

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

Scanned

Doc

137

IN THE COURT OF COMMON PLEAS
- - - - -

LENORE LIND, et al.,
plaintiffs,

vs.

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

Case No. 93CV110798

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.

FLOWERS & VERSAGI



COURT REPORTERS

Computerized Transcription

Computerized Litigation Support

THE 113 SAINT CLAIR BUILDING - SUITE 505

CLEVELAND, OHIO 44114-1273

(216) 771-8018

1-800-837-DEPO

1 APPEARANCES:

2 ON BEHALF OF THE PLAINTIFFS:

3
4 Charles Kampinski, Esq.

5 Christopher M. Mellino, Esq.

6 Charles Kampinski Co., L.P.A.

7 1530 Standard Building

8 Cleveland, Ohio 44113,

9 (216) 781-4110

10 and

11 Gerald R. Horning, Esq.

12 1419 W. 9th Street

13 Cleveland, Ohio 44113.

14 (216) 241-2258.

15 -----

16
17 ON BEHALF OF THE DEFENDANT COMPREHENSIVE HEALTH

18 CARE of OHIO, INC./ELYRIA MEMORIAL HOSPITAL:

19
20 Joseph Feltes, Esq.

21 Buckingham, Doolittle & Burroughs

22 624 Market Avenue N

23 Canton, Ohio 44702

24 (216) 456-2491.

25 -----

1 APPEARANCES: (continued)

2 ON BEHALF OF THE DEFENDANTS DAVID BRANCH, M.D.:

3 and ACUTE CARE SPECIALISTS, INC.:

4
5 Burt J. Fulton, Esq.

6 Gallagher, Sharp, Fulton & Norman

7 Seventh Floor Bulkley Building

8 Cleveland, Ohio 44114.

9 (216) 241-5310

10 -----

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

12
13 John P. Gallagher, Esq.

14 Fauver, Tattersall & Gallagher

15 400 Premier Building

16 Elyria, Ohio 44035

17 (216) 322-3784.

18 -----

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

20
21 Robert G. Quandt, Esq.

22 Quandt, Giffels & Buck

23 800 Leader Building

24 Cleveland, Ohio 44114.

25 (216) 241-2025.

1 APPEARANCES: (continued)

2
3 ON BEHALF OF THE DEFENDANT PARESH PATEL, M.D.:

4
5 Robert F. Orth, Esq.
6 1500 One Cascade Plaza
7 Akron, Ohio 44308
8 (216) 434-3000
9

10 -----

11
12 ON BEHALF OF THE DEFENDANT DINUBHAI C. PATEL, M.D.:

13
14 John R. Scott, Esq.
15 Reminger & Reminger
16 The 113 Saint Clair Building
17 Cleveland, Ohio 44114-1273
18 (216) 687-1311.
19
20
21

22 -----
23
24
25

I N D E XWITNESS :ANTHONY DiMARCO, M.D.PAGE

Cross-examination by Mr. Kampinski

6

DR. DiMARCO DEPOSITION EXHIBITSMARKED

1 - file folder cover	21
2 - 1-27-94 report of Dr. DiMarco	21
3 - 9-21-94 letter from Mr. Scott to Dr. DiMarco	21
4 - 1-09-95 letter from Mr. Scott to Dr. DiMarco	21

(FOR EVERY WORD INDEX, SEE APPENDIX)

1 ANTHONY DiMARCO, M.D.

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

7 - - - - -

8 CROSS-EXAMINATION

9 BY MR. KAMPINSKI:

10 Q. Would you state your name, please?

11 A. Anthony DiMarco.

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

13 A. I do.

14 Q. Can I see it?

15 Is this up-to-date?

16 A. Yes.

17 Q. Are those copies for me?

18 A. Yes, you can have that.

19 Q. Where are you currently employed, Doctor?

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

23 Q. What is the name of your private practice?

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

1 Q. Where is the practice located?

2 A. In Geauga County.

3 Q. And the address?

4 A. 13346 Ravenna Road, Chardon.

5 Q. Is there anyone in practice with you?

6 A. No.

7 Q. What is the nature of your practice?

8 A. Pulmonary medicine.

9 Q. How long have you been in private practice at
10 that location?

11 A. Let's see, 11 years.

12 Q. I'm sorry. You said you had a part time --

13 A. I am employed by MetroHealth Medical Center.

14 Q. What do you do for them?

15 A. I'm involved in teaching, research, and also
16 I see patients at that hospital also.

17 Q. How often do you teach?

18 A. Daily.

19 Q. Is it didactic?

20 A. It is -- well, most teaching is informal with
21 residents and interns, and also didactic teaching
22 at the medical school,

23 Q. Beg your pardon? Didactic --

24 A. I have didactic teaching at the medical
25 school and also at the hospital.

- 1 Q. You say the medical school?
- 2 A. Case Western Reserve.
- 3 Q. How often do you teach there?
- 4 A. I teach there approximately one month a
- 5 year.
- 6 Q. Is this in a classroom --
- 7 A. Yes.
- 8 Q. -- the entire month?
- 9 A. The entire month, yes.
- 10 Q. What do you teach?
- 11 A. Pulmonary medicine to first year medical
- 12 students.
- 13 Q. During that month are you also involved in
- 14 your private practice?
- 15 A. Yes.
- 16 Q. So how many days a week would you teach?
- 17 A, During that month long period I am involved
- 18 probably two to three hours per day.
- 19 Q. Five days a week or --
- 20 A. Between three and five days a week.
- 21 Q. Is it the same month every year or does it
- 22 change?
- 23 A, Approximately the same.
- 24 Q. When is that?
- 25 A. Usually November.

1 Q. What books do you use in conjunction with
2 your didactic teaching at the school?

3 A. We use Berne and Levy.

4 Q. Berne did you --

5 A, B-e-r-n-e and Levy, general physiology
6 textbook,

7 Q. Is that the name of the book or is that the
8 description of the book?

9 A, The exact name I don't recall. It's just a
10 general physiology textbook.

11 Also Pulmonary Physiology by John
12 West.

13 Q. Okay.

14 A. Just those two textbooks.

15 Q. What does your research consist of at
16 MetroHealth?

17 A. I am involved in the study of respiratory
18 muscles, respiratory muscle physiology, and various
19 forms of lung disease.

20 Q. And you also said that you are involved in
21 patient care at Metro?

22 A. Yes.

23 Q. Would these be private patients of yours or
24 staff patients of Metro; how is it that you see
25 patients?

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

8 Q. Is that a rotating position?

9 A. Yes.

10 Q. Between you and other physicians?

11 A. Other pulmonary physicians, yes.

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

14 A. Yes.

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

17 A. Yes.

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

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

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

24 A. Yes.

25 Q. Are you also an employee of Case Western?

1 A. No.

2 Q. So how is it that you teach at Case Western
3 Reserve, is this through your affiliation with
4 Metro?

5 A. MetroHealth Medical Medical Center is an
6 affiliate of the university.

7 Q. So as part of your job at Metro you teach at
8 Case?

9 A. Yes.

10 Q. Have you acted as an expert in any case prior
11 to this one?

12 A. Yes, I have.

13 Q. Could you tell me for whom, name of the case,
14 and what it involved?

15 A. Involved several cases, most of them involve
16 industrial related accidents, so I do some work
17 evaluating patients for the Industrial Commission
18 of Ohio and I am probably involved in -- I see
19 patients approximately once or twice a month for
20 them at MetroHealth Medical Center and I've
21 given --

22 Q. Are you employed by them or is this --

23 A. No.

24 Q. -- a contract type of job?

25 A. I get referrals from them.

1 Q. In other words, if they have a case involving
2 a claim for pulmonary disability --

3 A. Yes.

4 Q. -- they would call you and ask you to evaluate
5 it on their behalf?

6 A. Yes.

7 Q. That happens approximately once or twice a
8 month?

9 A. Yes.

10 Q. I'm sorry. Go ahead.

11 A. And in term of serving as an expert witness,
12 approximately once or twice a year I'm called upon
13 to give a deposition in relation to those cases.

14 Q. How about malpractice cases, have you ever
15 served as an expert in a medical malpractice case?

16 A. Yes.

17 Q. Would you tell us about those?

18 A. One case earlier this year, that was the only
19 case, other case in the past 12 months.

20 Q. You say this year?

21 A. '94, only other case in 1994; that involved a
22 decision by a pulmonologist concerning evaluation
23 of a patient with pulmonary embolism.

24 Q. For whom were you the expert?

25 A. For the defendant.

1 Q. Who was the defendant?

2 A. I don't recall the name,

3 Q. Who retained you?

4 A. An attorney at PIE Mutual, I don't know his
5 name either.

6 Q. Do you recall the name of the plaintiff, the
7 name of the case?

8 A. I believe it was Ragan, R-a-g-a-n.

9 Q. Were you deposed in that case?

10 A. No, I was not.

11 Q. Did the case go to trial?

12 A. I don't know,

13 Q. When you say you acted as expert in '94, is
14 it that you were retained in '94 to review the
15 case?

16 A. Yes.

17 Q. What was your involvement?

18 A. I was retained to review the case and submit
19 a report.

20 Q. How long have you been or have you acted as
21 an expert in medical malpractice cases?

22 A. I'm not sure what you mean how long.

23 Q. When did you start doing it, are you talking
24 five, ten years, 15?

25 A. Very first case I reviewed was in I believe

1 **1985.**

2 Q. **So** ten years?

3 A. Off and on.

4 Q. How many cases have you reviewed in that
5 ten years, medical malpractice?

6 A. I would say approximately four or five.

7 Q. Do you remember the names of them?

8 A. No.

9 Q. Can you remember when you were retained?

10 A. No ,

11 Q. Have you testified on behalf of the defendant
12 in all of them?

13 A. No.

14 Q. Do you remember the allegations in them?

15 A. I remember the allegation in the first one.

16 Q. Okay, what was that?

17 A. That was that a physician failed to diagnose
18 a pulmonary disorder,

19 Q. What was the disorder?

20 A. My recollection is that it was pulmonary
21 embolism or pulmonary infection possibly.

22 Q. Who were you retained by in that?

23 A. The plaintiff.

24 Q. Who was that?

25 A. I don't **recall**.

1 Q. Did you testify in that case?

2 A, Yes, I did.

3 Q. What was the name of the case?

4 A, I don't recall.

5 Q. Where did you testify, here in Cleveland?

6 A. It was not in Cleveland, it was in the State
7 of Ohio but not in Cleveland.

8 Q. You don't remember where in Ohio?

9 A. I don't recall,

10 Q. How about any of the other cases, do you
11 remember anything about them?

12 A. I believe another case related to the
13 diagnosis of pulmonary embolism, but I don't
14 remember the specifics or the name of the parties
15 involved.

16 Q. How long ago was that?

17 A. Five or six years ago,

18 Q. Who retained you in that case?

19 A. I don't recall.

20 Q. Were you deposed?

21 A, No.

22 Q. Did you go to trial?

23 A, No, never been to trial on any of these
24 cases.

25 Q. Have you ever been retained by Reminger &

1 Reminger?

2 A. Yes.

3 Q. When was that?

4 A. It was either 1993 or 1994.

5 Q. That's the only time?

6 A. That was the only time,

7 Q. Who retained you?

8 A. Which attorney do you mean?

9 Q. Yes.

10 A. May have been Mr. Scott, but I'm not certain.

11 Q. What was the nature of the case?

12 A. Involved an outpatient test done at a
13 hospital in Cleveland where there was an injury to
14 a patient during the performance of a blood test,
15 and a needle was inserted to obtain blood for a
16 blood gas, and there was resultant nerve injury.

17 Q. What was the name of the case?

18 A. I don't recall.

19 Q. Is it still pending?

20 A. No, it's not.

21 Q. Did you testify in that case?

22 A. No, I did not.

23 Q. Were you deposed?

24 A. No.

25 Q. Do you remember the name of the case?

1 A. I don't,

2 Q. Any others that you recall?

3 A. No others come to mind. I haven't been
4 deposited in any others.

5 Q. When were you first contacted in this case?

6 A. By phone I was contacted in September of 1994
7 and that was followed by a letter from Mr. Scott.

8 Q. And you are looking at that now?

9 A. Yes.

10 Q. Can I see it?

11 A, Yes.

12 Q. Are there other letters from Mr. Scott?

13 A. There is one other.

14 Q. In the September 21st letter to you from
15 Mr. Scott he lists 19 items that he forwarded to
16 you, and then in the January 9th letter, which I
17 guess was yesterday, he indicates that he forwarded
18 the deposition transcript of Dr. Ferguson to you;
19 did you receive any other materials in this case
20 other than those listed and these two letters?

21 A. Yes. I also received an expert report from
22 Dr. Larry Martin.

23 Q. When did you get that?

24 A. I believe it was four to six weeks ago.

25 Q. How was that delivered?

1 A. By mail.

2 Q. With no forwarding letter?

3 A. If there was, I may have misplaced it.

4 Q. Anything else that you received?

5 A. No.

6 Q. You wrote a report October 27th, 1994,
7 correct?

8 A. That's correct.

9 Q. It is not on letterhead, it's on plain
10 stationery; is there a reason for that?

11 A. There is no reason for that. Ordinarily
12 my -- I have a new secretary at my Geauga office
13 where I dictated this and reviewed the case, and
14 ordinarily it would be on stationery at that
15 hospital.

16 Q. I'm sorry?

17 A. Ordinarily it would be on my own private
18 stationery.

19 Q. Was this the only report that you authored?

20 A. This is the only report, yes,

21 Q. Did you prepare any drafts of that report?

22 A. Yes.

23 Q. Were they changed?

24 A. There were typographical changes made, and
25 nothing in terms of content.

1 Q. What happened to the drafts?

2 A. They were discarded.

3 Q. By whom?

4 A. By myself.

5 Q. Were they submitted to Mr. Scott either
6 verbally or in writing?

7 A. One earlier draft was submitted and then a
8 final version was submitted.

9 Q. Did he have input into the changes?

10 A. No, he did not,

11 Q. Well, how is it that you gave him a draft and
12 then it was changed?

13 A. Because he explained that he had a deadline
14 to meet and I also -- also was pressed for time.
15 At that point I gave him the draft that -- the last
16 draft that I had at that point, and then I made
17 some small changes, mostly typographical changes,
18 and sent him that final version.

19 Q. What about the not mostly typographical
20 changes, what substantive changes did you make?

21 A. There were no substantive changes.

22 Q. Do you have a copy of the draft?

23 A. I don't have that here.

24 Q. Where do you have it?

25 A. I believe that was sent to Mr. Scott and I

1 may have a copy of that at my office.

2 Q. Is there a reason you didn't bring it?

3 A. No, there's not. I think that I looked at
4 this, at the final copy, this was the basis for my
5 review.

6 MR. KAMPINSKI: Well, can we
7 have an agreement that he'll provide me with a copy
8 of the draft?

9 MR. SCOTT: Sure.

10 Q. Is there more than one draft?

11 A. No, there is not.

12 Q. Is there anything else that you have that
13 pertains to this case that you didn't bring with
14 you, bring with you today?

15 A. I have binders similar to these that contain
16 all the information related to these documents that
17 I didn't bring,

18 Q. When you say similar to these, obviously the
19 record can't reflect what you're pointing to.

20 There are black binders on the
21 table that --

22 A. These are not mine.

23 Q. The only thing that you brought -- what did
24 you bring with you?

25 A. Everything I brought is contained in this

1 folder, which you have seen.

2 Q. The two letters from Mr. Scott and your
3 report?

4 A. And my report.

5 Q. Were you told not to bring anything else?

6 A. No, I was not.

7 MR. KAMPINSKI: Frank, why
8 don't you mark the whole thing.

9 -----

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

12 -----

13 Q. Doctor, I've marked Exhibits 1 through 4.

14 A. Okay.

15 Q. And those constitute all of the documents we
16 just referred to that you brought, correct?

17 A. That's correct.

18 A. Have you had an opportunity to read the
19 deposition of Dr. --

20 MR. MELLINQ: Ferguson.

21 Q. -- Ferguson?

22 A. Yes, I did.

23 Q. You read that last night, presumably or
24 yesterday?

25 A. Sometime yesterday.

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

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

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

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

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

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

19 A. Yes.

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

23 A. Yes.

24 Q. Have you ever been sued?

25 A. Yes, I have.

1 Q. How many times?

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

4 A. Three times.

5 Q. What were the names of the cases?

6 MR. SCOTT: Continuing
7 objection.

8 A. One case the last name was Thompson.

9 Q. When was that?

10 A. That was in 1994.

11 Q. What was that for?

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

15 Q. What was the disorder?

16 A. TTP, which is thrombotic thrombocytopenia
17 purpura.

18 Q. Why were you sued?

19 MR. SCOTT: Objection.

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

22 Q. How were you treating the patient?

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

1 this disorder.

2 Q. Who was plaintiff's attorney?

3 A. I'm sorry?

4 Q. Who was the plaintiff's attorney?

5 A. I don't recall.

6 Q. Where was the suit filed?

7 A. In Cleveland.

8 Q. Still pending?

9 A. Pes.

10 Q. Who is representing you?

11 A. PIE Mutual.

12 Q. How long have you been insured by PIE?

13 A. Since 1981.

14 Q. How about the other cases?

15 MR. SCOTT: Continuing
16 objection.

17 A, I don't recall the names of either case. I
18 can tell you the details of the case.

19 Q. They were both filed here in Cleveland?

20 A. One was in Cleveland, one was in Chardon.

21 Q. Do you remember the names of the attorneys?

22 A. No, I don't.

23 Q. When were they?

24 A. One case was approximately four years ago.

25 Q. Which was the one --

1 A. The one in Cleveland.

2 Q. And the other one?

3 A. The other one approximately ten years ago,
4 that was in Chardon,

5 Q. What were these about?

6 A, The first case in 1995 --

7 MR. SCOTT: Objection.

8 A. -- related to --

9 Q. 1995?

10 A. I'm sorry, 1985.

11 -- related to an elderly gentleman
12 who was approximately 75 years old, suffered a
13 stroke, heart attack, pneumonia, respiratory
14 failure, and had diabetes, who had a prolonged
15 hospitalization and died during that
16 hospitalization; and the lawsuit regarded cause of
17 death, whether or not it was a wrongful death or
18 not.

19 Q. How did this suit turn out?

20 A. The case was dropped,

21 Q. What was your involvement in that case?

22 A. I was the attending physician of this
23 patient.

24 Q. How about the one in Cleveland?

25 A. That one in Cleveland involved a diabetic

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

4 Q. What was your involvement?

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

9 Q. What was the result of that case?

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

13 Q. Did you testify in any of these cases?

14 A. No.

15 Q. Either by way of deposition or at trial?

16 A. No.

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

19 A. No, I don't.

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

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

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

3 Q. Well, is that negligence, Doctor?

4 MR. FELTES: Objection.

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

6 MR. FELTES: Objection.

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

9 Q. Well, I don't know if you're making a
10 distinction from what I said or if you are not,
11 Can you not bring yourself to say
12 the word or --

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

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

19 A. I'm not certain of that.

20 Q. No? You are not?

21 A. Well, let me explain.

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

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

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

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

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

14 MR. FELTES: Objection.

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

17 Q. So we're in agreement?

18 A, We're in agreement about that.

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

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

22 Q. Did it get better?

23 A. No, it did not.

24 Q. Did she have a respiratory arrest after that?

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

1 primary etiology was respiratory or not.

2 Q. What do you think the primary etiology was?

3 A. I'm not certain.

4 Q. What do you think it probably was?

5 A. Well, probably a cardiopulmonary arrest. She
6 had multiple medical problems going on at that time
7 including an infection, etiology which was not
8 clear; she was in renal failure and had a
9 subsequent metabolic acidosis as a result of that;
10 she was in some respiratory distress and had high
11 respiratory rates as a consequence of that; and she
12 was an obese lady who was -- that also puts some
13 increase work load on her cardiopulmonary status,
14 all these factors together I think lead to the
15 arrest situation.

16 Q. I'm sorry. Go ahead.

17 A. In terms of defining it as a specific
18 respiratory arrest as opposed to a cardiopulmonary
19 arrest, where the primary disease process may have
20 been something other than respiratory, is unclear
21 to me.

22 Q. Well, what did the physicians label it as
23 after she had an arrest, respiratory arrest or
24 cardiopulmonary arrest?

