THE STATE of OHIO, :
: SS:
COUNTY OF LORAIN. :

Scanned

DOC 137

- - - - -

IN THE COURT OF COMMON PLEAS

- - - - -

LENORE LIND, et al.,
plaintiffs,

vs. : Case No. 93CV110798

COMPREHENSIVE HEALTH CARE of OHIO, INC., et al.,
defendants.

- - - - -

Deposition of ANTHONY DiMARCO, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, Registered Professional Reporter, Certified Legal Video Specialist, Notary Public within and for the State of Ohio, taken at the offices of Reminger & Reminger, The 113 Saint Clair Building, Cleveland, Ohio, taken on TUESDAY, JANUARY 30, 1995, commencing at 4:15 p.m. pursuant to notice.

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

Charles Kampinski, Esq.
Christopher M. Mellino, Esq.
Charles Kampinski Co., L.P.A.
1530 Standard Building
Cleveland, Ohio 44113,
(216) 781-4110
and
Gerald R. Horning, Esq.
1419 W. 9th Street
Cleveland, Ohio 44113.
(216) 241-2258.

ON BEHALF OF THE DEFENDANT COMPREHENSIVE HEALTH CARE of OHIO, INC./ELYRIA MEMORIAL HOSPITAL:

Joseph Feltes, Esq.
Buckingham, Doolittle & Burroughs
624 Market Avenue N
Canton, Ohio 44702
(216) 456-2491.

APPEARANCES: (continued)

ON BEHALF OF THE DEFENDANTS DAVID BRANCH, M.D.; and ACUTE CARE SPECIALISTS, INC.:

Burt J. Fulton, Esq.
Gallagher, Sharp, Fulton & Norman
Seventh Floor Bulkley Building
Cleveland, Ohio 44114.
(216) 241-5310

ON BEHALF OF THE DEFENDANT HARINATHROA DACHA, M.D.:

John P. Gallagher, Esq.
Fauver, Tattersall & Gallagher
400 Premier Building
Elyria, Ohio 44035
(216) 322-3784.

ON BEHALF OF THE DEFENDANT ROMEO MICLAT, M.D.:

Robert G. Quandt, Esq.
Quandt, Giffels & Buck
800 Leader Building
Cleveland, Ohio 44114.
(216) 241-2025.

APPEARANCES: (continued)

ON BEHALF OF THE DEFENDANT PARESH PATEL, M.D.:

Robert F. Orth, Esq.
1500 One Cascade Plaza
Akron, Ohio 44308
(216) 434-3000

ON BEHALF OF THE DEFENDANT DINUBHAI C. PATEL, M.D.:

John R. Scott, Esq.
Reminger & Reminger
The 113 Saint Clair Building
Cleveland, Ohio 44114-1273
(216) 687-1311.

I N D E X

WITNESS: **ANTHONY DiMARCO, M.D.**

(FOR EVERY WORD INDEX, SEE APPENDIX)

ANTHONY DiMARCO, M.D.

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

- - - - -

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your name, please?

A. Anthony DiMarco.

Q. Doctor, do you have a CV, sir?

A. I do.

Q. Can I see it?

Is this up-to-date?

A. Yes.

Q. Are those copies for me?

A. Yes, you can have that.

Q. Where are you currently employed, Doctor?

A. I have a private practice in addition to being employed part time at MetroHealth Medical Center.

Q. What is the name of your private practice?

A. Just my private practice I have. My own name.

Q. Where is the practice located?
A. In Geauga County.
Q. And the address?
A. 13346 Ravenna Road, Chardon.
Q. Is there anyone in practice with you?
A, No.
Q. What is the nature of your practice?
A. Pulmonary medicine.
Q. How long have you been in private practice at that location?
A. Let's see, 11 years.
Q. I'm sorry. You said you had a part time --
A. I am employed by MetroHealth Medical Center.
Q. What do you do for them?
A, I'm involved in teaching, research, and also I see patients at that hospital also.
Q. How often do you teach?
A. Daily.
Q. Is it didactic?
A. It is -- well, most teaching is informal with residents and interns, and also didactic teaching at the medical school,
Q. Beg your pardon? Didactic --
A. I have didactic teaching at the medical school and also at the hospital.

Q. You say the medical school?
A. Case Western Reserve.
Q. How often do you teach there?
A. I teach there approximately one month a year.
Q. Is this in a classroom --
A. Yes.
Q. -- the entire month?
A. The entire month, yes.
Q. What do you teach?
A. Pulmonary medicine to first year medical students.
Q. During that month are you also involved in your private practice?
A. Yes.
Q. So how many days a week would you teach?
A, During that month long period I am involved probably two to three hours per day.
Q. Five days a week or --
A. Between three and five days a week.
Q. Is it the same month every year or does it change?
A, Approximately the same.
Q. When is that?
A. Usually November.

Q. What books do you use in conjunction with your didactic teaching at the school?
A. We use Berne and Levy.
Q. Berne did you --
A, B-e-r-n-e and Levy, general physiology textbook,
Q. Is that the name of the book or is that the description of the book?
A, The exact name I don't recall. It's just a general physiology textbook.
Also Pulmonary Physiology by John West.
Q. Okay.
A. Just those two textbooks.
Q. What does your research consist of at MetroHealth?
A. I am involved in the study of respiratory muscles, respiratory muscle physiology, and various forms of lung disease.
Q. And you also said that you are involved in patient care at Metro?
A. Yes.
Q. Would these be private patients of yours or staff patients of Metro; how is it that you see patients?

A. The private practice of my own, and I also cover the medical intensive care unit, which are staffed patients; and I am involved in that two or three months of the year depending upon the year, in which I am the attending physician and I see all the patients in the night in the intensive care unit.

Q. Is that a rotating position?

A. Yes.

Q. Between you and other physicians?

A. Other pulmonary physicians, yes.

Q. So two or three months out of the year you cover the I.C.U.?

A. Yes.

Q. As the attending for all the patients in the I.C.U.?

A. Yes.

Q. Or as an attending for those having pulmonary problems?

A. All the patients in I.C.U.

Q. Are you an employee of MetroHealth for purposes of this teaching, research, and clinical care?

A. Yes.

Q. Are you also an employee of Case Western?

A. No.
Q. So how is it that you teach at Case Western Reserve, is this through your affiliation with Metro?
A. MetroHealth Medical Medical Center is an affiliate of the university.
Q. So as part of your job at Metro you teach at Case?
A. Yes.
Q. Have you acted as an expert in any case prior to this one?
A. Yes, I have.
Q. Could you tell me for whom, name of the case, and what it involved?
A. Involved several cases, most of them involve industrial related accidents, so I do some work evaluating patients for the Industrial Commission of Ohio and I am probably involved in -- I see patients approximately once or twice a month for them at MetroHealth Medical Center and I've given --
Q. Are you employed by them or is this --
A. No.
Q. -- a contract type of job?
A. I get referrals from them.

Q. In other words, if they have a case involving a claim for pulmonary disability --
A. Yes.
Q. -- they would call you and ask you to evaluate it on their behalf?
A. Yes.
Q. That happens approximately once or twice a month?
A. Yes.
Q. I'm sorry. Go ahead.
A. And in term of serving as an expert witness, approximately once or twice a year I'm called upon to give a deposition in relation to those cases.
Q. How about malpractice cases, have you ever served as an expert in a medical malpractice case?
A. Yes.
Q. Would you tell us about those?
A. One case earlier this year, that was the only case, other case in the past 12 months.
Q. You say this year?
A. '94, only other case in 1994; that involved a decision by a pulmonologist concerning evaluation of a patient with pulmonary embolism.
Q. For whom were you the expert?
A. For the defendant.

Q. Who was the defendant?
A, I don't recall the name,
Q. Who retained you?
A. An attorney at PIE Mutual, I don't know his name either.
Q. Do you recall the name of the plaintiff, the name of the case?
A. I believe it was Ragan, R-a-g-a-n.
Q. Were you deposed in that case?
A. No, I was not.
Q. Did the case go to trial?
A. I don't know,
Q. When you say you acted as expert in '94, is it that you were retained in '94 to review the case?
A. Yes.
Q. What was your involvement?
A. I was retained to review the case and submit a report.
Q. How long have you been or have you acted as an expert in medical malpractice cases?
A. I'm not sure what you mean how long.
Q. When did you start doing it, are you talking five, ten years, 15?
A. Very first case I reviewed was in I believe

1985.
Q. So ten years?
A. Off and on.
Q. How many cases have you reviewed in that ten years, medical malpractice?
A. I would say approximately four or five.
Q. Do you remember the names of them?
A. No.
Q. Can you remember when you were retained?
A. No.
Q. Have you testified on behalf of the defendant in all of them?
A. No.
Q. Do you remember the allegations in them?
A. I remember the allegation in the first one.
Q. Okay, what was that?
A. That was that a physician failed to diagnose a pulmonary disorder,
Q. What was the disorder?
A. My recollection is that it was pulmonary embolism or pulmonary infection possibly.
Q. Who were you retained by in that?
A. The plaintiff.
Q. Who was that?
A. I don't recall.

Q. Did you testify in that case?
A, Yes, I did.
Q. What was the name of the case?
A, I don't recall.
Q. Where did you testify, here in Cleveland?
A. It was not in Cleveland, it was in the State of Ohio but not in Cleveland.
Q. You don't remember where in Ohio?
A. I don't recall,
Q. How about any of the other cases, do you remember anything about them?
A. I believe another case related to the diagnosis of pulmonary embolism, but I don't remember the specifics or the name of the parties involved.
Q. How long ago was that?
A. Five or six years ago,
Q. Who retained you in that case?
A. I don't recall.
Q. Were you deposed?
A, No.
Q. Did you go to trial?
A, No, never been to trial on any of these cases.
Q. Have you ever been retained by Reminger &

Reminger?
A. Yes.
Q. When was that?
A. It was either 1993 or 1994.
Q. That's the only time?
A. That was the only time,
Q. Who retained you?
A. Which attorney do you mean?
Q. Yes.
A. May have been Mr. Scott, but I'm not certain.
Q. What was the nature of the case?
A. Involved an outpatient test done at a hospital in Cleveland where there was an injury to a patient during the performance of a blood test, and a needle was inserted to obtain blood for a blood gas, and there was resultant nerve injury.
Q. What was the name of the case?
A. I don't recall.
Q. Is it still pending?
A. No, it's not.
Q. Did you testify in that case?
A. No, I did not.
Q. Were you deposed?
A, No.
Q. Do you remember the name of the case?

A. I don't,
Q. Any others that you recall?
A. No others come to mind. I haven't been deposed in any others.
Q. When were you first contacted in this case?
A. By phone I was contacted in September of 1994 and that was followed by a letter from Mr. Scott.
Q. And you are looking at that now?
A. Yes.
Q. Can I see it?
A, Yes.
Q. Are there other letters from Mr. Scott?
A. There is one other.
Q. In the September 21st letter to you from Mr. Scott he lists 19 items that he forwarded to you, and then in the January 9th letter, which I guess was yesterday, he indicates that he forwarded the deposition transcript of Dr. Ferguson to you; did you receive any other materials in this case other than those listed and these two letters?
A. Yes. I also received an expert report from Dr. Larry Martin.
Q. When did you get that?
A. I believe it was four to six weeks ago.
Q. How was that delivered?

A. By mail.
Q. With no forwarding letter?
A. If there was, I may have misplaced it.
Q. Anything else that you received?
A. No.
Q. You wrote a report October 27th, 1994, correct?
A. That's correct.
Q. It is not on letterhead, it's on plain stationery; is there a reason for that?
A. There is no reason for that. Ordinarily my -- I have a new secretary at my Geauga office where I dictated this and reviewed the case, and ordinarily it would be on stationery at that hospital.
Q. I'm sorry?
A, Ordinarily it would be on my own private stationery.
Q. Was this the only report that you authored?
A. This is the only report, yes,
Q. Did you prepare any drafts of that report?
A. Yes.
Q. Were they changed?
A. There were typographical changes made, and nothing in terms of content.

