IN THE COURT OF COMMON PLEAS

STARK COUNTY, OHIO

LEONA G. SHAFFER,
EXECUTRIX, etc., et al.,

Plaintiffs,

-vs-

JUDGE HAAS
CASE NO. 2002 CV 1940

R. KIRK ELLIOTT, D.O.,
et al.,

Defendants.

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Deposition of R. KIRK ELLIOTT, D.O., taken as if upon cross-examination before Judith A. Gage, a Certified Realtime Reporter and Notary Public within and for the State of Ohio, at the offices of Buckingham, Doolittle & Burroughs, 4518 Fulton Avenue, N.W., Canton, Ohio, at 3:00 p.m. on Monday, October 28, 2002, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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W I T N E S S I N D E X

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R. KIRK ELLIOTT, D.O., of lawful age, called by the Plaintiffs for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF R. KIRK ELLIOTT, D.O.

BY MR. CONWAY:

Q. Hi, doctor. My name is Tom Conway. I represent William Guthrie's family in this case. We're going to be taking your deposition. Would you please state your full name for the record, spelling your last name for the court reporter?

A. Yes. It's Richard Kirk, K-i-r-k, Elliott. E-l-l-i-o-t-t.

Q. And your date of birth?

A. Is November 4, 1948.

Q. You have your attorney seated over here; I assume you had an opportunity to meet with him prior to this deposition?

A. Yes.

Q. Do you know what a deposition is?

A. Yes.

Q. I'm going to be asking you questions regarding your involvement in this case. I would like to

emphasize that you should not answer any question that you don't understand, okay?

A. Yes.

Q. If you don't understand a question, somehow indicate that to me and I will be glad to rephrase it or repeat it.

A. Okay.

Q. But if you do answer a question I'm going to assume and rely upon the fact that you understood it. Is that fair?

A. Yes.

Q. At any time you want to take a break and talk to your attorney, feel free to do so.

A. Yes.

Q. And any time you want to add, subtract, delete, modify anything that you have said previously in the deposition, let us know and we can go on the record and let the court reporter know what you want to say, all right?

A. Okay.

Q. And you understand that this deposition which is being taken under oath has the same effect as if you were in front of a judge and jury testifying. You understand that?

A. Yes.

Q. I would like to take you back to May of 2000. At that time, you were a gastroenterologist, correct?
A. Yes.
Q. And you still are?
A. Yes.
Q. You had a patient by the name of William Guthrie, is that correct?
A. Yes.
Q. Going back to, I believe May 23 of 2000, was that the first time that you had an opportunity to be in contact with William Guthrie?
A. Yes.
Q. And you were requested to perform a gastroenterology consult on William Guthrie, correct?
A. Yes.
Q. What you may want to do is make sure you answer out loud yes or no, and give yourself a second after I finish speaking before you give the answer. Okay?
A. Okay.
Q. That way she can take it down a little bit easier.

William Guthrie would have been your patient

for purposes of doing the EGD, which you performed on May 24, as well as a colonoscopy that you performed on May 25, is that correct?

A. Yes.

Q. He would have been considered your patient during the postoperative period as well, correct, from those two procedures?

A. As a consultant I was asked to perform those two procedures at the request of the referring physicians. As an in-patient, many times I may not follow him postoperatively. The primary care physician may assume the care after that.

Q. Okay. Someone has to have, someone has to be providing care and treatment to a patient post --

A. Right.

Q. -- operatively, correct?

A. Right.

Q. In this particular case, was it your responsibility or the attending physician's responsibility to follow Mr. Guthrie post colonoscopy?

MR. MOSS: Object to the form.

MR. FRASURE: Do you understand the question?

THE WITNESS: No, I don't.

A. Could you rephrase it?
Q. You performed a colonoscopy on William Guthrie on May 25, correct?
A. Yes.
Q. Did you have any postoperative responsibility regarding William Guthrie?
A. Yes.
Q. Okay. Tell me in detail what your postoperative responsibilities were with regard to following William Guthrie after that May 25 colonoscopy.
A. Following the colonoscopy was communicating -- first of all, dictating a report of what the procedure entailed, communicating the findings back to the physician who requested I perform it for them, and getting my recommendations on diet. And in this particular case, we discussed whether to continue aspirin or Plavix or neither as far as anti-coagulants, since ten polyps were removed at the time of the colonoscopy. And the primary care physician, primary physician, Dr. Gross, related back that he would follow the patient thereafter.
Q. Fair enough. So your responsibilities as the consulting gastroenterologist in this case were to perform the procedures --

A. Right.
Q. -- that you felt were medically indicated, correct?
A. Correct.
Q. And in this case you felt both of these procedures were medically indicated, correct?
A. Correct.
Q. The EGD, which is a -- for the record?
A. Upper GI endoscopy.
Q. Right. Which was performed on May 24, 2000, and the colonoscopy which was performed on May 25, 2000, correct?
A. Yes.
Q. And then it was your responsibility to communicate the findings of both of those procedures to, in this particular case Dr. Gross, correct?
A. Yes.
Q. And in fact, you did send Dr. Gross the surgical op notes for both of those procedures, is that correct?
A. Yes.
Q. Going to the EGD with biopsy that you performed on May 24, on what date did you send a copy of the results of that procedure? What date did you

send that report to Dr. Gross?
A. On the 24th. The same day it was performed.
Q. In fact, you dictated it and it was transcribed and you sent it out on May 24, correct?
A. The hospital sent it out, since it was an in-patient procedure.
Q. And then going to the colonoscopy?
A. The same.
Q. Okay. So your report was dictated, transcribed on May 25, correct?
A. Correct.
Q. And would have been sent out to the hospital by Dr. Gross, correct?
A. Yes. In addition to personal telephone call, too.
Q. Did you place a telephone call to Dr. Gross' office or Dr. Gross on May 24 and May 25, do you recall?
A. I told the hospital operator to have him paged. I'm not sure where he was located. But he returned --

MR. FRASURE: Which day are you talking about?

THE WITNESS: After the colonoscopy.

Q. Did you talk with Dr. Gross after the May 24 EGD?
A. I don't recall. I called the daughter, I know for sure, after the EGD and discussed it with her. I'm not sure I discussed it with Dr. Gross following the EGD because our previous discussion prior to the EGD after I did the consultation was that we would start with the EGD; if we found a bleeding site, an ulcer bleeding or something actively bleeding in the stomach we would stop there. If we didn't, we would proceed on with the colonoscopy.
Q. Following the colonoscopy, you did in fact talk with Dr. Gross?
A. Yes, I did.
Q. Would that be your standard custom and practice, to talk with the referring physician after a procedure such as that?
A. Yes.
Q. Do you recall what you told Dr. Gross and what his response was on May 25 following the colonoscopy?
A. I informed him of both the results of the EGD and the colonoscopy, even though I didn't know whether he had the written report yet, but what I had found.

