IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

CHRISTOPHER S. LONG, etc.,
Plaintiffs,
vs
CLEVELAND CLINIC FOUNDATION)
Defendant.
) Case No. 321518

DEPOSITION OF DELOS M. COSGROVE, M.D.

TUESDAY, FEBRUARY 16, 1999

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The deposition of DEWS M. COSGROVE, M.D., the Witness herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Diplomate Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio, commencing at 8:00 o'clock a.m. on the day and date above set forth.

APPEARANCES

On behalf of the Plaintiff
Becker & Mishkind
BY MICHAEL BECKER, ESQ.
JEANNE M. TOSTI, ESQ.
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On behalf of the Defendant
Roetzel & Andress
BY JOHN V. JACKSON, III, ESQ.
INGRID KINKOPF-ZAJAC, ESQ.
1375 E. 9th Street
Cleveland, Ohio 441 14

DELOS M. COSGROVE, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF DELOS M. COSGKOVE, M.D.

BY-MR. BECKER:

Q. Would you tell me your full name, please.
A. Delos Marshall Cosgrove, III.
Q. Doctor, what is your current position with the Cleveland Clinic Foundation?
A. Chairman of the department of thoracic cardiovascular surgery.
Q. I know you have had your deposition taken before. I just want to review the ground rules with you. This is a question and answer session under oath. It's important that you understand the question that I ask.

If the question doesn't make sense or is inartfully phrased, you stop and tell me so and I will attempt to rephrase the question. However, unless you indicate otherwise to me, I am going to assume that you fully understood the question that I have asked. Fair enough?
A. Fair.

Q. What have you reviewed in preparation for this deposition?
A. The chart.
Q. Does the cardiothoracic surgery department have a separate chart on each patient aside from the hospital's main chart?
A. No.
Q. If a patient prior to coming to the Cleveland Clinic sent you or your office correspondence or faxes relative to his problem, his conditions, would you expect those faxes to be within the hospital chart?
A. Yes.
Q. And is the complete hospital chart in front of you?
A. Yes.
Q. Doctor, in August of 1996, I am interested to know whether or not there was any written policy within the cardiothoracic surgery department relative to how a patient is to be managed, observed, postoperatively.
A. No.
Q. Any type of written policy as to, to your knowledge, as to what nurses, residents or fellows should do in the event that in an aortic valve or

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a chest patient, postoperatively there are signs and symptoms of bleeding, hypotension -- and/or hypotension and/or the development of cardiac tamponade?
A. No.
Q. Are there any kind of written rules, guidelines?
A. No.
Q. Now, back in August of 1996, I am interested to know what your surgery schedule was. How many surgeries were you doing per se on average in August per day?
A. Well, Without looking at the August record, I can't tell you.
Q. I have heard that you generally work on two waves per day; anywhere from two to four cases in the morning and two to four cases in the afternoon. Is that accurate?
A. Not correct.
Q. Not true?
A. Not true.
Q. 'what is the maximum number of patients you work on per day?
A. By law, two. Two per round.
Q. And what does round mean?

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A. I do two rooms that will be staggered.
Q. Two rooms in the morning and two rooms in theafternoon?
A. Probably, yes.
Q. So the maximum you could work would be four cases per day?
A. No. You can't have more than two patients in the operating room undergoing operations at the same time.
Q. Right. But assuming that each operation takes a half day, have you ever done four cases per day?
A. Yes.
Q. Now, you said by law you can't do that.
A. That's right,
Q. 'what law are you refemng to?
A. Medicare reimbursement law.
Q. When did that law, to your knowledge, take effect?
A. I can't remember.
Q. What year?
A. I don't remember.
Q. Incidentally, doctor, any time during this deposition -- this is going to be a short deposition -- I want you to know you are more than

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free to look at the chart before responding to a question.
Back in August of 1996, what percentage of your time was spent on minimally invasive surgery, approximately?
A. I can't answer that Without going back and looking at the record. I can't remember what percentage of my time was done With coronaries and what percentage was done with valves.
Q. Is it a misnomer to speak of minimally invasive surgery when one is talking about a valve replacement?
A. I don't understand your question.
Q. Fine. When one is doing a minimally invasive surgery, is it by definition a CABG?
A. No.
Q. Can it also be an aortic valve replacement?
A. Yes.
Q. Can you estimate for me back in 1996, would you have been doing 50 percent minimally invasive?
I am not holding you to a percentage, but just a sense as to how much minimally invasive versus traditional surgery you were doing.
A. Are you talking about valves or

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coronaries?
Q. I am interested in valves, excuse me.
A. Probably half.
Q. Now, were there various types of minimally invasive surgeries relative to valves? Different ways to do minimally invasive surgery on replacement of an aortic valve?
A. Yes.
Q. Would you delineate what those types were?
A. Various types of incisions.
Q. Okay. And would you describe the types of incisions for me?
A. There is about a dozen. Would you like to go through them all?
Q. Not if there is a dozen, no.
Did Mr. Long have a minimally invasive surgery?
A. Yes.
Q. Now, he had a transverse sternotomy; correct?
A. Yes.
Q. Are there various types of transverse sternomoties?
A. Yes.
Q. That would fall under the category of

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minimally invasive?
A. Yes.
Q. How many types of those would there be?
A. Aboutthree.
Q. All right.

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(Thereupon, COSGROVE Deposition Exhibit 1 was mark'd for purposes of identification.)

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Q. Doctor, handing you what's been marked as Plaintiff's Exhibit 1, which is a gross anatomical drawing of the chest, can you mark on Exhibit 1 the three different types of incision? Could you reflect that on that exhibit?

MR. JACKSON: Three different types of transverse sternotomies?

A. You want three on one drawing?
Q. I have two more then, if that would be easier. Let's just do one then.

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(Thereupon, COSGROVE Deposition Exhibits 2 and 3 were mark'd for purposes of identification.)

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Q. We have now marked these Exhibits 1, 2 and 3. And as to Exhibit 1, what type of a transverse sternotomy is that? What would you call that?
A. It's a transverse incision that's going through the third interspace.
Q. Okay. Is that what Mr. Long actually had?
A. Yes.
Q. And what does Exhibit 2 reflect relative to a transverse sternotomy?
A. It's a vertical incision in the sternum with a transverse of the third inner space.
Q. Kind of like an upside down T?
A. Yes.
Q. And what is number 3?
A. That's a T incision, the same way.
Q. Okay. Now, when is one exhibit more indicated than the other?

MR. JACKSON: You mean one incision?

Q. Yes, one incision as reflected on these exhibits. If you can generalize for me.
A. I don't think you can generalize.
Q. Let me ask you this, sir. Why was it that you used the type of incision as demonstrated on Exhibit 1 on Mr. Long?

