

1 IN THE COURT OF COMMON PLEAS

2 STARK COUNTY, OHIO

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

5 Plaintiffs,

6 -vs-

JUDGE HAAS

CASE NO. 2002 CV 1940

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

9 Defendants.

10 - - - - -

11 Deposition of R. KIRK ELLIOTT, D.O., taken
12 as if upon cross-examination before Judith A.
13 Gage, a Certified Realtime Reporter and Notary
14 Public within and for the State of Ohio, at the
15 offices of Buckingham, Doolittle & Burroughs,
16 4518 Fulton Avenue, N.W., Canton, Ohio, at 3:00
17 p.m. on Monday, October 28, 2002, pursuant to
18 notice and/or stipulations of counsel, on behalf
19 of the Plaintiffs in this cause.

20 - - - - -

21 MEHLER & HAGESTROM
22 Court Reporters

23 CLEVELAND
24 1750 Midland Building
25 Cleveland, Ohio 44115
26 216.621.4984
27 FAX 621.0050
28 800.822.0650

29 AKRON
30 1015 Key Building
31 Akron, Ohio 44308
32 330.535.7300
33 FAX 535.0050
34 800.562.7100

35 **SCANNED**
36 **5-6-03**

APPEARANCES:

Thomas E. Conway, Esq.
Friedman, Domiano & Smith
600 Standard Building
Cleveland, Ohio 44113
(216) 621-0070,

On behalf of the Plaintiffs;

Mark D. Frasure, Esq.
Buckingham, Doolittle & Burroughs
4375 Fulton Drive, N.W.
Canton, Ohio 44735
(330) 492-8717,

On behalf of the Defendant
R. Kirk Elliott, D.O.;

Andrew D. Jamison, Esq.
Reminger & Reminger
1400 Midland Building
Cleveland, Ohio 44115
(216) 687-1311,

On behalf of the Defendant
Massillon Community Hospital;

David Moss, Esq.
Hanna, Campbell & Powell
3737 Embassy Parkway
Akron, Ohio 44333
(330) 670-7300,

On behalf of the Defendant
Gross.

W I T N E S S I N D E XPAGE

CROSS-EXAMINATION

R. KIRK ELLIOTT, D.O.

BY MR. CONWAY..... 4

CROSS-EXAMINATION

R. KIRK ELLIOTT, D.O.

BY MR. MOSS..... 48

FURTHER CROSS-EXAMINATION

R. KIRK ELLIOTT, D.O.

BY MR. CONWAY..... 61

FURTHER CROSS-EXAMINATION

R. KIRK ELLIOTT, D.O.

BY MR. MOSS..... 67

FURTHER CROSS-EXAMINATION

R. KIRK ELLIOTT, D.O.

BY MR. CONWAY..... 71

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

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

8 BY MR. CONWAY:

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

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

16 Q. And your date of birth?

17 A. Is November 4, 1948.

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

21 A. Yes.

22 Q. Do you know what a deposition is?

23 A. Yes.

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

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

3 A. Yes.

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

7 A. Okay.

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

11 A. Yes.

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

14 A. Yes.

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

20 A. Okay.

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

25 A. Yes.

1 Q. I would like to take you back to May of 2000. At
2 that time, you were a gastroenterologist,
3 correct?

4 A. Yes.

5 Q. And you still are?

6 A. Yes.

7 Q. You had a patient by the name of William Guthrie,
8 is that correct?

9 A. Yes.

10 Q. Going back to, I believe May 23 of 2000, was that
11 the first time that you had an opportunity to be
12 in contact with William Guthrie?

13 A. Yes.

14 Q. And you were requested to perform a
15 gastroenterology consult on William Guthrie,
16 correct?

17 A. Yes.

18 Q. What you may want to do is make sure you answer
19 out loud yes or no, and give yourself a second
20 after I finish speaking before you give the
21 answer. Okay?

22 A. Okay.

23 Q. That way she can take it down a little bit
24 easier.

25 William Guthrie would have been your patient

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

4 A. Yes.

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

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

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

15 A. Right.

16 Q. -- operatively, correct?

17 A. Right.

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

22 MR. MOSS: Object to the form.

23 MR. FRASURE: Do you understand
24 the question?

25 THE WITNESS: No, I don't.

1 A. Could you rephrase it?

2 Q. You performed a colonoscopy on William Guthrie on
3 May 25, correct?

4 A. Yes.

5 Q. Did you have any postoperative responsibility
6 regarding William Guthrie?

7 A. Yes.

8 Q. Okay. Tell me in detail what your postoperative
9 responsibilities were with regard to following
10 William Guthrie after that May 25 colonoscopy.

11 A. Following the colonoscopy was communicating --
12 first of all, dictating a report of what the
13 procedure entailed, communicating the findings
14 back to the physician who requested I perform it
15 for them, and getting my recommendations on diet.
16 And in this particular case, we discussed whether
17 to continue aspirin or Plavix or neither as far
18 as anti-coagulants, since ten polyps were removed
19 at the time of the colonoscopy. And the primary
20 care physician, primary physician, Dr. Gross,
21 related back that he would follow the patient
22 thereafter.

