as an
7 attending are responsible for what occurs to your
8 patient when it's done by residents, so your
9 response to Mr. Seibel about Dr. Steele, I assume
10 if asked in the correct context would be that he is
11 responsible for that?

12 A. Right. And I think my answer had something
13 to do with the same sort of confusion that you
14 admitted about Dr. Varma being the hospital
15 resident, and it is, you know, the -- I don't
16 like -- I didn't write the guy's paycheck. He is
17 not in my employ. He's an employee of the
18 hospital. That's what -- what I had mentioned
19 before with being responsible for patients.

20 Q. So what happened to her in relation to what
21 Dr. Varma did is Dr. Steele's responsibility, isn't
22 it?

23 A. I am not able to answer that.

24 Q. Why not?

25 A. Again, because I told you I don't -- the

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

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

8 A. Yes.

9 Q. Right.

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

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

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

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

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

25 He's subjecting her to surgery,

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

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

5 Q. How about standard of humanity?

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

9 Q. How about sometime afterwards?

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

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

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

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

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

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

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

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

7 A. Yes.

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

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

15 Q. Is there any notes by a physician?

16 A. There is no notes.

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

20 A. That is the way they communicate, yes.

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

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

25 Q. You don't?

1 A. Not always.

2 Q. Was there a doctor there?

3 A. I don't know. I have no way of knowing.

4 Q. What do you think?

5 A. I have no way of knowing.

6 Q. Well then, what do you assume?

7 A. There is nothing that I can assume. There is
8 no note there so I do not know a physician saw her
9 or not.

10 Q. So the absence of a note in your expert
11 review of the chart doesn't tell you anything,
12 right; it doesn't allow you to evaluate whether or
13 not appropriate care was given to the patient?

14 A. Correct.

15 Q. Well, let's assume that he saw her, was
16 anything done for her condition?

17 A. For that then I would like to look at the
18 order to see if any orders were written. I think
19 that would be the most reliable way of telling
20 that.

21 Back to the orders late on the
22 night of the 14th, do you have it handy or --

23 Q. You know what, you can look for it between
24 now and the time of trial or when we come back next
25 time, okay.

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

3 A. Yes, I will.

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

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

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

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

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

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

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

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

25 MR. COYNE: We're not

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

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

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

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

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

18 MR. KAMPINSKI: Just one more
19 thing.

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

24 MR. KNOPP: Objection.

25 MR. COYNE: Show an

1 objection.

2 A. I would not say that necessarily this
3 resident was having -- was failed to be trained.

4 Q. Do you mean --

5 MR. COYNE: Is this a
6 hypothetical?

7 A. Are you asking a hypothetical rather than --

8 Q. Absolutely. Sure.

9 MR. COYNE: What's the
10 question?

11 - - - - -

12 (Question read.)

13 - - - - -

14 MR. KAMPINSKI: See, she hasn't
15 rendered an opinion on that yet.

16 MR. COYNE: Well, I think
17 it's the jury who will determine the competence in
18 this particular case.

19 All I was asking, I think the
20 Doctor was wondering if you were talking about this
21 case or a hypothetical.

22 MR. KAMPINSKI: This case we
23 know that he had no idea what he was doing.

24 MR. FULTON: Objection.

25 MR. KNOPP: Objection.

1 Move that be stricken.

2 BY MR. KAMPINSKI:

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

8 MR. KNOPP: Objection.

9 MR. COYNE: Hypothetically.

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

14 MR. KAMPINSKI: Thank you.

15 MR. FULTON: All right.

16 Going back to the wires again here.

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

25 MR. FULTON: I can't just

1 sit here and get paid for doing nothing.

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

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

7 MR. KAMPINSKI: I object. Go
8 ahead.

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

11 -----

12 FURTHER RECROSS EXAMINATION

13 BY MR. FULTON:

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

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

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

23 MR. KAMPINSKI: Asked and
24 answered. Objection.

25 A. Is the question does University Hospital have

1 technologists or do I --

2 Q. University Hospital.

3 MR. COYNE: If you know.

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

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

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

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

12 A. Yes.

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

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

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

21 MR. COYNE: If you know.

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

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

1 A. Yes, sir.

2 Q. Have you inserted them in the radial line?

3 A. Yes.

4 Q. How about the femoral line?

5 A. Yes.

6 Q. A femoral line, what is the degree of
7 difficulty between a radial and a femoral
8 insertion?

9 A. I don't think I could prioritize as one more
10 difficult than the other.

11 Q. Do they use a different type of wire in each
12 instance?

13 A. The wires are longer in the femoral, but
14 other than length, I think in general it would be
15 the same.

16 Q. Why is it longer?

17 A. I think partially they're longer to be
18 certain that the path is clear for getting in the
19 sheath, which is what remains behind when the wire
20 is removed. The sheath is also longer. It is so
21 that it is more securely anchored.

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

25 In the femoral you can move and

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

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

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

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

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

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

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

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

21 A. Yes, on x-ray.

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

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

1 an x-ray.

2 MR. FULTON: No further
3 questions.

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

7 ----

8 CROSS-EXAMINATION

9 BY MR. KNOPP:

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

15 A. Yes.

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

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

21 Q. Are you familiar with any of these
22 instructions?

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

25 Q. But you would anticipate that anyone doing

1 this procedure would follow the instructions of the
2 manufacturer?

3 A. Yes.

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

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

10 Q. Yes. Very beginning?

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

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

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

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

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

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

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

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

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

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

10 Q. Is there anything unique about that
11 procedure?

12 MR. KAMPINSKI: Unique to
13 whom?

14 Q. To that particular procedure?

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

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

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

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

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

17 Q. Let me back up, if I may.

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

22 A. Yes.

23 Q. Do you teach that as well?

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

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

8 Q. You teach that?

9 A. Absolutely.

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

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

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

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

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

1 I object.

2 MR. KNOPP: You may ask
3 your questions later.

4 MR. KAMPINSKI: I object.

5 - - - - -

6 (Question read.)

7 - - - - -

8 Q. Do you want me to rephrase that?

9 A. I think I have it.

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

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

17 A. Yes.

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

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

1 Q. If all those things happened, you believe
2 someone would have been properly trained as long as
3 they have the mechanical ability then to do it?

4 A. Yes.

5 Q. There's some of talk here about whether or
6 not the appropriate medical standard would have
7 been met if someone didn't report this.

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

15 That's a convoluted question.

16 A. Yeah. I had most of that.

17 Q. Well, how would you -- if someone's training
18 a physician -- be able to tell whether or not he or
19 she is the kind of person that wouldn't -- that
20 would lose two wires and not report them?

21 A. I don't know that there is any way to predict
22 that. I think human nature, you evaluate people as
23 best you can.

24 MR. KNOPP: Thank you.

25 MR. COYNE: Are we through?

1 MR. FULTON: I have a
2 question.

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

5 MR. FULTON: You may
6 objec .

7 -----

8 FURTHER RECROSS-EXAMINATION

9 BY MR. FULTON:

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

14 A. I have no idea.

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

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

20 MR. FULTON: No further
21 questions.

22 -----

23 FURTHER RECROSS-EXAMINATION

24 BY MR. KAMPINSKI:

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

1 gives it to you?

2 A. Often you go to the supply cabinet yourself
3 and pick it out, or there's a nurse who's being
4 nice to you who might bring it.

5 Q. So the nurse brings them to you, then how
6 would they give them to you, is the kit closed, or
7 would it be opened, would they hand it to you?

8 A. They need to open it and expose the sterile
9 part that's inside for you to take out.

10 Q. So you as a physician, if that's what you do,
11 you don't stop to read the labels on the kit, do
12 you?

13 A. No. What I would do is look at the outside
14 of the kit to make sure they're opening the right
15 one, not the wrong one and wasted it. You can read
16 the headline. That's all I would read.

17 MR. KAMPINSKI: Thanks.

18 MR. COYNE: She'll read it
19 rather than waive signature.

20

21 - - - - -

22 (Deposition concluded; signature not waived.)

23 - - - - -

24

25

ERRATA SHEET

PAGE

LINE

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

CAROL M. BUCHTER, M.D.

1 The State of Ohio,
2 County of Cuyahoga.

CERTIFICATE:

3 I, Frank P. Versagi, Registered Professional
4 Reporter, Certified Legal Video Specialist, Notary
5 Public within and for the State of Ohio, do hereby
6 certify that the within named witness, CAROL M.
7 BUCHTER, M.D., was by me first duly sworn to
8 testify the truth in the cause aforesaid; that the
9 testimony then given was reduced by me to stenotypy
10 in the presence of said witness, subsequently
11 transcribed onto a computer under my direction, and
12 that the foregoing is a true and correct transcript
13 of the testimony so given as aforesaid. I do
14 further certify that this deposition was taken at
15 the time and place as specified in the foregoing
16 caption, and that I am not a relative, counsel or
17 attorney of either party, or otherwise interested
18 in the outcome of this action. IN WITNESS WHEREOF,
19 I have hereunto set my hand and affixed my seal of
20 office at Cleveland, Ohio, this 10th day of May,
21 1993.

22 
23 -----

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

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 PAGES

WORD RANGES @ BOTTOM OF 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

AI [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; 102:14; 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

appropriate [6] 26:17; 74:15; 86:11; 107:9; 108:13; 123:6
 appropriately [7] 72:22; 25; 75:10; 11; 76:22; 110:20; 112:5
 appropriateness [1] 87:12
 approximately [4] 40:5; 14; 99:22; 107:3
 apt [1] 123:12
 ARDS [3] 29:5; 37:1; 7
 area [3] 13:10; 91:7; 119:8
 aren't [1] 102:5
 argue [1] 57:12
 arguing [4] 57:10; 62:9; 12; 113:3
 argument [2] 52:25; 80:3
 arm [12] 42:22; 64:20; 66:23; 67:3,4, 6, 11, 13, 15, 16; 70:5
 arms [1] 67:5
 arranged [1] 38:20
 arrest [5] 31:8, 21, 25; 60:1; 83:8
 arrests [1] 31:12
 arrhythmias [1] 822:3
 Arrow [1] 114:20
 arterial [21] 24:11, 19, 21; 36:8; 24; 92:22; 93:1; 95:6; 110:21; 112:5; 113:15, 18, 22; 114:7, 11, 25; 117:12; 118:6; 119:23; 124:12, 17
 arteries [1] 119:21
 artery [8] 91:6, 10; 114:7; 115:22; 116:4, 7; 119:21, 22
 article [6] 16:11, 21; 30:4; 31:13, 17, 23
 articles [7] 6:15; 16:10; 28:19; 29:19; 30:14, 21; 80:18
 Ashland [1] 59:24
 asking [19] 5:15; 6:9; 11:1; 22:22; 24:14; 32:10, 12; 33:24; 35:6; 54:16; 72:9; 74:5; 82:9; 90:23; 105:3; 111:7, 19; 112:18
 aspects [1] 6:24
 aspirin [1] 45:7
 assess [1] 73:2
 assessment [1] 18:7
 assist [6] 18:15; 58:13; 74:16; 81:11; 84:24; 85:1
 Assume [1] 83:4
 assume [13] 6:23; 19:20; 26:1, 6; 51:15; 52:25; 63:6; 69:1; 95:3; 104:9; 108:6, 7, 15
 Assuming [1] 26:3
 assuming [2] 26:2; 118:20
 assure [1] 119:22
 Assures [1] 54:21
 assures [1] 54:19
 attack [20] 23:5, 9, 12, 15, 16, 17; 24:5, 6, 9, 12, 16, 20; 25:8, 12, 15, 21; 26:2, 8, 9; 86:18
 attacks [1] 28:17
 attempt [2] 42:18; 89:20
 attempted [1] 89:20
 attempts [1] 100:19
 attend [5] 25:20, 24; 26:4, 7; 33:13
 attendants [1] 37:5
 Attending [1] 106:10
 attending [11] 21:12, 16, 19; 23:1; 37:10; 64:3; 87:23; 88:2; 94:5; 104:7; 106:4
 attendings [1] 93:14
 attorney [3] 10:21, 24; 127:17
 attorneys [1] 79:15
 author [1] 28:9
 authoritative [2] 109:21; 110:4
 Automobile [1] 13:19
 automobile [2] 8:1; 13:1
 autopsy [2] 34:11, 15
 availability [1] 109:14
 available [2] 32:12; 83:19
 average [8] 79:5, 6, 10; 118:21, 22; 119:1

awake [7] 39:17; 40:17, 24; 55:23; 56:1, 7; 75:10
 awakening [2] 39:16; 46:23
 aware [10] 41:4; 81:17; 97:22; 98:7, 9; 114:5, 9, 13, 16