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A. Because that was the one that I thought at the time gave me the best exposure.
Q. Okay. *So* of the three exhibits, Exhibit 1 is the one that permits the best exposure?
A. That was what I was using at that time.
Q. Okay. Can you tell me, sir, how many transverse sternotomies for a minimally invasive surgery you had done prior to Mr. Long?
A. No.
Q. Can you give me an estimate in terms of -- less than 25, less than a hundred?
A. I can't tell you. I don't know, I don't remember.
Q. Doctor, do you keep kind of a spreadsheet or a data entry system within your records here as to each patient you have operated on and complications therefrom?
A. Yes.
Q. And is that something subject to redaction of the patient's name to be reproduced?
A. I am sorry, I don't know what reduction means.
Q. Redaction. Taking out the name of the patient. Are they by patient number only on your list?

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A. By both.
Q. Okay. So if need be, you could reproduce that off your computers; correct?
A. It's a hand kept.
Q. How far back does that go, sir?
A. The beginning of the minimally invasive and then until about 1970. Total, about 60,000 patients then.
Q. What year did you start minimally invasive?
A. 1960. '96, I'm sorry.
Q. And on this -- what would you call this document, sir, that you keep tabs or tally of your minimally invasive surgery experience?
A. What do I call it? It's a record that we keep that doesn't have a name. It's a record that we keep for purposes of looking at complications, et cetera.
Q. Okay.
A. It doesn't have a name.
Q. Do you have a separate data sheet for minimally invasive or do you mix traditional and minimally invasive on that same data sheet?
A. No, we have one for minimally invasive.
Q. Okay.

MR. BECKER: John, we will ask you

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for a copy of that. Will you let me know if you need a formal request for production?

MR. JACKSON I will. I will let you know.

Q. Now, back in August of 1996, what patients were candidates for minimally invasive surgery for aortic valve replacements?

A. Primarily isolated without history of pericarditis or pectus excavatum.

Q. I am not familiar with that last term. What does that mean?

A. That means a caved in chest. Congenital anomaly.

Q. You just told me what the contraindications were, essentially as far as the patient, the exclusion criterion.

Now, once one would fall under the category where they can be operated on minimally invasive, is there something about a patient's history that you knew back in August of 1996 that would make them at higher risk for minimally invasive surgery than another patient?

A. No.

Q. If a man was a former weightlifter, as Mr.

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Long was, and had a massively bulky chest, would that have put him at any increased risk for minimally invasive surgery?

A. No.

Q. Do you recall whether or not the Clinic had an informed consent form for minimally invasive surgery back in 1996?

A. No, we didn't.

Q. Were you one of the pioneers in minimally invasive surgery?

A. Yes.

Q. Is that a copy of your current CV in front of you?

MR. JACKSON There is one right in front of you.

A. Yes.

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("hereupon, COSGROVE Deposition Exhibit 4 was mark'd for purposes of identification.)

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Q. Doctor, handing you what has been marked as Plaintiff's Exhibit 4, would you identify that for me?

A. My curriculum vitae.

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Q. And that is current?

A. Yes.

Q. Are there any articles within those publications that speak to the Cleveland Clinic's experience in minimally invasive surgery and complications thereof?

A. Yes.

Q. Would you just identify them by number, please, and tell me whether you are in journals or textbooks or abstracts.

A. 325, 320, 319, 311, 310. I think that's it.

Q. Okay. Is it true, doctor, that with minimally invasive cardiac surgery you have less visualization of the organs and the structure as you do with a full sternotomy?

A. I am not sure I understand which organs you are talking about.

Q. I am talking about -- unless I indicate otherwise, in my questions, I am talking about aortic valve replacement, minimally invasive.

A. What organs are you talking about?

Q. The heart.

A. You see less heart, yes.

Q. With minimally invasive aortic valve

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replacement, the cardiopulmonary bypass pump may be on longer?

A. No.

Q. Can you give me a sense as to the median period of time in an aortic valve replacement that the cardiopulmonary bypass pump should be on?

A. Depends on what kind of an operation you are doing.

Q. Let's say we are doing an aortic valve replacement utilizing an incision that's previously been depicted in Exhibit 1.

A. The aortic occlusion time and the cardiac pulmonary bypass time are 45 and 60 minutes, respectively.

Q. Could you tell me that one more time, please, say that one more time?

A. Would she like to read it back.

(Record read.)

Q. Would one have a potential for greater coagulopathy problems with a longer pump time?

A. Yes.

Q. Why?

A. Because of the contact with the cardiopulmonary bypass circuit.

Q. Is it generally more difficult to cannulize

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blood vessels with minimally invasive surgery?
A. No.
Q. Now, you obviously need special surgical instruments to perform minimally invasive surgery on an aortic valve; correct?
A. No.
Q. You do not?
A. No.
Q. So would it be fair for me to conclude that there are not specially designed instruments solely for the use of minimally invasive?
A. That's correct.
Q. Was there anything about Mr. Long's medical history or his physical stature that caused him to be at increased risk for minimally invasive surgery?
A. No.
Q. I want to explore your recollection of James Long. I know you see a lot of patients, doctor. Do you have any recollection of him?
A. Uh-huh.
Q. Tell me what you remember about him.
A. A big guy.
Q. A big man, big-boned man, big mass, muscle mass?

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A. Yes.
Q. Anything else you remember about him?
A. I remember he specifically was anxious to have a small incision and we talked about it at length ahead of time and I told him what my experience had been.
Q. In person or on the phone?
A. In person.
Q. Okay.
A. And I discussed the risk of the operation with him.
Q. Would anybody else have been present during this discussion?
A. No. His family didn't come with him.
Q. Okay. Was Mr. Long given any options relative to the three various types of incisions?
A. No.
Q. You choose the incision route?
A. Yes.
Q. Do you remember Mr. Long's son, Christopher Long?
A. Yes.
Q. What do you remember about Christopher Long?
A. He was very difficult to communicate with.

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Q. What do you mean?
A. Exactly that.
Q. He was difficult to get ahold of, or when you were sitting down with him, he didn't understand what you were saying?
A. No. Difficult to communicate with on a face-to-face basis.
Q. Can you be any more specific than that?
A. No, I don't think so.
Q. Doctor, when you meet with a family member after an untoward event from surgery, is it your practice to generate any notes?
A. No.
Q. Do you recall any conversations you had with Christopher Long?
A. Not the content.
Q. You just remember that he was difficult to communicate with?
A. Yes.
Q. I mean, are you saying that he kind of gave you a hard time?
A. I didn't know that he understood what I was telling him.
Q. Okay. Christopher Long has a number of specific recollections regarding conversations

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with you. I am going to run by them and see if you can -- if they might refresh your recollection and you can say I have no idea or no, I didn't say that or I may have said that. Okay?
I am not limiting you to your answer, but I will run by some of his recollections.
Chris Long had got a phone call from you on the day of his dad's surgery at around 6:00 o'clock and you told him that everything went well, quote, according to the book.
Would that be something that you may have said?
A. I don't ever remember using that phrase, but it's possible.
Q. Okay.
A. It's not one I use frequently.
Q. Now, Mr. Long's surgery was moved up one day from -- I think it was on a Wednesday and moved up to Tuesday or Tuesday to Monday, I don't remember now which day, because there was an opening in your afternoon schedule.
Do you recall that?
A. No.
Q. The fact that the patient is moved up, is there any significance to that?