I told him that I recommended -- we had discussed the fact that ten polyps were removed. I told him my recommendations typically are not to take aspirin or Plavix for two weeks after removal of polyps, but in this particular case he knows the patient better than I, all of his other medical problems and his recent stroke, and I was going to leave it up to his judgment. If he felt it was absolutely necessary that these be continued, there would be an increased risk of bleeding complications. And he felt that absolutely both should be continued because he felt that it was just too dangerous to stop and that the patient should be on a soft diet.

Basically at this point, I didn't feel that the patient should undergo a small bowel x-ray, that was the next step if the hemoglobin continued to drop despite removal of these ten polyps, and we had discussed the fact that he has a stricture in the left side of the colon with extensive diverticulosis, and I recommended that normally in this situation a barium enema x-ray a couple months later be performed to get another view of the colon since it was difficult to see some areas, but given this gentleman's poor

condition, I would leave that up to Dr. Gross. I didn't know what his survival was going to be as far as his heart and lungs and his stroke and his other situation.

Q. So from your perspective, after dictating your report, you communicated the results --

A. Yes.

Q. -- of your procedures to Dr. Gross, and you made your recommendations or gave your input for whatever weight he wanted to give it, correct?

A. Yes.

Q. Following your conversation with Dr. Gross on May 25, did you have any further involvement with William Guthrie as far as rendering any care and treatment to him, seeing him postoperatively, anything?

A. On the 25th, which was a Thursday, the colonoscopy was done.

On Friday morning, I was in the hospital and I dropped by the rehab unit to see if everything was going well and I was told by the nursing staff it was. There were no problems. And so I didn't see him after that.

Q. Did you chart a note for the 26th?

A. No, I didn't.

Q. And you would not have had direct contact with him on the 26th, correct?
A. No. I saw him in the room.
Q. Did you talk to him?
A. I talked to him, examined his abdomen, and I wasn't impressed that there were any problems.
Q. The original reason you became involved as a consultant was that they were trying to rule out a GI bleed, correct?
A. He had been bleeding and his stools were repeatedly positive and his hemoglobin was dropping, and so they asked me to determine the source of his gastrointestinal bleeding.
Q. And were you able to determine it?
A. And try to do something therapeutically to get it to stop.
Q. Were you able to determine the source of his GI bleed?
A. He had several possibilities of occult bleeding, not active bleeding. When I scoped him he had pretty severe gastritis, although no bright red bleeding. He had ten polyps in the colon that we removed, any of which could have caused intermittent bleeding, but they were not bleeding at the time I did the scope test.

Q. So you didn't determine any direct cause of bleeding, is that correct?
A. I didn't see any active bleeding at the time that I scoped him.
Q. So you were not able to determine definitively the cause of his bleeding, correct?
A. No.
Q. Correct?
A. Correct.
Q. And I'm not saying that to be rude, but sometimes "no" gets interpreted differently.
A. Right.
Q. Colonoscopy -- strike that.

A colonoscopy carries with it a recognized complication or risk of perforation, correct?
A. Correct.
Q. And different parts of the colon can become perforated, correct?
A. Correct.
Q. In this particular case it was the sigmoid colon, correct?
A. Yes.
Q. Where does the sigmoid colon rate as far as the amount of times that that gets perforated compared to other parts of the colon? Is that

one of the more common areas of perforation or rarer areas of perforation?

A. I'm not sure as far as the frequency. The right side of the colon is the thinnest part, so I would think that that would probably carry a greater risk, although the sigmoid colon also --

Q. Perforated sigmoid colon is a recognized risk of a colonoscopy procedure, correct?

A. Correct.

Q. That would have been explained to the patient and his family, correct?

A. Correct.

Q. Do you recall when you were dealing with William Guthrie as a patient that his daughter, Leona Shaffer, was involved in different discussions? Do you recall that?

A. I don't understand the question.

Q. Okay. Obviously, you would have dealt with William Guthrie verbally.

A. Right.

Q. Do you recall dealing with any of his family members verbally?

A. Yes.

Q. Do you recall the names of those family members?

A. Yes, Leona Shaffer, because she was power of

attorney on the chart.

Q. So in explaining the risks of the procedure to William Guthrie, you would have also included Leona Shaffer in that conversation, correct?

A. Yes. It was by telephone with the daughter. Leona Shaffer.

Q. A perforation can occur during the actual colonoscopy procedure, correct?

A. Correct.

Q. And that's what we refer to as a perforation during the procedure. Is there such a thing as a delayed perforation resulting from a colonoscopy?

A. There can be a very rare incidence of delayed perforation.

Q. And what occurs in that type of situation?

MR. FRASURE: Just in general, you're asking?

A. In general, I would think the same sort of symptoms that would occur during an acute perforation while the procedure was underway.

Typically, a perforation is one of the more catastrophic complications of a procedure, and typically if a perforation did occur, there would be leakage of air and fluid or stool outside the colon and cause severe infection of the abdominal

cavity. Typically, within 12 to 24 hours, I would expect a very rapid deterioration in the patient's condition, fever and abdominal pain, usually leading to sepsis to shock to death fairly quickly, within usually 24 hours if it is not treated.

Q. And that would follow from an acute perforation during the procedure, correct?

MR. MOSS: Objection.

A. I would think it would follow either one. Whenever a perforation occurs in the intestinal tract, the same sequence of events typically follows.

Q. Physically, what happens when a part of the colon such as the sigmoid colon is perforated?

A. As I described a moment ago, there would be a leakage of air and fluid or fecal material outside the colon.

Q. How does the actual perforation occurs? What causes the perforation?

MR. FRASURE: On a delayed versus an acute?

MR. CONWAY: No. Just on an acute perforation.

A. Acute perforation can occur either directly while

you are removing a polyp, or it can occur by introducing the scope, the tip of the scope, or it could be due to air insufflation of the colon in an area that is a already weakened from some other pathology.

Q. So you could cause a perforation by putting air in a part of colon that is already weakened --

A. Yes.

Q. -- that would stretch the tissue and it would rupture, is that what happens?

A. Yes. That could potentially occur.

Q. You could also stick the instrument physically and perforate the colon, correct? Stick it through the colon?

A. Right.

Q. And the other way it could occur is during the removal of a polyp?

A. Correct.

Q. How does that occur mechanically? How does the colon become perforated?

A. When you removed a polyp you use cautery, an electric cautery snare and you try to remove the entire polyp, and in doing so, you always remove the superficial layers of the lining of the colon, so there is always a chance that the

electrocautery could cause a deeper hole in the wall of the colon, and if it was a full thickness hole it would be a free perforation.

Q. Now, let's go and talk about a delayed perforation, okay, one that did not become evident during or occur or become evident during the actual procedure. Okay?

A. Yes.

Q. You testified that that's a rare occurrence, correct?

A. Yes. Extremely rare.

Q. But it does occur.

A. It may occur, I would think within a maximum of a week or two after a procedure at the most.

Q. Have you read the autopsy in this case?

A. No, I didn't.

Q. The death certificate in this case?

A. No.

Q. Are you under the understanding that William Guthrie suffered a perforated colon in this case?

A. That's what I was told.

Q. In reading through the medical records that you have in front of you or other medical records that you have had an opportunity to review, do you agree that he suffered a perforated colon?