* * B * *

B-r-a-u-n-w-a-l-d [1] 28:9
 background [1] 110:11
 backwards [8] 39:4; 43:16; 44:25; 47:7, 15; 48:2; 58:21; 116:8
 balloon [5] 8:19; 14:17; 15:6, 11; 84:1
 Bamett [3] 9:22; 11:19, 25
 base [3] 28:4, 5; 35:20
 Based [1] 45:22
 based [15] 13:12; 27:23, 24, 25; 28:1, 2; 37:25; 43:11; 57:12, 13; 58:25; 80:22; 110:7, 10
 basement [1] 42:23
 bases [1] 27:22
 basis [1] 27:20
 bed [2] 68:7; 69:4
 bedside [1] 64:10
 Beg [1] 55:2
 beg [1] 29:1
 begins [2] 45:3, 4
 BEHALF [1] 4:2
 behalf [1] 80:1
 behind [2] 104:4; 115:19
 belief [2] 35:18, 21
 believe [26] 8:10, 22; 13:2, 13, 24; 16:17; 22:16; 27:19; 28:10; 31:14, 17; 39:16; 44:10, 13; 45:19; 50:10; 60:5; 62:6; 68:4; 87:10; 92:5; 96:12; 107:1; 112:22; 123:1, 11
 believed [1] 53:15
 Belong [1] 99:13
 benefit [1] 70:7
 besides [1] 124:16
 bit [4] 6:8; 49:25; 120:14; 121:7
 bleed [5] 33:12, 14, 25; 34:2, 3
 bleeding [1] 121:1
 blink [6] 42:21; 64:20; 66:18, 22; 67:6; 70:4
 blinks [1] 58:16
 block [3] 43:14; 65:21
 blockade [11] 39:19; 42:1, 6; 43:19, 20; 46:18, 23; 48:17; 64:11, 13; 70:3
 blockage [1] 72:7
 blocker [1] 65:15
 blocking [2] 9:21; 65:19
 blocks [2] 65:14; 71:5
 blood [23] 34:8, 17, 18, 19, 22; 35:2, 6, 18; 30:7, 16, 17; 61:9; 65:20; 84:10; 85:16, 19; 106:20, 24; 107:2; 116:4, 9; 119:23; 120:8
 Bob [1] 83:15
 body [4] 34:12; 64:24; 65:7; 86:2
 Bonezzi [1] 15:22
 book [4] 6:13; 28:14; 62:16; 96:4
 books [3] 93:12, 24; 96:7
 Boy [1] 11:1
 Brain [1] 56:12
 brain [16] 46:21; 51:22; 53:18, 19; 57:8, 10; 30:17; 63:9; 66:13; 622:4; 68:1; 78:5, 8, 10, 12; 79:7
 Braunwald [3] 28:7, 9; 31:14
 Breach [1] 91:17
 breathing [4] 68:8; 84:12, 19; 85:3
 briefly [3] 49:23; 65:2; 118:4
 wings [1] 125:5
 road [1] 23:2
 BUCHTER [4] 4:10; 5:1; 126:25; 127:7

Buchter [2] 5:11; 67:25
 Building [1] 4:6
 Bulkley [1] 4:6
 Butt [1] 124:4
 Button [1] 4:3
 bypass [2] 115:9; 84:1

* * C * *

C.I.C.U. [1] 22:8
 cabinet [1] 125:2
 Call [1] 105:24
 call [8] 59:25; 69:9; 70:9; 81:11; 87:14; 100:16; 101:4; 102:6
 calm [1] 69:23
 cancer [1] 18:10
 candidate [2] 83:4, 17
 capabilities [1] 40:19
 capability [1] 62:18
 capable [1] 74:2
 caption [1] 127:16
 Carafate [1] 45:5
 cardiac [13] 15:8; 19:5, 19; 31:8, 21; 36:8; 38:14, 15; 60:1; 82:11, 21; 83:8, 16
 Cardio [1] 16:19
 cardiologist [1] 18:14
 cardiologists [3] 20:11, 15; 99:23
 cardiology [20] 6:24; 13:9, 10, 11; 19:24; 21:11; 28:7, 11, 12; 42:13, 15; 48:8; 64:2; 81:18; 86:6; 88:23; 92:21; 94:19, 21
 care [35] 19:1, 2, 7, 19, 20; 20:8, 9, 12, 13, 20, 25; 21:2, 20, 21; 22:11; 26:18; 31:22; 36:9, 18; 37:5, 10; 87:19, 24; 89:13, 16, 25; 101:25; 105:6, 12, 13; 106:3, 11, 12; 107:10; 108:13
 cared [1] 20:16
 careful [2] 43:12; 45:22
 cares [1] 21:7
 CAROL [3] 5:1; 126:25; 127:6
 Carol [1] 5:11
 CAROLE [1] 4:10
 carries [1] 29:5
 case [51] 7:22, 24, 25; 8:1, 3, 7, 12, 14, 16, 17, 18; 9:20, 23, 25; 10:7, 22, 25; 11:4, 6, 9, 12, 18, 23; 12:17, 18, 24; 13:1, 2, 3, 4, 11, 14, 19, 21; 14:9, 11, 12; 15:16; 17:4; 37:17; 58:14; 78:14; 82:22; 88:2; 96:15; 99:18; 110:17; 111:18, 21, 22; 116:17
 cases [3] 19:2; 14:4; 88:23
 catheter [12] 91:6; 102:9, 12, 16, 22; 115:24; 116:1, 11, 14; 120:13; 122:22
 catheterization [1] 15:8
 caused [5] 25:1; 33:6, 8, 14; 35:8
 cc [1] 34:9
 Center [1] 89:6
 centimeter [1] 96:24
 certainty [1] 78:24
 CERTIFICATE [1] 127:2
 Certified [1] 127:4
 certified [1] 5:5
 certify [2] 127:6, 14
 chairman [1] 94:23
 change [8] 50:13, 22; 53:15, 17; 106:15, 16, 18; 107:2
 changed [2] 73:14; 106:25
 changes [3] 42:7; 107:4, 5
 hanging [1] 62:5
 chapter [1] 6:13
 charity [3] 40:10, 13; 74:18
 harms [4] 7:18; 8:15; 10:25; 15:15
 hart [16] 28:1; 37:24, 25; 38:1, 19, 23; 41:7;

43:12; 49:19, 21; 68:19, 21, 24, 25; 107:19; 108:11
charts [4] 14:6; 46:25; 103:5; 107:13
chest [2] 96:16, 24
chief [4] 6:3, 5; 94:18, 19
chose [1] 105:18
Chuck [1] 94:14
circulation [1] 86:3
circumstances [1] 26:15
cite [1] 28:14
City [1] 59:24
Civil [1] 54
clap [1] 58:17
clarification [3] 41:14; 90:23; 99:1
clear [2] 80:25; 115:18
Cleveland [6] 4:7; 5:12; 112:5; 124:11, 15; 127:20
Clinic [4] 117:5; 124:11, 15, 19
closed [1] 125:6
clot [1] 85:19
CLVS [1] 127:24
co-authored [1] 6:13
co-signed [1] 64:2
cognitive [1] 61:2
Combination [1] 37:14
combination [2] 23:14; 37:9
comfort [1] 70:9
comfortable [2] 69:22, 24
coming [9] 9:13, 14; 11:3; 49:22; 97:2; 116:8; 119:24; 121:7; 122:21
command [11] 42:22; 51:17; 52:20; 58:16; 64:21; 66:24; 67:3, 14, 15; 70:5; 77:14
commanded [1] 67:12
commands [25] 51:10, 11, 20; 52:5, 6, 18; 55:24; 56:2, 22; 59:7, 13; 61:24, 25; 62:7; 72:23; 73:13, 24; 75:10; 76:4, 5, 7, 9, 24, 25; 77:12
comment [7] 10:8; 13:8; 41:4; 51:5; 94:5; 102:1, 3
comments [5] 50:6; 51:1; 58:5; 73:12, 13
Commission [1] 127:25
committees [1] 99:11
common [2] 119:15, 19
communicate [6] 53:1, 21; 54:18; 73:4; 74:8; 107:20
communicates [1] 102:18
communicating [1] 54:5
comparison [1] 59:17
comparisons [1] 59:11
compelled [1] 110:1
competence [1] 111:17
completely [5] 44:18; 51:22; 53:11; 57:8, 9
complication [6] 8:19; 15:9, 10; 103:4, 6, 7
complications [3] 103:2, 15
computer [1] 127:11
concern [4] 49:8; 54:2; 60:9; 85:15
concerned [1] 66:25
Concerning [1] 15:6
concerning [1] 6:15
concerns [1] 85:17
conclude [3] 68:20, 22; 109:9
concluded [3] 68:20; 80:15; 125:22
conclusion [6] 28:13; 47:5, 13; 48:10; 49:14; 59:20
Concurrent [1] 10:11
condition [9] 19:12; 25:23; 37:2; 72:3; 73:14; 82:21; 105:22; 106:1; 108:16
conduct [3] 21:13; 22:4, 18
confinement [1] 109:20
confused [3] 72:22; 99:4, 8
confusing [3] 12:21; 100:19; 105:15

confusion [1] 104:13
conjunction [2] 19:10; 37:5
connection [1] 17:3
consensus [1] 86:12
consistent [2] 61:19; 78:2
consultant [1] 19:11
consultants [1] 51:24
consultations [1] 19:24
consulting [3] 87:23; 88:2, 6
context [3] 104:10; 105:4; 112:24
continue [7] 20:19; 21:2; 39:15; 48:3; 52:24; 77:19; 110:3
continued [1] 41
Continuing [1] 14:14
continuing [1] 94:9
contra-implicated [1] 107:24
contractual [1] 105:1
contractually [1] 105:3
contrar [1] 69:21
contrary [2] 75:14; 123:9
contributed [1] 23:15
contributing [1] 35:17
control [3] 16:12; 84:24; 85:1
convoluted [1] 123:15
Cook [1] 114:19
copy [3] 6:12; 60:3; 89:11
corneal [1] 58:17
counsel [1] 127:16
county [1] 1222
couple [9] 13:25; 16:9; 49:20; 63:3; 80:16; 88:18; 91:19; 109:2; 117:6
course [4] 81:25; 82:20; 84:18; 90:7
court [1] 11:15
courtroom [1] 12:5
cover [1] 104:3
covering [1] 103:22
COYNE [5] 14:13; 23:20; 30:20, 24; 33:17; 34:14; 35:9, 22; 36:1, 5; 41:13; 43:5; 46:5; 48:16; 49:11; 57:11, 16, 19, 23; 58:3, 7; 62:21; 63:23; 68:23; 70:21; 71:10; 73:17; 76:18, 20; 79:16, 22; 90:14, 22; 91:4; 92:7; 98:18, 21, 24; 99:5; 109:4, 12, 19, 25; 110:9, 15, 25; 111:5, 9, 16; 112:9; 113:2, 9; 114:3, 21; 116:19; 123:25; 125:18
Coyne [10] 7:11, 23; 11:4, 6, 9, 12:8, 24; 14:1; 17:13; 76:17
credence [2] 74:20, 21
CROSS-EXAMINATION [4] 5:8; 81:4; 82:7; 117:8
Cross-examination [4] 4:12, 13, 14, 18
cross-examination [1] 53
Cup [1] 9:17
curious [1] 101:23
currently [1] 93
curved [1] 97:3
Cuyahoga [1] 127:2
CV [2] 6:8; 78:19

* * D * *

daily [1] 106:10
damage [16] 15:11; 23:8; 24:5; 46:21; 63:9; 76:2; 78:1, 3, 5, 8, 12; 79:7; 82:25; 83:5, 18, 21
Data [1] 32:2
data [5] 32:12, 16; 37:24; 75:19; 76:2
date [7] 27:7, 9, 51:6; 55:25; 56:3; 70:19; 109:11
dated [1] 91:3
day [24] 21:5, 9, 27:4; 31:1; 39:23; 40:16; 45:24; 47:18; 55:10; 58:23; 62:10, 11, 16;