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A. No,
Q. Now, Chris Long had difficulty -- strike that.
When did you first learn about the serious complication of James Long?
A. Which serious complication?
Q. Of the cardiac tamponade and his brain injury.
A. I am not sure that I learned about a tamponade. I learned about his brain injury the next morning.
Q. Okay. The next morning?
A. After the surgery, the day after the surgery.
Q. Okay. Who would have been responsible for contacting a family member if the family member is out of state relative to a serious Complication of a patient?
A. Well, it is generally done with a number of different individuals. I can't remember in this particular case who did that.
Q. I Will represent to you, doctor, that Chris Long did not learn about the serious complications of his father until Friday, three days after surgery, three days after his dad's serious

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complication.
Is that an appropriate period of time to advise a family member of a serious complication?
MR. JACKSON I'll object. Go ahead andanswer.
A. No.
Q. Chris Long felt that it was necessary for him to work through an Ombudsman person to reach you.
Do you recall whether that, in fact, was necessary?
A. I don't remember.
Q. Okay. Is that unusual for a patient's family to have to go through the Ombudsman -- how do you pronounce the word?
A. Ombudsman.
Q. -- department or division to reach you?
A. Yes.
Q. I assume you don't have an explanation as to why it took so long to notify Chris Long of his father's condition?
A. No.
Q. Chris Long flew out to Cleveland and ultimately met you the following week on or about 2:15 on August 27th. And Chris recalls the

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conversation in person with you where you said I have been pouring over the records day and night to figure out what went wrong.
Does that sound like something you would have said?
A. It's possible.
Q. And Chris Long also specifically recalls you telling him -- Chris -- that his father James Long was the largest man on whom I have ever performed this procedure.
Is that true?
A. It's possible.
Q. And you told Chris Long that you were quite surprised by Mr. Long's chest mass and that his father, Mr. Long's chest mass initially caused technical difficulties.
Is that true?
A. That I said that?
Q. That you said that and did it actually happen?
A. I can't remember that I said that or not, and I can't remember it being a problem, but we certainly accomplished the procedure reasonably.
Q. Okay. Now, if you saw Mr. Long the night before surgery, would you have done a physical

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exam of him?
A. No.
Q. You also told Chris Long at this meeting at 2:15 on 8-27-97 that immediately after you took his dad off the heart/lung bypass, and once his heart took over, his heart pumped so hard that it blew one of the stitches that you had made on the heart.
Is that true?
A. Yeah.
Q. Why did that happen?
A. Well, I can't tell you why it happened.
Q. Is that the first time that it has happened to you?
A. No.
Q. Chris Long further recalls that you were very surprised by this complication.
A. I am.
Q. And you had to once again place his dad on the heart/lung machine and to sew up the blown stitch.
A. Correct.
Q. Now, when you use the phrase blown stitch, does that mean a stitch actually broke or came loose?

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A. Probably pulled through the tissue.
Q. And at that meeting, on the 27th, Chris recalls you telling Chris or talking to him about the quality of life that his dad is going to have to live with.
Do you remember any discussion along those lines?
A. No.
Q. You also told Chris at that meeting that because his dad had had critical stenosis of the aortic valve for some time, his heart was enlarged and his heart muscle was thick.
Do you remember that?
A. That's correct. I don't remember saying that, but that was correct.
Q. And the fact that his heart was enlarged, that fact alone is not unusual for an aortic valve replacement; correct?
A. That's correct.
Q. Now, the fact that his heart muscle was thick, would you consider that unusual for an aortic valve replacement?
A. No.
Q. The fact that his heart muscle was thick, did that present an additional challenge or

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additional degree of difficulty because of the thickness of the heart muscle?
A. Just in controlling his blood pressure.
Q. Can you explain that a little bit further?
A. Yes. People that have very thick heart muscles generally generate very high blood pressures and you have to give medicine to control the blood pressure.
Q. And to your knowledge, was Mr. Long on blood pressure medication prior to?
A. No, after surgery you have to control the blood pressure.
Q. Oh, so that statement was postoperatively?
A. Yes.
Q. And then Chris Long indicates that he had difficulty reaching you and then when you did finally hook up with him you apologized for the poor communication.
Do you remember that?
A. No.
Q. Now, as far as the surgery itself on Mr. Long, is it your practice to start and finish the whole operation or just come in when the technical aspect of the valve has to be addressed?
A. I don't open and generally do not

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cannulate. I do the operation and decannulate and *dry* up and the team closes.
Q. So you are not there during the whole surgery?
A. No.
Q. Are you saying, doctor, that the massive chest size of Mr. Long didn't present any difficulties as far as you doing the intricate work of the valve itself?
A. That's correct.
Q. In addition to the spreadsheet or data bank that we talked about with your surgeries, do you have an actual surgery schedule that you can go back and say on August 20th, for example, these were my cases and this is how many I did?
A. Yes.
Q. Now, going back to this complication where there was a pull through or a rupture of the suture, what did you do?
A. Placed him back on cardiopulmonary bypass, decompressed the heart and replaced the stitch.
Q. Did you inspect the other stitches to see if there was any loosening?
A. Sure.
Q. You had a duty to do that; correct?

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A. I had a duty to do that?
Q. If you go back in to --
A. I didn't go back in. You know, we had not taken the tubes out of the heart. We had let the heart start working. As the heart started working, we recognized that we had a bleeding site. We then put it back on the bypass without ever taking the tubes out, fixed the stitch. There was no other bleeding, And he came off the heart/lung machine again.
Q. Did you examine the other stitching areas?
A. Well, there was no bleeding so there was no other stitches, there was no other bleeding areas.
Q. Did you tell Chris Long that the problem of the suture rupture had not occurred to you with any other homograft procedures?
A. I don't remember.
Q. Is it true that that's the first time that's occurred to you in a homograft valve replacement?
A. I haven't had a lot of bleeding problems with homografts like this.
Q. I am assuming you didn't do any reinforcing of sutures after the suture ruptured; you simply put a new suture in in that one location?

