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1
2 IN THE COURT OF COMMON PLEAS
3 OF CUYAHOGA COUNTY, OHIO
4
5 JULIA VERSAU, Individually
6 and as Administratrix
7 of the Estate of
8 Laura Versau Nisbet Adams,
9 deceased
10 Plaintiff,
11 vs. Case No.
12 THE CLEVELAND CLINIC FOUNDATION, 477704
13 Defendant.
14 DEPOSITION OF DELOS M. COSGROVE, III, M.D.
15 TUESDAY, APRIL 15, 2003
16
17 Deposition of DELOS M. COSGROVE, III,
18 M.D., the Witness herein, called by the
19 Plaintiff for examination under the statute,
20 taken before me, Cynthia A. Sullivan, a
21 Registered Professional Reporter and Notary
22 Public in and for the State of Ohio, pursuant to
23 notice and stipulations of counsel, at the
24 offices of The Cleveland Clinic Foundation, 9500
25 Euclid Avenue, Cleveland, Ohio, on the day and
date set forth above, at 8:04 a.m.

3/8/05

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1 APPEARANCES:
2 On behalf of the Plaintiff:
3 Becker & Mishkind Co., L.P.A., by
4 HOWARD MISHKIND, ESQ.
5 Skylight Office Tower, Suite 660
6 1660 West Second Street
7 Cleveland, Ohio 44113
8 (216) 241-2600
9
10 Morganstern, MacAdams & DeVito Co., by
11 CHRISTOPHER M. DeVITO, ESQ.
12 623 West St. Clair Avenue
13 Cleveland, Ohio 44113
14 (216) 687-1212
15
16 On behalf of the Defendant:
17 Reminger & Reminger Co., L.P.A., by
18 WILLIAM A. MEADOWS, ESQ.
19 LESLIE M. JENNY, ESQ.
20 1400 Midland Building
21 101 Prospect Avenue West
22 Cleveland, Ohio 44115
23 (216) 687-1311
24
25

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1 DELOS M. COSGROVE, III, M.D., of lawful
2 age, called for examination, as provided by the
3 Ohio Rules of Civil Procedure, being by me first
4 duly sworn, as hereinafter certified, depose
5 and said as follows:
6 EXAMINATION OF DELOS M. COSGROVE, III, M.D.
7 BY MR. MISHKIND:
8 Q. Would you please state your name for
9 the record?
10 A. Delos Marshall Cosgrove.
11 Q. Dr. Cosgrove, you and I have not met
12 before. My name is Howard Mishkind, and along
13 with Chris DeVito, I think you understand that
14 we represent the family of Laura Adams. You do
15 understand that, don't you?
16 A. Yes.
17 MR. MISHKIND: Let's mark this as
18 Plaintiff's Exhibit 1.
19
20 (Thereupon, Plaintiff's Deposition
21 Exhibit 1 was marked for purposes
22 of identification.)
23
24 Q. Plaintiff's Exhibit 1 is a document
25 that was sent over to me yesterday by your

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1 attorney by e-mail. Would you just verify for
2 me that this is a current CV?
3 A. Yes.
4 Q. It is current?
5 A. Yes.
6 Q. Doctor, just before I begin my
7 questioning, I understand it's now about five
8 after 8:00, and I was advised just actually by
9 you off the record that you have a commitment at
10 9:15 today, so the deposition has to end for
11 today at 9:15; is that true?
12 A. That's right.
13 Q. I'll do the best I can in terms of
14 trying to accomplish as much as I can, but I
15 don't know whether I'll be able to finish my
16 questioning. We may have to get back together
17 at another time.
18 A. My answers will be very short. I
19 hope your questions are, too.
20 Q. I'll try to do that. You've had
21 your deposition taken before, true?
22 A. I have.
23 Q. Have you ever been named as a
24 defendant in a medical malpractice case?
25 A. Yes.

<p style="text-align: right;">Page 5</p> <p>1 Q. On how many occasions, sir?</p> <p>2 A. I don't know.</p> <p>3 Q. Can you give me an estimate?</p> <p>4 A. Half a dozen.</p> <p>5 Q. Are you currently a defendant in any</p> <p>6 medical negligence cases?</p> <p>7 A. Yes.</p> <p>8 Q. How many?</p> <p>9 A. One; two counting this.</p> <p>10 MR. MEADOWS: Show a continuing</p> <p>11 objection to other lawsuits.</p> <p>12 MR. MISHKIND: That's fine.</p> <p>13 Q. The other case, does it have similar</p> <p>14 issues to this case?</p> <p>15 A. No.</p> <p>16 Q. What is the subject matter of the</p> <p>17 other case?</p> <p>18 A. It is aortic dissection.</p> <p>19 Q. What was the nature of the surgery</p> <p>20 that you were performing?</p> <p>21 A. It was relative to a cannulation</p> <p>22 site for an aortic valve replacement.</p> <p>23 Q. It was an aortic valve replacement</p> <p>24 as well?</p> <p>25 A. Yes, it was.</p>	<p style="text-align: right;">Page 7</p> <p>1 involved as the surgeon in any cases where</p> <p>2 complications occurred secondary to an aortic</p> <p>3 valve replacement surgery? I know that may</p> <p>4 sound like the same question I just asked you,</p> <p>5 but at any time either during the perioperative</p> <p>6 period or during the recovery period where you</p> <p>7 had done an aortic valve replacement.</p> <p>8 A. Yes.</p> <p>9 Q. Do you remember how many such cases?</p> <p>10 A. No.</p> <p>11 Q. Do you remember the name of any of</p> <p>12 those patients?</p> <p>13 A. No.</p> <p>14 Q. Have you ever served as an expert</p> <p>15 witness?</p> <p>16 A. Once.</p> <p>17 Q. What was the subject matter of that?</p> <p>18 A. Coronary bypass surgery.</p> <p>19 Q. Did that case involve valve</p> <p>20 replacement as well?</p> <p>21 A. No.</p> <p>22 Q. Where was the case that you were</p> <p>23 testifying in?</p> <p>24 A. In Atlanta.</p> <p>25 Q. How long ago was that, sir?</p>
<p style="text-align: right;">Page 6</p> <p>1 Q. But in that case there was an aortic</p> <p>2 dissection at the time of the aortic valve</p> <p>3 replacement?</p> <p>4 A. Yes.</p> <p>5 Q. Intraoperatively?</p> <p>6 A. Yes.</p> <p>7 Q. Did the patient die?</p> <p>8 A. No.</p> <p>9 Q. What was the name of that patient?</p> <p>10 A. I don't remember.</p> <p>11 Q. It's a case that's filed here in</p> <p>12 Cuyahoga County?</p> <p>13 A. I assume.</p> <p>14 Q. Has your deposition been taken in</p> <p>15 that case?</p> <p>16 A. No.</p> <p>17 Q. Other than that aortic valve</p> <p>18 replacement case and this case, have you been</p> <p>19 involved as a defendant or an employee at the</p> <p>20 Cleveland Clinic in any cases that have involved</p> <p>21 aortic valve replacement surgeries where some</p> <p>22 complications occurred either intraoperatively</p> <p>23 or during the postoperative period?</p> <p>24 A. No.</p> <p>25 Q. Have you ever been named or been</p>	<p style="text-align: right;">Page 8</p> <p>1 A. 15 years.</p> <p>2 Q. Were you testifying on behalf of the</p> <p>3 patient or on behalf of the physician?</p> <p>4 A. Physician.</p> <p>5 Q. Who was the physician that was</p> <p>6 named?</p> <p>7 A. Joe Craver.</p> <p>8 Q. Is that with a C?</p> <p>9 A. Uh-huh.</p> <p>10 Q. That's a yes?</p> <p>11 A. Yes.</p> <p>12 Q. That's the only time that you've</p> <p>13 been an expert?</p> <p>14 A. Yes.</p> <p>15 Q. You have written on minimally</p> <p>16 invasive aortic and mitral valve replacement?</p> <p>17 A. Uh-huh.</p> <p>18 Q. Correct?</p> <p>19 A. Yes.</p> <p>20 Q. I scanned your CV, and I came up</p> <p>21 with a few areas where I believe that there are</p> <p>22 articles that touch on aortic valve replacement</p> <p>23 surgery. Are all of the articles that you have</p> <p>24 published as it relates to aortic valve</p> <p>25 replacement set forth in your CV?</p>

<p>Page 9</p> <p>1 A. Yes.</p> <p>2 Q. Do you consider the articles that</p> <p>3 you have written on this topic to be</p> <p>4 authoritative?</p> <p>5 A. They're my views.</p> <p>6 Q. But in your opinion are they</p> <p>7 authoritative?</p> <p>8 A. They're my views.</p> <p>9 Q. Do you believe that they are</p> <p>10 reasonably reliable opinions on the subject</p> <p>11 matter?</p> <p>12 A. Yes.</p> <p>13 Q. Do you have anything that you are</p> <p>14 currently publishing or have submitted for</p> <p>15 publication on the subject of aortic valve</p> <p>16 replacement surgery?</p> <p>17 A. No.</p> <p>18 Q. Are all the articles that you've</p> <p>19 written on aortic valve replacement dealing with</p> <p>20 minimally invasive procedures, or have you</p> <p>21 written on both open sternotomy as well as</p> <p>22 minimally invasive?</p> <p>23 A. Written on both.</p> <p>24 Q. You have, Doctor, it looks like</p> <p>25 Dr. Klein's deposition?</p>	<p>Page 11</p> <p>1 entire deposition, a lot of the opinions that he</p> <p>2 expressed and statements that he made as to the</p> <p>3 patient's postoperative course --</p> <p>4 A. I expect you will.</p> <p>5 Q. -- although I don't know whether</p> <p>6 I'll be able to do that in the time we have</p> <p>7 today. That's why I was asking with specific</p> <p>8 regard to his involvement from the 18th of</p> <p>9 January until the time of discharge, are you</p> <p>10 able -- maybe I'll give it to you this way.</p> <p>11 Are you able to comment at all on</p> <p>12 the medical management of this patient from the</p> <p>13 18th to the time of discharge which is what I</p> <p>14 focused in with Dr. Klein on during the</p> <p>15 deposition?</p> <p>16 MR. MEADOWS: Same objection. Go</p> <p>17 ahead and answer, if you can.</p> <p>18 A. I don't know what the question is.</p> <p>19 I'm not sure.</p> <p>20 Q. I was hoping to do it the simple</p> <p>21 way, but I guess I won't be able to do it that</p> <p>22 way.</p> <p>23 Have you talked to Dr. Klein</p> <p>24 since --</p> <p>25 A. No.</p>
<p>Page 10</p> <p>1 A. Yes.</p> <p>2 Q. Have you read it over?</p> <p>3 A. Yes.</p> <p>4 Q. Did you make any notes at all when</p> <p>5 you read his deposition?</p> <p>6 A. No.</p> <p>7 Q. Did you note anything in the</p> <p>8 deposition or highlight anything in the</p> <p>9 deposition?</p> <p>10 A. No.</p> <p>11 Q. Did you turn back any pages in the</p> <p>12 depo?</p> <p>13 A. No.</p> <p>14 Q. When did you read the depo, Doctor?</p> <p>15 A. In the last 24 hours.</p> <p>16 Q. Is there anything that stands out</p> <p>17 from your recent review of the deposition that</p> <p>18 you believe to be noteworthy?</p> <p>19 MR. MEADOWS: Objection. It's</p> <p>20 awfully broad. It was a long deposition.</p> <p>21 MR. MISHKIND: Sure. I understand</p> <p>22 that.</p> <p>23 A. I think you'll have to be more</p> <p>24 specific for me.</p> <p>25 Q. I can certainly go through the</p>	<p>Page 12</p> <p>1 Q. Let me finish. Have you talked to</p> <p>2 Dr. Klein since his deposition?</p> <p>3 A. No.</p> <p>4 Q. Have you talked to Dr. Klein about</p> <p>5 Laura Adams --</p> <p>6 A. No.</p> <p>7 Q. -- at any time since Laura Adams</p> <p>8 left the hospital?</p> <p>9 A. No.</p> <p>10 Q. Have you talked to Dr. Kerr, who</p> <p>11 apparently was your assistant during the</p> <p>12 surgeries, since Laura Adams died?</p> <p>13 A. No.</p> <p>14 Q. How about Dr. Rattlife, the</p> <p>15 pathologist, have you talked to him at all about</p> <p>16 the cause of the patient's death?</p> <p>17 A. I've read his report. I haven't</p> <p>18 talked to him about it.</p> <p>19 Q. You're talking about his pathology</p> <p>20 report?</p> <p>21 A. Yes.</p> <p>22 Q. Have you talked to anyone,</p> <p>23 Dr. Cosgrove, about this case outside of the</p> <p>24 Cleveland Clinic in terms of any of the</p> <p>25 complications or issues that arose with Laura</p>