25 A. I saw cardiopulmonary arrest written and also

1 saw respiratory arrest written,

2 Q. You don't have an opinion as to which it was?

3 A. Based upon the vital signs and the
4 description of the case, in my opinion it was
5 cardiopulmonary arrest.

6 Q. Which vital signs?

7 A. I'm sorry?

8 Q. What is it you base that on specifically?

9 A. The patient had problems maintaining a normal
10 blood pressure, her blood pressure was low on
11 May 7th.

12 Q. Yes.

13 A. Indicating that there were factors other than
14 respiratory that were causing some of these
15 problems. So I think it is with -- it is more than
16 just a primary pulmonary respiratory process,

17 Q. Anything else other than low blood pressure?

18 A. She also had abdominal pain and she had
19 abdominal findings which also pointed to a
20 nonrespiratory cause,

21 Q. What was the cause of her abdominal pain?

22 A. I don't know that.

23 Q. I mean, you reviewed the record, haven't you?

24 A. I have reviewed the record.

25 Q. That didn't lead you to reach a conclusion as

1 to what the cause of her pain was?

2 A. No, it did not.

3 Q. Was there some intra-abdominal process that
4 was causing it?

5 A, It's likely there was some intra-abdominal
6 process causing it, yes.

7 Q. What was that?

8 A, I don't know.

9 Q. Were there tests done to determine --

10 A. There were tests done to attempt to evaluate
11 the cause of it, yes.

12 Q. What did they show?

13 A. The CAT scan did not define a specific
14 abnormality, and the HIDA scan I believe was
15 incomplete.

16 Q. Well, she had surgery later on?

17 A. She did have surgery.

18 Q. What did that show?

19 A. To my knowledge they didn't find any specific
20 abnormality.

21 Q. Well, so once again, the question was what
22 was causing her abdominal pain?

23 MR. SCOTT: Objection.

24 Asked and answered,

25 A. I don't know.

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

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

4 A. I believe she did.

5 Q. Was that a cause of her pain?

6 MR. SCOTT: Objection.

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

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

13 A. In part, yes.

14 Q. What else?

15 A. Well, she had a metabolic acidosis.

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

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

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

21 A. The one performed on May 7th.

22 Q. What time?

23 A. I don't recall the time.

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

25 A, Okay, let's pull the chart,

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

A. I was asked to review the specific care
4 provided by Dr. Patel in terms of the standard of
5 care provided.
6

Q. Okay.

A. And I believe I addressed those issues.

Q. I see. So that you believe as a
9 pulmonologist you're --
10

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

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

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

Q. So that you don't have any difficulty as a
20 pulmonologist in rendering an opinion with respect
21 to the care of Dr. Dacha, who is the pulmonologist,
22 right?
23

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

Q. I understand, but you don't have a problem
25

1 doing that, that's within your specialty, right?

2 A. Well, as I said, I didn't review the entire
3 case with that in mind.

4 As a pulmonologist I feel competent
5 to review the care provided by another
6 pulmonologist.

7 Q. And obviously you feel competent to review
8 the case on behalf of Dr, D.C. Patel, who was a
9 gastroenterologist, correct?

10 A. Insomuch as the care provided in this case,
11 yes.

12 Q. How about any opinions with respect to Dr. P.
13 Patel, do you have a problem rendering opinions as
14 to his care?

15 A. Well, I am not a surgeon, I would have some
16 difficulty.

17 Q. That's a fair answer. Let me qualify the
18 question.

19 A. Okay.

20 Q. In the context of his meeting with the other
21 physicians and recommending the CT scan?

22 A. In that capacity I agree with -- I agree with
23 his decision.

24 Q. And that would also be true then with respect
25 to Dr. Miclat, right?

1 A. In terms of that decision, yes.

2 Q. How about with respect to the care rendered
3 by the emergency room physicians?

4 A. I didn't review that in great detail, so I
5 can't really form at this -- give you an opinion
6 about that,

7 Q. Did you review it at all?

8 A. I did very briefly,

9 Q. Do you have any opinion with respect to their
10 care?

11 A, No.

12 MR. FULTON: He just said he
13 can't give one.

14 MR. KAMPINSKI: Well, doesn't
15 mean he doesn't have an opinion maybe.

16 MR. FULTON: That's the only
17 thing I've heard so far in this deposition.

18 Q. Well, you can't give an opinion now,
19 all right.

20 A, As I said before, my review centered around
21 the care provided by Dr. Patel. He got involved
22 several days after the patient was admitted,

23 Q. You were about to point out to me the
24 arterial blood gases that led you to conclude that
25 she had metabolic acidosis, and when you look at

1 these, refer to a page?

2 MR. SCOTT: Do you have it?

3 Do you have it by chance, Chuck?

4 MR. KAMPINSKI: What?

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

7 MR. FELTES: 333.

8 MR. KAMPINSKI: I don't know.

9 MR. SCOTT: Then we're in
10 trouble.

11 A. Yes, on May 7th.

12 Q. What time?

13 A. 6:35.

14 Q. 6:35 a.m.?

15 A. Yes.

16 Q. Okay. What are --

17 A. The pH recorded is 7.28.

18 Q. You got me confused. Page 333?

19 A. 330, I have.

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

22 MR. SCOTT: Count on it.

23 MR. KAMPINSKI: Okay,

24 Q. At 6:35 the pH was 7.28?

25 A. Yes.

1 Q. That's low?

2 A. Yes.

3 Q. Is that abnormal?

4 A. Yes, it is.

5 Q. The next one is at 10:46, right, that's 7.26?

6 A. That's correct.

7 Q. That's also low?

8 A. Yes, it is.

9 Q. What does that mean with respect to the
10 patient? I mean, is that good for her or is it bad
11 or --

12 A. Well, it's a modest reduction in pH.

13 Q. Modest?

14 A. Yes.

15 Q. But that **you're** saying is evidence of
16 metabolic acidosis?

17 A. Yes, it is.

18 Q. What does that mean, metabolic acidosis?

19 A. It means that there most likely is inadequate
20 tissue perfusion or --

21 Q. What causes that?

22 MR. SCOTT: Let him
23 finish.

24 A. Or there -- she's not able to eliminate the
25 normal production of acid in her body, which can

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

7 Q. Renal failure?

8 A. Yes.

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

11 A, To excrete the acid.

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

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

17 Q. Throughout the entire day?

18 A, Yes.

19 Q. How about on May the 5th?

20 A. She also did on May 5th.

21 Q. She did or did not?

22 A. She did.

23 Q. What time on May 5th?

24 A, 6:39 in the morning.

25 Q. The pH is not abnormal, is it?

1 A. No, but her pCO₂, which is the number just
2 before that, is low.

3 Q. That is evidence of metabolic acidosis?

4 A. That coupled with the -- that pH.

5 Q. In other words, the two combined --

6 A. The two together leads you to a diagnosis of
7 metabolic acidosis.

8 Q. So we got a low blood pressure, we got
9 metabolic acidosis as a result of the modest
10 reduction in the pH, and that's what caused her
11 cardiopulmonary arrest; that was the evidence that
12 tells you it was a cardiopulmonary arrest as
13 opposed to respiratory arrest?

14 A. Alone, that's correct.

15 Q. I'm sorry?

16 A. Those factors are consistent with some other
17 process, that other process is what lead to this
18 cardiopulmonary arrest,

19 Q. What other process is that?

20 A. Well, we have a number of possibilities. I
21 don't know what the process was.

22 Q. Well, now you're confusing me again, sir.

23 You're saying this is a process
24 that was never found or determined in Mrs. Lind?

25 A. Well, at least not up until the time of her

1 arrest.

2 Q. How about afterwards?

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

8 Q. Go ahead.

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

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

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

17 MR. SCOTT: Objection.

18 A. What?

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

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

1 Q. Was there some process in Mrs. Lind that
2 would explain a respiratory arrest?

3 A. At that point in time there was no specific
4 process to explain respiratory arrest alone, no.

5 *a.* How about pneumonia?

6 A. The patient had pneumonia for -- since her
7 admission.

8 Q. Yes?

9 A. She was in respiratory failure since her
10 admission, up until the time she was extubated,
11 when the tube was removed.

12 Q. Yes?

13 A. At that point in time arterial blood gases
14 were checked and she was even, throughout all of
15 the blood gases, even on the 7th she demonstrated
16 she was able to maintain adequate ventilation on
17 her own, she was not in respiratory failure; and
18 the fact that she had pneumonia on chest x-ray by
19 itself doesn't preclude her ability to breathe on
20 her own, and she demonstrated that she could do
21 that both before she was extubated, while she was
22 on this CPP ventilation and afterwards; and her
23 oxygenation was more than adequate. I think the
24 **P02's** were over 100 and she was appropriately
25 handling this metabolic acidosis by

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

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

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

8 Q. Wait a minute. Wait a minute.

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

11 A. On the 7th on page 330.

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

14 A. That's correct.

15 Q. Do you know what time?

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

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

20 A. First one was **5:13** was **108**.

21 Q. Is that normal?

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

24 Q. How about at **9:52**?

25 A. Her PO2 then was 124.

1 Q. Is that good?

2 A. Well, it means she's adequately oxygenated.

3 Q. It means she's adequately oxygenated?

4 A. Yes.

5 Q. Is that normal?

6 A. The P02 124 is not normal, if she's is on a
7 substantial amount of oxygen.

8 Q. It's not normal, explain that to me.

9 A. Well, we -- normal level of P02
10 conventionally is measured with room air, normal
11 values ranging from approximately 80 to 95; and if
12 it drops below that level it would be abnormal, but
13 yet you can have a low P02 that is abnormal but yet
14 it could not be compromising your metabolic
15 process. You could have P02 as low as 60, for
16 example, and still have adequate oxygenation but
17 have abnormal P02's.

18 Now, in cases where the P02 drops
19 below that level, let's say, for example, it falls
20 to 40, that would be a detrimental level of
21 oxygenation requiring treatment, and the treatment
22 would be additional oxygen; and during her course
23 she was given oxygen, and the oxygen that she was
24 given allowed her P02 level to rise to a level that
25 resulted in adequate oxygenation, so that the level

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

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

6 A. Yes.

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

9 A. Yes, it said --

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

12 A. Yes. On that day her -- she was getting
13 40 percent oxygen.

14 Q. How about the next reading then of 94?

15 A. She was also receiving 40 percent oxygen.

16 Q. Where do you see that?

17 A. On the far left, under test there is a
18 notation "percent oxygen," just below S O 2.

19 Q. Okay. All right.

20 Then the next reading 74?

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

22 Q. She they increased it?

23 A. Evidently.

24 Q. Next reading?

25 A. Also on 50 percent.

1 Q. 105?

2 A. Yes.

3 Q. Then goes up to 123?

4 A. Yes, 50 percent also,

5 Q. That one is 126?

6 A. Yes.

7 Q. Also 50 percent?

8 A. Yes.

9 Q. So then it is going up?

10 A. It was improving, yes.

11 Q. So that's getting better?

12 A. Yes.

13 Q. So the higher it goes, the better it is?

14 A. Yes.

15 Q. So if there was 1,000, that would be great?

16 A. That would be impossible.

17 Q. 500 would be pretty good?

18 A. Also impossible.

19 Q. How high could you get it?

20 A. Well, a normal level of PO2 on 50 percent

21 oxygen would be a range of some number over 200.

22 Q. So it was actually low then?

23 A. This is abnormal, but it was providing

24 adequate oxygenation to her.

25 Q. Well, how do you know it was providing

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

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

8 Q. What would it have been without the
9 50 percent oxygen, is there some formula --

10 A. No.

11 Q. -- that allows you to tell that?

12 A. No.

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

15 MR. SCOTT: Objection.

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

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

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

22 THE WITNESS: No.

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

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

1 these levels is a stimulant to breathing.

2 Q. It's make you breathe better?

3 A. Yes. Well, it makes you breathe --

4 Q. Harder?

5 A. Harder.

6 Q. Because you're not getting enough oxygen?

7 A. Exactly. These numbers for a respiratory
8 arrest would be characterized by much higher levels
9 of PCO₂, her level was 47, so this would not be
10 consistent with respiratory arrest.

11 Q. Going back to something you said just a
12 minute ago, Doctor.

13 In other words, if a person's not
14 getting enough oxygen, that means they breathe
15 harder and they take more respirations because
16 they're not getting enough oxygen?

17 A. Well, low oxygen level is a stimulant and
18 it's one of the body's defense mechanism to improve
19 the level of oxygen, so the stimulant is to breathe
20 and increase ventilation.

21 Q. That would increase respiration?

22 A. Either respiratory rates or the depth of
23 respiration,

24 Q. What level of respiratory rate would you
25 anticipate with the reading of 49?

1 A. It's not predictable.

2 Q. Give me a range.

3 MR. SCOTT: Objection.

4 Q. This is your profession.

5 A. But it's not readily predictable.

6 Q. Would you expect it to be in the 70's, 50's
7 40's, 20's?

8 A. It is expected it to be higher than 20, but
9 it's extremely variable between patients. I can't
10 really give you a number what it should be.

11 Q. What is normal respiration?

12 A. Normal respiratory rates varies between
13 probably 10 to 12, up to 14 or 15 breaths
14 per minute,

15 Q. So that if someone is having higher levels
16 than that, that would be an indication to you as a
17 pulmonologist that they're not getting enough
18 oxygen?

19 A. No, that wouldn't.

20 Q. It wouldn't?

21 A. There's many causes of rapid respiratory
22 rates and increases in depths of breathing.

23 Q. Well, what if it was, for example, in
24 the 30's, would that be an indication to you that
25 person was compensating in trying to get more

1 oxygen?

2 A. No, it wouldn't,

3 Q. How about the **40's**?

4 A. No. Respiratory rate would indicate --

5 Q. Doesn't matter?

6 A. By itself if the patient's oxygen level is
7 low you need to have -- to do these tests to
8 determine that.

9 Q. So if somebody's in the **40's**, that's really
10 meaningless?

11 A. It's not meaningless. Means the patient is
12 having respiratory distress but that doesn't mean
13 the patient's oxygen level is low,

14 Q. What does it mean to someone who is having
15 respiratory distress?

16 A. Just that. It's respiratory distress and you
17 hope to determine the etiology of it.

18 Q. Why don't you define respiratory distress for
19 me.

20 A. Anybody experiencing difficulty breathing, it
21 could be a respiratory rate of **10** or **12**, **20**, **30**,
22 any number you like,

23 Q. What you are saying is the difficulty in
24 breathing may not be in fact related to the oxygen
25 they're receiving?

1 A. That's right,

2 Q. Was Mrs. Lind having respiratory distress
3 subsequent to her extubation?

4 A. She was having some respiratory difficulty,
5 yes.

6 Q. Some?

7 A. Yes.

8 Q. Or a great deal?

9 A. Well, I say some. Her respiratory rates were
10 high but she had adequate oxygenation.

11 Q. Were they --

12 A, She was hyperventilating.

13 Q. Were they getting worse, those respiratory
14 rates?

15 A. Respiratory rates were variable. There were
16 indications they were getting worse, particularly
17 when she went for this first test in x-ray. She
18 got somewhat better when she came back to the
19 intensive care unit.

20 Q. What is the reason they were so high?

21 A. One of the reasons I suspect was the fact
22 that she had abdominal pain, that in and of itself
23 can increase respiratory rates,

24 Q. When she came back she wasn't having abdomen
25 pain?

1 MR. SCOTT: Objection.
2 Misstatement of the records.

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

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

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

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

9 Q. Okay.

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

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

12 Why don't you pull that out for
13 me.

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

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

18 THE WITNESS: Yes.

19 MR. KAMPINSKI: Yes.

20 MR. SCOTT: And this?

21 THE WITNESS: And also the
22 nurses' notes.

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

1 Q. Do you want to finish that? Do you want to
2 read the whole note, sir?

3 A. I am having trouble reading the rest of this
4 line due to the handwriting,

5 Q. State feels better since has -- since had
6 bowel movement?

7 A. Movement and large stool.

8 Q. So she was feeling better then?

9 A. But she still had abdomen pain.

10 Q. It was vague?

11 A. Evidently.

12 Q. Is it your testimony that that's the reason
13 that her respirations were in the high 40's and
14 low --

15 A. It's my testimony that abdomen pain in part
16 was contributing to her high respiratory rates.

17 Q. What else?

18 A. She also had metabolic acidosis, Acidosis is
19 also a stimulant to breathing.

20 Q. That mild elevation that you pointed to
21 before in the ABG's?

22 A. The mild decrease.

23 Q. Decrease?

24 A. Decrease in pH, yes. And also indicated in
25 the other parts of the blood gas was the fact that

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

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

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

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

15 Q. And the fever was due to what?

16 A. I don't know.

17 Q. Was it due to her pneumonia?

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

22 Q. What intra-abdominal process, sir?

23 A. Well, there were several possibilities,

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

1 A. And I answered at that point I didn't know.

2 Q. So what are you talking about?

3 A. I'm talking about a process, etiology which
4 is not determined.

5 Q. But there's no process?

6 MR. SCOTT: Objection.

7 A. Well, that's your opinion. My opinion there
8 was, was a process.

9 Q. Tell me what it is.

10 A. I don't know what -- what it is. There's a
11 number of possibilities at this point. These were
12 being investigated.

13 Q. Which one was it?

14 MR. SCOTT: Objection.

15 A. Again, I don't know.

16 Q. Was it any of them?

17 MR. SCOTT: Objection.

18 A. I don't know.

19 Q. Why don't you know?

20 MR. SCOTT: Objection.

21 A. Well, there's certain diagnoses that are not
22 evidenced just by the mere performance of these
23 tests.

24 Q. So once again, it's a mysterious ailment that
25 was causing --

1 MR. SCOTT: Objection.

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

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

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

11 Q. Why?

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

13 Q. Well, how was that treated?

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

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

21 Q. Did it?

22 A. Yes.

23 Q. Got much better?

24 A, Well, it improved.

25 Q. Improved from what to what?

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

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

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

9 Q. How about at 2:00?

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

11 Q. So it went back down?

12 A. Slightly. They were all in the same 89, 100,
13 95, with the exception of one blood pressure was
14 116. They were all around the range of 95 to 100
15 systolic.

16 Q. How about diastolic?

17 A. Diastolic blood pressures were low, 47, 48,
18 49 at 10:15, at 10:30; and they were -- remained in
19 approximately that range and improved at 1:15, and
20 that was back down to 50 at two o'clock.

21 Q. So you consider that a significant
22 improvement then?

23 A. Yes, I do.

24 Q. How about at 2:30?

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

1 66 over 46.

2 Q. What caused that to happen?

3 A, Several possibilities.

4 Q. Well, what probably caused it to happen?

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

8 Q. Wait a minute.

9 A. Infection, others --

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

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

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

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

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

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

25 Q. So the answer is you don't?

1 A* So it's --

2 Q. Look, Doctor --

3 A. I do not know for certain, no. I think I can
4 give you two or three possibilities that are
5 probable. I can't give you a specific diagnosis.

6 Q. Two or three possibilities that are probable?

7 A. They -- each of which are probable.

8 Q. Each one is probable?

9 A. Yes.

10 Q. What are those? What are the probabilities
11 or the possibilities that are probable?

12 A. One would be still dehydration, and by that I
13 mean that the amount of fluid inside the blood
14 vessels is low.

15 Q. So that she didn't get enough hydration then?

16 A. She may have been -- gotten enough fluids at
17 that point. Patients with infection frequently
18 leak fluid outside their blood vessels.

19 Q. What infection did she have?

20 MR. SCOTT: Pardon me?

21 A. I'm not certain.

22 Q. What was the infection that she had?

23 MR. SCOTT: That question
24 has been asked.

25 A. Several times.

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

4 MR. SCOTT: Objection to
5 that.

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

9 Q. Sepsis is an infection in the blood?

10 A. Yes.

11 Q. And did she have sepsis?

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

14 Q. Did she have sepsis --

15 MR. SCOTT: Objection,

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

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

20 Q. Can pneumonia cause a fever?

21 A. Yes, it can.

22 Q. Elevated white count?

23 A, Yes,

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

25 A. Many other things can also cause those things

1 there.

