

State of Ohio,)
County of Cuyahoga.)

Doc. 103

- - -

IN THE COURT OF COMMON PLEAS

- - -

DEWEY GLEN JONES, et al.,)
)
 Plaintiffs,)
)
 V.)
)
MERIDIA HURON HOSPITAL,)
et al.,)
)
 Defendants.)

Case No. 306012
Judge Lillian Greene

- - -

THE DEPOSITION OF HELMUT F. CASCORBI, M.D., Ph.D.

WEDNESDAY, AUGUST 6, 1997

- - -

The deposition of HELMUT F. CASCORBI, M.D., Ph.D.,
a witness herein, called for examination by the
Plaintiffs, under the Ohio Rules of Civil Procedure,
taken before me, Lauren I. Zigmont-Miller, Registered
Professional Reporter and Notary Public in and for the
State of Ohio, pursuant to notice, at University
Hospitals, Department of Anesthesiology, 11100 Euclid
Avenue, Cleveland, Ohio, commencing at 12:20 p.m., the
day and date above set forth.

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Page 2

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Page 3

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5
 6 - - -

9 ALSO PRESENT:

1 Ret!! McGregor - Videographics

Page 4

1	INDEX	
2		PAGES
3		
4	CROSS-EXAMINATION BY	
5	MR. KEENAN	5
6	MS. REINKER	65
7	MR. KEENAN	69
8		
9	- - -	
0		
1		
2	PLAINTIFFS' EXHIBITS MARKED	
3	1 and 2	5
4		
5	- - -	
6		
7		
8	OBJECTIONS BY	
9	MR. CASEY	19, 23, 25, 50
0	MS. REINKER	17, 19(3), 21, 36, 38(2),
1		42(3), 49, 53
2	MR. JONES	28
3	MR. WALTERS	38, 40, 51
4		
5	- - -	

Page 5

1 (Thereupon, Plaintiffs' Exhibit 1 and 2 to
 2 the deposition of Helmut F. Cascorbi,
 3 M.D., Ph.D., were marked for purposes of
 4 identification.)

5 - - -
 6 HELMUT F. CASCORBI, M.D., Ph.D.,
 7 a Witness herein, called for examination by the
 8 Plaintiffs, under the Rules, having been first duly
 9 sworn, as hereinafter certified, deposed and said as
 10 follows:

11 CROSS-EXAMINATION

12 BY MR. ALLEN:

13 Q. Doctor, I'm Charles Allen, one of the
 14 attorneys for the plaintiff. If I ask you a question
 15 you don't understand, just ask me to repeat it. If you
 16 need to take a break, we'll do so. I expect this whole
 17 process to take about an hour and a half, two hours at
 18 the max.

19 MR. CASEY: Just so you're
 20 aware, Charles, he's got to be somewhere
 21 after 2:00, so push it.

22 MR. ALLEN we'll push it.
 23 I'll try to talk fast for a southern boy.

24 Q. Doctor, if you'll state your name and your
 25 address for the record for me.

Page 6

1 A. Helmut F. Cascorbi, 2844 Fairmount
2 Boulevard, Cleveland Heights.
3 Q. Doctor, what medical records have you
4 reviewed for today's deposition?
5 A. I reviewed the perianesthetic records of
6 Meridia.
7 Q. Any other records?
8 A. I reviewed or read some depositions, one
9 by Dr. -- a statement by Dr. Downs, deposition by
10 Dr. Kaplan, statement by Dr. Kaplan. I think -- did I
11 have anything on Senchyshak or not, I don't know.
12 Q. You don't know whether you reviewed the
13 deposition of Dr. Senchyshak?
14 A. Is there a deposition, yes, then I did.
15 Q. All right. And you said you reviewed the
16 anesthesia records. Did you review any of the other
17 records of Meridia?
18 A. Only as they pertain to the perianesthetic
19 event.
20 Q. And define that for me.
21 A. The time before anesthesia, the
22 pre-anesthetic assessment management, the anesthetic
23 management and the post-anesthetic management, to the
24 unit, and from then on, no.
25 Q. And so before anesthesia, we're talking

Page 7

1 the night before in which there was clearance given?
2 A. Correct.
3 Q. You reviewed those records, okay.
4 Then everything up until -- did you
5 review the Dr. Heart records and the subsequent --
6 A. Dr. who?
7 Q. The Dr. Heart record in which the patient
8 was resuscitated.
9 A. The resuscitation record, yes.
10 Q. All right. Did you generate any reports
11 other than the one marked as Exhibit 2?
12 A. No.
13 Q. That's your original report, Doctor?
14 A. That's a copy of the original.
15 Q. Is that the only draft of the original?
16 Did you make another draft?
17 A. No, this was the only document.
18 Q. You wrote that yourself?
19 A. Yes, I did.
20 Q. Did you have any conversation with any of
21 the parties in the case, any of the defendant doctors?
22 A. No.
23 Q. When did you first discuss your opinions
24 with the lawyers that hired you?
25 A. Whenever I was contacted.

Page 8

1 Q. That would have been around May of this
2 year, or was it earlier than that?
3 A. Without checking my calendar, I don't
4 know.
5 Q. But it was sometime this year, correct?
6 A. Oh, yes.
7 Q. How much time have you spent reviewing
8 this case?
9 A. Two to three hours.
10 Q. And that includes all of the depositions
11 and reviewing the records?
12 A. I'm a fast reader.
13 Q. Sorry?
14 A. I'm a fast reader.
15 Q. You're a fast reader. All right.
16 Now, if I understand it -- kind of
17 maybe shortcut things -- you're here to give opinions
18 as to anesthesia care as it relates to the resident in
19 this case, correct?
20 A. I was asked whether the resident was
21 acting properly for a resident.
22 Q. So you were not asked to look at how
23 Dr. Adamek's care was given to Dewey Jones?
24 A. I was not asked about the care by
25 Dr. Adamek.

Page 9

1 Q. And you're not asked about the care of
2 Dr. Ho or Dr. Badri, correct?
3 A. I was not.
4 Q. You're not going to give opinions as to
5 causation, meaning what occurred and how it occurred to
6 put Levey Jones into the state that he is in today?
7 A. I don't know how to answer that, because
8 if it pertains to how the resident was supervised, I
9 can, of course, not fail to have an opinion about this
10 case, I am an anesthesiologist.
11 Q. Sure.
12 A. But my specific -- if I understand it
13 correctly -- reason for being here is that I am an
14 educator in anesthesia, a chairman of the anesthesia
15 department, and I'm asked whether the resident did
16 something that he shouldn't have done or did something
17 that he should have done and whether he acted outside
18 his competence.
19 Q. And that is the extent of what you expect
20 to testify if you go to court, correct?
21 A. Yes.
22 Q. Do you have any opinion as to how long
23 Dewey Jones would have lived if this operation had not
24 occurred or how long he would live today?
25 A. No.

Page 10

Page 12

1 Q. As far as your report, Exhibit 2, if you
2 can just go to that real quick. This is it, correct?

3 A. Yes.

4 Q. Okay. It says -- before you wrote this
5 report it says you reviewed depositions. Which
6 depositions did you review, Dr. Senchyshak and
7 Dr. Adamek before?

8 A. Yes.

9 MR. CASEY. He may not have
10 reviewed Senchyshak before.

11 It was right at that time that he was
12 taken, so I can't tell you if I had yet
13 sent that to you at the time you wrote
14 this report, Doctor. His deposition was
15 taken right around that same time, May
16 29th, just so you know.

17 BY MR. ALLEN:

18 Q. You state here that you came to the
19 conclusion that the resident was properly supervised
20 and acted under the direction of his attending faculty
21 anesthesiologist, correct?

22 A. That's correct.

23 Q. And that means that he was properly
24 supervised, meaning that Dr. Adamek properly oversaw
25 what Dr. Senchyshak was doing; is that correct?

Page 11

1 A. Dr. Adamek was there and was in charge of
2 the case and discussed, as far as I know, the case with
3 his resident and the resident never acted
4 independently.

5 Q. Okay. Well, let's -- if I can kind of get
6 your understanding as to the roles between a resident
7 and an attending anesthesiologist. What is -- is a
8 resident a student in the field of anesthesiologist?
9 If you can, explain to me your opinion.

10 A. He is a student in the wider sense of the
11 word. He is a graduate medical doctor who is at that
12 point after an internship undergoing or doing specialty
13 training. He/she will be instructed for three years in
14 the clinical management of patients who require
15 anesthesia, pain management, et cetera. There are
16 class courses and there's, of course, the clinical
17 work.

18 Residents are not independent
19 practitioners, and until the day they graduate from a
20 legal point of view they don't have the direct
21 responsibility for the patient, certainly not in my
22 program, in no program. It is the attending who is
23 responsible for the care of the patient.

24 Having said that, since we are trying
25 to teach people how to fly, they must be able to take

1 the plane off one of these days by themselves.

2 Q. So there are periods in which they're not
3 directly under the supervising eye of an attending; is
4 that what you mean?

5 A. Well, it comes -- it is a gradual process.
6 If you are totally new, everything that you do is
7 tightly supervised. As a matter of fact, you show this
8 is how you do it. At the end of the training, if the
9 training was successful you have a young doctor who in
10 consultation with you will make a plan for the
11 anesthetic management and will execute it. You will be
12 there at all times available, and in the final analysis
13 you still will say I approve of this plan, it is my
14 plan.

15 Q. Okay. Is it your opinion that Dr.
16 Senchyshak was totally new to the field of
17 anesthesiology?

18 A. No, it is not, because he had been for at
19 least a year, I believe, at Cincinnati, so he had some
20 experience, and he had been about three months in this
21 program. So he knew many of the things, I hope, how to
22 do them and certainly knew his way around the
23 anesthesia machine and the monitors, et cetera.

24 Q. Okay. So you would give him a level of
25 training of over a year, is that what you would

Page 13

1 categorize it?

2 A. That's what the record says.

3 Q. Due to his 11 months before and three or
4 four months in this program?

5 A. Yes.

6 Q. Now, what about, how does a resident and
7 an attending communicate when they're overseeing the
8 care of a patient? I want to just in a general sense
9 ask you that, but kind of focus you on a high risk
10 patient and a resident that's in his first year of
11 residency in anesthesiology. How would you expect the
12 two to communicate?

13 A. They'll talk to each other.

14 Q. Would that be -- at what stages would you
15 expect in this case, in the Dewey Jones case, for the
16 attending, Dr. Adamek, to have -- at what stages would
17 you expect him to be there and communicate to his
18 resident?

19 A. I don't understand that question.

20 Q. Would you expect Dr. Adamek to be at the
21 bedside of Dewey Jones while the resident was doing a
22 pre-op evaluation?

23 A. No, I would not.

24 Q. Okay. What would you expect to happen?

25 A. I would expect the resident or a member of

Page 14

1 the department to see the patient and prepare a
2 pre-anesthetic report. I would expect the resident, a
3 resident, if he or she didn't do the preoperative visit
4 him or herself, to be familiar with the preoperative
5 visit. I would expect the resident and the faculty
6 before the case, either on the day of the case or the
7 evening before the case, to have a conversation and
8 develop a treatment plan.

9 Q. And did that occur in this case?

10 A. I understand that there was a discussion
11 in the morning between Dr. Adamek and the resident.

12 Q. And in your opinion, it's appropriate for
13 the pre-op evaluation to be done by an outside, another
14 resident, one that did not do the anesthesia?

15 A. That's appropriate.

16 Q. Would you expect that resident to have
17 then communicated his pre-op evaluation verbally to
18 Dr. Adamek?

19 A. Not necessarily.

20 Q. How would you expect him to communicate?

21 A. That's why we have pre-anesthetic records.

22 Q. All right. So in your opinion, all the
23 communication in this case that occurred between the
24 pre-op resident that evaluated Dewey the night before
25 and Dr. Adamek was done through the record, medical

Page 15

1 record?

2 A. I have no knowledge and I don't even know
3 who did the preoperative visit, whether there was a
4 conversation, as well.

5 Q. So you don't know whether or not there was
6 a conversation between the pre-op resident and
7 Dr. Adamek?

8 A. I do not know that.

9 Q. Would you expect that to have occurred?

10 A. No. I've already answered that. No, not
11 necessarily.

12 Q. Not necessarily. But you didn't get that
13 pre-op resident to get enough information in the
14 medical record to then communicate to Dr. Adamek; is
15 that a fair statement?

16 A. That's correct.

17 Q. So now we go to the pre-op evaluation the
18 day of surgery in this case, the Dewey Jones case. Do
19 you expect Dr. Adamek to be at the bedside when
20 Dr. Senchyshak was doing his pre-op evaluation?

21 A. No, I don't.

22 Q. When do you expect Dr. Adamek to be there?

23 A. After the resident has finished a separate
24 evaluation the resident presents his finding to the
25 attending and the attending checks certain things if

Page 16

1 that is necessary, and then a discussion of the
2 treatment plan should take place.

3 Q. Do you know whether or not Dr. Adamek
4 reviewed the pre-op notes of the resident that did the
5 evaluation the night before before surgery started?

6 A. I don't know that.

7 Q. Would you have expected him to do that?

8 A. Yes.

9 Q. That would have been good medical care,
10 correct?

11 A. That's correct.

12 Q. Okay. Now, as you're at the bedside -- as
13 Dr. Senchyshak and Dr. Adamek are communicating about
14 Dewey Jones' plan for anesthesia, you'd expect
15 Dr. Adamek to take the lead as to what shouldn't be
16 done during the operation; is that true?

17 A. Partially true. It depends on the age of
18 the resident. At his status I would not be surprised
19 if the resident would say, should we do the case in
20 such and such way, make a proposal, and then the
21 attending would say, that sounds all right or we will
22 do this for the following reason.

23 Q. Now, you know that in this case
24 Dr. Senchyshak suggested a Swan-Ganz be in place during
25 the operation, true?

Page 17

1 MS. REINKER: Objection.

2 A. I don't know whether I know that. Did he
3 state so in his deposition? If so, then I know that.

4 Q. Right. So do you remember -- you
5 don't remember seeing that in the deposition, but --

6 A. I reviewed the deposition sometime ago and
7 I didn't review it recently.

8 Q. Okay. So anyway, if Dr. Senchyshak had
9 stated we should insert a Swan-Ganz and Dr. Adamek
10 said, no, it's not necessary, all the responsibility of
11 whether or not that was appropriate thus lies with
12 Dr. Adamek in your opinion?

13 A. Well, that's precisely the point about
14 this teaching, the resident will make a proposal and
15 the attending will approve or not approve. The
16 responsibility is the attending's, not the resident's.

17 Q. I understand. I just want to ask you
18 specific definitions of that as it relates to this
19 case. I'm not trying to be tricky.

20 Now, if you can tell me, do you have an
21 opinion as to whether a Swan-Ganz should have been in
22 place for this patient during this operation?

23 A. Yes, I have an opinion.

24 Q. What is that?

25 A. More likely than not there should have

Page 18

1 I been a Swan-Ganz.

2 Q. And why is that?

3 A. Because the patient represents a high risk
4 patient and the anesthetic management for this patient
5 required, in my opinion, pretty aggressive monitoring.

6 Q. And a Swan-Ganz would have given them what
7 sort of information during the operation?

8 A. It gives you information about the status
9 of cardiac output and of fluid load.

10 Q. And that's important with Dewey Jones
11 because?

12 A. A patient of Jones' history represents a
13 likelihood of having hypertension, cardiac damage,
14 problems with ventilation. They are risky patients.
15 Their risk of morbidity and mortality is considerably
16 higher than a normal patient and there are anesthetic
17 techniques that decrease the risk.

18 Q. And that Swan-Ganz is one of those
19 techniques that decreases the risk, true?

20 A. A Swan-Ganz catheter, insertion of, has
21 its own morbidity and mortality. The risk-benefit
22 ratio of that risk versus the information has to be
23 weighed and can be, in the judgment of reasonable
24 people the result can be different.

25 Q. But in your opinion, the risk

Page 19

1 I think -- I mean, the risk -- that I
2 think the risk in this case and a Swan-Ganz should
3 have been placed, correct?

4 A. Partially correct. I might have -- I
5 personally might have started with a central line, see
6 whether that, which is a lesser monitor, but also a
7 lesser risk, was sufficient.