<p style="text-align: right;">Page 13</p> <p>1 Adams?</p> <p>2 MR. MEADOWS: Other than us, right?</p> <p>3 A. No.</p> <p>4 Q. Other than your attorneys.</p> <p>5 A. No.</p> <p>6 Q. Have you reviewed any medical</p> <p>7 literature for purposes of today's deposition?</p> <p>8 A. No.</p> <p>9 Q. I take it that if you wanted</p> <p>10 reliable information as it relates to the</p> <p>11 indications for minimally invasive aortic valve</p> <p>12 replacement, the first place that you would look</p> <p>13 would be your publications, correct?</p> <p>14 A. I developed the operation.</p> <p>15 Q. I understand that, and I'm not in</p> <p>16 any way trying to suggest that you would need to</p> <p>17 look anywhere other than your publications.</p> <p>18 A. I think I've read most of the</p> <p>19 literature that has been written on that topic.</p> <p>20 Q. And certainly your publications and</p> <p>21 what you've written are as good if not better</p> <p>22 than what's out there by anyone else, correct?</p> <p>23 A. That's your judgment.</p> <p>24 Q. Do you agree with me?</p> <p>25 A. I've done more than anybody else out</p>	<p style="text-align: right;">Page 15</p> <p>1 A. I write what I think. You know, I</p> <p>2 write what the facts are and what my thoughts</p> <p>3 are.</p> <p>4 MR. MEADOWS: Let's go off the</p> <p>5 record.</p> <p>6 (Discussion off the record.)</p> <p>7 Q. You have not only journals but also</p> <p>8 book chapters on minimally invasive aortic valve</p> <p>9 replacement, true?</p> <p>10 A. Yes.</p> <p>11 Q. Some of your publications, are they</p> <p>12 in Topol's textbook?</p> <p>13 A. No.</p> <p>14 Q. Where are they?</p> <p>15 A. One is in Topol's textbook, yes.</p> <p>16 Q. Do you have a text that you have</p> <p>17 written on minimally invasive aortic valve</p> <p>18 replacement?</p> <p>19 A. No.</p> <p>20 Q. Where are the book chapters, what</p> <p>21 books?</p> <p>22 A. I think they are listed in there</p> <p>23 (indicating).</p> <p>24 Q. What comes to mind in terms of the</p> <p>25 most recent book chapter that you have</p>
<p style="text-align: right;">Page 14</p> <p>1 there.</p> <p>2 Q. So your publications and what you've</p> <p>3 written would probably be the best on the</p> <p>4 subject of minimally invasive aortic valve</p> <p>5 replacement, true?</p> <p>6 A. That's a judgment that I can't make.</p> <p>7 Q. You won't quarrel with me on that</p> <p>8 judgment, though, will you?</p> <p>9 A. I wouldn't quarrel with you on</p> <p>10 anything.</p> <p>11 Q. Is that a fair assessment, that what</p> <p>12 you have written is not only considered in your</p> <p>13 mind but by most of your colleagues to be the</p> <p>14 leading thought process in the leading</p> <p>15 literature on the area of minimally invasive</p> <p>16 aortic valve replacement?</p> <p>17 A. You'll have to ask my colleagues</p> <p>18 what they think about that.</p> <p>19 Q. You don't have an opinion on your</p> <p>20 own publications, or are you too modest?</p> <p>21 A. I write what I think.</p> <p>22 Q. I take it what you write and what</p> <p>23 you think you believe to be authoritative?</p> <p>24 MR. MEADOWS: Objection, asked and</p> <p>25 answered. We've been through that.</p>	<p style="text-align: right;">Page 16</p> <p>1 published?</p> <p>2 A. Well, I'm not sure I remember.</p> <p>3 Q. Have you lectured within the last</p> <p>4 year on the topic of minimally invasive aortic</p> <p>5 valve replacement?</p> <p>6 A. Yes.</p> <p>7 Q. Where?</p> <p>8 A. Probably --</p> <p>9 Q. Most recently.</p> <p>10 A. Kuala Lumpur most recently.</p> <p>11 Q. I'm sorry?</p> <p>12 A. Kuala Lumpur, Malaysia.</p> <p>13 Q. How about within the U.S.?</p> <p>14 A. I think most recently in Palm</p> <p>15 Springs.</p> <p>16 Q. What was the occasion?</p> <p>17 A. It was a meeting sponsored by</p> <p>18 Edwards Corporation for current strategies in</p> <p>19 cardiac surgery.</p> <p>20 Q. Did you submit any written material</p> <p>21 at the time of that presentation?</p> <p>22 A. No.</p> <p>23 Q. Dr. Cosgrove, I take it that you</p> <p>24 believe that the surgical management of Laura</p> <p>25 Adams by you complied with the standard of care?</p>

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1 A. Yes.
2 Q. With minimally invasive aortic valve
3 replacement surgery, would you agree that there
4 is less visualization of the heart as compared
5 to when a full sternotomy is done?
6 A. I would agree with the heart. I
7 would disagree in terms of the relevant areas
8 for the aortic valve.
9 Q. When you're doing a minimally
10 invasive valve replacement, are you the only one
11 that's able to visualize the aortic valve?
12 A. No.
13 Q. How is the visualization appreciated
14 by others in the operating room?
15 A. My assistant sees the same thing I
16 see.
17 Q. What I have in my mind, and
18 obviously I've not seen you perform the surgery,
19 but sort of a keyhole view of the aortic valve.
20 Is my assessment inaccurate, in other words,
21 that you're looking into a very limited --
22 A. The incision is 6 to 8 centimeters.
23 Q. How is it that your assistant is
24 able to visualize that during the course of the
25 replacement with minimally invasive surgery and

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1 Q. Was this a fellowship?
2 A. Yes.
3 Q. A fellowship under your tutelage?
4 A. In our department yes.
5 Q. I'm sorry, sir?
6 A. In our department.
7 Q. Did you work with him on a regular
8 basis?
9 A. Yes.
10 Q. When you did your aortic valve
11 replacement surgeries, was Dr. Kerr back during
12 that time period the assistant that you would
13 have in most cases?
14 A. Fellows rotate with me for a
15 three-month period. There was two of them, so
16 they would help me during that three months of
17 time.
18 Q. Do you remember who else was the
19 other fellow besides Dr. Kerr at that time?
20 A. No. I don't remember, but he would
21 have been in a different room at the time, not
22 scrubbed on this case.
23 Q. This surgery was in January of 1999.
24 Do you know when Dr. Kerr left the Cleveland
25 Clinic?

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1 the technique that you use?
2 A. He looks right at it. You see the
3 aortic valve the same way you would see it if
4 you were doing it through a full sternotomy.
5 Q. Dr. Kerr was your assistant?
6 A. Yes.
7 Q. Where is Dr. Kerr located now?
8 A. I don't know.
9 Q. Is he affiliated with the Cleveland
10 Clinic?
11 A. No.
12 Q. Dr. Kerr is an osteopathic
13 physician?
14 A. Yes.
15 Q. Where was he in terms of his
16 training?
17 A. He was a fully trained thoracic
18 surgeon, cardiothoracic surgeon.
19 Q. How long had he been at the
20 Cleveland Clinic back in '99?
21 A. He was coming back. He had been in
22 practice in Buffalo for a number of years, and
23 he came back and spent an additional year with
24 us. I don't remember where in the course of the
25 year that was.

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1 A. I don't.
2 Q. Do you remember Laura Adams?
3 A. Yes.
4 Q. You performed two surgeries on her,
5 correct?
6 A. Yes.
7 Q. Both surgeries were on the 14th?
8 A. Yes.
9 Q. After the second surgery on the
10 14th, did you follow Laura through the time of
11 her discharge?
12 A. Well, I think you have to understand
13 how we do it here. Generally, we look after the
14 surgical problems that are related to them, and
15 the cardiologists look after the medical
16 problems, and it goes from the intensive care
17 unit. When she left the intensive care unit,
18 generally they will transfer mainly to the
19 cardiology service. So one of my team saw her.
20 I may or may not have seen her, and I don't
21 remember.
22 Q. Were you responsible for the
23 decision that was ultimately made to discharge
24 this patient?
25 A. No.

5 (Pages 17 to 20)

<p style="text-align: right;">Page 21</p> <p>1 Q. Whose responsibility was it to 2 decide whether the patient should be discharged 3 or should stay in the hospital? 4 A. A cardiologist decides that. 5 Q. It's not a shared responsibility 6 between cardiothoracic and cardiology? 7 A. No. 8 Q. Do you have any opinions as it 9 relates to whether this patient was an 10 appropriate candidate to be discharged on 11 January 24th from the hospital? 12 A. I didn't make the decision, so I'm 13 not in a position to have an opinion. 14 Q. Again, obviously, you know the legal 15 issues that are involved, so I just want to find 16 out whether or not you intend to express an 17 opinion on that topic. 18 A. No. 19 Q. When I asked you whether you 20 remember Laura, you said, yes, you do. Do you 21 remember anything about Laura after the second 22 surgery in terms of your clinical assessment of 23 her condition on the 15th or at any time that 24 you saw her during the postoperative period? 25 A. No.</p>	<p style="text-align: right;">Page 23</p> <p>1 me in some of her responses to things. 2 Q. Could you give me an example? 3 A. No, I can't. I just remember the 4 impression. That was four years ago. 5 Q. Sure. I understand that. But the 6 fact that you remember that it was somewhat 7 inappropriate, even though you may not be able 8 to give me a specific example, can you 9 generalize at all in terms of was she rude to 10 you? 11 A. No. 12 Q. Was she short with you? 13 A. No. 14 Q. Did she cut you off? 15 A. No. 16 Q. Did she disagree with what you were 17 saying? 18 A. No. She was not argumentative at 19 all. 20 Q. Can you verbalize anything that 21 would give me a better understanding as to why 22 you believed that her anxiety was outside of the 23 realm of normal? 24 A. No. I can just tell you that's my 25 memory of it. I can't remember specifically.</p>
<p style="text-align: right;">Page 22</p> <p>1 Q. So your memory of her would have 2 been -- 3 A. Preoperatively. 4 Q. -- preoperatively and 5 intraoperatively; is that fair? 6 A. Yes. 7 Q. Dr. Klein made some mention about 8 Laura having an abnormal affect during the 9 hospital. Did you encounter that in any 10 respect? 11 A. I saw her preoperatively, and I 12 thought she was a very hyper lady when I saw her 13 preoperatively. It was a slightly strange 14 affect. 15 Q. She was a young woman; was she not? 16 A. Yes. 17 Q. Is it unusual to be anxious when one 18 is coming for cardiac or cardiothoracic surgery? 19 A. Everybody is anxious. 20 Q. So was her anxiety from what you 21 perceived, was it outside of the realm of 22 normal? 23 A. Yes. 24 Q. In what respect? 25 A. She seemed slightly inappropriate to</p>	<p style="text-align: right;">Page 24</p> <p>1 Q. You won't be able to take the stand 2 and say I remember her doing this or I remember 3 her doing that which is an example? 4 A. I can remember my impression of her 5 outright. 6 Q. Again, I'm trying to put words 7 behind that impression. 8 A. I can't do it for you. 9 Q. Did her affect, her anxiety, in your 10 opinion complicate the surgical approach? 11 A. No. 12 Q. Did it cause or contribute in any 13 way to any of the intraoperative complications 14 that you encountered? 15 A. No. 16 Q. This is just what you remember about 17 her, but from a clinical standpoint can we agree 18 that you didn't feel it to be significant? 19 A. It didn't affect the intraoperative 20 portion of it. 21 Q. There's nothing about her affect and 22 her personality that you believe caused or 23 contributed to any of her complications, true? 24 A. True. 25 Q. The decision to do a minimally</p>

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1 invasive aortic valve replacement with the
2 homograft technique, did you discuss with the
3 patient prior to doing the surgery the various
4 techniques or options that existed for aortic
5 valve replacement?
6 A. Yes.
7 Q. Based upon her prior medical
8 history, her age, her physical condition, did
9 you make certain recommendations to her?
10 A. No. I told her I'd do it either
11 way. She could have a small incision or a large
12 one.
13 Q. But in terms of using a homograft,
14 were there other options that you had in terms
15 of the AVR replacement?
16 A. Uh-huh.
17 Q. What were they?
18 A. Do a pericardial valve, a mechanical
19 valve, but she wanted a homograft.
20 Q. Had she done, to your knowledge, any
21 studying on the topic?
22 A. I don't remember whether she had or
23 not, but she came -- I remember quite definitely
24 that she wanted the homograft.
25 Q. Did you ever talk with her

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1 A. Yes.
2 Q. Did he do the preoperative
3 assessment on the patient?
4 A. Yes.
5 Q. Can you explain to me briefly, and
6 again to try to streamline things, how the
7 process takes place when a patient is referred
8 to the Cleveland Clinic as a candidate for
9 aortic valve replacement, what happens before
10 they get to you, please?
11 A. They come in one of two ways. They
12 are either referred directly to me, or they are
13 referred through a cardiologist, or they come
14 through them referred to me. As I remember,
15 this lady was referred to me, and I always have
16 a cardiologist see them preoperatively to do the
17 clinical evaluation of the cardiac status, and I
18 saw her preoperatively and discussed the
19 findings with her and what we would do in the
20 operating room.
21 Q. She came to the Cleveland Clinic, I
22 believe, on the 13th. Did you see her on the
23 day before the surgery?
24 A. I think I did. I can't remember the
25 day I saw her exactly, a day or two before.

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1 cardiologist back in Connecticut?
2 A. I don't remember whether I did or
3 not.
4 Q. Do you have, Doctor, outside of the
5 hospital records any notes at all about Laura
6 Adams?
7 A. No.
8 Q. The reason I asked that is because
9 you probably read when the deposition started --
10 A. Well, I don't keep those notes.
11 Q. So what Dr. Klein generated after
12 the fact --
13 A. I didn't.
14 Q. -- you have not done that?
15 A. No.
16 Q. So what we have that has come from
17 your mouth by way of dictation or your
18 handwriting is in the Cleveland Clinic chart,
19 true?
20 A. That's correct.
21 Q. You may or may not have had some
22 communication verbally?
23 A. I may or may not have. I don't
24 remember.
25 Q. There was a Dr. Grimm?