Q. What happened to the drafts?
A. They were discarded.
Q. By whom?
A. By myself.
Q. Were they submitted to Mr. Scott either verbally or in writing?
A. One earlier draft was submitted and then a final version was submitted.
Q. Did he have input into the changes?
A. No, he did not,
Q. Well, how is it that you gave him a draft and then it was changed?
A. Because he explained that he had a deadline to meet and I also -- also was pressed for time. At that point I gave him the draft that -- the last draft that I had at that point, and then I made some small changes, mostly typographical changes, and sent him that final version.
Q. What about the not mostly typographical changes, what substantive changes did you make?
A. There were no substantive changes.
Q. Do you have a copy of the draft?
A. I don't have that here.
Q. Where do you have it?
A. I believe that was sent to Mr. Scott and I

may have a copy of that at my office.
Q. Is there a reason you didn't bring it?
A. No, there's not. I think that I looked at this, at the final copy, this was the basis for my review.
MR. KAMPINSKI: Well, can we have an agreement that he'll provide me with a copy of the draft?
MR. SCOTT: Sure.
Q. Is there more than one draft?
A. No, there is not.
Q. Is there anything else that you have that pertains to this case that you didn't bring with you, bring with you today?
A. I have binders similar to these that contain all the information related to these documents that I didn't bring,
Q. When you say similar to these, obviously the record can't reflect what you're pointing to.
There are black binders on the table that --
A. These are not mine.
Q. The only thing that you brought -- what did you bring with you?
A. Everything I brought is contained in this

folder, which you have seen.
Q. The two letters from Mr. Scott and your report?
A. And my report.
Q. Were you told not to bring anything else?
A. No, I was not.
MR. KAMPINSKI: Frank, why don't you mark the whole thing.

(Dr. DiMarco Deposition Exhibits 1 through 4 marked for identification.)

Q. Doctor, I've marked Exhibits 1 through 4.
A. Okay.
Q. And those constitute all of the documents we just referred to that. you brought, correct?
A. That's correct.
A. Have you had an opportunity to read the deposition of Dr. --
MR. MELLINQ: Ferguson.
Q. __ Ferguson?
A. Yes, I did.
Q. You read that last night, presumably or yesterday?
A. Sometime yesterday.

Q. Do you have any opinions with respect to the care rendered by Dr. Dacha to Mrs. Lind in this case?

A. I reviewed the case with Dr. D.C. Patel in mind, so I concentrated my efforts really on the time period that he was involved, so I didn't review the case in detail with respect to Dr. Dacha's care.

From the portion I read, though, I found that the care provided based upon my review to be consistent with accepted medical standards.

Q. Well, there's portions that you didn't review?

A, Yes, I didn't review portions beyond the -- I believe May 10th on through the remainder of the hospitalization.

Q. So you think it was good medical care to extubate Mrs. Lind?

A. Yes.

Q. Do you think it's good medical care for him to send her back to CAT scan without protecting her airway?

A. Yes.

Q. Have you ever been sued?

A. Yes, I have.

Q. How many times?

MR. SCOTT: Objection, You may answer, Doctor,

A. Three times.

Q. What were the names of the cases?

MR. SCOTT: Continuing objection.

A. One case the last name was Thompson.

Q. When was that?

A. That was in 1994.

Q. What was that for?

A. That related to care provided by a hematologist in failing to diagnose hematologic disorder.

Q. What was the disorder?

A. TTP, which is thrombotic thrombocytopenia purpura.

Q. Why were you sued?

MR. SCOTT: Objection.

A. I was named as a co-defendant, I was involved in treating the patient for pneumonia.

Q. How were you treating the patient?

A. I was treating with antibiotics; and in fact, the pneumonia had cleared and I stopped seeing the patient prior to the catastrophe associated with

this disorder.
Q. Who was plaintiff's attorney?
A. I'm sorry?
Q. Who was the plaintiff's attorney?
A. I don't recall.
Q. Where was the suit filed?
A. In Cleveland.
Q. Still pending?
A. Pes.
Q. Who is representing you?
A. PIE Mutual.
Q. How long have you been insured by PIE?
A. Since 1981.
Q. How about the other cases?
MR. SCOTT: Continuing objection.
A, I don't recall the names of either case. I can tell you the details of the case.
Q. They were both filed here in Cleveland?
A. One was in Cleveland, one was in Chardon.
Q. Do you remember the names of the attorneys?
A. No, I don't.
Q. When were they?
A. One case was approximately four years ago.
Q. Which was the one --

A. The one in Cleveland.
Q. And the other one?
A. The other one approximately ten years ago, that was in Chardon,
Q. What were these about?
A, The first case in 1995 --
MR. SCOTT: Objection.
A. -- related to --
Q. 1995?
A. I'm sorry, 1985.
-- related to an elderly gentleman who was approximately 75 years old, suffered a stroke, heart attack, pneumonia, respiratory failure, and had diabetes, who had a prolonged hospitalization and died during that hospitalization; and the lawsuit regarded cause of death, whether or not it was a wrongful death or not.
Q. How did this suit turn out?
A. The case was dropped,
Q. What was your involvement in that case?
A. I was the attending physician of this patient.
Q. How about the one in Cleveland?
A. That one in Cleveland involved a diabetic

patient who was undergoing a GI procedure and during that procedure suffered an arrest and subsequently died as a consequence of that.

Q. What was your involvement?

A. I was the attending physician in that case and the GI procedure was done prior to my seeing the patient, so the arrest took place prior to my seeing the patient.

Q. What was the result of that case?

A. The -- all charges were dropped against myself and I am not certain about the involvement of the other physicians.

Q. Did you testify in any of these cases?

A. No.

Q. Either by way of deposition or at trial?

A. No.

Q. Do you know any of the physicians that were involved in the care of Mrs. Lind?

A. No, I don't.

Q. Do you have any opinions with respect to the care rendered by the nurses in the case, specifically the administration of Demerol.

A. Based upon my reading the report, the order by Dr. Dacha was %hat no sedatives or analgesics be given to this patient, and the patient received

this, I suspect, inadvertently by the nurse, so in that sense there was an error made,

Q. Well, is that negligence, Doctor?

MR. FELTES: Objection.

Q. Failure of a nurse to follow doctor's orders?

MR. FELTES: Objection.

A. Failure to follow doctor's orders is a mistake.

Q. Well, I don't know if you're making a distinction from what I said or if you are not,

Can you not bring yourself to say the word or --

A. I'm not sure if negligence has more than one meaning. My intention was to say it was a mistake, if you want to group that as negligence, fine; but I just call it a mistake.

Q. We're in agreement that the Demerol should not have been given?

A. I'm not certain of that.

Q. No? You are not?

A. Well, let me explain.

The orders stipulated that a drug such as that not be given, and I was of the opinion that it was from the physician who was in charge; so in that sense it was an error.

In the sense as to whether or not the patient at that moment in time would have benefited from receiving that drug is another question.

Based upon the report, the patient had considerable discomfort and pain and would have benefited from an analgesic agent. So from the standpoint of it being given, was that judgment itself a mistake, I'm not certain.

Q. I'm not trying to be argumentative, but I don't know what you just said.

If a physician had given an order not to give a sedative, should Demerol be given?

MR. FELTES: Objection.

A. It should not have been given if the order was not to give it.

Q. So we're in agreement?

A, We're in agreement about that.

Q. Did her condition in your opinion get worse after the administration of the Demerol?

A. No, I don't believe so.

Q. Did it get better?

A. No, it did not.

Q. Did she have a respiratory arrest after that?

A. She had an arrest, I don't know if the

primary etiology was respiratory or not.
Q. What do you think the primary etiology was?
A. I'm not certain.
Q. What do you think it probably was?
A. Well, probably a cardiopulmonary arrest. She had multiple medical problems going on at that time including an infection, etiology which was not clear; she was in renal failure and had a subsequent metabolic acidosis as a result of that; she was in some respiratory distress and had high respiratory rates as a consequence of that; and she was an obese lady who was -- that also puts some increase work load on her cardiopulmonary status, all these factors together I think lead to the arrest situation.
Q. I'm sorry. Go ahead.
A. In terms of defining it as a specific respiratory arrest as opposed to a cardiopulmonary arrest, where the primary disease process may have been something other than respiratory, is unclear to me.
Q. Well, what did the physicians label it as after she had an arrest, respiratory arrest or cardiopulmonary arrest3
A. I saw cardiopulmonary arrest written and also

saw respiratory arrest written,
Q. You don't have an opinion as to which it was?
A. Based upon the vital signs and the description of the case, in my opinion it was cardiopulmonary arrest.
Q. Which vital signs?
A. I'm sorry?
Q. What is it you base that on specifically?
A. The patient had problems maintaining a normal blood pressure, her blood pressure was low on May 7th.
Q. Yes.
A. Indicating that there were factors other than respiratory that were causing some of these problems. So I think it is with -- it is more than just a primary pulmonary respiratory process,
Q. Anything else other than low blood pressure?
A. She also had abdominal pain and she had abdominal findings which also pointed to a nonrespiratory cause,
Q. What was the cause of her abdominal pain?
A. I don't know that.
Q. I mean, you reviewed the record, haven't you?
A. I have reviewed the record.
Q. That didn't lead you to reach a conclusion as

to what the cause of her pain was?
A. No, it did not.
Q. Was there some intra-abdominal process that was causing it?
A, It's likely there was some intra-abdominal process causing it, yes.
Q. What was that?
A, I don't know.
Q. Were there tests done to determine --
A. There were tests done to attempt to evaluate the cause of it, yes.
Q. What did they show?
A. The CAT scan did not define a specific abnormality, and the HIDA scan I believe was incomplete.
Q. Well, she had surgery later on?
A. She did have surgery.
Q. What did that show?
A. To my knowledge they didn't find any specific abnormality.
Q. Well, so once again, the question was what was causing her abdominal pain?
MR. SCOTT: Objection. Asked and answered,
A. I don't know.

MR. SCOTT: He said he doesn't know.

Q. Did she have a bowel movement on the 7th?

A. I believe she did.

Q. Was that a cause of her pain?

MR. SCOTT: Objection.

A. That may have been responsible for some portion of her pain,

Q. If I understand correctly, you're telling me that her blood pressure was low before her arrest, which is what is leading you to conclude that it was a cardiopulmonary arrest, correct?

A. In part, yes.

Q. What else?

A. Well, she had a metabolic acidosis.

Q. How was that -- what is it that leads you to believe she had a metabolic acidosis?

A. The pH in the blood that was determined by arterial blood gases was low.

Q. Which blood gas are you referring to that --

A. The one performed on May 7th.

Q. What time?

A. I don't recall the time.

Q. Why don't you look at the chart then?

A, Okay, let's pull the chart,

Q. While you're looking for that, is there a reason, by the way, that none of this is set forth in your report?

A. I was asked to review the specific care provided by Dr. Patel in terms of the standard of care provided.

Q. Okay.

A. And I believe I addressed those issues.

Q. I see. So that you believe as a pulmonologist you're --

MR. **SCOTT:** Objection. I'd like follow your questioning. If you're going to continue, I'll just put these down. Can we do it that way. I don't want to be searching for this while you're asking another question,

MR. KAMPINSKI: Do it any way you want, Mr. Scott.

MR. SCOTT: Okay. Do you want to finish up your question.

Q. So that you don't have any difficulty as a pulmonologist in rendering an opinion with respect to the care of Dr. Dacha, who is the pulmonologist, right?

A. Well, I didn't review the case --

Q. I understand, but you don't have a problem

doing that, that's within your specialty, right?
A. Well, as I said, I didn't review the entire case with that in mind.
As a pulmonologist I feel competent to review the care provided by another pulmonologist.
Q. And obviously you feel competent to review the case on behalf of Dr, D.C. Patel, who was a gastroenterologist, correct?
A. Insomuch as the care provided in this case, yes.
Q. How about any opinions with respect to Dr. P. Patel, do you have a problem rendering opinions as to his care?
A. Well, I am not a surgeon, I would have some difficulty.
Q. That's a fair answer. Let me qualify the question.
A. Okay.
Q. In the context of his meeting with the other physicians and recommending the CT scan?
A. In that capacity I agree with -- I agree with his decision.
Q. And that would also be true then with respect to Dr. Miclat, right?

A. In terms of that decision, yes.
Q. How about with respect to the care rendered by the emergency room physicians?
A. I didn't review that in great detail, so I can't really form at this -- give you an opinion about that,
Q. Did you review it at all?
A. I did very briefly,
Q. Do you have any opinion with respect to their care?
A, No.
MR. FULTON: He just said he can't give one.
MR. KAMPINSKI: Well, doesn't mean he doesn't have an opinion maybe.
MR. FULTON: That's the only thing I've heard so far in this deposition.
Q. Well, you can't give an opinion now, all right.
A, As I said before, my review centered around the care provided by Dr. Patel. He got involved several days after the patient was admitted,
Q. You were about to point out to me the arterial blood gases that led you to conclude that she had metabolic acidosis, and when you look at

these, refer to a page?

MR. SCOTT: Do you have it? Do you have it by chance, Chuck?

MR. KAMPINSKI: What?

MR. SCOTT: You just asked him about blood gases.

MR. FELTES: 333.

MR. KAMPINSKI: I don't know.

MR. SCOTT: Then we're in trouble.