64:6; 73:19; 75:23; 76:14, 21; 84:15; 101:3; 106:12; 127:20
days [24] 21:1; 29:9; 30:13, 21; 39:20, 21; 43:15; 45:19, 20; 50:25; 60:10, 11, 12, 15; 61:10; 62:6, 7; 80:16; 82:15, 21; 83:2; 109:2
dead [7] 51:23; 53:18, 20; 57:8, 10; 67:25; 68:1
deal [2] 6:24; 30:18
dealing [3] 18:24; 37:1; 117:11
dealt [2] 37:2, 4
death [7] 9:24; 23:11, 15; 27:1; 33:14; 34:20; 35:17
decided [2] 53:19; 61:15
decisions [2] 21:20, 25
decreased [1] 107:4
decreases [1] 86:19
deemed [1] 95:13
DEFENDANT [1] 42
defendant [4] 14:8, 10; 15:4; 112:21
defendants [1] 15:2
defending [1] 85
defibrillated [1] 82:18
deficit [5] 18:24; 19:4; 38:18; 77:7, 24
define [2] 86:22, 23
Definitely [1] 96:2
definitely [1] 106:25
definition [2] 27:3; 98:11
definitions [1] 26:25
degree [7] 18:7, 13; 78:24; 84:13, 21; 115:6; 120:15
delayed [1] 100:2
demonstrated [2] 42:20; 66:7
denied [1] 76:23
denies [1] 77:11
deny [1] 75:18
department [3] 81:16; 88:23; 94:23
depend [1] 65:10
depending [2] 20:22; 72:11
depends [1] 18:8
depo [1] 110:3
Deposition [1] 125:22
deposition [13] 7:4, 10; 12:4; 14:5; 17:7; 30:22; 33:21; 57:20; 80:15; 93:19; 104:6; 109:15; 127:14
depositions [2] 7:5, 20
depressed [1] 42:20
derive [1] 38:17
desperately [1] 56:25
detail [2] 49:21; 50:1
details [4] 12:20; 13:22; 61:21; 84:25
detetmine [6] 17:25; 29:25; 30:5; 46:20; 79:1; 111:17
detetmines [2] 37:6, 11
determining [1] 74:16
develop [1] 85:18
deviation [2] 103:17; 107:9
diagnosis [1] 26:11
diagnostic [1] 69:24
die [10] 23:4, 8, 24:4; 32:25; 33:3, 7, 9, 34:22; 35:8; 45:19
died [9] 10:3; 23:7; 27:5, 12, 17; 33:4, 24; 35:16, 19
difference [3] 52:19; 76:13; 79:23
difficult [8] 41:1; 44:7; 73:2; 77:23; 83:20; 115:10; 121:14
difficulty [2] 30:18; 115:7
Dig [1] 45:7
direct [6] 23:17; 25:7, 11; 33:12, 25; 95:15
direction [1] 127:11
disagree [2] 33:10, 20
disagreement [1] 99:25

discharge [6]10:4; 32:10, 11, 13, 19, 24
 discharged [4] 32:5, 7, 15, 19
 discomfort [1] 76:24
 discomforts [1] 77:11
 discontinue [1] 45:13
 discontinued [2] 44:10; 46:10
 discovery [1] 102:6
 Discuss [1] 43:8
 discuss [1] 91:11
 discussed [1] 69:12
 discusses [1] 28:15
 discussing [1] 62:15
 disease [5]3:3, 4; 18:17; 19:5, 6
 dislodge [2]15:24; 116:1
 distant [1] 14:4
 distinct [1] 67:2
 distress [3]28:15; 29:20; 33:1
 division [2]59:23; 94:19
 Djordjevic [1] 15:22
 Doctor [35] 5:13, 24; 6:7; 7:1; 18:5; 23:11;
 24:22; 25:21; 31:13; 33:3; 36:9; 43:5; 45:12;
 17; 46:8; 48:11; 49:18; 51:25; 52:23; 55:5;
 59:19; 62:14; 71:15; 74:19; 75:14; 78:22; 82:9;
 87:18; 99:9; 105:16; 106:19; 107:17; 109:2;
 111:20; 117:4
 doctor [10] 20:20; 24:21; 25:1; 44:21; 63:6;
 80:16; 89:17; 108:2; 109:14; 112:22
 doctors [10] 20:1; 21:4; 73:8; 74:22, 23;
 76:12; 78:18; 90:24; 102:1; 110:16
 document [2] 93:25; 94:20
 documented [1] 60:15
 documents [3]7:5; 109:16, 18
 Doesn't [1] 77:17
 doesn't [18] 6:23; 20:4; 31:13; 36:21; 43:24;
 44:3; 58:16; 64:1, 5; 68:7, 8; 69:4; 93:21;
 108:11, 12; 112:4; 122:11
 Doll [5]2:21; 64:19; 66:7, 17; 70:4
 dolls [1] 66:11
 doubt [2]27:11, 13
 Dr [29] 22:17, 18; 25:14; 33:10, 21; 37:16;
 64:3; 67:25; 78:16, 17; 80:1; 97:15; 98:16, 19,
 22; 99:1, 9, 24; 102:8, 23; 104:9, 14, 21;
 105:10, 12, 18
 drip [2]43:9; 69:14
 Drowsy [2]44:5, 6
 drug [1] 65:8
 due [3]24:5; 63:8, 9
 duly [2]5:5; 127:7
 duties [2]9:10, 15
 dysfunction [1] 54:2

* * E * *

early [1] 84:1
 early-on [1] 104:5
 easier [1] 47:24
 easiest [1] 86:23
 easily [1] 120:3
 easy [1] 71:15
 edema [1] 77:20
 editorial [1] 58:5
 education [1] 110:10
 effect [3]5:14; 66:3
 effective [1] 84:1
 effort [1] 76:25
 efforts [1] 77:12
 elective [8] 86:13, 20, 22, 25; 87:3, 7, 9;
 98:11
 elsewhere [1] 85:19
 emergency [2]5:7; 59:23
 employ [5] 93:12; 104:17; 113:14, 16; 114:6

employed [1] 112:21
 employee [5]21:24; 87:20; 98:23; 99:7;
 104:17
 EMS [1] 59:25
 end [13] 39:14; 47:23; 52:1; 97:8, 10, 11;
 116:23, 24; 119:24; 120:12; 121:5; 122:22
 enjoy [1] 61:4
 entitled [2]10:2, 3
 environment [1] 61:6
 episode [1] 60:16
 equal [2]56:19
 equate [1] 40:19
 equipment [3]90:3; 121:19, 20
 ERRATA [1] 126:1
 Esq [2]4:3, 4
 essentially [2] 60:9; 84:18
 evaluate [4]77:23; 108:12; 123:22
 evaluated [4]106:17, 23; 107:6, 13
 evaluation [2]74:21, 22
 evening [1] 26:16
 event [2]34:7; 78:6
 events [3]23:18; 26:16, 21
 Eventually [1] 86:2
 eventually [1] 85:22
 Everybody [2]3:21; 98:9
 everybody [2]79:6
 evidence [2]59:5; 123:9
 exact [4]6:21; 27:7, 9; 84:25
 Exactly [4]56:17; 90:6; 95:20; 96:2
 EXAMINATION [1] 113:12
 examined [1] 5:6
 example [3]24:10; 86:23; 95:5
 exceedingly [2]29:6; 31:7
 exceeds [1] 29:7
 Except [1] 116:19
 exclusion [1] 74:23
 Excuse [3]50:19; 93:16; 94:8
 excuse [1] 59:21
 excused [1] 94:12
 exhausted [1] 74:25
 exhaustive [1] 71:24
 EXHIBITS [1] 4:22
 existence [1] 98:14
 expect [1] 92:25
 expectancy [5]10:19; 13:12; 78:22, 23; 79:4
 experience [8]27:23; 28:3; 36:6, 21, 23;
 114:24; 119:3; 123:11
 expert [11] 10:12; 59:20; 61:15; 98:19, 24;
 99:1, 2, 8; 103:13; 108:10; 109:20
 experts [2]7:11, 14
 expiration [1] 127:25
 explain [2]120:5, 7
 expose [1] 125:8
 extent [5] 18:16; 29:23; 80:15; 85:4; 88:12
 extraneous [1] 115:23
 extremities [4]56:8; 57:4; 60:14; 62:1
 extremity [1] 56:15
 eye [2]56:17; 70:4
 eyes [20] 42:21; 51:16; 52:20, 21; 55:8;
 58:16; 60:13; 61:11; 62:10; 64:20; 66:7, 11,
 12, 13; 67:6; 72:24; 76:23; 77:10; 122:25

* * F * *

facetious [1] 41:4
 fact [15] 6:18; 24:18; 26:8; 59:15; 61:9; 63:4;
 72:14, 21; 74:2; 78:3; 93:8; 97:22; 104:3;
 114:13; 120:20
 factor [2]3:2; 35:17
 factors [3]23:7; 48:11; 79:3
 Factual [1] 10:16

failed [4]87:23; 101:15; 111:3; 112:7
 Failure [1] 16:23
 failure [12] 6:15, 16, 20; 16:12, 20; 25:19;
 28:16; 29:8, 21; 33:13; 107:8; 110:20
 fair [4]8:25; 21:18; 95:10; 123:8
 familiar [1] 117:21
 family [1] 41:1
 fashion [1] 53:8
 fast [2]86:7, 10
 February [14] 23:5, 10; 47:6; 51:2; 52:3;
 60:11; 71:9; 72:2, 8; 73:11; 76:19, 20; 102:9,
 23
 feel [1] 119:21
 fellow [1] 92:7
 Fellows [3]21:11; 92:21; 94:22
 femoral [18] 91:5, 10; 95:6; 113:15, 17, 22;
 114:7, 11; 115:4, 6, 7, 13, 25; 116:3; 117:12;
 118:6; 124:12, 17
 fib [1] 31:9
 fibrillation [1] 31:12
 figure [3]46:8; 58:2; 99:6
 find [16] 30:14; 38:19, 22; 39:8; 41:6, 16;
 50:2, 16; 51:6; 52:11; 55:12; 63:20, 25; 70:23;
 77:8; 107:2
 finding [2] 66:14, 75
 findings [3]55:6, 7; 58:12
 finds [1] 30:16
 Fine [1] 41:17
 fine [6]55:15; 62:9, 10, 11; 76:5; 95:8
 finger [2]53:5; 77:13
 fingers [2] 76:25; 77:12
 finish [1] 40:7
 fire [1] 59:23
 firm [1] 17:13
 firms [1] 7:12
 First [3]27:23; 95:11; 117:16
 first [25] 5:5; 24:16; 27:25; 40:14, 16, 22;
 49:15; 52:8, 10; 53:9; 82:15; 83:1, 23; 86:8,
 17; 92:17; 105:4; 116:6; 118:13, 17, 18; 119:2,
 6; 127:7
 five [2]67:24; 94:15
 five-minute [3]42:18; 66:4, 6
 Flight [2]59:21, 22
 flip [1] 47:24
 Floor [1] 4:6
 flow [4]60:17; 116:8, 10; 119:23
 Fluoroscopy [1] 89:8
 fluoroscopy [2]39:2, 5
 fluorscopy [3]39:7, 24, 25
 focal [1] 42:6
 follow [8]51:20; 58:16; 59:7, 13; 62:6; 73:24;
 76:7; 118:1
 follow-up [2]105:23; 109:11
 followed [5] 73:12; 76:4, 5, 9, 105:21
 following [7] 9:25; 10:4; 15:7; 61:24, 25; 72:7,
 23
 Follows [1] 56:22
 follows [10] 5:6; 51:9, 11; 52:5, 6, 18; 55:23;
 56:2; 76:24; 77:11
 foot [1] 89:10
 force [1] 120:15
 foregoing [3]126:21; 127:12, 15
 foreign [2]36:2; 92:1
 forget [1] 17:20
 form [1] 37:25
 formal [1] 81:12
 formulating [1] 58:13
 Fortaz [1] 45:8
 forth [4]54:1; 80:19; 88:12; 113:4
 forward [2]47:16, 25
 found [3]51:19; 90:4, 17