A. Yes.
Q. When do you believe the colon actually perforated?
A. I think it occurred myself within 24 hours of June 1, when he came to the Emergency Room.
Q. So you think the colon perforated sometime June 1 or after.
A. Yes.
Q. All right.
A. Well, sometime within 24 hours preceding June 1, either May 31 or June 1, within 24 hours of arriving at the hospital.

MR. FRASURE: Just for reference sake, what time was the arrival?

MR. CONWAY: Well, he arrived --

Q. You have the record in front of you. He was called by EMS -- he was called -- excuse me, EMS was called at 12:51 p.m. --
A. So he came in the afternoon.
Q. Well, you did, and I'm not trying to trick you or anything, you did the procedure on May 25.
A. Right. One week before.
Q. You're saying that the colon perforated up to 24 hours before he goes into the Emergency Room on June 1. Correct?

A. That's my opinion.
Q. So it's your opinion he suffered a delayed perforation, correct?
A. Yes.
Q. What caused that delayed perforation, in your opinion, doctor?
A. I don't know the exact cause of the delayed perforation.
Q. Could it have been the weakening of the intestinal lining due to the polypectomies?
A. That's one possible cause.
Q. What would be some other possible causes?
A. He also had very severe diverticulosis of the left side of the colon in the area where the polyp was removed.
Q. And how could that contribute to possibly a delayed perforation?
A. It's a thin portion of the wall of the bowel to begin with, and anything that increases the pressure or causes inflammation in that vicinity, whether he had diverticulosis or he had constipation or whether he had poor circulation, he is a man with known vascular disease, I don't know what his vascular status was right at that time because I didn't see him, that was a week

after I saw him, and people can get a localized ischemic colitis.

I just don't know what the exact cause of the perforation was, but I was told that it occurred in the sigmoid colon.

Q. All right. Was the colonoscopy that you performed on May 25 a difficult procedure?

A. Yes.

Q. Just cutting to the chase, what was out of the ordinary as far as being difficult regarding Mr. Guthrie's procedure on May 25?

A. He had a very tortuous colon, also narrowing of the sigmoid colon --

Q. What does tortuous colon mean?

A. Tortuous colon means sharp angulation. Hopefully the colonoscopist finds a straight colon; his was not. We used a pediatric scope on him, the smallest diameter soft flexible scope to make it as easy as possible, and even with the pediatric scope it was difficult to get around the sharp turns or corners. And also it was hard to fully insufflate the colon with air because of spasm and because of stricture in the sigmoid colon.

Q. And obviously the more difficult the procedure, the greater the likelihood of a perforation.

Would that follow?

A. I would think the increase -- it would be increased somewhat if it was a technically difficult procedure.

Q. I'm just saying that would follow if you have a very technically difficult procedure. That's going to increase the risk of a complication, correct?

A. Correct.

Q. And the risks we're talking about here is that it would increase the risk of a perforation. Correct?

A. Correct.

Q. The polypectomy times ten, how did you find those procedures to be as far as difficult with regards to Mr. Guthrie? Did that question make sense?

A. No.

Q. You're being honest, at least.

MR. FRASURE: I understood it.

MR. MOSS: We'll let you answer it.

A. Was it difficult to remove the polyps?

Q. Yes. There were ten of them.

A. Yes.

Q. Was it difficult to remove them in this case,

compared to your normal case?
A. I've had other ones that were more difficult than this, but on the degree of difficulty, it was difficult.
Q. What about the numbers of polyps that you removed? Is ten normal, high, low, for --
A. Ten would be high.
Q. Obviously, the more polyps you are removing, the greater the risk that there could be a perforation from the removal of polyps, correct?
A. Correct.
Q. At the time you performed these procedures and the time subsequently, to the best of your knowledge, Dr. Gross was Mr. Guthrie's primary care physician?
A. Yes.
Q. And Dr. Gross was Mr. Guthrie's attending physician while he was hospitalized at Massillon Community Hospital, to the best of your knowledge?

MR. MOSS: Which time?

MR. CONWAY: During the time period when you performed the procedures --

A. Dr. Scheatzle was the attending physician technically, because he was in the rehabilitation

unit. Dr. Gross has known him for a long time and I understood took care of his wife, too, before she died, and was his cardiologist and general internist.

Q. So let's just stick to the use of primary care physician.

At the time that you performed these procedures and afterwards, to the best of your knowledge, Dr. Gross was Mr. Guthrie's primary care physician, correct?

A. Yes, along with I think Dr. -- there were other internists involved too, Dr. Perry and Dr. David had seen him too while he was in the hospital, but Dr. Gross --

Q. Have you known Dr. Gross for a while --

MR. MOSS: I don't think he finished the answer.

A. Dr. Gross, he was the one communicating with me during this time frame, during these two days that I saw him.

Q. And he was the one that requested these procedures be done, correct?

MR. MOSS: Objection.

MR. FRASURE: Or requested the consult, you mean?

MR. CONWAY: Yes.

A. Technically, the consult was requested by one of the internists. I don't know whether it was Dr. David or Dr. Perry. They are all within the same group, basically, Stark Medical Specialties.

Dr. Gross had, I had discussed this case with him personally, he seemed the most available and, you know, directly managing him from a medical standpoint in the rehab unit, and that's why I felt that that's who I communicated with and he in turn would communicate anything important to the other doctors, too, that were seeing him.

Q. Did you have any role or input into the discharge of William Guthrie on May 27 from Massillon Community Hospital?

A. No.

Q. Obviously, the description you've giving here in deposition regarding the difficulty of the procedure you performed on Mr. Guthrie was communicated to Dr. Gross, correct?

A. Yes.

Q. Do you know Dr. Gross personally?

A. I know him professionally. I don't know him personally, but we worked together on many cases over the years.

Q. Were you aware of the circumstances surrounding the discharge to home health care nursing which Dr. Gross ordered on May 27?
A. No.
Q. Have you ever had the opportunity to be an attending physician for a patient where you have had that patient discharged to Massillon Community Hospital home health care nursing?
A. No. I work as a consultant basically at Massillon, and the primary care physician handles that.
Q. So you would not typically have any involvement in the discharge of any patients which you have performed any type of gastroenterology procedure on?
A. Only if they were an outpatient that just came in for that test and left that same day.
Q. Then they probably wouldn't be going to home health care nursing, then.
A. Right. Sometimes they return to a nursing home.
Q. When you have patients return to a nursing home, do you ever communicate with the nursing home as to what the procedure you performed on the patient was?
A. We send a report of what we found, and the nurses

call the nursing home directly to discuss it with them. When it is an in patient like this, the nurses communicate with the rehab unit, the head nurse, of what was found, and I write the orders afterwards, and he is returned up to the floor after a period of observation.

Q. Can we go through and have you list what the signs and symptoms of a perforated colon are?

MR. FRASURE: That can be seen but not always?

MR. CONWAY: No. Just the possible signs of, recognized signs and symptoms of a perforated colon.

A. I would think that --

MR. FRASURE: Let me ask. From a scope or just in general, for any reason?