A. Yes, on May 7th.

Q. What time?

A. 6:35.

Q. 6:35 a.m.?

A. Yes.

Q. Okay. What are --

A. The pH recorded is 7.28.

Q. You got me confused. Page 333?

A. 330, I have.

Q. Okay, I'm sorry. I was misled. Probably unintentional.

MR. SCOTT: Count on it.

MR. KAMPINSKI: Okay.

Q. At 6:35 the pH was 7.28?

A. Yes.

Q. That's low?
A. Yes.
Q. Is that abnormal?
A. Yes, it is.
Q. The next one is at 10:46, right, that's 7.26?
A. That's correct.
Q. That's also low?
A. Yes, it is.
Q. What does that mean with respect to the patient? I mean, is that good for her or is it bad or --
A. Well, it's a modest reduction in pH.
Q. Modest?
A. Yes.
Q. But that you're saying is evidence of metabolic acidosis?
A. Yes, it is.
Q. What does that mean, metabolic acidosis?
A. It means that there most likely is inadequate tissue perfusion or --
Q. What causes that?
MR. SCOTT: Let him finish.
A. Or there -- she's not able to eliminate the normal production of acid in her body, which can

occur with renal failure, which she had; but another possibility that contributed to this was inadequate tissue perfusion, which can result from reduction in blood pressure or even a normal blood pressure. In her case it was most likely the cause of this renal failure, though.

Q. Renal failure?

A. Yes.

Q. That's the inability of the kidneys to process --

A, To excrete the acid.

Q. Did she have metabolic acidosis before the reading on May the 7th? I guess we have to go to page 329.

A. Yes, on May 6th she also had metabolic acidosis throughout the entire day.

Q. Throughout the entire day?

A, Yes.

Q. How about on May the 5th?

A. She also did on May 5th.

Q. She did or did not?

A. She did.

Q. What time on May 5th?

A, 6:39 in the morning.

Q. The pH is not abnormal, is it?

A. No, but her pCO2, which is the number just before that, is low.
Q. That is evidence of metabolic acidosis?
A. That coupled with the -- that pH.
Q. In other words, the two combined --
A. The two together leads you to a diagnosis of metabolic acidosis.
Q. So we got a low blood pressure, we got metabolic acidosis as a result of the modest reduction in the pH, and that's what caused her cardiopulmonary arrest; that was the evidence that tells you it was a cardiopulmonary arrest as opposed to respiratory arrest?
A. Alone, that's correct.
Q. I'm sorry?
A, Those factors are consistent with some other process, that other process is what lead to this cardiopulmonary arrest,
Q. What other process is that?
A. Well, we have a number of possibilities. I don't know what the process was.
Q. Well, now you're confusing me again, sir.
You're saying this is a process that was never found or determined in Mrs. Lind?
A. Well, at least not up until the time of her

arrest.

Q. How about afterwards?

A. Well, I examined the records for several days, just several days beyond that, not more than probably four or five days, and I focused my attention on the care provided by Dr. Patel, D.C. Patel.

Q. Go ahead.

A. And so whether or not there was a determination somewhat much later in the her course, I am not certain.

In my brief review, however, in the remainder of the course they never determined etiology of an arrest.

Q. So it's a mysterious process that caused you to conclude it was a cardiopulmonary arrest?

MR. SCOTT: Objection.

A. What?

Q. There's some mysterious process that was going on in Mrs. Lind that caused you to conclude this was a cardiopulmonary arrest?

A. I wouldn't call it mysterious. I don't know what it is. If that's what you would call it. I would call it something yet to be determined. I don't know the etiology. It's unknown etiology.

Q. Was there some process in Mrs. Lind that would explain a respiratory arrest?
A. At that point in time there was no specific process to explain respiratory arrest alone, no.
Q. How about pneumonia?
A. The patient had pneumonia for -- since her admission.
Q. Yes?
A. She was in respiratory failure since her admission, up until the time she was extubated, when the tube was removed.
Q. Yes?
A. At that point in time arterial blood gases were checked and she was even, throughout all of the blood gases, even on the 7th she demonstrated she was able to maintain adequate ventilation on her own, she was not in respiratory failure; and the fact that she had pneumonia on chest x-ray by itself doesn't preclude her ability to breathe on her own, and she demonstrated that she could do that both before she was extubated, while she was on this CPP ventilation and afterwards; and her oxygenation was more than adequate. I think the PO2's were over 100 and she was appropriately handling this metabolic acidosis by

hyperventilation and dropping her pCO2 level below normal indicating that her respiratory system itself was functioning reasonably well.

Q. So you're saying the PO2's were normal; is that your testimony?

A. I didn't say normal. I said the PO2 was adequate.

Q. Wait a minute. Wait a minute.

What were her PO2's, Doctor, from the time she was extubated?

A. On the 7th on page 330.

Q. Let's start with the 6th, when she was extubated on %he 6th?

A. That's correct.

Q. Do you know what time?

A. I don't recall the exact time. I believe it was in the late morning.

Q. Well, what were her PO2's let's say throughout the 6th?

A. First one was 5:13 was 108.

Q. Is that normal?

A. I believe she was on the ventilator at that time.

Q. How about at 9:52?

A. Her PO2 then was 124.

Q. Is that good?
A. Well, it means she's adequately oxygenated.
Q. It means she's adequately oxygenated?
A. Yes.
Q. Is that normal?
A. The PO2 124 is not normal, if she's is on a substantial amount of oxygen.
Q. It's not normal, explain that to me.
A. Well, we -- normal level of PO2 conventionally is measured with room air, normal values ranging from approximately 80 to 95; and if it drops blow that level it would be abnormal, but yet you can have a low PO2 that is abnormal but yet it could not be compromising your metabolic process. You could have PO2 as low as 60, for example, and still have adequate oxygenation but have abnormal PO2's.

Now, in cases where the PO2 drops below that level, let's say, for example, it falls to 40, that would be a detrimental level of oxygenation requiring treatment, and the treatment would be additional oxygen; and during her course she was given oxygen, and the oxygen that she was given allowed her PO2 level to rise to a level that resulted in adequate oxygenation, so that the level

of oxygenation would not be threatening to her, the rest of her body,

Q. So what you're telling me is that the levels that are set forth here reflect the fact that she was receiving oxygen?

A. Yes.

Q. How much oxygen was she getting at that time, do you know?

A. Yes, it said --

Q. What blood gases are you referring? I thought we were talking about the 124 at 9:52?

A. Yes. On that day her -- she was getting 40 percent oxygen.

Q. How about the next reading then of 94?

A. She was also receiving 40 percent oxygen.

Q. Where do you see that?

A. On the far left, under test there is a notation "percent oxygen," just below s *o* 2.

Q. Okay. All right.

Then the next reading 74?

A. Right. She's on 50 percent oxygen.

Q. She they increased it?

A. Evidently.

Q. Next reading?

A. Also on 50 percent.

Q. 105?
A. Yes.
Q. Then goes up to 123?
A. Yes, 50 percent also,
Q. That one is 126?
A. Yes.
Q. Also 50 percent?
A. Yes.
Q. So then it is going up?
A. It was improving, yes.
Q. So that's getting better?
A. Yes.
Q. So the higher it goes, the better it is?
A. Yes.
Q. So if there was 1,000, that would be great?
A. That would be impossible.
Q. 500 would be pretty good?
A. Also impossible.
Q. How high could you get it?
A. Well, a normal level of PO2 on 50 percent oxygen would be a range of some number over 200.
Q. So it was actually low then?
A. This is abnormal, but it was providing adequate oxygenation to her.
Q. Well, **how do** you **know it was providing**

adequate oxygenation if it was -- if it should have been over 200 and it was 1263

A. Well, we know that the body's stores of oxygen have a certain capacity, and we have a PO2 that's over 65 or 70, you achieve the maximum amount of oxygen content in the blood, and so the PO2 of 123 shows she was adequately oxygenated.

Q. What would it have been without the 50 percent oxygen, is there some formula --

A. No.

Q. -- that allows you to tell that?

A. No.

Q. The next reading at 2:46, that's a 49, that's not very good, is it?

MR. SCOTT: Objection.

Q. That's not very good, is it?

A. It's low at 49, that would be -- would indicate that she was not getting adequate oxygenation at that point.

MR. SCOTT: Do you need to make a call?

THE WITNESS: No.

Q. Is that consistent with an arrest, respiratory arrest, the 49?

A. No, it's not; oxygenation when it falls to

these levels is a stimulant to breathing.
Q. It's make you breathe better?
A. Yes. Well, it makes you breathe --
Q. Harder?
A. Harder.
Q. Because you're not getting enough oxygen?
A. Exactly. These numbers for a respiratory arrest would be characterized by much higher levels of PCO2, her level was 47, so this would not be consistent with respiratory arrest.
Q. Going back to something you said just a minute ago, Doctor.

In other words, if a person's not getting enough oxygen, that means they breathe harder and they take more respirations because they're not getting enough oxygen?
A. Well, low oxygen level is a stimulant and it's one of the body's defense mechanism to improve the level of oxygen, so the stimulant is to breathe and increase ventilation.
Q. That would increase respiration?
A. Either respiratory rates or the depth of respiration,
Q. What level of respiratory rate would you anticipate with the reading of 49?

A. It's not predictable.
Q. Give me a range.
MR. SCOTT: Objection.
Q. This is your profession.
A. But it's not readily predictable.
Q. Would you expect it to be in the 70's, 50's 40's, 20's?
A. It is expected it to be higher than 20, but it's extremely variable between patients. I can't really give you a number what it should be.
Q. What is normal respiration?
A. Normal respiratory rates varies between probably 10 to 12, up to 14 or 15 breaths per minute,
Q. So that if someone is having higher levels than that, that would be an indication to you as a pulmonologist that they're not getting enough oxygen?
A, No, that wouldn't.
Q. It wouldn't?
A. There's many causes of rapid respiratory rates and increases in depths of breathing.
Q. Well, what if it was, for example, in the 30's, would that be an indication to you that person was compensating in trying to get more

oxygen?
A. No, it wouldn't,
Q. How about the 40's?
A. No. Respiratory rate would indicate --
Q. Doesn't matter?
A. By itself if the patient's oxygen level is low you need to have -- to do these tests to determine that.
Q. So if somebody's in the 40's, that's really meaningless?
A, It's not meaningless. Means the patient is having respiratory distress but that doesn't mean the patient's oxygen level is low,
Q. What does it mean to someone who is having respiratory distress?
A. Just that. It's respiratory distress and you hope to determine the etiology of it.
Q. Why don't you define respiratory distress for me.
A. Anybody experiencing difficulty breathing, it could be a respiratory rate of 10 or 12, 20, 30, any number you like,
Q. What you are saying is the difficulty in breathing may not be in fact related to the oxygen they're receiving?

A. That's right,
Q. Was Mrs. Lind having respiratory distress subsequent to her extubation?
A. She was having some respiratory difficulty, yes.
Q. Some?
A. Yes.
Q. Or a great deal?
A. Well, I say some. Her respiratory rates were high but she had adequate oxygenation.
Q. Were they --
A, She was hyperventilating.
Q. Were they getting worse, those respiratory rates?
A. Respiratory rates were variable. There were indications they were getting worse, particularly when she went for this first test in x-ray. She got somewhat better when she came back to the intensive care unit.
Q. What is the reason they were so high?
A. One of the reasons I suspect was the fact that she had abdominal pain, that in and of itself can increase respiratory rates,
Q. When she came back she wasn't having abdomen pain?

MR. SCOTT: Objection. Misstatement of the records.

MR. KAMPINSKI: I don't think it is.

A, My recollection is she was still having some abdomen pain.

Q. Could you point that out to me, please?

A. We'll have to pull the records again.

Q. Okay.

A. The other -- there's other causes too.

Q. We'll deal with one thing at a time.

Why don't you pull that out for me.

A. Can we pull the progress reports, progress notes, and go to May 7th.

MR. FULTON: Is he talking about May 7th?

THE WITNESS: Yes.

MR. KAMPINSKI: Yes.

MR. SCOTT: And this?

THE WITNESS: And also the nurses' notes.

A. On the page 50 there's a note with a prescript S, and C/O indicating complaints of vague abdominal pain.

Q. Do you want to finish that? Do you want to read the whole note, sir?
A. I am having trouble reading the rest of this line due to the handwriting,
Q. State feels better since has -- since had bowel movement?
A. Movement and large stool.
Q. So she was feeling better then?
A. But she still had abdomen pain.
Q. It was vague?
A. Evidently.
Q. Is it your testimony that that's the reason that her respirations were in the high 40's and low --
A. It's my testimony that abdomen pain in part was contributing to her high respiratory rates.
Q. What else?
A. She also had metabolic acidosis, Acidosis is also a stimulant to breathing.
Q. That mild elevation that you pointed to before in the ABG's?
A. The mild decrease.
Q. Decrease3
A. Decrease in pH, yes. And also indicated in the other parts of the blood gas was the fact that

her pCO2 level was low, which is appropriate for somebody that's breathing fast since that's a direct reflection of level of ventilation.