2 Q. But we know she had pneumonia?

3 A, She had pneumonia on admission.

4 Q. Did she still have pneumonia on May the 7th?

5 A. She had infiltrates on chest x-ray.

6 Q. Did she have pneumonia on May 7th to a
7 reasonable degree of probability?

8 A, Yes.

9 Q. Okay. Well --

10 A. Can I finish one thought?

11 Q. Absolutely.

12 A. At this point in time I think it is much less
13 likely pneumonia that's contributing to these
14 abnormalities since they developed over the
15 previous 24 to 36 hours.

16 Q. She developed them after she was extubated?

17 A. Yes.

18 Q. Well, her pneumonia was -- I mean her
19 breathing was being assisted by a ventilator up
20 until May the 6th, wasn't it?

21 A. That's correct.

22 Q. As I understand it, after she was extubated,
23 the abnormalities started occurring?

24 A. That's correct.

25 Q. Well, you as a pulmonologist and myself as

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

4 MR. SCOTT: What
5 difficulties are we talking about?

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

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

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

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

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

18 a. No?

19 A, No.

20 Q. Why not?

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

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

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

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

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

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

21 MR. SCOTT: He agrees with
22 you.

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

25 MR. SCOTT: That's not --

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

3 A. I said --

4 MR. SCOTT: Objection.

5 Q. -- report or what?

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

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

9 A. Yes, she did.

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

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

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

19 MR. SCOTT: Objection.

20 Q. -- is that your testimony?

21 A. My testimony is that it can.

22 Q. It can, okay.

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

25 A. Yes.

1 Q. -- that can cause her symptomatology --

2 A. Yes.

3 Q. -- as opposed to some mysterious illness that
4 you can't tell me what it is because there is no
5 evidence in the record to indicate that it exists
6 that you believe caused her problem?

7 MR. SCOTT: Objection,

8 Q. Do I understand your opinion correctly?

9 A. I don't think so.

10 Q. What is it I don't understand?

11 A, Well, the disease process you call
12 mysterious.

13 Q. You are right. Go ahead.

14 A. I believe is real.

15 Q. What was it?

16 MR. SCOTT: Objection.

17 A. Just because we can't define it specifically
18 doesn't mean it didn't exist or was mysterious.

19 The fact is that patient had abdominal pain that
20 had a cause --

21 Q. Well --

22 A, -- yet to be defined --

23 MR. SCOTT: Let him
24 finish.

25 A. You have to define all parts. Just because

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

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

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

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

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

17 Q. You think --

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

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

22 A. Yes.

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

25 MR. SCOTT: Objection.

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

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

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

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

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

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

24 MR. SCOTT: Objection.

25 Q. -- would that change your opinion?

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

2 a. Would it change your opinion in any way if he
3 told them that?

4 A. My opinion in what sense?

5 Q. In any sense?

6 A. What do you mean?

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

11 MR. SCOTT: Objection.

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

14 Q. Do you remember the question?

15 A. I guess, yes.

16 Q. Let me restate it.

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

21 A. No, it means something.

22 Q- What does it mean?

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

1 Q. What does it mean to you as an expert?

2 A. It means that --

3 MR. SCOTT: As to whether
4 there was abdominal process?

5 MR. KAMPINSKI: As to his
6 opinion.

7 A. Well --

8 Q. He prefaced his opinion earlier on the fact
9 that they thought there was something going on.
10 I'm telling him to read the deposition where the
11 doctor said he didn't; read his expert reports,
12 where his expert says that, I assume you read that?

13 MR. SCOTT: Objection.

14 A. Yes. Okay. Well, there's big if's there and
15 it's in conflict with the progress notes.

16 Q. I'm not making it up.

17 A. I'm not making up the progress notes.

18 Q. But answer my question.

19 A. Well then, based upon the if's, if the -- if
20 that's what he thought, there was nothing
21 intra-abdominal, that would make it -- make me
22 think there was less likely a process; but two of
23 the -- or two physicians involved in her care
24 believe there was, so there's some conflict here
25 and controversy.

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

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

7 MR. SCOTT: Objection.

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

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

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

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

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

22 A. Okay.

23 Q. I mean --

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

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

3 MR. SCOTT: Objection.

4 MR. KAMPINSKI: I understand.

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

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

10 Q. It is?

11 A. This is a diagnostic test.

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

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

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

17 A. In rare instances, yes,

18 Q. Rare instances?

19 Such as?

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

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

25 A. Absolutely.

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

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

6 Q. I'm sorry, arrest?

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

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

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

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

15 A. Yes.

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

18 A. That's correct.

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

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

4 Q. I wasn't speaking in any terms,

5 A. I was clarifying my answer,

6 Q. What are the risks and benefits then?

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

9 Q. Radiation?

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

13 Can we take a break here?

14 -----

15 (Recess had.)

16 (Record read,)

17 -----

18 BY MR. KAMPPNSKI:

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

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

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

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

1 report?

2 A. I don't recall seeing this one.

3 Q. The report of October?

4 A. 19?

5 Q. 1994?

6 A. Yes.

7 Q. Did you ask him for any other reports in this
8 case?

9 A. No, I didn't.

10 Q. Do you know why he didn't give that to you?

11 MR. SCOTT: Objection.

12 That's assumption on your part. He indicated that
13 he does not recall seeing it.

14 Q. Do you know why he didn't give it to you?

15 MR. SCOTT: Objection.

16 A. No.

17 Q. Well, do you know that doctor?

18 A. No, I don't.

19 Q. Well, the expert that's been retained by
20 Mr. Orth on behalf of Dr. Paresh Patel, and he says
21 that Dr. Patel was asked to evaluate the patient in
22 regard to an intra-abdominal source of her sepsis,
23 which he did not think she had; and subsequently
24 established that at the time of her necessary
25 abdominal exploration.

1 I mean, do you disagree with that?

2 A. Well, it is internally inconsistent,

3 Q. It's what?

4 A. Internally inconsistent.

5 Q. What is there that's internally inconsistent?

6 A. If he didn't believe she had an
7 intra-abdominal process, why did he have to do a
8 laparotomy.

9 Q. If he believed that he did an unnecessary
10 surgery on her --

11 MR. SCOTT: Objection.

12 Q. -- while she was in a coma?

13 A. Well, if he believed she had nothing wrong
14 intra-abdominally, then it was inappropriate
15 surgery.

16 Q. Well, let's try it another way.

17 Whether or not it was inappropriate
18 or not, the fact that he found no basis for an
19 intra-abdominal process, does that affect you at
20 all or do you still stick to this mysterious source
21 for there being one?

22 MR. SCOTT: Objection,

23 A. I don't refer to it as mysterious.

24 Q. You're right, I do.

25 In the absence of you're telling me

1 what it is, it is mysterious to me,

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

4 *a.* I've been the one using it, I know, but --

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

7 Q. Yes.

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

13 Q. What process was that?

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

16 Q. I'm sorry. I forgot.

17 So you disagree with him then?

18 A. To what extent?

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

21 MR. SCOTT: Objection.

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

24 Q. So he's making it up now?

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

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

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

6 MR. SCOTT: Objection.

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

9 MR. SCOTT: Objection.

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

12 Q. That's Paresh Patel, right?

13 A. P. Patel.

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

17 A. Make up anything?

18 Q. Well, add anything after the fact?

19 MR. SCOTT: Objection.

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

22 Q. He clarified it? Added it?

23 A. Yeah.

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

1 A. Well, he added a phrase.

2 Q. Why did he do that?

3 MR. SCOTT: Objection.

4 Answer it, if you can.

5 A. I believe to clarify the order he gave the
6 nurse.

7 Q. Well, in Mr. Scott's letter to you he put
8 that phrase in quotation. As a matter of fact, I
9 think you repeated it in quotes in your report, so
10 obviously it was important to you in terms of your
11 evaluation, correct?

12 MR. SCOTT: Objection.

13 A. Yes.

14 Q. You would agree with me for purposes of
15 analyzing Dr. Patel's involvement in this case it
16 would be important to him as to whether he made the
17 order or whether he relied on Dr. Dacha, wouldn't
18 it?

19 MR. SCOTT: Objection.

20 A. Which Patel?

21 Q. D.C. The guy who you're rendering an opinion
22 for.

23 MR. SCOTT: Objection.

24 What's the question. One of you two repeat it.

25 -----

1 (Question read,)

2 -----

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

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

8 MR. SCOTT: Objection.

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

11 MR. SCOTT: Objection.

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

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

17 MR. SCOTT: Objection.

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

20 Q. Yes.

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

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

25 A. No, I did not.

1 Q. Is there a reason that you didn't?

2 A. Because I didn't think that was important.

3 Q. You didn't?

4 A. No.

5 Q. Well, when was it added, or is that a mystery
6 too?

7 MR. SCOTT: Objection.

8 A. I have no way of knowing exactly when was --
9 it was added,

10 Q. Well, was it important to determine when it
11 was added?

12 A. It may be.

13 Q. Why would it be important to you?

14 A. I think it possibly would be important if it
15 was ordered -- it was added many days after the
16 fact.

17 Q. Yes?

18 A. Because it would imply that he was --

19 Q. Covering up?

20 A. Yeah, making some changes to cover tracks.

21 Q. Yeah. Well, how about if he added it after
22 the arrest; I mean, any time after the arrest?

23 A. Same conclusion.

24 Q. Did you make an inquiry of Mr. Scott or
25 Dr. Patel to determine when it was added?

1 A. Not specifically, no.

2 Q. I don't understand your answer.

3 What do you mean by not --

4 A, Well, I have discussed with Mr. Scott about
5 the fact that it was added and I reviewed the
6 progress notes, and Mr. Scott had said he had
7 spoken to Dr. Patel and indicated it was added at
8 the time of that conference he had with the other
9 physicians.

10 Q. I see. Dr. Patel told him that, according to
11 Mr. Scott?

12 MR. SCOTT: Objection,

13 A. Yes.

14 Q. When were you told that?

15 A. One day last week, I think.

16 Q. Were you told at that time of any
17 additional -- any other additions --

18 A. No, I wasn't.

19 Q. -- to the records?

20 A. No.

21 Q. Did you notice any other addition to the
22 record by Dr. Patel?

23 A, Not specifically.

24 Q. What does that mean "not specifically"?

25 A. I didn't see any other reference to

1 additions.

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

4 MR. SCOTT: Objection,

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

7 Q. I don't understand that.

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

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

13 A. Of course.

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

17 A. Certainly.

18 Q. What would that do to your opinion?

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

25 MR. KAMPINSKI: Could you speak

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

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

5 MR. KAMPINSKI: I don't know.

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

8 -----

9 (Discussion had off the record.)

10 -----

11 MR. KAMPINSKI: Where was I?

12 -----

13 (Record read.)

14 -----

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

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

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

1 about a patient such as that?

2 A. It could suppress ventilation.

3 Q. And it could make her status even worse?

4 A. Possibly.

5 Q. By the way, the discussion that we started on
6 earlier as to whether she had respiratory distress
7 or cardiopulmonary arrest, does that really matter
8 one way or the other in terms of what caused it?

9 MR. SCOTT: Objection.

10 A. In terms of the etiology it does, because if
11 it was a pure respiratory arrest, that would point
12 to certain diagnoses; whereas cardiopulmonary
13 arrest might point to some others.

14 Q. But I mean, a person having a respiratory
15 distress can go into cardiopulmonary arrest; can
16 they not?

17 A. Can, sure,

18 Q. We were discussing that she had, you believe
19 that she had metabolic acidosis; that would be the
20 same as abnormal acid base, correct?

21 A. Yes, it would.

22 Q. That can affect the patient's respiratory
23 status; can it not?

24 A. Yes, it can.

25 Q. Especially post extubation; can it not?

1 MR. SCOTT: Objection.

2 A. No more than at any other time.

3 Q. Okay, That's fine.

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

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

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

12 A. Correct .

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

15 A. No, it doesn't affect oxygenation.

16 Q. What does it affect?

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

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

25 MR. FULTON: 24 hours.

1 THE WITNESS: We got all
2 night.

3 MR. KAMPINSKI: We're okay.

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

6 MR. KAMPINSKI: Okay.

7 BY MR. KAMPINSKI:

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

10 A* Yes, she did.

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

12 A. Probably several causes. One --

13 Q. What was the probable cause?

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

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

18 A. She had a low blood pressure --

19 MR. SCOTT: Objection.

20 Asked and answered.

21 A. -- on the 7th.

22 Q- What time?

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

25 Q. How about before?

1 A. Before **it** was modestly low,

2 Q. Did she have tachycardia before that?

3 A. Yes, she had tachycardia.

4 Q. What was the cause of the tachycardia before
5 she --

6 A. Even that level blood pressure would result
7 in some tachycardia, depending on a lot of other
8 factors in terms of tissue perfusion; so that blood
9 pressure, even though we consider **it** adequate at
10 100 over **60**, that could be contributing to her
11 tachycardia, that's one of the factors.

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

16 Q. Was the tachycardia getting worse?

17 A. Between what times?

18 Q. Well, the 6th to the 7th? From the time she
19 was extubated until she was arrested, getting
20 better or worse?

21 A. Give me a minute to look through that. Do
22 you have the other --

23 Q. I believe it's page 988.

24 A. This is -- is the 7th.

25 Q. Well, 6th to the 7th, 980 to 988, I think.

1 MR. SCOTT: That's the 4th.

2 MR. KAMPINSKI: Which one?

3 THE WITNESS: Can't make out
4 that.

5 MR. GALLAGHER: Looks like it
6 is 980 and 988.

7 MR. KAMPINSKI: Right. May 6th
8 and May the 7th.

9 Do you have that now, John?

10 MR. SCOTT: I put them back
11 into the binder in a different location.

12 Here is 5-6, okay, Here is 5-6 and
13 here is 5-7.

14 A. So from the time then -- all of the 5-6, or
15 are you looking at a specific time?

16 Q- Well, I guess what I am asking you: Was it
17 getting worse? You know, if you look at this from
18 7:00 a.m. to 3:00 p.m. on the 6th, it is in the
19 120's; 3:00 p.m. to 10:00 p.m. in the 130's, right?

20 A. I have 110, 114, 115 -- or the pulse? Are
21 you talking about the pulse rates or talking about
22 the blood pressure.

23 Q. I'm sorry. What am I talking about?

24 Well, the pulse, isn't that what I
25 said.

1 MR. GALLAGHER: Tachycardia,
2 you said.

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

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

6 A. I'm not trying to confuse you.

7 Q. It's the --

8 A. Here, the early part of the day between
9 8:00 a.m. and 2:00 p.m. it's ranging in the 120's,
10 low 130.

11 Q. That's what I thought.

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

14 Q. Then the 7th?

15 A, 7th?

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

18 A. Back in the 120's.

19 Q. Yes. And early morning it's creeping up 130,
20 134, 135; by 6:00 a.m. it's 142?

21 A. Right.

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

23 A. Right.

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

25 A. It's high.

1 Q. Well, what was causing that?

2 MR. SCOTT: Objection.

3 A. Just the factors that I mentioned.

4 Q. Why was it getting worse?

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

13 Q. Did she --

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

17 Q. So anxiety can cause --

18 A. Tachycardia.

19 Q. -- tachycardia also?

20 A. Yes.

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

23 A. Yes.

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

1 distress?

2 A. No, it would cause the blood pressure to
3 rise, generally.

4 Q. Rise, I see.

5 Well, what did they do for this
6 worsening tachycardia and increasing respiration,
7 these fine physicians that you're here to defend?

8 MR. SCOTT: Objection.

9 MR. KAMPINSKI: Which part, the
10 fine physicians?

11 MR. SCOTT: What time
12 location are you talking about?

13 MR. KAMPINSKI: I'll withdraw
14 the fine physicians.

15 Eight o'clock.

16 MR. SCOTT: Eight o'clock
17 on May 7th.

18 A. At that point they were concentrating their
19 efforts on the fact that she had abdominal pain,
20 and their need to evaluate that process,

21 Q. Well, I mean, you can't ignore the
22 tachycardia and the respirations, can you?

23 A. I don't think they were ignored, I think
24 they were addressed.

25 Q. That was the questions: What did they do?

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

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

19 A. Comes back and --

20 Q. And the numbers are 56 as far as respiration,
21 158 as far as the pulse, right?

22 A. Right.

23 Q. They give fluids for that?

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

1 Q. The numbers over by the pulse ox, do you see
2 those at 10:00 a.m., the 80/97; do you see those
3 numbers?

4 A. Yes.

5 Q. What do those mean?

6 A. That's the measurement of the oxygen
7 saturation in the blood,

8 Q. What is 86, is that a good number?

9 A. 86 is low.

10 Q. It's low?

11 A. Yes.

12 Q. How do you treat that?

13 A. You administer oxygen.

14 Q. Did they give her additional oxygen?

15 A. Not that I can tell.

16 Q. Okay. But I suppose that doesn't concern you
17 since it went up to 97 and 98, right?

18 A. All repeat determinations were good.

19 Q. Well, how low is real low, is 86 real bad?

20 MR. SCOTT: Objection.

21 A. No.

22 Q. How about 70, would that be real bad?

23 A. Would be very bad,

24 Q. How would you treat that?

25 A. You give additional amounts of oxygen.

1 Q. That's it?

2 A. Well, you evaluate, you probably check your
3 arterial blood gases to find what abnormalities
4 were responsible for that low oxygen level.

5 Q. Which blood gas would you be looking at?

6 A. Well, she had blood gas I think on arrival
7 back to the I.C.U., next set done, I believe that
8 would be the next one, **10:46.**

9 Q. What page?

10 MR. SCOTT: This is after?

11 A. This is after the HIDA scan.

12 Q. That's page **330?**

13 A. Yes.

14 Q. And which one would you be looking at then?

15 A. Which -- what set of blood gases?

16 Q. Yes. Which would be important, the pH, CO2,
17 PO2?

18 A. All of those, and the pCO2 was low indicating
19 that she was still hyperventilating, which is good;
20 oxygen level was more than adequate at **126.**

21 So during that course of time she
22 had no deterioration in her blood gas.

23 Q. How long does it take to get these readouts;
24 do you have any idea?

25 These blood gases are sent down to

1 the lab or --

2 A. Yes.

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

4 A. They're sent to a lab.

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

7 A. Yes.

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

10 A. Yes.

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

13 MR. SCOTT: Objection.

14 A. Of blood gas?

15 Q. Yes.

16 A. No.

17 Q. How long does it typically take?

18 A. The blood gas?

19 Q. Yes.

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

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

25 MR. SCOTT: Objection.

1 Q. Right?

2 A. Around that time. I don't remember the exact
3 timing.

4 Q. Right. There is a reading of her blood
5 pressure at **2:00**, so she had to be in the I.C.U.
6 when that was done?

7 A. Yes.

8 Q. It would have been after that reading we know
9 she went back, somewhere in the 2:30 area, right?

10 A. Back in I.C.U.?

11 Q. Yes.

12 A. Yes. P.m.

13 Q. They didn't finish the CT or did they or do
14 you know?

15 A. I thought they did finish the test, is my
16 recollection.

17 Q. What?

18 A. I thought they had completed it.

19 Q. You did?

20 You are saying in your report
21 something that I found a little curious. I guess I
22 need to know where you got it from, that she did
23 not actually suffer cardiopulmonary arrest while
24 undergoing the CT but this occurred after she
25 arrived back in the intensive care unit and that

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

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

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

8 MR. SCOTT: Objection.

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

11 Q. She did?

12 A. Yes, shortness of breath.

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

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

17 A. No.

18 Q. Because you didn't?

19 A, Well, I may have not.

20 MR. SCOTT: Is there a
21 question pending?

22 Q. Did you point out --

23 MR. SCOTT: He said no.

24 A. No.

25 Q. Why not?

1 A, At the time I didn't feel it was important.

2 Q. How about now, do you think it's important
3 now?

4 A. The fact that she had that occurrence?

5 Q. While she was down at the CT?

6 A. Not in terms of the care delivered by
7 Dr. Patel.

8 Q. How about in terms of the care delivered by
9 anybody?

10 A. No, I don't --

11 Q. It was great care she got when she was down
12 at the CT?

13 A, She was closely monitored.

14 Q. She was closely monitored?

15 A. Yes.

16 Q. By whom?

17 A. By the nurse.

18 Q. And what was the nurse doing to monitor her?

19 A. Well, she was checking patient's pulse,
20 respiratory rates,

21 Q. Where do you see that?

22 A, In the -- in the notes of the 7th.

23 Q. What notes of the 7th?

24 A. I'm looking at page 988 where there is blood
25 pressure recordings and pulse recordings and oxygen

1 saturation recordings.