MR. CONWAY: All right. We'll start with from any procedure, perforated colon, the signs and symptoms.

A. I would think abdominal pain, fever, bleeding, perhaps vomiting. Like I say, leading to more severe signs of peritonitis, septic shock.

Q. What would be the more severe signs of peritonitis?

A. If a person had diffuse abdominal pain, absent

bowel sounds, running a high fever, perhaps shortness of breath.

Q. And then going on to --

A. Going on to --

Q. Septic shock?

A. Septic shock and a drop in blood pressure, loss of consciousness.

Q. Now, would these signs and symptoms that you have described in general for perforated colon be the same signs and symptoms you would see in a perforation that results from a colonoscopy that's perforated the colon?

A. I didn't understand the question. These same signs and symptoms would be for a spontaneous perforation as compared to a procedural perforation?

MR. FRASURE: I think I mucked it up.

MR. CONWAY: But that's good because we'll ask it that way.

Q. Would these signs and symptoms be applicable to an acute perforation that occurs during a colonoscopy?

A. Yes.

Q. Would they be applicable to a delayed perforation

that occurs some days after a colonoscopy?
A. Yes. And also apply to a spontaneous that occurs --
Q. In the absence of any colonoscopy?
A. In the absence of any procedure. Right.
Q. Very good. If postoperatively nurses became aware of any of these signs and symptoms following your performance of a colonoscopy and you were the patient's attending physician, would you expect to be notified of those conditions that a patient was experiencing?

MR. JAMISON: Objection.

MR. FRASURE: What's the hypothetical now, or the scenario?

MR. CONWAY: It was at the beginning of the sentence. Would you read it back?

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(Thereupon, the requested portion of the record was read by the Notary.)

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MR. MOSS: I object.

MR. JAMISON: Objection.

Q. You can answer.
A. I would expect the nurses to notify a physician

if there was any severe pain, fever, drop in blood pressure, vomiting, bleeding, just as they do on any other patient in the hospital who has any of those same problems, too.

Q. In this particular case, were you ever contacted by anyone from Massillon Community Hospital home health care regarding --

A. No.

Q. -- regarding this patient at any time subsequent to your May 25 colonoscopy?

A. No.

Q. Do you know a Nurse Geraldine Shandt?

A. No.

Q. I take it you were not contacted by Nurse Shandt at any time subsequent to your May 25 colonoscopy, correct?

A. Correct.

Q. Were you ever contacted by Dr. Gross following that conversation that you had with him on May 25?

A. No.

Q. Were you ever contacted or was your office ever contacted by anyone from Dr. Gross' office after that May 25 conversation between you and Dr. Gross?

A. No.
Q. Were you ever contacted by Dr. Seese?
A. No.
Q. Do you know who Dr. Seese is?
A. Yes. Dr. Gross' partner.
Q. Doctor, did you comply with the standard of care at all times during your involvement with the care and treatment of William Guthrie?
A. To my knowledge I did.
Q. Did you comply with the standard of care during your EGD which you performed on May 24, 2000?
A. Yes.
Q. Did you comply with the standard of care during your colonoscopy on May 25, 2000?
A. Yes.
Q. Did you comply with the standard of care during Mr. Guthrie's postoperative period following his May 25, 2000 colonoscopy?
A. Yes.
Q. And as you indicated before, you were not the doctor responsible for discharging Mr. Guthrie from Massillon Community Hospital on May 27, 2000, correct?
A. Correct.
Q. Did you become involved in the care and treatment

of Mr. Guthrie after he was readmitted to Massillon Community Hospital on June 1?

A. I did see him postoperatively. My partner, Dr. Shay, was covering the hospital the first day or two of his hospitalization and he had gone to surgery on the first day or two after that, and I saw him I forget how many, a couple days, two or three days in a row when he was in the intensive care unit, and then I think my other partner, Dr. Schirack, we rotate our hospital coverage, he saw him I think the remainder of the hospitalization, I believe.

Q. Did you have any conversations with William Guthrie at the time you saw him during his hospitalization in June?

A. He couldn't communicate very well at all postoperatively, and the days that you saw him, it was not conversation. It was not like it was before his procedures.

Q. Was he conscious when you saw him during his June hospitalization?

A. Semi-conscious. He couldn't communicate.

Q. Do you know what his prognosis was at the time that you saw him in June?

A. It was very, very poor. And it was poor when I

saw him earlier, too, in May, from his overall problems, his heart disease, his stroke, his severe COPD, and it was worse obviously having a major surgery and anesthetic.

Q. Well, it was a lot worse after you saw him in May since he had suffered septic shock in the interim, correct?

A. Right. He had renal failure, too.

Q. As a result of the septic shock, correct?

MR. MOSS: Objection.

MR. JAMISON: Objection.

Q. If you know.

A. I don't know for sure, but I assume.

Q. Did you have any conversations with any members of his family during the June hospitalization?

A. I did not.

Q. Do you recall having any conversations with Dr. Gross regarding William Guthrie during the time period of William Guthrie's June hospitalization?

A. I didn't personally. I think two or three days that I followed him I didn't. He was there different times than I was making rounds. Our role in June was extremely limited since he was primarily postoperative and Dr. Meshekow, the surgeon, was managing him in the intensive care

unit, and Dr. Gross was managing his cardiopulmonary needs and ventilator and everything else, and we were pretty much on the sidelines.

Q. Did there come a point in time when you learned that William Guthrie had died?

A. Yes.

Q. Do you recall when that was?

A. I don't recall the exact time. I think it was a few days later, after he passed away, when I was notified about it.

Q. Did you have a conversation with Dr. Gross at that time?

A. No.

Q. Since the time that --

A. I believe that -- if I recall, one of my partners had told me, so I think Dr. Schirack, I believe, was covering for me at the hospital there those days and I think he had relayed to me the information that he had passed away, and I didn't discuss it with Dr. Meshekow or Dr. Gross either.

Q. At any time after this rehospitalization on June 1, 2000, up until today's date, have you discussed William Guthrie with Dr. Gross?

A. No.

Q. At any time from June 1, 2000, up until today's date, have you had any conversations that you recall with any members of his family, and by "his," I'm referring to William Guthrie.

A. No. There's one correction I would like to add back to my answer a little bit ago about discussing the case with Dr. Gross.

The only discussion that I know of since all this was last year, when this was originally filed, and I was supposed to give a deposition on a Saturday here, and I showed up for three hours and no one else showed up, none of the attorneys came, and I sat in the parking lot for three hours and I saw Dr. Gross a week later and I said that was the first time I ever spent my day off on a Saturday in the cold in my truck outside for three hours and no one else showed up for the deposition, and one of the attorneys here contacted me and said it was a screw up, all the attorneys knew it was cancelled but I didn't.

MR. FRASURE: See, I'm amazed I'm still his lawyer.

THE WITNESS: And the thing was dropped shortly thereafter and I never gave a deposition after. That was just the

extent of our conversation.

MR. FRASURE: Let it all out, Kirk.

THE WITNESS: Does that go in the record?

MR. MOSS: That is down forever now.

MR. FRASURE: Somebody paid the price for that.