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A. I did reinforce that particular stitch, yes.
Q. Okay. How did you do that?
A. Pledgets.
Q. Is that reflected in the operative report?
A. Yes.
Q. Now, once you finished the operation, and if it's the last case, would you be going home roughly between 6:00 and 7:00 p.m.?
A. I wish.
Q. Okay. Can you tell by the chart or by your records as to what time you went home on the day of this surgery?
A. No.
Q. I want to get a sense as to who is responsible for post-op management of Mr. Long or who was responsible in this case.
Can you tell me from the chart or from your recollection as to who would have been responsible for the surgical aspect of Mr. Long's postoperative care?
A. Well, there is a team.
Q. Explain to me how that team works.
A. Junior resident in the house, chief resident and myself.

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Q. Junior resident?
A. Yes.
Q. You say there is a junior resident in the house?
A. Yes.
Q. And then you said there is a chief resident?
A. Yes.
Q. And do you remember who the chief resident was at this time?
A. Dr. Muellbach.
Q. Now, to your knowledge, had Dr. Muellbach done his residency, all of his surgical residency at the Cleveland Clinic?
A. No.
Q. Had Dr. Muellbach essentially come to the Cleveland Clinic for specialized cardiothoracic surgical training?
A. He had come to the Cleveland Clinic because the staff where he was training in Kansas City were anxious to put him back on the faculty there and they wanted him to have an additional year of experience at the Cleveland Clinic and then to return to their faculty.
Q. Well, was he doing cardiothoracic surgery prior to coming to the Cleveland Clinic?
A. Yes. He was board eligible.
Q. So the reason that he came here?
A. Was for the special expertise at the Cleveland Clinic.
Q. Okay. He was considered the chief resident?
A. Yes.
Q. Now, was he in-house or was he at home?
A. I can't tell you where he was.
Q. Well, do you expect him to be in-house?
A. No.
Q. Or at home in between 7:00 and 10:00 p.m.?
A. I expect him to be, you know, where its necessary to be for patient care.
Q. Right. But can he, if he is ultimately responsible, can he be ultimately responsible at home?
A. Yes.
Q. Okay. Based on your review of the chart, is there anything that tells you that Dr. Muellbach was in person or on campus that evening?
A. I don't know where he was.
Q. Okay. So Dr. Muellbach, did he begin as most residencies begin, July 1st of that year?

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A. Yes.
Q. So he had been with the Cleveland Clinic approximately six or seven weeks at the time of Mr. Long's surgery?
A. Yes.
Q. He wasn't considered, quote, an attending; he was considered the chief resident?
A. Exactly.
Q. Can you explain to me why, because of his experience, why he wouldn't have been considered anattending?
A. Because we don't take anybody on the staff -- I hadn't appointed him as an attendant. It's a closed staff here, as you know, and anybody cannot get admitted to it, and we hired him as a resident.
Q. But was there actually a contract with him, to your knowledge?
A. He gets a letter telling him what his --
Q. Duties and responsibilities would be?
A. No, what his salary will be and the term and the length of his employment.
Q. To your knowledge, is there any document that would delineate what his duties and responsibilities would be?

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A. No.
Q. To your knowledge, he is back in Kansas City?
A. Yes.
Q. Do you recall talking with him about this particular patient after Mr. Long's complication?
A. Well, I am sure we talked. I can't tell you what the conversation was.
Q. Okay. Do you know whether or not Dr. Muellbach was contacted either two or three times that evening by phone, by a nurse?
A. I don't know how many times he was contacted.
Q. Did the patient know that his postoperative care was going to be managed by residents?
A. We didn't specifically discuss that.
Q. Do you think that's something that a patient should be told?
A. No.
Q. Would it be fair to state, doctor, that people who are managing postoperatively recovery people, patients, have a duty to be more aggressive with a patient who has sustained an intraoperative complication, such as bleeding, as compared to one who didn't sustain it.

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MR. JACKSON: I'll object, but you may answer if you can.
A. No.
Q. All things being equal, given the complication that Mr. Long sustained intraoperatively, was he at increased risk over the average patient to sustain a postoperative complication, such as a bleed at a suture site?
A. Idon'tthinkso.
Q. Is it your routine, doctor, that after you operate on the patient to go to their bedside sometime in early evening to see how they are doing?
A. Yes.
Q. Doctor, you have had -- strike that. Do you recall sitting down with Dr. Muellbach or any of the nursing staff to review the vitals contained in Mr. Long's postoperative recovery flow sheets?
MR. JACKSON: What point in time are you talking about?
MR. BECKER: Within days after this serious complication.
A. No.
Q. Doctor, as a result of one of your earlier

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answers, is it your position that Mr. Long did not sustain a cardiac tamponade?
A. I didn't say that.
Q. Okay. Do you agree that Mr. Long, in fact, did sustain a cardiac tamponade?
A. No.
Q. What's the basis for that opinion? What was the cause of his arrest?
A. I don't know.
Q. Did you ever tell Mr. Long's son that his dad sustained a cardiac tamponade?
A. I don't remember.
Q. So you don't know and you don't have an opinion as to what caused his arrest?
A. No.
Q. Do you acknowledge that he was bleeding in the recovery unit?
A. Every patient bleeds in the recovery unit.
Q. Okay. As you sit here, doctor, do you have any criticism of any of the residents, whether junior residents, senior residents, chief residents or nurses, as to the way they managed this patient in the recovery room?
A. No.
Q. Doctor, I want to talk a little bit about

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transesophageal echoes. Do you regularly use those in the recovery unit on a heart patient?
A. Not regularly. Intermittently.
Q. Do they have a TE, portable one on the floor?
A. Uh-huh.
Q. That's a yes?
A. Yes.
Q. And do you need a special technician to operate that or can nurses or doctors?
A. In-house doctors can do it.
Q. You say house doctors?
A. In-house doctors are available to do that.
Q. Okay. When you suspect a patient is having an intraoperative bleed around the suture site in a heart patient, is that generally the first diagnostic test you would turn to, a TE?
A. No.
Q. Tell me what would be.
A. Reexploration.
Q. That means take him back to the operating room and open up his chest?
A. Yes.
Q. And as far as physical location between the recovery unit and the operating suite, I assume

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they are very close?
A. Yes.
Q. In terms of minutes, how long would it take to transfer a patient from the recovery unit to the operating suite?
A. Physically wheeling through the space?
Q. Right.
A. Five minutes.
Q. Okay. And as far as organizing a surgical team anywhere from 7:00, 8:00, 9:00, 10:00 p.m. at night, would that take some time or would they generally be available?
A. They are available.
Q. Can you give me an idea as to how often -- strike that.
Why is it that you would simply crack his chest, the patient's chest rather than utilizing a TE, if you suspect a bleed?
A. Because we found TE is a very poor prognosis for tamponade, very poor diagnosis for tamponade.
Q. Okay. When did you come to that conclusion?
A. A decade ago.
Q. If you had a resident that was managing

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someone postoperatively and if they had the slightest suspicion that a cardiac tamponade was going forward or occurring, you would expect them to just immediately take the patient to the operating suite?
A. No, they would call you.
Q. They would call you?
A. Yes.
Q. Hypothetically, they would call you and what would you say to them?
A. I would discuss the problem and if I thought that they were tamponading from the description, I would tell them to take him back to the operating room.
Q. And what criteria would you be looking for in that discussion with the resident?
A. Low cardiac output.
Q. Low?
A. Low cardiac output. Low urine output.
Q. Anything else?
A. Persistent bleeding.
Q. Those are the --
A. Those are the main factors.
Q. Okay. So would it be, you would expect to be called, number one?