23 Q. Fair enough. So your responsibilities as the
24 consulting gastroenterologist in this case were
25 to perform the procedures --

1 A. Right.

2 Q. -- that you felt were medically indicated,
3 correct?

4 A. Correct.

5 Q. And in this case you felt both of these
6 procedures were medically indicated, correct?

7 A. Correct.

8 Q. The EGD, which is a -- for the record?

9 A. Upper GI endoscopy.

10 Q. Right. Which was performed on May 24, 2000, and
11 the colonoscopy which was performed on May 25,
12 2000, correct?

13 A. Yes.

14 Q. And then it was your responsibility to
15 communicate the findings of both of those
16 procedures to, in this particular case Dr. Gross,
17 correct?

18 A. Yes.

19 Q. And in fact, you did send Dr. Gross the surgical
20 op notes for both of those procedures, is that
21 correct?

22 A. Yes.

23 Q. Going to the EGD with biopsy that you performed
24 on May 24, on what date did you send a copy of
25 the results of that procedure? What date did you

1 send that report to Dr. Gross?

2 A. On the 24th. The same day it was performed.

3 Q. In fact, you dictated it and it was transcribed
4 and you sent it out on May 24, correct?

5 A. The hospital sent it out, since it was an
6 in-patient procedure.

7 Q. And then going to the colonoscopy?

8 A. The same.

9 Q. Okay. So your report was dictated, transcribed
10 on May 25, correct?

11 A. Correct.

12 Q. And would have been sent out to the hospital by
13 Dr. Gross, correct?

14 A. Yes. In addition to personal telephone call,
15 too.

16 Q. Did you place a telephone call to Dr. Gross'
17 office or Dr. Gross on May 24 and May 25, do you
18 recall?

19 A. I told the hospital operator to have him paged.
20 I'm not sure where he was located. But he
21 returned --

22 MR. FRASURE: Which day are you
23 talking about?

24 THE WITNESS: After the
25 colonoscopy.

1 Q. Did you talk with Dr. Gross after the May 24 EGD?

2 A. I don't recall. I called the daughter, I know
3 for sure, after the EGD and discussed it with
4 her. I'm not sure I discussed it with Dr. Gross
5 following the EGD because our previous discussion
6 prior to the EGD after I did the consultation was
7 that we would start with the EGD; if we found a
8 bleeding site, an ulcer bleeding or something
9 actively bleeding in the stomach we would stop
10 there. If we didn't, we would proceed on with
11 the colonoscopy.

12 Q. Following the colonoscopy, you did in fact talk
13 with Dr. Gross?

14 A. Yes, I did.

15 Q. Would that be your standard custom and practice,
16 to talk with the referring physician after a
17 procedure such as that?

18 A. Yes.

19 Q. Do you recall what you told Dr. Gross and what
20 his response was on May 25 following the
21 colonoscopy?

22 A. I informed him of both the results of the EGD and
23 the colonoscopy, even though I didn't know
24 whether he had the written report yet, but what I
25 had found.

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

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

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

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

7 A. Yes.

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

11 A. Yes.

12 Q. Following your conversation with Dr. Gross on May
13 25, did you have any further involvement with
14 William Guthrie as far as rendering any care and
15 treatment to him, seeing him postoperatively,
16 anything?

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

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

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

25 A. No, I didn't.

1 Q. And you would not have had direct contact with
2 him on the 26th, correct?

3 A. No. I saw him in the room.

4 Q. Did you talk to him?

5 A. I talked to him, examined his abdomen, and I
6 wasn't impressed that there were any problems.

7 Q. The original reason you became involved as a
8 consultant was that they were trying to rule out
9 a GI bleed, correct?

10 A. He had been bleeding and his stools were
11 repeatedly positive and his hemoglobin was
12 dropping, and so they asked me to determine the
13 source of his gastrointestinal bleeding.

14 Q. And were you able to determine it?

15 A. And try to do something therapeutically to get it
16 to stop.

17 Q. Were you able to determine the source of his GI
18 bleed?

19 A. He had several possibilities of occult bleeding,
20 not active bleeding. When I scoped him he had
21 pretty severe gastritis, although no bright red
22 bleeding. He had ten polyps in the colon that we
23 removed, any of which could have caused
24 intermittent bleeding, but they were not bleeding
25 at the time I did the scope test.

1 Q. So you didn't determine any direct cause of
2 bleeding, is that correct?

3 A. I didn't see any active bleeding at the time that
4 I scoped him.

5 Q. So you were not able to determine definitively
6 the cause of his bleeding, correct?

7 A. No.

8 Q. Correct?

9 A. Correct.

10 Q. And I'm not saying that to be rude, but sometimes
11 "no" gets interpreted differently.

12 A. Right.

13 Q. Colonoscopy -- strike that.

14 A colonoscopy carries with it a recognized
15 complication or risk of perforation, correct?

16 A. Correct.

17 Q. And different parts of the colon can become
18 perforated, correct?

19 A. Correct.

20 Q. In this particular case it was the sigmoid colon,
21 correct?

22 A. Yes.

23 Q. Where does the sigmoid colon rate as far as the
24 amount of times that that gets perforated
25 compared to other parts of the colon? Is that

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

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

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

9 A. Correct.

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

12 A. Correct.

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

17 A. I don't understand the question.

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

20 A. Right.

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

23 A. Yes.

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

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

1 attorney on the chart.