8 MS. REINKER: Move to strike.

9 BY MR. ALLEN:

10 Q. Was that done in this case?

11 A. I think there was a central line, but it
12 wasn't used for monitoring, it was used for infusion.

13 Q. Would that have been -- in your opinion,
14 was the standard of care violated by Dr. Adamek by not
15 inserting a Swan-Ganz?

16 MS. REINKER: Objection.

17 A. It's the same answer that I just gave.
18 Reasonable people can come to different conclusions
19 here.

20 Q. Would it have been the standard throughout
21 the country for a patient like Dewey Jones more likely
22 than not that they'd use a Swan-Ganz?

23 MR. CASEY objection.

24 MS. REINKER: objection.

25 MR. CASEY He just

Page 20

1 answered that question. He said that
2 reasonable. It can be to different
3. I think

4 BY MR. ALLEN:

5 Q. All right, Doctor. Now, as we talk about
6 the Swan-Ganz, it measures fluid overload and cardiac
7 output, correct?

8 A. Correct.

9 Q. When you have that type of
10 can you predict or anticipate pulmonary edema?

11 A. You can anticipate it and predict it
12 better than without the monitor.

13 Q. Why is that?

14 A. Because you have information that you
15 don't have when you don't have the monitor.

16 Q. That information being?

17 A. What the pulmonary wedge pressure is, what
18 the cardiac output is, what the fluid status of the
19 patient is.

20 Q. All right. What would you expect to see
21 in the Swan-Ganz readings that would indicate that
22 pulmonary edema would occur or might occur?

23 A. I would like to make a comment here.

24 Q. Yes, sir.

25 A. I consider myself as an expert on the

Page 21

1 case. -- are
2 asking me as an expert on the management of this case.

3 Q. That question was just, I wanted to
4 understand the relationship of the Swan-Ganz. It's
5 general medical knowledge in which the resident in this
6 case suggested it occur, so I think it's kind of along
7 the same line.

8 A. I don't understand your answer.

9 MS. REINKER: I would like
10 the record to note a continuing objection
11 to this entire line of questioning in this
12 case.

13 BY MR. ALLEN:

14 Q. Can you answer the question? I'm not
15 going to spend too much more time with it.

16 A. What is your last question?

17 Q. Last question was, what would you expect
18 the Swan-Ganz to read to anticipate possible pulmonary
19 edema?

20 A. Decreased cardiac output, increased wedge
21 pressure, increased -- period.

22 Q. Now, when there's a difference of opinion
23 between a resident, in this case Dr. Senchyschak and
24 Dr. Adamek, does the resident have any responsibility
25 to second-guess the order of the attending doctor?

Page 22

1 A. Only in absurd situations. If the
2 attending tells the patient to throw the patient out of
3 the window, he shouldn't do that. But as far as the
4 use of a Swan-Ganz catheter in this case -- we went
5 over this ground before -- there can be a difference of
6 opinion, and a first-year resident is generally not in
7 the position, doesn't have enough knowledge to really
8 make a convincing case.

9 As a matter of fact, again, in the
10 educational situation, I expect a good resident to
11 argue his case and I expect a good attending to argue
12 his side of the case, and it has happened certainly to
13 me that the residents have convinced me of a change in
14 management. That's what this whole process is about.

15 Q. Do you know if the two argued about
16 whether or not the Swan-Ganz shouldn't have been
17 placed?

18 A. I do not know that.

19 Q. Do you know what was communicated for the
20 reason why the Swan-Ganz should be in place when he
21 talked to Dr. Senchysak?

22 A. I do not know that.

23 Q. Now, at 12:30 -- you can look at the
24 anesthesia record if you'd like, Doctor, at any time --
25 is it your opinion that at that time they were

Page 23

1 reversing the neuromuscular block and bringing this
2 patient out?

3 A. Since you state that, it's probably true.

4 Q. Thank you.

5 A. Yes.

6 Q. So is it your understanding of the facts
7 that at that time Dr. Adamek was in the room?

8 A. No. I don't know whether Adamek was at
9 the beginning of the reversal in the room; I do not
10 know that.

11 Q. Would it be good medical practice for the
12 attending in this high risk patient to be at the
13 bedside when the reversal began?

14 A. More likely yes than not.

15 Q. Now, after the reversal began do you
16 understand in your opinion whether this patient was
17 completely extubated at that time or not?

18 A. My reading of the record is that the
19 patient was not extubated.

20 Q. And what occurred at the time, 12:30, when
21 the neuromuscular block was reversed to cause the
22 pulmonary edema?

23 MR. CASEY: objection.

24 That question makes an assumption that the
25 pulmonary edema started at 12:30.

Page 24

1 A. If the patient was reversed at that time,
2 spontaneous respirations would have started. That
3 changes airway pressures. The record, as far as I can
4 see, doesn't say whether the patient bucked, that is,
5 coughed on the tube or not, but it's possible that he
6 did. And these are some of the things that in a
7 precariously balanced system like Dr. Jones might be
8 the final trigger for pulmonary edema. There are many
9 reasons for pulmonary edema, that could be one.

10 Q. Now, is it your understanding that the
11 resident proceeded the reversal on his own accord?

12 A. No, it's not my understanding. I don't
13 know.

14 Q. You don't know whether or not he took it
15 on himself to start reversal at that time?

16 A. That's correct.

17 Q. And you don't know whether or not
18 Dr. Adamek gave that order, correct?

19 A. I do not know.

20 Q. So would you be critical of the resident
21 if he started that procedure by his own accord without
22 talking to the attending?

23 A. Yes.

24 Q. Would you be critical of the resident for
25 starting the reversal process if Dr. Adamek in his

Page 25

1 preoperative plan did not tell him what to do at that
2 point in the procedure?

3 A. What is your question, sir?

4 Q. During the pre-op evaluation if Dr. Adamek
5 had not given the resident a complete plan of
6 management for this care of Dewey Jones to include at
7 what time to reverse the anesthesia, would you still be
8 critical of the resident to have taken that on himself?

9 MR. CASEY: I'm confused by
10 the question, Charles. Are you asking him
11 should he had reversed the patient --
12 should Adamek have said whether to reverse
13 the patient intraoperatively or wait until
14 they go to the ICU, is that what you're
15 asking?

16 MR. ALLEN: Right.

17 BY MR. ALLEN:

18 Q. If you had this preoperative meeting and
19 Dr. Adamek didn't walk down the road to say at what
20 stage you should reverse and at what stage you should
21 go to room air and at what stage et cetera, if the
22 resident took it on himself to do those steps, would
23 you be critical of the resident?

24 MR. CASEY: objection.

25 That's two questions now.

Page 26

Page 28

1 Q. Pull the room air out of it.
2 MR. CASEY It's two
3 questions. You're asking should Adamek
4 have done it and then would you be
5 critical of the resident. Break them up
6 and we can go forward with the question.

7 BY MR. ALLEN:

8 Q. Would you be critical of the resident?
9 I'm just asking about the resident at this point.

10 A. About what?

11 MR. ALLEN Let me try this
12 on my own, Jim, if you don't mind.

13 Q. Would you be critical of the resident if
14 he started this reversal process without a preoperative
15 plan by the attending, Dr. Adamek, that stated that,
16 you know, you should or shouldn't -- didn't state
17 whether or not he should or should not reverse at that
18 time?

19 A. If I understand your question correctly,
20 if the resident had no information of whether to
21 reverse or not, then a prudent resident would ask
22 should we go ahead with reversal.

23 Q. Would a prudent resident also go ahead and
24 ask whether or not the patient should go to room air?

25 A. No. I expect a resident with that amount

1 testimony, he's the only one in the room at this time
2 and he's doing things on his own accord, so I'm asking
3 you, what, in your opinion, is the appropriate thing to
4 do at 12:30, to leave the patient ventilated or on room
5 air?

6 A. The patient is not to be on room air at
7 that point.

8 Q. Does that same opinion hold true for the
9 next 30 45 minutes?

10 A. Zero resuscitate, yes.

11 Q. Now, as proper management of this patient
12 would it be reasonable to expect this patient to stay
13 ventilated for a matter of hours or even days after
14 this procedure?

15 A. That's one way of handling a patient of
16 this kind.

17 Q. You were able to look at the fluid
18 management of this patient intraoperatively, correct?

19 A. Yes.

20 Q. Do you feel that too much fluid was given
21 to this patient intraoperatively?

22 A. That's borderline. The answer is no, not
23 really.

24 Q. But it's a jump ball, is that basically --

25 MR. JONES: Objection.

Page 27

Page 29

1 of training to know that these patients stay on oxygen.

2 Q. For how long?

3 A. It depends on the vital signs.

4 Q. So at 12:30 according to the vital signs,
5 between 12:00 and 12:30 what would you -- how long
6 would you expect the patient to stay ventilated?

7 MR. CASEY: you're asking
8 about 12:00 and 12:30?

9 MR. ALLEN 12:30.

10 BY MR. ALLEN:

11 Q. Just the progression here, Doctor.

12 A. The vital signs are not changing there.
13 There was a little increase in pressure which, of
14 course, I would expect. The pulse ox starts to fall
15 later.

16 Q. So before 12:30 would it, in your
17 opinion, be appropriate to bring the patient to room
18 air?

19 A. Again, you are asking me the management of
20 this case. I'm the expert for the education of the
21 resident.

22 Q. I understand that. But the resident is
23 the one that's in the room at this time, correct?

24 A. Correct.

25 Q. My understanding from deposition

1 BY MR. ALLEN:

2 Q. Now, as far as this intraoperative care of
3 Dewey Jones, to your knowledge, at what points was the
4 tending, Dr. Adamek, actually in the room?

5 A. The record doesn't state that. I don't
6 know.

7 Q. Do you expect a resident on his own accord
8 to understand that the attending should have been with
9 him the entire case?

10 A. No; that's not up to the resident.

11 Q. Would you expect a resident of that
12 training and education and background to question the
13 tending as to when the attending should be in the
14 operating room?

15 A. No.

16 Q. And, in your opinion, a resident of
17 this education and this training should not be making
18 independent medical judgments, correct?

19 A. Correct.

20 Q. And all of those independent medical
21 judgments should be done by the attending?

22 A. Correct.

23 Q. Have you ever testified for the law firm
24 of Jacobson, Maynard before, reviewed cases for them?

25 A. Yes, I have.

Page 30

1 Q. Tell me how many times. Just take it the
2 review of , how many times have you reviewed a
3 case?

4 MS. REINKER: when you stated
5 before this case, he has not reviewed on
6 behalf of that firm.

7 MR. ALLEN: I understand.

8 A. I'd better make a general statement. I do
9 not review more than four cases a year and last year I
0 reviewed none. My guess is that for Jacobson six,
1 seven times.

2 Q. Over a period of?

3 A. Many years.

4 Q. Ten years, five years?

5 A. Ten years maybe.

6 Q. And of those reviews, how many times have
7 you given a deposition?

8 A. Too many times. Again, five, six. I
9 don't know.

0 Q. How many times have you gone to trial?

1 A. Once.

2 Q. For that firm, once?

3 A. Once.

4 Q. Now, the law firm of Reminger & Reminger,
5 the same question, how many cases have you reviewed for

Page 31

1 them in the past?

2 A. I think one.

3 Q. That's other than this case?

4 A. Correct.

5 Q. When was that?

6 A. I tried to ask Mr. Malone. I don't know.
7 Several years ago.

8 Q. Was it for Mr. Malone?

9 A. Yes.

0 Q. Do you know what that case involved?

1 A. No, I forgot.

2 Q. Okay. Did you give a trial --

3 A. No, we didn't go to trial.

4 Q. Did you give a deposition?

5 A. Yes.

6 Q. Total, Doctor, how many times have you
7 given trial testimony?

8 A. Given what?

9 Q. Trial testimony.

0 A. Being in court?

1 Q. Yes, sir.

2 A. I think once.

3 Q. That was one for the Jacobson firm?

4 A. Wait a second. The one was out of town.
5 Twice.

Page 32

1 Q. Twice?

2 A. Twice.

3 Q. Does that include maybe any videotaped
4 depositions that you know were going to be used for
5 trial?

6 A. I don't remember.

7 Q. So there may have been another time that
8 you got in front of a video camera and you knew it was
9 going to go to a courtroom?

10 A. Could be.

11 Q. You just don't recall?

12 A. I don't recall.

13 MR. CASEY: He doesn't know
14 if this one is going to be used in the
15 courtroom, Charles.

16 BY MR. ALLEN

17 Q. You know, sometimes you sit down in front
18 of the camera and you know beforehand because of your
19 schedule, you couldn't come to court.

20 A. I'm not camera shy. I'm being videotaped
21 all the time when I give lectures.

22 Q. Now, tell me, have you ever been sued for
23 malpractice?

24 A. Of course.

25 Q. How many times, Doctor?

Page 33

1 A. I can't tell you. But since I am the
2 chairman of this department, I usually get named
3 because I'm a chairman, so it is many times.

4 Q. How many times have you given a deposition
5 because you were a defendant in the case?

6 A. Once.

7 Q. When was that?

8 A. I think -- I think '84.

9 Q. What was the nature of that case, did it
10 involve anything similar to this?

11 A. It was a resuscitation of a baby.

12 Q. Did you have to go to trial?

13 A. No.

14 Q. The case was concluded before trial?

15 A. It was settled.

16 Q. Now, were you represented or been
17 represented by any of the two law firms?

18 A. Yes, I was represented by Jacobson.

19 Q. Would that encompass every time you've
20 been sued for medical malpractice you've been
21 represented by Jacobson?

22 my group --
23 as a matter of fact, all of the physicians at
24 University Hospitals are with PIE, and PIE is with
25 Jacobson, Maynard & Tuschman.

Page 34

1 Q. And they've always had your insurance, so
 2 it's always been this group of lawyers that have
 3 represented you?
 4 A. Really not before PIE existed.
 5 Q. And when was that? When did you -- do you
 6 remember when you went to PIE?
 7 A. In the late '70s, early '80s, something
 8 like that.
 9 Q. Do you know Dr. David Rapkin?
 10 A. Yes. If he is the David Rapkin who was a
 11 resident here, then I know him.
 12 Q. Did you teach him during his residency?
 13 A. I tried.
 14 Q. Did you succeed?
 15 A. He passed his boards.
 16 Q. When was the last time you had any contact
 17 with him?
 18 A. Years.
 19 Q. What about Dr. J. Conomy do you know
 20 him?
 21 A. Who?
 22 Q. Conomy.
 23 A. No.
 24 Q. Dr. Howard Nearman?
 25 A. Yes. He works in my department.

Page 35

1 Q. He works where?
 2 A. In my department.
 3 Q. And you work with him on a daily basis?
 4 A. Yes, I do.
 5 Q. Tell me how long you've worked with
 6 Dr. Nearman.
 7 A. I have known him since 1976, I believe.
 8 Q. Do you know him on a personal basis?
 9 A. Yes, I do.
 10 Q. Do you go out to dinner or go to do other
 11 things outside the --
 12 A. Occasionally.
 13 Q. What about Dr. Richard Schlanger?
 14 A. I don't know the name.
 15 Q. Surgeon out of Columbus, Ohio.
 16 A. Sorry.
 17 Q. What about Dr. John Downs, an
 18 anesthesiologist out of Tampa?
 19 A. I know John Downs.
 20 Q. How do you know Dr. Downs?
 21 A. He is a chairman and chairmen meet at
 22 national meetings. I don't know him well, but I know
 23 him. As a matter of fact, I was a visiting professor
 24 there once a long time ago.
 25 Q. I'm going to run through some other

Page 36

1 doctors' names. If any of them rings a bell, say yea,
 2 okay. Joseph Bussey?
 3 A. Nay.
 4 Q. Joel Kaplan?
 5 A. Yea.
 6 Q. How do you know Joel Kaplan?
 7 A. Same.
 8 Q. Same, national?
 9 A. Yes.
 10 Q. Do you know he's written textbooks on
 11 anesthesiology?
 12 A. Yes, I do.
 13 Q. Is that a good textbook that he put out?
 14 A. It's a textbook, yes.
 15 Q. Do you have any opinion as to whether
 16 it's --
 17 A. I don't do much cardiac anesthesia, so I
 18 don't know whether it's the best, but it's certainly a
 19 reputable book.
 20 Q. And he is a reputable doctor, I take it?
 21 MS. REINKER: Objection.
 22 A. Yes, he's from New York.
 23 Q. Meaning the two coincide?
 24 A. M-hm.
 25 Q. Okay. Dr. Marc Semigran, the

Page 37

1 cardiologist, do you know him?
 2 A. No.
 3 Q. Dr. Alvin Kahn?
 4 A. No.
 5 Q. Another New York doctor.
 6 A. No.
 7 Q. Dr. Francis Barnes, surgeon?
 8 A. No.
 9 Q. Dr. Robert Greendyke, pathologist out of
 10 New York?
 11 A. No.
 12 Q. Dr. Charles Greenhouse?
 13 A. No.
 14 Q. Dr. Marshall Orloff, the surgeon?
 15 A. No.
 16 Q. Dr. Paul Thompson, cardiologist?
 17 A. No.
 18 Q. Now, you're Board certified according to
 19 your curriculum vitae. Do you anticipate or expect all
 20 your attending physicians on staff to be Board
 21 certified?
 22 A. Yes.
 23 Q. Is there a hospital policy that they be
 24 Board certified?
 25 A. Board certified or equivalent with

Page 38

1 exceptions being granted by special action of the
2 clinical council.