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A. Absolutely.
Q. You wouldn't want a decision to be made by a junior resident or a chief resident?
A. No.
Q. So in fact, they would make you very unhappy if you found out that they took one of your patients back without calling you?
A. Yes.
Q. If they did call you, and you advised them to take the patient back, would you come back for that surgery or would you expect them to do that?
A. It would depend on the situation.
Q. You have done both?
A. Yes.
Q. Stayed at home or gotten in the car and come back to the hospital?
A. Yes.
Q. Dr. Muellbach, did he finish his one year of residency here?
A. Yes.
Q. It's not your practice, doctor, to order by way of a standing order in your heart patients to have PT and PTT checked?
A. No.
Q. Why not?

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A. They are notoriously inaccurate after cardiacsurgery.
Q. Now, there was a postoperative order to keep Mr. Long systolic's blood pressure less than 100.
A. Yes.
Q. I think we touched on that before. Once again, what was the reason for that?
A. Because I routinely keep homografts for that kind of blood pressure because of multiple suture lines.
Q. If a blood pressure was permitted to go above 100, there would be an increased risk of bleeding?
A. Well, it's not just 100. It's an arbitrary number that I pick.
Q. If you are to be called regarding a patient of yours postoperatively and you are home, do you have a system or an understanding in place that you only want to be called by the senior resident as compared to a nurse or a junior resident?
A. No. Anybody can call me if it's necessary, but usually it's a senior resident.
MR. BECKER: It's 9:00 o'clock.
MR. JACKSON: Do you want to go on,

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doctor?
THE WITNESS: Let me see where we are.
(Thereupon, a recess was taken.)
THE WITNESS: I have ten minutes.
MR. JACKSON Let's go as far as we can.
- - - -
(Thereupon, COSGROVE Deposition Exhibit 5 was mark'd for purposes of identification.)
- - - -
Q. Doctor, I am going to hand you what's been marked as Plaintiff's Exhibit Number 5. And I want to particularly call your attention to the mean blood pressure. I want you to take a look at that for me.
First of all, would you agree that Exhibit 5 is a flow sheet of the surgical intensive care unit?
A. Yes.
Q. I want to call your attention, doctor, to, first of all, the far column. To your knowledge where it has letters, A through Z, do you know what those letters represent?

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A. Those are times in which vital signs are taken.
Q. And just kind of identifies that line?
A. Yes.
Q. All right. I want to draw your attention to between lines H through M. You agree that during that period of time, notwithstanding the administration of pressors, Mr. Long remained hypotensive?
A. He did.
Q. Is that consistent with a cardiac tamponade, developing cardiac tamponade?
A. Low blood pressure is, yes.
Q. Now, doctor, if a patient has low blood pressure, will that also have a direct effect on how much blood is being pumped out of the chest tube?
A. I am not sure I understand.
Q. If one has low blood pressure, would there have been a tendency, would there also be a concomitant reduction in flow from a chest tube because of the patient's own blood pressure?
A. Shouldn't affect the chest tube any.
Q. But should it affect the manner that the pressure within the abdominal cavity pushes out

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fluid?
A. The pressure within the abdominal cavity pushes out fluid?
Q. Right. The chest cavity. Not abdominal cavity, chest cavity,
A. To the best of my knowledge, the pressure in the chest cavity is unrelated to the blood pressure.
Q. Is there a general proposition, doctor, that a trend towards equalization of CVP to diastolic pressure of the Swan Ganz catheter has been shown to be indicative of a cardiac tamponade developing?
A. Yes.
Q. Were you responsible for the development of that particular theory yourself?
A. No.
Q. Do you know who was?
A. No.
Q. How long have you known that theory in chest surgery?
A. 20 years.
Q. Five?
A. 20.
Q. 20 years. Do you see any indication here

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on the chart, doctor, where there has been an apparent trend toward equalization of CVP to diastolic pressure of a Swan Ganz?
A. They were equal, essentially, since the time that he came in on reading number A when they were 20 and 17, 18 and 16, 22 and 19.
Q. Okay.
A. So from the entire postoperative period they are equal.
Q. I guess, doctor, and in particular, did I --
A. They seem no more equal to me in H through M than they do through A through E or M through R.
Q. Excuse me. What is it about that period of time, let's say, E through M, that points away from an intraoperative bleed or the development of cardiac tamponade?
A. It has a cardiac index that is somewhere between 3 and 2.5.
Q. Anything else?
A. Urine output is over 200 cc's per hour.
Q. At L, line L, what is his cardiac index at line L?
A. Index is 2.
Q. Is that good?

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A. It's certainly compatible with life. The next one is 2.5 and the one after that is 2.9. Urine output through those times is somewhere between 600 and 300 cc's an hour, which is not compatible with low cardiac output.
Q. Now, the fact that he is on Amicar --
A. All patients are on Amicar after surgery.
Q. Can you tell by looking at Exhibit 5 what time the Amicar was begun?
A. It looks like it was begun about F.
Q. When do you expect the patient to start to receive the Amicar?
A. We give them to him in the operating room and through the procedure into the postoperative period.
Q. Is it routine for you to do a chest film on a patient after you complete your surgery?
A. Yes.
Q. Why?
A. To look for inflation of the lungs, placement of the nasogastric fube, placement of the endotracheal tube, chest silhouette, all the things we see on chest X-ray.
Q. Okay. And are you aware that the chest X-ray interpretation, are you aware of what the

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postoperative chest X-ray said in this case?
A. I can't remember.
Q. It suggested, I will tell you, sir, it suggested that there be another reshoot or another taking of the chest film.
A. Okay.
Q. If that is done, when should that be done?
A. It depends on the reason and what we interpret the thing to be. The reading is generally not done until substantially subsequently of the taking.
Q. Can you give me a sense as to the percentage of time that you might take a patient back for a relook at their chest, not so much you, but --
A. Reoperation for bleeding at the Cleveland Clinic runs about five percent.
Q. So one out of 20 patients may be taken back to surgery within hours after the initial surgery?
A. Any time afterwards.
Q. For a concern about bleeding and around the suture lines?
A. Yes.
Q. Okay. Can we agree that cardiac tamponade is a life-threatening condition?