Foundation [1] 124:11
Four [1] 45:21
four [4] 7:7; 29:9; 45:19; 83:2
fourth [1] 118:16
Franey [2] 12:16; 13:3
Frank [2] 127:3, 24
frankly [1] 30:17
front [2] 38:23; 76:17
full [1] 20:23
FULTON [43] 17:22; 22:24; 24:13, 23; 25:2; 33:15; 43:3; 79:14, 20, 25; 80:5, 8, 11, 25; 81:5; 82:4; 85:8, 25; 88:5, 17, 21; 91:1, 13; 92:4; 96:20; 97:25; 98:5; 102:11, 15, 19, 25; 103:12, 23, 25; 111:24; 112:15, 25; 113:13; 117:2; 124:1, 5, 9, 20
Fukon [9] 4:3, 5, 13, 15, 17, 19; 80:23; 91:16; 97:24
function [8] 43:2; 53:21, 24; 56:14; 61:2; 71:22; 75:21; 83:25
functioning [2] 62:13; 76:6
functions [2] 42:24; 85:2

*** * G * ***

Gallagher [1] 4:5
gather [2] 80:17; 117:12
Gave [1] 66:6
gave [8] 21:23; 64:10, 16, 25; 65:2, 25; 71:23; 72:1
gentleman [1] 92:5
germane [2] 70:23; 72:2
gets [5] 6:21; 39:15; 68:7; 80:13; 110:1
GI [2] 41:12; 42:4
Give [1] 9:9
give [13] 14:18, 20; 27:7, 9; 41:16; 51:17; 64:13; 65:13; 70:2; 74:20, 21; 109:4; 125:6
Given [3] 55:1, 3, 6
given [13] 7:10; 42:16; 45:11; 63:11, 13; 71:8, 12; 72:6; 83:25; 87:19; 108:13; 127:9, 13
gives [1] 125:1
Giving [1] 7:4
giving [4] 69:23; 70:8; 87:1, 4
goes [5] 67:5; 115:23; 116:14; 120:3; 122:15
gotten [2] 26:20; 83:14
graduated [1] 40:4
great [3] 30:18; 60:9; 78:24
greatest [1] 54:2
grossly [1] 51:7
guess [7] 18:9; 20:24; 54:16; 63:2; 74:11; 100:21; 101:23
Guide [1] 25:17
guide [14] 24:11, 15, 19; 25:5, 13, 16, 17; 26:13; 91:6; 116:3, 11, 13, 14; 121:11
guy [1] 104:16

*** * H * ***

Half [1] 42:3
halfway [2] 41:24; 42:4
hand [5] 121:1, 3, 19; 125:7; 127:19
hands [2] 77:15, 20
handy [1] 108:22
happens [3] 68:13; 83:22; 105:11
happy [2] 5:17; 30:10
hard [6] 17:1; 12:20; 29:25; 41:6; 86:7, 10
hardest [1] 121:17
harm [1] 85:11
hasn't [1] 111:14
haven't [2] 17:7; 92:11
head [7] 5:22; 15:24; 29:14; 66:11; 72:22; 75:11; 76:22

headline [1] 125:16
healthy [3] 34:20, 23; 35:12
Heart [1] 16:23
heart [41] 6:15, 16, 20; 8:2, 4; 16:12, 20; 18:17, 18; 19:12; 23:5, 9, 12, 15, 16, 17; 24:5, 6, 8, 12, 15, 20; 25:8, 12, 14, 21; 26:2, 8, 9; 28:16; 42:14; 61:10; 79:8; 82:24, 25; 83:5, 18, 20; 86:18; 106:20
heavily [5] 50:5, 11, 19, 23; 51:2
Heights [1] 5:12
help [2] 26:12; 48:21
Helpful [1] 48:24
helpful [2] 48:22, 25
helps [1] 49:14
Heparin [1] 45:6
hereby [1] 127:5
herein [1] 5:2
hereinafter [1] 5:5
hereunto [1] 127:19
hierarchal [1] 22:5
high [3] 29:6; 53:22; 97:20
higher [4] 53:20, 24; 68:11; 76:6
hired [1] 98:24
hires [1] 99:8
hold [7] 19:16; 52:1; 87:18; 88:10; 120:21; 122:14, 15
holding [1] 122:19
Holland [5] 33:10, 21; 97:15; 98:16; 99:9
hollow [1] 116:6
home [3] 22:14; 101:7, 9
honestly [2] 13:6; 52:22
hope [3] 54:11, 13; 81:25
Hopefully [1] 22:24
Hospital [7] 6:5; 16:16; 74:18; 81:14; 113:21, 25; 114:2
hospital [47] 10:4; 20:23; 22:7; 23:13; 25:19, 24; 26:3, 6, 9, 10; 27:16, 17, 19; 31:8, 11, 21, 25; 32:1, 3, 4, 5, 7, 9, 10, 11, 13, 19, 23; 35:14, 19; 39:2; 82:16; 83:2, 10, 11, 15; 87:20; 94:2; 96:6; 98:16, 23; 101:10; 104:14, 18; 105:2
hospitalization [3] 38:25; 82:13, 16
Hospitals [2] 5:24; 81:6
hours [5] 21:5, 9; 27:2; 83:23, 24
house [1] 107:11
human [1] 123:22
humanitarian [1] 106:11
humanity [1] 106:5
humor [1] 70:24
hundred [1] 49:20
Hupp [2] 9:18; 15:20
husband [1] 40:25
hypothetical [4] 111:6, 7, 21; 112:10
Hypothetically [1] 112:9
hypothetically [1] 52:23

*** * I * ***

I'd [2] 30:25; 63:6
I've [2] 94:14; 120:20
I.C.U. [7] 19:10, 11, 12, 14, 15; 69:5; 105:22
I.V. [1] 119:18
iatrogenic [1] 25:1
iatrogenic [1] 24:12
idea [2] 111:23; 124:14
image [1] 89:8
imagine [1] 89:10
immediately [1] 106:7
impact [2] 73:1; 74:6
impaired [2] 61:1; 77:4
implii [1] 68:6

implii [3] 31:4; 32:14; 39:17
importance [1] 122:19
important [5] 37:19; 39:1, 7; 47:22; 63:10
impossible [1] 53:11
improbable [1] 123:13
improve [1] 83:25
improved [2] 82:22; 84:13
improvement [1] 70:4
improving [4] 38:10, 12; 84:3, 16
inabillii [2] 24:21; 25:22
inadvertently [1] 36:24
inappropriate [1] 22:2
inch [1] 121:6
include [2] 36:21, 23
Includes [1] 79:7
includes [3] 45:5; 79:7, 8
inclusive [3] 6:25; 69:1, 8
inconsistent [2] 62:3; 78:1
increases [1] 86:18
INDEX [1] 4:24
indicated [4] 78:19; 86:11; 87:6; 104:1
individual [4] 88:25; 94:24; 114:14; 123:10
individuals [2] 81:7, 13
infected [1] 85:20
infection [1] 119:9
infer [1] 68:11
inferred [1] 67:20
inferring [1] 68:17
information [2] 38:17; 50:15
initial [2] 82:16; 83:7
initially [1] 82:18
inquire [1] 80:20
insert [8] 113:15, 17, 22; 114:6; 116:6; 118:6; 121:10; 124:16
inserted [6] 15:7; 91:5; 114:25; 115:2; 116:9, 11
insertion [6] 8:19; 15:11; 115:8; 116:5; 117:11; 124:12
inserts [1] 116:3
inside [2] 81:20; 125:9
instance [4] 89:23; 101:6; 115:12; 119:17
institution [3] 110:22; 112:6, 10
institutional [1] 113:16
institutions [1] 114:5
instruct [2] 119:6; 120:1
instructions [4] 117:17, 22; 118:1; 120:18
insult [3] 60:8; 61:7; 75:25
intact [1] 51:7
intend [1] 80:14
intensive [9] 19:1, 2, 7, 19, 20; 31:22; 36:9; 37:5, 10
interact [1] 61:6
interest [2] 6:17, 21
interested [1] 127:17
Intermittently [1] 76:10
intermittently [5] 76:7, 9, 10, 11, 13
intern [1] 118:18
internal [2] 18:20; 92:20
interpret [3] 43:1; 64:19; 70:15
interpretation [1] 68:24
interrupted [1] 119:5
intra-aortic [1] 15:6
intra-operatively [1] 33:13
intravenous [1] 119:18
introduced [1] 119:9
involved [5] 10:12, 14; 29:7; 51:25; 78:13
involvement [4] 10:7; 13:7, 9; 88:3
involves [1] 114:7
involving [1] 11:23
isolate [1] 33:5

* * J * *

Jackson [1] 15:18
 Jacobson [7] 7:14, 15, 16; 8:24; 9:15; 13:2; 16:2
 January [2] 8:25; 29:2
 Jeff [1] 11:23
 JMR [3] 39:11; 41:11; 49:1
 job [2] 102:9, 24
 jobs [1] 94:20
 jog [1] 87:2
 John [2] 7:21, 23
 journal [2] 16:16, 19
 judgment [3] 7:14; 100:15; 101:4
 July [1] 6:4
 jumped [1] 69:4
 June [1] 6:4
 Junior [2] 52:9; 56:1
 junior [19] 39:5, 25; 40:3, 18, 19, 21; 41:18; 43:12; 45:24; 46:2, 14, 16, 22; 47:2; 48:15; 50:3; 59:14; 63:15; 73:15
 jury [1] 111:17

* * K * *

Kalut [5] 8:24; 9:16; 14:1; 15:23; 16:3
 KAMPINSKI [69] 5:9; 22:25; 23:23; 24:25; 25:4; 30:15, 23; 33:19; 34:16; 35:11, 24; 36:1; 46:7; 49:13; 57:18, 21, 25; 58:6, 10, 11; 63:2; 76:16, 19; 79:12; 80:2, 6, 10, 12; 81:2; 83:12; 86:19, 15; 88:9, 11; 91:15, 19, 24; 92:10; 93:2; 94:11; 96:22; 97:24; 98:2, 20, 22; 99:3, 7; 102:13, 1; 109:6, 10, 17, 23; 110:6, 13, 18; 111:14, 22; 112:2, 14, 17; 113:7, 23; 119:12; 121:24; 122:4; 124:3, 24; 125:17
 Kampinski [4] 4:12, 16, 20; 82:9
 keep [10] 35:4; 69:23; 74:11; 84:9; 93:24; 94:1; 98:2; 101:9; 122:25
 keeping [2] 11:22; 42:19
 keeps [4] 5:11; 121:1, 2
 KEYWORD [1] 4:24
 kinds [1] 85:1
 kit [5] 17:20; 124:25; 125:6, 11, 14
 Kitchen [1] 78:16
 kits [4] 14:10, 17; 117:17; 122:15
 knee [2] 87:1
 Knock [1] 48:6
 KNOPP [12] 93:16, 22; 94:8, 13; 109:8; 110:24; 111:25; 112:8; 117:4, 9; 122:2; 123:1
 Knopp [2] 18; 117:5
 knowing [5] 30:1; 40:12; 108:3, 5; 123:13
 knowledge [2] 14:4, 8

* * L * *

labels [1] 125:11
 lack [1] 63:8
 lady [1] 78:4
 large [4] 9:9; 34:6; 61:6; 110:6
 last [4] 7:12; 49:25; 94:14; 117:10
 lasting [1] 65:8
 late [2] 2:1; 108:21
 latter [1] 38:24
 lawful [1] 5:2
 lawyer [2] 7:17; 40:24
 Lawyers [1] 41:3
 lawyers [1] 41:5
 lead [1] 109:18
 leafing [1] 76:15
 learn [1] 69:25
 learned [2] 9:25; 70:5

learning [1] 70:25
 leave [2] 22:11; 22:16
 leaving [2] 5:15; 70:7
 leg [1] 15:12
 Legal [1] 127:4
 legal [1] 22:20
 legalities [1] 22:23
 legibly [1] 54:6
 length [1] 115:14
 lethargic [1] 51:8
 lets [1] 18:3
 letter [2] 54:1; 92:4
 letters [4] 3:2, 5, 6; 54:6
 level [9] 42:24; 53:20, 22, 24; 60:13; 62:12; 13; 84:10; 92:25
 levels [5] 9:16; 61:3, 4; 92:18, 19
 Life [2] 59:21, 22
 life [10] 10:19; 13:12; 61:4; 78:22, 23; 79:4; 87:5, 6; 98:12
 light [2] 56:19; 105:21
 limit [1] 100:21
 limited [1] 77:19
 limiting [1] 18:9
 LINE [1] 126:2
 line [16] 24:22; 41:12; 52:8, 10; 83:21; 93:1; 94:9; 95:6; 110:21; 112:5; 114:10, 11; 115:2, 4, 6; 118:6
 lines [13] 92:23; 94:17; 113:15, 18, 22; 114:7, 15, 25; 117:12; 124:13, 17, 18, 25
 list [9] 6:22, 25; 45:3, 9; 68:6, 13; 69:1, 8; 71:24
 listed [3] 5:19; 68:9, 12
 liening [1] 60:2
 literature [1] 27:24; 28:2, 4, 18; 29:11, 17; 30:16; 31:23; 35:20, 23; 36:2
 live [5] 18:1, 3, 16; 32:23; 87:3
 log [2] 4:3; 96:6
 logged [1] 96:4
 longitudinal [1] 59:16
 looks [3] 9:9; 41:21; 46:13
 lose [5] 4:21; 35:2; 103:19; 122:24; 123:20
 loss [3] 34:18; 35:6, 19
 lot [5] 1:1; 36:7; 78:10; 102:4, 5
 lots [2] 8:12; 87:1
 low [3] 2:23; 62:9, 12
 lowers [1] 92:7
 Lynn [1] 4:4