3 Q. Well, is it important for it to be Board
4 certified?

5 MR. ALLEN: Objection.

6 MS. REINKER: Objection.

7 A. It is a way to assess the knowledge and
8 possibly the skills of a specialist. It is not
9 perfect. As a matter of fact, it's the only thing we
10 have. It could be better.

11 Q. But it's a fair indication of the
12 knowledge and skill of a practicing anesthesiologist?

A. Yes.

14 MS. REINKER: objection.

15 BY MR. ALLEN:

16 Q. In general, do you have -- have you
17 ever been asked to file a patient,
18 independently called in for a consult in the past?

19 A. Yes, clear a patient?

20 Q. Whether or not they were stable or in a
21 condition to go through the surgery.

22 A. Are you asking me whether I have been
23 acting as a consultant in anesthesiology? The answer
24 is yes.

25 Q. Okay. Whenever you medically clear a

Page 39

1 patient, it's as an anesthesiologist?

2 A. Yes, of course.

3 Q. Explain to me, an anesthesiologist when he
4 does a pre-op evaluation of a patient, he is looking as
5 to whether or not that patient is a candidate for the
6 surgery, correct?

7 A. That's correct.

8 Q. Okay. So his entire focus is the overall
9 health of that patient as to whether they can undergo
10 the knife?

11 A. No, it's not undergo the knife, whether he
12 can undergo the stress of anesthesia and surgery.

13 Q. So it's the stress of the anesthesia
14 and --

15 A. And surgery.

16 Q. -- and surgery. Meaning, what part of the
17 surgery, just the opening and the length of the time?

18 A. I don't understand what you're asking me.

19 Q. Okay. Let me just back up and rephrase
20 another question.

21 It's more of the medical determination
22 of whether they can -- it's not so much, say, the risk
23 of gallbladder surgery or colon surgery, but it's the
24 risk of the anesthesia and the surgery together?

25 A. That's correct.

Page 40

1 Q. Okay. Have you ever had that when you're
2 looking at a patient deciding whether or not a cardiology
3 consult was needed?

4 A. Of course.

5 Q. How often have you called in a cardiology
6 consult?

7 A. I can't answer that, because certainly
8 recently the pre-anesthetic evaluation that I do is for
9 a very special population, and cardiology consults,
10 or not

11 necessary. So personally I have not asked for a
12 some

13 The system here works somewhat
14 different from what you seem to assume. The patient,
15 our now go a

16 research clinic and are evaluated by members of the
17 department of anesthesia and hopefully proper tests and
18 hopefully only the proper tests will be asked and the
19 proper consultations and only the proper consultations
20 requested.

21 Q. Have you ever stopped -- let me pick up.
22 Do you expect a resident of Dr. Senchyshak's education
23 and training to recognize the need for a cardiology
24 consult in Dewey Jones on the morning of the 20th?

25 MR. WALTERS: I'm going to

Page 41

1 object. It assumes he needs a cardiology
2 consult.

3 Go ahead.

4 A. No, I wouldn't expect him. I would hope
5 that he could, but that's what the attending is for, to
6 tell the resident you didn't request, we should
7 request.

8 Q. Now, have you ever -- you've had the
9 occasion as an anesthesiologist to stop a surgery from
10 occurring, correct?

11 A. I have occasions to advise my surgical
12 colleague about the risk and advise my surgical
13 colleague about the things that should be done before
14 we proceed with surgery. In the final analysis it is a
15 risk-benefit assessment, and I, of course, listen to
16 the surgical side of the equation, and if the surgeon
17 can convince me that the delaying of the surgery
18 outweighs the risk of whatever consultation or whatever
19 is requested then we will go ahead.

20 The question here is always that the
21 total picture of the patient's treatment is seen. I'm
22 not an expert in surgery, but if I work with surgeons I
23 will find out that they can tell me about certain
24 things for this case that make the risk of delaying
25 higher than the risk of getting the test.

Page 42

Page 44

1 Q. Would you expect Dr. S to tell his
2 education, knowledge and background to recognize
3 whether this procedure should have been delayed?

4 A. Same answer as before. He certainly -- I
5 would be pleased if he questioned me on that, but I
6 wouldn't necessarily expect it.

7 Q. But you would expect an attending
8 anesthesiologist to be able to recognize that, true?

9 MS. REINKER: Objection.

10 A. The attending anesthesiologist has to be
11 able to evaluate the risk for this patient regarding
12 the surgery -- regarding the anesthesia and in
13 consultation with the surgeon making a plan whether to
14 proceed or not.

15 Q. Do you have an opinion as to whether this
16 case should have been delayed?

17 MS. REINKER: Objection.

18 A. This is really Monday quarterbacking. I
19 just cannot tell you whether this case should have been
20 delayed or not. I would have been there.

21 Q. Do you have an opinion as to whether a
22 cardiology consult should have been called in by
23 anesthesia before surgery progressed?

24 MS. REINKER: Objection.

25 A. It probably wouldn't have -- with his

Page 43

1 history, assessment of his cardiac status was
2 necessary, and as far as I can make out, some of the
3 steps were taken by Dr. Ho.

4 Q. My question is a little more specific than
5 that, but do you have an opinion as to whether
6 anesthesia should have called in a cardiology consult?

7 A. They had the information from Dr. Ho who
8 had treated this patient before, so it's a toss-up
9 whether they should have or should have not. It
10 depends on their working relationship with Dr. Ho.

11 Q. Do you know if Dr. Ho has any specialty in
12 cardiology?

13 A. I do not.

14 Q. Do you know if he's Board certified?

15 A. I do not.

16 Q. Would those be important conclusions as to
17 whether or not they should have relied on Dr. Ho?

18 A. Not necessarily.

19 Q. Doctor, have you -- as an
20 anesthesiologist, they don't diagnose the existence of
21 all the other diseases, that's not your job?

22 A. That's not my job.

23 Q. It's not the job of pretty much any
24 anesthesiologist, correct?

1 A. No, but I can do it.

2 Q. You can do it, you have the ability to do
3 it, but in this case it wasn't the duty of either
4 Dr. Adamek or Dr. Senchysyak to determine how severe
5 the gallbladder was?

6 A. That would be absurd. That's what the
7 surgical -- the input with the surgeon is in the
8 situation.

9 Q. That's what I'm trying to understand.
10 That would be the surgeon's duty in this case, correct?

11 A. Correct.

12 Q. And in your understanding of the facts, it
13 was Dr. Ho who was called in just to see if the patient
14 could medically withstand anesthesia and surgery; is
15 that true?

16 A. Well, I don't know whether that's what
17 they did because internists and non-anesthesiologists
18 really cannot assess whether somebody can withstand
19 anesthesia. But I expect the non-anesthesiologist,
20 internist, whoever, the information that I expect from
21 them is the status of the patient is as follows, the
22 status is as good as it can be or the following things
23 could be done to improve it, and that information goes
24 into my assessment together then with the risk-benefit
25 of having the surgery now or delaying surgery.

Page 45

1 Q. So the risk-benefit is decided by
2 three of the physicians?

3 A. That's correct.

4 Q. But it is -- in your understanding of the
5 case, it wasn't the role of Dr. Ho to determine how bad
6 the gallbladder was?

7 A. No.

8 Q. That was Badri's?

9 A. That's correct.

10 Q. If we go to trial and you're asked to come
11 to trial, if you're asked to give testimony, you don't
12 expect to give any testimony as to how severe the
13 gallbladder was and whether or not gallbladder surgery
14 was indicated?

15 A. No.

16 Q. Correct?

17 A. No.

18 Q. So you're not going to give any opinions
19 as to whether alternatives to surgery were appropriate,
20 true?

21 A. That's true.

22 Q. You don't have any opinions as to
23 rendering any -- scratch that. You don't feel -- I'm
24 sorry.

25 You don't feel that you will come to

Page 46

1 trial and testify as to whether or not the pathology
2 report in this case indicated the gallbladder was in
3 any way diseased, et cetera, correct?

4 A. Yes, that's absurd.

5 Q. In your opinion, is hypertension under
6 control if there is medication being given?

7 A. It can be under control.

8 Q. So a patient that has medicated
9 hypertension and stayed under control, that's
10 controlled hypertension?

11 A. If the hypertension is controlled, it is
12 controlled hypertension, that's correct.

13 Q. Whether or not it's medically controlled
14 by medicine or not?

15 A. That's correct.

16 Q. So a patient that strictly takes medicine
17 to control his hypertension would not be, in your
18 opinion, a patient that has uncontrolled hypertension,
19 correct?

20 A. Yes.

21 Q. Is it your opinion that hypertension will
22 decrease if on bedrest?

23 A. I'm sorry?

24 Q. Will hypertension decrease if on bedrest?

25 A. It can.

Page 47

1 Q. More than likely it will, true?

2 A. Depends on the type of hypertension.

3 Q. In this case did you review the status of
4 Dewey's hypertension?

5 A. No. I reviewed the perianesthetic facts
6 and, yes, he was a hypertensive.

7 Q. Is it your opinion that before surgery
8 Mr. Jones' hypertension was under control?

9 A. I have no opinion.

10 Q. Do you have an opinion as to whether a
11 resident of Dr. Senchyshak's training should have
12 recognized whether or not this hypertension was under
13 control?

14 A. Probably not.

15 Q. Did Dewey Jones have what's called cor
16 pulmonale?

17 A. I don't know that.

18 Q. If Dewey Jones had cor pulmonale, would
19 that affect any readings of a Swan-Ganz catheter?

20 A. Probably.

21 Q. How would that affect it?

22 A. It would make the readings unreliable.

23 Q. Is there any determination as to the
24 extent of the cor pulmonale, that it would be, you
25 know, if it's minor or major, if that would have any

Page 48

1 effect on the Swan-Ganz?

2 A. What has that to do with resident
3 education?

4 Q. The need or not the need for the
5 Swan-Ganz.

6 A. I think we discussed that already.

7 Q. Okay. Does cor pulmonale -- is there any
8 range of cor pulmonale in which a Swan-Ganz is
9 appropriate to insert?

10 A. I'm not testifying about the treatment of
11 this patient, I'm testifying about the education of
12 Dr. Senchyshak.

13 MR. CASEY: Jim, I think
14 that's a fair question. I mean, I'm not
15 asking --

16 MR. CASEY: If you
17 understand the question, Doctor. I mean,
18 I guess you have already told him that the
19 existence of cor pulmonale would not make
20 the readings unreliable in a Swan-Ganz
21 catheter, and I think as it pertains --

22 MS. REINKER: He said the
23 opposite.

24 MR. CASEY: I thought you
25 said would not.

Page 49

1 THE WITNESS: Might make it
2 unreliable.

3 MR. CASEY Might make it
4 unreliable.

5 BY MR. ALLEN:

6 Q. My question is, is there an extent, is
7 there a disease process that it would be reliable and
8 still have cor pulmonale?

9 A. I really don't know how to answer that
10 because there is a huge gamut of cor pulmonale and that
11 now gets us into specifics of cardiology and cardiac
12 anesthesia, and I don't think I'm going to testify on
13 that.

14 Q. And so as an anesthesiologist, to
15 determine the extent of cor pulmonale you would expect
16 a cardiologist to be called in to determine that?

17 A. Yes, I would.

18 Q. Do you have an opinion as to whether
19 anesthesia should have called in a cardiologist to
20 evaluate the extent of Dewey Jones' cor pulmonale if he
21 had it?

22 MS. REINKER: Objection.

23 A. In this particular case the patient was
24 evaluated by Dr. Ho, and I think it is proper, unless
25 there is something glaring that the anesthesia team,

Page 50

Page 52

1 rely upon the medical team that was taking care of
 2 Mr. Jones.
 3 Q. So in other words, it's okay not to call
 4 in a cardiology consult to determine the cor pulmonale?
 5 MR. CASEY: objection.
 6 That's not what he just said.
 7 MR. ALLEN: Is that what he
 8 just said?
 9 MR. CASEY: He said that it
 10 was proper to rely on the medical team and
 11 their decision whether to call in a
 12 cardiology consult, Charles. Don't
 13 rephrase what he says.
 14 A. I agree, it's proper for them to work with
 15 the team.
 16 MR. ALLEN: I rephrase it
 17 to understand, Jim, you know that.
 18 MR. MALONE: He's trying to
 19 answer your question.
 20 MR. ALLEN I know he is.
 21 I'm just trying to understand. I'm not
 22 trying to be difficult.
 23 MR. MALONE: I know you're
 24 not, you're not being difficult. He's
 25 trying to answer, he just did.

1 A. That's correct.
 2 Q. What are the risk factors that Dewey Jones
 3 had that led him to be a high risk surgical patient?
 4 A. He was morbidly obese, he had a history of
 5 heart disease, he had a history of sleep apnea.
 6 Q. Hypertension?
 7 A. And hypertension.
 8 Q. Did you say -- I'm sorry, did you say
 9 congestive heart failure?
 10 MR. MALONE: He said heart
 11 disease.
 12 A. No, I said heart disease.
 13 Q. Okay. Is it your opinion that Dr. Adamek
 14 was available during the induction of Dewey Jones?
 15 A. Yes.
 16 Q. Is it your opinion that the induction
 17 phase of Dewey Jones was properly done?
 18 A. It was one way of inducing that patient,
 19 yes.
 20 Q. What time do you understand that
 21 Dr. Adamek was physically in the room during the
 22 induction?
 23 A. You asked me that before and I don't know.
 24 Q. During induction I don't know if I asked
 25 you.

Page 51

Page 53

1 BY MR. ALLEN:
 2 Q. Doctor, I appreciate it. We're almost
 3 finished here.
 4 A. I appreciate it.
 5 Q. Before I leave the subject of cor
 6 pulmonale, there is a wide gamut of cor pulmonale and
 7 the best way to determine the extent of cor pulmonale
 8 is to get a cardiology consult, true?
 9 MR. WALTERS: Objection.
 10 A. That's correct.
 11 Q. Doctor, can you look at the record at
 12 12:30 and tell me what a Swan-Ganz would have read if
 13 in place at 12:30?
 14 A. No.
 15 Q. Can anybody do that?
 16 A. No.
 17 Q. It would be pure speculation, true?
 18 A. Yes.
 19 Q. And why is that?
 20 A. Because people are not machines. There
 21 are too many factors. It's just simply not possible to
 22 say with any reasonable certainty what the Swan would
 23 read at this point. It's not doable.
 24 Q. Do you -- in your opinion, Dewey Jones is
 25 a high risk surgical patient, true?