So she was -- her pCO2 level was lower than normal. She was working in excess of the amount required to maintain a normal level of carbon dioxide in her blood, which is what you'd expect to see with somebody breathing fast,

Q. Does that then complete the reasons that you believe her respirations were high?

A. The other reason that contributed to this is temperature elevation. Fever also increases respiratory rates, that could also be contributing to her fast rates.

Q. And the fever was due to what?

A. I don't know.

Q. Was it due to her pneumonia?

A, I don't believe so, she was two weeks out. I think one would might guess that it's from an intra-abdominal process they were evaluating at that point.

Q. What intra-abdominal process, sir?

A. Well, there were several possibilities,

Q. What intra-abdominal process did she have? I thought I have asked you this before.

A. And I answered at that point I didn't know.
Q. So what are you talking about?
A. I'm talking about a process, etiology which is not determined.
Q. But there's no process?
MR. SCOTT: Objection.
A. Well, that's your opinion. My opinion there was, was a process.
Q. Tell me what it is.
A. I don't know what -- what it is. There's a number of possibilities at this point. These were being investigated.
Q. Which one was it?
MR. SCOTT: Objection.
A. Again, I don't know.
Q. Was it any of them?
MR. SCOTT: Objection.
A. I don't know.
Q. Why don't you know?
MR. SCOTT: Objection.
A. Well, there's certain diagnoses that are not evidenced just by the mere performance of these tests.
Q. So once again, it's a mysterious ailment that was causing --

MR. SCOTT: Objection.

A. I wouldn't call it mysterious. The etiology of this process had not been determined.

Q. What is it that caused her to experience increased respiratory distress while she was having the HIDA scan, Doctor?

A. I'm not certain as to why she had more distress down there either. I know that during that time period she had a drop in her blood pressure.

Q. Why?

A. I don't know why that occurred either.

Q. Well, how was that treated?

A. Well, again, they didn't know the etiology of this. Usually patients receive fluid administration, because one common cause of a low blood pressure is a dehydration,

She, in fact, was treated with fluids and the response to her was that her blood pressure improved,

Q. Did it?

A. Yes.

Q. Got much better?

A, Well, it improved.

Q. Improved from what to what?

A, I'd have to find those nursing reports.

It is on page 988 at 10:15 her blood pressure was 74 over 47; and repeated several times, and each pressure is in that range of the next hour or so.

Then subsequently her pressure improved to 89, then 116, then 100 systolic at one o'clock, 1:15, and 1:30.

Q. How about at 2:00?

A. At 2:00 it was 95 over 50.

Q. So it went back down?

A. Slightly. They were all in the same 89, 100, 95, with the exception of one blood pressure was 116. They were all around the range of 95 to 100 systolic.

Q. How about diastolic?

A. Diastolic blood pressures were low, 47, 48, 49 at 10:15, at 10:30; and they were -- remained in approximately that range and improved at 1:15, and that was back down to 50 at two o'clock.

Q. So you consider that a significant improvement then?

A. Yes, I do.

Q. How about at 2:30?

A. At 2:30 her blood pressure was very low, was

66 over 46.

Q. What caused that to happen?

A, Several possibilities.

Q. Well, what probably caused it to happen?

A. Again, there's several possibilities. I'm not certain of the etiology. Again, her fluids status may have been still low.

Q. Wait a minute.

A. Infection, others --

Q. I'd like to deal with this one. Wait.

I just thought you just told me that she had received fluids sufficiently to stabilize her, now you're telling me that she didn't?

A. Well, I'm -- as I said, I am not certain. One of the possibilities is that --

Q. Well, please, Doctor, and I am really -- I don't want to quarrel with you -- one of the things that we try to deal with is probability.

Do you have an opinion to a reasonable degree of probability as to what caused her blood pressure to go down?

A. I'd have to give you several possibilities. I'm not --

Q. So the answer is you don't?

A* So it's --
Q. Look, Doctor --
A. I do not know for certain, no. I think I can give you two or three possibilities that are probable. I can't give you a specific diagnosis.
Q. Two or three possibilities that are probable?
A. They -- each of which are probable.
Q. Each one is probable?
A. Yes.
Q. What are those? What are the probabilities or the possibilities that are probable?
A. One would be still dehydration, and by that I mean that the amount of fluid inside the blood vessels is low.
Q. So that she didn't get enough hydration then?
A. She may have been -- gotten enough fluids at that point. Patients with infection frequently leak fluid outside their blood vessels.
Q. What infection did she have?
MR. SCOTT: Pardon me?
A. I'm not certain.
Q. What was the infection that she had?
MR. SCOTT: That question has been asked.
A. Several times.

MR. KAMPINSKI: Well, you know, maybe he's talking about a different infection other than the mysterious one.

MR. SCOTT: Objection to that.

A. I'm not talking -- talking about anything different. Infection is a cause, sepsis is a cause of this type of problem.

Q. Sepsis is an infection in the blood?

A. Yes.

Q. And did she have sepsis?

A. Based upon these numbers, that's a possibility.

Q. Did she have sepsis --

MR. SCOTT: Objection,

Q. -- as depicted by any values in the chart?

A, Based upon her fever, the fact that she had a low blood pressure, she had elevated white counts, they were all high suspects for sepsis.

Q. Can pneumonia cause a fever?

A. Yes, it can.

Q. Elevated white count?

A, Yes,

Q. What was the other one? I'm --

A. Many other things can also cause those things

there.
Q. But we know she had pneumonia?
A, She had pneumonia on admission.
Q. Did she still have pneumonia on May the 7th?
A. She had infiltrates on chest x-ray.
Q. Did she have pneumonia on May 7th to a reasonable degree of probability?
A, Yes.
Q. Okay. Well --
A. Can I finish one thought?
Q. Absolutely.
A. At this point in time I think it is much less likely pneumonia that's contributing to these abnormalities since they developed over the previous 24 to 36 hours.
Q. She developed them after she was extubated?
A. Yes.
Q. Well, her pneumonia was -- I mean her breathing was being assisted by a ventilator up until May the 6th, wasn't it?
A. That's correct.
Q. As I understand it, after she was extubated, the abnormalities started occurring?
A. That's correct.
Q. Well, you as a pulmonologist and myself as

just a lay person, is there a reason that you don't attribute these difficulties to the extubation as opposed to some mysterious illness?

MR. SCOTT: What difficulties are we talking about?

Q. Well, the increase in respiration, the drop in blood pressure, the worsening condition of this patient, you know?

MR. SCOTT: Objection. What worsening condition of this patient?

MR. KAMPINSKI: She wasn't getting any better.

MR. SCOTT: If you want to ask something specify, that's fine.

A. I wouldn't attribute the drop in blood pressure to the fact that she was off the ventilator.

Q. No?

A, No.

Q. Why not?

A. Because generally that -- by placing a patient on a ventilator, generally if anything it causes a reduction in blood pressure, The fact that she was off the ventilator, if anything I would except her blood pressure to have gotten

better; and it didn't, it got worse, suggesting there's some process other than pneumonia causing this.

Her pneumonia, it was treated over this course of time, and when you say pneumonia you have to be careful about whether that's the etiology of what is going on or not. She had pneumonia that was treated, and patients with pneumonia who symptomatically recover completely can still have abnormalities on chest x-ray that linger for several weeks longer without causing any symptoms.

Q. Doctor, I thought we just agreed she still had pneumonia?

A. Again, I'm just trying to explain though that fact that she had x-ray evidence of infiltrate, doesn't mean that that process of pneumonia is causing these abnormalities.

Q. Did she or didn't she have pneumonia on May the 7th, I thought we agreed?

MR. SCOTT: He agrees with you.

MR. KAMPINSKI: But now apparently he wants to take it back.

MR. SCOTT: That's not --

Q. You don't like the result of having admitted she had pneumonia for purposes of your --

A, I said --

MR. SCOTT: Objection.

Q. -- report or what?

A. That's how you're interpreting it,

Q. Did she or didn't she have pneumonia on May 7th?

A. Yes, she did.

MR. FULTON: I was going to ask you to raise your voice, I was having trouble hearing, but I didn't the last couple questions.

MR. KAMPINSKI: Any time you have difficulty, Mr. Fulton, I'd be happy to assist.

Q. It's your testimony that pneumonia will not cause the symptomatology that Mrs. Lind had on May the 7th --

MR. SCOTT: Objection.

Q. -- is that your testimony?

A. My testimony is that it can.

Q. It can, okay.

Now, that's a disease process we know she had, is that agreed, she had --

A. Yes.

Q. -- that can cause her symptomatology --
A. Yes.
Q. -- as opposed to some mysterious illness that you can't tell me what it is because there is no evidence in the record to indicate that it exists that you believe caused her problem?
MR. SCOTT: Objection,
Q. Do I understand your opinion correctly?
A. I don't think so.
Q. What is it I don't understand?
A, Well, the disease process you call mysterious.
Q. You are right. Go ahead.
A. I believe is real.
Q. What was it?
MR. SCOTT: Objection.
A. Just because we can't define it specifically doesn't mean it didn't exist or was mysterious. The fact is that. patient had abdominal pain that had a cause --
Q. Well --
A, -- yet to be defined --
MR. SCOTT: Let him finish.
A. You have to define all parts. Just because

she improved following her bowel movement wasn't going relieve everything. E don't believe that her -- that the cause of her pain was solely the result of not having a bowel movement, and then was eliminated by her bowel movement, I think there was still a process there and this is evidenced by the fact of persistent pain.

Q. The doctors did a CT, they did a HIDA scan, they opened her up and they didn't find anything?

A, They were down there at a different point in time.

Q. Despite everything that was done, you still say she had an abdominal process going on?

A. On the 6th and 7th she had very significant abdominal pain. I think they opened her sometime much later.

Q. You think --

A. In the interval there could have been significant resolution of this process.

Q. The surgeon, I assume you read his deposition, didn't you?

A, Yes.

Q. He didn't think that she had any intra-abdominal process; are you aware of that?

MR. SCOTT: Objection.

A. I read the deposition but it's in conflict with the progress notes where he is calling €or a plan -- he planned to call the family about doing surgery in the notes. He seems to indicate -- he does indicate that he believes the patient may need surgery that day,

Q. Well, he's saying that he may do it if her clinical condition permits. In his deposition he testified that he did not -- he didn't think there that was any process going on, that's what he said?

A. I don't know what's the exact wording, but it's hard to image and believe any process, since he's following the patient, seeing the patient two or three times a day, following this abdomen process --

Q. Well, you don't believe his testimony?

A, At least in two of the notes, he states clearly in the progress notes at that time, and I am sure he conveyed this to the other physicians because there's indication there was a conference, that they were contemplating surgery.

Q. What if he told them she didn't need surgery --

MR. SCOTT: Objection.

Q. -- would that change your opinion?

A, That's in conflict with the progress notes.

Q. Would it change your opinion in any way if he told them that?

A. My opinion in what sense?

Q. In any sense?

A. What do you mean?

Q. You are positing this mysterious illness that you seem to think others thought she had too, and the surgeon said he didn't think she had anything going on?

MR. SCOTT: Objection.

A. Well, he did think so and indicated in the progress notes.

Q. Do you remember the question?

A. I guess, yes.

Q. Let me restate it.

If in fact the surgeon was of the opinion that she did not have an intra-abdominal process, would that change your opinion in any way, or don't you really care what he said?

A. No, it means something.

Q. What does it mean?

A. It means that at least one of the physicians involved with her care didn't think there was an abdominal process.

Q. What does it mean to you as an expert?
A. It means that --
MR. SCOTT: As to whether there was abdominal process?
MR. KAMPINSKI: As **to** his opinion.
A. Well --
Q. He prefaced his opinion earlier on the fact that they thought there was something going on. I'm telling him to read the deposition where the doctor said he didn't; read his expert reports, where his expert says that, I assume you read that?
MR. SCOTT: Objection.
A. Yes. Okay. Well, there's big if's there and it's in conflict with the progress notes.
Q. I'm not making it up.
A. I'm not making up the progress notes.
Q. But answer my question.
A. Well then, based upon the if's, if the -- if that's what he thought, there was nothing intra-abdominal, that would make it -- make me think there was less likely a process; but two of the -- or two physicians involved in her care believe there was, so there's some conflict here and controversy.

In reviewing this as an expert with it in hindsight, I have to now question a little bit whether or not there was an intra-abdominal process.

Q. Especially in light of the fact that nothing was found?

MR. SCOTT: Objection.

A. Well, especially wouldn't matter at that point because those tests are not definitive and these tests can miss things.