* * M * *

M.D. [5] 4:2, 10; 5:1; 126:25; 127:7
 Ma'am [1] 75:15
 ma'am [6] 34:4; 38:18; 46:12; 58:14; 77:1, 18
 MAE [1] 77:22
 main [1] 84:7
 maintain [1] 120:8
 maintained [1] 31:21
 major [2] 5:15; 96:12
 majority [3] 9:3; 84:19; 119:2
 malpractice [6] 8:18; 9:24; 12:18; 131:2, 21
 management [1] 22:6
 manner [4] 5:7; 81:8; 106:16, 18
 manufacturer [3] 6:21; 117:18; 118:2
 manufacturers [3] 14:14, 19, 23
 March [16] 26:16; 27:8; 39:5; 40:3; 41:14, 15; 45:3, 4; 48:16; 49:1; 50:11; 60:10; 73:11; 87:9; 90:24
 MARKED [1] 4:22
 markedly [1] 106:22
 Marty [1] 12:16
 material [3] 30:5; 31:3; 117:19

materials [2] 30:21, 22
 matter [6] 6:18; 38:2, 5; 44:16; 80:20; 93:21
 matters [1] 109:16
 Maynard [7] 7:14, 15, 16; 8:24; 9:15; 13:25; 16:2
 mean [31] 6:23; 7:4; 10:12; 11:5; 12:9; 20:4; 22:17; 24:4; 29:3; 32:19; 51:13, 18, 20; 54:13, 22; 73:25; 74:10; 75:12, 18; 84:24; 85:3; 87:25; 88:7; 89:15; 96:17, 20; 97:1; 103:3; 105:23; 111:4; 121:24
 meaning [1] 60:16
 meaningful [3] 54:3, 19, 23
 Means [1] 51:22
 means [9] 25:1; 39:19; 40:4; 51:15; 52:22; 77:21; 80:14; 89:6; 97:2
 meant [1] 24:6
 measure [2] 1:6; 70:9
 measurements [1] 106:21
 mechanical [2] 84:23; 123:3
 medical [56] 8:18; 9:24; 18:19; 22:21, 22; 39:6, 25; 40:3, 4, 18, 20, 21, 22; 41:2, 3, 5, 18; 43:8, 12; 45:25; 46:2, 14, 17, 22; 47:2; 48:15; 50:4; 52:9; 56:1; 59:14, 24; 60:25; 63:15; 68:5; 69:12, 18; 73:15; 86:11; 89:17, 18; 103:11, 14, 24; 104:2, 4; 106:12; 113:14, 21; 114:6; 118:15, 16; 119:4; 123:6; 124:11, 16
 medically [1] 86:10
 medicated [1] 63:4
 medication [23] 39:20; 42:19; 45:2, 5, 10, 15; 62:20, 22, 23; 63:8, 11; 64:10, 17, 25; 65:2, 14; 67:24; 69:9; 71:6, 20; 72:5, 11, 17
 medications [1] 71:24
 medicine [17] 17:24; 18:2, 6, 12, 21; 64:13; 65:19, 24; 66:1, 3, 6; 70:2, 12, 13; 92:20; 94:22, 23
 medicines [1] 30:2
 meet [2] 7:24; 120:3
 meetings [1] 99:15
 MELLINO [1] 92:11
 members [2] 23; 41:1
 mental [1] 71:21
 mention [1] 120:20
 mentioned [5] 9:5; 11:18; 14:17; 16:9; 104:18
 metabolii [1] 65:11
 metabolize [4] 4:25; 65:7, 16, 19
 method [1] 82:2
 MI [3] 86:8, 14; 99:20
 Michelson [1] 5:11
 middle [2] 30:14; 67:17
 Mild [1] 16:22
 mild [1] 16:20
 milligrams [2] 2:16, 17
 mind [4] 3:16, 17; 60:7; 99:6
 minimal [6] 4:19; 66:14, 15, 19; 68:10; 69:9
 minimally [3] 43:1; 49:2, 7
 minimized [1] 73:23
 Minor [1] 57:7
 minor [3] 9:17; 57:6; 120:15
 minute [7] 9:9; 14:23; 41:16; 52:12; 61:12; 69:13; 80:10
 minutes [4] 30:6; 61:9; 67:24; 117:11
 minutiae [1] 60:13
 missed [1] 94:14
 missing [2] 4:15; 106:21
 mission [2] 8:1, 8
 Moasis [1] 25:14
 Moderate [1] 16:22
 moderate [2] 16:20; 34:8
 modem [1] 86:6
 monitor [1] 102:20
 month [3] 30:24; 23:13; 60:12

months [13] 19:17, 25; 20:15, 19; 29:3; 40:5; 86:8, 17; 99:22; 100:3; 101:2, 9
Moore [1] 4:4
morning [2] 11:21; 50:1
mortality [4] 27:1; 29:6, 7, 9
motion [3] 67:8, 9; 115:23
movable [1] 66:12
Move [3] 67:13, 15; 112:1
move [7] 56:15; 67:4, 5, 11, 16; 94:6; 115:25
Moved [1] 67:2
moved [3] 42:21; 64:20; 67:8
moves [3] 56:7; 57:4; 67:6
moving [5] 60:14; 61:11; 62:1; 66:23; 70:5
Mrs [15] 22:19; 23:4; 25:16, 20; 26:13; 27:5; 40:9; 82:10; 85:7; 87:9, 19; 88:4; 100:4; 102:22; 105:11
multiple [2] 29:20; 33:4
multitude [3] 23:7; 27:22; 28:16
muscle [4] 82:24; 83:5, 18, 21
muscular [1] 44:3
myself [2] 12:22; 58:2

*** N * ***

name [23] 5:10; 6:20; 7:22, 24; 8:7, 14; 9:13, 20, 22; 11:5, 10; 13:14; 14:12, 18, 20, 25; 16:4, 21; 17:17; 72:24; 76:23; 77:10; 117:4
named [2] 79:20; 127:6
names [7] 9:14; 11:2, 22; 28:20, 23; 29:19, 22
nature [7] 7:25; 8:1, 3, 17; 13:4, 7; 123:22
needle [8] 116:7, 9, 13; 119:22, 25; 120:2, 10
needs [1] 80:17
negatives [1] 68:6
negligence [1] 110:22
negligent [2] 88:3, 14
neighborhood [1] 28
Neostigmine [1] 42:17
Neuro [2] 51:7; 52:2
neuro [16] 41:24; 42:3; 50:8, 11, 13, 16, 17, 21, 23; 55:17, 18, 19, 21; 56:2; 57:3
neurologic [24] 15:11; 18:24; 38:18; 39:22; 42:24; 43:1; 44:2, 17; 50:9; 51:1, 5; 53:21; 54:2, 11; 55:6, 7; 60:8; 62:5, 9; 66:15; 75:25; 76:6; 77:7; 78:1
neurological [15] 19:4; 50:6; 51:19, 24; 55:4; 58:12; 60:18; 66:14; 71:22; 72:11; 74:3, 17; 75:2, 21; 78:3
neurologically [2] 42:20; 77:3
neurologist [4] 58:15, 20; 59:10, 12
Neurology [1] 50:3
neurology [9] 39:15; 48:13, 14; 49:2; 50:2, 7; 55:8; 58:22; 76:1
Neuromuscular [1] 48:17
neuromuscular [13] 39:18; 42:1, 6; 43:14, 19, 20; 46:17, 23; 50:4; 64:11; 65:4; 71:5; 72:6
neuromuscularly [1] 71:22
newspaper [1] 68:16
nice [1] 125:4
night [2] 49:25; 108:22
NIH [1] 91:6
nine [1] 46:12
Nitroglycerin [1] 45:6
nobody [1] 36:11
Nocuron [1] 69:15
nodded [1] 75:11
nodding [1] 72:22
Nods [1] 76:22
nods [1] 5:21
nonexistent [1] 97:16
nonmedical [1] 60:23
nonpurposeful [1] 67:9

nonresidents [1] 88:7
normal [2] 83:3; 119:16
normalize [1] 82:25
normalied [1] 83:1
normally [1] 118:13
Norman [1] 4:5
Notary [2] 127:4, 24
note [36] 39:6, 13, 14, 22; 40:11, 14; 41:11; 42:13, 15; 45:25; 46:2, 15, 17, 22; 47:10; 48:8, 14, 23, 25; 49:1; 50:2, 3, 16; 58:15, 21; 59:13; 63:11, 24; 64:4; 69:11; 70:15; 89:19; 90:1; 91:3; 108:8, 10
noted [1] 113:10
notes [30] 38:21, 22; 43:4, 6; 44:21; 46:24; 47:2, 4; 49:15; 50:6, 9; 51:4; 58:25; 59:10, 19; 61:13, 21; 63:16, 22; 72:19; 73:10, 15; 75:6, 23; 77:1; 90:24; 103:5; 107:15, 16, 18
noxious [2] 49:2, 7
Number [1] 91:5
number [11] 5:15; 8:10; 12:19; 13:5; 51:24; 93:25; 94:2, 24; 98:15; 112:22, 23
numerous [1] 68:9
Nurse [1] 42:8
nurse [3] 64:16; 125:3, 5
nurses [14] 61:13, 19, 21; 72:19, 21; 73:6; 74:1, 14, 20, 22; 75:6, 23; 76:4, 8
nursing [1] 107:11
nutrition [2] 41:12; 42:4

*** O * ***

o'clock [1] 46:12
oath [2] 43:11; 98:1
object [12] 80:12; 83:12; 85:25; 86:10; 88:11; 92:1; 112:19; 113:7; 122:1, 4; 124:4, 6
objecting [2] 80:24; 98:3
OBJECTION [1] 4:24
Objection [14] 24:13; 33:15, 16; 85:8; 88:9; 102:11, 25; 103:12, 23; 110:24; 111:24, 25; 112:8; 113:24
objection [12] 14:14, 15; 25:3; 68:24; 86:16; 88:6; 93:17, 23; 94:9; 98:19; 111:1; 113:9
observation [1] 75:1
observe [1] 42:8
observed [1] 64:17
occasion [1] 81:10
occasions [1] 81:20
occur [1] 95:10
occurred [3] 23:5, 18; 26:16
occurs [1] 104:7
offer [1] 20:16
office [9] 7:11; 12:8, 12, 13, 24; 13:17; 14:1; 30:14; 127:20
Oh [1] 69:21
Ohio [6] 4:7; 5:4; 127:1, 5, 20, 25
Okay [9] 5:23; 12:25; 30:23; 34:16; 39:9, 14; 42:14; 77:19; 95:2
okay [4] 22:9; 39:8; 91:10; 108:25
old [4] 71:13; 78:20; 79:4, 11
oncologist [1] 18:11
ones [1] 120:20
open [3] 51:15; 52:20; 125:8
opened [3] 52:21; 62:10; 125:7
opening [4] 60:13; 61:11; 72:24; 125:14
opens [3] 51:16; 76:23; 77:10
operated [1] 87:4
operation [1] 27:2
operative [3] 27:1; 33:25; 119:19
opined [1] 99:18
opinion [34] 10:16; 27:21, 22; 33:11; 32:25; 38:6; 44:17, 18; 46:20; 49:5; 53:25; 54:4, 10;