1 A. It appears that he was there during
 2 induction, but I don't think that the record states
 3 specifically when and when he -- when he was in the
 4 room and when he wasn't.
 5 Q. Do you have an opinion that Dewey Jones
 6 had or did not have chronic obstructive lung disease?
 7 A. I don't know whether he had chronic
 8 obstructive lung disease, but his -- I don't know.
 9 Q. If he did, would that change the course of
 10 management of anesthesia?
 11 MS. REINKER: Objection.
 12 A. No, not essentially.
 13 Q. Are there any anesthesia risk factors
 14 associated with chronic obstructive lung disease?
 15 A. Yes, of course.
 16 Q. What are they?
 17 A. The question of work of breathing, the
 18 question of whether or not shunting develops, the
 19 question of general oxygenation. The patient just is
 20 not as able to react to particularly anesthetic that
 21 changes the response of pulmonary vasculature to
 22 hypoxia.
 23 Q. Would you expect a resident of Dr.
 24 Senchyshak's training to be able to recognize the
 25 extent of Dewey's chronic obstructive lung disease if

Page 54

1 he had any?
 2 A. I doubt it.
 3 Q. But you would expect an attending to be
 4 able to do that, correct?
 5 A. Yes.
 6 Q. Now, Dewey Jones had sleep apnea, correct?
 7 A. Yes.
 8 Q. And sleep apnea increases the risk during
 9 surgery and anesthesia of what?
 10 A. As a matter of fact, it does not increase
 11 the risk during surgery and anesthesia, it increases
 12 the risk postsurgery because people don't breathe.
 13 Q. So during the reversal phase?
 14 A. That's where it would start, yes.
 15 Q. If the patient was extubated then it would
 16 carry over and have an effect on extubation, true?
 17 A. No, it wouldn't have an effect on
 18 extubation, extubation would have an effect on it.
 19 Q. Okay. I said it backwards.
 20 What effect would that be?
 21 A. Again, this is -- for Mr. Jones
 22 particularly, his work of breathing, because of his
 23 obesity, is tremendously increased. After surgery,
 24 after drugs, et cetera, he is weaker. If you combine
 25 that with abnormal pulmonary functions you have a setup

Page 55

1 for people who become apneic and hypoxic. That's why
 2 such people have to be in an ICU regardless of how you
 3 manage them postoperatively.
 4 Q. Would you expect a resident of
 5 Senchyshak's training to recognize that?
 6 A. He may or may not. The understanding of
 7 how dangerous morbid obesity is postoperatively, it
 8 takes a while to learn that.
 9 Q. But you do expect an attending to
 10 appreciate that, true?
 11 A. Yes.
 12 Q. Do you have an opinion as to if taking
 13 Dewey Jones off his anti-hypertensive medications the
 14 night before had any effect one way or another as to
 15 his operative anesthesia?
 16 A. It probably didn't.
 17 Q. How is that?
 18 A. It probably did not because he probably
 19 still has a bit of a hangover from the medication the
 20 next day.
 21 Q. So it's just too short of a time frame?
 22 A. Probably.
 23 Q. Eight hours or so?
 24 A. Probably.
 25 Q. Was Mr. Jones at high risk for cardiac

Page 56

1 dysrhythmia postoperatively?
 2 A. Higher than normal, yes.
 3 Q. He was at a higher risk for developing
 4 pulmonary edema, true?
 5 A. Yes.
 6 Q. He was at a higher risk for developing
 7 either cardiac or pulmonary arrest, true?
 8 A. I don't know what pulmonary arrest is.
 9 Q. Cardiac -- cardiac arrest.
 10 A. Yes.
 11 Q. Pulmonary complications that could lead to
 12 the cessation of breathing, he was at a higher risk for
 13 that?
 14 A. Yes.
 15 Q. Were you aware that oxygen was given to
 16 Mr. Jones preoperatively?
 17 A. Yes.
 18 Q. What was your understanding of why that
 19 was given?
 20 A. He was morbidly obese, has sleep apnea, he
 21 is probably chronically somewhat hypoxic.
 22 Q. And how would that affect his management
 23 of anesthesia?
 24 A. During the anesthesia he is better off
 25 because we can feed him a hundred percent oxygen which

Page 57

1 he cannot get while he's awake.
 2 Q. So it would have no difference as to
 3 whether or not he was preoperative oxygenation?
 4 A. Not for oxygenation during the anesthetic.
 5 Q. Would it make any difference as to the
 6 postoperative care?
 7 A. Of course.
 8 Q. How?
 9 A. His oxygenation has to be carefully
 10 watched.
 11 Q. And in your opinion, was it up to
 12 Dr. Senchyshak to recognize that need?
 13 A. Same answer as before, maybe, maybe not.
 14 Q. Do you know if Dr. Senchyshak was aware of
 15 whether Dewey was on preoperative oxygen?
 16 A. I do not know that.
 17 Q. But you'd expect him to know that, true?
 18 A. Yes.
 19 Q. I know you probably answered this, but you
 20 said no as to the impact of events that led
 21 to Mr. Jones' arrest, true?
 22 MR. MALONE: You mean the
 23 physiologic sequence of events?
 24 MR. ALLEN: Physiological.
 25 A. I can speculate on it, but, no, I don't

Page 58

1 have an opinion.

2 Q. And within a reasonable degree of medical
3 certainty, you can't tell me exactly what happened --

4 A. No.

5 Q. -- inside Dewey's body to create the
6 arrest, true?

7 A. No.

8 Q. Do you have an -- you're not expected to
9 come to trial and form an opinion, correct, as to that?

10 A. I don't expect to have an opinion at
11 trial.

12 Q. Do you have any knowledge as to Mr. Jones'
13 present state?

14 A. No.

15 Q. If Mr. Jones had a history of a previous
16 TIA, would that have any effect as to his operative
management of anesthesia?

A. Not more or less than all his other
disease.

20 Q. Just another risk factor?

21 A. Yes.

22 Q. And it's a risk factor because why?

23 A. It shows that his cardiovascular system is
24 in poor shape.

25 Q. Poor shape to -- poor shape in what way?

Page 59

1 A. Well, at one time it clearly didn't
2 perfuse his brain because he fainted.

3 Q. And would it be more of a problem during
4 the operation or postoperatively?

5 A. Same answer, not during the operation.

6 Q. But during his postoperative management,
7 true?

8 A. That's true, with the proviso that the
9 blood pressure during the operation did not go too low
10 for a long period of time.

11 Q. Do you have an opinion as to if that
12 happened?

13 A. It didn't happen here according to this
14 record.

15 Q. Do you have an opinion as to whether
16 Mr. Jones was in active congestive heart failure before
17 the operation?

18 A. The record certainly doesn't show that.

19 Q. So your opinion is he wasn't in active --

20 A. Probably not.

21 Q. What is your fee in a review, Doctor?

22 A. I charge a little less than lawyers, but I
23 charge \$250 an hour.

24 Q. And then does it change to give deposition
25 testimony?

Page 60

1 A. No, it does not.

2 Q. What about trial testimony?

3 A. Same.

4 Q. Same all the way across the board, okay.

5 Have those numbers been the same since
6 you started doing this?

7 A. No. I started with a little less.

8 Incidentally, I really am not going to do this for the
9 money at all. I have a very good income. I'm doing
10 this because maybe I can help make medical care,
11 delivery of medical care a little better.

12 Q. I understand that and appreciate that,
13 Doctor.

14 MR. CASEY: Just so you
15 know, Charles, we've got 25 minutes until
16 2:00 and I think some of the other people

20 BY MR. ALLEN:

21 Q. This is Exhibit 1. Is this up-to-date,
22 sir?

23 A. When did you get it?

24 Q. I don't know, a couple months ago.

25 A. Well, obviously I'm a couple of months

Page 61

1 older. Yes, I guess so.

2 Q. Is the anything that needs to be added
3 to it?

4 A. No, not now.

5 Q. Is there any articles, publications, et
6 cetera, listed that would shed light on your opinions
7 as it relates to this case?

8 A. Yes, there are some articles on resident
9 education.

10 Q. Which ones are those Doctor?

11 A. I think you are chasing -- I don't know
12 when those were. Somewhere in the '70s.

13 MR. CASEY: Are the titles
14 self-explanatory, Doctor?

15 THE WITNESS: Yes.

16 BY MR. ALLEN:

17 Q. They are self explanatory?

18 A. Something about the function of the
19 resident conference, and I believe there's the other
20 one of the frequency of teaching cases somewhere.

21 Q. Doctor, you have some publications that
22 were written in German?

23 A. Yes.

24 Q. That's not self-explanatory to me. Is
25 there anything that was written in German that you

Page 62

1 could draw my attention to?

2 A. No, and the French one wouldn't either and
3 the Spanish one wouldn't either.

4 Q. Other than the State of Ohio, have you
5 testified in any other states?

6 A. No, I have not.

7 Q. How many times have you testified for a
8 plaintiff or a patient?

9 A. I have been consulted on the plaintiff,
10 but not testified.

11 Q. How many times have you been consulted?

12 A. I think it was two times. One time I
13 refused to get involved.

14 Q. Why was that? You felt the care was
15 appropriate?

16 A. I was too busy.

17 Q. But at that time you did feel the care was
18 inappropriate?

19 A. I was too busy to evaluate it.

20 Q. Too busy to evaluate. And the other time?

21 A. Not that I recall.

22 Q. I'm sorry?

23 A. Not that I recall.

24 Q. Do you have any upcoming trial dates
25 held for depositions held?

Page 63

1 A. No, I have not.

2 Q. Have you ever testified in a similar case
3 to this such as the standard of care required an
4 anesthesiologist to stop the surgery preoperatively?

5 A. No.

6 Q. Have you ever testified in a similar case
7 in which the standard of care required the placement of
8 a Swan-Ganz catheter intraoperatively?

9 A. I have not.

10 Q. Have you ever testified to a similar case
11 in which the standard of care required the patient to
12 stay intubated postoperatively hours to days?

13 A. I have not.

14 Q. Have you ever testified in a similar case
15 in which the standard of care required proper
16 management of postoperative ventilation?

17 A. I have not.

18 Q. Have you ever testified in a similar case
19 where the issues concerned the standard of care
20 requiring proper resuscitation postoperatively to avoid
21 brain damage?

22 A. I have not.

23 Q. You read Dr. Kaplan's report, true?

24 A. I read his report and his deposition.

25 Q. Do you agree with Dr. Kaplan when he

Page 64

1 stated that Dewey Jones was severely hypertensive on
2 admission with a blood pressure of 189/127? Do you
3 agree with that statement?

4 A. If he had that blood pressure, that's
5 severe hypertension, of course.

6 Q. Do you consider any literature
7 authoritative as to the standard of care of causation
8 in this case, authoritative?

9 A. Ask this question again.

10 Q. Do you consider any specific -- is there
11 any specific authoritative literature upon which you
12 base your opinion of the standard of care in this
13 case?

14 MR. MALONE: That's actually
15 a different question than you asked him.

16 BY MR. ALLEN

17 Q. That's a different question.

18 A. Is there an authoritative text that gives
19 the recipe for treating this patient? No, that's not
20 the way it works. There are many textbooks, and the
21 synthesis of the opinions in those textbooks is
22 probably the standard of care.

23 Q. When you formed your opinions you assumed
24 the were entirely correct, true?

25 A. Yes, we have to do that.

Page 65

1 MR. ALLEN: That's all I
2 have right now. Pass.

3 MR. CASEY: Mark?

4 MR. JONES: No, I have no
5 questions.

6 MR. CASEY: Steve?

7 MR. WALTERS: None.

8 MR. CASEY: Susan?

9 MS. REINKER: Yes.

10 ---

11 EXAMINATION

12 BY MS. REINKER:

13 Q. Dr. Cascorbi, I represent Dr. Adamek.
14 just have a couple questions for you.

15 You said earlier that there are risks
16 to using a Swan-Ganz catheter, correct?

17 A. ---

18 Q. And that a physician in any given
19 situation will do a risk-benefit analysis in deciding
20 whether or not to use a Swan-Ganz?

21 A. Correct.

22 Q. What are some of the risks, can you list
23 them for me?

24 A. Arrhythmias, perforation of major vessels
25 in the heart, knotting of the catheter making it

Page 66

Page 68

1 impossible to withdraw the catheter are some of the
2 major risks.

3 Q. Are you familiar --

4 A. Infection.

5 Q. I'm sorry?

6 A. And infection.

7 Q. How about actually causing the patient or
8 worsening their condition in some way, are you familiar
9 with any --

10 A. Yes. If you have somebody that could
11 cause a tachyarrhythmia through introduction of the
12 Swan you may make the situation very serious.

13 Q. I think you said earlier that reasonable
14 physicians may come to different conclusions as to
15 whether or not to use a Swan-Ganz?

16 A. That's correct.

17 Q. And that's true in this case, too?

18 A. That's correct.

19 Q. That's a judgment call that the physician
20 makes based on the best knowledge they have at the
21 time?

22 A. That's correct.

23 Q. By the way, I think I missed the answer to
24 this question earlier. You prepared a report directed
25 to Mr. Casey dated May 29th of 1997?

1 A. Yes.

2 Q. And to call you when necessary?

3 A. At home.

4 Q. Or during the case?

5 A. Yes.

6 Q. By the way, you were discussing Board
7 certification before. Now, Board certification is
8 obtained through taking a test, or taking two tests
9 actually?

10 A. That's correct.

11 Q. One an oral and one a written?

12 A. That's correct.

13 Q. In your lifetime I would gather you've
14 seen some people who just are not good at taking tests?

15 A. That's correct.

16 Q. And there could be some very fine
17 practicing physicians who for some reason just are not
18 good test takers?

19 A. That's correct.

20 MS. REINKER: I have nothing
21 else.

22 MR. ALLEN Follow-up.

23 MR. CASEY: Go ahead.

24 ---

25 ///

Page 67

Page 69

1 A. Is that my letter?

2 Q. Yes.

3 A. Yes.

4 Q. Is that the only report you prepared?

5 A. That's correct.

6 Q. You've prepared no supplemental reports of
7 any kind?

8 A. I have not.

9 Q. The relationship between an attending and
10 a resident is a two-way street, they each have some
11 responsibilities to each other?

12 A. If I understand your question that the
13 resident has to bring information to the attending, the
14 attending has to bring information to the resident and
15 that there is a sharing of information, then the answer
16 is, yes, of course. It's a teaching relationship, it
17 cannot be a one-way street.

18 Q. You rely on your residents to do certain
19 things?

20 A. I try to.

21 Q. And you rely on them to report to you
22 accurately?

23 A. I absolutely do.

24 Q. And to bring any problems to your
25 attention?

1 AM

2 BY MR. ALLEN

3 Q. Doctor, do you have an opinion as to if a
4 Swan-Ganz was placed in Dewey Jones whether that would
5 worsen his condition?

6 A. It could, but I don't -- I cannot have an
7 opinion. Is there a risk that it worsens, we just
8 discussed that, yes, that risk exists with him.

9 Q. But you can't tell me by your review of
10 the records that it would be more likely or not that it
11 would have worsened his condition, true?

12 A. The question is improper. You cannot by
13 review of a record, even by a physical exam of a
14 patient, predict whether one of the complications that
15 are known to occur with a Swan-Ganz would occur in this
16 patient, that's not possible.

17 MR. ALLEN: That's all I
18 have. Let me just talk to Paul real
19 quick.

20 Have you got some questions?

21 MR. CASEY No, I have no
22 questions.

23 MR. ALLEN Let me just
24 talk to him one second.

25 (Thereupon, there was a brief recess.)