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1 Q. Was it your preference, Doctor, to
2 do the procedure with an aortic homograft?
3 A. Not necessarily my preference. I
4 always discuss with the patient all the various
5 options for a valve replacement and the pluses
6 and minuses of those, and I always do what they
7 want to have done.
8 Q. What were the advantages of doing
9 the aortic valve replacement with an aortic
10 homograft?
11 A. The advantages are that it does not
12 require anticoagulation, that it has the best
13 durability of the tissue, operative advantages,
14 and it's the most resistant to infection.
15 Q. The advantages of doing the aortic
16 valve replacement by minimally invasive
17 technique as opposed to an open sternotomy,
18 could you just briefly tell me what those
19 advantages are?
20 A. Less trauma in terms of less blood
21 loss, smaller incision, better opportunity for
22 reoperation in terms of not disturbing the
23 pericardium over the right ventricular outflow
24 tract, shorter stays in the ICU, shorter stays
25 in the hospital, shorter recovery, less pain.

7 (Pages 25 to 28)

<p>Page 29</p> <p>1 Q. Are there any contraindications or 2 relative contraindications to doing the type of 3 procedure she needed by the minimally invasive 4 route? 5 A. Yes, reoperations. 6 Q. Can you be more specific when you 7 say reoperations? 8 A. I don't do reoperations -- 9 Q. I'm sorry? 10 A. I don't do reoperations through a 11 small incision. 12 Q. So that if there's a need for 13 reoperations, it can be an open sternotomy? 14 A. If she had had a previous operation, 15 I would not have done it through a small 16 incision. 17 Q. Oh, I'm sorry. I understand. So 18 that would be the only contraindication? 19 A. For an isolated aortic valve, yes. 20 Q. Is it unusual for a patient as young 21 as she was to require aortic valve replacement? 22 A. It's a spectrum of a bell-shaped 23 curve -- well, not bell shaped. The older you 24 are, the more likely you are to require a valve 25 replacement.</p>	<p>Page 31</p> <p>1 doing the replacement to address the aneurismal 2 area as well? 3 A. Yes. That was part of the reason 4 for using the homograft. 5 Q. Tell me who you remember meeting 6 besides Laura prior to her surgery. 7 A. Her husband was there, but I don't 8 remember who else. 9 Q. Do you recall anything about her 10 husband? 11 A. No. 12 Q. Are you able to picture him 13 physically? 14 A. No. 15 Q. Are you able to recall whether he 16 participated in any of the discussions? 17 A. No. He was physically there, 18 though. 19 Q. You don't know whether other family 20 members were there? 21 A. I don't remember the other family 22 members there. I remember that I wrote it in 23 the chart that I discussed this with she and her 24 family, and I didn't announce who in her 25 family was there.</p>
<p>Page 30</p> <p>1 Q. Tell me what your understanding was 2 as to her presurgical cardiac condition in terms 3 of her heart function aside from -- 4 A. She had normal left ventricles, 5 normal coronaries, a bicuspid aortic valve with 6 aortic stenosis, an aortic insufficiency, and a 7 dilated ascending aorta of 4.7 centimeters. 8 Q. She was not aneurismal, correct? 9 A. It depends on the definition of 10 aneurismal. For somebody who is small, and she 11 certainly had an abnormal-sized aortic valve, 12 and it's been our experience that women, 13 particularly who have enlarged aortas, are apt 14 to have aortic dissections subsequently if you 15 don't do something about them in the first 16 operation. 17 So she was within 3 millimeters of 18 reaching the definition of where almost 19 everybody would do an aortic valve replacement 20 or an aortic replacement. Most people do them 21 at 5 centimeters. She was small, so relatively 22 that was big for her. So you can call it an 23 aneurysm or you can call it a relative 24 enlargement. 25 Q. Was it your intent at the time of</p>	<p>Page 32</p> <p>1 Q. When you marked down discussed with 2 her and her family, it could have just as easily 3 been her and her husband used in sort of a 4 general sense, true? 5 A. Yes. 6 Q. Did Laura, and I'm not asking you to 7 tell me the specifics of what she asked, but do 8 you recall her asking you any questions to 9 understand better what it was that was being 10 contemplated to be done? 11 A. No. I don't remember. 12 Q. Is that to say that she didn't, or 13 you just don't remember one way or another? 14 A. I don't remember. 15 Q. Is there anything about your 16 preoperative discussion with her that you 17 remember in terms of any exchange between her 18 and you? 19 A. No. 20 Q. You have a routine where you explain 21 things, it probably rolls right off your tongue, 22 in terms of explaining the advantages and 23 disadvantages? 24 A. Yes. 25 Q. And the type of recuperation that</p>

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1 will be involved, true?
2 A. Yes.
3 Q. As well as the potential
4 complications that may ensue during the surgery?
5 A. I don't generally go through all the
6 complications. I go through the risk of death.
7 Q. Besides the risk of death, you don't
8 normally indicate any other complications?
9 A. I don't go through all of the list.
10 Those would take about a half an hour.
11 Q. Do you go through anything besides
12 you may die during the surgery?
13 A. I go through the choices of the
14 prostheses. I tell them the type of incision,
15 the risk of the operation, the length of the
16 expected stay in the intensive care unit, the
17 length of expected stay in the hospital, and the
18 recovery time expected.
19 Q. What do you tell them about the risk
20 of the operation?
21 A. I say it is 1 percent.
22 Q. That risk of 1 percent is a risk of
23 what happening?
24 A. Dying.
25 Q. Are there any other risks of the

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1 A. Yes.
2 Q. Can you put into words as to how
3 that incision was made?
4 A. Yes. You make about a 6 centimeter
5 incision in the skin from over the manubrium,
6 you cut the sternum down to the fourth right
7 intracostal space and make an L over into the
8 right and put a retractor in, and it brings you
9 down on the aortic valve.
10 Q. Who did what you just described?
11 A. Dr. Kerr.
12 Q. Were you present when Dr. Kerr did
13 it?
14 A. I don't remember.
15 Q. Do you know what time you arrived in
16 the OR?
17 A. Not without looking at the chart.
18 Q. Please.
19 A. I'll tell you I arrived -- they
20 didn't go on the heart-lung machine until I was
21 there, if that helps you. I'll go back and
22 look, if you'd like me to, at the exact hour,
23 but I don't come in generally until -- they do
24 not go on the heart-lung machine until I'm
25 there.

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1 operation that you explain other than the
2 1 percent risk of dying?
3 A. Generally, I don't go through all
4 the other risks.
5 Q. Did you have any reason to believe
6 in this case that you would have gone through
7 any other risks other than dying?
8 A. No.
9 Q. The homograft that you used to
10 replace the aortic valve, is there a name that
11 you use for this type of homograft and this type
12 of incision that you used?
13 A. I'm not sure I understand your
14 question.
15 Q. I'll break it down. There's
16 different incisions that you use in terms of
17 approaching an aortic valve replacement,
18 correct?
19 A. There hasn't been over the last few
20 years, but yes, there are different options.
21 Q. As I understand it, there are
22 several techniques that you can use in terms of
23 making the incision.
24 A. This was a hemisternotomy.
25 Q. Hemisternotomy?

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1 Q. Is it your testimony that up until
2 the time that she was ready to go on the
3 heart-lung machine you most likely would not
4 have been in the room?
5 A. I don't remember.
6 Q. Is that a reasonable conclusion?
7 A. It's reasonable.
8 Q. As I understand it, you're limited
9 to doing what, two cases?
10 A. You're allowed to have two people
11 under operation at the same time.
12 Q. In fact, on that day did you have
13 another patient under operation?
14 A. I don't remember.
15 Q. Those records are maintained; are
16 they not?
17 A. Yes.
18 Q. Prior to January of 1999, how many
19 of the homograft AVR surgeries using the
20 minimally invasive technique had you performed?
21 A. I don't know without looking, but
22 over a hundred.
23 Q. You continue to use the same
24 technique?
25 A. Yes.

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1 Q. Have you modified the technique in
2 any respect --
3 A. No.
4 Q. -- since January of '99, sir?
5 MR. MEADOWS: Objection. You can
6 answer.
7 A. No.
8 Q. Since January of '99, so
9 approximately three years, three or four years,
10 how many additional AVR surgeries using a
11 homograft through the minimally invasive
12 technique have you performed?
13 A. I'm coming up on about 3,000
14 minimally invasive, and I can't -- about a third
15 of those are aortic valves, and I can't tell you
16 how many are homografts.
17 Q. Are the other two-thirds mitral?
18 A. Yes, or combinations.
19 Q. A combination of mitral and aortic
20 valve?
21 A. Yes, or tricuspid.
22 Q. Her mitral valve was not involved,
23 correct?
24 A. Correct.
25 Q. You, as I understand it, keep on a

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1 when she probably would have needed it?
2 A. You know, I can do it much more
3 accurately if I get the data out for you.
4 Q. Could you point me to where the data
5 would be?
6 A. Yes.
7 Q. Where would that be?
8 A. Down the hall in Dr. Blackstone's
9 office.
10 Q. Who is Dr. Blackstone?
11 A. He's our statistician.
12 Q. He's like the guy at the Cleveland
13 Indians that keeps track of things?
14 A. Yes. I don't know about the guy for
15 the Cleveland Indians, but he does keep track of
16 our data.
17 Q. Of the aortic valve replacements
18 using a homograft similar to Laura Adams, how
19 many have you had to resort to an open
20 sternotomy?
21 A. Our incidence of converting a closed
22 minimally invasive operation to an open
23 sternotomy is approximately 1 percent.
24 Q. Of the 1 percent that you have had
25 to resort to an open sternotomy, what has been

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1 data entry system the number of AVRs that are
2 performed at the Cleveland Clinic?
3 A. We have almost all the data.
4 Q. It indicates each patient and what
5 the complications were that were incurred, true?
6 A. Yes.
7 Q. What has been your experience in
8 terms of the life expectancy of the valve when
9 replaced without complication intraoperatively
10 or during the immediate postoperative period for
11 this type of valve on a patient in her 30s?
12 A. The valve durability, you're asking
13 me about?
14 Q. Right.
15 A. I can get the data out for you. I
16 can't do it off the top of my head.
17 Q. Do you recall Dr. Klein indicating
18 that with a woman in her 30s she probably would
19 have required secondary valve replacement in a
20 15- to 20-year time period?
21 A. It probably would have been sooner
22 than that actually.
23 Q. Less than 15 years?
24 A. Probably, yes.
25 Q. Can you give me an estimate as to

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1 your death rate? In other words, did the
2 1 percent of patients survive or did they die?
3 A. The mortality rate for all the
4 minimally invasive aortic valves is .7 percent.
5 Q. What about those that are resorted
6 or reverted or converted to an open sternotomy?
7 A. I don't know that number.
8 Q. Is it reasonable to conclude that
9 the mortality would be higher in that subgroup?
10 A. No, it wouldn't be.
11 Q. Why is that?
12 A. Because I don't have the data, I
13 don't think I can assume that.
14 Q. So if you resort to an open
15 sternotomy and are able to address the
16 complication --
17 A. That's not always complications. In
18 some cases it was unrecognized coronary artery
19 disease. Sometimes it was unrecognized mitral
20 valve disease. Occasionally, we had to place a
21 chest tube. Sometimes it was because we
22 couldn't cannulate. It was a variety of
23 reasons.
24 Q. Are there any studies that address
25 the incidence of complications when a minimally

10 (Pages 37 to 40)

<p style="text-align: right;">Page 41</p> <p>1 invasive is converted to an open sternotomy? 2 A. No. 3 Q. Do you know of any articles outside 4 of what you have published that address that 5 issue? 6 A. No. 7 Q. You indicate the overall 8 complication rate is -- 9 A. Conversion rate. 10 Q. Is? 11 A. It's 1 percent. 12 Q. 1 percent, and then the .7 percent 13 is what? 14 A. The mortality rate. 15 Q. That includes conversion as well? 16 A. Yes. That includes everything. 17 Q. All comers? 18 A. Yes. 19 Q. Is the mortality rate higher as the 20 patient's age is older? 21 A. I don't think we have enough deaths 22 to make a statistically meaningful correlation 23 between age and mortality. 24 Q. Would the mortality be higher where 25 there is increased comorbidity?</p>	<p style="text-align: right;">Page 43</p> <p>1 MR. MEADOWS: Objection. 2 A. I'm sure there are such people. 3 There are also people who don't believe in 4 penicillin. 5 Q. So you would put people who don't 6 believe in minimally invasive sort of at the 7 extreme? 8 A. No. I didn't say that. I said that 9 you can find any kind of opinion that you want. 10 Q. Are you the only one that's doing 11 the minimally invasive as the chief 12 cardiothoracic surgeon here at the Cleveland 13 Clinic, or are there others? 14 A. My colleagues all use it. 15 Q. I'm sorry? 16 A. My colleagues all use it. 17 Q. How many surgeons are there in the 18 department? 19 A. There are nine cardiac surgeons. 20 Q. Once Laura was placed on the 21 heart-lung machine, you believe that -- strike 22 that. 23 You would have been in the room at 24 the time that the patient was placed on the 25 heart-lung machine, true?</p>
<p style="text-align: right;">Page 42</p> <p>1 A. Usually, that's the case, but you're 2 dealing with such a low operative mortality rate 3 that in order to do a multivariable analysis to 4 figure out what the comorbidity is and what the 5 effect is, I don't know if you have enough 6 deaths to make it statistically significant. 7 Q. How long have minimally invasive 8 surgeries of this nature been performed? 9 A. I did the first one in 1996. 10 Q. Is this considered a standard 11 approach to aortic valve replacement in the U.S. 12 at this time? 13 A. It's my standard approach. 14 Q. That I appreciate, but do you know 15 whether it's recognized as an accepted approach 16 to aortic valve replacement by your peers 17 throughout the country? 18 MR. MEADOWS: Objection to form and 19 otherwise. 20 A. Well, certainly they're aware of it. 21 I don't know whether they accept it or not. 22 Most people practice it. 23 Q. Are you aware of anyone that feels 24 that minimally invasive aortic valve replacement 25 is contraindicated?</p>	<p style="text-align: right;">Page 44</p> <p>1 A. Absolutely. 2 Q. Then can you tell me from the 3 standpoint of the procedure itself what aspect 4 of the initial aortic valve replacement you 5 performed as opposed to Dr. Kerr? 6 A. The whole thing. 7 Q. What was Dr. Kerr's role? 8 A. He was my assistant. 9 Q. Physically was he assisting in any 10 aspect of the surgery, or was he there to help 11 you in the event that you needed an extra set of 12 hands? 13 A. He assisted me. We worked together. 14 He was on the assistant's side of the table, and 15 I was on the surgeon's side of the table. I did 16 all of the aortic homograft replacement. 17 Q. So he was on the opposite side of 18 the table? 19 A. Uh-huh. 20 Q. When you are doing the minimally 21 invasive surgery, is he able from where he's 22 standing to visualize through the hole that 23 you've created the aortic valve? 24 A. Yes. 25 Q. During Laura's first surgery, did</p>