58:14; 60:18; 72:10; 73:1; 86:13; 87:11, 22, 25; 88:1, 8, 10; 100:4, 6, 8, 13; 102:18, 23; 103:13; 105:20; 111:15
opinions [9] 10:18; 12:3; 20:17; 54:14; 57:12; 80:19, 22; 87:18; 110:10
opportunities [1] 118:23
opportunity [3] 118:21; 119:1; 120:19
opposed [4] 10:16; 48:10; 86:10; 100:17
options [1] 91:11
order [13] 41:8; 44:14; 45:13, 18; 46:10; 62:19; 64:8, 15; 68:12; 76:6; 103:1; 108:18; 121:18
ordered [1] 71:11
orders [11] 44:9; 45:1, 2, 10; 49:10, 12, 16; 62:18; 70:17; 108:18, 21
organ [4] 28:16; 29:7, 8, 20
oriented [2] 72:24; 73:3
ought [2] 93:6; 96:4
ounces [4] 34:17, 19, 21; 35:2
outcome [1] 127:18
outside [1] 125:13
overall [1] 21:20
oxygenation [4] 84:9, 14, 22

*** P * ***

p.m. [1] 45:14
p.r.n. [1] 71:11
PAGE [2] 4:11; 126:2
page [8] 39:11, 13; 41:24; 42:3; 52:8, 10; 71:8; 72:18
pages [5] 42:12; 47:24; 49:20; 50:5, 9
paid [1] 113:1
pain [4] 57:4; 87:2, 3, 5
palpate [1] 119:20
paper [1] 54:6
paragraph [3] 67:18, 22; 68:3
paralyze [3] 39:20; 43:24; 44:6
paralyzing [1] 43:20
pardon [2] 29:1; 55:2
Part [1] 93:6
part [24] 13:13; 24:16, 17; 28:12; 31:2; 34:5, 6, 21, 25; 35:1, 10, 16; 38:24; 41:23; 44:23; 45:1; 81:12; 90:4; 94:6; 95:4; 110:22; 121:13, 17; 125:9
partial [1] 70:9
Partially [1] 10:20
partially [1] 115:17
parts [1] 44:21
patty [1] 127:17
passively [1] 66:10
patch [1] 45:6
path [1] 115:18
Patient [2] 36:18; 42:16
patient [23] 14:25; 15:8; 19:21; 20:17; 21:20, 21, 25; 22:3, 8; 23:2; 42:20; 51:8, 25; 58:15, 16; 85:3; 88:25; 94:1; 104:8; 105:14; 106:7; 108:13; 121:6
patients [14] 6:14; 19:3, 4; 20:1, 2, 4; 31:7; 32:2, 3, 4, 7; 36:23; 104:19; 105:6
Pavulon [3] 71:7, 23; 72:1
paycheck [1] 104:16
pedal [2] 89:9, 10
pending [4] 8:9, 21; 9:2; 15:13
people [23] 9:7; 13:23; 18:3, 16; 19:11; 31:24; 36:7, 12; 51:17; 53:2; 59:11, 15; 70:12; 74:15; 79:7, 8; 81:9; 98:15; 101:7; 117:13; 119:2; 123:22
percent [3] 29:8, 10; 32:18
Percentage [1] 18:25
percentage [2] 19:2, 3

percutaneous [2] 81:8; 82:1
percutaneously [3] 100:20; 101:14, 19
perforation [5] 85:15; 96:13; 97:6, 16, 20
perform [1] 112:12
performed [2] 10:3; 86:14
period [12] 42:18; 50:14; 62:24; 63:13; 66:4, 6; 81:10; 86:20; 99:19; 100:2, 10
peripheral [1] 10:3
permanent [1] 89:11
persists [1] 29:8
person [11] 34:20, 23; 35:12, 15; 68:5; 81:21; 92:2; 121:22; 122:13; 123:12, 19
personally [1] 101:6
personnel [3] 25:19; 26:3, 6
pertained [3] 22:19; 92:1; 101:25
pertains [2] 22:3; 40:15
phrase [1] 25:8
physically [1] 40:15
physician [17] 10:9, 15; 19:13, 18, 25; 22:23; 51:18; 64:16; 106:13, 17; 107:6, 13, 15, 17; 108:8; 123:18; 125:10
physicians [10] 64:9; 75:1; 78:13; 87:23; 88:2; 99:18; 106:10; 107:11; 113:18
Pick [2] 75:23; 76:21
pick [3] 76:14; 125:3
picture [1] 89:16
piece [9] 54:6; 90:4, 5, 16; 91:8, 11; 121:19; 122:23
pieces [1] 75:19
place [11] 24:21; 59:9, 12; 84:5; 89:17, 18; 92:22; 93:1; 95:6; 112:5; 127:15
placement [4] 24:10, 14; 102:22; 110:21
placing [1] 100:24
plaintiff [2] 10:21, 24
plaintiffs [1] 5:3
please [4] 5:10, 20; 27:4; 28:6
plenty [1] 118:24
plural [1] 86:14
plus [1] 71:5
Point [1] 47:1
point [16] 15:3; 34:24; 38:16; 39:17; 48:9; 53:1; 61:20; 62:22; 63:5, 10; 70:7; 71:19; 80:20; 82:12; 83:16; 116:5
points [2] 62:9; 107:3
Polito [1] 17:21
poor [1] 31:7
pop [1] 120:115
portion [1] 110:6
pose [1] 85:6
position [3] 19:16; 119:25; 120:8
positive [5] 42:21; 58:17; 66:7, 17
possibilities [1] 54:15
possibility [2] 18:8; 54:3
post [4] 26:18, 22; 99:20; 105:21
postoperatively [3] 33:14; 87:19; 106:14
potential [5] 15:10; 77:24; 85:11, 13, 21
potentially [2] 15:10; 85:14
Practice [1] 16:16
practice [8] 5:24; 18:23; 103:11, 14, 18, 24; 104:2, 4
pre-existing [1] 8:2
precisely [2] 18:3, 5
predict [1] 123:21
preface [1] 54:14
PREM [1] 4:2
prep [1] 119:7
preparing [1] 72:14
presence [3] 85:16; 95:17; 127:10
present [2] 94:18; 99:21
presentation [1] 83:7
presented [2] 94:4, 17

Presently [1] 15:17
presently [1] 14:10
press [2] 16:18, 24
pressure [7] 60:7, 16; 61:10; 106:124; 107:3; 120:10, 24
presumably [1] 96:1
pretty [2] 49:19; 102:8
previous [6] 11:7, 12; 13:21; 21:22; 40:6; 42:13
previously [2] 7:10; 14:16
primarily [2] 20:17; 37:2
primary [5] 19:10, 13, 20, 25; 26:11
principal [1] 114:19
printed [1] 117:19
prior [2] 40:10; 72:14
prioritize [1] 115:9
probabilities [1] 54:15
probability [3] 54:19, 21; 75:25
probable [1] 54:22
problem [2] 18:17; 59:10
problems [4] 18:18, 19; 54:1; 79:8
Procedure [1] 5:4
procedure [19] 81:10, 11; 93:12, 24; 94:2, 17; 96:4, 6; 112:12; 118:1; 119:5, 11, 14, 16, 17; 121:13, 14, 22; 122:13
procedures [5] 87:6; 93:13, 25; 94:25; 119:19
process [1] 118:5
produces [1] 109:16
Professional [1] 127:3
profound [2] 38:17; 77:7
prognosis [1] 31:7
prognostically [1] 39:1
Progress [2] 38:21; 63:23
progress [4] 43:4, 6; 44:21; 50:22
project [1] 94:7
prolonged [2] 41:25; 42:5
proper [1] 86:11
properly [2] 121:25; 123:2
protocol [1] 91:18
provide [5] 30:9, 21; 71:20; 80:17; 93:7
provided [2] 17:12; 32:2
provides [2] 17:25; 117:18
Public [2] 127:5, 24
published [3] 6:7, 11; 16:13
pull [1] 121:10
Pulling [1] 29:14
pulmonologist [7] 37:3, 4, 8, 10, 20; 38:3; 84:8
pulmonology [1] 84:4
pulse [2] 60:6, 16
pump [4] 8:19; 14:17; 15:6, 11
puncture [3] 85:16; 120:11, 25
pupils [1] 56:18
Purely [1] 86:25
purely [3] 86:13, 22; 87:9
purpose [4] 5:3; 93:19; 120:5, 7
purposefully [1] 42:25
purposely [2] 60:15; 61:11
pursuant [1] 5:4
pushing [1] 120:15
puts [1] 124:18
putting [6] 102:9; 119:13, 15, 17, 18; 121:18

*** * Q * ***

qualifications [1] 94:6
qualified [1] 94:25
qualifier [3] 67:1, 7, 14
quantify [1] 54:16
Question [2] 111:12; 122:6
question [36] 5:16; 21:23; 22:21; 24:16, 17,

24; 25:9; 40:7; 46:6; 53:13, 23; 58:4, 9; 63:1; 69:7; 71:1; 72:4; 80:9; 83:13; 85:10; 89:23; 90:15; 92:13; 96:11; 101:22; 102:14, 21; 105:4; 111:10; 113:5, 17, 20, 25; 123:15; 124:2
questioning [3] 11:10; 30:18; 94:10
questions [31] 5:18, 19; 11:1; 22:20; 35:25; 57:17; 63:3; 72:22; 74:5; 75:12; 76:23; 79:17, 24; 80:1, 7, 24; 82:5, 10; 88:16, 18; 91:20, 21; 102:4; 109:9, 18; 112:18, 23; 117:3, 6; 122:3; 124:21
quick [1] 63:20
quickly [2] 41:7; 65:24
quote [1] 28:20
quotes [1] 59:20

*** * R * ***

radial [4] 114:10; 115:2, 7, 22
radiology [2] 81:16, 17
raised [2] 83:18, 23
ran [1] 69:4
rate [3] 29:7; 61:10; 106:20
rates [1] 31:20
re-admission [1] 10:4
re-assess [1] 70:1
reactive [2] 56:19
Read [2] 23:25; 91:4
read [34] 24:2; 28:19; 30:4; 33:21; 37:16, 19, 24; 40:1; 45:25; 48:18, 22; 50:19; 52:4, 10, 12; 53:10; 62:2; 64:2; 72:18; 73:15, 18, 22; 77:8; 91:12; 111:12; 117:124; 120:20; 122:6, 14; 125:11, 15, 16, 18; 126:21
reading [6] 43:16; 62:16; 68:14, 5; 77:19; 96:23
real [1] 63:20
realized [1] 85:12
Reason [1] 72:9
reason [6] 11:21; 35:16; 81:19; 93:17; 97:15; 123:11
recall [8] 7:19; 8:23; 13:5, 6; 61:23; 63:24; 90:18; 92:2
receive [1] 31:1
Recently [1] 6:13
recitation [1] 95:10
recollection [1] 14:3
reconvene [1] 30:16
record [12] 19:18; 20:1, 20; 34:14; 38:16; 45:15, 22; 47:3; 89:17, 18; 96:23; 103:3
recording [1] 89:6
recorded [1] 89:14
recording [1] 60:5
records [5] 12:3; 57:13; 71:13; 90:8; 109:21
recover [1] 60:21
recovery [3] 41:25; 42:5; 61:12
RE CROSS [1] 113:12
RE CROSS-EXAMINATION [4] 88:20; 91:23; 124:8, 23
Recross-examination [2] 4:15, 16
recross-examination [3] 4:17, 19, 20
reduce [1] 100:3
reduced [1] 127:9
refer [1] 31:3
reference [3] 30:1; 31:3; 84:5
referred [2] 63:16; 80:18
referring [1] 82:12
refers [1] 31:12
reflected [1] 64:15
reflex [8] 16:11; 42:21; 58:17; 64:20; 66:14, 18; 70:4
regard [6] 22:4; 31:25; 37:21; 54:3; 62:21;