Q. Well, I mean, that raises an interesting point.

What is the efficacy or accuracy in your opinion of the CT?

A. Well, that is very disease specific, and to give you -- I can't give you an accurate assessment of the accuracy of every disease process, particularly since you don't know which disease process she had.

Q. I guess my question is much more general than that.

A. Okay.

Q. I mean --

A. If there was a large abscess, I think the yield would be 100 percent.

Q. No, no, no. Okay. The question was obviously much too confusing.

MR. SCOTT: Objection.

MR. KAMPINSKI: I understand.

Q. In general what is the efficacy of doing a CT, period, on somebody?

A. Efficacy I guess kind of carries -- that's a word we use in determining how they respond to a therapy.

Q. It is?

A. This is a diagnostic test.

Q. What is the -- would you consider a CT test as being a vague test, for example?

A. I wouldn't use that word, no.

Q. Would you say that the risks of a CT can outweigh the benefits?

A. In rare instances, yes,

Q. Rare instances?

Such as?

A. If the patient, for example, was having a lot of seizures, I would think the patient would be too unstable to undergo that test,

Q. The stability of a patient then has to be taken into account in determining whether --

A. **Absolutely.**

Q. Okay, And you gave an example of seizures, any other examples in terms of stability of the patient?

A. I would say certainly if a patient had any type of an arrest situation.

Q. I'm sorry, arrest?

A. Yes. If the patient was arresting, obviously the patient wouldn't be stable.

Q. How about in distress as opposed to an arrest?

A. Yes, in that circumstance you have to weigh the benefit of the tests against the risk.

Q. Can a patient undergo a CT if they're intubated?

A. Yes.

Q. So she could have in fact been intubated and then been sent for a CT?

A. That's correct.

I should also add from the previous comment I made about the -- you talked about the benefit and risk of doing this test, I used the word "rare." I think that's probably incorrect. I think that when I used that word I meant in terms of the clinical status of the patient in terms of doing the test. There are other reasons why risks

may outweigh benefits in other types of patients, if you're speaking in terms of stability of the patient.

Q. I wasn't speaking in any terms,

A. I was clarifying my answer,

Q. What are the risks and benefits then?

A. All these tests would pose some type of radiation exposure.

Q. Radiation?

A. Yes, and so in routine performance of these tests, there has to be indication for performing them.

Can we take a break here?

(Recess had.)

(Record read,)

BY MR. KAMPPNSKI:

Q. Doctor, I just want to clear up one thing if it wasn't already clear.

One of the reports I assume that you saw was by Dr. Flynn on behalf of Dr. Paresh Patel; is that correct, did you see that one?

A. I don't believe I saw this one.

Q. You mean Mr. Scott didn't give that you

report?
A. I don't recall seeing this one.
Q. The report of October?
A. 19?
Q. 1994?
A. Yes.
Q. Did you ask him for any other reports in this case?
A. No, I didn't.
Q. Do you know why he didn't give that to you?
MR. SCOTT: Objection. That's assumption on your part. He indicated that he does not recall seeing it.
Q. Do you know why he didn't give it to you?
MR. SCOTT: Objection.
A. No.
Q. Well, do you know that doctor?
A. No, I don't.
Q. Well, the expert that's been retained by Mr. Orth on behalf of Dr. Paresh Patel, and he says that Dr. Patel was asked to evaluate the patient in regard to an intra-abdominal source of her sepsis, which he did not think she had; and subsequently established that at the time of her necessary abdominal exploration.

I mean, do you disagree with that?
A. Well, it is internally inconsistent,
Q. It's what?
A. Internally inconsistent.
Q. What is there that's internally inconsistent?
A. If he didn't believe she had an intra-abdominal process, why did he have to do a laparotomy.
Q. If he believed that he did an unnecessary surgery on her --
MR. SCOTT: Objection.
Q. -- while she was in a coma?
A. Well, if he believed she had nothing wrong intra-abdominally, then it was inappropriate surgery.
Q. Well, let's try it another way.
Whether or not it was inappropriate or not, the fact that he found no basis for an intra-abdominal process, does that affect you at all or do you still stick to this mysterious source for there being one?
MR. SCOTT: Objection,
A. I don't refer to it as mysterious.
Q. You're right, I do.
In the absence of you're telling me

what it is, it is mysterious to me,

A. I clarified it. I don't refer to it as mysterious,

Q. I've been the one using it, I know, but --

A. So I was just clarifying my answer in reference to your question.

Q. Yes.

A. And this laparotomy was done a number of days following the acute event that occurred prior to her arrest, and it is possible that that process was nearly resolved or completely resolved by the time he did the laparotomy.

Q. What process was that?

A. I don't even -- I don't know what the process was.

Q. I'm sorry. I forgot.

So you disagree with him then?

A. To what extent?

Q. To the extent that he says Dr. Paresh didn't think she had an intra-abdominal process?

MR. SCOTT: Objection.

A, Based upon the progress notes he did think there was an intra-abdominal process.

Q. So he's making it up now?

A. Based -- he didn't write the note,

Dr. Flynn wrote this note, so Patel's not making up anything.

Q. Well, I mean Dr. Patel said precisely what Dr. Flynn is saying in his report, in his deposition?

MR. SCOTT: Objection.

Q. So he made it up at the time of his deposition; is that what you're suggesting?

MR. SCOTT: Objection.

A. I am not suggesting anything. I can't speak for Dr. Patel.

Q. That's Paresh Patel, right?

A. P. Patel.

Q. Did Dr. D.C. Patel make up anything in this case that you observed in your careful review of this record?

A. Make up anything?

Q. Well, add anything after the fact?

MR. SCOTT: Objection.

A. There was a verbal order I think that he clarified.

Q. He clarified it? Added it?

A. Yeah.

Q. Which did he do, he clarified or he added it? What did he do with that verbal order?

A. Well, he added a phrase.
Q. Why did he do that?
MR. SCOTT: Objection.
Answer it, if you can.
A. I believe to clarify the order he gave the nurse.
Q. Well, in Mr. Scott's letter to you he put that phrase in quotation. As a matter of fact, I think you repeated it in quotes in your report, so obviously it was important to you in terms of your evaluation, correct?
MR. SCOTT: Objection.
A. Yes.
Q. You would agree with me for purposes of analyzing Dr. Patel's involvement in this case it would be important to him as to whether he made the order or whether he relied on Dr. Dacha, wouldn't it?
MR. SCOTT: Objection.
A. Which Patel?
Q. D.C. The guy who you're rendering an opinion for.
MR. SCOTT: Objection.
What's the question. One of you two repeat it.

(Question read,)

A. Well, I was -- thought it was one of the issues concerning his care in terms of the extent of his involvement in this case.

Q. That addition to the verbal order is important on that issue; is it not --

MR. SCOTT: Objection.

Q. -- otherwise you wouldn't have put it in your report?

MR. SCOTT: Objection.

A. Important to the extent I included it because he's clarify the extent of his involvement.

Q. And is there a reason that you are aware of that Mr. Scott didn't inform you that that was added later?

MR. SCOTT: Objection.

A. Well, I could tell from the -- just looking at the orders, that it was a verbal order.

Q. Yes.

A. And that the phrase that was added was not in the handwriting of the person taking the orders.

Q. But you didn't mention that in your report that it is added later?

A. No, I did not.

Q. Is there a reason that you didn't?
A, Because I didn't think that was important.
Q. You didn't?
A. No.
Q. Well, when was it added, or is that a mystery too?
MR. SCOTT: Objection.
A. I have no way of knowing exactly when was -- it was added,
Q. Well, was it important to determine when it was added?
A. It may be.
Q. Why would it be important to you?
A, I think it possibly would be important if it was ordered -- it was added many days after the fact.
Q. Yes?
A. Because it would imply that he was --
Q. Covering up?
A. Yeah, making some changes to cover tracks.
Q. Yeah. Well, how about if he added it after the arrest; I mean, any time after the arrest?
A. Same conclusion.
Q. Did you make an inquiry of Mr. Scott or Dr. Patel to determine when it was added?

A. Not specifically, no.
Q. I don't understand your answer.
What do you mean by not --
A, Well, I have discussed with Mr. Scott about the fact that it was added and I reviewed the progress notes, and Mr. Scott had said he had spoken to Dr. Patel and indicated it was added at the time of that conference he had with the other physicians.
Q. I see. Dr. Patel told him that, according to Mr. Scott?
MR. SCOTT: Objection,
A. Yes.
Q. When were you told that?
A. One day last week, I think.
Q. Were you told at that time of any additional -- any other additions --
A. No, I wasn't.
Q. -- to the records?
A. No.
Q. Did you notice any other addition to the record by Dr. Patel?
A, Not specifically.
Q. What does that mean "not specifically"?
A. I didn't see any other reference to

additions.

Q. Would that concern you if there were other additions?

MR. SCOTT: Objection,

A, I'd be interested in knowing what took place.

Q. I don't understand that.

A. I would be interested to know. I can't give you opinion based upon some mysterious, you know, possible addition.

Q. So I mean, would it matter then what the addition was?

A. Of course.

Q. In other words, if it were an exculpatory addition to the addition that was added to the order?

A. Certainly.

Q. What would that do to your opinion?

A, I'm not certain it would affect my final opinion but it would certainly affect my opinion of Dr. Patel, if he added material to the chart or to the orders that were certainly after the arrest, because that would imply that he was hiding something.

MR. KAMPINSKI: Could you speak

up, Mr. Fulton, I can't hear you.

MR. FULTON: I wanted to know if the garage closes. I got to get my wife to the airport at 6:30 tomorrow morning.

MR. KAMPINSKI: I don't know.

MR. FULTON: May I ask a question off the record.

(Discussion had off the record.)

MR. KAMPINSKI: Where was I?

(Record read.)

Q. What does Demerol do to the respiratory status of an individual or what can it do? What effect can it have?

A, Well, depends on dose that's administered relative to the patient's size, and it depends on the status of the patients in terms of what effect it might have.

Q. Well, how about a patient who has got pneumonia, who has just been extubated, who, you know, is not supposed to receive any sedation, who has got labored breathing, rapid respiration; how

about a patient such as that?
A. It could suppress ventilation.
Q. And it could make her status even worse?
A. Possibly.
Q. By the way, the discussion that we started on earlier as to whether she had respiratory distress or cardiopulmonary arrest, does that really matter one way or the other in terms of what caused it?
MR. SCOTT: Objection.
A. In terms of the etiology it does, because if it was a pure respiratory arrest, that would point to certain diagnoses; whereas cardiopulmonary arrest might point to some others.
Q. But I mean, a person having a respiratory distress can go into cardiopulmonary arrest; can they not?
A. Can, sure,
Q. We were discussing that she had, you believe that she had metabolic acidosis; that would be the same as abnormal acid base, correct?
A. Yes, it would.
Q. That can affect the patient's respiratory status; can it not?
A. Yes, it can.
Q. Especially post extubation; can it not?

MR. SCOTT: Objection.

A. No more than at any other time.

Q. Okay, That's fine.

The abnormal acid base or metabolic acidosis can have a negative effect on respiratory status, correct?

A, Well, it's a stimulant to breathe, so it would cause a person to breathe rapidly and deeply.

Q. Well, it's a stimulant because that's -- because it's an abnormality?

A. Correct.

Q. Makes it more difficult for them to get adequate oxygenation?

A. No, it doesn't affect oxygenation.

Q. What does it affect?

A. It affects the efforts the patient has to undertake to breathe, increased respirations are to eliminate the acid, so when they breathe faster and deeper, it eliminates the carbon dioxide, which is a compensatory mechanism to reduce the degree of acidosis.

MR. KAMPINSKP: Okay. How late are they open?

MR. FULTON: 24 hours.

THE WITNESS: We got all night.

MR. KAMPINSKI: We're okay.

MR. FULTON: I'm ready to sit back and relax.

MR. KAMPINSKI: Okay.

BY MR. KAMPINSKI:

Q. What was the cause of her rapid heart rate? She did have tachycardia; did she not?

A* Yes, she did.

Q. What was the cause of that, in your opinion?

A. Probably several causes. One --

Q. What was the probable cause?

A. Several probable causes. One certainly was the fact that she had a low blood pressure, normal response is to increase heart rates.

Q. When did she have a low blood pressure, sir?

A. She had a low blood pressure --

MR. SCOTT: Objection. Asked and answered.

A. -- on the 7th.

Q. What time?

A. Certainly at 10:15 she had a low blood pressure.

Q. How about before?

A. Before it was modestly low,
Q. Did she have tachycardia before that?
A, Yes, she had tachycardia.
Q. What was the cause of the tachycardia before she --
A. Even that level blood pressure would result in some tachycardia, depending on a lot of other factors in terms of tissue perfusion; so that blood pressure, even though we consider it adequate at 100 over 60, that could be contributing to her tachycardia, that's one of the factors.