2 Q. Wait. I don't understand.

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

5 A, She was down at the CT approximately 2:00 to
6 2:30.

7 Q. Yes?

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

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

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

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

17 A. I think so.

18 Q. What is the answer?

19 MR. SCOTT: He answered it.

20 MR. KAMPINSKI: No, he didn't.

21 MR. SCOTT: What was your
22 question?

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

1 2:00 p.m., were while she was down in the CT?

2 A. It's my testimony some of these measurements
3 were made when she was -- made there, yes,

4 Q. Which ones?

5 A. I -- I'd have to check back to see exactly
6 what the -- when she is back down there and
7 correlate that with this.

8 Q. Go ahead.

9 A. We have to check the times that she was in
10 CT.

11 She is transported --

12 Q. Where are you referring?

13 A. Page 1135.

14 Q. Which entry?

15 A. The top line,

16 Q. Go ahead,

17 A. Time's listed as 2:00 p.m., transported to CT
18 for abdomen, pelvis region, per the bed with
19 monitors pack, pulse oximetry and OT at 50 percent,
20 with RN present.

21 Q. Yes?

22 MR. SCOTT: What was the
23 question.

24 Q. Question is which of these entries correspond
25 to her being at the CT?

1 A. Okay. Go back to the 7th, see the blood
2 pressure at 2:30.

3 Q. Okay?

4 A. During when she was at the CT there.

5 Q. That 66 over 46 was while she was at the CT?

6 A. Yes.

7 Q. Is that good?

8 A. No.

9 Q. How do you treat that?

10 A. Well, initial treatment would consist of I.V.
11 fluids.

12 Q. Are there any other readings that were on
13 that line that were done while she was down at the
14 CT?

15 A. The second, the next reading was at 2:45
16 according to the nurse's note; at 2:45 she is
17 returned from CT scan. So if these times are
18 accurate, the next reading was done in the I.C.U.
19 and not in CT scan.

20 Q. Well, if you read the notes, sir, they show a
21 blood pressure at 2:45 at page 1135 as 70 over 50;
22 does that correspond to any of these numbers that
23 you see?

24 A. Well, it's very close to the initial read at
25 2:30.

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

4 A. No, you're not.

5 Q. Well, how about the pulses, the 131 and the
6 119, were those done while at CT or were they done
7 when she was back from CT?

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

10 Q- Yes?

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

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

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

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

21 A. That was done also during that hour.

22 Q. Is that a fever?

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

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

1 mean, the way you say that is as if it doesn't
2 count?

3 A. Well, it's very inaccurate,

4 Q. So why take it?

5 A. I think if it's elevated, it may mean the
6 patient has a fever; if it's low, I don't think it
7 means very much,

8 Q. So it's meaningless,

9 What about the 69 under the
10 pulse ox, is that a meaningful number?

11 A. Yes, and it indicates the oxygen level was
12 low.

13 Q. What time was that?

14 A. Again, that was some time during that hour
15 between 2:00 and three o'clock.

16 Q. But we don't know when?

17 A. I can't tell when from the records.

18 Q. Were you provided with any nurses'
19 depositions?

20 A. Yes, I was.

21 Q. Did you read any of them?

22 A. I read them.

23 Q. Well, do you know what nurse wrote these
24 numbers in there?

25 A. I don't recall.

1 Q. Did you read her deposition, whoever she
2 might have been?

3 A. I probably did,

4 Q. Do you recall what she said in terms of what
5 time these readings were taken and whether they
6 were --

7 A. My recollection is that she recorded these
8 sometime later, near the end of her shift and put
9 these times in at that time; and she put the times
10 to the best of her recollection.

11 Q. Well, going to page 1135 of the nurses'
12 notes, sir, when it says 2:45 returned from CT
13 scan?

14 A. Yes.

15 Q. It's got unable to finish procedure,
16 discontinue, patient began having respiratory
17 distress and shallow labored respirations at
18 50 beats per minute; you read all that --

19 A. Yes.

20 Q. -- I assume?

21 A. Yes.

22 Q. Well, so they didn't finish the procedure?

23 A. According to that note.

24 Q. I mean, is there something else that caused
25 you to believe that they did?

1 A. I'm just recalling reading something about
2 the CT showed -- didn't show any abnormality.

3 Q. That led you to conclude that they at least
4 got enough of it to show --

5 A. To make a reading.

6 Q. Well, Doctor, if a patient is in I.C.U., and
7 I think you told me that this is one of your areas
8 of expertise, you actually head the I.C.U. at Metro
9 for a month every year; two months, is that it?

10 A. Two to three months a year.

11 Q. The reason that that patient is in I.C.U. is
12 because they're not feeling good, right?

13 A. I wouldn't say not feeling good.

14 Q. Not doing well?

15 A. Right.

16 Q. You want more to monitor them closely?

17 A. Exactly, that's the reason they are there.

18 Q. And the reason you want to do that is so you
19 can intervene if there is some problem, so you can
20 do it fairly quickly?

21 A. That's accurate.

22 Q. If you take a patient away from the I.C.U.,
23 that sort of prevents your ability to care for the
24 patient in the way that you are intending to do
25 that, doesn't it?

1 A. It does to a certain degree, yes.

2 Q. Well, with somebody like Mrs. Lind who is
3 having respiratory distress, and I think we agreed
4 that she was, right?

5 A. Yes.

6 Q. You want to be able to act fairly quickly,
7 don't you, if she started getting worse?

8 A. That's accurate.

9 Q. Would that be a fair statement?

10 A, Yes.

11 Q. When we say "fairly quickly," how quickly
12 would you want to deal with any difficulty that she
13 started having?

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

16 Q. Respiratory difficult that would cause her to
17 go to cardiopulmonary arrest,

18 A. Well, if you had the ability to somehow know
19 it would lead to cardiopulmonary arrest, it would
20 be immediate.

21 Q. What do you mean by "immediate"?

22 A. By immediate, immediate speaks for itself.

23 Q. No, it doesn't. I don't want to get caught
24 up in semantics.

25 Are you talking within seconds?

1 A. Within minutes, a few.

2 Q. Couple minutes?

3 A, Within minutes, short few minutes,

4 Q. Few being three?

5 A. Three or less.

6 Q. Three or less.

7 Because if somebody is not
8 breathing, that's not good for them?

9 A. That's accurate.

10 Q. Causes them to potentially have brain cells
11 die because they're not getting enough oxygen?

12 A. That's right.

13 Q. Causing brain damage, just like Mrs. Lind
14 sustained?

15 A. That's accurate.

16 Q. And it takes a period of time for that to
17 occur?

18 A. Yes, it does.

19 Q. How long would you say that takes; I know
20 it's variable, but give me some range?

21 A. Well, if a patient stopped breathing
22 completely, that is no ventilation whatsoever,
23 zero,

24 Q. Okay?

25 A. Then within five minutes they're going to

1 have some brain death.

2 Q. And respiratory distress can be a precursor
3 to cardiopulmonary arrest, I think we've already
4 covered that?

5 A. Yes, we did.

6 Q. So that's something you have to be concerned
7 about when someone's having respiratory distress?

8 A. Yes.

9 Q. So I suppose you can protect them from that
10 occurring by protecting their airway?

11 MR. SCOTT: Objection as to
12 what is meant by protecting the airway.

13 Q. Well, intubation?

14 MR. SCOTT: All right.

15 A. Intubation will not prevent respiratory
16 distress.

17 Q. How about cardiopulmonary arrest --

18 A. It won't prevent --

19 Q. -- due to respiratory distress?

20 A. It won't prevent that either: unless the cause
21 is some obstruction of the upper airway that's
22 bypassed by this intubation.

23 Q. What does intubation do then?

24 A. Intubation is just a means of really just
25 inserting a tube in the airway.

1 Q. What do you attach the tube to?

2 A. Attach the tube to the -- it depends on the
3 clinical situation, may attach it to nothing except
4 oxygen.

5 Q. What does a ventilator do?

6 A. A ventilator will take over a patient's
7 respiration.

8 Q. Help them breathe?

9 A. It would assist their breathing.

10 Q. Would that prevent a cardiopulmonary arrest?

11 A. Not necessarily, no.

12 Q. Can it?

13 A. Only if the primary cause of the
14 cardiopulmonary arrest is respiratory failure.

15 Q. I see.

16 After she had her arrest what did
17 they do for her?

18 A. After she had the arrest she was
19 resuscitated, she received CPR.

20 Q. Then what, they hook her to a ventilator?

21 A. She was hooked up to a ventilator at that
22 point, yes.

23 Q. Would it be a failure -- well, when she had
24 this reading of 69 for the oxygen saturation and
25 she had the 66 over 46 blood pressure, then the 52

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

4 A. No, I don't think so.

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

7 MR. SCOTT: Objection.

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

10 Q. What would have been appropriate treatment?

11 A. Correct the blood pressure.

12 Q. How would you do that?

13 A. First administration of fluids.

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

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

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

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

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

21 MR. SCOTT: Objection.

22 A. Immediately.

23 Q. Once again, sooner than three minutes?

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

1 specific time. As soon as it can be done.

2 Q. When was it done?

3 A. It was done after she returned to I.C.U.

4 Q. When?

5 A. **2:45.**

6 Q. It was?

7 A, That's when she returned from I.C.U.

8 Q. According to the nurse note?

9 A, According to the nurse's notes she returned
10 to I.C.U. at **2:45** and they paged Dr. Dacha at that
11 point and --

12 MR, SCOTT: Wait for a
13 question.

14 Q. Then when was the code called?

15 A. **2:55.**

16 Q. When did they give fluids?

17 A. Well, the next blood pressure I see is 120
18 over 63 under the notes at -- I think it's the
19 three o'clock notes.

20 Q. **3:15?**

21 A, **No, 3:10.**

22 Q. Okay. You're looking at the nurses' notes?

23 A. Yes. Says blood pressure **120** over **63**.

24 Q. Yeah.

25 A. There is no mention about fluids

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

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

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

11 Q. Wait a minute, Doctor.

12 We just went through that she had a
13 blood pressure of 66 over 46 at 2:30 p.m., and you
14 are telling me that she didn't get fluids until
15 2:55 p.m., that's 25 minutes, sir.

16 MR. SCOTT: Objection.

17 That's not what he said.

18 Q. Am I wrong?

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

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

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

25 Q. Which was 2:55?

1 A. Right.

2 Q. Should she have gotten fluids before that
3 time based upon the blood pressure?

4 MR. SCOTT: Objection.

5 A. One of the therapies for a low blood pressure
6 would be additional fluids.

7 Q. The question was should she have gotten in
8 your opinion additional fluids when she exhibited
9 the blood pressure of 66 over 46 when she was down
10 in the CAT scan?

11 MR. SCOTT: Objection.

12 A. Yes, I believe so.

13 Q. Was that a failure to do -- a failure to
14 adhere to the appropriate nursing standard of care
15 with respect to whoever the nurse was?

16 MR. FELTES: Objection.

17 MR. SCOTT: Objection.

18 A. No, I don't believe so, that's a physician
19 decision.

20 Q. What physician was there to make that
21 decision, Dr. Dacha had left, Dacha or Patel wasn't
22 there; who was around to --

23 A. There was probably no physician in the I.C.U.
24 either at that point, The appropriate thing to do
25 was contact the physician, which I think they did.

1 Q. Where, down in the CAT scan?

2 A. They didn't page Dr. Dacha until she's back
3 up to the I.C.U., he is not in the hospital.

4 MR. SCOTT: What is the
5 question?

6 Q. Question is who is responsible for this,
7 that's the question?

8 MR. SCOTT: Responsible for
9 what?

10 Q. For not giving her the fluids that you say
11 should have been given?

12 MR. SCOTT: Objection.

13 A. The responsibility is for the nurse to
14 contact the physician.

15 Q. When the blood pressure drops in the CAT
16 scan?

17 A. Yes.

18 MR. SCOTT: Objection.

19 Q. All right. If they didn't do that, then she
20 is responsible?

21 MR. FELTES: Objection.

22 A, If she did not contact the physician, then
23 she is responsible, yes, so they could start
24 additional fluids administration and other therapy
25 besides fluids.

1 Q. Such as?

2 A. Such as agents that would increase her blood
3 pressure.

4 Q. Which? Such as what?

5 A. There is a variety of different agents, one
6 that is common is Dopamine.

7 Q. Was she given Dopamine?

8 A. No --

9 Q. What else?

10 A. -- she wasn't.

11 There's other pressor agents that
12 are also used that are similar to Dopamine such as
13 Levophed.

14 Q. Let me cut this short.

15 Was she given any treatment at all?

16 A. No.

17 Q. Should she have been given some treatment?

18 MR. SCOTT: Objection.

19 MR. FELTES: Objection.

20 A. I think the physician should have been
21 contacted at that point.

22 Q. If he wasn't, that was negligence on the part
23 of the nurse, wasn't it?

24 MR. FELTES: Objection.

25 MR. SCOTT: Objection.

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

3 MR. FELTES: Objection.

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

5 Q. An error?

6 A, Yes.

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

9 MR. FELTES: Objection.

10 MR. SCOTT: Objection,

11 A. The interval of time between --

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

13 A. That 25 minute period her blood pressure --

14 Q. Got worse?

15 A. Was worse.

16 Q. Yes.

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

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

22 MR. SCOTT: Objection.

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

24 A. Well, I think --

25 Q. Should just send her home?

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

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

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

8 Q. Yes.

9 A. And --

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

12 A. I don't know that.

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

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

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

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

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

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

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

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

13 MR. SCOTT: Objection.

14 MR. QUANDT: Objection.

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

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

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

24 MR. SCOTT: Objection.

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

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

3 Q. Available to do what?

4 MR. SCOTT: Objection.

5 A. To give orders,

6 *a.* I see.

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

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

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

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

19 A. No.

20 Q. What are ultrasounds used for?

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

1 Q. Gallbladder?

2 A, In the gallbladder.

3 Q. Diverticulitis?

4 A. They're used to detect possible abdomen
5 distress.

6 Q. Are they used to detect diverticulitis?

7 A, Not diverticulitis, per say.

8 Q. Appendicitis?

9 A, Not per se, no,

10 Q. What do you mean "not per se"?

11 A, If the disease is associated with abscess
12 formation, then an ultrasound can be used to detect
13 that.

14 Q. How about peritonitis?

15 A. Again, it could be used to detect fluid,
16 which peritonitis is often associated with.

17 Q. Can you do that at bedside, ultrasound?

18 A. Yes, you can.

19 Q. What do you think it was about sending her
20 down to both the HIDA scan and the CAT scan that
21 caused her to go into respiratory distress?

22 A. I don't know,

23 Q. Well, I mean, you point this out in your
24 report she was heavy?

25 A. Yes.

1 Q. So they had to move her from her setting in
2 the I.C.U.?

3 A. Yes.

4 Q. Do you think that contributed to it?

5 A. Moving her, no, I don't think so.

6 Q. How about moving her around in the radiology
7 department?

8 A. I don't see that that would cause a
9 substantial stress on a patient to cause --

10 Q. Do you think it was just serendipity this
11 happened both times they sent her down?

12 A. I wouldn't answer it that way.

13 Q. Just a coincidence?

14 A. Coincidence.

15 Q. A mysterious coincidence?

16 MR. SCOTT: Objection.

17 A. I wouldn't use the word mysterious but it is
18 serendipity,

19 Q. Just her karma?

20 MR. SCOTT: Objection.

21 Q. Did she have viral pneumonia?

22 A. I didn't review the records carefully to see
23 the etiology of her pneumonia. My recollection is
24 that it was the impression of Dr. Dacha that it was
25 viral.

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

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

11 Q. Did hers respond to antibiotics?

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

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

22 A. Basically, yes.

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

1 A. That's correct.

2 Q. So if you don't treat the pneumonia for, I
3 don't know, a month period of time, or two weeks,
4 or three weeks, that's probably not good --

5 MR. SCOTT: Objection.

6 Q. -- is it?

7 A. If you don't treat it for two or three
8 weeks?

9 A. Yes.

10 A. That's an accurate statement.

11 Q. That it's not good?

12 A. It's not good,

13 Q. Would you expect such a patient who wasn't
14 being supported while the disease process could
15 work its way through, to in fact, get better -- or
16 to get worse, I'm sorry?

17 MR. SCOTT: Objection.

18 A. I don't understand.

19 Q. Would you expect a patient who had pneumonia
20 that was not being supported otherwise, okay, to
21 get worse?

22 A. No, most pneumonia gets better on its own.

23 Q. So if somebody kept returning to you with
24 complaints that were diagnosed as pneumonia, for
25 example, originally --

1 A. Yes.

2 Q. -- four times, for example, over a two-week
3 period --

4 A. Okay.

5 Q. -- should that patient be treated?

6 MR. FULTON: Objection,

7 A. Absolutely.

8 Q. And the failure to do so would constitute a
9 deviation of the standard of care required of those
10 physicians?

11 MR. FULTON: Objection.

12 MR. SCOTT: Objection.

13 A. Yes, if the patient was not treated,
14 certainly.

15 Q. When you say "not treated," would you admit
16 such a patient to a hospital?

17 MR. SCOTT: Objection.

18 MR. FULTON: Objection.

19 A. It would depend upon my clinical assessment
20 of the patient as to whether the patient needed
21 admission or not.

22 Q. So even though they came back four times over
23 a period of two weeks, that wouldn't necessarily
24 mean they had to be admitted?

25 MR. FULTON: Objection.

1 A. No, it wouldn't.

2 Q. What about given the fact they didn't respond
3 to antibiotics, would that cause them to be
4 admitted?

5 MR. SCOTT: Objection.

6 MR. FULTON: Objection,

7 A. Not necessarily.

8 Q. Should it be followed up?

9 A. Absolutely.

10 Q. By a repeat x-ray, for example?

11 A. Absolutely.

12 Q. Failure to do repeat x-ray would be failure
13 to adhere to the appropriate standard of care?

14 MR. FULTON: Objection.

15 MR. SCOTT: Objection.

16 A. Yes, it would.

17 Q. In your report, sir, you say somewhere on
18 page 4 of your report, you may remember it, if you
19 need to look at it, go ahead, that Dr. Patel at the
20 bottom of the page, speaking of Dr. D.C. Patel, he
21 clearly had some reservations concerning the safety
22 of its performance, referring to the CT
23 performance; however, this is evident by his notes
24 in the medical records and orders.

25 Those reservations I assume you

1 were referring to are the reservations pertaining
2 to her respiratory status?

3 A. Yes.

4 Q. And in that regard you believe that it was
5 appropriate for him to rely on Dr. Dacha in
6 assessing that status in determining whether she
7 could go to the CT?

8 A. That's correct.

9 Q. What reservations did he have --

10 MR. SCOTT: Objection.

11 Q. -- that you're referring to?

12 A. Well, the fact that he -- that he indicated
13 in his notes, both in progress notes and order,
14 that the test be performed only if okay with
15 Dr. Dacha, implied that he had reservations about
16 it.

17 Q. I understand,

18 My question is what reservations
19 were they? What were these reservations?

20 MR. SCOTT: Objection.

21 A. I don't know what was going on in his mind,
22 so I don't know exactly what the reservations were.

23 Q. But it's clear to you that he had
24 reservations, you just don't know what they were?

25 A. Exactly.

1 Q. Are you assuming then that he raised those
2 reservations with Dr. Dacha and/or Miclat or Patel?

3 A. Yes.

4 Q. Could you show me where those are in the
5 record?

6 A. Where the reservations are?

7 Q. Sure. Any discussion about the respiratory
8 status between two of them, three of them, or four
9 of them?

10 A. There was -- wasn't one about respiratory
11 status, there was discussion with other physicians
12 concerning the tests that were going on.

13 Q. Well, if the reservations pertained to her
14 respiratory status --

15 A. I didn't say that his reservations were
16 pertaining to that.

17 Q. You didn't? I thought you did.

18 A. I said I didn't know what his reservations
19 were specifically, only that he had them.

20 Q. Well, where did he discuss what those
21 reservations were?

22 A. I don't believe they were discussed in the
23 progress notes,

24 a. Well, if he had reservations, shouldn't he
25 have discussed them with the other doctors if he

1 had concerns?