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Page 7

\$250 [1] 1:59:23	above [1] 1:1:24	air [6] 1:25:21 1:26:1 1:26:24 1:27:18 1:28:5 1:28:6
'70s [2] 1:34:7 1:61:12	absolutely [1] 1:67:23	airway [1] 1:24:3
'80s [1] 1:34:7	absurd [3] 1:22:1 1:44:6 1:46:4	allen [33] 1:2:3 1:5:12 1:5:13 1:5:22 1:10:17 1:19:9 1:20:4 1:21:13 1:25:16 1:25:17 1:26:7 1:26:11 1:27:9 1:27:10 1:29:1 1:30:7 1:32:16 1:38:15 1:49:5 1:50:7 1:50:16 1:50:20 1:51:1 1:57:24 1:60:18 1:60:20 1:61:16 1:64:16 1:65:1 1:68:22 1:69:2 1:69:17 1:69:23
'84 [1] 1:33:8	accord [4] 1:24:11 1:24:21 1:28:2 1:29:7	almost [2] 1:51:2 1:60:19
Ill [1] 1:68:25	according [3] 1:27:4 1:37:18 1:59:13	along [1] 1:21:6
1001 [2] 1:2:22 1:3:3	accurately [1] 1:67:22	alternatives [1] 1:45:19
1040 [1] 1:2:7	acted [3] 1:9:17 1:10:20 1:11:3	alvin [1] 1:37:3
11100 [1] 1:1:22	acting [2] 1:8:21 1:38:23	always [3] 1:34:1 1:34:2 1:41:20
113 [2] 1:2:12 1:2:17	action [2] 1:38:1 1:71:20	amount [1] 1:26:25
148 [1] 1:2:4	active [2] 1:59:16 1:59:19	analysis [3] 1:12:12 1:41:14 1:65:19
1600 [2] 1:2:22 1:3:3	adamek [35] 1:2:20 1:8:25 1:10:7 1:10:24 1:11:1 1:13:16 1:13:20 1:14:11 1:14:18 1:14:25 1:15:7 1:15:14 1:15:19 1:15:22 1:16:3 1:16:13 1:16:15 1:17:9 1:17:12 1:19:14 1:21:24 1:23:7 1:23:8 1:24:18 1:24:25 1:25:4 1:25:12 1:25:19 1:26:3 1:26:15 1:29:4 1:44:4 1:52:13 1:52:21 1:65:13	anesthesia [33] 1:6:16 1:6:21 1:6:25 1:8:18 1:9:14 1:9:14 1:11:15 1:12:23 1:14:14 1:16:14 1:22:24 1:25:7 1:36:17 1:39:12 1:39:13 1:39:24 1:40:17 1:42:12 1:42:23 1:43:6 1:44:14 1:44:19 1:49:12 1:49:19 1:49:25 1:53:10 1:53:13 1:54:9 1:54:11 1:55:15 1:56:23 1:56:24 1:58:17
1891127 [1] 1:64:2	adamek's [1] 1:8:23	anesthesiologist [51] 1:9:10 1:10:21 1:11:7 1:11:8 1:35:18 1:38:12 1:39:1 1:39:3 1:41:9 1:42:8 1:42:10 1:43:20 1:43:25 1:49:14 1:63:4
1976 [1] 1:35:7	added [1] 1:61:2	anesthesiology [5] 1:1:22 1:12:17 1:13:11 1:36:11 1:38:23
1997 [3] 1:1:14 1:66:25 1:71:23	address [1] 1:5:25	anesthetic [6] 1:6:22 1:12:11 1:18:4 1:18:16 1:53:20 1:57:4
20th [1] 1:40:24	admission [1] 1:64:2	answer [15] 1:9:7 1:19:17 1:21:8 1:21:14 1:28:22 1:38:23 1:40:7 1:42:4 1:49:9 1:50:19 1:50:25 1:57:13 1:59:5 1:66:23 1:67:15
216 [5] 1:2:8 1:2:13 1:2:18 1:2:23 1:3:4	advise [2] 1:41:11 1:41:12	answered [3] 1:15:10 1:20:1 1:57:19
241-7000 [1] 1:2:8	affect [3] 1:47:19 1:47:21 1:56:22	anti-hypertensive [1] 1:55:13
2844 [1] 1:6:1	affixed [1] 1:71:22	anticipate [4] 1:20:10 1:20:11 1:21:18 1:37:19
29th [2] 1:10:16 1:66:25	aforesaid [2] 1:71:9 1:71:14	anyway [1]
30303 [1] 1:2:5	afterwards [1] 1:71:11	
306012 [1] 1:1:8	again [5] 1:22:9 1:27:19 1:30:18 1:54:21 1:64:9	
404 [1] 1:2:5	age [1] 1:16:17	
44113-1904 [1] 1:2:8	aggressive [1] 1:18:5	
44114 [4] 1:2:13 1:2:18 1:2:22 1:3:3	ago [4] 1:17:6 1:31:7 1:35:24 1:60:24	
523-2200 [1] 1:2:5	agree [3] 1:50:14 1:63:25 1:64:3	
687-1311 [2] 1:2:13 1:2:18	ahead [5] 1:26:22 1:26:23 1:41:3 1:41:19 1:68:23	
736-8600 [2] 1:2:23 1:3:4		
7th [1] 1:71:23		
ability [1] 1:44:2		
able [7] 1:11:25 1:28:17 1:42:8 1:42:11 1:53:20 1:53:24 1:54:4		
abnormal [1] 1:54:25		

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1:42:22	1:43:6	1:43:12	certainly [7]	1:6:2	1:71:22
1:49:11	1:50:4	1:50:12	1:11:21	1:12:22	1:22:12
1:51:8			1:36:18	1:40:7	1:42:4
ardiovascular [1]			1:59:18		
1:58:23			certainty [2]		
are [24]			1:51:22	1:58:3	
1:8:18	1:8:23	1:8:24	certificate [1]		
1:9:1	1:11:23	1:13:8	1:71:2		
1:16:9	1:19:14	1:25:6	certification [2]		
1:29:2	1:50:1	1:57:6	1:68:7	1:68:7	
1:60:10	1:60:11	1:62:14	certified [7]		
1:62:17	1:63:3	1:63:7	1:5:9	1:37:18	1:37:21
1:63:11	1:63:15	1:63:19	1:37:24	1:37:25	1:38:4
1:64:7	1:64:12	1:64:22	1:43:14		
arefully [1]			certify [3]		
1:57:9			1:71:6	1:71:15	1:71:18
arry [1]			cessation [1]		
1:54:16			1:56:12		
ascorbi [7]			cetera [6]		
1:1:13	1:1:16	1:5:2	1:11:15	1:12:23	1:25:21
1:5:6	1:6:1	1:65:13	1:46:3	1:54:24	1:61:6
1:71:7			chairman [4]		
ase [58]			1:9:14	1:33:2	1:33:3
1:1:8	1:7:21	1:8:8	1:35:21		
1:8:19	1:9:10	1:11:2	chairmen [1]		
1:11:2	1:13:15	1:13:15	1:35:21		
1:14:6	1:14:6	1:14:7	change [3]		
1:14:9	1:14:23	1:15:18	1:22:13	1:53:9	1:59:24
1:15:18	1:16:19	1:16:23	changes [2]		
1:17:19	1:19:2	1:19:10	1:24:3	1:53:21	
1:21:1	1:21:2	1:21:6	changing [1]		
1:21:12	1:21:23	1:22:4	1:27:12		
1:22:8	1:22:11	1:22:12	charge [3]		
1:27:20	1:29:9	1:30:3	1:11:1	1:59:22	1:59:23
1:30:5	1:31:3	1:31:10	charles [8]		
1:33:5	1:33:9	1:33:14	1:2:3	1:5:13	1:5:20
1:41:24	1:42:16	1:42:19	1:25:10	1:32:15	1:37:12
1:44:3	1:44:10	1:45:5	1:50:12	1:60:15	
1:46:2	1:47:3	1:49:23	chasing [1]		
1:61:7	1:63:2	1:63:6	1:61:11		
1:63:10	1:63:14	1:63:18	checking [1]		
1:64:8	1:64:13	1:66:17	1:8:3		
1:68:4			checks [1]		
ases [5]			1:15:25		
1:29:24	1:30:2	1:30:9	chronic [4]		
1:30:25	1:61:20		1:53:6	1:53:7	1:53:14
asey [26]			1:53:25		
1:2:11	1:4:19	1:5:19	chronically [1]		
1:10:9	1:19:23	1:19:25	1:56:21		
1:23:23	1:25:9	1:25:24	Cincinnati [1]		
1:26:2	1:27:7	1:32:13	1:12:19		
1:48:13	1:48:16	1:48:24	civil [1]		
1:49:3	1:50:5	1:50:9	1:1:18		
1:60:14	1:61:13	1:65:3	clair [2]		
1:65:6	1:65:8	1:66:25	1:2:12	1:2:17	
1:68:23	1:69:21		class [1]		
ategorize [1]			1:11:16		
1:13:1			clear [3]		
atheter [8]			1:38:17	1:38:19	1:38:25
1:18:20	1:22:4	1:47:19	clearance [1]		
1:48:21	1:63:8	1:65:16	1:7:1		
1:65:25	1:66:1		clearly [1]		
ausation [2]			1:59:1		
1:9:5	1:64:7		Cleveland [8]		
ausing [1]			1:1:23	1:2:8	1:2:13
1:66:7			1:2:18	1:2:22	1:3:3
entral [2]					
1:19:5	1:19:11				
ertain [3]					
1:15:25	1:41:23	1:67:18			
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1:18:15			1:24:5			define [1]		
consult [11]			council [1]			1:6:20		
1:38:18	1:40:3	1:40:6	1:38:2			definitions [1]		
1:40:12	1:40:24	1:41:2	country [1]			1:17:18		
1:42:22	1:43:6	1:50:4	1:19:21			degree [1]		
1:50:12	1:51:8		county [2]			1:58:2		
consultant [1]			1:1:2	1:71:2		delayed [3]		
1:38:23			couple [3]			1:42:3	1:42:16	1:42:20
consultation [3]			1:60:24	1:60:25	1:65:14	delaying [3]		
1:12:10	1:41:18	1:42:13	course [12]			1:41:17	1:41:24	1:44:25
consultations [2]			1:9:9	1:11:16	1:27:14	delivery [1]		
1:40:19	1:40:19		1:32:24	1:39:2	1:40:4	1:60:11		
consulted [2]			1:41:15	1:53:9	1:53:15	department [7]		
1:62:9	1:62:11		1:57:7	1:64:5	1:67:16	1:1:22	1:9:15	1:14:1
consults [1]			courses [1]			1:33:2	1:34:25	1:35:2
1:40:9			1:11:16			1:40:17		
contact [13]			court [4]			deposed [1]		
1:34:16			1:1:4	1:9:20	1:31:20	1:5:9		
contacted [1]			1:32:19			deposition [19]		
1:7:25			courtroom [2]			1:1:13	1:1:16	1:5:2
continuing [1]			1:32:9	1:32:15		1:6:4	1:6:9	1:6:13
1:21:10			create [1]			1:6:14	1:10:14	1:17:3
control [6]			1:58:5			1:17:5	1:17:6	1:27:25
1:46:6	1:46:7	1:46:9	critical [7]			1:30:17	1:31:14	1:33:4
1:46:17	1:47:8	1:47:13	1:24:20	1:24:24	1:25:8	1:59:24	1:63:24	1:70:2
controlled [4]			1:25:23	1:26:5	1:26:8	1:71:15		
1:46:10	1:46:11	1:46:12	1:26:13			depositions [6]		
1:46:13			cross-examination [2]			1:6:8	1:8:10	1:10:5
conversation [4]			1:4:4	1:5:11		1:10:6	1:32:4	1:62:25
1:7:20	1:14:7	1:15:4	curriculum [1]			determination [2]		
1:15:6			1:37:19			1:39:21	1:47:23	
convince [1]			cuyahoga [2]			determine [6]		
1:41:17			1:1:2	1:71:2		1:44:4	1:45:5	1:49:15
convinced [1]			daily [1]			1:49:16	1:50:4	1:51:7
1:22:13			1:35:3			develop [1]		
convincing [1]			damage [2]			1:14:8		
1:22:8			1:18:13	1:63:21		developing [2]		
copy [1]			dangerous [1]			1:56:3	1:56:6	
1:7:14			1:55:7			develops [1]		
cor [14]			date [1]			1:53:18		
1:47:15	1:47:18	1:47:24	1:1:24			dewey [27]		
1:48:7	1:48:8	1:48:19	dated [1]			1:1:6	1:8:23	1:9:6
1:49:8	1:49:10	1:49:15	1:66:25			1:9:23	1:13:15	1:13:21
1:49:20	1:50:4	1:51:5	dates [1]			1:14:24	1:15:18	1:16:14
1:51:6	1:51:7		1:62:24			1:18:10	1:19:21	1:25:6
correct [57]			david [2]			1:29:3	1:40:24	1:47:15
1:7:2	1:8:5	1:8:19	1:34:9	1:34:10		1:47:18	1:49:20	1:51:24
1:9:2	1:9:20	1:10:2	days [3]			1:52:2	1:52:14	1:52:17
1:10:21	1:10:22	1:10:25	1:12:1	1:28:13	1:63:12	1:53:5	1:54:6	1:55:13
1:15:16	1:16:10	1:16:11	decide [1]			1:57:15	1:64:1	1:69:4
1:19:3	1:19:4	1:20:7	1:40:2			dewey's [3]		
1:20:8	1:24:16	1:24:18	deciding [1]			1:47:4	1:53:25	1:58:5
1:27:23	1:27:24	1:28:18	1:65:19			diagnose [1]		
1:29:18	1:29:19	1:29:22	decision [1]			1:43:20		
1:31:4	1:39:6	1:39:7	1:50:11			difference [4]		
1:39:25	1:41:10	1:43:25	decrease [3]			1:21:22	1:22:5	1:57:2
1:44:10	1:44:11	1:45:3	1:18:17	1:46:22	1:46:24	1:57:5		
1:45:9	1:45:16	1:46:3	decreased [1]			different [7]		
1:46:12	1:46:15	1:46:19	1:21:20			1:18:24	1:19:18	1:20:2
1:51:10	1:52:1	1:54:4	decreases [1]			1:40:14	1:64:15	1:64:17
1:54:6	1:58:9	1:64:24	1:18:19			1:66:14		
1:65:16	1:65:17	1:65:21	defendant [5]			difficult [2]		
1:66:16	1:66:18	1:66:22	1:2:10	1:2:20	1:3:1	1:50:22	1:50:24	
1:67:5	1:68:10	1:68:12	1:7:21	1:33:5		dinner [1]		
1:68:15	1:68:19	1:71:13	defendants [2]			1:35:10		
correctly [2]			1:1:10	1:2:15		direct [1]		
1:9:13	1:26:19					1:11:20		
roughed [1]								

le:page:line 1:97-133.txt

directed [1] 1:66:24			1:52:14	1:52:21	1:52:24	event [2] 1:6:19	1:71:20	
direction [1] 1:10:20			1:53:1	1:54:8	1:54:11	events [2] 1:57:20	1:57:23	
directly [1] 1:12:3			1:54:13	1:56:24	1:57:4	exactly [1] 1:58:3		
discuss [1] 1:7:23			1:59:3	1:59:5	1:59:6	exam [1] 1:69:13		
discussed [3] 1:11:2	1:48:6	1:69:8	duty [2] 1:44:3	1:44:10		examination [3] 1:1:17	1:5:7	1:65:11
discussing [1] 1:68:6			dysrhythmia [1] 1:56:1			exceptions [1] 1:38:1		
discussion [2] 1:14:10	1:16:1		early [1] 1:34:7			execute [1] 1:12:11		
disease [10] 1:43:21	1:49:7	1:52:5	edema [8] 1:20:10	1:20:22	1:21:19	exhibit [4] 1:5:1	1:7:11	1:10:1
1:52:11	1:52:12	1:53:6	1:23:22	1:23:25	1:24:8	1:60:21		
1:53:8	1:53:14	1:53:25	1:24:9	1:56:4		exhibits [1] 1:4:12		
1:58:19			education [9] 1:21:1	1:27:20	1:29:12	existed [1] 1:34:4		
diseased [1] 1:46:3			1:29:17	1:40:22	1:42:2	existence [2] 1:43:20	1:48:19	
doable [1] 1:51:23			1:48:3	1:48:11	1:61:9	exists [1] 1:69:8		
doctor [27] 1:5:13	1:5:24	1:6:3	educational [1] 1:22:10			expect [43] 1:5:16	1:9:19	1:13:11
1:7:13	1:10:14	1:11:11	educator [1] 1:9:14			1:13:15	1:13:17	1:13:20
1:12:9	1:20:5	1:21:25	effect [7] 1:48:1	1:54:16	1:54:17	1:13:24	1:13:25	1:14:2
1:22:24	1:27:11	1:29:16	1:54:18	1:54:20	1:55:14	1:14:5	1:14:16	1:14:20
1:31:16	1:32:25	1:36:20	1:58:16			1:15:9	1:15:12	1:15:19
1:37:5	1:38:16	1:43:19	eight [1] 1:55:23			1:15:22	1:16:14	1:20:20
1:48:17	1:51:2	1:51:11	either [7] 1:14:6	1:40:10	1:44:3	1:21:17	1:22:10	1:22:11
1:59:21	1:60:13	1:61:10	1:56:7	1:62:2	1:62:3	1:26:25	1:27:6	1:27:14
1:61:14	1:61:21	1:69:3	1:71:19			1:28:12	1:29:7	1:29:11
doctors [1] 1:7:21			employee [1] 1:71:19			1:37:19	1:40:22	1:41:4
doctors' [1] 1:36:1			encompass [1] 1:33:19			1:42:1	1:42:6	1:42:7
document [1] 1:7:17			end [2] 1:12:8	1:60:19		1:44:19	1:44:20	1:45:12
doesn't [5] 1:22:7	1:24:4	1:29:5	entire [3] 1:21:11	1:29:9	1:39:8	1:49:15	1:53:23	1:54:3
1:32:13	1:59:18		entirely [1] 1:64:24			1:55:4	1:55:9	1:57:17
done [11] 1:9:16	1:9:17	1:14:13	equation [1] 1:41:16			1:58:10		
1:14:25	1:16:16	1:19:10	equivalent [1] 1:37:25			expected [2] 1:16:7	1:58:8	
1:26:4	1:29:21	1:41:13	esq [7] 1:2:3	1:2:6	1:2:11	experience [1] 1:12:20		
1:44:23	1:52:17		1:2:11	1:2:16	1:2:21	expert [4] 1:20:25	1:21:2	1:27:20
doubt [1] 1:54:2			1:3:2			1:41:22		
down [2] 1:25:19	1:32:17		essentially [1] 1:53:12			explain [2] 1:11:9	1:39:3	
downs [4] 1:6:9	1:35:17	1:35:19	euclid [1] 1:1:22			extent [7] 1:9:19	1:47:24	1:49:6
1:35:20			evaluate [4] 1:42:11	1:49:20	1:62:19	1:49:15	1:49:20	1:51:7
haft [2] 1:7:15	1:7:16		1:62:20			1:53:25		
draw [1] 1:62:1			evaluated [3] 1:14:24	1:40:16	1:49:24	extubated [3] 1:23:17	1:23:19	1:54:15
drugs [1] 1:54:24			evaluation [10] 1:13:22	1:14:13	1:14:17	extubation [3] 1:54:16	1:54:18	1:54:18
due [1] 1:13:3			1:15:17	1:15:20	1:15:24	eye [1] 1:12:3		
duly [3] 1:5:8	1:71:5	1:71:7	1:16:5	1:25:4	1:39:4	fact [6] 1:12:7	1:22:9	1:33:23
during [20] 1:16:16	1:16:24	1:17:22	1:40:8			1:35:23	1:38:9	1:54:10
1:18:7	1:25:4	1:34:12	evening [1] 1:14:7			factor [2] 1:58:20	1:58:22	
						factors [3] 1:51:21	1:52:2	1:53:13