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1 you experience any complications?
2 A. Yes.
3 Q. The first complication that you
4 experienced was ventricular fibrillation?
5 A. Yes.
6 Q. Reading through the operative
7 report -- and trying to be as respectful as I
8 can to your time, if I put words in your mouth,
9 I'm sure you'll tell me I'm using the wrong
10 phraseology -- was that at or about the time of
11 closure?
12 A. Yes.
13 Q. Had you encountered that
14 complication with ventricular fibrillation at or
15 about the time of closure on any prior cases?
16 A. Jeez, I don't remember.
17 Q. Does any case stand out in your mind
18 that you can say, yes, Mr. Mishkind, I remember?
19 A. We have almost 18,000 heart
20 operations. I've had almost every complication
21 you can imagine at one time or another, so this
22 is not one of those common things that you
23 expect to see.
24 Q. What is it, in your opinion, that
25 caused the patient to go into defib at the time,

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1 until the time that she had the dissection?
2 A. About an hour.
3 Q. Now, look at your operative report
4 on page 2, if you want to look at it, otherwise,
5 I'm looking at a section where it says, as we
6 were about ready to close the patient, the
7 patient had ventricular fibrillation which did
8 not respond to defibrillation multiple times;
9 therefore, the incision was lengthened, the
10 sternum was completely divided, and manual
11 compression of the heart was begun.
12 Do you remember that taking place?
13 A. I remember she fibrillated. I don't
14 remember the exact details of it.
15 Q. Who handled the chest compression?
16 Was that you, or was that Dr. Kerr?
17 A. I don't remember.
18 Q. Now, you did a TEE at that time,
19 correct?
20 A. Yes.
21 Q. It showed hypokinesia?
22 A. Yes.
23 Q. Was it of the left ventricular wall?
24 A. Yes.
25 Q. From a pathophysiology standpoint,

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1 at or around the time of closure which I show at
2 about 10:23?
3 A. It appeared that she had an acute
4 dissection of her left main coronary artery.
5 Q. What caused the acute dissection?
6 A. I assume that -- I don't know, to be
7 honest with you. You know, she -- we placed
8 sutures around the orifice of it. Whether that
9 tore part of the intima of the artery and it
10 went on to dissect, I don't know. She came off
11 the pump initially fine, which she would not
12 have done had she had a dissection.
13 So I assume the dissection must have
14 taken place as the blood pressure got higher and
15 she came off the heart-lung machine.
16 Q. When she is on the heart-lung
17 machine, what position is she in bodywise?
18 A. Lying on her back.
19 Q. I'm sorry?
20 A. Lying on her back.
21 Q. She's lying on her back, okay. And
22 when she came off the machine?
23 A. She's still lying on her back.
24 Q. What time frame are we talking about
25 from the time that she came off the heart-lung

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1 what caused that?
2 A. Well, the concern was that she was
3 not getting a normal blood supply to her left
4 ventricle. I suspected something was the matter
5 with her left coronary artery, and I put her
6 back on the pump and reexplored that area.
7 Q. Was this secondary to the
8 dissection?
9 A. Yes, I think it was.
10 Q. Now, why was the distal anastomosis
11 and the left main anastomosis taken down at that
12 time?
13 A. Because you can't get to the left
14 main to see what the problem is until you take
15 down the distal anastomosis.
16 Q. After checking for the area of
17 dissection, then you had to reanastomose the
18 area?
19 A. Yes.
20 Q. Do you use a different technique
21 when you have to reanastomose now for a second
22 time during the first operative procedure?
23 A. No.
24 Q. What is the technique that's used to
25 reanastomose?

12 (Pages 45 to 48)

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1 A. It's a running proline suture.
2 Q. Literally, is it done by hand?
3 A. Yes.
4 Q. Were you doing the suturing?
5 A. Yes.
6 Q. Do you always do the suturing?
7 A. Yes.
8 Q. So Dr. Kerr would not have been
9 doing this?
10 A. No.
11 Q. You indicate that the
12 transesophageal echo was suspicious for no flow
13 down the left main. Again, what was your
14 concern at that point as to the cause for that?
15 A. She had a dissection. That was my
16 concern.
17 Q. Again, that's all part and parcel of
18 the dissection?
19 A. Yes.
20 Q. There were two episodes of
21 ventricular fibrillation during this procedure;
22 were there not?
23 A. Yes. She didn't have normal
24 contraction after I did the one graft to the
25 circumflex, so I did the second one to the

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1 MR. MEADOWS: Here you go
2 (indicating).
3 A. It looks like she went to sleep at
4 10:00 and left the operating room at roughly
5 3:00.
6 Q. So the total procedure wasn't
7 extended that drastically by these
8 complications, but by another hour perhaps?
9 A. Probably longer than that, but it
10 was extended.
11 Q. You say you have experienced with
12 this type of surgery two episodes of ventricular
13 fib like this on prior aortic valve
14 replacements?
15 A. Yes.
16 Q. Did you have any options when after
17 the cannulas were removed and she went into
18 V-fib and didn't respond initially -- you recall
19 she didn't respond to the defibrillation, and
20 that's the point in time where the incision was
21 lengthened; do you recall that?
22 A. Uh-huh.
23 Q. Were there any other options that
24 you had short of resorting to an open sternotomy
25 at that point?

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1 diagonal.
2 Q. Had you ever encountered the
3 multiple, and I don't mean to state that there
4 were a lot of complications, but a number of
5 complications similar to what you encountered
6 during operation number one with Laura Adams?
7 A. I've had a lot more complications
8 than this.
9 Q. After you did the reanastomosis,
10 there still appeared to be severe impairment of
11 the left ventricle?
12 A. Yes.
13 Q. And the anterior wall?
14 A. Yes. She started to get better.
15 Q. What are bulldogs?
16 A. Clamps.
17 Q. This procedure normally takes how
18 long, Doctor, without intraoperative
19 complications?
20 A. Four hours.
21 Q. This case took how long?
22 A. I don't remember. I haven't looked
23 at the anesthesia sheet.
24 Q. Could you do that for me real
25 quickly, please?

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1 A. Not in doing bypass grafts. I had
2 to do bypass grafts. I had to enlarge the
3 incision.
4 Q. Did you know at that point when she
5 was not responding to the defibrillation that
6 you were going to have to do bypass grafts?
7 A. No.
8 Q. So when she didn't respond to the
9 defibrillation, your decision was to do an open
10 sternotomy?
11 A. One of the things is you can do a
12 defibrillation, and you have a bigger chance to
13 get paddles in to defibrillate her, so we could
14 put bigger paddles in to defibrillate her.
15 Q. At that point you discovered that
16 you were going to have to do bypass surgery?
17 A. Yes.
18 Q. Other than the dissection, was there
19 any other reason that you had to do the bypass
20 surgery?
21 A. No.
22 Q. So had there not been a dissection,
23 she wouldn't have needed to have coronary artery
24 bypass surgery?
25 A. Exactly.

13 (Pages 49 to 52)

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1 Q. Are there techniques that you have
2 available in your arsenal in doing this type of
3 surgery to minimize the likelihood of a
4 dissection taking place?
5 A. Well, we're pretty careful with our
6 sutures. That's the main thing.
7 Q. If one is not careful with the
8 suturing, can that precipitate a dissection?
9 MR. MEADOWS: Objection.
10 A. Yes, it could, but I'm not sure we
11 know what caused the dissection in this lady.
12 Q. Can you rule out the sutures as
13 being a cause of the dissection?
14 A. No.
15 Q. Are you able to come up with
16 anything that's more likely to be an explanation
17 of the dissection in this case?
18 MR. MEADOWS: Objection.
19 A. Well, I think you have to figure
20 that this is a pretty unusual complication in a
21 lady who did have an enlarged aorta suggesting
22 that she did not have normal tissues.
23 Q. So they were more friable?
24 A. One would assume so, yes. Certainly
25 thinner, we know that.

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1 Q. Again, I'm trying to look at a
2 differential in terms of the cause of dissection
3 aside from sutures. Whether she had normal
4 tissue or more friable or thinner tissue,
5 carefully performed are there any explanations
6 for a dissection that you can think of that
7 would be more likely than sutures?
8 A. No.
9 MR. MEADOWS: Other than what he
10 just told you. You just asked that question.
11 He gave you an answer.
12 MR. MISHKIND: Okay. That's fine.
13 I think the record will be clear.
14 Q. The sutures that were inserted, you
15 did the suturing, correct?
16 A. Yes.
17 Q. When the dissection occurred, it
18 indicates that you had to reanastomose the area.
19 Did you remove the sutures?
20 A. Yes.
21 Q. Were you able to determine whether
22 or not the sutures most likely caused the
23 dissection?
24 A. I couldn't determine. She had a
25 dissection at the origin which I sewed up, and

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1 then, because I am never sure whether you can
2 completely obliterate the dissection, I elected
3 to go ahead and do a coronary bypass on top of
4 that for surety, to ensure she had blood supply
5 to her heart.
6 Q. Would you agree that it is the
7 desired intent when doing this surgery to avoid
8 causing the dissection?
9 A. Yeah. I think I agree with that.
10 Q. I suspected that you would. Have
11 you had dissections in AVRs before?
12 A. Yes.
13 Q. Have you had dissections in aortic
14 valve replacements where they were caused by the
15 sutures?
16 A. I've had dissections where I didn't
17 suture, and I've had dissections where I did
18 suture.
19 Q. Let's talk about the cases where you
20 did suture. Were you able to determine whether
21 or not the suturing was the cause of the
22 dissection?
23 A. No.
24 Q. In some of those cases, were you
25 able to come up with other explanations for the

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1 dissection?
2 A. Yeah.
3 Q. In those other cases, what were some
4 of the explanations?
5 A. Coronary profusion cannulas. It's a
6 fairly well-recognized cause of that.
7 Q. That's not the case in Laura's
8 situation?
9 A. I don't know.
10 Q. You don't have an opinion to a
11 reasonable degree of probability that that's
12 what caused her dissection?
13 A. It's certainly one of the recognized
14 causes of dissections of the coronary arteries.
15 Q. But again, in this case can you say
16 to a probability that's what caused hers?
17 A. I can't say what caused hers. I
18 don't know what caused that.
19 Q. Besides what you've just explained
20 and the suturing, what else have you encountered
21 that are causes of dissection?
22 A. Well, it's so rare that I've only
23 seen about three of them, so I really can't tell
24 you that.
25 Q. Why is it so rare, in your

14 (Pages 53 to 56)

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1 experience, that dissections don't happen?
2 A. Well, we don't sew inside the
3 coronary arteries, so you would have to assume
4 that -- you know, a dissection does begin within
5 the artery, so it's unlikely that you're going
6 to have disruption of the lining of the coronary
7 artery. Sutures don't go in there.
8 Q. About two hours later she had to be
9 brought back for surgery secondary to bleeding,
10 true?
11 A. Yes. 3.5 percent of the patients
12 come back for bleeding.
13 Q. Were you present at the time that
14 the patient was transferred at the end of the
15 first surgery to the intensive care unit?
16 A. I don't remember.
17 Q. Normally, with this type of surgery
18 would there be a point in time that you would
19 turn the matter over to your assistant?
20 A. Yes.
21 Q. Again, without specifically
22 recalling this case, what would be your custom
23 and practice in terms of when you would turn the
24 case over, especially with the complications you
25 had encountered?

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1 A. When the patient is hemodynamically
2 stable, the tubes are out, they are off the
3 heart-lung machine, bleeding is stopped, and
4 you're ready to close the chest.
5 Q. How do you go about making certain
6 that the reanastomosis is secure and that there
7 is no bleeding at the time that the closure is
8 done?
9 A. We suck, we look, and we put sponges
10 in and wait until they come out without blood on
11 them. We don't close them when they're
12 bleeding.
13 Q. You would agree that the standard of
14 care, especially after reanastomosing an area,
15 is to make sure that there are no signs that
16 there is a bleed from the anastomotic site,
17 true?
18 A. We don't close people when they are
19 actively bleeding.
20 Q. If there are signs that there may be
21 inadequate reanastomosis, you need to make sure
22 that you secure the area so as to prevent a
23 bleed during the immediate postoperative period?
24 A. The only sign I know of of an
25 inadequate anastomosis is bleeding.