2 MR. SCOTT: Objection.

3 A. I assume he did.

4 Q. Where does he **say** that?

5 A. He doesn't say that.

6 Q. So that's another mystery?

7 A. No, I think in his deposition --

8 MR. SCOTT: Objection.

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

11 Q. Yes?

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

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

16 A. Yes, I think.

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

20 MR. SCOTT: Objection.

21 MR. GALLAGHER: Objection.

22 Q. -- or anybody, somebody?

23 A. Yes, I think so.

24 Q. Did he?

25 A. Well, based upon his deposition he did

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

4 Q. Do you have his deposition?

5 A. I don't know.

6 Q. You didn't bring it?

7 A. No.

8 Q. You can't give me a page?

9 A. Probably not.

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

13 MR. SCOTT: Objection.

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

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

1 because of respiratory distress there, right?

2 A. Yes.

3 Q. But you are saying that the three of them are
4 exculpated as long as Dr. Dacha knows --

5 MR. SCOTT: Objection.

6 MR. GALLAGHER: Objection.

7 Q. -- in terms of informing Dr. Dacha about the
8 respiratory status?

9 A. Only if there was some information that they
10 had privy to that he didn't would be there be any
11 reason.

12 Q. I follow you. Okay,

13 How long does it take to intubate a
14 patient typically; is that something that can be
15 done fairly quickly?

16 MR. SCOTT: Objection.

17 A. In general it's done within minutes.

18 Q. Hook them up to a ventilator, how long does
19 that take?

20 A. A few more minutes, depending upon the access
21 they have to the ventilator,

22 Q. Well, in an I.C.U. unit they have access,
23 wouldn't they?

24 A. Within ten minutes they should have a
25 ventilator in the unit and the patient hooked up.

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

4 A. No, I don't think so.

5 MR. KAMPINSKI: That's all I
6 have.

7 MR. SCOTT: Any other
8 questions?

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

12 -----

13 (Discussion had off the record.)

14 -----

15 CROSS-EXAMINATION

16 BY MR. FULTON:

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

20 A. Yes, I think so.

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

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

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

1 ventilator?

2 A. No, I don't recall.

3 MR. FULTON: No further
4 questions.

5 MR. SCOTT: Any other
6 questions?

7 MR. ORTH: No questions.

8 MR. FELTES: No.

9 MR. SCOTT: Doctor will not
10 waive.

11

12

13

14

15

16

17 (Deposition concluded; signature not waived.)

18

19

20

21

22

23

24

25

ERRATA SHEETPAGELINE

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

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

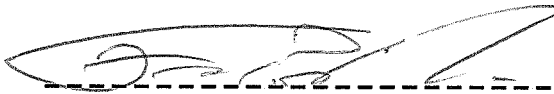
ANTHONY DiMARCO, M.D.

1 The State of Ohio,
2 County of Cuyahoga.

CERTIFICATE:

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

19 IN WITNESS WHEREOF, I have hereunto set my hand and
20 affixed my seal of office at Cleveland, Ohio, this
21 13th day of January, 1995.

22 
23 -----

24 Frank P. Versagi, RPR, CLVS, Notary Public/State of
25 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

PHRASEWORD 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 [10]

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

36 [1]
60:15
37.4 [1]
101:19
3:00 [2]
37:18, 19
.10 [1]
110:21
3:15 [1]
110:20

* * **4** * *

4 [3]
21:10, 13; 124:18
40 [3]
43:20; 44: 13, 15
40's [4]
48:7; 49:3, 9; 52:13
45 [1]
88:13
46 [6]
57:1; 100:5; 108:25; 109:18; 111:13;
112:9
47 [3]
47:9; 56:3, 17
48 [1]
56:17
49 [5]
46: 13, 17, 24; 47:25; 56: 18
4th [1]
87:1

* * **5** * *

5-6 [3]
87:12, 14
7 [1]
87:13
50 [12]
44:21, 25; 45:4, 7, 20; 46:9; 51:23;
56:10, 20; 99:19; 100:21; 103:18
50's [1]
48:6
500 [1]
45:17
52 [2]
101:2; 108:25
56 [1]
91:20
5:13 [1]
42:20
5th [3]
38: 19, 20, 23

* * **6** * *

60 [2]
43:15; 86:10
63 [2]
110:18, 23
65 [1]
46:5
66 [6]
57:1; 100:5; 108:25; 109:18; 111:13;
112:9
69 [2]
102:9; 108:24
.00 [1]
88:20
6:30 [1]
82:4

6:35 [3]
36:13, 14, 24
639 [1]
38:24
6th [10]
38:15; 42:12, 13, 19; 60:20; 65:14;
86:18, 25; 87:7, 18

* * **7** * *

7.26 [1]
37:5
7.28 [2]
36:17, 24
70 [3]
46:5; 92:22; 100:21
70's [1]
48:6
74 [2]
44:20; 56:3
75 [1]
25: 12
7:00 [1]
87:18
7th [26]
30:11; 32:3, 21; 36:11; 38:13; 41:15;
42:11; 51:15, 17; 60:4, 6; 62:20; **63:8**,
18; 65:14; 85:21; 86:18, 24, 25; 87:8;
88: 14, 15; 90:17; 97:22, 23; 100:1

* * **8** * *

80 [1]
43:11
80/97 [1]
92:2
86 [3]
92:8, 9, 19
89 [2]
56:7, 12
800 [1]
88:9

* * **9** * *

94 [4]
12:21; 13:13, 14; 44:14
95 [4]
43:11; 56:10, 13, 14
97 [1]
92:17
98 [1]
92:17
980 [2]
86:25; 87:6
988 [7]
56:2; 86:23, 25; 87:6; 97:24; 98:11, 25
952 [2]
42:24; 44:11
9th [1]
17:16

* * **A** * *

a.m. [5]
36:14; 87:18; 88:9, 20; 92:2
abdomen [7]
50:24; 51:6; 52:9, 15; 66:14; **99:18**;
119:4
abdominal [13]
30:18, 19, 21; 31:22; 50:22; 51:25;
64:19; 65:13, 15; 67:25; 68:4; 73:25;
90: 19

ABG's [1]
52:21
ability [3]
41:19; 104:23; 105:18
able [4]
37:24; 41:16; 105:6; 121:7
abnormal [8]
37:3; 38:25; 43:12, 13, 17; 45:23; 83:20;
84:4
abnormalities [5]
60:14, 23; 62:10, 18; 93:3
abnormality [4]
31:14, 20; 84:11; 104:2
abscess [2]
69:24; 119:11
absence [1]
74:25
Absolutely [5]
60:11; 70:25; 123:7; 124:9, 11
accepted [1]
22:11
access [2]
129:20, 22
accidents [1]
11:16
According [3]
103:23; 110:8, 9
according [3]
80:10; 100:16; 101:17
account [1]
70:24
accumulation [1]
118:23
accuracy [2]
69:13, 17
accurate [7]
69:16; 100:18; 104:21; 105:8; 106:9, 15;
122:10
achieve [1]
46:5
acid [5]
37:25; 38:11; 83:20; 84:4, 19
Acidosis [1]
52:18
acidosis [16]
29:9; 32:15, 17; 35:25; 37:16, 18; 38:12,
16; 39:3, 7, 9; 41:25; 52:18; 83:19; 84:5,
22
act [1]
105:6
acted [3]
11:10; 13:13, 20
acute [1]
75:9
add [2]
71:19; 76:18
Added [1]
76:22
added [15]
76:24; 77:1; 78:16, 21, 24; 79:5, 9, 11,
15, 21, 25; 80:5, 7; 81:15, 21
addition [6]
78:6; 80:21; 81:10, 12, 15
additional [9]
43:22; 80:17; 92:14, 25; 771:8, 24;
112:6, 8; 113:24
additions [3]
80:17; 81:1, 3
address [1]
7:3
addressed [5]

33:8; 90:24; 109:1; 121:24; 127:19
adequate [12]
 41:16; 23; 42:7; 43:16; 25; 45:24; 46:1;
 18; 50:10; **84:14**; 86:9; 93:20
adequately [3]
 43:2; 3; 46:7
adhere [2]
 112:14; 124:13
administer [1]
 92:13
administered [2]
 82:18; 111:3
administration [7]
 26:22; 28:20; 55:16; 109:13; 14; 111:1;
 113:24
admission [4]
 41:7; 10; 60:3; 123:21
admit [1]
 123:15
admitted [4]
 35:22; 63:1; 123:24; 124:4
affect [6]
 74:19; 81:19; 20; 83:22; **84:15**, 16
affects [1]
 84:17
affiliate [1]
 11:6
affiliation [1]
 11:3
afterwards [2]
 40:2; 41:22
agent [1]
 28:7
agents [3]
 114:2; 5; 11
agree [3]
 34:22; 77:14
agreed [5]
 62:13; 20; 63:24; 105:3; 117:11
agreement [4]
 20:7; 27:17; 28:17, 18
agrees [1]
 62:21
ailment [1]
 54:24
air [1]
 43:10
airport [1]
 82:4
airway [5]
 22:22; 107:10; 12, 21, 25
allegation [1]
 14:15
allegations [1]
 14:14
allowed [1]
 43:24
allows [1]
 46:11
Alone [1]
 39:14
alone [2]
 41:4; 115:17
amount [7]
 43:7; 46:6; 53:6; 58:13; 109:16; 111:21;
 22
amounts [1]
 92:25
analgesic [1]
 28:7
analgesics [1]

26:24
analyzing [1]
 77:15
anoxic [1]
 115:18
Answer [1]
 77:4
answer [9]
 23:3; 34:17; 57:25; 68:18; 72:5; 75:5;
 80:2; 98:18; 120:12
answered [4]
 31:24; 54:1; 85:20; 98:19
antibiotics [8]
 23:23; 121:1, 4, 10, 11, 14, 19; 124:3
anticipate [1]
 47:25
anxiety [3]
 89:9; 17, 22
Anybody [1]
 49:20
anybody [2]
 97:9; 127:22
anyhow [1]
 115:21
apparently [2]
 62:24; 101:2
appeared [1]
 121:13
Appendicitis [1]
 119:8
appropriate [7]
 53:1; 109:9; 10; 112:14; 24; 124:13;
 125:5
appropriately [1]
 41:24
Approximately [1]
 8:23
approximately [11]
 8:4; **11:19**; 12:7, 12; 14:6; 24:24; **25:3**,
 12; 43:11; 56:19; 98:5
area [2]
 94:24; 95:9
areas [1]
 104:7
aren't [1]
 111:4
argumentative [1]
 28:10
arrested [1]
 86:19
arresting [1]
 71:7
arrival [2]
 91:24; 93:6
arrived [1]
 95:25
arterial [4]
 32:19; 35:24; 41:13; 93:3
asking [2]
 33:15; 87:16
aspect [1]
 130:23
assessing [1]
 125:6
assessment [2]
 69:16; 123:19
assist [3]
 63:15; 108:9; 109:2
assisted [1]
 60:19
associated [3]

23:25; 119:11, 16
assume [6]
 65:20; 68:12; 72:21; 103:20; 124:25;
 127:3
assuming [1]
 126:1
assumption [1]
 73:12
Attach [1]
 108:2
attach [2]
 108:1, 3
attack [1]
 25:13
attempt [1]
 31:10
attending [7]
 10:5, 15, 18; 25:22; 26:5; 117:7, 18
attending's [1]
 117:17
attention [1]
 40:6
attorney [4]
 13:4; 16:8; 24:2, 4
attorneys [1]
 24:21
attribute [2]
 61:2, 15
atypical [2]
 121:7, 9
authored [1]
 18:19
Available [1]
 118:3
available [3]
 117:18; 25; 118:2
awake [1]
 89:7
aware [2]
 65:24; 78:14
axillary [1]
 101:23

*** * B * ***

B-e-r-n-e [1]
 9:5
bacteria [1]
 121:6
base [3]
 30:8; 83:20; 84:4
Based [9]
 26:23; 28:5; 30:3; 59:12, 17; 75:22, 25;
 111:7; 115:17
based [6]
 22:10; 68:19; 81:9; 101:8; 112:3; 127:25
Basically [1]
 121:22
basis [2]
 20:4; 74:18
beats [2]
 88:13; 103:18
bed [1]
 99:18
bedside [1]
 119:17
Beg [1]
 7:23
begins [1]
 98:25
behalf [5]

12:5; 14:11; 34:8; 72:22; 73:20

believe [34]

13:8, 25; 15:12; 17:24; 19:25; 22:15;
28:21; 31:14; 32:4, 17; 33:8, 9; 42:16;
22: 53:10, 18; 64:6, 14; 65:2; 66:12, 16;
68:24; 72:24; 74:6; 77:5; 83:18; 86:23;
93:7; 101:11; 103:25; 112:12, 18; 125:4;
126:22

believed [2]

74:9, 13

believes [1]

66:5

benefit [2]

71:12, 21

benefited [2]

28:3, 7

benefits [3]

70:16; 72:1, 6

Berne [2]

9:3, 4

besides [1]

113:25

binder [1]

87:11

binders [2]

20:15, 20

bit [1]

69:3

black [1]

20:20

blow [1]

43:12

body [4]

37:25; 44:2; 86:14; 118:24

body's [2]

46:3; 47:18

ok [2]

9:7, 8

books [1]

9:1

bowel [5]

32:3; 52:6; 65:1, 4, 5

box [1]

89:21

brain [6]

106:10, 13; 107:1; 115:8, 18; 130:3

break [1]

72:13

breath [1]

96:12

breathe [10]

41:19; 47:2, 3, 14, 19; 84:7, 8, 18, 19;
108:8

breathing [13]

47:1; 48:22; 49:20, 24; 52:19; 53:2, 8;
60:19; 82:25; 106:8, 21; 108:9; 109:3

breaths [1]

48:13

brief [1]

40:12

briefly [1]

35:8

broken [1]

101:17

busy [1]

89:7

ypassed [1]

107:22

* * C *

call [10]

12:4; 27:16; 40:22, 23, 24; 46:21; 55:2;
64:1; 66:3; 115:1

calling [1]

66:2

capacity [2]

34:22; 46:4

carbon [2]

53:7; 84:20

cardiopulmonary [23]

29:5, 13, 18, 24, 25; 30:5; 32:12; 39:11,
12, 18; 40:16, 21; 83:7, 12, 15; 95:23;
105:17, 19; 107:3, 17; 108:10, 14; 130:2

care [39]

9:21; 10:2, 6, 23; 22:2, 8, 10, 17, 20;
23:12; 26:18, 21; 33:4, 6, 22; 34:5, 10,
14; 35:2, 10, 21; 40:6; 50:19; 67:20, 24;
68:23; 78:4; 95:25; 97:6, 8, 11; 104:23;
112:14; 123:9; 124:13; 128:12, 16, 23;
130:24

careful [2]

62:6; 76:15

carefully [1]

120:22

carries [1]

70:7

Case [4]

8:2; 10:25; 11:2, 8

cases [11]

11:15; 12:13, 14; 13:21; 14:4; 15:10, 24;
23:5; 24:14; 26:13; 43:18

CAT [10]

22:21; 31:13; 94:23; 109:17; 112:10;
113:1, 15; 117:21; 118:17; 119:20

catastrophe [1]

23:25

caught [1]

105:23

caused [11]

39:10; 40:15, 20; 55:4; 57:2, 4, 21; 64:6;
83:8; 103:24; 119:21

cells [1]

106:10

Center [3]

7:13; 11:5, 20

centered [1]

35:20

chance [1]

36:3

change [4]

8:22; 66:25; 67:2, 19

changed [2]

18:23; 19:12

changes [8]

18:24; 19:9, 17, 20, 21; 79:20

characterized [1]

47:8

Chardon [3]

7:4; 24:20; 25:4

charge [1]

27:24

charges [1]

26:10

chart [4]

32:24, 25; 59:16; 81:21

check [5]

89:15; 93:2; 99:5, 9; 118:22

checked [1]

41:14

checking [1]

97:19

chest [3]

41:18; 60:5; 62:10

Chuck [1]

36:3

circumstance [1]

71:11

claim [1]

12:2

clarified [4]

75:2; 76:21, 22, 24

clarify [2]

77:5; 78:13

clarifying [2]

72:5; 75:5

class [1]

121:6

classroom [1]

8:6

clear [4]

29:8; 72:19, 20; 125:23

cleared [1]

23:24

Cleveland [10]

15:5, 6, 7; 16:13; 24:7, 19, 20; 25:1, 24,
25

clinical [5]

10:22; 66:8; 71:24; 108:3; 123:19

closes [1]

82:3

co-defendant [1]

23:20

CO2 [1]

93:16

code [1]

110:14

Coincidence [1]

120:14

coincidence [2]

120:13, 15

coma [1]

74:12

combined [1]

39:5

comment [1]

71:20

Commission [1]

11:17

common [4]

55:16; 86:13; 89:9; 114:6

community [1]

117:1

compensating [1]

48:25

compensatory [1]

84:21

competent [2]

34:4, 7

complaints [2]

51:24; 122:24

complete [1]

53:9

completed [1]

95:18

completely [3]

62:9; 75:11; 106:22

compromising [1]

43:14

concentrated [1]

22:5

concentrating [1]

90:18

concern [3]
81:2; 92:16; 127:17
concerned [1]
107:6
concerning [4]
12:22; 78:4; 124:21; 126:12
concerns [1]
127:1
conclude [5]
32:11; 35:24; 40:16, 20; 104:3
concluded [1]
131:17
conclusion [2]
30:25; 79:23
condition [4]
28:19; 61:7, 10; 66:8
conference [2]
66:20; 80:8
conflict [4]
66:1; 67:1; 68:15, 24
confuse [2]
88:5, 6
confused [1]
36:18
confusing [2]
39:22; 70:2
conjunction [1]
9:1
consents [1]
118:17
consequence [2]
26:3; 29:11
consider [3]
56:21; 70:12; 86:9
considerable [1]
28:6
consist [2]
9:15; 100:10
consistent [4]
22:11; 39:16; 46:23; 47:10
constitute [2]
21:15; 123:8
consulting [1]
117:8
contact [4]
112:25; 113:14, 22; 116:1
contacted [4]
17:5, 6; 114:21; 115:20
contain [1]
20:15
contained [1]
20:25
contemplating [1]
66:21
content [2]
18:25; 46:6
context [1]
34:20
continue [1]
33:13
Continuing [2]
23:6; 24:15
contract [1]
11:24
contribute [1]
115:7
contributed [3]
38:2; 53:11; 120:4
contributing [4]
52:16; 53:13; 60:13; 86:10
controversy [1]

68:25
conventionally [1]
43:10
conveyed [1]
66:19
copy [4]
19:22; 20:1, 4, 7
correctly [2]
32:9; 64:8
correlate [1]
99:7
correspond [2]
99:24; 100:22
Count [1]
36:22
count [2]
59:22; 102:2
counts [1]
59:18
County [1]
7:2
Couple [1]
106:2
couple [1]
63:12
coupled [1]
39:4
course [7]
40:11, 13; 43:22; 62:5; 81:13; 93:21;
101:16
cover [3]
10:2, 13; 79:20
covered [1]
107:4
Covering [1]
79:19
CPP [1]
41:22
CPR [4]
108:19; 111:2, 4, 6
creeping [1]
88:19
crossovers [1]
121:5
CT [36]
34:21; 65:8; 69:14; 70:6, 12, 15; 71:13;
17:95:13, 24; 96:1, 3, 7, 9; 97:5, 12;
98:4, 5, 12, 13; 99:1, 10, 17, 25; 100:4,
5, 14, 17, 19; 101:6, 7, 9; 103:12; 104:2;
124:22; 125:7
cultures [1]
121:8
curious [1]
95:21
cut [1]
114:14
cylinder [1]
89:21