file:page:line

1:97-133.txt

facts [31]			foregoing [2]			1:23:11	1:36:13	1:44:22
1:23:6	1:44:12	1:47:5	1:71:13	1:71:16		1:60:9	1:68:14	1:68:18
faculty [2]			forgot [1]			gradual [1]		
1:10:20	1:14:5		1:31:11			1:12:5		
fail [1]			form [1]			graduate [2]		
1:9:9			1:58:9			1:11:11	1:11:19	
failure [2]			formed [1]			granted [1]		
1:52:9	1:59:16		1:64:23			1:38:1		
fainted [1]			forth [1]			greendyke [1]		
1:59:2			1:1:24			1:37:9		
fair [3]			forward [1]			greene [1]		
1:15:15	1:38:11	1:48:14	1:26:6			1:1:8		
fairmount [1]			four [2]			greenhouse [1]		
1:6:1			1:13:4	1:30:9		1:37:12		
fall [1]			frame [1]			grieco [1]		
1:27:14			1:55:21			1:2:6		
familiar [3]			francis [1]			ground [1]		
1:14:4	1:66:3	1:66:8	1:37:7			1:22:5		
far [6]			french [1]			group [3]		
1:10:1	1:11:2	1:22:3	1:62:2			1:2:15	1:33:22	1:34:2
1:24:3	1:29:2	1:43:2	frequency [1]			guess [3]		
fast [4]			1:61:20			1:30:10	1:48:18	1:61:1
1:5:23	1:8:12	1:8:14	front [2]			half [1]		
1:8:15			1:32:8	1:32:17		1:5:17		
fee [1]			function [1]			hand [1]		
1:59:21			1:61:18			1:71:21		
feed [1]			functions [1]			handling [1]		
1:56:25			1:54:25			1:28:15		
felt [1]			gallbladder [6]			hangover [1]		
1:62:14			1:39:23	1:44:5	1:45:6	1:55:19		
field [2]			1:45:13	1:45:13	1:46:2	he/she [1]		
1:11:8	1:12:16		gallstone [1]			1:11:13		
final [3]			1:43:21			health [1]		
1:12:12	1:24:8	1:41:14	gallstones [1]			1:39:9		
finding [1]			1:43:21			heart [8]		
1:15:24			gamut [2]			1:7:5	1:7:7	1:52:5
fine [1]			1:49:10	1:51:6		1:52:9	1:52:10	1:52:12
1:68:16			gather [1]			1:59:16	1:65:25	
finished [2]			1:68:13			heights [1]		
1:15:23	1:51:3		general [5]			1:6:2		
firm [7]			1:13:8	1:21:5	1:30:8	helmut [6]		
1:2:3	1:2:7	1:29:23	1:38:16	1:53:19		1:1:13	1:1:16	1:5:2
1:30:6	1:30:22	1:30:24	generally [1]			1:5:6	1:6:1	1:71:6
1:31:23			1:22:6			help [1]		
firms [1]			generate [1]			1:60:10		
1:33:17			1:7:10			hereby [1]		
first [4]			georgia [1]			1:71:6		
1:5:8	1:7:23	1:13:10	1:2:5			herein [2]		
1:71:7			german [2]			1:1:17	1:5:7	
first-year [1]			1:61:22	1:61:25		hereinafter [1]		
1:22:6			given [15]			1:5:9		
five [2]			1:7:1	1:8:23	1:18:6	hereunto [1]		
1:30:14	1:30:18		1:25:5	1:28:20	1:30:17	1:71:21		
fluid [5]			1:31:17	1:31:18	1:33:4	herself [1]		
1:18:9	1:20:6	1:20:18	1:46:6	1:56:15	1:56:19	1:14:4		
1:28:17	1:28:20		1:65:18	1:71:10	1:71:14	high [6]		
fly [1]			glaring [1]			1:13:9	1:18:3	1:23:12
1:11:25			1:49:25			1:51:25	1:52:3	1:55:25
focus [2]			glen [1]			higher [6]		
1:13:9	1:39:8		1:1:6			1:18:16	1:41:25	1:56:2
follow-up [1]			goes [1]			1:56:3	1:56:6	1:56:12
1:68:22			1:44:23			himself [3]		
following [2]			gone [1]			1:24:15	1:25:8	1:25:22
1:16:22	1:44:22		1:30:20			hired [1]		
follows [2]			good [9]			1:7:24		
1:5:10	1:44:21		1:16:9	1:22:10	1:22:11	history [5]		

file:page:line 1:97-133.txt

1:18:12	1:43:1	1:52:4	increases [2]		jacobson [8]		
1:52:5	1:58:15		1:54:8	1:54:11	1:2:21	1:3:2	1:29:24
hold [1]			independent [3]		1:30:10	1:31:23	1:33:18
1:28:8			1:11:18	1:29:18	1:33:21	1:33:25	
home [1]			independently [2]		ames [2]		
1:68:3			1:11:4	1:38:18	1:2:11	1:2:11	
hope [2]			index [1]		im [3]		
1:12:21	1:41:4		1:4:1		1:26:12	1:48:13	1:50:17
hopefully [2]			indicate [1]		ob [3]		
1:40:17	1:40:18		1:20:21		1:43:22	1:43:23	1:43:24
hospital [3]			indicated [2]		oel [2]		
1:1:9	1:2:10	1:37:23	1:45:14	1:46:2	1:36:4	1:36:6	
hospitals [2]			indication [1]		ohn [3]		
1:1:22	1:33:24		1:38:11		1:34:19	1:35:17	1:35:19
hour [2]			inducing [1]		ones [34]		
1:5:17	1:59:23		1:52:18		1:1:6	1:3:2	1:4:22
hours [5]			induction [5]		1:8:23	1:9:6	1:9:23
1:5:17	1:8:9	1:28:13	1:52:14	1:52:16	1:13:15	1:13:21	1:15:18
1:55:23	1:63:12		1:52:24	1:53:2	1:18:10	1:19:21	1:24:7
howard [1]			infection [2]		1:25:6	1:28:25	1:29:3
1:34:24			1:66:4	1:66:6	1:40:24	1:47:15	1:47:18
huge [1]			information [14]		1:50:2	1:51:24	1:52:2
1:49:10			1:15:13	1:18:7	1:52:14	1:52:17	1:53:5
hundred [1]			1:18:22	1:20:9	1:54:6	1:54:21	1:55:13
1:56:25			1:20:16	1:26:20	1:55:25	1:56:16	1:58:15
huron [2]			1:44:20	1:44:23	1:59:16	1:64:1	1:65:4
1:1:9	1:2:10		1:67:14	1:67:15	1:69:4		
hypertension [17]			infusion [1]		ones' [6]		
1:18:13	1:46:5	1:46:9	1:19:12		1:16:14	1:18:12	1:47:8
1:46:10	1:46:11	1:46:12	input [1]		1:49:20	1:57:21	1:58:12
1:46:17	1:46:18	1:46:21	1:44:7		oseph [1]		
1:46:24	1:47:2	1:47:4	insert [2]		1:36:2		
1:47:8	1:47:12	1:52:6	1:17:9	1:48:9	udge [1]		
1:52:7	1:64:5		inserting [1]		1:1:8		
hypertensive [2]			1:19:15		udgment [2]		
1:47:6	1:64:1		insertion [1]		1:18:23	1:66:19	
hypoxia [1]			1:18:20		udgments [2]		
1:53:22			inside [1]		1:29:18	1:29:21	
hypoxic [2]			1:58:5		ump [1]		
1:55:1	1:56:21		instructed [1]		1:28:24		
icu [2]			1:11:13		ahn [1]		
1:25:14	1:55:2		insurance [1]		1:37:3		
identification [1]			1:34:1		alur [2]		
1:5:4			interested [1]		1:2:21	1:3:2	
important [3]			1:7:20		aplan [5]		
1:18:10	1:38:3	1:43:16	internist [1]		1:6:10	1:6:10	1:36:4
impossible [1]			1:44:20		1:36:6	1:63:25	
1:66:1			internists [1]		aplan's [1]		
improper [1]			1:44:17		1:63:23		
1:69:12			internship [1]		eenan [4]		
improve [1]			1:11:12		1:2:3	1:2:4	1:4:5
1:44:23			intraoperative [1]		1:4:7		
inappropriate [1]			1:29:2		reith [1]		
1:62:18			intraoperatively [4]		1:3:11		
incidentally [1]			1:25:13	1:28:18	cind [6]		
1:60:8			1:63:8		1:8:16	:11:5	1:13:9
include [2]			introduction [1]		1:21:6	:28:16	1:67:7
1:25:6	1:32:3		1:66:11		mew [3]		
includes [1]			intubated [1]		1:12:21	:12:22	1:32:8
1:8:10			1:63:12		knife [2]		
income [1]			involve [1]		1:39:10	:39:11	
1:60:9			1:33:10		cnotting [1]		
increase [2]			involved [2]		1:65:25		
1:27:13	1:54:10		1:31:10	1:62:13	nowledge [9]		
increased [3]			issues [1]		1:15:2	1:21:5	1:22:7
1:21:20	1:21:21	1:54:23	1:63:19		1:29:3	1:38:7	1:38:12
					1:42:2	1:58:12	1:66:20

known [2] 1:35:7 1:69:15	literature [2] 1:64:6 1:64:11	1:3:11
lakeland [1] 1:2:15	live [1] 1:9:24	mean [5] 1:12:4 1:19:1 1:48:14 1:48:17 1:57:22
lakeside [2] 1:2:22 1:3:3	lived [1] 1:9:23	meaning [4] 1:9:5 1:10:24 1:36:23 1:39:16
landskroner [1] 1:2:7	load [1] 1:18:9	means [1] 1:10:23
last [4] 1:21:16 1:21:17 1:30:9 1:34:16	look [4] 1:8:22 1:22:23 1:28:17 1:51:11	measures [1] 1:20:6
late [1] 1:34:7	looking [2] 1:39:4 1:40:2	medical [17] 1:2:15 1:6:3 1:11:11 1:14:25 1:15:14 1:16:9 1:21:5 1:23:11 1:29:18 1:29:20 1:33:20 1:39:21 1:50:1 1:50:10 1:58:2 1:60:10 1:60:11
lauren [3] 1:1:19 1:71:3 1:71:24	Low [1] 1:59:9	medically [5] 1:38:17 1:38:19 1:38:25 1:44:14 1:46:13
law [5] 1:2:3 1:2:7 1:29:23 1:30:24 1:33:17	lung [4] 1:53:6 1:53:8 1:53:14 1:53:25	medicated [1] 1:46:8
lawyers [3] 1:7:24 1:34:2 1:59:22	m-hm [1] 1:36:24	medication [2] 1:46:6 1:55:19
lead [2] 1:16:15 1:56:11	machine [1] 1:12:23	medications [1] 1:55:13
learn [1] 1:55:8	machines [1] 1:51:20	medicine [2] 1:46:14 1:46:16
least [1] 1:12:19	major [3] 1:47:25 1:65:24 1:66:2	meet [1] 1:35:21
leave [2] 1:28:4 1:51:5	majority [1] 1:40:15	meeting [1] 1:25:18
lectures [1] 1:32:21	makes [2] 1:23:24 1:66:20	meetings [1] 1:35:22
led [2] 1:52:3 1:57:20	malone [8] 1:2:11 1:31:6 1:31:8 1:50:18 1:50:23 1:52:10 1:57:22 1:64:14	member [1] 1:13:25
legal [1] 1:11:20	malpractice [2] 1:32:23 1:33:20	members [1] 1:40:16
Length [1] 1:39:17	manage [1] 1:55:3	meridia [4] 1:1:9 1:2:10 1:6:6 1:6:17
Less [3] 1:58:18 1:59:22 1:60:7	management [18] 1:6:22 1:6:23 1:6:23 1:11:14 1:11:15 1:12:11 1:18:4 1:21:2 1:22:14 1:25:6 1:27:19 1:28:11 1:28:18 1:53:10 1:56:22 1:58:17 1:59:6 1:63:16	might [7] 1:19:4 1:19:5 1:20:22 1:24:7 1:49:1 1:49:3 1:60:17
Lesser [2] 1:19:6 1:19:7	marc [1] 1:36:25	mind [1] 1:26:12
letter [1] 1:67:1	mark [2] 1:3:2 1:65:3	minor [1] 1:47:25
level [1] 1:12:24	marked [3] 1:4:12 1:5:3 1:7:11	minutes [2] 1:28:9 1:60:15
lies [1] 1:17:11	marshall [1] 1:37:14	missed [1] 1:66:23
lifetime [1] 1:68:13	matter [7] 1:12:7 1:22:9 1:28:13 1:33:23 1:35:23 1:38:9 1:54:10	monday [1] 1:42:18
likelihood [1] 1:18:13	max [1] 1:5:18	money [1] 1:60:9
likely [5] 1:17:25 1:19:21 1:23:14 1:47:1 1:69:10	may [9] 1:8:1 1:10:9 1:10:15 1:32:7 1:55:6 1:55:6 1:66:12 1:66:14 1:66:25	monitor [3] 1:19:6 1:20:12 1:20:15
lillian [1] 1:1:8	maynard [4] 1:2:21 1:3:2 1:29:24 1:33:25	monitoring [2] 1:18:5 1:19:12
line [4] 1:19:5 1:19:11 1:21:7 1:21:11	mccgregor [1]	monitors [1] 1:12:23
list [1] 1:65:22		months [5] 1:12:20 1:13:3 1:13:4
listed [1] 1:61:6		
listen [1] 1:41:15		
file:page:line 1:97-133.txt		