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A. Yes.
Q. You said that there is a TE on the floor?
A. In the hospital.
Q. Not one in the unit --
A. No.
Q. -- per se? Well, when would you since you feel that they are not so diagnostic for developing cardiac tamponades, when would you utilize a TE post-op?
A. If I am concerned about valve function, ventricular function.
Q. Now, what will the administration of Amicar, what effect would that have on the blood coming out through the chest tube?
A. It may have none. Unpredictable.
Q. Is it also, is there a risk of clotting around the chest tube from the Amicar?
A. Not that I'm aware of.
Q. Is it the nurses responsibility when there is bleeding to continually milk the chest tube?
A. Even when there isn't.
Q. When what?
A. When there is no bleeding, they milk the chest tubes.
Q. Why do you want them to do that?

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A. Make sure the chest tubes don't clot.
Q. Have you Written, doctor, on postoperative bleeding in any of your articles?
A, Yes.
Q. The ones that we have spoken to at the beginning of the deposition?
A. No.
Q. If you can turn to the CV again, which I guess is marked as Exhibit 4, and tell us which of those numbers reference your comments about intraoperative bleeding, how to manage intraoperative bleeding, or excuse me, postoperative bleeding, and the complication of bleeding and need for an additional surgery?
A. Do you want me to go through all 400 articles to find them? They were written almost 20 years ago.
Q. Okay.
A. So I would have to go through the whole CV to find them for you.
Q. Is it likely that some of those -- I'm assuming that you have also published in textbooks?
A. Yes.
Q. Okay. And is that subject matter covered

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in any particular textbook?
A. It's all part of the CV. They are all in together.
Q. If you could just focus in on the textbook, that might save us some time.
MR. JACKSON Your question specifically is?
Q. My question is, which of the textbook publications --
A. They are all intermixed. I would have to go through the whole thing for you, if you like.
Q. No, but I just --
MR. JACKSON: Let me ask this, Mike. It looks like from looking at your notes, you are getting closer to the end.
If there is a possibility to complete this within the next couple minutes and that's okay with you, I would like to get it done.
MR. BECKER: Off the record.
(Thereupon, a discussion was had off the record.)
MR. BECKER: I prefer to close it down now and get you on your schedule and we will reconvene and I suspect the time

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that I will need next time will be less than 35 minutes.
MR. JACKSON: Is that your preference?
THE WITNESS: It's not my preference.
MR. JACKSON Can we finish it today? Do you want to try it?
THE WITNESS: Yes.
(Thereupon, a discussion was had off the record.)
(Thereupon, a recess was taken.)
Q. I want to establish whether or not you were ever called the night of the surgery by anyone?
A. Yes, I was.
Q. Who were you called by?
A. Dr. Muellbach.
Q. Okay.
A. As I remember, it was Dr. Muellbach.
Q. What time were you called?
A. I don't remember.
Q. What was the reason you were called?
A. He was bleeding.
Q. Did you generate any notes as a result of the phone conversation?

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A. No.
Q. Do you have any sense as to whether or not that phone call took place towards late evening, middle evening? You don't have a sense as to the time?
A. This was three years ago now and I frankly can't remember the time I was called.
Q. What do you recall the doctor telling you?
A. I don't remember.
Q. Well, he was obviously concerned because he called you; correct?
A. Yes.
Q. Okay. Would it be fair for me to conclude because he called you and what you have already told us about the procedures as to when you expect to be called, that you made the decision at home that the patient should not be taken back to the operating room?
A. No, I made the decision he should go back to the operating room and I came in.
Q. When did you come in?
A. I came in for the reoperation.
Q. Were you there after his -- at what point in the reoperation did you arrive in the operating suite?

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A. After he had been put on the table.
Q. Does your name appear in the operating suite?
A. I don't know.
Q. Should it appear in the operating suite, if, in fact, you were present?
A. Yes.
Q. What did you do for him?
A. I did the rest of his operation.
Q. Well, what did you find at the time of getting in to the surgery?
A. I found he was hypotensive. We resuscitated him, He became hypertensive. He was bleeding from the distal suture line and I sutured it.
Q. Can you tell me one way or the other as to whether there was evidence of cardiac tamponade at the time they opened up his chest?
A. I can't.
Q. Based on what you were told.
A. I can't tell you. I don't have recollection in that particular time.
Q. Why did you choose to come in for this reoperation rather than let Dr. Muellbach operate?
A. Because he was bleeding, and when I am

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worried about bleeding, I come in.
Q. I thought we established earlier, doctor, there are some cases that you let the senior resident do the surgery?
A. There are.
Q. Why was it in this case, sir, that you chose to come back to the hospital?
A. Because I had a high enough level of anxiety about it that I came in.
Q. Should there be any document generated, either by you or Dr. Muellbach or anyone else on this staff as to what time you were called and what time you arrived in the hospital?
A. Should there be?
Q. Yes.
A. No.
Q. Okay. Do you have a recollection Dr. Muellbach called you from home, from his home?
A. I don't know where he called me from.
Q. Okay. How long would it take you in terms of minutes to leave your home and arrive in the operating suite?
A. 20 minutes.
Q. In the immediate post-op period, how much CT drainage is acceptable per hour?

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A. Generally -- well, it depends on the operation.
Q. Let's stay with an aortic valve minimally invasive surgery where there was an intraoperative complication of a suture bleed.
A. Well, I am not sure I have enough -- whether a complication of an intraoperative suture? It depends upon how the patient is hemodynamically. It depends upon the type of operation that I have done, what my expectations are.
It's not just an acceptable amount. Zero is acceptable. More than that we don't want to see.
You know, it is a judgment as to the particulars of the situation.
Q. Would you expect the drainage to decrease over the hours?
A. Yes.
Q. And not increase?
A. Yes.
Q. And in fact, if you see an increase in the amount of fluid coming from the chest tube, what would that be indicative of?
A. That would be a concern about either the

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tubes were not draining adequately to start with or that we had a new bleeding situation.
Q. Now, apparently the nurse that was in charge of this person was a fairly new nurse at the Clinic. She testified that she was in her orientation at the time she rendered care to Mr. Long.
If a nurse is within her orientation period, would you expect her to be monitored by another nurse?
A. Yes. There is a head nurse in each unit that oversees the whole unit.
Q. And can you tell by what's been marked as Exhibit 5, who the head nurse was at this time?
A. No.
Q. At the top of Exhibit 5, there are a number of -- in the middle section of Exhibit 5, there are a number of letters, A through F. Can you tell me what those are for?
A. Those relate to infusions, intake, down here.
Q. But does it signify the person that did the infusion?
A. No.
Q. Help me out. What does it mean?