* * D * *

D.C. [6]
22:4; 34:8; 40:6; 76:14; 77:21; 124:20
Dacha [20]
22:2; 26:24; 33:22; 77:17; 110:10;
112:21; 113:2; 120:24; 125:5, 15; 126:2;
127:12, 19; 128:3, 10, 15, 17; 129:4, 7
Dacha's [1]
22:8
Daily [1]
7:18

damage [4]
106:13; 115:8, 18; 130:3
day [9]
8:18; 38:16, 17; 44:12; 66:6, 14; 80:15;
88:8, 12
days [10]
8:16, 19, 20; 35:22; 40:4, 5; 75:8; 79:15;
130:21
deadline [1]
19:13
deal [5]
50:8; 51:11; 57:10, 19; 105:12
death [3]
25:17; 107:1
decide [1]
127:13
decision [5]
12:22; 34:23; 35:1; 112:19, 21
Decrease [2]
52:23, 24
decrease [1]
52:22
deeper [1]
84:20
deeply [1]
84:9
defend [1]
90:7
defendant [3]
12:25; 13:1; 14:11
defense [1]
47:18
define [4]
31:13; 49:18; 64:17, 25
defined [1]
64:22
defining [1]
29:17
definitive [1]
69:9
degree [4]
57:21; 60:7; 84:21; 105:1
dehydration [2]
55:17; 58:12
delivered [3]
17:25; 97:6, 8
Demerol [5]
26:22; 27:17; 28:13, 20; 82:15
demonstrated [2]
41:15, 20
department [1]
120:7
depend [1]
123:19
depending [3]
10:4; 86:7; 129:20
depends [3]
82:18, 19; 108:2
depicted [1]
59:16
deposed [4]
13:9; 15:20; 16:23; 17:4
Deposition [2]
21:10; 131:17
deposition [16]
12:13; 17:18; 21:19; 26:15; 35:17;
65:21; 66:1, 8; 68:10; 76:5, 8; 103:1;
127:7, 25; 128:1, 4
depositions [1]
102:19
depth [1]

47:22
depths [1]
 48:22
description [2]
 9:8; 30:4
spite [1]
 65:12
detail [2]
 22:7; 35:4
details [2]
 24:18; 111:3
detect [6]
 118:23, 24; 119:4, 6, 12, 15
deterioration [1]
 93:22
determination [1]
 40:10
determinations [1]
 92:18
determine [6]
 31:9; 49:8, 17; 79:10, 25; 121:17
determined [6]
 32:18; 39:24; 40:13, 24; 54:4; 55:3
determining [3]
 70:8, 24; 125:6
detrimental [1]
 43:20
developed [2]
 60:14, 16
deviation [1]
 123:9
diabetes [1]
 25:14
diabetic [1]
 25:25
diagnose [2]
 14:17; 23:13
diagnosed [2]
 121:8; 122:24
diagnoses [2]
 54:21; 83:12
diagnosis [3]
 15:13; 39:6; 58:5
diagnostic [1]
 70:11
Diastolic [1]
 56:17
diastolic [1]
 56:16
dictated [1]
 18:13
Didactic [1]
 7:23
didactic [4]
 7:19, 21, 24; 9:2
die [1]
 106:11
died [2]
 25:15; 26:3
difficult [3]
 84:13; 105:16; 121:16
difficulties [2]
 61:2, 5
difficulty [8]
 33:20; 34:16; 49:20, 23; 50:4; 63:14;
 105:12, 15
iMarco [1]
 21:10
dioxide [2]
 53:7; 84:20
direct [1]

53:3
disability [1]
 12:2
disagree [2]
 74:1; 75:17
discarded [1]
 19:2
discomfort [1]
 28:6
discontinue [1]
 103:16
discuss [2]
 126:20; 128:10
discussed [4]
 80:4; 126:22, 25; 128:2
discussing [1]
 83:18
Discussion [2]
 82:9; 130:13
discussion [3]
 83:5; 126:7, 11
disease [12]
 9:19; 29:19; 63:23; 64:11; 69:15, 17, 18;
 119:11; 121:9, 16, 20; 122:14
disorder [5]
 14:18, 19; 23:14, 15; 24:1
distinction [1]
 27:10
distress [24]
 29:10; 49:12, 15, 16, 18; 50:2; 55:5, 8;
 71:9; 83:6, 15; 90:1; 103:17; 105:3;
 107:2, 7, 16, 19; 117:6, 22; 119:5, 21;
 127:10; 129:1
Diverticulitis [1]
 119:3
diverticulitis [2]
 119:6, 7
Doctor [17]
 21:13; 23:3; 27:3; 42:9; 47:12; 55:6;
 57:17; 58:2; 62:13; 72:19; 88:5; 98:16;
 104:6; 109:15; 111:11; 130:17; 131:9
doctor [5]
 68:11; 73:17; 115:21, 23; 116:24
doctor's [2]
 27:5, 7
doctors [4]
 65:8; 117:9; 126:25; 128:24
documents [2]
 20:16; 21:15
Doesn't [1]
 49:5
doesn't [15]
 32:2; 35:14, 15; 41:19; 49:12; 62:17;
 64:18; 84:15; 92:16; 102:1; 104:25;
 105:23; 121:19, 25; 127:5
Dopamine [3]
 114:6, 7, 12
dose [1]
 82:18
draft [7]
 19:7, 11, 15, 16, 22; 20:8, 10
drafts [2]
 18:21; 19:1
drawn [1]
 94:5
drop [4]
 55:9; 61:6, 15; 89:25
dropped [2]
 25:20; 26:10
dropping [1]
 42:1

drops [3]
 43:12, 18; 113:15
drug [2]
 27:22; 28:3
due [4]
 52:4; 53:15, 17; 107:19

*** * E * ***

early [2]
 88:8, 19
easy [1]
 88:5
effect [3]
 82:17, 20; 84:5
Efficacy [1]
 70:7
efficacy [2]
 69:13; 70:5
efforts [3]
 22:5; 84:17; 90:19
Eight [2]
 90:15, 16
eight [1]
 88:22
elderly [1]
 25:11
Elevated [1]
 59:22
elevated [2]
 59:18; 102:5
elevation [2]
 52:20; 53:12
eliminate [2]
 37:24; 84:19
eliminated [1]
 65:5
eliminates [1]
 84:20
embolism [3]
 12:23; 14:21; 15:13
emergency [1]
 35:3
employed [2]
 7:13; 11:22
employee [2]
 10:21, 25
end [2]
 101:15; 103:8
entries [2]
 98:11; 99:24
entry [2]
 99:14; 101:1
error [5]
 27:2, 25; 115:4, 5, 7
established [1]
 73:24
etiology [14]
 29:1, 2, 7; 40:14, 25; 49:17; 54:3; 55:2,
 14; 57:6; 62:7; 83:10; 120:23
evaluate [5]
 12:4; 31:10; 73:21; 90:20; 93:2
evaluating [2]
 11:17; 53:20
evaluation [2]
 12:22; 77:11
event [1]
 75:9
evidence [5]
 37:15; 39:3, 11; 62:16; 64:5
evidenced [2]

54:22; 65:6
evident [2]
 124:23; 128:14
Evidently [2]
 44:23; 52:11
exact [4]
 9:9; 42:16; 66:11; 95:2
Exactly [4]
 47:7; 91:10; 104:17; 125:25
exactly [3]
 79:8; 99:5; 125:22
examined [1]
 40:3
example [9]
 43:16; 19; 48:23; 70:13; 20; 71:1;
 122:25; 123:2; 124:10
examples [1]
 71:2
except [2]
 61:25; 108:3
exception [1]
 56:13
excess [1]
 53:5
excrete [1]
 38:11
exculpated [1]
 129:4
exculpatory [1]
 81:14
exhibited [1]
 112:8
Exhibits [2]
 21:10; 13
exist [1]
 64:18
exists [1]
 64:5
expect [4]
 48:6; 53:8; 122:13; 19
expected [2]
 48:8; 115:18
experience [1]
 55:4
experiencing [1]
 49:20
expert [12]
 11:10; 12:11; 15; 24; 13:13; 21; 17:21;
 68:1; 11; 12; 69:1; 73:19
expertise [1]
 104:8
explain [5]
 27:21; 41:2; 4; 43:8; 62:15
explained [1]
 19:13
exploration [1]
 73:25
exposure [1]
 72:8
extent [5]
 75:18; 19; 78:4; 12; 13
extra [2]
 111:21; 22
extremely [1]
 48:9
extubate [1]
 22:18
extubated [9]
 41:10; 21; 42:10; 13; 60:16; 22; 82:23;
 86:19; 121:13
extubation [3]

50:3; 61:2; 83:25

* * F * *

Fact [30]
 23:23; 41:18; 44:4; 49:24; 50:21; 52:25;
 55:18; 59:17; 61:16; 23; 62:16; 64:19;
 65:7; 67:17; 68:8; 69:5; 71:16; 74:18;
 76:18; 77:8; 79:16; 80:5; 85:15; 90:19;
 91:17; 97:4; 121:1; 122:15; 124:2;
 125:12
factor [1]
 86:12
factors [6]
 29:14; 30:13; 39:16; 86:8; 11; 89:3
failed [1]
 14:17
failing [1]
 23:13
Failure [3]
 27:5; 7; 124:12
failure [13]
 25:14; 29:8; 38:1; 6; 7; 41:9; 17; 108:14;
 23; 112:13; 123:8; 124:12
fair [2]
 34:17; 105:9
fairly [4]
 104:20; 105:6; 11; 129:15
falls [2]
 43:19; 46:25
family [1]
 66:3
fast [3]
 53:2; 8; 14
faster [1]
 84:19
feel [3]
 34:4; 7; 97:1
feeling [3]
 52:8; 104:12; 13
feels [1]
 52:5
FELTES [11]
 27:4; 6; 28:14; 36:7; 112:16; 113:21;
 114:19; 24; 115:3; 9; 131:8
Ferguson [3]
 17:18; 21:20; 21
Fever [1]
 53:12
fever [7]
 53:15; 59:17; 20; 86:12; 15; 101:22;
 102:6
figured [1]
 96:5
filed [2]
 24:6; 19
final [4]
 19:8; 18; 20:4; 81:19
find [6]
 31:19; 56:1; 65:9; 91:4; 8; 93:3
findings [1]
 30:19
fine [6]
 27:15; 61:14; 84:3; 90:7; 10; 14
finish [10]
 33:19; 37:23; 52:1; 60:10; 64:24; 91:7;
 95:13; 15; 103:15; 22
finished [1]
 96:5
First [2]
 42:20; 109:13

first [8]

8:11; 13:25; 14:15; 17:5; 25:6; 50:17;
111:6; 130:21

Five [2]

8:19; 15:17

five [5]

8:20; 13:24; 14:6; 40:5; 106:25

floor [1]

94:3

fluid [5]

55:15; 58:13; 18; 118:23; 119:15

fluids [28]

55:19; 57:6; 12; 58:16; 91:23; 24;
100:11; 109:13; 15; 16; 110:16; 25;
111:2; 5; 8; 14; 19; 20; 21; 22; 24; 112:2;
6; 8; 113:10; 24; 25

Flynn [3]

72:22; 76:1, 4

focused [1]

40:5

folder [1]

21:1

follow [4]

27:5; 7; 33:12; 129:12

followed [2]

17:7; 124:8

following [4]

65:1; 66:13; 14; 75:9

forgot [1]

75:16

form [1]

35:5

formation [1]

119:12

forms [1]

9:19

formula [1]

46:9

forth [3]

33:2; 44:4; 98:25

forwarded [2]

17:15; 17

forwarding [1]

18:2

found [5]

22:10; 39:24; 69:6; 4:18; 95:21

four [8]

14:6; 17:24; 24:24; 40:5; 123:2; 22;
126:8; 128:24

Frank [1]

21:7

frequently [3]

58:17; 86:12; 89:14

FULTON [17]

35:12; 16; 51:16; 63:10; 82:2; 6; 84:25;
85:4; 123:6; 11; 18; 25; 124:6; 14;
130:9; 16; 131:3

Fulton [2]

63:14; 82:1

functioning [1]

42:3

* * G * *

GALLAGHER [4]

87:5; 88:1; 127:21; 129:6

Gallbladder [1]

119:1

gallbladder [1]

119:2

garage [1]

82:3
gas [8]
 16:16; 32:20; 52:25; 93:5, 6, 22; 94:14, 18
gases [9]
 32:19; 35:24; 36:6; 41:13, 15; 44:10; 93:3, 15, 25
gastroenterologist [1]
 34:9
Gave [1]
 91:24
gave [4]
 19:11, 15; 71:1; 77:5
Geauga [2]
 7:2; 18:12
gentleman [1]
 25:11
gets [1]
 122:22
GI [3]
 26:1, 6; 91:1
Give [2]
 48:2; 86:21
give [23]
 12:13; 28:13, 16; 35:5, 13, 18; 48:10; 57:23; 58:4, 5; 69:16; 72:25; 73:10, 14; 81:8; 91:23; 92:14, 25; 106:20; 110:16; 118:5; 128:8
given [18]
 11:21; 26:25; 27:18, 23; 28:8, 12, 13, 15; 43:23, 24; 89:11; 111:4; 113:11; 114:7, 15, 17; 118:16; 124:2
giving [3]
 111:20; 113:10
goes [3]
 45:3, 13; 86:15
often [5]
 58:16; 61:25; 112:2, 7; 116:16
great [4]
 35:4; 45:15; 50:8; 97:11
group [1]
 27:15
guess [9]
 17:17; 38:13; 53:19; 67:15; 69:20; 70:7; 87:16; 94:23; 95:21
guy [1]
 77:21

* * H * *

handling [1]
 41:25
handwriting [2]
 52:4; 78:22
happens [4]
 12:7; 117:7, 15, 19
happy [1]
 63:14
hard [1]
 66:12
Harder [2]
 47:4, 5
harder [1]
 47:15
haven't [2]
 77:3; 30:23
he'll [1]
 20:7
he's [5]
 59:2; 66:7, 13; 75:24; 78:13
head [1]

104:8
hear [1]
 82:1
heard [1]
 35:17
hearing [1]
 63:12
heart [6]
 25:13; 85:8, 16; 89:14, 24; 118:23
heavy [1]
 119:24
Help [1]
 108:8
hematologic [1]
 23:13
hematologist [1]
 23:13
HIDA [9]
 31:14; 55:6; 65:8; 91:12, 18; 93:11; 109:17; 119:20; 128:25
hiding [1]
 81:23
high [10]
 29:10; 45:19; 50:10, 20; 52:13, 16; 53:10; 59:19; 88:24, 25
higher [5]
 45:13; 47:8; 48:8, 15; 88:13
hindsight [1]
 69:2
history [1]
 121:15
home [1]
 115:25
Hook [1]
 129:18
hook [1]
 108:20
hooked [2]
 108:21; 129:25
hope [2]
 49:17; 118:14
hospital [7]
 7:16, 25; 16:13; 18:15; 113:3; 123:16; 130:22
hospitalization [3]
 22:16; 25:15, 16
hospitalized [1]
 130:18
hospitals [1]
 117:1
hour [6]
 56:5; 101:16, 17, 21; 102:14; 118:12
hours [5]
 8:18; 60:15; 84:25; 117:23; 118:11
hydration [1]
 58:15
hyperventilating [2]
 50:12; 93:19
hyperventilation [1]
 42:1

* * I * *

I'd [8]
 33:11; 56:1; 57:10, 23; 63:14; 81:5; 89:15; 99:5
I've [4]
 11:20; 21:13; 35:17; 75:4
I.C.U. [29]
 10:13, 16, 20; 89:7; 91:24; 93:7; 94:8, 11; 95:5, 10; 100:18; 101:12; 104:6, 8,

11, 22; 109:19; 110:3, 7, 10; 112:23; 113:3; 116:18, 24, 25; 117:2, 5; 120:2; 129:22
I.V. [1]
 100:10
idea [1]
 93:24
identification [1]
 21:11
if's [2]
 68:14, 19
ignore [1]
 90:21
ignored [1]
 90:23
illness [3]
 61:3; 64:3; 67:7
image [1]
 66:12
immediate [5]
 94:12; 105:20, 21, 22
immediately [1]
 109:22
immediately [1]
 116:21
implied [1]
 125:15
imply [2]
 79:18; 81:23
important [1]
 78:12
important [10]
 77:10, 16; 78:7; 79:2, 10, 13, 14; 93:16; 97:1, 2
impossible [2]
 45:16, 18
impression [1]
 120:24
improve [1]
 47:18
Improved [1]
 55:25
improved [7]
 55:20, 24; 56:7, 19; 65:1; 121:12, 16
improvement [2]
 56:22; 121:14
improving [2]
 45:10; 130:17
inability [1]
 38:9
inaccurate [1]
 102:3
inadequate [2]
 37:19; 38:3
inadvertently [1]
 27:1
inappropriate [2]
 74:14, 17
incident [1]
 118:12
included [1]
 78:12
incomplete [1]
 31:15
inconsistent [3]
 74:2, 4, 5
incorrect [2]
 71:22; 101:2
increase [8]
 29:13; 47:20, 21; 50:23; 61:6; 85:16; 89:24; 114:2

increased [4]
 44:22; 55:5; 84:18; 89:9
increases [2]
 48:22; 53:12
increasing [1]
 90:6
indicate [5]
 46:18; 49:4; 64:5; 66:4, 5
indicated [6]
 52:24; 67:12; 73:12; 80:7; 125:12;
 130:17
indicates [2]
 17:17; 102:11
Indicating [1]
 30:13
indicating [3]
 42:2; 51:24; 93:18
indication [5]
 48:16, 24; 66:20; 72:11; 111:8
indications [1]
 50:16
individual [1]
 82:16
Industrial [1]
 11:17
industrial [1]
 11:16
Infection [2]
 57:9; 59:7
infection [8]
 14:21; 29:7; 58:17, 19, 22; 59:2, 9;
 86:14
infections [2]
 121:3, 4
infiltrate [1]
 62:16
infiltrates [1]
 60:5
inform [1]
 78:15
informal [1]
 7:20
information [4]
 20:16; 118:10; 128:17; 129:9
informed [1]
 118:16
informing [1]
 129:7
initial [2]
 100:10, 24
injury [2]
 16:13, 16
input [1]
 19:9
inquiry [1]
 79:24
inserted [1]
 16:15
inserting [1]
 107:25
inside [1]
 58:13
insomuch [1]
 34:10
instances [2]
 70:17, 18
instituted [1]
 116:21
insured [1]
 24:12
intending [1]

104:24
intensive [4]
 10:2, 6; 50:19; 95:25
intention [1]
 27:14
interested [2]
 81:5, 8
interesting [1]
 69:11
Internally [1]
 74:4
internally [2]
 74:2, 5
interns [1]
 7:21
interpreting [1]
 63:6
interval [2]
 65:18; 115:11
intervene [1]
 104:19
intra-abdominal [14]
 31:3, 5; 53:20, 22, 24; 65:24; 67:18;
 68:21; 69:3; 73:22; 74:7, 19; 75:20, 23
intra-abdominally [1]
 74:14
intravenous [1]
 111:19
intubate [1]
 129:13
intubated [2]
 71:14, 16
Intubation [2]
 107:15, 24
intubation [3]
 107:13, 22, 23
investigated [1]
 54:12
involve [1]
 11:15
Involved [2]
 11:15; 16:12
involved [17]
 7:15; 8:13, 17; 9:17, 20; 10:3; 11:14, 18;
 12:21; 15:15; 22:6; 23:20; 25:25; 26:18;
 35:21; 67:24; 68:23
involvement [7]
 13:17; 25:21; 26:4, 11; 77:15; 78:5, 13
involving [1]
 12:1
irreversible [2]
 116:5; 130:3
issue [2]
 78:7; 128:2
issues [3]
 33:8; 78:4; 128:21
items [1]
 17:15

* * J * *

January [1]
 17:16
job [2]
 11:7, 24
John [2]
 9:11; 87:9
judgment [1]
 28:8

* * K * *

KAMPINSKI [30]
 20:6; 21:7; 33:16; 35:14; 36:4, 8, 23;
 51:3, 19; 59:1; 61:11; 62:23; 63:13;
 68:5; 70:4; 72:18; 81:25; 82:5, 11;
 84:23; 85:3, 6, 7; 87:2, 7; 88:3; 90:9, 13;
 98:20; 130:5
karma [1]
 120:19
kept [1]
 122:23
kidneys [1]
 38:9
knowing [2]
 79:8; 81:5
knowledge [2]
 31:19; 128:15