63:11
regarding [7] 8:18; 18:8; 71:1; 75:1; 80:21;
 101:25; 109:14
regards [1] 37:22
Registered [1] 122:3
Reglan [1] 45:7
Reinker [1] 16:1
relates [2] 97:5; 105:12
relation [2] 23:17; 104:20
relative [2] 34:6; 127:16
relatively [3] 34:7; 101:11; 121:17
reliable [1] 108:19
reliance [1] 74:25
rely [1] 74:16
remainder [1] 19:23
remained [1] 116:16
remains [3] 15:13; 115:19; 120:11
remember [14] 7:24; 8:7; 16; 12:20; 13:14;
 22; 14:6; 16:4; 28:23; 29:18; 46:1; 49:20;
 61:20; 75:6
remiss [2] 112:7, 11
removal [3] 92:1; 100:22; 105:19
remove [11] 25:13; 26:14; 81:7; 25; 87:8, 13;
 97:7; 100:1, 19; 101:14, 18
removed [15] 25:17; 43:15; 81:23; 86:3;
 88:24; 91:8; 100:9, 10, 12, 15, 16, 18; 101:5;
 115:20; 116:13
renal [1] 39:12
render [3] 12:3; 57:12; 72:10
rendered [1] 111:15
rephrase [2] 5:17; 122:8
replaced [1] 87:1
report [18] 6:19; 17:4, 6; 29:24; 31:2; 34:15;
 49:18; 59:20; 61:16; 72:15; 88:12; 93:19;
 101:23, 24; 102:5; 105:16; 123:7, 20
reported [1] 90:7
Reporter [1] 127:4
reports [4] 59:24; 61:24; 109:1, 13
represent [1] 117:5
represented [1] 15:17
representing [1] 15:15
require [2] 65:18; 84:9
required [2] 107:10; 112:6
requirements [1] 84:22
requiring [2] 41:25; 42:5
research [1] 30:5
resident [35] 5:12; 21:24; 22:2, 4, 7; 39:6, 25;
 40:3, 18, 20, 22; 41:18; 43:13; 45:25; 46:2, 15,
 17, 22; 47:2; 50:4; 52:9; 56:1; 63:15; 69:12;
 73:15; 93:1, 2, 5; 98:16, 23; 104:15; 110:20;
 111:3; 118:18, 19
residents [17] 21:10, 13, 17; 22:12; 43:8;
 69:18; 92:15, 20, 22; 93:11, 24; 95:4; 104:8;
 105:1, 7; 107:10; 123:10
resistance [1] 120:4
resolving [1] 39:18
respect [6] 10:19; 32:6; 38:3; 44:16; 81:6;
 93:12
respects [1] 84:4
respiration [1] 60:7
respiratory [3] 28:15; 29:20; 33:1
respond [7] 5:19; 44:8; 49:7; 53:2; 63:5;
 67:23; 78:5
responded [2] 59:25; 101:22
responding [3] 62:18; 72:23; 75:9
responds [2] 49:2; 72:24
response [7] 63:8; 64:17, 19; 68:12; 69:10;
 96:11; 104:9
responses [2] 68:25; 69:8
responsibility [2] 19:21; 104:21
responsible [17] 20:18; 21:6, 7, 12, 19, 25;

22:3, 7, 15, 18; 23:1; 104:7, 11, 19; 105:5, 11,
 13
rest [1] 69:11
restart [2] 43:9; 69:14
restraint [1] 77:20
restricted [1] 109:15
result [17] 23:8, 9; 24:4, 20; 25:11, 14, 15, 21,
 22; 26:2; 32:25; 33:3, 4, 12, 25; 35:7; 78:6
resulted [1] 12:4
results [1] 90:3
retained [6] 12:2, 7; 13:16; 98:15; 103:8;
 112:21
retrieval [2] 91:3, 11
retrieve [1] 81:14
reversal [1] 65:23
reverse [6] 42:18; 44:18; 63:12; 64:10; 65:9;
 70:3
reverses [1] 65:21
Reversing [1] 65:13
reversing [1] 65:10
review [10] 6:15; 12:2; 16:11; 28:1; 43:12;
 45:22; 49:22; 50:1; 61:13; 108:11
reviewed [7] 14:6; 17:3, 5; 28:22; 29:19;
 49:23; 109:22
rid [2] 65:19; 66:3
Right [10] 6:25; 29:16; 70:19; 77:9; 79:10;
 102:7; 104:12; 105:9; 116:6
right [28] 16:7, 18; 26:5; 27:18; 35:15; 41:23;
 42:9, 11; 43:7; 52:17; 58:10; 59:8; 63:21;
 65:25; 69:6; 73:1; 76:21; 79:9; 80:3, 5; 86:24;
 92:14; 97:23; 108:12; 112:15, 22; 121:19;
 125:14
risk [11] 79:3; 85:6, 11; 86:18; 96:12, 14;
 97:6, 7, 16, 20; 99:21
risks [3] 85:13, 21; 100:3
Robinul [1] 42:17
Rollins [3] 64:3; 78:16, 17
round [1] 56:19
rounds [1] 106:11
routine [2] 45:2, 10
RPR [1] 127:24
RT [2] 77:20, 21
Rubin [4] 9:21; 11:18, 23, 25
rule [1] 86:7
Rules [1] 5:4
running [1] 116:4

* S *

Saint [2] 74:17; 82:17
sake [1] 52:25
saying [18] 30:17; 32:13; 54:1; 57:9; 59:13,
 14; 62:8; 67:2, 15; 68:2; 70:15; 73:23; 74:11,
 14; 75:13, 14; 89:19; 110:7
school [1] 40:4
screen [1] 89:9
seal [1] 127:19
second [5] 92:17; 93:2, 4; 112:20; 118:19
secondary [2] 19:5; 31:9
securely [1] 115:21
Sedate [1] 48:19
sedate [1] 44:4
sedated [7] 48:20; 50:5, 12, 20, 24; 51:3;
 72:6
sedates [1] 43:25
sedation [7] 42:1, 6; 43:9, 23; 46:18; 69:14,
 23
Sedatol [1] 48:20
SEIBEL [6] 16:1; 33:16; 79:18; 82:8; 88:15;
 91:17
Seibel [6] 4:14; 15:22; 91:25; 92:6; 96:11;

104:9
send [3] 30:25; 101:7; 114:14
sense [2] 22:5, 6
sentence [2] 31:10; 77:18
separate [2] 21:4; 23:18
sequela [2] 25:7; 28:16
sequelae [3] 23:4; 34:2; 35:7
sequence [1] 26:21
series [1] 121:16
serious [4] 60:8, 18, 20; 96:14
service [1] 59:24
setting [2] 31:22; 109:11
settings [1] 37:6
Seventh [1] 4:6
severally [1] 61:1
severe [1] 78:1
share [1] 84:12
shares [2] 119:15, 19
Sharon [3] 35:5, 13; 36:22
Sharp [1] 4:5
sharp [3] 92:9, 13, 14
She'd [1] 84:15
She'll [1] 125:18
sheath [6] 91:5; 115:19, 20; 121:3, 5, 10
SHEET [1] 126:1
sheets [1] 59:21
shifts [1] 21:3
shortening [2] 87:6; 98:12
Show [5] 14:13; 25:2; 68:23; 98:18; 110:25
show [9] 67:18, 22; 68:2; 93:6, 17; 102:12;
 119:7, 20; 120:12
shows [3] 89:7; 103:1, 3
shy [1] 40:5
sght [2] 78:17; 122:11
sign [6] 57:6, 7; 67:10, 16, 17; 69:5
signature [4] 40:1; 91:12; 125:19, 22
significant [6] 75:24; 76:1; 82:24; 97:5;
 106:16, 18
signs [4] 60:5; 67:19, 20; 106:14
simple [8] 42:23; 76:4, 5, 7, 9; 119:17, 18;
 121:17
single [1] 89:15
singular [1] 86:4
sir [1] 115:1
sit [1] 113:1
site [2] 120:11, 25
six [7] 86:8, 17; 99:22; 100:3; 101:2, 9
six-month [2] 86:19; 100:10
sizeable [1] 19:3
skin [2] 120:14, 16
skipped [1] 91:15
sleepy [1] 44:4
slides [1] 120:16
slow [1] 44:22
Slowly [1] 39:18
slowly [2] 28:8; 86:19
smoothly [2] 120:3, 16
snagged [1] 91:9
snare [1] 91:6
snared [1] 91:8
societies [2] 99:13, 14
soft [1] 77:20
sole [1] 34:7
solely [2] 35:22; 36:2
Solu-Medrol [2] 45:7, 9
Somebody [1] 16:2
somebody [11] 37:7, 11; 66:21; 67:2; 77:3, 6;
 95:7, 23; 101:18; 112:20; 121:25
somehow [1] 94:4
Someone [1] 92:13
someone [24] 12:12; 18:1; 20:25; 31:20;

40:23; 41:19; **43:14**; 46:21; 49:5; 53:6, 10;
54:17; 66:10, 12; 73:3; 77:7, 10; 95:8, 11;
112:4; 118:5; 123:2, 7, 17
somewhere [4] 7:7; 31:5; 67:17; 116:17
sophisticated [1] 79:5
Sopko [1] 37:16
Sorry [1] 12:1
[8] 9:21; 41:15; 42:2; **45:4**; 51:10;
56:3; 65:12; 80:23
sort [4] 78:11; 86:6; 104:13; 119:19
sound [1] 98:13
sounds [1] 29:10
source [1] 30:1
sources [5] 10:2, 4, 8, 11
speak [2] 2:22; 53:3
speaks [3] 23:21; 46:17; 90:16
special [3] 17:17, 21; 18:4
Specialist [1] 127:4
specialist [2] 8:21; 37:3
specialist [1] 37:4
specialties [2] 8:6, 12
specialty [5] 16:16; 17:24; 18:2, 16; 21:11
Specific [1] 10:5
specific [4] 11:12; 87:16; **94:1**; 105:23
Specifically [1] 102:3
specifically [3] 3:20; 51:14; 122:24
specified [1] 127:15
spectrum [2] 100:14; 101:5
spend [1] 18:25
spent [2] 8:23; 19:9
split [1] 76:12
spoken [1] 17:11
spontaneous [1] 67:8
squeeze [2] 6:25; 77:12
squeezing [1] 77:13
stabilized [6] 82:21, 25; **83:1**, 9, 11, 17
stable [5] 8:14, 15; **82:10**, 18; **84:18**
staff [2] 16:2; 107:11
standard [11] 87:24; 89:13, 16, 25; 96:7;
101:25; 103:18; 106:3, 5; 107:10; 123:6
standpoint [5] 22:22; **38:11**; 82:11; 84:4, 8
start [3] 7:6; 38:24; 118:20
started [6] 43:17; 47:15; **48:1**; 80:13; 98:13;
106:14
startle [1] 66:21
starts [3] 9:11; 41:12; 42:3
State [3] 127:1, 5, 24
state [1] 5:10
Statement [4] 11:18; 23:3; **38:14**, 15
stationery [1] 6:18
statistics [4] 2:6, 9, 21, 22
status [14] 44:2, 17; 51:19; **54:12**; 55:4; 62:5,
10; 70:6; 71:21; 72:11; 74:3, 17; 75:2; 83:16
stay [1] 74:17
steadily [1] 86:19
Steele [7] 22:17; 78:16; 99:24; 104:9, 21;
105:10, 18
stem [2] 6:12; 66:13
stenotypy [1] 127:9
step [1] 89:9
steps [2] 21:17, 18
sterile [4] 19:6, 8, 16; 125:8
Steve [3] 17:18; 9:17, 78
sticking [1] 121:5
stiff [1] 97:13
stimuli [2] 9:2, 7
stop [1] 125:11
straight [7] 11:22; 97:3, 18, 19; 114:15, 17;
116:24
straits [1] 60:19
strength [2] 44:4; 77:24

stressed [1] 18:5
stricken [1] 112:1
strong [1] 67:15
structure [1] 22:6
stuck [1] 59:14
student [4] 40:23; 118:15, 16; 119:4
students [1] 69:18
subjecting [2] 101:19; 105:25
Subsequent [1] 10:10
subsequent [2] 25:20; 103:5
subsequently [1] 127:10
substance [2] 55:20; 58:13
substantially [1] 59:16
successful [1] 89:21
successfully [1] 91:8
suctioning [1] 58:18
sudden [1] 34:19
suffer [3] 1:8, 24; 79:15
suffered [1] 76:1
suffers [1] 31:20
sufficient [3] 6:14; 59:5; 94:24
sufficiently [1] 32:14
suggest [2] 7:11; 80:14
supervision [5] 5:15, **22**; 112:13; 118:25;
119:3
supply [1] 125:2
support [8] 30:17; **48:10**; 49:14; 75:13, 18;
78:2, 3; 80:19
supports [3] 8:13; 47:5, 13
surge [1] 119:24
surgeon [2] 1:9; 101:13
surgery [26] 9:25; 10:3; 15:9; 25:13, 20;
26:14, 20; 34:1; **84:1**; **86:7**, 13, 21, **22**, 25;
87:8, 9, 12; 98:11, 13; 99:19; 100:1; 101:20;
105:19, 25; 106:2, 8
surgical [4] 6:18, 22, 25; **100:22**
surgically [2] 100:21; 105:21
survival [8] 7:8, 9; 31:20, 24; 32:8; 54:4, 21
23
survive [2] 2:1, 3
survived [4] 7:15; 32:3, 5, 14
Susan [1] 16:1
sustained [5] 3:9, 12; 33:12; 35:7; **46:21**
Sweeney [2] 4:24; 15:24
swollen [1] 77:16
sworn [2] 5:5; 127:7
syndrome [4] 8:15; 29:5, 20; 33:1
system [3] 4:11, 19; 81:21
systems [3] 9:7; 36:8, 24