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A. It means the type of drug. B, for example, would be cardiac output. SNP would be sodium nitroprusside.
Q. And what would the D and E be?
A. I can't read them.
Q. What would A be?
A. Buratrol.
Q. Now, doctor, if you see blood drainage from the CT tube in a patient post aortic valve replacement, and the drainage started at 50 and increases up to 250, would you consider that a concerning or alanning sign?
A. It's something to watch.
Q. Now, would you expect your senior resident -- first of all, would you expect the nurse to contact a senior resident between H and M if the blood pressure remained below 90, notwithstanding the administration of two pressors and the increase titrating of those pressors?
A. Well, there were two people at the bedside. One notified and one at the bedside. Dr. Yared is a staff doctor and Dr. Muellbach was advised.
Q. Dr. Yared has been deposed and he says he is an anesthesia person.

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A. Correct.
Q. He doesn't --
A. He is an intensivist.
Q. Should his responsibility include postoperative bleeding?
A. No.
Q. What is your understanding of what Dr. Yared's role to be in a post-op patient?
A. He mostly manages the anesthesia aspect of things.
Q. Why would anesthesia be seeing this patient roughly at 8:00 o'clock?
A. There is an anesthesiologist on duty anyhow in the intensive care unit.
Q. Okay. And help me out. Why would anesthesia see a patient after the surgery?
A. They always see them.
Q. But --
A. He is an intensivist who works in the intensive care unit and sees the patients.
Q. My understanding of an intensivist is that he is a specialized physician responsible for critical care of a patient, all aspects of critical care.
Would you agree with that?

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A. They obviously did because the drug got started.
Q. Whichdrug?
A. Epinephrine.
Q. If someone from the surgical department didn't come in but simply gave a verbal order, would you be disappointed in that particular person for not coming to see the patient?
A. Well, it depends on the situation completely.
Q. If you make the decision to come see and reoperate, take the patient back, would you tell them to wait until I get there?
A. No.
Q. Would you normally tell them get him ready, that means crack the chest, get everything ready so I can come in and do everything I have to do; fully prepare the patient to save time?
A. Well, I would tell them to go ahead and then tell them I was coming in; to go as fast as they could.
Q. What is the difference between Dr. Hernandez and Dr. Muellbach as it was in August of 1996?
A. One is a junior resident and one is a chief

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A. Yes.
Q. So let's go back to my question. I think the answer would be yes, you would expect a nurse to contact somebody given those low blood pressures, notwithstanding the administration of the pressors and continued titration of those pressors?
A. Yes.
Q. Would you expect to have been contacted between 8:00 and 9:30 given those blood pressures and what it took by way of administration, not only of those pressors, but albumin administration?
A. Yes. And I can't say that I wasn't contacted. I don't remember.
Q. Well, if you were contacted, isn't it routine, based on your experience, that it would be reflected in the chart that you are contacted?
A. No. It's definitely not routine.
Q. Would you expect someone from the surgical service to actually come and see the patient, given those blood pressures that were going on between H and M?
A. Yes.
Q. Okay.

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resident.
Q. Hernandez being the junior?
A. Yes.
Q. If Dr. Muellbach wasn't in-house between 8:00 and 9:30 p.m., shouldn't Dr. Hernandez have been called to come in and see this patient between 8:00 and 9:30 p.m., if he was, in fact, in-house?
A. Dr. Hernandez was in-house.
Q. Shouldn't he have come to see the patient between 8:00 and 9:30 --
A. Which is 8:00 and which is 9:30? It would be I and --
Q. -- between H and M?
A. H and M. He probably should. And I am not sure whether he did or didn't.
Q. I want to make sure I understand what you are saying. He probably should have come to see the patient at bedside?
A. Yes.
Q. What is the advantage -- I am not trying to be cute here, but what is the advantage to a surgeon to actually make a physical assessment of the patient versus listening to a nurse delineate the numbers off the flow sheet?

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What's the advantage to the surgeon of being able to come in and actually eyeball the patient?
A. You can assess the level of perfusion is one thing. There is about 100 other things that we get the opportunity to do.
Q. It's much better to make a personal assessment than try to do it over the phone?
A. Yes.
Q. Now, he was given albumin?
A. Yes.
Q. Based on your interpretation of the chart, why was he given albumin?
A. Because his hematocrit was in his mid 30's and we generally don't transfuse people until they get in the low 20's.
Q. What is the effect of albumin on one's blood pressure?
A. Per se, it has no effect on blood pressure.
Q. Well, would it have an indirect effect on blood pressure?
A. It can raise blood pressure if you are hypovolemic. As can any volume replacement.
Q. And packed red blood cells can also raise blood pressure when it's hypovolemic; correct?

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A. Yes.
Q. Now, doctor, did you note on Exhibit 5 under the pulmonary artery column that it's not continuously charted after -- I understand that there is a clerical error in L and M. That's what has been testified to, to be fair with you, by a nurse; that there was a clerical error on line L and M under pulmonary artery.
Do you expect pulmonary artery to be continuously charted by your nurses?
A. Yes.
Q. Okay. And why do you want that?
A. The same reason we want everything else charted.
Q. And do you expect the cardiac output to be continuously charted by your nurses?
A. No. Intermittently.
Q. Why do you make a distinction between cardiac output and pulmonary artery readings?
A. Because cardiac output is an intermittent measurement, There is no continuous cardiac output currently available.
Q. Is cardiac output something that you can assess by doing some calculations or is it immediately observable by looking at a machine on

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a patient? How does one go about calculating?
A. You take 10 cc's of saline and you inject it and get a curve for the area and you calculate the area under the curve and you, from that, get cardiac output. And this is only obtained when somebody injects 10 cc's of saline in order to get that.
Q. Would it be a nurse or resident that would be doing this?
A. Nurse.
Q. And if there was an error in the cardiac output in her calculations?
A. The calculation is made by a machine.
Q. So what, there are certain data put into the machine by the nurse, correct, for a cardiac output?
A. You know, you inject into a thermodilution catheter. It reads it automatically and gives you a number on the cardiac output machine.
Q. In other words, there is no chance for error in the nurses running this particular maneuver; correct?
A. The nurse reads what is off the machine.
Q. That's it?
Do you have an opinion, doctor, in terms of