* * L * *

lab [3]
 94:1, 4, 8
label [1]
 29:22
labored [2]
 82:25; 103:17
lady [1]
 29:12
laparotomy [3]
 74:8; 75:8, 12
large [3]
 52:7; 69:24; 109:16
Larry [1]
 17:22
last [5]
 19:15; 21:23; 23:8; 63:12; 80:15
late [2]
 42:17; 84:23
lawsuit [1]
 25:16
lay [2]
 61:1; 96:1
lead [6]
 29:14; 30:25; 39:17; 105:19; 116:14, 16
leading [1]
 32:11
leads [2]
 32:16; 39:6
leak [1]
 58:18
leave [1]
 118:1
leaves [1]
 117:5
leaving [1]
 127:12
Let's [2]
 7:11; 42:12
let's [4]
 32:25; 42:18; 43:19; 74:16
letter [5]
 17:7, 14, 16; 18:2; 77:7
letterhead [1]
 18:9
letters [3]
 17:12, 20; 21:2
level [23]
 42:1; 43:9, 12, 19, 20, 24, 25; 45:20;
 47:9, 17, 19, 24; 49:6, 13; 53:1, 3, 4, 6;
 86:6; 93:4, 20; 102:11
levels [4]
 44:3; 47:1, 8; 48:15

Levophed [1]

114:13

Levy [2]

9:3, 5

light [1]

39:5

.nd [11]22:2, 18; 26:18; 39:24; 40:20; 41:1;
50:2; 63:17; 105:2; 106:13; 115:8**line** [5]

52:4; 98:25; 99:15; 100:13; 101:16

linger [1]

62:11

listed [4]

17:20; 99:17; 101:15; 111:4

lists [1]

17:15

load [1]

29:13

location [3]

7:10; 87:11; 90:12

Looks [1]

87:5

lot [2]

70:20; 86:7

lots [1]

89:8

low [38]30:10, 17; 32:10, 19; 37:1, 7; 39:2, 8;
43:13, 15; 45:22; 46:17; 47:17; 49:7, 13;
52:14; 53:1; 55:16; 56:17, 25; 57:7;
58:14; 59:18; 85:15, 17, 18, 23; 86:1;
88:10; 92:9, 10, 19; 93:4, 18; 102:6, 12;
112:5**lower** [1]

53:5

ng [1]

9:19

* * M *

mail [1]

18:1

maintain [2]

41:16; 53:6

maintaining [1]

30:9

malpractice [4]

12:14, 15; 13:21; 14:5

mark [1]

21:8

marked [2]

21:11, 13

Martin [1]

17:22

material [1]

81:21

materials [1]

17:19

matter [8]49:5; 69:8; 77:8; 81:11; 83:7; 91:17;
115:20, 23**mattered** [1]

109:6

maximum [1]

46:5

May [21]16:10; 22:15; 30:11; 32:21; 36:11;
38:13, 15, 19, 20, 23; 51:15, 17; 60:4, 6,
20; 62:19; 63:8, 18; 87:7, 8; 90:17**mean** [39]13:22; 16:8; 30:23; 35:15; 37:9, 10, 18;
49:12, 14; 58:13; 60:18; 62:17; 64:18;
67:6, 22; 68:1; 69:11, 23; 72:25; 74:1;
76:3; 79:22; 80:3, 24; 81:11; 83:14;
90:21; 92:5; 102:1, 5; 103:24; 105:21;
109:18; 111:20; 116:25; 119:10, 23;
123:24; 128:24**meaning** [1]

27:14

meaningful [1]

102:10

meaningless [3]

49:10, 11; 102:8

Means [1]

49:11

means [9]37:19; 43:2, 3; 47:14; 67:21, 23; 68:2;
102:7; 107:24**meant** [2]

71:23; 107:12

measured [1]

43:10

measurement [2]

92:6; 98:23

measurements [4]

98:8, 10, 14; 99:2

measures [2]

116:2, 21

mechanical [1]

109:2

mechanism [2]

47:18; 84:21

Medical [4]

7:13; 11:5, 20

medical [13]7:22, 24; 8:1, 11; 10:2; 12:15; 13:21;
14:5; 22:11, 17, 20; 29:6; 124:24**medications** [2]

89:14; 111:3

medicine [2]

7:8; 8:11

meet [1]

19:14

meeting [1]

34:20

MELLINO [1]

21:20

mention [3]

78:23; 89:5; 110:25

mentioned [1]

89:3

mere [1]

54:22

metabolic [16]29:9; 32:15, 17; 35:25; 37:16, 18; 38:12,
15; 39:3, 7, 9; 41:25; 43:14; 52:18;
83:19; 84:4**Metro** [5]

9:21, 24; 11:4, 7; 104:8

MetroHealth [5]

7:13; 9:16; 10:21; 11:5, 20

Miclat [2]

34:25; 126:2

mild [2]

52:20, 22

mind [4]

17:3; 22:5; 34:3; 125:21

mine [1]

20:22

minute [10]

42:8; 47:12; 48:14; 57:8; 86:21; 88:13;

103:18; 111:11; 115:13

minutes [15]94:21; 96:1, 4; 106:1, 2, 3, 25; 109:23,
25; 111:15; 115:12; 129:17, 20, 24**misled** [1]

36:20

misplaced [1]

18:3

miss [1]

69:10

Misstatement [1]

51:2

mistake [4]

27:8, 14, 16; 28:9

Modest [1]

37:13

modest [2]

37:12; 39:9

modestly [1]

86:1

moment [1]

28:2

monitor [2]

97:18; 104:16

monitored [2]

97:13, 14

monitors [1]

99:19

month [10]8:4, 8, 9, 13, 17, 21; 11:19; 12:8; 104:9;
122:3**months** [5]

10:4, 12; 12:19; 104:9, 10

morning [4]

38:24; 42:17; 82:4; 88:19

mostly [2]

19:17, 19

motion [1]

118:22

move [1]

120:1

Movement [1]

52:7

movement [5]

32:3; 52:6; 65:1, 4, 5

Moving [1]

120:5

moving [1]

120:6

Mrs [11]22:2, 18; 26:18; 39:24; 40:20; 41:1;
50:2; 63:17; 105:2; 106:13; 115:8**multiple** [1]

29:6

muscle [1]

9:18

muscles [1]

9:18

Mutual [2]

13:4; 24:11

myself [3]

19:4; 26:11; 60:25

mysterious [18]40:15, 19, 22; 54:24; 55:2; 59:3; 61:3;
64:3, 12, 18; 67:7; 74:20, 23; 75:1, 3;
81:9; 120:15, 17**mystery** [2]

79:5; 127:6

* * N * *

name [12]
 9:7, 9; 11:13; 13:2, 5, 6, 7; 15:3, 14;
 16:17, 25; 23:8
named [1]
 23:20
names [4]
 14:7; 23:5; 24:17, 21
natural [1]
 121:15
nature [2]
 7:7; 16:11
needle [1]
 16:15
needs [2]
 117:25; 118:1
negative [1]
 84:5
negligence [4]
 27:3, 13, 15; 114:22
nerve [1]
 16:16
night [4]
 10:6; 21:23; 85:2; 88:16
nighttime [1]
 89:6
nonrespiratory [1]
 30:20
Normal [1]
 48:12
normal [17]
 30:9; 37:25; 38:4; 42:2, 4, 6, 21; 43:5, 6,
 8, 9, 10; 45:20; 48:11; 53:5, 6; 85:15
notation [1]
 44:18
note [7]
 51:23; 52:2; 75:25; 76:1; 100:16;
 103:23; 110:8
notes [26]
 51:15, 22; 66:2, 4, 17, 18; 67:1, 13;
 68:15, 17; 75:22; 80:6; 97:22, 23;
 100:20; 103:12; 110:9, 18, 19, 22;
 111:7, 23; 124:23; 125:13; 126:23
notice [1]
 80:21
November [1]
 8:25
number [9]
 39:1, 20; 45:21; 48:10; 49:22; 54:11;
 75:8; 92:8; 102:10
numbers [10]
 47:7; 59:12; 91:4, 9, 13, 20; 92:1, 3;
 100:22; 102:24
nurse [12]
 27:1, 5; 77:6; 97:17, 18; 102:23; 110:8;
 112:15; 113:13; 114:23; 116:20; 118:9
nurse's [3]
 100:16; 110:9; 115:1
nurses [7]
 26:21; 51:22; 102:18; 103:11; 110:22;
 111:7, 23
nursing [2]
 56:1; 112:14

 * * O *

o'clock [9]
 56:8, 20; 88:22; 90:15, 16; 94:23, 24;
 102:15; 110:19
obese [1]
 29:12
objection [2]

23:7; 24:16
obligation [1]
 115:1
observed [1]
 76:15
obstruction [1]
 107:21
obtain [1]
 16:15
obviously [5]
 20:18; 34:7; 70:2; 71:7; 77:10
occur [2]
 38:1; 106:17
occurred [6]
 55:12; 75:9; 95:24; 96:7, 13; 118:13
Occurrence [1]
 97:4
occurring [2]
 60:23; 107:10
October [2]
 18:6; 73:3
office [2]
 18:12; 20:1
Ohio [3]
 11:18; 15:7, 8
Okay [28]
 9:13; 14:16; 21:14; 32:25; 33:7, 18;
 34:19; 36:16, 20, 23; 44:19; 51:9; 60:9;
 68:14; 69:22; 70:1; 71:1; 84:3, 23; 85:6;
 91:11; 92:16; 100:1, 3; 106:24; 110:22;
 123:4; 129:12
okay [6]
 63:22; 85:3; 87:12; 118:1; 122:20;
 125:14
old [1]
 25:12
one's [1]
 89:24
ones [2]
 98:3; 99:4
open [1]
 84:24
opened [2]
 65:9, 15
opinion [32]
 27:23; 28:19; 30:2, 4; 3:21; 35:5, 15,
 18; 54:7; 57:20; 64:8; 66:25; 67:2, 18,
 19; 68:6, 8; 69:14; 77:21; 81:9, 18, 0;
 85:11; 112:8; 115:7; 116:10; 117:20;
 118:18
opinions [4]
 22:1; 26:20; 34:12, 13
opportunity [1]
 21:18
opposed [5]
 29:18; 39:13; 61:3; 64:3; 71:9
order [11]
 26:23; 28:12, 15; 76:20, 25; 77:5, 17;
 78:6, 19; 81:16; 125:13
ordered [2]
 79:15; 94:20
orders [10]
 27:5, 7, 22; 78:19, 22; 81:22; 89:15, 16;
 118:5; 124:24
Ordinarily [2]
 18:11, 77
ordinarily [1]
 18:14
originally [1]
 122:25
ORTH [1]

131:7
Orth [1]
 73:20
OT [1]
 99:19
outpatient [1]
 16:12
outside [1]
 58:18
outweigh [2]
 70:16; 72:1
ox [2]
 92:1; 102:10
oximetry [1]
 99:19
oxygen [36]
 43:7, 22, 23; 44:5, 7, 13, 15, 18, 21;
 45:21; 46:4, 6, 9; 47:6, 14, 16, 17, 19;
 48:18; 49:1, 6, 13, 24; 92:6, 13, 14, 25;
 93:4, 20; 97:25; 98:9; 102:11; 106:11;
 108:4, 24
oxygenated [3]
 43:2, 3; 46:7
oxygenation [12]
 41:23; 43:16, 21, 25; 44:1; 45:24; 46:1,
 19, 25; 50:10; 84:14, 15

 * * p * *

P.m. [1]
 95:12
p.m. [9]
 87:18, 19; 88:9; 98:11; 99:1, 17; 111:13,
 15
pack [1]
 99:19
Page [2]
 36:18; 99:13
page [17]
 36:1; 38:14; 42:11; 51:23; 56:2; 86:23;
 93:9, 12; 97:24; 98:11, 25; 100:21;
 103:11; 113:2; 124:18, 20; 128:8
paged [1]
 110:10
pain [18]
 28:6; 30:18, 21; 31:1, 22; 32:5, 8; 50:22,
 25; 51:6, 25; 52:9, 15; 64:19; 65:3, 7,
 15; 90:19
Pardon [1]
 58:20
pardon [1]
 7:23
Paresh [4]
 72:22; 73:20; 75:19; 76:12
part [8]
 7:12; 11:7; 32:13; 52:15; 73:12; 88:8;
 90:9; 114:22
parties [1]
 15:14
parts [3]
 52:25; 64:25; 118:24
Patel [27]
 22:4; 33:5; 34:8, 13; 35:21; 40:6, 7;
 72:23; 73:20, 21; 76:3, 11, 12, 13, 14;
 77:20; 79:25; 80:7, 10, 22; 81:21; 97:7;
 112:21; 124:19, 20; 126:2; 128:21
Patel's [2]
 76:1; 77:15
patient's [7]
 49:6, 13; 82:19; 83:22; 97:19; 108:6;
 128:19

Patients [1]
 58:17
patients [15]
 7:16; 9:23, 24, 25; 10:3, 6, 15, 20;
 11:17, 19; 48:9; 55:15; 62:8; 72:1; 82:20
:02 [1]
 47:9
pCO2 [5]
 39:1; 42:1; 53:1, 4; 93:18
pelvis [1]
 99:18
pending [3]
 16:19; 24:8; 96:21
people [1]
 94:11
percent [11]
 44:13, 15, 18, 21, 25; 45:4, 7, 20; 46:9;
 69:25; 99:19
perform [1]
 91:1
performance [6]
 16:14; 54:22; 72:10; 96:3; 124:22, 23
performed [2]
 32:21; 125:14
performing [1]
 72:11
perfusion [3]
 37:20; 38:3; 86:8
period [11]
 8:17; 22:6; 55:9; 70:6; 106:16; 111:1, 9;
 115:13; 122:3; 123:3, 23
peritonitis [2]
 119:14, 16
permits [1]
 66:8
rsistent [1]
 35:7
person [6]
 48:25; 61:1; 78:22; 83:14; 84:8; 117:16
person's [1]
 47:13
pertained [1]
 126:13
pertaining [2]
 125:1; 126:16
pertains [1]
 20:13
pH [9]
 32:18; 36:17, 24; 37:12; 38:25; 39:4, 10;
 52:24; 93:16
phone [1]
 17:6
phrase [3]
 77:1, 8; 78:21
physician [20]
 10:5; 14:17; 25:22; 26:5; 27:24; 28:12;
 112:18, 20, 23, 25; 113:14, 22; 114:20;
 115:2; 116:1, 18; 117:2, 8, 18; 128:18
physicians [16]
 10:10, 11; 26:12, 17; 29:22; 34:21; 35:3;
 66:19; 67:23; 68:23; 80:9; 90:7, 10, 14;
 123:10; 126:11
Physiology [1]
 9:11
physiology [3]
 9:5, 10, 18
E [3]
 13:4; 24:11, 12
place [2]
 26:7; 81:6
placing [1]

61:21
plain [1]
 18:9
plaintiff [2]
 13:6; 14:23
plaintiffs [2]
 24:2, 4
plan [1]
 66:3
planned [1]
 66:3
please [2]
 51:7; 57:17
pneumonia [35]
 23:21, 24; 25:13; 41:5, 6, 18; 53:17;
 59:20; 60:2, 3, 4, 6, 13, 18; 62:2, 4, 5, 8,
 9, 14, 17, 19; 63:2, 7, 16; 82:23; 120:21,
 23; 121:19, 25; 122:2, 19, 22, 24;
 130:19
pneumonias [1]
 121:7
PO2 [12]
 42:6, 25; 43:6, 9, 13, 15, 18, 24; 45:20;
 46:4, 7; 93:17
PO2's [5]
 41:24; 42:4, 9, 18; 43:17
point [29]
 19:15, 16; 35:23; 41:3, 13; 46:19; 51:7;
 53:21; 54:1, 11; 58:17; 60:12; 65:10;
 69:9, 12; 83:11, 13; 89:12; 90:18; 96:15,
 22; 108:22; 109:5; 110:11; 112:24;
 114:21; 116:2, 5; 119:23
pointed [2]
 30:19; 52:20
pointing [1]
 20:19
portion [2]
 22:9; 32:8
portions [2]
 22:12, 14
pose [1]
 72:7
positing [1]
 67:7
position [1]
 10:8
possibilities [log]
 39:20; 53:23; 54:11; 57:3, 5, 16, 23;
 58:4, 6, 11
possibility [2]
 38:2; 59:13
post [1]
 83:25
potentially [1]
 106:10
practice [5]
 7:5, 7, 9; 8:14; 10:1
precisely [1]
 76:3
preclude [1]
 41:19
precursor [1]
 107:2
predictable [2]
 48:1, 5
prefaced [1]
 68:8
prepare [1]
 18:21
prescript [1]
 51:24

present [1]
 99:20
pressed [1]
 19:14
pressor [1]
 114:11
pressure [47]
 30:10, 17; 32:10; 38:4, 5; 39:8; 55:10,
 17, 20; 56:3, 4, 6, 13, 25; 57:22; 59:18;
 61:7, 16, 23, 25; 85:15, 17, 18, 24; 86:6,
 9; 87:22; 89:25; 90:2; 95:5; 97:25; 98:8,
 24; 100:2, 21; 108:25; 109:11; 110:17,
 23; 111:13; 112:3, 5, 9; 113:15; 114:3;
 115:13
pressures [1]
 56:17
presumably [2]
 21:23; 88:16
pretty [2]
 45:17; 88:24
prevent [4]
 107:15, 18, 20; 108:10
prevents [1]
 104:23
previous [2]
 60:15; 71:19
primary [6]
 29:1, 2, 19; 30:16; 108:13; 128:18
prior [5]
 11:10; 23:25; 26:6, 7; 75:9
private [5]
 7:9; 8:14; 9:23; 10:1; 18:17
privy [1]
 129:10
probabilities [1]
 58:10
probability [3]
 57:19, 21; 60:7
probable [7]
 58:5, 6, 7, 8, 11; 85:13, 14
problem [5]
 33:25; 34:13; 59:8; 64:6; 104:19
problems [6]
 10:19; 29:6; 30:9, 15; 96:10; 121:23
procedure [5]
 26:1, 2, 6; 103:15, 22
production [1]
 37:25
profession [1]
 48:4
progress [12]
 51:14; 66:2, 18; 67:1, 13; 68:15, 17;
 75:22; 80:6; 125:13; 126:23
prolonged [1]
 25:14
protect [1]
 107:9
protecting [3]
 22:21; 107:10, 12
provide [2]
 20:7; 118:10
provided [10]
 22:10; 23:12; 33:5, 6; 34:5, 10; 35:21;
 40:6; 102:18; 116:19
providing [2]
 45:23, 25
pull [4]
 32:25; 51:8, 12, 14
Pulmonary [3]
 7:8; 8:11; 9:11
pulmonary [9]

10:11, 18; 12:2, 23; 14:18, 20, 21;
15:13; 30:16
pulmonologist [8]
12:22; 33:10, 21, 22; 34:4, 6; 48:17;
60:25
pulse [13]
87:20, 21, 24; 89:10, 25; 91:21; 92:1;
97:19, 25; 98:9, 24; 99:19; 102:10
pulses [1]
101:5
pure [1]
83:11
purposes [4]
10:22; 63:2; 77:14; 118:22
purpura [1]
23:17
puts [1]
29:12
putting [1]
109:2

* * Q * *

qualify [1]
34:17
QUANDT [1]
117:14
quarrel [1]
57:18
quarter [1]
101:17
Question [3]
78:1; 99:24; 113:6
question [25]
28:4; 31:21; 33:15, 19; 34:18; 58:23;
67:14; 68:18; 69:2, 20; 70:1; 75:6;
77:24; 82:7; 91:7; 96:21; 98:16, 22;
99:23; 110:13; 112:7; 113:5, 7; 118:14;
125:18
questioning [1]
33:12
questions [7]
63:12; 90:25; 130:8, 10; 131:4, 6, 7
quickly [5]
104:20; 105:6, 11; 129:15
quotation [1]
77:8
quotes [1]
77:9