Q. Well, I was not involved in this case at that time.

MR. FRASURE: We can't blame it on you or your predecessor.

Q. Doctor, what records do you have in front of you?

A. This is records of Mr. Guthrie's hospitalization, in May of 2000, when I was involved.

Q. Those have been provided to you by your attorney?

A. Yes.

Q. Have you had an opportunity to review those?

A. Yes.

Q. Let's go through, and I just need to know where you wrote some charting here.

Why don't we go to the progress notes for May 23, 2000.

A. Yes.

Q. Am I correct in assuming this May 23, 2000, 6:15 a.m. note is your first note in these medical records pertaining to William Guthrie?
A. Yes. I had dictated the report prior to this. Then I wrote the progress note.
Q. Why don't you read this progress note into the record.
A. 5/23/2000, 6:15 a.m., gastroenterology consult done, my impression is anemia with hemoccult positive stools, unknown etiology.

My recommendations were that we start a colon cleansing prep over the next 48 hours, check serial H and H, EGD at 7:00 a.m. on Wednesday the 24th, and a colonoscopy at 7:00 a.m. on Thursday the 24th -- I put the 24th, it should have been the 25th.

Q. And that's your signature?
A. That's my signature.
Q. The next note would be May 24?
A. Right.
Q. At 6:40 a.m., correct?
A. Right.
Q. Why don't you read into the record your progress note at that time.
A. EGD with biopsies, and these are my impressions

listed. Mild GERD, small hiatal hernia, diffuse chronic atrophic gastritis with coffee ground colored blood flecks in the stomach, and the last impression is mild duodenitis.

My recommendations are discussed with daughter, who is power of attorney, Leona Shaffer, by phone, and explained the findings. Since the hemoglobin was dropping and no active upper GI bleeding or peptic ulcer, et cetera, found, she agrees to proceed with colonoscopy at 7:00 a.m. tomorrow.

And then the last one was Prevacid 30 milligrams Q day and check serial H and H.

Q. The next written progress note would be May 25 at 8:00 a.m., is that correct?

A. Yes.

Q. Do you want to read that into the record?

A. Colonoscopy to cecum with polypectomy times ten.

First impression was colon polyps times ten, five to fifteen millimeters, that's in diameter, basically --

Q. Are those large or small?

A. Medium size. Scattered throughout the entire colon. Removed.

Diverticulosis with extrinsic stricturing of

the sigmoid colon, 30 centimeters, and marked narrowing of the lumen.

Third finding was hemorrhoids.

Recommendations. No added salt, low residue diet for two weeks until the polypectomy sites have healed, ideally stop aspirin, Plavix and anticoagulants for two weeks postoperatively, but this patient is too high a risk of life threatening CVA, myocardial infarction, et cetera to stop them.

Check serial -- excuse me. Check serial CBC and monitor closely for signs of active bleeding, consider barium enema x-ray in two to three months to recheck the sigmoid stricture after the polypectomy sites have healed, but patient states he doesn't want surgery even if malignancy found, and that's my signature.

Q. And that's your signature?

A. Yes.

Q. Were there any more written progress notes that you were responsible for?

A. Not during this hospitalization.

Q. The dictated notes would be --

MR. FRASURE: Do you have orders?

Q. The dictated notes would be from the May 23,

2000 -- excuse me. There was a consult note, correct, that you dictated from May 23, 2000, correct?

A. Yes.

Q. And then there was an operative note for the May 24, 2000 EGD with biopsy, correct?

A. Correct.

Q. Then there was the May 25, 2000, operative note for the colonoscopy to the cecum with polypectomy times ten, correct?

A. Correct.

Q. Any orders that you issued in this particular case?

A. The orders are in the chart that I wrote.

Q. Why don't we go to the specific orders that you are responsible for.

A. The first order was May 23, 2000, at 6:05 I think it is, or 6:15. I'm not sure. I think it is 6:05 a.m.

Q. You want to read that?

A. And I wrote clear liquid diet plus Ensure, one can p.o., t.i.d.; number two is milk of magnesia, 60 cc p.o. at 10:00 a.m. today and 10:00 a.m. on Wednesday; Number 3 is milk of magnesia citrate, ten ounces, p.o., 2:00 p.m. today and 2:00 p.m.

on Wednesday.

Number 4 was n.p.o. post midnight for 7:00 a.m. EGD on Wednesday, May 24, 2000, and the next is colonoscopy scheduled at 7:00 a.m. on Thursday by Dr. Elliott, and the last is start IV D5 and a half normal saline, a hundred cc's an hour at 6:00 a.m. on Wednesday for EGD, and that's the extent of the orders on that morning until after the procedure.

Q. Well, go ahead then. What other orders?

A. The next order would have been -- let me see.

On May 24, 2000, at 6:45 a.m., this was after the EGD, the first was a listing of the medications that were given for the EGD, Demerol 35 milligrams IV, Versed one milligram IV, and Sensorcaine.

The next one is n.p.o. until 8:00 a.m., then restart clear liquid diet plus Ensure t.i.d. if fully awake. Soap suds enema this a.m. and repeat times one this afternoon. Give milk of magnesia and magnesia citrate today as ordered. Dulcolax suppository times one at 7:00 p.m. today. N.p.o. after midnight, colonoscopy at 7:00 a.m. on Thursday by Dr. Elliott, Prevacid, 30 milligrams p.o., 8:00 a.m. today and Q 6:00

a.m. daily, and I ordered a CBC and Chem 7 at 6:00 a.m. on Thursday.

Q. At no time did you speak with Dr. Blankenhorn regarding either one of these procedures, correct?

A. No.

Q. Correct?

A. That's correct. And then the last orders were on May 25, 2000, at 8:00 a.m., post colonoscopy. Again I listed the medications that were given for the colonoscopy, the Demerol, 50 milligrams IV, and Versed 1.4 milligrams IV slowly.

Number two is n.p.o. until 9:30 a.m., then full liquid diet for breakfast, advance to no added salt, low residue diet at lunch as tolerated. CBC Friday at 6:00 a.m. IV, 75 cc's per hour until fully awake and tolerating p.o. liquids well until 10:00, then DC IV if fully awake and tolerating p.o. liquids as well. And that's it.

Q. Is what you have testified to this afternoon the extent of your charting for William Guthrie prior to his May 27, 2000 discharge?

A. Yes, including the dictated procedural notes and the recommendations following the procedures that

were dictated that we didn't read just now.

Q. We didn't read them because they are pretty --

MR. FRASURE: They are typed.

Q. They are typed.

A. Correct.

Q. Do patients ever become constipated following a colonoscopy?

A. I think it's common for a day or two, for the bowel activity to slow down because it is empty, the colon is empty, and it takes a few days to start picking back up again.

Q. What about a decrease in appetite following a colonoscopy? Is that fairly typical?

A. It would be common for a short period of time, but usually by 12 to 24 hours it is picked back up to fairly normal.

Q. How about a patient who experiences a blood pressure of 84 over 44 five days subsequent to a colonoscopy? Any significance to you?

MR. MOSS: Objection.