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probability as to what was the source of the cause of Mr. Long's drop in blood pressure between H and M?
A. It was systemic vascular resistance.
Q. What does that mean?
A. SVR. It's charted right here and that's why we started the Levophed. He was vasodilated.
Q. What did he come in with, SVR. 5597
A. What did he come in with?
Q. Yes. Into the recovery unit. 559, that number?
A. 955.
Q. At D he is 579?
A. Yes.
Q. Okay.
A. Those are all about half of normal.
Q. Doctor, Chris Long talked to a nurse by the name of Pam Marinelli who told him that intraoperatively his dad's heart wasn't pumping consistently a lot of blood, but occasionally would shoot up very high.
A, is that true and, B, if so, what is the significance of that?
A. I don't understand what you are asking me.
Q. I am reading a quote to you. You don't

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understand that?
A. I don't understand.
Q. Apparently Mr. Long was on the heart/lung machine for 143 minutes. Is that an abnormally long time to be on a heart/lung machine?
A. Depends on the procedure.
Q. For someone --
A. Because I had to go back a second time, that's longer than average.
Q. Of the signs or symptoms that we talked about for diagnosing postoperative bleed, is there any one -- you talked about, we talked about blood pressure, we talked about urine output and we talked about a number of different conditions.
Is there any one that is more critical to you than the other in your ultimate decision-making process as to when you are to go back in and reoperate?
A. No, it's a constellation.
Q. Why wasn't Mr. Long at increased risk to have a post-op complication given the fact that he had an intraoperative complication upon being hooked up to the -- taken off the heart/lung machine?
A. I am not sure I understand your question.

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Q. The fact that Mr. Long had an intraoperative complication --
A. Intraoperative bleeding.
Q. -- intraoperative bleeding, a complication where a suture actually pulled through, are you telling me here today that that should not have played any fact in the resident, junior or chief resident's decision as to whether this patient needs to be taken back to surgery, that intraoperative complication of bleeding?
A. I don't think the intraoperative complication should, you know, be a factor. What you do is you judge people on how they are doing.
I have intraoperative complications regularly and they may do very well afterwards. They may not do well, but it's totally independent.
Q. But if you are leaving the hospital, for example, have you ever said to someone managing one of your patients, a resident, chief or junior, that we had a problem with this guy, we better watch him very closely?
MR. JACKSON: I am going to object to that. Did he ever say such a thing?
A. If I ever did? I have said that. I have

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also done 14,000 heart operations.
Q. Okay. But it was just said that way because of a certain experience intraoperatively; correct?
A. Right, and it may or may not be due to a suture pulling through.
Q. Okay. In the postoperative period with an aortic valve replacement patient who has minimally invasive surgery, would you expect the pulmonary artery pressure to remain elevated or to drop back into a normal range?
A. Pressures do not come down instantly.
Q. Would you expect it to come down within an hour or two within the recovery unit?
A. No, it comes down over time.
Q. Time being 10 to 12 hours or a day?
A. Time may be, depending on the valve lesion, maybe a matter of weeks or months.
Q. Mr. Long's postoperative chest film was interpreted as cardiac silhouette, prominent peripheral congestion noted.
What does that mean to you, that radiology interpretation?
A. Not verymuch.
Q. Well, could that be consistent with

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bleeding around the heart?
A. Yes. As could a normal chest X-ray.
Q. Your radiology department recommended a repeat of that film. Who is responsible within the surgical team to see that that chest film was repeated?
MR. JACKSON: You have been through this already.
MR. BECKER I don't think so on that question. I know on that subject I have.
A. It depends on why they did it. I don't know whether they recommended a repeat because it was technically a problem or recognized that something needed to be further examined. It depends. If it is technically a problem, they redo it.
Q. Okay. And if they are concerned there might be something brewing, then whose responsibility is it to ensure that that is taken?
A. The house officers.
Q. Now, is the house officer the same as a junior resident?
A. Yes.
Q. Would you routinely, yourself, ever look at

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a patient's post-op chest film?
A. If it's done by the time that I make rounds, yes.
Q. Would it be up on his floor in the recovery unit?
A. It's beside the bed.
Q. Can you give me an estimate as to how long it should take in terms of minutes from once a surgeon at the bedside decides that we need to operate on this patient again until the time that they are able to get in and have access to his heart in terms of minutes?
A. You generally can do it in 20 minutes.
Q. Do you have an opinion, doctor, that had Mr. Long's chest been cracked open and been a relook surgically by 10:00 p.m. whether or not bleeding would have been observed?
A. No.
Q. You don't have an opinion one way or the other?
A. I don't know.
Q. What did you expect the homograft valve replacement to do to Mr. Long vis-a-vis his anticipated life expectancy?
A. Prolong it.

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Q. Ten, 20 years?
A. I am not an actuarial. I can't testify.
Q. Okay. If one has a homograft, should that homograft be good for at least ten years before you might have to repeat it?
A. Yes.
Q. Is there anything about Mr. Long's medical condition and medical history that would tell you that he would have had a reduced life expectancy?
A. No.
Q. The issue, doctor, of -- well, the allegation, doctor, that a patient postoperatively had a bleeding complication and that was a delay in the personnel at the Clinic from operating, whether that applies to minimally invasive or traditional surgery, are you familiar with any other cases, current medical/legal cases either pending or that have been resolved on that same issue?

MR. JACKSON: You don't have to answer that.

MR. BECKER: Why not?

MR. JACKSON: Why would he have to answer that? That's not an issue. That's not relevant here, whether there are other

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cases. We are trying this case. Allegations, what they may be in any other case are not, in my opinion, important here.

MR. BECKER: If it's analogous, I disagree with you, John. You are instructing him not to answer?

MR. JACKSON: If he has another case like that and you want to explore that with him, fine. Any other cases at any time at the Cleveland Clinic with those allegations, I don't think that's a fair question and I don't think he has to answer that.

As it relates to him, if you want to ask that question, I will let him answer that question.

Q. It relates to you, doctor, but not only directly against you, but as to your residents or surgeons or senior, junior resident, as well.
A. I have no other cases.
Q. Okay. And you are not aware of any past cases where there has been an allegation by anyone that either a junior or a senior resident or some other attending other than yourself failed to

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timely respond to a situation suggestive of bleeding and timely took the patient back to the operating room?

MR. JACKSON I will object to that. If you can answer such a question, go ahead, doctor.

A. I am not aware of that.

MR. BECKER: That's all I have for you, doctor. Thank you for your time.

MR. JACKSON: He will read it.

(Deposition concluded at 10:00 o'clock a.m.; signature not waived.)

Delos M. Cosgrove, M.D.

CERTIFICATE

state of Ohio,)
) SS:
County of Cuyahoga.)

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named DELOS M. COSGROVE.M.D.Was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, after transcription and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affiied my seal of office at Cleveland, Ohio, on this 18th day of February, 1999.

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

My commission expires May 22, 1999.

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LONG, etc. v. THE CLEVELAND CLINIC FOUNDATION

Page/Line	Description	Reason

DELOS COSGROVE III, M.D.