* * R * *

R-a-g-a-n [1]
13:8
Radiation [1]
72:9
radiation [1]
72:8
radiology [1]
120:6
Ragan [1]
13:8
raise [4]
63:11; 89:10; 128:21, 23
raised [1]
126:1
raises [1]
69:11
range [6]
45:21; 48:2; 56:4, 14, 19; 106:20
ranging [2]
43:11; 88:9

rapid [3]
48:21; 82:25; 85:8
rapidly [1]
84:8
Rare [1]
70:18
rare [2]
70:17; 71:22
rate [6]
47:24; 49:4, 21; 85:8; 89:14, 24
rates [15]
29:11; 47:22; 48:12, 22; 50:9, 14, 15,
23; 52:16; 53:13, 14; 85:16; 87:21;
89:11; 97:20
Ravenna [1]
7:4
reach [1]
30:25
read [19]
21:18, 23; 22:9; 52:2; 65:20; 66:1;
68:10, 11, 12; 72:16; 78:1; 82:13; 94:8;
100:20, 24; 102:21, 22; 103:1, 18
readily [1]
48:5
reading [16]
26:23; 38:13; 44:14, 20, 24; 46:13;
47:25; 52:3; 95:4, 8; 96:14; 100:15, 18;
104:1, 5; 108:24
readings [2]
100:12; 103:5
readout [1]
94:12
readouts [1]
93:23
real [4]
64:14; 92:19, 22
realize [1]
96:13
reason [14]
18:10, 11; 20:2; 33:2; 50:20; 52:12;
53:11; 61:1; 78:14; 79:1; 104:11, 17, 18;
129:11
reasonable [2]
57:21; 60:7
reasonably [1]
42:3
reasons [3]
50:21; 53:9; 71:25
recall [19]
9:9; 13:2, 6; 14:25; 15:4, 9, 19; 16:18;
17:2; 24:5, 17; 32:23; 42:16; 73:2, 13;
102:25; 103:4; 130:23; 131:2
recalling [1]
104:1
receive [4]
17:19; 55:15; 82:24; 109:14
received [8]
17:21; 18:4; 26:25; 57:12; 108:19;
109:16, 20; 116:10
receiving [5]
28:3; 44:5, 15; 49:25; 111:9
Recess [1]
72:15
recollection [6]
14:20; 51:5; 95:16; 103:7, 10; 120:23
recommending [1]
34:21
recommends [1]
117:8
Record [2]
72:16; 82:13

record [11]
20:19; 30:23, 24; 64:5; 76:16; 80:22;
82:7, 9; 126:5; 130:11, 13
recorded [3]
36:17; 98:4; 103:7
recordings [3]
97:25; 98:1
records [7]
40:3; 51:2, 8; 80:19; 102:17; 120:22;
124:24
recover [1]
62:9
reduce [1]
84:21
reduction [4]
37:12; 38:4; 39:10; 61:23
refer [4]
36:1; 74:23; 75:2; 130:1
reference [2]
75:6; 80:25
referrals [1]
11:25
referred [1]
21:16
referring [6]
32:20; 44:10; 99:12; 124:22; 125:1, If
reflect [2]
20:19; 44:4
reflection [1]
53:3
regard [2]
73:22; 125:4
regarded [1]
25:16
region [1]
99:18
related [7]
11:16; 15:12; 20:16; 23:12; 25:8, 11;
49:24
relation [1]
12:13
relative [1]
82:19
relax [1]
85:5
relied [1]
77:17
relieve [1]
65:2
rely [1]
125:5
remainder [2]
22:15; 40:13
remained [1]
56:18
remember [12]
14:7, 9, 14, 15; 15:8, 11, 14; 16:25;
24:21; 67:14; 95:2; 124:18
Reminger [2]
15:25; 16:1
removed [1]
41:11
Renal [1]
38:7
renal [3]
29:8; 38:1, 6
rendered [3]
22:2; 26:21; 35:2
rendering [3]
33:21; 34:13; 77:21
repeat [4]

77:24; 92:18; 124:10, 12
repeated [2]
 56:3; 77:9
report [24]
 13:19; 17:21; 18:6, 19, 20, 21; 21:3, 4;
 26:23; 28:5; 33:3; 63:5; 73:1, 3; 76:4;
 77:9; 78:10, 23; 95:20; 96:14, 16;
 119:24; 124:17, 18
reports [5]
 51:14; 56:1; 68:11; 72:21; 73:7
representing [1]
 24:10
required [3]
 53:6; 123:9; 128:12
requiring [1]
 43:21
research [3]
 7:15; 9:15; 10:22
reservations [19]
 124:21, 25; 125:1, 9, 15, 18, 19, 22, 24;
 126:2, 6, 13, 15, 18, 21, 24; 127:14, 18;
 128:11
Reserve [2]
 8:2; 11:3
residents [1]
 7:21
resolution [1]
 65:19
resolved [2]
 75:11
respect [11]
 22:1, 7; 26:20; 33:21; 34:12, 24; 35:2, 9;
 37:9; 112:15; 130:18
respiration [9]
 47:21, 23; 48:11; 61:6; 82:25; 90:6;
 91:20; 98:24; 108:7
aspirations [1]
 101:15
respirations [7]
 47:15; 52:13; 53:10; 84:18; 90:22;
 101:13; 103:17
Respiratory [3]
 49:4; 50:15; 105:16
respond [6]
 70:8; 121:3, 10, 11, 19; 124:2
response [2]
 55:19; 85:16
responsibility [3]
 113:13; 117:4, 17
Responsible [1]
 113:8
responsible [6]
 32:7; 93:4; 113:6, 20, 23; 117:12
rest [2]
 44:2; 52:3
restate [1]
 67:16
result [7]
 26:9; 29:9; 38:3; 39:9; 63:1; 65:4; 86:6
resultant [1]
 16:16
resulted [1]
 43:25
resuscitated [1]
 108:19
resuscitation [1]
 111:2
etained [9]
 13:3, 14, 18; 14:9, 22; 15:18, 25; 16:7;
 73:19
returned [6]

100:17; 103:12; 109:19; 110:3, 7, 9
returning [1]
 122:23
reverse [2]
 116:2, 4
review [19]
 13:14, 18; 20:5; 22:7, 10, 13, 14; 33:4,
 24; 34:2, 5, 7; 35:4, 7, 20; 40:12; 76:15;
 120:22; 130:23
reviewed [7]
 13:25; 14:4; 18:13; 22:4; 30:23, 24; 80:5
reviewing [1]
 69:1
Right [9]
 44:21; 87:7; 88:21, 23; 91:22; 95:1, 4;
 104:15; 112:1
right [24]
 33:23; 34:1, 25; 35:19; 37:5; 44:19;
 50:1; 64:13; 74:24; 76:12; 87:19; 91:11,
 18, 21; 92:17; 94:3; 95:9; 104:12; 105:4;
 106:12; 107:14; 113:19; 121:25; 129:1
Rise [1]
 90:4
rise [3]
 43:24; 89:15; 90:3
risk [2]
 71:12, 21
risks [3]
 70:15; 71:25; 72:6
RN [1]
 99:20
Road [1]
 7:4
room [2]
 35:3; 43:10
rotating [1]
 10:8
routine [1]
 72:10
running [1]
 111:19
rushed [1]
 91:17

*** * S * ***

safety [1]
 124:21
saturation [4]
 92:7; 98:1, 9; 108:24
saying [11]
 37:15; 39:23; 42:4; 49:23; 66:7; 76:4;
 95:20; 98:3; 111:5; 116:4; 129:3
scan [25]
 22:21; 31:13, 14; 34:21; 55:6; 65:8;
 91:13, 18; 93:11; 94:23; 96:3; 98:13;
 100:17, 19; 103:13; 109:17; 112:10;
 113:1, 16; 117:21; 118:17; 119:20;
 128:25
school [4]
 7:22, 25; 8:1; 9:2
Scott [14]
 16:10; 17:7, 12, 15; 19:5, 25; 21:2;
 33:17; 72:25; 78:15; 79:24; 80:4, 6, 11
Scott's [1]
 77:7
se [2]
 119:9, 10
searching [1]
 33:14
second [2]

100:15; 116:22
seconds [1]
 105:25
secretary [1]
 18:12
sedation [1]
 82:24
sedative [1]
 28:13
sedatives [1]
 26:24
seizures [2]
 70:21; 71:1
semantics [1]
 105:24
send [3]
 22:21; 94:22; 115:25
sending [1]
 119:19
sense [5]
 27:2, 25; 28:1; 67:4, 5
Sepsis [1]
 59:9
sepsis [6]
 59:7, 11, 14, 19; 73:22; 86:14
September [2]
 17:6, 14
serendipity [2]
 120:10, 18
served [1]
 12:15
serving [1]
 12:11
setting [1]
 120:1
shallow [1]
 103:17
She's [1]
 44:21
she's [5]
 37:24; 43:2, 3, 6; 113:2
shift [1]
 103:8
shortness [1]
 96:12
show [6]
 31:12, 18; 100:20; 104:2, 4; 126:4
shows [1]
 46:7
signature [1]
 131:17
significant [3]
 56:21; 65:14, 19
Significantly [1]
 91:15
signs [2]
 30:3, 6
sir [9]
 39:22; 52:2; 53:22; 85:17; 98:16;
 100:20; 103:12; 111:15; 124:17
sit [1]
 85:5
situation [3]
 29:15; 71:5; 108:3
six [2]
 15:17; 17:24
size [1]
 82:19
sleeping [2]
 88:16; 89:6
Slightly [1]

56:12
slightly [1]
 88:12
solely [1]
 65:3
somebody [9]
 53:2, 8; 70:6; 105:2; 106:7; 116:24;
 121:18; 122:23; 127:22
somebody's [1]
 49:9
somehow [1]
 105:18
someone [2]
 48:15; 49:14
someone's [1]
 107:7
somewhat [2]
 40:10; 50:18
somewhere [3]
 94:23; 95:9; 124:17
sooner [1]
 109:23
sorry [13]
 7:12; 12:10; 18:16; 24:3; 25:10; 29:16;
 30:7; 36:20; 39:15; 71:6; 75:16; 87:23;
 122:16
sot [1]
 104:23
source [2]
 73:22; 74:20
speak [2]
 76:10; 81:25
speaking [3]
 72:2, 4; 124:20
speaks [1]
 105:22
specialty [1]
 34:1
specific [9]
 29:17; 31:13, 19; 33:4; 41:3; 58:5;
 69:15; 87:15; 110:1
specifically [8]
 26:22; 30:8; 64:17; 80:1, 23, 24; 101:18;
 126:19
specifics [1]
 15:14
specify [1]
 61:14
specifying [1]
 105:15
spoken [1]
 80:7
stability [3]
 70:23; 71:2; 72:2
stabilize [1]
 57:13
stable [1]
 71:8
staff [1]
 9:24
staffed [1]
 10:3
standard [7]
 33:5; 112:14; 123:9; 124:13; 128:12, 16,
 22
standards [1]
 22:11
standing [1]
 89:16
standpoint [1]
 28:8

start [3]
 13:23; 42:12; 113:23
started [4]
 60:23; 83:5; 105:7, 13
State [2]
 15:6; 52:5
stated [1]
 128:2
statement [2]
 105:9; 122:10
states [2]
 66:17; 127:9
stationery [3]
 18:10, 14, 18
status [17]
 29:13; 57:7; 71:24; 82:16, 20; 83:3, 23;
 84:6; 125:2, 6; 126:8, 11, 14; 127:15;
 128:19; 129:8
stick [1]
 74:20
stimulant [6]
 47:1, 17, 19; 52:19; 84:7, 10
stipulated [1]
 27:22
stones [1]
 118:25
stool [1]
 52:7
stopped [2]
 23:24; 106:21
stores [1]
 46:3
strange [1]
 118:14
stress [1]
 120:9
stroke [1]
 25:13
students [1]
 8:12
study [1]
 9:17
submit [1]
 13:18
submitted [3]
 19:5, 7, 8
subsequent [2]
 29:9; 50:3
subsequently [3]
 26:3; 56:6; 73:23
substantial [2]
 43:7; 120:9
substantive [2]
 19:20, 21
sued [2]
 22:24; 23:18
suffer [1]
 95:23
suffered [3]
 25:12; 26:2; 115:19
sufficiently [1]
 57:12
suggesting [3]
 62:1; 76:8, 10
suit [2]
 24:6; 25:19
supine [1]
 96:1
support [1]
 121:20
supported [2]

122:14, 20
suppose [2]
 92:16; 107:9
supposed [2]
 82:24; 118:7
suppress [1]
 83:2
surgeon [4]
 34:15; 65:20; 67:9, 17
surgery [8]
 31:16, 17; 66:4, 6, 21, 23; 74:10, 15
suspect [2]
 27:1; 50:21
suspects [1]
 59:19
sustained [3]
 106:14; 115:8; 130:2
symptomatically [1]
 62:9
symptomatology [2]
 63:17; 64:1
symptoms [1]
 62:12
system [1]
 42:2
systolic [2]
 56:7, 15

* * T * *

table [1]
 20:21
Tachycardia [2]
 88:1; 89:18
tachycardia [11]
 85:9; 86:2, 3, 4, 7, 11, 13, 16; 89:19;
 90:6, 22
takes [2]
 106:16, 19
talked [1]
 71:20
talking [15]
 13:23; 44:11; 51:16; 54:2, 3; 59:2, 6;
 61:5; 87:21, 23; 88:4; 90:12; 105:25
teach [7]
 7:17; 8:3, 4, 10, 16; 11:2, 7
teaching [6]
 7:15, 20, 21, 24; 9:2; 10:22
telling [6]
 32:9; 44:3; 57:13; 68:10; 74:25; 111:14
tells [1]
 39:12
temperature [4]
 53:12; 98:24; 101:19, 24
ten [5]
 13:24; 14:2, 5; 25:3; 129:24
term [1]
 12:11
terms [20]
 18:25; 29:17; 33:5; 35:1; 71:2, 23, 24;
 72:2, 4; 77:10; 78:4; 82:20; 83:8, 10;
 86:8; 97:6, 8; 103:4; 117:4; 129:7
test [15]
 16:12, 14; 44:17; 50:17; 70:11, 12, 13,
 22; 71:21, 25; 95:15; 117:5, 9, 11;
 125:14
testified [2]
 14:11; 66:9
testify [4]
 15:1, 5; 16:21; 26:13
testimony [12]

42:5; 52:12, 15; 63:16, 20, 21; 66:16;
98:10, 12, 13, 23; 99:2

tests [11]

31:9, 10; 49:7; 54:23; 69:9, 10; 71:12;
72:7, 11; 91:2; 126:12

tbody [2]

9:6, 10

textbooks [1]

9:14

therapies [1]

112:5

therapy [5]

70:9; 113:24; 116:10, 13, 19

There's [5]

40:19; 48:21; 54:10; 109:25; 114:11

there's [12]

20:3; 22:12; 51:10, 23; 54:5, 21; 57:5;
62:2; 66:20; 68:14, 24; 118:9

They're [3]

94:4; 118:22; 119:4

they're [12]

47:16; 48:17; 49:25; 71:13; 94:20;
101:16; 104:12; 106:11, 25; 118:23, 24;
121:8

Thompson [1]

23:8

threatening [1]

44:1

Three [3]

23:4; 106:5, 6

three [16]

8:18, 20; 10:4, 12; 58:4, 6; 66:14;
102:15; 104:10; 106:4; 109:23; 110:19;
122:4, 7; 126:8; 129:3

thrombocytopenia [1]

23:16

rombotic [1]

23:16

Time's [1]

99:17

times [18]

23:1, 4; 56:4; 58:25; 66:14; 86:17;
98:14; 99:9; 100:17; 101:8, 11; 103:9;
117:3; 120:11; 123:2, 22; 127:9

timing [1]

95:3

tissue [3]

37:20; 38:3; 86:8

tomorrow [1]

82:4

tracks [1]

79:20

transcript [1]

17:18

transported [2]

99:11, 17

treat [6]

92:12, 24; 100:9; 121:1; 122:2, 7

treated [7]

55:13, 18; 62:4, 8; 123:5, 13, 15

treating [5]

23:21, 22, 23; 91:3, 5

treatment [8]

43:21; 89:12; 100:10; 109:9, 10; 114:15,
17

trial [4]

13:11; 15:22, 23; 26:15

trouble [3]

36:10; 52:3; 63:11

true [2]

34:24; 121:6

TTP [1]

23:16

tube [4]

41:11; 107:25; 108:1, 2

twice [3]

11:19; 12:7, 12

two-week [1]

123:2

type [4]

11:24; 59:8; 71:5; 72:7

types [2]

72:1; 121:4

typically [2]

94:17; 129:14

typographical [3]

18:24; 19:17, 19

* * U * *

ultrasound [2]

119:12, 17

Ultrasounds [1]

118:21

ultrasounds [1]

118:20

unable [1]

103:15

unclear [1]

29:20

undergo [2]

70:22; 71:13

undergoing [2]

26:1; 95:24

understand [15]

32:9; 33:25; 60:22; 64:8, 10; 70:4; 80:2;
81:7; 96:9; 98:2, 16; 116:23; 122:18;
125:17; 130:19

undertake [1]

84:18

unintentional [1]

36:21

unit [6]

10:2, 7; 50:19; 95:25; 129:22, 25

university [1]

11:6

unknown [1]

40:25

unnecessary [1]

74:9

unstable [1]

70:22

upper [1]

107:21

usual [2]

96:3; 121:8

* * V * *

vague [3]

51:24; 52:10; 70:13

values [2]

43:11; 59:16

variable [3]

48:9; 50:15; 106:20

varies [1]

48:12

variety [2]

114:5; 118:21

ventilated [1]

130:22

ventilation [7]

41:16, 22; 47:20; 53:3; 83:2; 106:22;

109:2

ventilator [13]

42:22; 60:19; 61:17, 22, 24; 108:5, 6,
20, 21; 129:18, 21, 25; 131:1

verbal [4]

76:20, 25; 78:6, 19

verbally [1]

19:6

version [2]

19:8, 18

vessels [2]

58:14, 18

viral [5]

120:21, 25; 121:3, 9, 18

vital [2]

30:3, 6

voice [1]

63:11

* * W * *

Wait [7]

42:8; 57:8, 10; 98:2; 110:12; 111:11

waive [1]

131:10

waived [1]

131:17

wanted [1]

82:2

wants [1]

62:24

We'll [2]

51:8, 11

We're [3]

27:17; 28:18; 85:3

we're [2]

28:17; 36:9

we've [1]

107:3

week [4]

8:16, 19, 20; 80:15

weeks [7]

17:24; 53:18; 62:11; 122:3, 4, 8; 123:23

weigh [1]

71:11

weren't [1]

91:3

West [1]

9:12

Western [3]

8:2; 10:25; 11:2

What's [1]

77:24

what's [1]

66:11

whatsoever [1]

106:22

whereas [1]

83:12

white [2]

59:18, 22

whoever [2]

103:1; 112:15

wife [1]

82:3

withdraw [1]

90:13

WITNESS [5]

46:22; 51:18, 21; 85:1; 87:3

witness [1]

12:11

woke [1]

89:6

won't [2]

107:18, 20

word [6]

27:12; 70:8, 14; 71:22, 23; 120:17

wording [1]

66:11

words [6]

12:1; 39:5; 47:13; 81:14; 91:3; 94:5

work [3]

11:16; 29:13; 122:15

working [2]

53:5; 121:20

worse [17]28:19; 50:13, 16; 62:1; 83:3; 86:16, 20;
87:17; 89:4; 91:13, 15; 105:7; 115:14,
15; 121:25; 122:16, 21**worsening** [3]

61:7, 10; 90:6

wouldn't [21]40:22; 48:19, 20; 49:2; 55:2; 61:15;
69:8; 70:14; 71:8; 77:17; 78:9; 104:13;
109:5; 115:17; 116:16, 23; 120:12, 17;
123:23; 124:1; 129:23**write** [1]

75:25

writing [1]

19:6

written [2]

29:25; 30:1

wrong [2]

74:13; 111:18

wrongful [1]

25:17

wrote [3]

18:6; 76:1; 102:23

* * X *

x-ray [7]41:18; 50:17; 60:5; 62:10, 16; 124:10,
12

* * y *

Yeah [4]

76:23; 79:20, 21; 110:24

year [11]8:5, 11, 21; 10:4, 12; 12:12, 18, 20;
104:9, 10**years** [8]7:11; 13:24; 14:2, 5; 15:17; 24:24; 25:3,
12**yesterday** [3]

17:17; 21:24, 25

yield [1]

69:25

you'd [1]

53:7

yours [1]

9:23

yourself [1]

27:11

* * Z *

zero [1]

106:23