1:60:24	1:60:25	1:71:25	1:2:18	1:2:22	1:3:3
morbid [1]		note [1]	1:35:15	1:62:4	1:71:1
1:55:7		1:21:10	1:71:5	1:71:22	1:71:25
morbidly [2]		notes [1]	older [1]		
1:18:15	1:18:21	1:16:4	1:61:1		
morbidly [2]		nothing [2]	once [6]		
1:52:4	1:56:20	1:68:20	1:30:21	1:30:22	1:30:23
morning [2]		notice [1]	1:31:22	1:33:6	1:35:24
1:14:11	1:40:24	1:1:21	one [25]		
mortality [2]		now [26]	1:5:13	1:6:8	1:7:11
1:18:15	1:18:21	1:8:16	1:12:1	1:14:14	1:18:18
move [1]		1:16:12	1:24:9	1:27:23	1:28:1
1:19:8		1:20:5	1:28:15	1:31:2	1:31:23
must [1]		1:23:15	1:31:24	1:32:14	1:52:18
1:11:25		1:28:11	1:55:14	1:59:1	1:61:20
name [2]		1:32:22	1:62:2	1:62:3	1:62:12
1:5:24	1:35:14	1:40:15	1:68:11	1:68:11	1:69:14
named [1]		1:49:11	1:69:24		
1:33:2		1:54:6			
names [1]		1:65:2	me-way [1]		
1:36:1		numbers [1]	1:67:17		
nassau [1]		1:60:5	nes [1]		
1:2:4		obese [2]	1:61:10		
national [2]		1:52:4	opening [1]		
1:35:22	1:36:8	1:56:20	1:39:17		
nature [1]		obesity [2]	operating [1]		
1:33:9		1:54:23	1:29:14		
ay [1]		object [1]	operation [9]		
1:36:3		1:41:1	1:9:23	1:16:16	1:16:25
earman [2]		objection [19]	1:17:22	1:18:7	1:59:4
1:34:24	1:35:6	1:17:1	1:59:5	1:59:9	1:59:17
necessarily [5]		1:19:24	operative [2]		
1:14:19	1:15:11	1:25:24	1:55:15	1:58:16	
1:42:6	1:43:18	1:38:5	opinion [47]		
necessary [5]		1:42:9	1:9:9	1:9:22	1:11:9
1:16:1	1:17:10	1:49:22	1:12:15	1:14:12	1:14:22
1:43:2	1:68:2	1:53:11	1:17:12	1:17:21	1:17:23
need [5]		objections [1]	1:18:5	1:18:25	1:19:13
1:5:16	1:40:23	1:4:18	1:21:22	1:22:6	1:22:25
1:48:4	1:57:12	obstructive [4]	1:23:16	1:27:17	1:28:3
needed [1]		1:53:6	1:28:8	1:29:16	1:36:15
1:40:3		1:53:25	1:42:15	1:42:21	1:43:5
needs [2]		obtained [1]	1:46:5	1:46:18	1:46:21
1:41:1	1:61:2	1:68:8	1:47:7	1:47:9	1:47:10
neuromuscular [2]		obviously [1]	1:49:18	1:51:24	1:52:13
1:23:1	1:23:21	1:60:25	1:52:16	1:53:5	1:55:12
ever [1]		occasion [1]	1:57:11	1:57:20	1:58:1
1:11:3		1:41:9	1:58:9	1:58:10	1:59:11
ew [5]		occasionally [1]	1:59:15	1:59:19	1:64:12
1:12:6	1:12:16	1:35:12	1:69:3	1:69:7	
1:37:5	1:37:10	occasions [1]	pinions [8]		
ext [2]		1:41:11	1:7:23	1:8:17	1:9:4
1:28:9	1:55:20	occur [6]	1:45:18	1:45:22	1:61:6
ight [4]		1:14:9	1:64:21	1:64:23	
1:7:1	1:14:24	1:21:6	pposite [1]		
1:55:14		occurred [6]	1:48:23		
on-anesthesiologist [1]		1:9:5	ral [1]		
1:44:19		1:14:23	1:68:11		
on-anesthesiologists [1]		occurring [1]	rder [2]		
1:44:17		1:41:10	1:21:25	1:24:18	
one [2]		Off [3]	riginal [3]		
1:30:10	1:65:7	1:12:1	1:7:13	1:7:14	1:7:15
ormal [2]		office [1]	rlloff [1]		
1:18:16	1:56:2	1:71:22	1:37:14		
otary [4]		often [1]	therwise [1]		
1:1:20	1:71:4	1:40:5	1:71:19		
		ohio [15]	utput [41]		
		1:1:1	1:18:9	1:20:7	1:20:18
		1:1:23	1:21:20		
epage:line	1:97-133.txt				

outside[3] 1:9:17 1:14:13 1:35:11	1:51:25 1:52:3 1:52:18 1:53:19 1:54:15 1:62:8 1:63:11 1:64:19 1:66:7 1:69:14 1:69:16	1:63:7
outweighed[2] 1:19:1 1:19:2	patient's [1] 1:41:21	plaintiff [3] 1:5:14 1:62:8 1:62:9
outweighs [1] 1:41:18	patients [4] 1:11:14 1:18:14 1:27:1 1:40:15	plaintiffs [4] 1:1:7 1:1:18 1:2:2 1:5:8
overall [1] 1:39:8	paul [3] 1:2:6 1:37:16 1:69:18	plaintiffs' [2] 1:4:12 1:5:1
overload [13] 1:20:6	people [10] 1:11:25 1:18:24 1:19:18 1:20:2 1:51:20 1:54:12 1:55:1 1:55:2 1:60:16 1:68:14	plan [10] 1:12:10 1:12:13 1:12:14 1:14:8 1:16:2 1:16:14 1:25:1 1:25:5 1:26:15 1:42:13
oversaw [1] 1:10:24	perfect [1] 1:38:9	plane [1] 1:12:1
overseeing [1] 1:13:7	perforation [1] 1:65:24	pleas [1] 1:1:4
own [6] 1:18:21 1:24:11 1:24:21 1:26:12 1:28:2 1:29:7	percent [1] 1:56:25	pleased [1] 1:42:5
oxygen [4] 1:27:1 1:56:15 1:56:25 1:57:15	perfusion [1] 1:59:2	point [7] 1:11:12 1:11:20 1:17:13 1:25:2 1:26:9 1:28:7 1:51:23
oxygenation [4] 1:53:19 1:57:3 1:57:4 1:57:9	perianesthetic [3] 1:6:5 1:6:18 1:47: period [3] 1:21:21 1:30:12 1:59:10 periods [1] 1:12:2 personal [1] 1:35:8 personally [2] 1:19:5 1:40:11 pertain [1] 1:6:18 pertains [2] 1:9:8 1:48:21 peter [1] 1:2:20 phase [2] 1:52:17 1:54:13 physical [1] 1:69:13 physically [1] 1:52:21 physician [2] 1:65:18 1:66:19 physicians [6] 1:33:22 1:33:23 1:37:20 1:45:2 1:66:14 1:68:17 physiologic [1] 1:57:23 physiological [1] 1:57:24 picture [1] 1:41:21 pie [4] 1:33:24 1:33:24 1:34:4 1:34:6 place [6] 1:16:2 1:16:24 1:17:22 1:22:20 1:51:13 1:71:16 placed [3] 1:19:3 1:22:17 1:69:4 placement [1]	points [1] 1:29:3 policy [1] 1:37:23 poor [3] 1:58:24 1:58:25 1:58:25 population [1] 1:40:9 position [1] 1:22:7 possible [4] 1:21:18 1:24:5 1:51:21 1:69:16 possibly [1] 1:38:8 post-anesthetic [1] 1:6:23 postoperative [3] 1:57:6 1:59:6 1:63:16 postoperatively [6] 1:55:3 1:55:7 1:56:1 1:59:4 1:63:12 1:63:20 postsurgery [1] 1:54:12 practice [1] 1:23:11 practicing [2] 1:38:12 1:68:17 practitioners [1] 1:11:19 pre-anesthetic [5] 1:6:22 1:14:2 1:14:21 1:40:8 1:40:15 pre-op [11] 1:13:22 1:14:13 1:14:17 1:14:24 1:15:6 1:15:13 1:15:17 1:15:20 1:16:4 1:25:4 1:39:4 precariously [1] 1:24:7 precisely [1] 1:17:13 predict [3]

le:page:line

1:97-133.txt

1:20:10	1:20:11	1:69:14	public [4]	1:1:20	1:2:7	1:71:4	real [2]	1:10:2	1:69:18
preoperative [8]			1:71:25				really [7]		
1:14:3	1:14:4	1:15:3	publications [2]	1:61:5	1:61:21		1:22:7	1:28:23	1:34:4
1:25:1	1:25:18	1:26:14	pull [1]				1:42:18	1:44:18	1:49:9
1:57:3	1:57:15		1:26:1				1:60:8		
preoperatively [2]			pulmonale [14]				reason [4]		
1:56:16	1:63:4		1:47:16	1:47:18	1:47:24		1:9:13	1:16:22	1:22:20
prepare [1]			1:48:7	1:48:8	1:48:19		1:68:17		
1:14:1			1:49:8	1:49:10	1:49:15		reasonable [7]		
prepared [3]			1:49:20	1:50:4	1:51:6		1:18:23	1:19:18	1:20:2
1:66:24	1:67:4	1:67:6	1:51:6	1:51:7			1:28:12	1:51:22	1:58:2
presence [1]			pulmonary [14]				1:66:13		
1:71:10			1:20:10	1:20:17	1:20:22		reasons [1]		
present [3]			1:21:18	1:23:22	1:23:25		1:24:9		
1:3:9	1:40:10	1:58:13	1:24:8	1:24:9	1:53:21		recently [2]		
presents [1]			1:54:25	1:56:4	1:56:7		1:17:7	1:40:8	
1:15:24			1:56:8	1:56:11			recess [1]		
pressure [6]			pulse [1]				1:69:25		
1:20:17	1:21:21	1:27:13	1:27:14				recipe [1]		
1:59:9	1:64:2	1:64:4	pure [1]				1:64:19		
pressures [1]			1:51:17				recognize [6]		
1:24:3			purposes [1]				1:40:23	1:42:2	1:42:8
pretty [2]			1:5:3				1:53:24	1:55:5	1:57:12
1:18:5	1:43:24		pursuant [i]				recognized [1]		
previous [1]			1:1:21				1:47:12		
1:58:15			push [2]				record [17]		
problem [1]			1:5:21	1:5:22			1:5:25	1:7:7	1:7:9
1:59:3			put [3]				1:13:2	1:14:25	1:15:1
problems [2]			1:9:6	1:15:13	1:36:13		1:15:14	1:21:10	1:22:24
1:18:14	1:67:24		qualified [1]				1:23:18	1:24:3	1:29:5
procedure [5]			1:71:5				1:51:11	1:53:2	1:59:14
1:1:18	1:24:21	1:25:2	quarterbacking [1]				1:59:18	1:69:13	
1:28:14	1:42:3		1:42:18				records [11]		
proceed [2]			questioned [1]				1:6:3	1:6:5	1:6:7
1:41:14	1:42:14		1:42:5				1:6:16	1:6:17	1:7:3
proceeded [1]			questioning [1]				1:7:5	1:8:11	1:14:21
1:24:11			1:21:11				1:64:24	1:69:10	
process [7]			questions [7]				recross-examination [11]		
1:5:17	1:12:5	1:22:14	1:25:25	1:26:3	1:60:17		1:69:1		
1:24:25	1:26:14	1:49:7	1:65:5	1:65:14	1:69:20		reduced [1]		
1:71:12			1:69:22				1:71:10		
professional [2]			quick [2]				refused [1]		
1:1:20	1:71:4		1:10:2	1:69:19			1:62:13		
professor [1]			quite [1]				regarding [2]		
1:35:23			1:40:12				1:42:11	1:42:12	
program [4]			rafal [1]				regardless [1]		
1:11:22	1:11:22	1:12:21	1:3:1				1:55:2		
1:13:4			range [1]				registered [2]		
progressed [1]			1:48:8				1:1:19	1:71:3	
1:42:23			rapkin [2]				reinker [21]		
progression [1]			1:34:9	1:34:10			1:2:21	1:4:6	1:4:20
1:27:11			ratio [1]				1:17:1	1:19:8	1:19:16
proper [io]			1:18:22				1:19:24	1:21:9	1:30:4
1:28:11	1:40:17	1:40:18	react [1]				1:36:21	1:38:6	1:38:14
1:40:19	1:40:19	1:49:24	1:53:20				1:42:9	1:42:17	1:42:24
1:50:10	1:50:14	1:63:15	read [6]				1:48:22	1:49:22	1:53:11
1:63:20			1:6:8	1:21:18	1:51:12		1:65:9	1:65:12	1:68:20
properly [5]			1:51:23	1:63:23	1:63:24		relates [3]		
1:8:21	1:10:19	1:10:23	reader [3]				1:8:18	1:17:18	1:61:7
1:10:24	1:52:17		1:8:12	1:8:14	1:8:15		relationship [4]		
proposal [2]			reading [1]				1:21:4	1:43:10	1:67:9
1:16:20	1:17:14		1:23:18				1:67:16		
proviso [1]			readings [4]				relative [1]		
1:59:8			1:20:21	1:47:19	1:47:22		1:71:18		
prudent [2]			1:48:20				reliable [1]		
1:26:21	1:26:23						1:49:7		

file:page:line 1:97-133.txt

relied [1] 1:43:17			1:26:9	1:26:13	1:26:20	risk [33] 1:13:9	1:18:3	1:18:15
rely [4] 1:50:1	1:50:10	1:67:18	1:26:21	1:26:23	1:26:25	1:18:17	1:18:19	1:18:22
1:67:21			1:27:21	1:27:22	1:29:7	1:18:25	1:19:1	1:19:2
remember [4] 1:17:4	1:17:5	1:32:6	1:29:10	1:29:11	1:29:16	1:19:7	1:23:12	1:39:22
1:34:6			1:34:11	1:40:22	1:41:6	1:39:24	1:41:12	1:41:18
reminger [6] 1:2:12	1:2:12	1:2:17	1:47:11	1:48:2	1:53:23	1:41:24	1:41:25	1:42:11
1:2:17	1:30:24	1:30:24	1:55:4	1:61:8	1:61:19	1:51:25	1:52:2	1:52:3
rendering [1] 1:45:23			1:67:10	1:67:13	1:67:14	1:53:13	1:54:8	1:54:11
repeat [1] 1:5:15			resident's [1] 1:17:16			1:54:12	1:55:25	1:56:3
repetitive [1] 1:17:19			residents [3] 1:11:18	1:22:13	1:67:18	1:56:6	1:56:12	1:58:20
rephrase [3] 1:39:19	1:50:13	1:50:16	respirations [1] 1:24:2			1:58:22	1:69:7	1:69:8
report [11] 1:7:13	1:10:1	1:10:5	response [1] 1:53:21			risk-benefit [4] 1:18:21	1:41:15	1:44:24
1:10:14	1:14:2	1:46:2	responsibilities [1] 1:67:11			1:65:19		
1:63:23	1:63:24	1:66:24	responsibility [4] 1:11:21	1:17:10	1:17:16	risk-benefits [1] 1:45:1		
1:67:4	1:67:21		1:21:24			risks [3] 1:65:15	1:65:22	1:66:2
reporter [2] 1:1:20	1:71:4		responsible [1] 1:11:23			risky [1] 1:18:14		
reports [2] 1:7:10	1:67:6		result [1] 1:18:24			road [1] 1:25:19		
represent [1] 1:65:13			resuscitate [1] 1:28:10			robert [1] 1:37:9		
represented [5] 1:33:16	1:33:17	1:33:18	resuscitated [1] 1:7:8			role [1] 1:45:5		
1:33:21	1:34:3		resuscitation [3] 1:7:9	1:33:11	1:63:20	roles [1] 1:11:6		
represents [2] 1:18:3	1:18:12		reversal [9] 1:23:9	1:23:13	1:23:15	room [14] 1:23:7	1:23:9	1:25:21
reputable [2] 1:36:19	1:36:20		1:24:11	1:24:15	1:24:25	1:26:1	1:26:24	1:27:17
request [2] 1:41:6	1:41:7		1:26:14	1:26:22	1:54:13	1:27:23	1:28:1	1:28:4
requested [2] 1:40:20	1:41:19		reverse [5] 1:25:7	1:25:12	1:25:20	1:28:6	1:29:4	1:29:14
require [1] 1:11:14			1:26:17	1:26:21		1:52:21	1:53:4	
required [5] 1:18:5	1:63:3	1:63:7	reversed [3] 1:23:21	1:24:1	1:25:11	rpr [1] 1:71:24		
1:63:11	1:63:15		reversing [1] 1:23:1			rules [2] 1:1:18	1:5:8	
requiring [1] 1:63:20			review [10] 1:6:16	1:7:5	1:10:6	run [1] 1:35:25		
research [1] 1:40:16			1:17:7	1:30:2	1:30:9	says [4] 1:10:4	1:10:5	1:13:2
residency [2] 1:13:11	1:34:12		1:47:3	1:59:21	1:69:9	1:50:13		
resident [69] 1:8:18	1:8:20	1:8:21	1:69:13			schedule [1] 1:32:19		
1:9:8	1:9:15	1:10:19	reviewed [16] 1:6:4	1:6:5	1:6:8	scheduled [2] 1:62:25	1:62:25	
1:11:3	1:11:3	1:11:6	1:6:12	1:6:15	1:7:3	schlanger [1] 1:35:13		
1:11:8	1:13:6	1:13:10	1:10:5	1:10:10	1:16:4	scratch [1] 1:45:23		
1:13:18	1:13:21	1:13:25	1:17:6	1:29:24	1:30:2	seal [1] 1:71:22		
1:14:2	1:14:3	1:14:5	1:30:5	1:30:10	1:30:25	second [2] 1:31:24	1:69:24	
1:14:11	1:14:14	1:14:16	1:47:5			second-guess [1] 1:21:25		
1:14:24	1:15:6	1:15:13	reviewing [2] 1:8:7	1:8:11		see [5] 1:14:1	1:19:5	1:20:20
1:15:23	1:15:24	1:16:4	reviews [1] 1:30:16			1:24:4	1:44:13	
1:16:18	1:16:19	1:17:14	richard [1] 1:35:13			seeing [1] 1:17:5		
1:21:1	1:21:5	1:21:23	right [12] 1:6:15	1:7:10	1:8:15	seem [1] 1:40:14		
1:21:24	1:22:6	1:22:10	1:10:11	1:10:15	1:14:22	self-explanatory [31] 1:61:14	1:61:17	1:61:24
1:24:11	1:24:20	1:24:24	1:16:21	1:17:4	1:20:5			
1:25:5	1:25:8	1:25:22	1:20:20	1:25:16	1:65:2			
1:25:23	1:26:5	1:26:8	rings [1] 1:36:1					