MR. JAMISON: Objection.

A. It would depend upon the individual patient. Some patients, including Mr. Guthrie, carried a low blood pressure before procedures and after procedures.

Q. Certainly his blood pressure was not as low as 84 over 44.

MR. MOSS: Objection.

MR. JAMISON: Objection.

A. I don't know. I have not reviewed all the blood pressures on all the days that he was in the hospital, but I do know he did have very severe congestive heart failure and a very weak heart, and I understand low blood pressure was the norm for him.

Q. Your understanding of that blood pressure, was it in the range of 102 over 70 or do you know?

A. At what point?

MR. FRASURE: When you were treating him.

A. During the procedure, you mean?

Q. During the time you were treating him, during the procedure.

A. Blood pressure fluctuated at several points during the procedure. It was never as low as what you said earlier, 80, something like that. During the procedure it was above that. Systolic blood pressure was above 100 during the procedure.

Q. When you were treating him, did you ever know his

blood pressure systolic to be below 100 at any time you were involved in his care and treatment?

A. I wasn't aware during the procedure or when he was in the recovery room from the procedure. I wasn't notified by any nursing later in the day that it had dropped or anything following the procedure.

Q. That's something that you would want to be made aware of if in fact he did have a drop in blood pressure?

MR. MOSS: Objection.

MR. JAMISON: Objection.

A. I'm always available if they have any questions, the nurses have any questions or the attending physician has any questions, to call. I would be more than happy to field those. But usually in most cases, especially a patient like him, with as complicated of a history that he has, more likely than not they usually would contact Dr. Gross about blood pressure questions because he was managing all of his different cardiac medications.

Q. I'm just trying to get a feel for what your expectations regarding this patient were in this particular situation.

A. Right.
Q. You obviously were not expecting to be contacted by any home health care nurses regarding this patient, correct?
A. Correct.
Q. And you would expect any type of post surgical conditions which arose to be reported to Dr. Gross first and not yourself, correct?

MR. MOSS: Objection.

A. Correct.

MR. CONWAY: Doctor, I don't believe I have any further questions at this point in time. Thank you.

MR. FRASURE: Yes.

MR. MOSS: I just have a couple.

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CROSS-EXAMINATION OF R. KIRK ELLIOTT, D.O.

BY MR. MOSS:

Q. Dr. Elliott, we were introduced before the deposition; I represent Dr. Gross in this case. I have very few questions for you, primarily by way of clarification.

You talked about your recommendations with regard to discontinuance of anti-coagulant medication after the colonoscopy; do you recall

that testimony?
A. Yes.
Q. And you said typically following a colonoscopy you would recommend that anti-coagulant medication be discontinued for a period of about two weeks, correct?
A. Only if polypectomy was performed.
Q. I'm sorry. Following a polypectomy, because of the risk of bleeding.
A. Right.
Q. In this case, however, you believed that there were other risks which outweighed the risk of bleeding, namely, the risks of a further stroke or an MI if the anti-coagulant medication was discontinued, correct?
A. That's what Dr. Gross relayed to me --
Q. Okay.
A. And I agreed with him. It happens frequently that I defer to the cardiologist or to the specialist who is taking care of the patient.
Q. Okay.
A. For vascular disease.
Q. But in your op report for the polypectomy on May 25, you say "I feel the risks far outweigh the benefits in this situation and he should continue

his current medications and be watched very closely for any sign of active bleeding." Do you see that?

A. By risks --

Q. You talk in the previous sentence about the patient's severe stenotic disease with recent stroke. "I feel he is at risk of recurrent cardiovascular accident, MI, or sudden death," correct?

A. Okay.

Q. Is that what you believed following this patient's polypectomy?

A. Right.

Q. And you discussed those risks with Dr. Gross and you and he were in agreement that because of this patient's prior history of CVA, MI, that for this particular patient it was best to continue or resume the anti-coagulant medications following surgery.

A. Yes.

Q. In other words, the risk that this patient might bleed postoperatively because he was on anti-coagulant medication was outweighed by the risk that he would suffer another stroke or perhaps another heart attack if those medications

were not resumed. Is that fair?

A. Correct.

Q. You mentioned that you didn't think that this patient should undergo a small bowel x-ray, which again would have been a typical recommendation that you would make for a patient who had undergone a polypectomy?

MR. FRASURE: Barium enema? I'm sorry. Go ahead.

A. In this particular patient, he was extremely tachypneic and frail, elderly, just had suffered a stroke a couple weeks before, and there were no signs of any active bleeding, bright red blood seen coming through the bowel, so my recommendation was to stop at this point here, continue his other medical care Dr. Gross was giving, and then reassess him, I think I put in here in six weeks or something, to see if he is stronger and then able to complete a further workup.

Q. And you addressed that issue in your operative note, correct?

A. Correct.

Q. And is that paragraph three of your note?

A. Yes.

Q. You say, "in view of the stricture of the sigmoid colon I would normally recommend a barium enema x-ray approximately two months after all the polypectomy sites have fully healed to double check this area, but in view of this patient's otherwise poor health and desire not to have any surgery, we'll wait and see how he does over the next six weeks."

First, is that what we were just talking about?

A. Correct. That's what he told me, that he did not want to have surgery regardless of what was found. He gave his permission for the scope to be done to see if something could be controlled endoscopically, because I brought up at this point what if something like cancer was found.

Q. And what did he say when you brought that up?

A. He said absolutely not.

Q. Did he say why?

A. Because he said he wouldn't live through surgery.

Q. Did you believe that?

A. Yes, absolutely.

Q. Did you think his risks of surviving another surgery were very, very small?

A. Very small.

Q. And that's because of all of his co-morbid conditions?
A. Correct.
Q. Was that issue of -- was that issue, namely whether or not malignancy was found, whether further surgery would be performed, discussed with Miss Shaffer by you?
A. I had told her the results of the endoscopy, what I found, this recommendation of what would be done as far as further x-rays, that sort of thing, basically what I put down here, but to my recollection, I told her that he did not want surgery even if a problem was found.
Q. Did Miss Shaffer express any objection to that proposed course, or any disagreement with her father's wishes in that regard?
A. No.
Q. In terms of the postoperative management of this patient after the polypectomy, what was done to try to look for signs of perforation while he remained in the hospital? Did you order any tests or prescribe any other procedures which would alert the medical staff as to the possibility of perforation in the postoperative period while he remained in the hospital?

A. He had the normal postoperative monitoring done in the endoscopy unit, and then when he was felt to be stable he was returned to the floor with the normal routine nursing care that every inpatient receives, which basically would detect any of these things I talked about earlier as far as the presence of pain or the presence of vomiting or active bleeding, high fever.

Q. You were checking CBCs after the surgery?

A. I ordered one the following day after surgery, primarily as -- not because I suspected any problems, it was mainly because he had been anemic before, and I wanted to make sure his hemoglobin had remained stable.

Q. Is there anything based upon your recollection or your review of this chart that suggests that this patient was demonstrating any signs and symptoms of a perforation postoperatively up until the point of discharge?