* * T * *

tables [2] 8:25; 79:2
tachycardic [1] 106:22
takes [3] 3:20; 79:2; **120:14**
talk [6] 31:11, 23; 35:13; 109:13; 112:3; 123
talking [15] 26:15; **35:4**, 5, 12; 55:4; 58:7;
62:24; 63:15; 71:9, 13; 89:5; 94:21, **22**;
111:20; 118:8
taught [2] 3:13; 122:13
teach [5] 6:1; 118:5; 120:23; 121:8; **122:19**
teaching [3] 9:17; 93:15; 123:10
technique [1] 119:7
technologist [2] 13:17, 21
technologists [5] 13:15; **114:1**, 6; 124:12,
16
telling [5] 18:15; 62:4; 74:7; 103:24; 108:19
tells [1] 36:11
temporarily [2] 3:12; 65:20
term [7] 32:11, 17; 60:23; 64:12; 65:5; 76:1
terminology [1] 60:25

terms [12] 26:18, 25; 32:8; **33:11**; 37:1; 54:15;
71:22; 73:1, 23; 75:1; 98:11; 109:11
test [5] 4:12; 69:25; 70:11, 13
testified [8] 5:6; 7:1, 23; 8:15, 25; 9:7; 11:15;
117:10
testify [6] 7:9; 8:12; **11:17**; 43:11; 47:21;
127:8
testifying [1] 61:18
testimony [14] 10:16, 17; 12:4, 5; 17:9, 12;
33:18; 37:16, 20; **100:1**, 8; 110:16; 127:9, 13
text [4] 8:18; 31:16, 18, 19
textbook [4] 28:7, **10**, 12; 31:15
textbooks [1] 28:5
Thank [5] 8:7; 91:13; 94:13; 112:14; 123:24
thank [1] 90:20
Thanks [1] 125:17
therapy [2] 3:5, 24
They're [3] 7:7; 79:5; 81:16
they're [10] 6:9; 20:24; 75:18; 95:12; 96:24;
115:17; 116:4; 118:11; 122:15; 125:14
they've [2] 0:2; 93:25
thick [1] 49:19
thinking [1] 75:16
third [6] 2:23; 13:18; 39:13; 112:18, 19;
118:15
thousand [1] 68:13
threatening [2] 7:5; 98:12
Three [2] 7:7; 34:13
three [15] 13:17; **14:1**; 21:3, 4; 29:3, 6; 34:8,
11, 15; 39:20, 21; 43:15; 83:2; 86:8; 118:24
thrombus [1] 85:18
time-wise [1] 18:25
timed [1] 46:16
times [5] 7:3; 13:17; 82:19; 95:13; 120:21
timing [1] 87:12
tip [1] 97:3
tipped [4] 6:24; 97:1, 18, 19
Tobramycin [1] 45:8
tomorrow [1] 100:17
tools [1] 93:7
total [1] 29:3
totally [2] 3:18, 19
touch [1] 95:16
towards [2] 2:14; 116:5
towel [1] 119:8
train [5] 2:15, **22**; **110:20**; 112:6, 7
trained [7] 68:5; 81:7; 111:3; 112:11; 117:13;
121:25; 123:2
trainees [1] 21:11
training [15] 36:6; **41:2**, 3, 5; 81:9, 12, 19;
91:25; 93:6; 95:4; 110:10, 22; 113:19; 123:12,
17
transcribed [1] 127:11
transcript [2] 26:22; 127:12
transfer [2] 0:25; 109:5
transient [2] 9:8, 15
transiently [1] 65:15
transplant [1] 6:14
travel [1] 85:19
treat [4] 9:8; 20:4; 83:20, 22
treated [1] 82:23
treating [4] 0:9, **10**, 11, 15
treatment [3] 1:13; 83:18, 19
trial [5] 12:12; **14:5**; 30:12; 74:13; 108:24
tricky [2] 21:12, 15
trouble [3] 13:14; 11:22
true [5] 1:16; 30:2; **104:1**; 126:22; 127:12
truly [2] 53:9, 14
truth [1] 127:8
Tuschman [4] 8:24; 9:15; 13:25; 16:2
type [6] 12:17; 18:17; 89:15; 93:11; 114:15;

115:11

* * U * *

unable [2] 61:2, 3
 unblocks [1] 65:20
 Unchanged [1] 50:19
 unchanged [16] 50:4, 8, 17, 18, 21; 51:7, 9;
 52:2; 55:17, 18, 19, 21; 56:2; 73:20
 undergo [1] 105:18
 underneath [1] 21:17
 Understand [11] 5:16, 18; 25:23; 69:7; 72:4;
 78:4; 83:13; 98:10; 105:2; 109:24; 113:20
 understanding [2] 94:18; 98:8
 understands [1] 51:21
 understood [1] 53:7
 Unfortunately [1] 29:18
 unfortunately [1] 79:21
 Unique [1] 119:12
 unique [1] 119:10
 unit [7] 19:1, 2, 20; 31:22; 36:9; 37:5, 10
 units [2] 19:7, 19
 universal [1] 96:8
 University [9] 5:24; 81:6, 14; 89:5; 93:11;
 113:14, 20, 25; 114:2
 unstable [1] 82:20
 unsuccessful [1] 89:120
 unusual [1] 121:12
 up-to-date [1] 71:14
 urgently [1] 82:23
 uses [1] 124:15
 usual [1] 51:17
 utilized [1] 124:11
 utilizing [1] 114:15

* * V * *

VA [1] 6:5
 validity [1] 30:6
 Vancomycin [1] 45:8
 vanish [1] 122:11
 variable [1] 84:15
 variation [1] 99:22
 VARMA [1] 4:2
 Varna [11] 22:18; 80:1; 98:19, 21, 22; 99:1;
 102:8, 23; 104:14, 21; 105:12
 vary [1] 101:7
 vascular [3] 9:25; 10:3; 91:9
 Vasodilators [1] 16:22
 vasodilators [1] 16:20
 Vecuronium [1] 48:21
 vegetable [2] 60:22, 23
 ventilator [10] 37:12, 23; 38:5; 53:4; 73:3;
 84:11, 12, 17, 23; 85:2
 ventilators [1] 37:7
 ventilatory [1] 38:10
 ventricular [2] 31:9, 11
 Verapamil [2] 45:7, 8
 verbally [2] 5:20; 53:3
 verify [3] 94:20, 23; 110:11
 Versagi [2] 127:3, 24
 Versed [16] 43:9, 17, 19, 22, 23; 44:11; 45:10,
 13; 46:10; 48:21; 49:6; 51:3; 69:14; 70:8, 11;
 71:2
 versus [3] 9:21; 11:19, 25
 vessel [1] 120:8
 vessels [2] 85:16; 90:2
 Video [1] 127:4
 vigorous [1] 119:24
 Vincent [2] 74:18; 82:17
 virtue [1] 46:22
 vital [2] 60:15; 106:14

volume [1] 63:21

voluminous [1] 61:22

* * W * *

Wait [4] 52:4; 58:4; 80:10; 90:14
 wait [5] 14:22; 63:13; 66:1; 101:1, 2
 waiting [1] 39:23
 waive [1] 125:19
 waived [1] 125:22
 wake [2] 39:23; 42:24
 walking [1] 40:15
 wander [2] 55:8; 58:16
 wanted [1] 102:15
 wam [1] 122:24
 warning [1] 122:14
 warnings [1] 117:17
 wash [2] 65:16; 119:7
 wasted [1] 125:15
 watch [4] 39:15; 95:11, 16; 118:24
 Watched [1] 118:24
 watching [2] 118:9, 12
 waved [1] 76:23
 waves [1] 77:11
 ways [7] 32:2; 38:12, 13; 66:2; 100:20; 106:6
 We'll [2] 7:6; 39:8
 we'll [3] 22:23; 30:16; 52:23
 We're [9] 35:4; 47:7; 55:4; 57:11; 59:14;
 52:15, 24; 71:9; 109:25
 we're [5] 62:8, 12; 71:13; 94:21, 22
 weaned [3] 37:12, 23; 38:4
 wear [2] 63:14; 66:1
 wears [1] 65:23
 week [4] 21:2; 27:12, 14; 45:3
 weeks [2] 30:12; 74:13
 weight [3] 59:9, 12; 87:2
 Weitzel [18] 22:19; 23:4; 25:16, 20; 26:13;
 27:5; 35:5, 13; 36:22; 40:9; 82:10; 85:7; 87:9,
 19; 88:4; 100:4; 102:22; 105:11
 weren't [2] 73:6; 107:22
 whenever [1] 35:25
 WHEREOF [1] 127:18
 Whoever [1] 79:24
 whoever [1] 93:14
 wire [58] 25:13; 85:15, 17, 19, 20; 86:1; 87:8,
 13, 15, 16; 89:14; 91:3, 6, 7, 12; 96:12; 97:2,
 3, 9, 10, 11, 17, 19; 101:8; 103:8, 9; 105:19;
 114:15; 115:11, 19; 116:3, 5, 9, 12, 13, 14;
 120:2, 3, 6, 7, 11, 12, 21; 121:2, 4, 6, 11, 23;
 122:10,
 4, 16, 20, 21, 23, 24
 vires [45] 24:11, 15, 19; 25:5, 16, 17, 18;
 16:13; 27:5; 36:7, 12, 24; 81:8, 14, 20; 85:6,
 10, 14, 22; 86:1; 88:22, 24; 91:7; 96:15, 17,
 19, 25; 97:19, 23; 98:3, 8, 14; 100:2, 9; 103:9,
 10, 19; 104:3; 112:16; 114:18; 115:13; 116:2,
 6, 18;
 23:20
 withdraw [1] 86:15
 withdraws [1] 57:3
 WITNESS [3] 4:10; 92:8; 127:18
 witness [3] 5:2; 127:6, 10
 woman [4] 8:2; 10:2; 79:4, 11
 won't [2] 54:25; 95:16
 wonder [1] 52:15
 wondering [1] 111:20
 word [5] 18:5; 48:18, 21; 50:19; 52:15
 words [4] 70:10; 98:14; 99:20; 101:8
 work [10] 21:4; 22:23; 47:9; 61:3; 65:1; 84:10,
 2, 17, 23; 122:22
 working [3] 19:1; 44:25; 47:7

works [1] 85:1

worn [2] 43:10; 69:15

worse [3] 59:2, 3; 84:15

worsened [1] 8:4

worsening [1] 25:23

Wouldn't [1] 106:6

wouldn't [24] 14:5; 26:15, 19; 30:13; 34:6, 22;
 35:3; 38:6, 9; 44:18; 48:9; 62:7; 63:13; 74:7,
 22; 81:11; 89:22, 24; 100:16; 101:9, 14;
 116:25; 121:22; 123:19

wrists [1] 77:20

write [6] 61:15; 68:25; 89:22, 24; 90:1; 104:16

Writing [3] 41:21; 53:5, 6

writing [6] 40:10; 53:2, 10; 54:5, 6, 18

written [9] 6:14; 16:11; 31:4; 40:14; 68:15, 19,
 21; 108:18; 110:11

wrong [4] 22:14; 46:13; 95:4; 125:15

wrongful [1] 9:24

wrote [6] 6:19; 17:4, 5; 49:17; 63:24; 64:4

* * X * *

x-ray [5] 89:12; 96:16, 24; 116:21; 117:1

x-rays [1] 116:20

* * Y * *

Yeah [4] 29:4; 37:15; 38:19; 123:16

yeah [2] 5:12; 48:17

year [17] 6:3, 6; 17:4; 19:17, 23, 25; 40:22;
 79:4, 11; 92:17; 93:2, 4; 118:16, 17, 18, 19
 years [7] 8:10, 11; 12:19; 13:5; 40:5; 78:20;
 84:15

You'll [1] 110:4

you've [2] 47:8; 122:12

yourself [5] 14:8; 48:6; 95:24; 114:24; 125:2

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 expectancy 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 pulmonologist 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 neuromuscle 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 arrhythmias 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 in 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.