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1 Q. I'm sorry, sir?
2 A. The only sign that I'm aware of of
3 inadequate anastomosis is bleeding, and we don't
4 close patients when they are bleeding.
5 Q. Did you have any discussion with the
6 family in between the first surgery and the
7 second?
8 A. I don't remember. I generally call
9 people immediately after the patient is off the
10 heart-lung machine.
11 Q. You have no reason to believe that
12 didn't take place in this case?
13 A. I don't.
14 Q. As to what you said to Laura's
15 husband or any family members --
16 A. I don't remember.
17 Q. You just can't recall that?
18 A. I don't.
19 Q. The nature of your conversation in
20 terms of what happened and why the surgery was
21 complicated, that's not reflected in any of your
22 notes in terms of you discussed it with the
23 family?
24 A. No.
25 Q. I know we've touched on this, but

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1 before the aortic valve replacement surgery was
2 started, based upon her underlying coronary
3 pathology you did not anticipate the need to do
4 any type of coronary artery bypass surgery had
5 the AVR gone without incident, true?
6 A. That's correct.
7 Q. Are the risks associated with aortic
8 valve replacement, intraoperative risks, the
9 same or different than the risks associated with
10 mitral valve replacement?
11 A. Different.
12 Q. Are there greater intraoperative
13 risks, or are there less intraoperative risks
14 for AVR versus mitral valve?
15 A. The mortality rate is higher.
16 Q. For what?
17 A. Aortic valve.
18 Q. I'm sorry, sir?
19 A. For aortic valve.
20 Q. What is the mortality rate for
21 mitral valve?
22 A. Three-tenths of 1 percent.
23 Q. Is this the nationwide rate or your
24 personal?
25 A. It's my personal. The nationwide

15 (Pages 57 to 60)

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1 rate is about three or four times that for both
2 procedures.
3 Q. Without going through Laura's
4 preoperative history, you've told us about her
5 stenosis, you've talked about some of the
6 regurgitation and things of that nature, but was
7 she in your opinion at increased risk for
8 complications secondary to dissection more so
9 than any other patient undergoing this type of
10 surgery?
11 A. No.
12 Q. The time that she was on the
13 heart-lung machine was obviously increased by
14 virtue of having to reanastomose the area, true?
15 A. Yes.
16 Q. Let's jump ahead to the second
17 surgery. How did you get called; do you recall
18 that?
19 A. No.
20 Q. Obviously, someone beeped you and
21 said --
22 A. I don't remember.
23 Q. But you did come back?
24 A. I don't remember the details of it.
25 Q. Well, the second surgery has you as

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1 the homograft?
2 A. I don't know what that would be, no.
3 Q. If you didn't perform the surgery,
4 obviously it would have been Dr. Kerr, true?
5 A. Yes.
6 Q. Simply because you signed it at the
7 end, as you did on the other one, doesn't mean
8 that --
9 A. Right.
10 Q. -- you were present for the surgery,
11 true?
12 A. Right.
13 Q. Did you see the sine angiograms
14 before the surgery was done?
15 A. I'm sure I did.
16 Q. Did you make any comment at all in
17 the hospital records as to what the findings
18 were?
19 A. No.
20 Q. Understanding that you may or may
21 not have been present for the second surgery,
22 tell me what your understanding is as to the
23 reason she needed to have the emergent
24 operation?
25 A. She was bleeding from the distal

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1 the surgeon and Dr. Kerr as the assistant.
2 A. Yes.
3 Q. Did you do that surgery?
4 A. I don't remember. If it says I did,
5 I did. I have no memory. I have no memory of
6 the second operation.
7 Q. You signed it, but Dr. Kerr dictated
8 the report.
9 A. My residents dictate all my
10 operative notes.
11 Q. The same as for the first one,
12 correct?
13 A. Yes.
14 Q. But in all fairness, what you're
15 telling me is that you don't remember the
16 surgery to repair the bleeding point --
17 A. I don't.
18 Q. -- in Laura Adams?
19 A. No.
20 Q. Am I correct that you may or may not
21 have done the surgery?
22 A. You're correct.
23 Q. Is there any way for us to be
24 certain by way of some document as to whether or
25 not you were the surgeon that did the repair of

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1 anastomotic site.
2 Q. Was that the area where there was
3 the dissection?
4 A. No.
5 Q. Was there a dissection of the left
6 main coronary ostia?
7 A. Yes.
8 Q. What caused the dissection of the
9 left main coronary ostia?
10 A. I think we just talked about that.
11 Q. Was that during the first surgery?
12 MR. MEADOWS: Objection. You went
13 through that whole series.
14 A. We just went through the whole
15 business about the dissection of the left main
16 coronary.
17 Q. I thought I asked you, and maybe I
18 misunderstood what you explained in terms of the
19 reason that she had the bleed.
20 A. She had the bleed from the distal
21 anastomosis of the aorta, from the homograft to
22 the distal aorta, which is not related to the
23 coronary ostia. They are different sites.
24 Q. That's what I want to make sure I
25 understand. Your explanation to me is that the

16 (Pages 61 to 64)

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1 dissection of the left main coronary ostia
2 was --
3 A. A different surgical site.
4 Q. That was surgery number one,
5 correct?
6 A. Do you understand what a homograft
7 looks like?
8 Q. I do, yes.
9 A. The anastomosis to the left main is
10 in a different site than is the distal
11 anastomosis where she was bleeding.
12 Q. Again, maybe I'm making my question
13 more complicated than I need to, but the
14 bleeding that took her back into the second
15 surgery was a different location than the
16 dissection that occurred during the first
17 surgery?
18 A. Yes.
19 Q. Okay. That's all I meant.
20 Obviously, I convoluted my question. I just
21 wanted to make sure that we were talking about
22 two different sites.
23 In the operative report it says that
24 she had excessive bleeding from her chest tubes.
25 Can you explain that to me? Why would there be

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1 first surgery?
2 A. Most commonly a patient gets
3 hypertensive.
4 Q. How does one monitor that to
5 appreciate any potential of hypertension?
6 A. We have an arterial line, and we
7 constantly measure the blood pressure.
8 Q. Do you know whether she was being
9 monitored?
10 A. I'm sure she was.
11 Q. What other steps do you take as a
12 surgeon to minimize the potential for bleeding
13 from the distal anastomotic site at the time of
14 closure during the first surgery?
15 A. I'm sorry. I don't understand your
16 question.
17 Q. That's all right. Every once in a
18 while it's confusing.
19 What steps do you take to minimize
20 the potential for a bleed from an anastomotic
21 site?
22 A. You want to know how I do the
23 technical to do the anastomosis?
24 Q. That's probably going to be the
25 easiest way to explain it.

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1 excessive bleeding from the chest tubes?
2 A. Anybody that bleeds more than 300 or
3 400 cc's we consider abnormal and take them back
4 to the operating room. Everybody bleeds some
5 from their chest tubes. That's why we leave
6 them.
7 Q. The operative report dictated by
8 Dr. Kerr, it says that the distal anastomotic
9 site of the homograft did appear to have a
10 bleeding point coming from the posterior aspect
11 which was repaired with a single 4-0 pledgeted
12 proline stitch.
13 Would you have used a 4-0 pledgeted?
14 It's standard to use?
15 A. (Indicating.)
16 Q. That's a yes?
17 A. Yes.
18 Q. In terms of the reason that she
19 developed a bleeding point at the posterior
20 aspect when she didn't have a bleed at the time
21 of closure, can you explain that to me?
22 A. I can't.
23 Q. What are some of the potential
24 causes for a bleed from the distal anastomotic
25 site so close in time to the conclusion of the

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1 A. I use a 4-0 proline, large bites
2 close together. I evert the distal anastomosis
3 so I get double layers of the distal aorta.
4 After it's all finished, we check to make sure
5 there's no bleeding.
6 Q. Have you ever encountered, ever
7 encountered, within a two-hour period a bleed
8 from a distal anastomotic site on one of your
9 cases?
10 A. Yes.
11 Q. How many times has this happened to
12 you?
13 A. In the last 18,000?
14 Q. Yes.
15 A. I'm not sure I can tell you. I can
16 tell you the reoperation for bleeding rate, and
17 I told you that.
18 Q. I'm being very specific, though, in
19 terms of the distal anastomotic site.
20 A. I had one yesterday.
21 Q. Within two hours?
22 A. Yes.
23 Q. What caused that?
24 A. It was a bleeding between sutures.
25 Q. Do you know why that happened?

17 (Pages 65 to 68)

<p>Page 69</p> <p>1 A. I don't. 2 Q. Are there steps that you should have 3 taken to have minimized the likelihood of that 4 happening? 5 MR. MEADOWS: Objection. 6 A. I thought I did. 7 Q. Since this is not something that has 8 never happened to you before, I presume over 9 time you analyze why a bleed occurs from a 10 distal anastomotic site, true? 11 A. Uh-huh. 12 Q. That's a yes? 13 A. Yes. 14 Q. And you take steps to either improve 15 on your technique or to minimize this potential 16 complication from occurring, correct? 17 A. Right. 18 Q. I take it that's the standard of 19 care, to minimize and to appreciate the risk of 20 this happening, true? 21 A. Yes. I would suspect that there's 22 probably no surgeon alive who does very much of 23 this surgery who hasn't had bleeding from an 24 anastomotic site. This is one of the 25 complications of surgery, is bleeding, and it</p>	<p>Page 71</p> <p>1 Q. That's a yes? 2 A. Yes. 3 Q. Did the reopening of Laura's chest, 4 in your opinion, increase her risk for 5 infection? 6 A. No. 7 Q. Why? 8 A. Why do you think it would? 9 Q. Doesn't the reopening of a chest 10 twice for open heart surgery or a sternotomy, 11 doesn't that increase the potential for 12 infection? 13 A. Not in our experience. 14 Q. Are you aware of any literature that 15 would speak to the contrary? 16 A. No. 17 MR. MEADOWS: Objection. 18 Q. So your experience is that the 19 reopening of the chest didn't put her at any 20 greater risk of development of infection? 21 A. That's our experience. 22 Q. By the way, do you know Dr. Tyrone 23 David? 24 A. Yes. 25 Q. How do you know him?</p>
<p>Page 70</p> <p>1 happens from all sorts of locations. 2 Q. Now, aside from the bleed from the 3 distal anastomotic site, were there any other 4 complications that resulted in her having to go 5 back in for surgery? 6 A. No. 7 Q. What was done, whether it was you or 8 Dr. Kerr or both, at the time of the second 9 surgery? 10 A. One stitch was placed that stopped 11 the bleeding. 12 Q. Did she have to be put back on the 13 heart-lung? 14 A. No. 15 MR. MEADOWS: Off the record. 16 (Discussion off the record.) 17 Q. When the second surgery was 18 performed, the chest had to be reopened, the 19 sternum was reopened, correct? 20 A. Yes. 21 Q. At that time Dr. Kerr or you 22 evacuated the clot that had formed around the 23 heart and then evaluated the graft sites, or 24 someone evaluated the graft sites, correct? 25 A. Uh-huh.</p>	<p>Page 72</p> <p>1 A. Professionally. 2 Q. Have you talked to him about this 3 case? 4 A. No. 5 Q. Are you aware of the fact that he 6 has written a report in connection with this 7 case? 8 A. No. 9 Q. Did you suggest him as an expert on 10 behalf of the Clinic? 11 A. No. 12 Q. When you say you know him 13 professionally, that's sort of a loose term. 14 It's like me saying I know Mr. Meadows 15 professionally. 16 Have you lectured with him? 17 A. Yes. 18 Q. On how many occasions have you 19 lectured? 20 A. With him? He has lectured here. 21 I've lectured in Toronto. 22 Q. He has invited you; you've invited 23 him? 24 A. Yes. 25 Q. On how many occasions has that taken</p>