Another factor is fever, frequently causes -- is a common cause of a tachycardia; sepsis is another cause. Any infection in the body that goes along with fever.

Q. Was the tachycardia getting worse?
A. Between what times?
Q. Well, the 6th to the 7th? From the time she was extubated until she was arrested, getting better or worse?
A. Give me a minute to look through that. Do you have the other --
Q. I believe it's page 988.
A. This is -- is the 7th.
Q. Well, 6th to the 7th, 980 to 988, I think.

MR. SCOTT: That's the 4th.
MR. KAMPINSKI: Which one?
THE WITNESS: Can't make out that.
MR. GALLAGHER: Looks like it is 980 and 988.
MR. KAMPINSKI: Right. May 6th and May the 7th.
Do you have that now, John?
MR. SCOTT: I put them back into the binder in a different location.
Here is 5-6, okay, Here is 5-6 and here is 5-7.
A. So from the time then -- all of the 5-6, or are you looking at a specific time?
Q. Well, I guess what I am asking you: Was it getting worse? You know, if you look at this from 7:00 a.m. to 3:00 p.m. on the 6th, it is in the 120's; 3:00 p.m. to 10:00 p.m. in the 130's, right?
A. I have 110, 114, 115 -- or the pulse? Are you talking about the pulse rates or talking about the blood pressure.
Q. I'm sorry. What am I talking about?
Well, the pulse, isn't that what I said.

MR. GALLAGHER: Tachycardia, you said.

MR. KAMPINSKI: Yes. That's what I thought we were talking about.

Q. It's easy to confuse me, Doctor.

A. I'm not trying to confuse you.

Q. It's the --

A. Here, the early part of the day between 8:00 a.m. and 2:00 p.m. it's ranging in the 120's, low 130.

Q. That's what I thought.

A. Then later on that same day it's slightly higher, with the 45 beats per minute.

Q. Then the 7th?

A, 7th?

Q. At night while she is presumably sleeping, it is --

A. Back in the 120's.

Q. Yes. And early morning it's creeping up 130, 134, 135; by 6:00 a.m. it's 142?

A. Right.

Q. By eight o'clock it's 148?

A. Right.

Q. That's pretty high, isn't it?

A. It's high.

Q. Well, what was causing that?

MR. SCOTT: Objection.

A. Just the factors that I mentioned.

Q. Why was it getting worse?

A. Could have been that, as you mention too, she was sleeping during the nighttime, when she woke up or is more awake, particularly in a busy I.C.U. where there is lots of things going on, it's very common to have increased anxiety on top of everything else that can also raise her pulse rates. She may have been given some respiratory treatment at some point during the time.

Q. Did she --

A. The medications frequently cause a heart rate to rise. I'd have to check the orders to see what standing orders she had to see if she did or --

Q. So anxiety can cause --

A. Tachycardia.

Q. -- tachycardia also?

A. Yes.

Q. Like being put into a small cylinder box, that could cause anxiety?

A. Yes.

Q. Could cause one's heart rate to increase and pulse; blood pressure to drop and cause respiratory

distress?
A. No, it would cause the blood pressure to rise, generally.
Q. Rise, I see.
Well, what did they do for this worsening tachycardia and increasing respiration, these fine physicians that you're here to defend?
MR. SCOTT: Objection.
MR. KAMPINSKI: Which part, the fine physicians?
MR. SCOTT: What time location are you talking about?
MR. KAMPINSKI: I'll withdraw the fine physicians.
Eight o'clock.
MR. SCOTT: Eight o'clock on May 7th.
A. At that point they were concentrating their efforts on the fact that she had abdominal pain, and their need to evaluate that process,
Q. Well, I mean, you can't ignore the tachycardia and the respirations, can you?
A. I don't think they were ignored, I think they were addressed.
Q. That was the questions: What did they do?

Q. As a matter of fact, they rushed her back from the HIDA scan, right?

A. Comes back and --

Q. And the numbers are 56 as far as respiration, 158 as far as the pulse, right?

A. Right.

Q. They give fluids for that?

A. Gave her fluids on arrival back to I.C.U., yes.

Q. The numbers over by the pulse ox, do you see those at 10:00 a.m., the 80/97; do you see those numbers?
A. Yes.
Q. What do those mean?
A. That's the measurement of the oxygen saturation in the blood,
Q. What is 86, is that a good number?
A. 86 is low.
Q. It's low?
A. Yes.
Q. How do you treat that?
A. You administer oxygen.
Q. Did they give her additional oxygen?
A. Not that I can tell.
Q. Okay. But I suppose that doesn't concern you since it went up to 97 and 98, right?
A. All repeat determinations were good.
Q. Well, how low is real low, is 86 real bad?
MR. SCOTT: Objection.
A. No.
Q. How about 70, would that be real bad?
A. Would be very bad,
Q. How would you treat that?
A. You give additional amounts of oxygen.

Q. That's it?
A. Well, you evaluate, you probably check your arterial blood gases to find what abnormalities were responsible for that low oxygen level.
Q. Which blood gas would you be looking at?
A. Well, she had blood gas I think on arrival back to the I.C.U., next set done, I believe that would be the next one, 10:46.
Q. What page?
MR. SCOTT: This is after?
A. This is after the HIDA scan.
Q. That's page 330?
A. Yes.
Q. And which one would you be looking at then?
A. Which -- what set of blood gases?
Q. Yes. Which would be important, the pH, CO2, PO2?
A. All of those, and the pCO2 was low indicating that she was still hyperventilating, which is good; oxygen level was more than adequate at 126.
So during that course of time she had no deterioration in her blood gas.
Q. How long does it take to get these readouts; do you have any idea?
These blood gases are sent down to

the lab or --

A. Yes.

Q. -- are they done right there on the floor?

A. They're sent to a lab.

Q. So in other words, the blood has to be drawn from the patient --

A. Yes.

Q. -- at the I.C.U., sent to the lab and read out?

A. Yes.

Q. Is there any way that people in I.C.U. can get an immediate readout on those?

MR. SCOTT: Objection.

A. Of blood gas?

Q. Yes.

A. No.

Q. How long does it typically take?

A. The blood gas?

Q. Yes.

A. Usually if they're ordered, usually they take no more than around 10 or 15 minutes.

Q. Well, then they send her back down for the CAT scan I guess around two o'clock, somewhere in the two o'clock area?

MR. SCOTT: Objection.

Q. Right?
A. Around that time. I don't remember the exact timing.
Q. Right. There is a reading of her blood pressure at 2:00, so she had to be in the I.C.U. when that was done?
A. Yes.
Q. It would have been after that reading we know she went back, somewhere in the 2:30 area, right?
A. Back in I.C.U.?
Q. Yes.
A. Yes. P.m.
Q. They didn't finish the CT or did they or do you know?
A. I thought they did finish the test, is my recollection.
Q. What?
A. I thought they had completed it.
Q. You did?
You are saying in your report something that I found a little curious. I guess I need to know where you got it from, that she did not actually suffer cardiopulmonary arrest while undergoing the CT but this occurred after she arrived back in the intensive care unit and that

she lay supine for 10 to 15 minutes with the CT, and where did you get all that from?

A, Well, the usual performance of CT scan is 10 or 15 minutes.

Q. So you figured they finished it and they just brought her back up without anything having occurred in the CT?

MR. SCOTT: Objection.

A. Well, the CT, I understand that she had some problems there.

Q. She did?

A. Yes, shortness of breath.

Q. I didn't realize that that had occurred from reading your report.

Could you point out to me in your report where you say that?

A. No.

Q. Because you didn't?

A, Well, I may have not.

MR. SCOTT: Is there a question pending?

Q. Did you point out --

MR. SCOTT: He said no.

A. No.

Q. Why not?

A, At the time I didn't feel it was important.
Q. How about now, do you think it's important now?
A. The fact that she had that occurrence?
Q. While she was down at the CT?
A. Not in terms of the care delivered by Dr. Patel.
Q. How about in terms of the care delivered by anybody?
A. No, I don't --
Q. It was great care she got when she was down at the CT?
A, She was closely monitored.
Q. She was closely monitored?
A. Yes.
Q. By whom?
A. By the nurse.
Q. And what was the nurse doing to monitor her?
A. Well, she was checking patient's pulse, respiratory rates,
Q. Where do you see that?
A, In the -- in the notes of the 7th.
Q. What notes of the 7th?
A. I'm looking at page 988 where there is blood pressure recordings and pulse recordings and oxygen

saturation recordings.

Q. Wait. I don't understand.

Which ones are you saying that were being recorded while she was down for the CT?

A, She was down at the CT approximately 2:00 to 2:30.

Q. Yes?

A. There is measurements of blood pressure, and pulse, and oxygen saturation.

Q. Is it your testimony that those measurements on page 988 in the entries at 2:00 p.m. and 2:30 were down in the CT; is that your testimony?

A, My testimony is that she had her CT scan on about those times and those measurements were made at that time.

Q. Doctor, did you understand my question, sir?

A. I think so.

Q. What is the answer?

MR. SCOTT: He answered it.

MR. KAMPINSKI: No, he didn't.

MR. SCOTT: What was your question?

Q. Is it your testimony that the measurement of blood pressure, pulse, respiration, temperature, set forth on page 988, in the line that begins at

2:00 p.m., were while she was down in the CT?
A. It's my testimony some of these measurements were made when she was -- made there, yes,
Q. Which ones?
A. I -- I'd have to check back to see exactly what the -- when she is back down there and correlate that with this.
Q. Go ahead.
A. We have to check the times that she was in CT.
She is transported --
Q. Where are you referring?
A. Page 1135.
Q. Which entry?
A. The top line,
Q. Go ahead,
A. Time's listed as 2:00 p.m., transported to CT for abdomen, pelvis region, per the bed with monitors pack, pulse oximetry and OT at 50 percent, with RN present.
Q. Yes?
MR. SCOTT: What was the question.
Q. Question is which of these entries correspond to her being at the CT?

A. Okay. Go back to the 7th, see the blood pressure at 2:30.
Q. Okay?
A. During when she was at the CT there.
Q. That 66 over 46 was while she was at the CT?
A. Yes.
Q. Is that good?
A. No.
Q. How do you treat that?
A. Well, initial treatment would consist of I.V. fluids.
Q. Are there any other readings that were on that line that were done while she was down at the CT?
A. The second, the next reading was at 2:45 according to the nurse's note; at 2:45 she is returned from CT scan. So if these times are accurate, the next reading was done in the I.C.U. and not in CT scan.
Q. Well, if you read the notes, sir, they show a blood pressure at 2:45 at page 1135 as 70 over 50; does that correspond to any of these numbers that you see?
A. Well, it's very close to the initial read at 2:30.

Q. Well, but this is a 2:45 entry, and at 2:45 apparently it's 52 over 30; am I incorrect about that?

A. No, you're not.

Q. Well, how about the pulses, the 131 and the 119, were those done while at CT or were they done when she was back from CT?

A. The one at 2:30 based upon these times was done in CT.

Q. Yes?

A. One at 2:45, again if you believe the times, she was back in the I.C.U.

Q. What about the respirations, when were those done or can't we tell?

A. Respirations were listed on the end of the line over the course of that hour, they're not broken down according to quarter hour, so I don't think we can tell specifically.

Q. How about temperature, 37.4, when was that done?

A. That was done also during that hour.

Q. Is that a fever?

A. No, it's not; but it's an axillary temperature.

Q. Well then, why do you take it if that's -- I

mean, the way you say that is as if it doesn't count?
A. Well, it's very inaccurate,
Q. So why take it?
A. I think if it's elevated, it may mean the patient has a fever; if it's low, I don't think it means very much,
Q. So it's meaningless,
What about the 69 under the pulse ox, is that a meaningful number?
A. Yes, and it indicates the oxygen level was low.
Q. What time was that?
A. Again, that was some time during that hour between 2:00 and three o'clock.
Q. But we don't know when?
A. I can't tell when from the records.
Q. Were you provided with any nurses' depositions?
A. Yes, I was.
Q. Did you read any of them?
A. I read them.
Q. Well, do you know what nurse wrote these numbers in there?
A. I don't recall.

Q. Did you read her deposition, whoever she might have been?
A. I probably did,
Q. Do you recall what she said in terms of what time these readings were taken and whether they were --
A. My recollection is that she recorded these sometime later, near the end of her shift and put these times in at that time; and she put the times to the best of her recollection.
Q. Well, going to page 1135 of the nurses' notes, sir, when it says 2:45 returned from CT scan?
A. Yes.
Q. It's got unable to finish procedure, discontinue, patient began having respiratory distress and shallow labored respirations at 50 beats per minute; you read all that --
A. Yes.
Q. -- I assume?
A. Yes.
Q. Well, so they didn't finish the procedure?
A. According to that note.
Q. I mean, is there something else that caused you to believe that they did?