A. No.

Q. On May 27. No signs of perforation?

A. I did not, no. There were no signs of perforation.

Q. Would you agree that if a patient suffers a perforation postoperatively following a

colonoscopy/polypectomy, what is the -- let me go at this a different way.

What is the likelihood of a perforation occurring following a colonoscopy/polypectomy within, let's say 48 hours after the procedure?

MR. FRASURE: Percentage-wise?

MR. MOSS: Yes.

A. You're saying a perforation did not occur the day of the procedure, but what is the percentage of people that would suffer a perforation two days later?

Q. Delayed perforations happening within 24 hours.

A. To be honest with you, a delayed perforation, any perforation during an endoscopy is a rare event. A delayed perforation is an extreme event, and I'm not sure that you could put a percentage on it, to be honest with you. Maybe one in a hundred thousand or one in a million. I have no idea what percentage it would be.

MR. CONWAY: Objection, move to strike the answer.

Q. If he had sustained a perforation during a procedure, would you have expected to see signs and symptoms of that perforation by the time he was discharged on the 27th?

A. Yes.
Q. And likewise, if he had sustained a delayed perforation prior to his discharge, you would expect to see signs and symptoms very shortly after the perforation occurred?
A. Yes.
Q. Are you aware of any studies or literature that talks about the risks of delayed perforation as you move further out following a surgical procedure?
A. No.
Q. And it's your opinion that Mr. Guthrie sustained a perforation within 24 hours of his readmission to the hospital on June 1, within 24 hours before that?
A. That's my opinion.
Q. And what's the basis for that?
A. The basis is that if there was a perforation, whether it is due to a procedure or whether it is due to spontaneous perforation, diverticulitis, foreign bodies or whatever the reason is, patients rapidly deteriorate. All these things we have discussed earlier occur. Very rapid progression to septic shock, and it is considered a surgical emergency that within just a few

hours, that can make the difference between life and death.

Q. And because you did not see that rapid deterioration leading up to his re-hospitalization, that is what you are saying, that's the basis for your conclusion?

MR. FRASURE: Objection. He is not aware of the records.

MR. MOSS: Okay.

A. I'm not aware of what happened at home. I'm just saying during the hospitalization, the two days that he was in the hospital after the procedure, there were none of the signs or symptoms that I listed that I would expect if he had a perforation then. When he came back in the hospital I read the Emergency Room record. The Emergency Room record said twice on it from the Emergency Room physician that severe pain started this a.m. It said that twice. He said he was constipated two or three days, but severe pain started today. That sounded like it was an acute type of a situation from the Emergency Room report on 6/1/2000.

Q. Would you expect to see a bowel movement in a patient with a perforation?

A. No.
Q. Would you expect to see --
A. Unless it would be blood.
Q. I'm talking about --
A. Normal bowel movement, no.
Q. -- stool. Would you expect to see active bowel sounds in a patient with a perforation?
A. No.
Q. Would you expect to see a patient with the ability to tolerate food or liquids by mouth with a perforation?
A. No.
Q. You would expect to see vomiting and inability to tolerate food or liquid, correct?
A. Correct.
Q. Would you expect a patient who has suffered a perforation to be complaining of abdominal cramping versus severe abdominal pain?
A. The description of pain is so subjective on the part of a person, I can't really say how they would describe the pain. It would be severe if they had a perforation.
Q. And most patients would not call severe abdominal pain cramping.

MR. FRASURE: Objection.

MR. CONWAY: Objection.

Q. If you know.

A. It is impossible to say how the description of pain would be because it is different from one person to another.

Q. Dr. Elliott, do you have any opinion based upon your involvement with this patient as to what his life expectancy was as of May 25, 2000?

MR. FRASURE: You have not reviewed all the records.

A. The day I saw him? The day he had his procedure?

Q. Yes, sir.

MR. CONWAY: Objection.

MR. FRASURE: I don't think that's fair to let him answer because he hasn't reviewed all the records on his care after his perforation.

MR. MOSS: Okay.

Q. You said that the risk of a delayed perforation is even less than the risk of a perforation following an endoscopic procedure.

Do you have any --

A. During the procedure, you mean?

Q. Yes.

MR. CONWAY: Objection to the

form of that question.

MR. MOSS: I haven't finished it yet.

MR. CONWAY: Whatever.

MR. MOSS: Let me try it again.

MR. CONWAY: I'm just trying to be nice.

MR. MOSS: I know you are.

Q. What I'm trying to get at is do you have any statistics or information regarding the relative risks of a delayed perforation versus an acute perforation during a procedure?

MR. MOSS: Is that better?

MR. CONWAY: Yes.

A. I don't have any specifics as to statistics, but in general my belief is that it is much less likely to have a delayed perforation than it would be to have one at the time of the procedure.

MR. MOSS: That's all I have. Thank you.

MR. JAMISON: I don't have any questions for you right now.

MR. CONWAY: I just have a few, doctor.

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FURTHER CROSS-EXAMINATION OF

R. KIRK ELLIOTT, D.O.

BY MR. CONWAY:

Q. One of the signs and symptoms of a perforated colon I think you testified to based upon some questions asked by Mr. Moss was a high white blood cell count, is that correct?

A. I didn't say that.

Q. Is an --

A. I said fever.

Q. Then I misheard you. Is an elevated white blood cell count an indication of one of the indications of a perforated colon?

A. There are many causes of an elevated white blood cell count, including infection can be one cause. And a perforated colon can lead to an infection, so that is one of many causes of a white blood cell count being elevated.

Q. So with an infection following a perforation, you would expect to see an elevated white blood cell count, correct?

MR. JAMISON: Objection.

MR. FRASURE: Do you want to put any parameters on it?

A. You mean within 24 hours?
Q. You said whatever time. I don't mean to put words in your mouth. It logically follows based on what you said that if there is a perforation, the area becomes infected, peritonitis ensues, correct?
A. Right.
Q. And when an infection is developing, the person's white blood count becomes elevated, correct?
A. It may become elevated. It doesn't always. But it might become elevated. If it does become elevated, and the infection is a very severe, life threatening one, like peritonitis, you would expect it to go higher and higher and higher with time.
Q. But it would be a rising white blood cell count, correct, as the infection progresses?
A. Correct.
Q. So theoretically, before the white blood cell count gets to that highest level, it would have been at lower levels, correct, working its way upward?
A. Correct.

MR. CONWAY: Okay.

Q. Doctor, I want you to -- I'm going to ask you a

hypothetical, all right?

I want you to assume that immediately postoperatively you determined that Mr. Guthrie had suffered a perforated colon. What type of procedure would be done to repair the perforation prior to septic shock occurring? Does that question make sense?

A. If a perforation was recognized the day of his procedure?

Q. Yes. Let's deal with that situation first. Hypothetically. Mr. Guthrie suffers a perforated colon during the procedure, and it is immediately recognized by yourself.

A. Right.

Q. What do you do at that point?

MR. MOSS: Are you talking about it is recognized intraoperatively?

MR. CONWAY: Yes.

MR. MOSS: I would just note an objection.