<p>Page 73</p> <p>1 place?</p> <p>2 A. He was a visiting professor here a</p> <p>3 number of years ago, and I was a visiting</p> <p>4 professor there a number of years ago.</p> <p>5 Q. Have you and he authored or</p> <p>6 coauthored any articles?</p> <p>7 A. No.</p> <p>8 Q. Have you and he appeared outside of</p> <p>9 the Toronto-Cleveland Clinic arena at any</p> <p>10 symposiums or seminars and presented at the same</p> <p>11 time?</p> <p>12 A. Yes.</p> <p>13 Q. On how many occasions has that taken</p> <p>14 place?</p> <p>15 A. We have debated on a couple of</p> <p>16 occasions.</p> <p>17 Q. I'm sorry?</p> <p>18 A. We've debated on a couple of</p> <p>19 occasions.</p> <p>20 Q. I take it by that that there are</p> <p>21 issues that you and he don't necessarily agree</p> <p>22 upon?</p> <p>23 A. That's correct.</p> <p>24 Q. What are some of the issues?</p> <p>25 A. We've debated about stentless</p>	<p>Page 75</p> <p>1 Q. Would you agree that the risk of</p> <p>2 infection increases not only as cardiopulmonary</p> <p>3 bypass time increases, but also as the necessity</p> <p>4 to reexplore and reanastomose an area increases?</p> <p>5 A. No.</p> <p>6 Q. That's not been in your experience,</p> <p>7 that phenomenon?</p> <p>8 A. That's correct.</p> <p>9 Q. How does one quantify the increased</p> <p>10 risk of infection based upon increased</p> <p>11 cardiopulmonary bypass time? Is there some type</p> <p>12 of quantification?</p> <p>13 A. Not that I'm aware of.</p> <p>14 Q. Just that you recognize that the</p> <p>15 longer the time, the greater the risk of</p> <p>16 infection?</p> <p>17 A. Uh-huh.</p> <p>18 Q. True?</p> <p>19 A. Yes.</p> <p>20 Q. Were you the one that prescribed the</p> <p>21 Zinacef?</p> <p>22 A. It's one of our standard orders.</p> <p>23 Q. That's 1.5 grams, and it was q 12</p> <p>24 hours time three?</p> <p>25 A. I think that's the standard order.</p>
<p>Page 74</p> <p>1 valves.</p> <p>2 Q. What is your position on stentless</p> <p>3 valves?</p> <p>4 A. I developed one for the Edwards</p> <p>5 Company that I've never used or implanted, and</p> <p>6 he developed one.</p> <p>7 Q. I'm sorry?</p> <p>8 A. He developed one that's manufactured</p> <p>9 by St. Jude that he uses or has used.</p> <p>10 Q. When is the last time that you and</p> <p>11 Dr. David had any contact?</p> <p>12 A. Let's see, three months ago.</p> <p>13 Q. What was the occasion?</p> <p>14 A. I'm trying to think. It was -- no,</p> <p>15 it was two months ago. I saw him in Miami, and</p> <p>16 we were both speaking at a meeting.</p> <p>17 Q. So it's your testimony, Doctor, that</p> <p>18 the fact that she had undergone surgery followed</p> <p>19 by a reoperation in the afternoon for bleeding</p> <p>20 did not increase her risk for infection, true?</p> <p>21 A. In our experience that is the case.</p> <p>22 Q. Would you agree that the risk of</p> <p>23 infection increases as cardiopulmonary bypass</p> <p>24 time increases?</p> <p>25 A. Yes.</p>	<p>Page 76</p> <p>1 I'd have to look. I don't remember.</p> <p>2 Q. With the increased pump time, are</p> <p>3 there occasions where you will modify those</p> <p>4 standing orders?</p> <p>5 A. No.</p> <p>6 Q. So even though there's an increased</p> <p>7 risk of infection, the standing orders for</p> <p>8 Zinacef, 1.5 grams q 12 hours times three,</p> <p>9 remains without modification?</p> <p>10 A. Yes.</p> <p>11 Q. Have you reviewed the postoperative</p> <p>12 records?</p> <p>13 A. Yes.</p> <p>14 Q. Have you reviewed the records to</p> <p>15 determine when you last appear to have been</p> <p>16 involved actually by way of making some type of</p> <p>17 a note in the record?</p> <p>18 A. I don't think there is any notes in</p> <p>19 there by me.</p> <p>20 Q. I believe that there may be a</p> <p>21 reference to you seeing the patient.</p> <p>22 A. I don't think I wrote in the chart,</p> <p>23 though.</p> <p>24 Q. But would you agree that there's a</p> <p>25 reference to you seeing the patient I think on</p>

<p style="text-align: right;">Page 77</p> <p>1 the 15th?</p> <p>2 A. I don't remember.</p> <p>3 MR. MEADOWS: Can you show him what</p> <p>4 you're referring to?</p> <p>5 MR. MISHKIND: I don't have -- well,</p> <p>6 maybe I can.</p> <p>7 Q. As I'm looking for it, in reviewing</p> <p>8 the records, you did not see any entries made by</p> <p>9 you?</p> <p>10 A. No.</p> <p>11 Q. Who from your team was responsible</p> <p>12 for monitoring the patient during the</p> <p>13 postoperative period?</p> <p>14 A. Dr. Kerr and my other resident, who</p> <p>15 I don't remember.</p> <p>16 Q. Ultimately, would you have been</p> <p>17 responsible for Dr. Kerr and your other</p> <p>18 resident?</p> <p>19 A. Yes.</p> <p>20 Q. Do you have any recollection of</p> <p>21 discussing the case with Dr. Kerr or your other</p> <p>22 resident during the postoperative period?</p> <p>23 A. No.</p> <p>24 Q. There was a thoracentesis that was</p> <p>25 performed on January 22nd, 1999. Was that done</p>	<p style="text-align: right;">Page 79</p> <p>1 Q. Assuming that there wasn't one, do</p> <p>2 you have any explanation why a decision not to</p> <p>3 perform a culture would have been made?</p> <p>4 A. It was done as a therapeutic</p> <p>5 therapy, and it probably didn't look like it was</p> <p>6 infected.</p> <p>7 Q. Even though it's done</p> <p>8 therapeutically, when you drain fluid, that</p> <p>9 doesn't mean that one can't do a culture on the</p> <p>10 fluid, correct?</p> <p>11 A. Correct.</p> <p>12 Q. Do you know of any reason in this</p> <p>13 case why a culture couldn't have been done on</p> <p>14 the fluid?</p> <p>15 A. No.</p> <p>16 MR. MISHKIND: Did you find the</p> <p>17 note?</p> <p>18 MR. MEADOWS: No.</p> <p>19 MS. JENNY: I looked for it, Howard.</p> <p>20 I didn't see it.</p> <p>21 MR. MISHKIND: Off the record.</p> <p>22 (Discussion off the record.)</p> <p>23 Q. Doctor, according to the hospital</p> <p>24 records, the patient had temperature elevations</p> <p>25 each day after surgery, but blood cultures, at</p>
<p style="text-align: right;">Page 78</p> <p>1 by your team?</p> <p>2 A. Yes.</p> <p>3 Q. There was a Dr. Marullo. Might that</p> <p>4 have been the other resident?</p> <p>5 A. It's possible.</p> <p>6 Q. Do you know why a thoracentesis was</p> <p>7 required on January 22nd?</p> <p>8 A. Because she had a pleural effusion,</p> <p>9 right.</p> <p>10 Q. Was there a culture done on the</p> <p>11 fluid drained from the thoracentesis?</p> <p>12 A. I don't know.</p> <p>13 Q. Have you ever performed a</p> <p>14 thoracentesis?</p> <p>15 A. Yes.</p> <p>16 Q. On postoperative patients?</p> <p>17 A. Yes. Not in a long time.</p> <p>18 Q. When you performed a thoracentesis</p> <p>19 on a postoperative patient where there was fluid</p> <p>20 drained, did you normally perform a culture on</p> <p>21 the fluid?</p> <p>22 A. Usually.</p> <p>23 Q. Do you have any explanation in this</p> <p>24 case as to why there wasn't a culture done?</p> <p>25 A. I don't know if there was or wasn't.</p>	<p style="text-align: right;">Page 80</p> <p>1 least according to my review, were done on</p> <p>2 January 17th and on January 18th, but no</p> <p>3 additional blood cultures were done after that</p> <p>4 time.</p> <p>5 Do you recall, first, that blood</p> <p>6 cultures were done on the 17th and 18th?</p> <p>7 A. Only from reading the chart.</p> <p>8 Q. I think there were a total of five</p> <p>9 blood cultures, times three on the 17th and</p> <p>10 times two on the 18th. Does that ring true to</p> <p>11 you?</p> <p>12 A. Yes.</p> <p>13 Q. Do you know why there were no blood</p> <p>14 cultures done after the 18th?</p> <p>15 A. No.</p> <p>16 Q. Do you have an opinion as to whether</p> <p>17 or not blood cultures should have been done</p> <p>18 after the 18th?</p> <p>19 A. We don't routinely do blood cultures</p> <p>20 on everybody every day that has a fever in the</p> <p>21 hospital because almost every patient after</p> <p>22 cardiac surgery has a fever.</p> <p>23 Q. In this particular patient, though,</p> <p>24 do you know whether the decision when the</p> <p>25 patient continued to have elevated temperatures</p>

20 (Pages 77 to 80)

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1 where she was on aspirin, where she was on
2 Tylenol, where she also had an increase in her
3 WBC, why a decision was not made after the 18th
4 to do any repeat blood cultures?
5 MR. MEADOWS: Objection to form and
6 foundation.
7 Q. I'm sorry, Doctor. Go ahead.
8 A. I wasn't party to the decision.
9 Q. Do you know or do you have an
10 opinion to a probability as to what blood
11 cultures would have shown had they been done on
12 or prior to the date of discharge?
13 A. I don't think you know what blood
14 cultures will show until you do them.
15 Q. So you don't have an opinion based
16 upon the totality of this case as to whether or
17 not the blood cultures would have been positive?
18 A. I don't know.
19 Q. There was also an order for a repeat
20 CBC that was ordered on January 24th but, at
21 least according to what I've gathered from
22 Dr. Klein's depo and the records, there doesn't
23 appear to be any evidence that that CBC was
24 done, and make that an initial statement.
25 Do you recall, first, seeing the

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1 A. If it's ordered, it should be done.
2 Q. Do you know of anything from what
3 you've learned by reading Dr. Klein's depo or
4 looking at the hospital records as to why the
5 CBC was not done prior to discharge?
6 MR. MEADOWS: Objection.
7 A. I don't know why it wasn't done. I
8 don't know. Dr. Klein speculated on it. I can
9 only speculate on it.
10 Q. Yours would be double speculation,
11 speculating on what Dr. Klein has speculated?
12 A. I guess.
13 Q. There was some suggestion in the
14 deposition of Dr. Klein that he felt that the
15 patient was anxious to get home, back to
16 Connecticut. Do you have any evidence that you
17 can rely upon to say that you concur with that?
18 A. I wasn't party to any of that
19 portion of the hospital decision.
20 Q. The fact that this was your patient
21 that had to have two surgeries within a short
22 period of time on the 14th and then had elevated
23 temperatures, she had an elevated white blood
24 count, she had the fluid drain from the
25 thoracentesis and other symptoms that were going

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1 discussion in Dr. Klein's depo about that?
2 A. Yes.
3 Q. Do you recall seeing that there was
4 an order for a CBC on the 24th?
5 A. I haven't seen that order.
6 Q. You certainly have no reason to take
7 issue with what the record says or what
8 Dr. Klein indicated, true?
9 A. No.
10 Q. If a CBC is ordered on a patient
11 that is being discharged or the plan is to
12 discharge the patient and the patient has
13 continued to have elevated temperatures, has an
14 increased white blood count, would you agree
15 that it would be reasonable and prudent to
16 perform the CBC on the patient certainly before
17 the patient is discharged from the hospital?
18 MR. MEADOWS: Objection.
19 A. I think it's reasonable to do it and
20 reasonable not to do it.
21 Q. But if it's ordered and there's an
22 indication for it, would you agree that it
23 should be done?
24 MR. MEADOWS: Objection, asked and
25 answered.

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1 on, is there a reason why you were not
2 consulted --
3 A. She had --
4 Q. Let me finish first, and then you
5 can go ahead.
6 Is there any reason why you were not
7 consulted as it relates to the decision whether
8 this patient was appropriate to be discharged
9 given the fact that she was going to be going
10 back to Connecticut as opposed to staying in the
11 Cleveland area?
12 MR. MEADOWS: Objection to form and
13 foundation. Go ahead.
14 A. She had a normal echocardiogram, she
15 had normal blood cultures, she had a
16 defervescent temperature, and she was clinically
17 getting better. It was a judgment call that she
18 was discharged. I didn't make that call.
19 Q. Would you have made that call?
20 A. I wasn't on the spot. I can't say.
21 Q. Would you agree that the
22 temperatures that she had were suppressed to
23 some degree by the 81 milligram aspirins that
24 she was taking on a daily basis?
25 A. It's possible.

21 (Pages 81 to 84)

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1 Q. And also the Tylenol given on seven
2 occasions?
3 A. It's possible.
4 Q. She also received a dose of Percocet
5 on one occasion. Do you recall that?
6 A. Everybody gets Percocet after heart
7 surgery. They hurt.
8 Q. She also had multiple IV doses of
9 Toradol, correct?
10 A. Yes. I assume she did if you say
11 so.
12 Q. That is used for pain control,
13 correct?
14 A. Yes.
15 Q. It's a nonsteroidal
16 anti-inflammatory?
17 A. Yes.
18 Q. The anti-inflammatory property of
19 the drug may also mask temperature spikes, true?
20 A. It's possible.
21 Q. She appears to have what I would
22 describe as an unusual amount of incisional pain
23 for a patient ten days post-op. Would you agree
24 with that?
25 A. I wasn't daily evaluating her pain,

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1 A. Everybody has pain after heart
2 surgery.
3 Q. Would you agree that severe
4 persistent pain and incisional tenderness may be
5 an indication of a mediastinal infection?
6 A. Yes.
7 Q. Would you agree that her white blood
8 count was increasing before discharge?
9 A. Yes.
10 Q. And that she had persistent at least
11 low grade temperatures during the postoperative
12 period?
13 MR. MEADOWS: Objection to form,
14 vague.
15 A. She did have temperatures up until
16 she went home, but it was gradually coming down,
17 and everybody has temperatures after heart
18 surgery.
19 Q. If a CBC with a differential had
20 been done on the 24th, would that have shown
21 whether there were indications of an infectious
22 process?
23 A. I don't know.
24 Q. At any time during the postoperative
25 period was an infectious disease consult

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1 and I think it's probably hard for you to
2 evaluate it, too.
3 Q. It's probably more difficult for me
4 to evaluate it than for you to evaluate it. I
5 don't mean to be flippant by that, but do you
6 recall seeing that there was at least ongoing
7 complaints of incisional pain?
8 A. She had pain. She had pains in her
9 left arm, too, and she had that preoperatively,
10 and there was pain in the right arm. She had a
11 pain consult, a neurologic consult, she had
12 numbness of her face, all of which was
13 negatively worked up.
14 Q. I totally agree with you, but in
15 addition, Doctor, there was, at least on the
16 record, and obviously the record will speak for
17 itself, but from what I gathered there appeared
18 to be incisional pain that continued for the
19 ten-day postoperative period. Whether one calls
20 it unusual or normal, can we at least agree that
21 there was incisional pain that she had in
22 addition to the other complaints of pain?
23 MR. MEADOWS: Objection to form and
24 the colloquy that preceded the question. Go
25 ahead and answer the question, Doctor.