semigran [1] 1:36:25	1:51:21	staff [1] 1:37:20
senchyshak [17] 1:6:11 1:6:13 1:10:6 1:10:10 1:10:25 1:12:16 1:15:20 1:16:13 1:16:24 1:17:8 1:21:23 1:22:21 1:42:1 1:44:4 1:48:12 1:57:12 1:57:14	sit [1] 1:32:17	stage [3] 1:25:20 1:25:20 1:25:21
senchyshak's [4] 1:40:22 1:47:11 1:53:24 1:55:5	situation [4] 1:22:10 1:44:8 1:65:19 1:66:12	stages [2] 1:13:14 1:13:16
sense [2] 1:11:10 1:13:8	situations [1] 1:22:1	standard [10] 1:19:14 1:19:20 1:63:3 1:63:7 1:63:11 1:63:15 1:63:19 1:64:7 1:64:12 1:64:22
sent [13] 1:10:13	six [2] 1:30:10 1:30:18	start [2] 1:24:15 1:54:14
separate [1] 1:15:23	skill [1] 1:38:12	started [8] 1:16:5 1:19:5 1:23:25 1:24:2 1:24:21 1:26:14 1:60:6 1:60:7
sequence [2] 1:57:20 1:57:23	skills [1] 1:38:8	starting [1] 1:24:25
serious [1] 1:66:12	sleep [4] 1:52:5 1:54:6 1:54:8 1:56:20	starts [1] 1:27:14
set [2] 1:1:24 1:71:21	sometime [2] 1:8:5 1:17:6	state [14] 1:1:1 1:1:21 1:5:24 1:9:6 1:10:18 1:17:3 1:23:3 1:26:16 1:29:5 1:58:13 1:62:4 1:71:1 1:71:5 1:71:25
settled [1] 1:33:15	sometimes [1] 1:32:17	statement [5] 1:6:9 1:6:10 1:15:15 1:30:8 1:64:3
setup [1] 1:54:25	somewhat [2] 1:40:13 1:56:21	states [2] 1:53:2 1:62:5
seven [1] 1:30:11	somewhere [3] 1:5:20 1:61:12 1:61:20	status [7] 1:16:18 1:18:8 1:20:18 1:43:1 1:44:21 1:44:22 1:47:3
several [1] 1:31:7	sorry [7] 1:8:13 1:35:16 1:45:24 1:46:23 1:52:8 1:62:22 1:66:5	stay [4] 1:27:1 1:27:6 1:28:12 1:63:12
severe [3] 1:44:4 1:45:12 1:64:5	sort [1] 1:18:7	stayed [1] 1:46:9
severely [1] 1:64:1	sounds [1] 1:16:21	stenotypy [1] 1:71:10
severity [1] 1:43:21	southern [1] 1:5:23	Stephen [1] 1:2:16
shape [3] 1:58:24 1:58:25 1:58:25	spanish [1] 1:62:3	steps [2] 1:25:22 1:43:3
sharing [1] 1:67:15	special [2] 1:38:1 1:40:9	steve [1] 1:65:6
shed [1] 1:61:6	specialist [1] 1:38:8	still [4] 1:12:13 1:25:7 1:49:8 1:55:19
short [1] 1:55:21	specialty [2] 1:11:12 1:43:11	stop [2] 1:41:9 1:63:4
shortcut [1] 1:8:17	specific [5] 1:9:12 1:17:18 1:43:4 1:64:10 1:64:11	stopped [1] 1:40:21
show [2] 1:12:7 1:59:18	specifically [1] 1:53:3	street [3] 1:2:4 1:67:10 1:67:17
shows [1] 1:58:23	specifics [1] 1:49:11	stress [2] 1:39:12 1:39:13
shunting [1] 1:53:18	specified [1] 1:71:17	strictly [1] 1:46:16
shy [1] 1:32:20	speculate [1] 1:57:25	strike [1] 1:19:8
side [2] 1:22:12 1:41:16	speculation [1] 1:51:17	student [2] 1:11:8 1:11:10
signature [1] 1:70:3	spend [1] 1:21:15	subiect [1]
signs [3] 1:27:3 1:27:4 1:27:12	spent [1] 1:8:7	
similar [6] 1:33:10 1:63:2 1:63:6 1:63:10 1:63:14 1:63:18	spontaneous [1] 1:24:2	
simply [1]	square [1] 1:2:7	
	stable [1] 1:38:20	

1:51:5	1:24:7	1:40:13	1:58:23	throughout [2]
subsequent [1]	tachyarrhythmia [1]			1:19:20 1:29:9
1:7:5	1:66:11			throw [1]
succeed [1]	takers [1]			1:22:2
1:34:14	1:68:18			tia [1]
successful [1]	takes [2]			1:58:16
1:12:9	1:46:16 1:55:8			tightly [1]
such [4]	taking [5]			1:12:7
1:16:20 1:16:20 1:55:2	1:50:1 1:55:12 1:68:8			times [14]
1:63:3	1:68:8 1:68:14			1:12:12 1:30:1 1:30:2
sued [2]	tampa [1]			1:30:11 1:30:16 1:30:18
1:32:22 1:33:20	1:35:18			1:30:20 1:31:16 1:32:25
sufficient [1]	teach [2]			1:33:3 1:33:4 1:62:7
1:19:7	1:11:25 1:34:12			1:62:11 1:62:12
suggested [2]	teaching [3]			titles [1]
1:16:24 1:21:6	1:17:14 1:61:20 1:67:16			1:61:13
suite [3]	team [4]			today [2]
1:2:7 1:2:22 1:3:3	1:49:25 1:50:1 1:50:10			1:9:6 1:9:24
supervised [4]	1:50:15			today's [1]
1:9:8 1:10:19 1:10:24	techniques [2]			1:6:4
1:12:7	1:18:17 1:18:19			together [2]
supervising [1]	tells [1]			1:39:24 1:44:24
1:12:3	1:22:2			too [10]
supplemental [1]	ten [2]			1:21:15 1:28:20 1:30:18
1:67:6	1:30:14 1:30:15			1:51:21 1:55:21 1:59:9
surgeon [6]	test [3]			1:62:16 1:62:19 1:62:20
1:35:15 1:37:7 1:37:14	1:41:25 1:68:8 1:68:18			1:66:17
1:41:16 1:42:13 1:44:7	testified [9]			took [2]
surgeon's [1]	1:29:23 1:62:5 1:62:7			1:24:14 1:25:22
1:44:10	1:62:10 1:63:2 1:63:6			toss-up [1]
surgeons [1]	1:63:10 1:63:14 1:63:18			1:43:8
1:41:22	testify [3]			total [2]
surgery [27]	1:9:20 1:46:1 1:49:12			1:31:16 1:41:21
1:15:18 1:16:5 1:38:21	testifying [2]			totally [2]
1:39:6 1:39:12 1:39:15	1:48:10 1:48:11			1:12:6 1:12:16
1:39:16 1:39:17 1:39:23	testimony [9]			town [1]
1:39:23 1:39:24 1:41:9	1:28:1 1:31:17 1:31:19			1:31:24
1:41:14 1:41:17 1:41:22	1:45:11 1:45:12 1:59:25			training [11]
1:42:12 1:42:23 1:44:14	1:60:2 1:71:9 1:71:14			1:11:13 1:12:8 1:12:9
1:44:25 1:44:25 1:45:13	tests [4]			1:12:25 1:27:1 1:29:12
1:45:19 1:47:7 1:54:9	1:40:17 1:40:18 1:68:8			1:29:17 1:40:23 1:47:11
1:54:11 1:54:23 1:63:4	1:68:14			1:53:24 1:55:5
surgical [6]	text [1]			transcribed [1]
1:41:11 1:41:12 1:41:16	1:64:18			1:71:11
1:44:7 1:51:25 1:52:3	textbook [2]			transcript [1]
surprised [1]	1:36:13 1:36:14			1:71:13
1:16:18	textbooks [3]			transcription [1]
susan [2]	1:36:10 1:64:20 1:64:21			1:71:12
1:2:21 1:65:8	thank [1]			treated [1]
swan [2]	1:23:4			1:43:8
1:51:22 1:66:12	themselves [1]			treating [1]
swan-gam [29]	1:12:1			1:64:19
1:16:24 1:17:9 1:17:21	thereupon [2]			treatment [4]
1:18:1 1:18:6 1:18:18	1:5:1 1:69:25			1:14:8 1:16:2 :41:21
1:18:20 1:19:2 1:19:15	they've [1]			1:48:10
1:19:22 1:20:6 1:20:21	1:34:1			tremendously [1]
1:21:4 1:21:18 1:22:4	thompson [1]			1:54:23
1:22:16 1:22:20 1:47:19	1:37:16			trial [15]
1:48:1 1:48:5 1:48:8	thought [1]			1:30:20 1:31:12 :31:13
1:48:20 1:51:12 1:63:8	1:48:24			1:31:17 1:31:19 :32:5
1:65:16 1:65:20 1:66:15	three [5]			1:33:12 1:33:14 :45:10
1:69:4 1:69:15	1:8:9 1:11:13 1:12:20			1:45:11 1:46:1 1:58:9
sworn [2]	1:13:3 1:45:2			1:58:11 1:60:2 1:62:24
1:5:9 1:71:7	through [6]			tried [2]
synthesis [1]	1:14:25 1:35:25 1:38:21			1:31:6 1:34:13
1:64:21	1:66:11 1:68:8 1:71:12			trigger [1]
system [3]				1:24:8

file:page:line 1:97-133.txt

true [29] 1:16:16 1:16:17 1:16:25 1:18:19 1:23:3 1:28:8 1:42:8 1:43:22 1:44:15 1:45:20 1:45:21 1:47:1 1:51:8 1:51:17 1:51:25 1:54:16 1:55:10 1:56:4 1:56:7 1:57:17 1:57:21 1:58:6 1:59:7 1:59:8 1:63:23 1:64:24 1:66:17 1:69:11 1:71:13	truth [3] 1:71:8 1:71:8 1:71:9	try [3] 1:5:23 1:26:11 1:67:20	trying [7] 1:11:24 1:17:19 1:44:9 1:50:18 1:50:21 1:50:22 1:50:25	tube [1] 1:24:5	tuschman [3] 1:2:21 1:3:2 1:33:25	twice [3] 1:31:25 1:32:1 1:32:2	two [10] 1:5:17 1:8:9 1:13:12 1:22:15 1:25:25 1:26:2 1:33:17 1:36:23 1:62:12 1:68:8	two-way [1] 1:67:10	type [2] 1:20:9 1:47:2	uncontrolled [1] 1:46:18	under [9] 1:1:18 1:5:8 1:10:20 1:12:3 1:46:5 1:46:7 1:46:9 1:47:8 1:47:12	undergo [3] 1:39:9 1:39:11 1:39:12	undergoing [1] 1:11:12	understand [21] 1:5:15 1:8:16 1:9:12 1:13:19 1:14:10 1:17:17 1:21:4 1:21:8 1:23:16 1:26:19 1:27:22 1:29:8 1:30:7 1:39:18 1:44:9 1:48:17 1:50:17 1:50:21 1:52:20 1:60:12 1:67:12	unit [1] 1:6:24	university [2] 1:1:21 1:33:24	unless [1] 1:49:24	unreliable [4] 1:47:22 1:48:20 1:49:2 1:49:4	up-to-date [1] 1:60:21	upcoming [1] 1:62:24	used [4] 1:19:12 1:19:12 1:32:4 1:32:14	using [1] 1:65:16	usually [1] 1:33:2	vasculature [1] 1:53:21	ventilated [3] 1:27:6 1:28:4 1:28:13	ventilation [2] 1:18:14 1:63:16	verbally [1] 1:14:17	versus [1] 1:18:22	vessels [1] 1:65:24	video [1] 1:32:8	videographics [1] 1:3:11	videotaped [2] 1:32:3 1:32:20	view [1] 1:11:20	violated [1] 1:19:14	visit [3] 1:14:3 1:14:5 1:15:3	visiting [1] 1:35:23	vitae [1] 1:37:19	vital [3] 1:27:3 1:27:4 1:27:12	wait [2] 1:25:13 1:31:24	waived [1] 1:70:3	walk [1] 1:25:19	walters [6] 1:2:16 1:4:23 1:38:5 1:40:25 1:51:9 1:65:7	watched [1] 1:57:10	weaker [1] 1:54:24	wedge [2] 1:20:17 1:21:20	Wednesday [1] 1:1:14	weighed [2] 1:18:23 1:45:1	whereof [1] 1:71:21	whole [3] 1:5:16 1:22:14 1:71:8	wide [1] 1:51:6	wider [1] 1:11:10	window [1] 1:22:3	winston [1] 1:2:15	withdraw [1] 1:66:1	within [2] 1:58:2 1:71:4	within-named [1] 1:71:6	without [4] 1:8:3 1:20:12 1:24:21 1:26:14	withstand [2] 1:44:14 1:44:18	witness [7] 1:1:17 1:5:7 1:49:1 1:61:15 1:71:6 1:71:11 1:71:21	word [1] 1:11:11	words [1] 1:50:3	worked [1] 1:35:5	works [4] 1:34:25 1:35:1 1:40:13 1:64:20	worsen [1] 1:69:5	worsened [1] 1:69:11	worsening [1] 1:66:8	worsens [1] 1:69:7	written [4] 1:36:10 1:61:22 1:61:25 1:68:11	wrote [3] 1:7:18 1:10:4 1:10:13	yea [2] 1:36:1 1:36:5	year [7] 1:8:2 1:8:5 1:12:19 1:12:25 1:13:10 1:30:9 1:30:9	years [7] 1:11:13 1:30:13 1:30:14 1:30:14 1:30:15 1:31:7 1:34:18	yet [1] 1:10:12	york [3] 1:36:22 1:37:5 1:37:10	young [1] 1:12:9	yourself [1] 1:7:18	zero [1] 1:28:10	zigmont-miller [3] 1:1:19 1:71:3 1:71:24																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																													
file:page:lil		1:97-133.txt																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									