A. The first thing I would do would be to go ahead and initiate any emergency procedures in order to stave off worsening infection, like start antibiotics, not feed the patient, obviously, give them plenty of intravenous fluids, consult a

surgeon as soon as possible. Discuss it with the family as soon as possible.

Q. Do perforated colons have to be treated surgically, or can they be managed medically?

A. It would depend upon the degree of perforation and the signs and symptoms of perforation. If it was a very, very small, localized perforation, it may be treated medically.

Q. And in that particular case, you would want to treat the patient with antibiotics and avoid exacerbating the situation by not feeding him food. Correct?

A. Correct.

Q. Have you ever had patients where they have perforated during a colonoscopy on you?

A. One.

Q. Were you able to treat it medically?

A. No.

Q. It had to go directly to --

A. Directly to surgery.

Q. You opined earlier that this was not a patient that would in your opinion be able to survive another surgery, is that correct?

A. I felt -- I'm not as familiar as Dr. Gross and the other physicians treating all of his other

medical conditions, but in my opinion he was a very poor surgical candidate because of all of his medical problems and very, very high risk of complications, the morbidity or mortality, plus also his own answers to my questions and asking him how aggressive to be, because I ask everybody if they are conscious and can relay this information what their code status is in the event something should occur during the procedure, should heavy bleeding occur, perforation or cancer or something serious that would require surgery, do they have a surgeon they have seen before, so I have some idea, because if they are still sleepy during the sedative I may need to call a surgeon and would elect to call a surgeon they would choose, if possible.

Q. But in the time period immediately following your May 25 colonoscopy, I thought it was your opinion based upon a question that Mr. Moss asked that he would have difficulty surviving any further type of surgery.

A. You mean procedures?

Q. Yes.

A. At this point, I did not feel that he was strong

enough to undergo further gastrointestinal diagnostic tests, barium x-rays, endoscopy, further endoscopy --

Q. Because of his condition, his overall --

A. His overall condition. Unless it was -- if there was more information that came forward to warrant it, that at that point he seemed stable enough to just watch things for a little bit, be a little bit more conservative at this point.

Q. Okay. Now, where did you go to medical school?

A. In Kansas City.

Q. And what school in Kansas City?

A. It's called the -- they changed the name. Kansas City College of Osteopathic Medicine is what it was called when I was there, and it is University of Health Sciences now.

Q. Does the osteopathic board certify in the area of gastroenterology?

A. Yes.

Q. Do you have a Board certification in that area?

A. Yes.

Q. And how long have you been a practicing gastroenterologist?

A. Since 1984.

Q. Have you ever had your privileges revoked or had

disciplinary action taken against you in any way?

A. No.

Q. Is more than 50 percent of your professional time devoted to the clinical practice of medicine and/or teaching?

A. Yes.

MR. CONWAY: I don't have anything further. Thank you.

MR. MOSS: I just have one question.

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FURTHER CROSS-EXAMINATION OF

R. KIRK ELLIOTT, D.O.

BY MR. MOSS:

Q. You felt that Mr. Guthrie's prognosis was extremely poor following his May 25 procedure?

MR. FRASURE: Overall prognosis or just for the endoscopy?

MR. MOSS: Overall prognosis.

A. Let me clarify if I may. On May 23, 2000, when I did his consult, I felt his overall prognosis was very poor. After the two procedures, I didn't see any significant change because I didn't recognize any complications from either procedure, and he seemed about the same situation

two days later as he did before.

Q. So still very poor?

A. So his overall condition was very poor and his prognosis was poor.

Q. You mentioned your discussion with him, and we've touched on this already, I don't want to belabor it, but you talked about Mr. Guthrie's answers to your questions about how aggressive he wanted to be if malignancy or other problems --

A. Correct.

Q. What did he tell you in that regard? How aggressive did he want to be?

MR. CONWAY: Objection, asked and answered.

MR. MOSS: It may have been.

MR. FRASURE: You are welcome to refer to your notes if you have it there.

A. His mental alertness and ability to communicate would fluctuate. When I talked to him over these two days, some days it was a little clearer than other days.

When I talked to him on the 23rd when I did his consult, he was lucid, and I didn't know he had a power of attorney at that time but he understood the conversation completely about the

options that we discussed because I sat down and talked to him about doing nothing, and no endoscopy, but just made him aware that I was called in because his hemoglobin was dropping, because there was blood found in his stools on three different times, so there is some bleeding internally that is going on and what the significance of that was we didn't know, but his hemoglobin had dropped quite a bit. So there would be several choices. One is to do nothing, one is to do barium x-rays, the other one is to do endoscopy to try to search for the site.

He chose the endoscopic approach because of the therapeutic options that you have. He did not want to undergo a barium enema x-ray to find a polyp and then have to tolerate another two days of laxatives getting the barium cleaned out to do the colonoscopy. So he had given his consent to do the endoscopy with the consent that if a polyp was found to remove it, or if more polyps were found to remove them, to try to cauterize the blood vessel if it was discovered internally that could be the cause of his anemia, but then when I carried the conversation further and said what if the worst is found or what if a

major complication happens or if you have a heart or lung failure during the procedure, what do you want me to do. That's when he made it very clear to me that he did not want surgery regardless. He did not want to be resuscitated and on a ventilator and CPR performed during the procedure, if that happened.

Q. So did he give you a DNR order? Or his power of attorney?

A. To be honest with you, I didn't know whether it was -- he didn't specifically say DNR to me, but that's what he had directed me to do. I called his daughter when I returned to the nursing station and she said there was a power of attorney and I said I need to talk to her, too, so we called her and discussed everything and discussed the same options, and she understood all those options and gave permission, telephone permission to go ahead with the endoscopy.

Q. And her instructions were consistent with what her father had already told you?

A. Correct.

MR. MOSS: That's all I have. Thank you.

MR. CONWAY: One last question.

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FURTHER CROSS-EXAMINATION OF

R. KIRK ELLIOTT, D.O.

BY MR. CONWAY:

Q. Your opinions that you complied with the standard of care, were those opinions to a reasonable degree of medical probability?

A. Pardon? I don't understand the question.

MR. FRASURE: You want me to whisper in his ear?

MR. CONWAY: I thought you would have already done that.

THE WITNESS: He didn't.

MR. FRASURE: We thought you would not be so nice, but that's all right.

MR. CONWAY: Do you want to take a moment with your attorney and then I'll ask you a question?

- - - -

(Thereupon, a discussion was had off the record.)

- - - -

Q. Doctor, let me ask you a question real quick. Your opinions that you complied with the standard of care in your treatment of William

Guthrie, they were to a reasonable degree of medical certainty, is that correct?

A. Yes.

MR. CONWAY: Thank you. I have nothing further.

MR. MOSS: Nothing further.

MR. FRASURE: Are you having it typed, Tom?

MR. CONWAY: Yes. I do need this because I have to get it out to Dr. Slanger.

MR. FRASURE: We'll read.

R. KIRK ELLIOTT, D.O.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Judith Gage, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this 8th day of November A.D. 20 02.

Judith Gage

Judith Gage, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires March 24, 2005

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