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1 requested?
2 A. I don't know. I don't think so.
3 Q. Now, on the 22nd, Doctor, when the
4 thoracentesis was done, that day her WBC was
5 elevated to 15.94, and the record indicates that
6 she continued to have persistent low grade
7 temperatures. I think you told me that there
8 was some concern about pleural effusions.
9 A. She had a right pleural effusion.
10 MR. MEADOWS: Objection. You're
11 giving a speech and then asking the question.
12 I'm going to move to strike the statement you
13 make before the question.
14 MR. MISHKIND: You know what I'll
15 do, I'll even withdraw it and restate it.
16 MR. MEADOWS: That would be great.
17 MR. MISHKIND: How is that?
18 MR. MEADOWS: That would be great.
19 Q. A thoracentesis was done on
20 January 22nd, 1999, true?
21 A. Yes.
22 Q. Will you assume for purposes of my
23 question that her white blood count on that date
24 was 15.94?
25 A. Yes.

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1 Q. And that she was continuing to have
2 persistent low grade temperatures during the
3 postoperative period up to and including the
4 22nd?
5 A. Yes.
6 Q. Are those findings consistent with a
7 potential infectious process?
8 MR. MEADOWS: Objection to form,
9 vague.
10 A. They're consistent with a lot of
11 things, one of which is a normal postoperative
12 course, and one of them is infection.
13 Q. So infection certainly could not be
14 ruled out as of January 22nd, true?
15 A. True.
16 Q. The thoracentesis being performed on
17 January 22nd was done because of pleural
18 effusions?
19 A. Yes.
20 Q. Pleural effusions may be associated
21 with mediastinal infections, true?
22 A. Yes.
23 Q. Had they cultured the fluid, would
24 you agree that if in fact there was a
25 mediastinal infection, there was enough fluid

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1 probability as to whether it would have been
2 reasonable and prudent to send Laura Adams home
3 had she been cultured from the thoracentesis and
4 an infection diagnosed, knowing that as of
5 January 24th her white blood count was still
6 elevated and knowing on the 24th that she still
7 had a low grade temperature?
8 MR. MEADOWS: Objection to
9 foundation.
10 A. I don't understand what your
11 question is.
12 Q. What circumstances would you
13 discharge a patient after a thoracentesis is
14 done on day eight following this type of surgery
15 where there is evidence of an infection?
16 A. I still don't understand your
17 question.
18 Q. You say that sometimes we send
19 patients home after a thoracentesis. Where
20 there is an infection --
21 A. Absolutely we do. About half our
22 patients on the floor have a thoracentesis.
23 Q. When a patient is going to be going
24 from Cleveland to Connecticut --
25 A. Yes.

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1 that was drained during this therapeutic
2 thoracentesis that there would have been a
3 sufficient quantity of fluid to perform a
4 culture on the fluid?
5 MR. MEADOWS: Objection to form and
6 any assumptions within the question.
7 A. Do you want to ask that again? I'm
8 a little vague as to what you're asking me.
9 Q. Sure.
10 A. Was there enough fluid to culture?
11 Q. Yes.
12 A. 1,700 cc's, yes.
13 Q. If a culture had been done, I think
14 what you told me before is you don't know
15 whether or not an infection would have been
16 diagnosed, true?
17 A. True.
18 Q. If an infection had been diagnosed
19 based upon the culture, would you agree that the
20 patient most likely would have needed to remain
21 in the hospital for further treatment?
22 MR. MEADOWS: Objection.
23 A. We don't send patients home with
24 infections.
25 Q. Do you have an opinion to a

Page 92

1 Q. -- you need to be more concerned
2 about the medical management of that patient as
3 opposed to someone that's going to be staying in
4 the Cleveland area and can be seen by you or one
5 of your colleagues, true?
6 MR. MEADOWS: Objection.
7 A. I think we're equally concerned
8 about everybody we send home.
9 Q. If you have a concern about a
10 patient that has an infection, are there
11 occasions where you will discharge a patient but
12 tell them that they should stay in the Cleveland
13 area for 24 or 48 hours before they return to
14 their homeland, whether it's out of the country
15 or in the country?
16 MR. MEADOWS: Objection.
17 A. It totally depends on the individual
18 case.
19 Q. Do you intend to provide an opinion
20 in this case hypothetically if the thoracentesis
21 had been performed and a culture obtained on the
22 fluid and an infection was diagnosed whether it
23 would have been reasonable to discharge Laura
24 Adams two days later on January 24th?
25 MR. MEADOWS: Objection to form.

23 (Pages 89 to 92)

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1 A. Tell me what the question is again.
2 Q. Sure. If the thoracentesis had been
3 done and a culture obtained and that culture
4 came back indicating that she had an infection,
5 do you intend to provide an opinion at trial
6 that in that setting it would have been
7 reasonable to discharge the patient two days
8 later?
9 MR. MEADOWS: Objection.
10 A. The assumption is that she -- the
11 question is, am I going to give an opinion at
12 trial?
13 Q. Well, let's start with today. Do
14 you have an opinion whether it would have been
15 reasonable and acceptable care to have
16 discharged Laura if the thoracentesis had been
17 done with a culture obtained and the culture
18 returned indicating that she had an infection?
19 MR. MEADOWS: Objection.
20 A. If she had an empyema, we probably
21 would not have sent her home, and she would have
22 been a hell of a lot sicker. She wouldn't have
23 even been able to stand up. She would have been
24 too sick.
25 Q. Short of an empyema, what else would

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1 Q. I'm sorry?
2 A. I don't know. I wasn't the
3 decision-maker, and I wasn't looking after her
4 at this point.
5 Q. I take it you don't have an opinion,
6 considering you weren't the decision-maker,
7 whether it was or was not appropriate to
8 discharge Laura on January 24th?
9 A. I do not have an opinion.
10 Q. Do you have an opinion as to whether
11 it was appropriate to clear her to return to
12 Connecticut rather than stay in the area,
13 assuming it was appropriate to discharge her, on
14 January 24th?
15 A. No.
16 Q. You indicated that she would have
17 been in much more pain had she had an empyema.
18 If a culture had been done on the thoracentesis,
19 do you have an opinion as to what it likely
20 would have shown?
21 A. No.
22 Q. At the time of the autopsy -- you've
23 seen the autopsy, haven't you?
24 A. Yes.
25 Q. Do you have a copy of it there?

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1 you have --
2 A. That is the definition of an
3 empyema, fluid in -- bacteria in the pleural
4 space, that's an empyema.
5 Q. Patients are always going to be
6 sicker than she?
7 A. They're going to be very sick. I've
8 never seen one that wasn't very sick with an
9 empyema.
10 MR. MEADOWS: We're coming up on 45
11 minutes past our estimated close time here.
12 MR. MISHKIND: I know. I said it
13 was an estimate. Off the record.
14 (Discussion off the record.)
15 Q. Do you know why Laura was discharged
16 from the Cleveland Clinic with a white blood
17 count of 15.94?
18 A. No.
19 Q. Do you know why she was discharged
20 and not given any antibiotic therapy to take at
21 the time of discharge?
22 A. No.
23 Q. Would you have prescribed
24 antibiotics for this patient to take?
25 A. I don't know.

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1 A. Yes.
2 Q. I'm going to get it in front of me,
3 and you can certainly feel free, if you want to,
4 or you probably have it memorized.
5 In the autopsy it indicates that one
6 of the findings was acute suppurative
7 necrotizing bacterial aortitis.
8 A. Aortitis.
9 Q. Gram-positive cocci?
10 A. Yes.
11 Q. Can we agree that given that final
12 finding that it's likely that had a culture of
13 the thoracentesis fluid on January 22nd been
14 obtained, it would have shown evidence of
15 gram-positive cocci infection?
16 MR. MEADOWS: Objection, calls for
17 speculation.
18 A. Absolutely not.
19 Q. Why?
20 A. Why would it?
21 Q. Why do you say it wouldn't have?
22 A. You said the supposition was that it
23 would have shown, and I'm saying the infection
24 is on the inside of the blood vessel and the
25 fluid is on the outside. I don't think that

24 (Pages 93 to 96)

Page 97

1 they're related.
2 Q. Okay. So simply because she had
3 gram-positive cocci bacteria, there's no reason
4 to conclude that had a thoracentesis been done
5 the bacteria would have been discovered?
6 A. Absolutely.
7 Q. What about if a CBC had been done on
8 January 24th with a differential, do you have an
9 opinion as to whether or not that bacteria would
10 have been discovered?
11 MR. MEADOWS: Objection, calls for
12 speculation. It's been asked and answered.
13 MR. MISHKIND: Well, actually not
14 this particular one.
15 MR. MEADOWS: Yes, it has.
16 MR. MISHKIND: I appreciate it, but
17 go ahead, Doctor.
18 A. A CBC wouldn't have discovered the
19 bacteria.
20 Q. What would have had to have been
21 done, a blood culture?
22 A. She probably would have had to have
23 a culture of her aorta.
24 Q. Are you suggesting blood cultures
25 would not have detected it?

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1 A. It's possible.
2 Q. It's possible that it would have
3 detected it?
4 A. It's possible that it wouldn't have
5 detected it.
6 Q. And it's also possible that it would
7 have detected it?
8 A. It's possible.
9 Q. Would you agree that the probability
10 of the patient surviving would have been
11 increased had there been evidence prior to the
12 discharge that she had a gram-positive cocci
13 infection?
14 A. No.
15 Q. Subject to being treated?
16 A. No.
17 Q. Why?
18 A. It was a yes or no question. What's
19 the question now?
20 Q. Why do you say that her likelihood
21 of survival wouldn't have been greater had she
22 had infection, a gram-positive cocci infection,
23 diagnosed on January 24th and treated as opposed
24 to --
25 A. She would have ruptured her aorta

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1 here in the hospital, and she would have died,
2 too.
3 Q. If she had ruptured her aorta in the
4 hospital, wouldn't she have had a better
5 likelihood of survival being in the hospital as
6 opposed to being at home?
7 MR. MEADOWS: Objection.
8 A. Pretty small.
9 Q. So you think that she was doomed
10 regardless?
11 A. I didn't say that, did I?
12 Q. Well, you said that if she had a
13 gram-positive cocci bacterial infection that
14 caused a rupture of her aorta --
15 A. I said if she ruptured her aorta in
16 the hospital, people with aortic stenosis very
17 seldom survive if they've had a cardiac arrest
18 on the floor.
19 Q. What types of symptoms do you look
20 for in a patient that has a gram-positive cocci
21 infection that indicates a change in hemodynamic
22 status?
23 A. I've never seen a gram-positive
24 infection on an aorta.
25 Q. So when you look at this autopsy

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1 where it says acute suppurative necrotizing
2 bacterial aortitis, you've never seen that
3 before?
4 A. No.
5 Q. Where it says rupture of infected
6 necrotic aortic arch adjacent to the cannulation
7 site, do you have an explanation as to what
8 caused the aortic arch adjacent to the
9 cannulation site to become infected?
10 A. It said it had spread.
11 Q. I'm sorry?
12 A. It said in the autopsy report that
13 it had spread.
14 Q. Spread from where?
15 A. The infection had spread from the
16 homograft to the aorta.
17 Q. How do you prevent a spread of an
18 infection from a homograft to the aorta?
19 A. Since I've never seen an infected
20 aorta before, I don't know.
21 Q. An infected homograft, you mean?
22 A. Right.
23 Q. If you suspect that there is an
24 infection, though, you obviously need to treat
25 it, correct?