A. I'm just recalling reading something about the CT showed -- didn't show any abnormality.
Q. That led you to conclude that they at least got enough of it to show --
A. To make a reading.
Q. Well, Doctor, if a patient is in I.C.U., and I think you told me that this is one of your areas of expertise, you actually head the I.C.U. at Metro for a month every year; two months, is that it?
A. Two to three months a year.
Q. The reason that that patient is in I.C.U. is because they're not feeling good, right?
A. I wouldn't say not feeling good.
Q. Not doing well?
A. Right.
Q. You want more to monitor them closely?
A, Exactly, that's the reason they are there.
Q. And the reason you want to do that is so you can intervene if there is some problem, so you can do it fairly quickly?
A. That's accurate.
Q. If you take a patient away from the I.C.U., that sort of prevents your ability to care for the patient in the way that you are intending to do that, doesn't it?

A. It does to a certain degree, yes.
Q. Well, with somebody like Mrs. Lind who is having respiratory distress, and I think we agreed that she was, right?
A. Yes.
Q. You want to be able to act fairly quickly, don't you, if she started getting worse?
A. That's accurate.
Q. Would that be a fair statement?
A, Yes.
Q. When we say "fairly quickly," how quickly would you want to deal with any difficulty that she started having?

MR. SCOTT: Objection. What difficulty are you specifying?

Q. Respiratory difficult that would cause her to go to cardiopulmonary arrest,
A. Well, if you had the ability to somehow know it would lead to cardiopulmonary arrest, it would be immediate.
Q. What do you mean by "immediate"?
A. By immediate, immediate speaks for itself.
Q. No, it doesn't. I don't want to get caught up in semantics.

Are you talking within seconds?

A. Within minutes, a few.
Q. Couple minutes?
A, Within minutes, short few minutes,
Q. Few being three?
A. Three or less.
Q. Three or less.
Because if somebody is not breathing, that's not good for them?
A. That's accurate.
Q. Causes them to potentially have brain cells die because they're not getting enough oxygen?
A. That's right.
Q. Causing brain damage, just like Mrs. Lind sustained?
A. That's accurate.
Q. And it takes a period of time for that to occur?
A. Yes, it does.
Q. How long would you say that takes; I know it's variable, but give me some range?
A. Well, if a patient stopped breathing completely, that is no ventilation whatsoever, zero,
Q. Okay?
A. Then within five minutes they're going to

have some brain death.
Q. And respiratory distress can be a precursor to cardiopulmonary arrest, I think we've already covered that?
A. Yes, we did.
Q. So that's something you have to be concerned about when someone's having respiratory distress?
A. Yes.
Q. So I suppose you can protect them from that occurring by protecting their airway?
MR. SCOTT: Objection as to what is meant by protecting the airway.
Q. Well, intubation?
MR. SCOTT: All right.
A. Intubation will not prevent respiratory distress.
Q. How about cardiopulmonary arrest --
A. It won't prevent --
Q. -- due to respiratory distress?
A. It won't prevent that either: unless the cause is some obstruction of the upper airway that's bypassed by this intubation.
Q. What does intubation do then?
A. Intubation is just a means of really just inserting a tube in the airway.

Q. What do you attach the tube to?
A. Attach the tube to the -- it depends on the clinical situation, may attach it to nothing except oxygen.
Q. What does a ventilator do?
A. A ventilator will take over a patient's respiration.
Q. Help them breathe?
A. It would assist their breathing.
Q. Would that prevent a cardiopulmonary arrest?
A. Not necessarily, no.
Q. Can it?
A. Only if the primary cause of the cardiopulmonary arrest is respiratory failure.
Q. I see.
After she had her arrest what did they do for her?
A. After she had the arrest she was resuscitated, she received CPR.
Q. Then what, they hook her to a ventilator?
A. She was hooked up to a ventilator at that point, yes.
Q. Would it be a failure -- well, when she had this reading of 69 for the oxygen saturation and she had the 66 over 46 blood pressure, then the 52

over 30, is that something that should be addressed by putting her on mechanical ventilation to assist her in her breathing?

A, No, I don't think so.

Q. Not even at that point, it wouldn't have mattered?

MR. SCOTT: Objection.

A. Well, I don't think that would have been appropriate treatment,

Q. What would have been appropriate treatment?

A. Correct the blood pressure.

Q. How would you do that?

A. First administration of fluids.

Q. When did she receive the administration of fluids here, Doctor?

A. She received fluids, a Parge amount of fluids between the HIDA scan and CAT scan.

Q. No. No. I mean after the **66** over **46?**

A, After she returned to the I.C.U.

Q. Well, how soon should she have received them?

MR. SCOTT: Objection.

A. Immediately.

Q. Once again, sooner than three minutes?

A. Well, it should be as soon as possible, within minutes or as soon as possible. There's no

specific time. As soon as it can be done.
Q. When was it done?
A. It was done after she returned to I.C.U.
Q. When?
A. 2:45.
Q. It was?
A, That's when she returned from I.C.U.
Q. According to the nurse note?
A, According to the nurse's notes she returned to I.C.U. at 2:45 and they paged Dr. Dacha at that point and --
MR, SCOTT: Wait for a question.
Q. Then when was the code called?
A. 2:55.
Q. When did they give fluids?
A. Well, the next blood pressure I see is 120 over 63 under the notes at -- I think it's the three o'clock notes.
Q. 3:15?
A, No, 3:10.
Q. Okay. You're looking at the nurses' notes?
A. Yes. Says blood pressure 120 over 63.
Q. Yeah.
A. There is no mention about fluids

administration during that time period, but generally during a CPR resuscitation fluids are administered. The details of what medications were given during the CPR aren't listed here.

Q. You are saying she didn't get fluids until the CPR; is that the first time?

A. Based upon the nurses' notes there is no indication that she got additional fluids over and above what she was receiving during that period of time.

Q. Wait a minute, Doctor.

We just went through that she had a blood pressure of 66 over 46 at 2:30 p.m., and you are telling me that she didn't get fluids until 2:55 p.m., that's 25 minutes, sir.

MR. SCOTT: Objection. That's not what he said.

Q. Am I wrong?

A. This patient had intravenous fluids running all along, so by giving fluids I mean giving an extra amount of fluids.

Q. When did she get an extra amount of fluids?

A. I can't tell from the nurses' notes that she got any additional fluids before the --

Q. Which was 2:55?

A. Right.
Q. Should she have gotten fluids before that time based upon the blood pressure?
MR. SCOTT: Objection.
A. One of the therapies for a low blood pressure would be additional fluids.
Q. The question was should she have gotten in your opinion additional fluids when she exhibited the blood pressure of 66 over 46 when she was down in the CAT scan?
MR. SCOTT: Objection.
A. Yes, I believe so.
Q. Was that a failure to do -- a failure to adhere to the appropriate nursing standard of care with respect to whoever the nurse was?
MR. FELTES: Objection.
MR. SCOTT: Objection.
A. No, I don't believe so, that's a physician decision.
Q. What physician was there to make that decision, Dr. Dacha had left, Dacha or Patel wasn't there; who was around to --
A. There was probably no physician in the I.C.U. either at that point, The appropriate thing to do was contact the physician, which I think they did.

Q. Where, down in the CAT scan?
A. They didn't page Dr. Dacha until she's back up to the I.C.U., he is not in the hospital.
MR. SCOTT: What is the question?
Q. Question is who is responsible for this, that's the question?
MR. SCOTT: Responsible for what?
Q. For not giving her the fluids that you say should have been given?
MR. SCOTT: Objection.
A. The responsibility is for the nurse to contact the physician.
Q. When the blood pressure drops in the CAT scan?
A. Yes.
MR. SCOTT: Objection.
Q. All right. If they didn't do that, then she is responsible?
MR. FELTES: Objection.
A, If she did not contact the physician, then she is responsible, yes, so they could start additional fluids administration and other therapy besides fluids.

Q. Such as?
A. Such as agents that would increase her blood pressure.
Q. Which? Such as what?
A. There is a variety of different agents, one that is common is Dopamine.
Q. Was she given Dopamine?
A. No --
Q. What else?
A. -- she wasn't.
There's other pressor agents that are also used that are similar to Dopamine such as Levophed.
Q. Let me cut this short.
Was she given any treatment at all?
A. No.
Q. Should she have been given some treatment?
MR. SCOTT: Objection.
MR. FELTES: Objection.
A. I think the physician should have been contacted at that point.
Q. If he wasn't, that was negligence on the part of the nurse, wasn't it?
MR. FELTES: Objection.
MR. SCOTT: Objection.

A. I think it was a nurse's obligation to call a physician.

MR. FELTES: Objection.

A. If she didn't, that was an error.

Q. An error?

A, Yes.

Q. In your opinion did that error contribute to cause brain damage sustained by Mrs. Lind?

MR. FELTES: Objection.

MR. SCOTT: Objection,

A. The interval of time between --

Q. 2:30 and 2:55, the 25 minutes?

A. That 25 minute period her blood pressure --

Q. Got worse?

A. Was worse.

Q. Yes.

A. Based upon that alone, I wouldn't have expected her to have the anoxic brain damage that she suffered.

Q. So it didn't matter if they contacted a doctor anyhow --

MR. SCOTT: Objection.

Q. -- didn't matter what a doctor did?

A. Well, I think --

Q. Should just send her home?

A. They should still contact a physician at this point because measures need to be taken to reverse this process,

Q. What are you saying? Either you can reverse it or what, is it irreversible at this point?

A. I don't know. She led -- this led to an arrest.

Q. Yes.

A. And --

Q. In your opinion had she received therapy would it still have led to an arrest?

A. I don't know that.

Q. But she didn't get any therapy and we know it did lead to an arrest?

A. We know it led to her arrest, but we don't know if she had gotten it that it wouldn't lead to an arrest.

Q. As an I.C.U. physician would you have provided therapy to her?

A. If I was called by the nurse I would have instituted measures immediately.

Q. You said something a second ago that I didn't understand, that was there probably wouldn't have been somebody in the I.C.U., a doctor in the I.C.U.; what do you mean by that?

A. That most of the time in community hospitals there is not a physician in the I.C.U. at all times.

Q. So whose responsibility is it then in terms of a patient who leaves the I.C.U. to go for a test while she is in respiratory distress to be around in case something happens; is that the attending, is it the consulting physician who recommends the test; is it all the doctors?

Who is it, is it everyone who agreed that she should have the test? Who is responsible --

MR. SCOTT: Objection.

MR. QUANDT: Objection.

Q. -- to be around in case something happens to a person?

A. It's the attending's, responsibility of the attending physician to be available if something happens to a patient.

Q. Well, he left; should he have in your opinion while she went for this CAT scan after having gone into respiratory distress when she had just gone down a few hours before?

MR. SCOTT: Objection.

A. I think that he needs to be available. I

think it was -- it was okay to leave, but he needs to be available.

Q. Available to do what?

MR. SCOTT: Objection.

A. To give orders,

Q. I see.

How is he supposed to do that without seeing the patient?

A. Because there's a nurse there with the patient who can provide information to him, He also had seen the patient just a few hours -- or actually within an hour or two before the incident occurred.

Q. This may seem like a strange question, I hope it isn't.

Should a patient be given informed consents before being sent for a CAT scan in your opinion?

A. No.

Q. What are ultrasounds used for?

A. Ultrasounds are used for a variety of purposes, They're used to check motion of the heart, they're used to detect accumulation of fluid in various body parts, they're used to detect stones.

Q. Gallbladder?
A, In the gallbladder.
Q. Diverticulitis?
A. They're used to detect possible abdomen distress.
Q. Are they used to detect diverticulitis?
A, Not diverticulitis, per say.
Q. Appendicitis?
A, Not per se, no,
Q. What do you mean "not per se"?
A, If the disease is associated with abscess formation, then an ultrasound can be used to detect that.
Q. How about peritonitis?
A. Again, it could be used to detect fluid, which peritonitis is often associated with.
Q. Can you do that at bedside, ultrasound?
A. Yes, you can.
Q. What do you think it was about sending her down to both the HIDA scan and the CAT scan that caused her to go into respiratory distress?
A. I don't know,
Q. Well, I mean, you point this out in your report she was heavy?
A. Yes.