25 (Pages 97 to 100)

<p style="text-align: right;">Page 101</p> <p>1 A. If I had never seen one before or 2 read of one before, it would be hard to suspect 3 one, wouldn't it? 4 Q. Except you know what the signs and 5 symptoms are of an infection even though you 6 might not be able to isolate exactly where the 7 infection is within a patient's body, correct? 8 A. How am I going to treat it? The 9 only way you're going to treat it is get it out 10 of there. How are you going to diagnose it? 11 You've tried with blood cultures, you've tried 12 with echo, and no one has ever seen it before, 13 so how are you going to suspect it? 14 Q. The fact that she had five blood 15 cultures, the 17th times three, the 18th times 16 two, that were negative, that doesn't mean that 17 she wouldn't have had positive blood cultures on 18 the 19th to the 24th, correct? 19 A. True. That's why I do them, because 20 you don't know. 21 Q. Because of the fact that they didn't 22 do blood cultures on the 19th through the 24th, 23 we don't know what the blood cultures would have 24 shown? 25 A. We don't, and how would we have</p>	<p style="text-align: right;">Page 103</p> <p>1 hospital and the conclusion was that she had an 2 infection, would you have gone back in and 3 removed the homograft? 4 A. I never would have suspected that it 5 was infected because I had never heard of it 6 before. 7 Q. What recommendations would you have 8 made from a cardiothoracic standpoint if in fact 9 all the parameters indicated that the patient 10 had an infection and may have a mediastinal 11 infection? 12 MR. MEADOWS: Objection. 13 A. I don't know. It's pure 14 supposition. 15 Q. Would you have at least considered, 16 with evidence suggesting a mediastinal 17 infection, would you have at least considered 18 going back in and reexploring the area from the 19 homograft? 20 MR. MEADOWS: Objection. 21 A. I don't know, but I doubt it since 22 I've never heard of it, I've never read of it, 23 and I've never heard anybody talk about it. 24 Q. Do you have an opinion as to when 25 the proximal right coronary artery occluded?</p>
<p style="text-align: right;">Page 102</p> <p>1 known to suspect an aortic infection when no one 2 has ever seen one before? 3 Q. Do you have to automatically 4 conclude that it's an aortic infection to be 5 able to -- strike that. 6 A. That's what it says. 7 Q. I understand that, but if this 8 patient had been operated on by you twice on the 9 14th, she had increased heart-lung time, so she 10 was at increased risk of infection? 11 A. She did. 12 Q. Right? 13 A. Right. 14 Q. And if she has signs and symptoms at 15 least that are suggestive of an infection, what 16 you're saying is that the only way to treat this 17 patient would have been to go back in and to 18 remove the homograft? 19 A. Yes. 20 Q. Had you been consulted, 21 hypothetically the patient had been kept in the 22 hospital because there was a concern about an 23 infection, additional blood cultures were done, 24 cultures were taken on the thoracentesis and 25 there was reason to keep the patient in the</p>	<p style="text-align: right;">Page 104</p> <p>1 A. No. 2 Q. Do you have an opinion as to when 3 the left main coronary artery occluded? 4 A. Yes. 5 Q. When? 6 A. Right at the operating table. We 7 talked about that. 8 Q. What is cardiac tamponade? 9 A. It's a hemodynamic state caused by 10 fluid surrounding the heart allowing the heart 11 not to fill. 12 Q. You see in the autopsy that one of 13 the findings on the patient was cardiac 14 tamponade? 15 A. It's hard to make from an autopsy. 16 It's a physiologic finding. 17 Q. Would you take issue with the 18 autopsy as it related to cardiac tamponade? 19 A. I don't know how you can make that 20 diagnosis from an autopsy. 21 Q. I take it then you would take issue 22 with it? 23 A. I'd say I don't know how you would 24 do it. 25 Q. Do you have an opinion, Doctor, as</p>

<p style="text-align: right;">Page 105</p> <p>1 to what caused her necrotizing bacterial 2 aortitis? 3 A. I don't know what caused it. 4 Q. Do you have an opinion as to what 5 the cause of her death was? 6 A. I don't know. 7 Q. On autopsy the fact that there was a 8 rupture of the aorta measuring 4-by-3 9 millimeters with 1,000 cc's of blood removed in 10 the ER, aren't those findings clinically 11 consistent with a patient having cardiac 12 tamponade? 13 A. It's possible that it caused cardiac 14 tamponade. 15 Q. Do you know whether the microscopic 16 results from the Cleveland Clinic substantiate 17 that Laura Adams died of infection? 18 A. I don't know whether they do or not. 19 I haven't seen the microscopic results. 20 Q. The healing myocardial infarction at 21 the apex of the heart, I think it says it was 22 over ten days old? 23 A. Yes. 24 Q. Do you believe that that myocardial 25 infarction was at the time of the first surgery?</p>	<p style="text-align: right;">Page 107</p> <p>1 A. Lowest risk. 2 Q. What is the incidence of an 3 infection in a homograft? 4 A. I don't know. 5 Q. It's in the literature; is it not? 6 A. I'm sure it is someplace. 7 Q. You are just not familiar with it 8 off the top of your head? 9 A. No. 10 Q. If it had been determined by you or 11 someone else while still in the hospital that 12 she had an infected homograft, would surgical 13 intervention have been the first approach, or 14 would antibiotic treatment have been the first 15 approach? 16 A. I'm not sure I can answer the 17 question. I don't know. 18 Q. Because you've not encountered it? 19 A. I've not encountered it, I have no 20 experience with it, and I'm not aware of any 21 literature about it. 22 Q. If Laura had not ruptured at the 23 aortic arch and if she had not developed 24 necrotizing bacterial aortitis, in other words, 25 had she not died on January 28th, do you have an</p>
<p style="text-align: right;">Page 106</p> <p>1 A. Yes. 2 Q. So this is what likely occurred at 3 the time that she required the -- 4 A. Bypass grafts. 5 Q. -- bypass grafts, okay. If an 6 aortic homograft is infected at the time of 7 implantation, what is the probability of a 8 patient having a rupture of the necrotic aortic 9 arch ten days after the implantation? 10 A. I have no idea. 11 Q. Do you know back in 1999 whether the 12 Cleveland Clinic was having any increased 13 incidence of infection with regard to aortic 14 valve replacement? 15 A. I do have an idea. 16 Q. What is that? 17 A. No. 18 Q. How do you know that? 19 A. I remember we did do regular 20 bacteriologic cultures and monitoring. 21 Q. Are homografts by definition 22 immune -- perhaps that's a poor use of the term 23 -- from becoming infected? 24 A. No. 25 Q. They are basically lower risk?</p>	<p style="text-align: right;">Page 108</p> <p>1 opinion to a probability as to what her life 2 expectancy would have been? 3 A. It wouldn't have been normal. 4 Q. Normal nowadays is early 80s for 5 Caucasian women? 6 A. Yes. 7 Q. Hers would have been reduced by what 8 percent? 9 A. I don't know. 10 Q. What is your best probability? 11 A. I don't have a guess. 12 Q. Would she have lived into her 70s? 13 A. I don't know. 14 MR. MEADOWS: Objection. 15 Q. Can you state whether she would have 16 lived into her 60s? 17 A. I don't know. 18 Q. All you can say is that she just 19 would not have had a normal life expectancy? 20 A. I can say that pretty definitely. 21 Q. You can't rule out that she would 22 have lived into her 50s or 60s, true? 23 MR. MEADOWS: Objection. 24 A. Yes. I can also tell you that 25 people who don't have any infections and don't</p>

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1 have any complications of their aortic valve
2 have sudden death in the first year after their
3 aortic valve replacement with some regularity.
4 Q. What is the percentage of that?
5 A. I can get that for you, but I don't
6 have that with me.
7 Q. With regard to the cause of death,
8 do you have any opinions that you have not
9 shared with me?
10 A. No.
11 Q. With regard to the justification or
12 the appropriateness of discharging this patient,
13 either to go back to Connecticut or to stay in
14 Cleveland on an outpatient basis for a period of
15 time, are there any other opinions that you have
16 that you've not shared with me?
17 A. No.
18 Q. In terms of the two surgeries, the
19 surgery that you performed and then the second
20 surgery that you may or may not have been
21 involved in, are there any other aspects in
22 terms of complications that developed that we
23 have not talked about?
24 A. No.
25 Q. In terms of discussing the case with

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1 the public?
2 A. No, they are not.
3 Q. So if I wanted, for example, number
4 21, minimally invasive aortic valve surgery, or
5 24, minimally invasive valve surgery involving
6 two valves, I would have to ask you and then
7 hope that you would provide it to me, correct?
8 A. Correct.
9 Q. Are these lengthy videos?
10 A. Very long, a day or two.
11 Q. Seriously?
12 A. Uh-huh.
13 Q. Are you being serious with me, or
14 are you joking?
15 A. I'm joking. They're about eight
16 minutes.
17 Q. Are they maintained here at the
18 hospital?
19 A. Yes.
20 Q. Are they for teaching purposes?
21 A. Yes.
22 Q. I will follow up with a letter to
23 you requesting that. You also have a patent on
24 minimally invasive cardiac surgery procedures?
25 A. I do.

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1 Dr. Rattlife or anyone else as it relates to
2 opinions on standard of care or causation
3 issues, other than discussing matters with your
4 attorneys, have you shared with me all the
5 information that you have or have discussed with
6 others?
7 A. Yes. I haven't discussed it with
8 anybody else.
9 Q. All right. Doctor, let's take just
10 a minute break.
11 (Brief recess.)
12 Q. In your CV, Doctor, there's
13 reference to movies. Where would one obtain
14 those movies?
15 A. You'd probably have to ask me for
16 them.
17 Q. Specifically, they're on page 14,
18 the movie bibliography. Are these available at
19 a retail level, or can they be purchased
20 anywhere?
21 A. It's about \$500,000 for you. That's
22 a special deal. Usually, it's for a million.
23 Q. How about if I pay in cash.
24 A. I'll give it to you for 499.
25 Q. Seriously, are they not available to

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1 Q. Does that have anything to do with
2 aortic valve replacement?
3 A. Uh-huh.
4 Q. That's a yes?
5 A. Yes.
6 Q. Who is the patent with?
7 A. The Cleveland Clinic owns the
8 patent.
9 Q. You receive some type of royalty?
10 MR. MEADOWS: Objection. Don't
11 answer that.
12 MR. MISHKIND: Let me finish first.
13 MR. MEADOWS: He's not getting into
14 any kind of compensation he receives off the
15 patent or anything else.
16 MR. MISHKIND: Let me finish the
17 question, and then you can instruct him not to
18 answer.
19 MR. MEADOWS: Go ahead. I see where
20 it's going.
21 MR. MISHKIND: At least for
22 somebody's edification, I have to finish my
23 question.
24 MR. MEADOWS: Go ahead.
25 Q. Do you receive any type of

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1 remuneration as it relates to the patent that is
2 referenced on page 14 for minimally invasive
3 cardiac surgery procedures?
4 MR. MEADOWS: Objection. Don't
5 answer that.
6 MR. MISHKIND: Just for the record,
7 the basis for your objection?
8 MR. MEADOWS: It has got absolutely
9 nothing to do with this lawsuit, and I think
10 it's proprietary and certainly is not even
11 reasonably calculated to lead to admissible
12 evidence.
13 MR. MISHKIND: I think it certainly
14 can depending upon what is contained in there
15 and what financial interest he has.
16 MR. MEADOWS: No.
17 MR. MISHKIND: Suffice it to say, I
18 disagree with you. I think it is calculated to
19 lead to discovery of admissible evidence, but I
20 understand that you're instructing him not to
21 answer, so we'll move on.
22 Q. Doctor, the last question for you,
23 and then your five minutes are up. Your
24 residents who dictate the operative reports, how
25 soon are they to be dictated?

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1 A. No. We beat the boys up, and
2 sometimes they don't always behave.
3 Q. But in this situation, this was not
4 in compliance with Cleveland Clinic protocol,
5 correct?
6 A. That's the department's protocol.
7 Q. And it was not in compliance with
8 it, true?
9 A. Right.
10 MR. MISHKIND: Thanks, Doctor. No
11 further questions.
12 MR. MEADOWS: We're going to read
13 it. 28 days?
14 MR. MISHKIND: I didn't say that,
15 but if you ask nicely, I will.
16 -----
17 (Deposition concluded at 10:20 a.m.
18 (Signature not waived.)
19 -----
20
21
22
23
24
25

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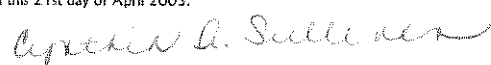
1 A. They are supposed to be dictated in
2 24 to 48 hours.
3 Q. Is that standard protocol here at
4 the hospital?
5 A. That's what we tell them to do.
6 They don't always behave.
7 Q. Do you have any explanation in this
8 case as to why the surgical report, second
9 surgical report which you may or may not have
10 been present for, was not dictated until the day
11 after Laura Adams died?
12 A. No.
13 Q. Has anyone ever explained to you
14 why?
15 A. I never noticed it before. I was
16 not aware of it.
17 Q. The fact that it was dictated 15
18 days later and a day after her death, you have
19 no knowledge as to that?
20 A. Right.
21 Q. It certainly should have been
22 dictated sooner, correct?
23 A. It should have.
24 Q. That's not in keeping with the
25 procedures at the hospital, true?

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1 AFFIDAVIT
2 I have read the foregoing transcript from
3 page 1 through 115 and note the following
4 corrections:
5 PAGE LINE REQUESTED CHANGE
6
7
8
9
10
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12
13
14
15
16
17
18
19
20 Subscribed and sworn to before me this
21 _____ day of _____, 2002.
22
23
24 _____
25 My commission expires _____.
Notary Public

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CERTIFICATE

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2
3 State of Ohio,)
4) SS:
5 County of Cuyahoga.)
6
7
8
9 I, Cynthia A. Sullivan, a Notary Public
within and for the State of Ohio, duly
10 commissioned and qualified, do hereby certify
that the within named DELOS M. COSGROVE, III,
11 M.D. was by me first duly sworn to testify to
the truth, the whole truth and nothing but the
12 truth in the cause aforesaid; that the testimony
as above set forth was by me reduced to
13 stenotypy, afterwards transcribed, and that the
foregoing is a true and correct transcription of
14 the testimony.
15 I do further certify that this deposition
was taken at the time and place specified and
16 was completed without adjournment; that I am not
a relative or attorney for either party or
17 otherwise interested in the event of this
action. I am not, nor is the court reporting
18 firm with which I am affiliated, under a
contract as defined in Civil Rule 28(D).
19
20 IN WITNESS WHEREOF, I have hereunto set my
hand and affixed my seal of office at Cleveland,
Ohio, on this 21st day of April 2003.
21
22 
23
24 Cynthia A. Sullivan, Notary Public
Within and for the State of Ohio
25
My commission expires October 6, 2006.

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6 Plaintiff's Deposition Exhibit 1 was marked. . . .3:20
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