Q. So they had to move her from her setting in the I.C.U.?
A. Yes.
Q. Do you think that contributed to it?
A, Moving her, no, I don't think so.
Q. How about moving her around in the radiology department?
A. I don't see that that would cause a substantial stress on a patient to cause --
Q. Do you think it was just serendipity this happened both times they sent her down?
A. I wouldn't answer it that way.
Q. Just a coincidence?
A. Coincidence.
Q. A mysterious coincidence?
MR. SCOTT: Objection.
A. I wouldn't use the word mysterious but it is serendipity,
Q. Just her karma?
MR. SCOTT: Objection.
Q. Did she have viral pneumonia?
A. I didn't review the records carefully to see the etiology of her pneumonia. My recollection is that it was the impression of Dr. Dacha that it was viral.

Q. So that antibiotics would not in fact treat that, would it?

A. Most viral infections don't respond to antibiotics, There are certain types of infections that are kind of crossovers, that are -- are not true bacteria but they are in a class of something called atypical pneumonias that are not able to be diagnosed by the usual cultures and they're an atypical viral disease and some of these don't respond to antibiotics,

Q. Did hers respond to antibiotics?

A. She was improved by the time she was extubated, so it had appeared that she had some improvement; whether that was from antibiotics themselves or that's just the natural history of the disease improved on its own, it is difficult to determine.

Q. So what do you do with somebody who has viral pneumonia who doesn't respond to antibiotics, just support them while the disease process is working its way through?

A. Basically, yes.

Q. So that if they have other problems, you make sure that those are addressed and make sure the pneumonia doesn't get any worse, right?

A. That's correct.
Q. So if you don't treat the pneumonia for, I don't know, a month period of time, or two weeks, or three weeks, that's probably not good --
MR. SCOTT: Objection.
Q. -- is it?
A. If you don't treat it for two or three weeks?
A. Yes.
A. That's an accurate statement.
Q. That it's not good?
A. It's not good,
Q. Would you expect such a patient who wasn't being supported while the disease process could work its way through, to in fact, get better -- or to get worse, I'm sorry?
MR. SCOTT: Objection.
A. I don't understand.
Q. Would you expect a patient who had pneumonia that was not being supported otherwise, okay, to get worse?
A. No, most pneumonia gets better on its own.
Q. So if somebody kept returning to you with complaints that were diagnosed as pneumonia, for example, originally --

A. Yes.
Q. -- four times, for example, over a two-week period --
A. Okay.
Q. -- should that patient be treated?
MR. FULTON: Objection,
A. Absolutely.
Q. And the failure to do so would constitute a deviation of the standard of care required of those physicians?
MR. FULTON: Objection.
MR. SCOTT: Objection.
A. Yes, if the patient was not treated, certainly.
Q. When you say "not treated," would you admit such a patient to a hospital?
MR. SCOTT: Objection.
MR. FULTON: Objection.
A. It would depend upon my clinical assessment of the patient as to whether the patient needed admission or not.
Q. So even though they came back four times over a period of two weeks, that wouldn't necessarily mean they had to be admitted?
MR. FULTON: Objection.

A. No, it wouldn't.
Q. What about given the fact they didn't respond to antibiotics, would that cause them to be admitted?
MR. SCOTT: Objection.
MR. FULTON: Objection,
A. Not necessarily.
Q. Should it be followed up?
A. Absolutely.
Q. By a repeat x-ray, for example?
A. Absolutely.
Q. Failure to do repeat x-ray would be failure to adhere to the appropriate standard of care?
MR. FULTON: Objection.
MR. SCOTT: Objection.
A. Yes, it would.
Q. In your report, sir, you say somewhere on page 4 of your report, you may remember it, if you need to look at it, go ahead, that Dr. Patel at the bottom of the page, speaking of Dr. D.C. Patel, he clearly had some reservations concerning the safety of its performance, referring to the CT performance; however, this is evident by his notes in the medical records and orders.
Those reservations I assume you

were referring to are the reservations pertaining to her respiratory status?
A. Yes.
Q. And in that regard you believe that it was appropriate for him to rely on Dr. Dacha in assessing that status in determining whether she could go to the CT?
A. That's correct.
Q. What reservations did he have --
MR. SCOTT: Objection.
Q. -- that you're referring to?
A. Well, the fact that he -- that he indicated in his notes, both in progress notes and order, that the test be performed only if okay with Dr. Dacha, implied that he had reservations about it.
Q. I understand,
My question is what reservations were they? What were these reservations?
MR. SCOTT: Objection.
A. I don't know what was going on in his mind, so I don't know exactly what the reservations were.
Q. But it's clear to you that he had reservations, you just don't know what they were?
A. Exactly.

Q. Are you assuming then that he raised those reservations with Dr. Dacha and/or Miclat or Patel?
A. Yes.
Q. Could you show me where those are in the record?
A. Where the reservations are?
Q. Sure. Any discussion about the respiratory status between two of them, three of them, or four of them?
A. There was -- wasn't one about respiratory status, there was discussion with other physicians concerning the tests that were going on.
Q. Well, if the reservations pertained to her respiratory status --
A. I didn't say that his reservations were pertaining to that.
Q. You didn't? I thought you did.
A. I said I didn't know what his reservations were specifically, only that he had them.
Q. Well, where did he discuss what those reservations were?
A. I don't believe they were discussed in the progress notes,
Q. Well, if he had reservations, shouldn't he have discussed them with the other doctors if he

had concerns?

MR. SCOTT: Objection.

A. I assume he did.

Q. Where does he say that?

A. He doesn't say that.

Q. So that's another mystery?

A. No, I think in his deposition --

MR. SCOTT: Objection.

A* -- he states several times that the patient had respiratory distress,

Q. Yes?

A. That he was leaving it up to Dr. Dacha to decide, asked whether the patient should go down.

Q. These were his reservations then about the respiratory status?

A. Yes, I think.

Q. Once again, if that was his concern, if he had reservations about those, don't you think he should have addressed those with Dr. Dacha --

MR. SCOTT: Objection.

MR. GALLAGHER: Objection.

Q. -- or anybody, somebody?

A. Yes, I think so.

Q. Did he?

A. Well, based upon his deposition he did

because he called this -- in his deposition he stated that he discussed this very issue with Dr. Dacha.

Q. Do you have his deposition?

A. I don't know.

Q. You didn't bring it?

A. No.

Q. You can't give me a page?

A. Probably not.

Q. If he didn't discuss it with Dr. Dacha and he had these reservations, would that be below the standard of care required of him?

MR. SCOTT: Objection.

A. I think if there was something evident that he had knowledge of that Dr. Dacha didn't, then it would be below the standard of care; but if this information was known to everyone and Dr. Dacha was a primary physician and should have known the status of this patient's respiratory status, then I didn't think -- I don't think that it was up to Dr. Patel to raise those issues with him and I don't think it would be the below of standard of care to not raise them.

Q. I mean, clearly all these doctors, all four of them knew that she came back from the HIDA scan

because of respiratory distress there, right?
A. Yes.
Q. But you are saying that the three of them are exculpated as long as Dr. Dacha knows --
MR. SCOTT: Objection.
MR. GALLAGHER: Objection.
Q. -- in terms of informing Dr. Dacha about the respiratory status?
A. Only if there was some information that they had privy to that he didn't would be there be any reason.
Q. I follow you. Okay,
How long does it take to intubate a patient typically; is that something that can be done fairly quickly?
MR. SCOTT: Objection.
A. In general it's done within minutes.
Q. Hook them up to a ventilator, how long does that take?
A. A few more minutes, depending upon the access they have to the ventilator,
Q. Well, in an I.C.U. unit they have access, wouldn't they?
A. Within ten minutes they should have a ventilator in the unit and the patient hooked up.

Q. If she had not had what you refer to as cardiopulmonary arrest, would she have sustained irreversible brain damage?

A. No, I don't think so.

MR. KAMPINSKI: That's all I have.

MR. SCOTT: Any other questions?

MR. FULTON: I just got two questions. Let me just ask something off the record.

(Discussion had off the record.)

CROSS-EXAMINATION

BY MR. FULTON:

Q. You indicated, Doctor, that she was improving after she was hospitalized with respect to her pneumonia; is that what I understand you to say?

A. Yes, I think so.

Q. For the first two days she was in the hospital she was not ventilated, was she?

A. I don't recall. I didn't review that aspect of her care very closely.

Q. So you don't know when she was put on the

ventilator?

A. No, I don't recall.

MR. FULTON: No further questions.

MR. SCOTT: Any other questions?

MR. ORTH: No questions.

MR. FELTES: No.

MR. SCOTT: Doctor will not waive.

(Deposition concluded; signature not waived.)

ERRATA SHEET

PAGE **LINE**

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

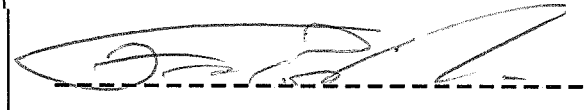
_____

ANTHONY DiMARCO, M.D.

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 13th day of January, 1995.



Frank P. Versagi, RPR, CLVS, Notary Public/State of Ohio. Commission expiration: 2-25-98.

Look-See Concordance Report

UNIQUE WORDS: 1,517
TOTAL OCCURRENCES: 5,822
NOISE WORDS: 385
TOTAL WORDS IN FILE: 19,575

SINGLE FILE CONCORDANCE

CASE SENSITIVE

PHRASE WORD LIST(S):

NOISE WORD LIST(S): NOISE.NOI

COVER PAGES = 6

INCLUDES ONLY TEXT OF:
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE THRESHOLD: ***50***

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: 9

LIST OF THRESHOLD WORDS:

---

arrest [56]
blood [73]
case [51]
Dr [51]
Objection [106]
patient [69]
process [51]
respiratory [67]
SCOTT [125]

* * DATES * *

January 9th [1]
17:16
May [1]
16:10
May 5th [2]
38:20, 23
May 6th [2]
38:15; 87:7
May 7th [8]
30:11; 32:21; 36:11; 51:15, 17; 60:6; 63:8; 90:17
May 10th [1]
22:15
May the 5th [1]
38:19
May the 6th [1]
60:20
May the 7th [5]
38:13; 60:4; 62:19; 63:18; 87:8
November [1]
8:25
October [1]
73:3
October 27th, 1994 [1]
18:6
September 21st [1]
17:14
September of 1994 [1]
17:6

* * 1 * *

1 [2]
21:10, 13
1,000 [1]
45:15
10 [5]
48:13; 49:21; 94:21; 96:1, 3
100 [6]
41:24; 56:7, 12, 14; 69:25; 86:10
105 [1]
45:1
108 [1]
42:20
1000 [2]
87:19; 92:2
10:15 [3]
56:2, 18; 85:23
10:30 [1]
56:18
10:46 [2]
37:5; 93:8
10th [1]
22:15
11 [1]
7:11
110 [1]
87:20
1135 [3]
99:13; 100:21; 103:11
114 [1]
87:20
115 [1]
87:20
116 [2]
56:7, 14
119 [1]
101:6
12 [3]
12:19; 48:13; 49:21
120 [2]
110:17, 23
120's [3]
87:19; 88:9, 18
123 [2]
45:3; 46:7
124 [3]
42:25; 43:6; 44:11
126 [3]
45:5; 46:2; 93:20
130 [2]
88:10, 19
130's [1]
87:19
131 [1]
101:5
13346 [1]
7:4
134 [1]
88:20
185 [1]
88:20
14 [1]
48:13
142 [1]
88:20
148 [1]
88:22
15 [5]
13:24; 48:13; 94:21; 96:1, 4
158 [1]
91:21
19 [2]
17:15; 73:4
1981 [1]
24:13
1985 [2]
14:1; 25:10
1993 [1]
16:4
1994 [6]
12:21; 16:4; 17:6; 18:6; 23:10; 73:5
1995 [2]
25:6, 9
1:15 [2]
56:8, 19
1:30 [1]
56:8

* * 2 * *

2 [1]
44:18
20 [2]
48:8; 49:21
20's [1]
48:7
200 [2]
45:21; 46:2
21st [1]
17:14
24 [2]
60:15; 84:25
25 [3]
111:15; 115:12, 13
27th [1]
18:6
2:00 [9]
56:9, 10; 88:9; 95:5; 98:5, 11; 99:1, 17; 102:15
2:30 [lo]
56:24, 25; 95:9; 98:6, 11; 100:2, 25; 101:8; 111:13; 115:12
2:45 [9]
100:15, 16, 21; 101:1, 11; 103:12; 110:5, 10
2:46 [1]
46:13
2:55 [4]
110:15; 111:15, 25; 115:12

* * 3 * *

30 [3]
49:21; 101:2; 109:1
30's [1]
48:24
329 [1]
38:14
330 [3]
36:19; 42:11; 93:12
333 [2]
36:7, 18

* * B * *

* * D * *

* * E * *

* * F * *

* * G * *

* * J * *

* * K * *

* * L *

* * M * *

* * N * *

* O *

* P *

* * S * *

* *T* *

* * U * *

* * V * *

* * W * *