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

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

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

9 A. Correct.

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

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

15 Q. And what occurs in that type of situation?

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

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

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

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

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

9 MR. MOSS: Objection.

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

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

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

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

21 MR. FRASURE: On a delayed versus
22 an acute?

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

25 A. Acute perforation can occur either directly while

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

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

8 A. Yes.

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

11 A. Yes. That could potentially occur.

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

15 A. Right.

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

18 A. Correct.

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

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

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

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

8 A. Yes.

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

11 A. Yes. Extremely rare.

12 Q. But it does occur.

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

15 Q. Have you read the autopsy in this case?

16 A. No, I didn't.

17 Q. The death certificate in this case?

18 A. No.

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

21 A. That's what I was told.

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

1 A. Yes.

2 Q. When do you believe the colon actually
3 perforated?

4 A. I think it occurred myself within 24 hours of
5 June 1, when he came to the Emergency Room.

6 Q. So you think the colon perforated sometime June 1
7 or after.

8 A. Yes.

9 Q. All right.

10 A. Well, sometime within 24 hours preceding June 1,
11 either May 31 or June 1, within 24 hours of
12 arriving at the hospital.

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

15 MR. CONWAY: Well, he arrived --

16 Q. You have the record in front of you. He was
17 called by EMS -- he was called -- excuse me, EMS
18 was called at 12:51 p.m. --

19 A. So he came in the afternoon.

20 Q. Well, you did, and I'm not trying to trick you or
21 anything, you did the procedure on May 25.

22 A. Right. One week before.

23 Q. You're saying that the colon perforated up to 24
24 hours before he goes into the Emergency Room on
25 June 1. Correct?

1 A. That's my opinion.

2 Q. So it's your opinion he suffered a delayed
3 perforation, correct?

4 A. Yes.

5 Q. What caused that delayed perforation, in your
6 opinion, doctor?

7 A. I don't know the exact cause of the delayed
8 perforation.

9 Q. Could it have been the weakening of the
10 intestinal lining due to the polypectomies?

11 A. That's one possible cause.

12 Q. What would be some other possible causes?

13 A. He also had very severe diverticulosis of the
14 left side of the colon in the area where the
15 polyp was removed.

16 Q. And how could that contribute to possibly a
17 delayed perforation?

18 A. It's a thin portion of the wall of the bowel to
19 begin with, and anything that increases the
20 pressure or causes inflammation in that vicinity,
21 whether he had diverticulosis or he had
22 constipation or whether he had poor circulation,
23 he is a man with known vascular disease, I don't
24 know what his vascular status was right at that
25 time because I didn't see him, that was a week

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

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

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

8 A. Yes.

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

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

14 Q. What does tortuous colon mean?

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

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

1 Would that follow?

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

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

9 A. Correct.

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

13 A. Correct.

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

17 A. No.

18 Q. You're being honest, at least.

19 MR. FRASURE: I understood it.

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

22 A. Was it difficult to remove the polyps?

23 Q. Yes. There were ten of them.

24 A. Yes.

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

1 compared to your normal case?

2 A. I've had other ones that were more difficult than
3 this, but on the degree of difficulty, it was
4 difficult.

5 Q. What about the numbers of polyps that you
6 removed? Is ten normal, high, low, for --

7 A. Ten would be high.

8 Q. Obviously, the more polyps you are removing, the
9 greater the risk that there could be a
10 perforation from the removal of polyps, correct?

11 A. Correct.

12 Q. At the time you performed these procedures and
13 the time subsequently, to the best of your
14 knowledge, Dr. Gross was Mr. Guthrie's primary
15 care physician?

16 A. Yes.

17 Q. And Dr. Gross was Mr. Guthrie's attending
18 physician while he was hospitalized at Massillon
19 Community Hospital, to the best of your
20 knowledge?

21 MR. MOSS: Which time?

22 MR. CONWAY: During the time

23 period when you performed the procedures --

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

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

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

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

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

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

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

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

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

23 MR. MOSS: Objection.

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

1 MR. CONWAY: Yes.

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

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

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

16 A. No.

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

21 A. Yes.

22 Q. Do you know Dr. Gross personally?

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

1 Q. Were you aware of the circumstances surrounding
2 the discharge to home health care nursing which
3 Dr. Gross ordered on May 27?

4 A. No.

5 Q. Have you ever had the opportunity to be an
6 attending physician for a patient where you have
7 had that patient discharged to Massillon
8 Community Hospital home health care nursing?

9 A. No. I work as a consultant basically at
10 Massillon, and the primary care physician handles
11 that.

12 Q. So you would not typically have any involvement
13 in the discharge of any patients which you have
14 performed any type of gastroenterology procedure
15 on?

16 A. Only if they were an outpatient that just came in
17 for that test and left that same day.

18 Q. Then they probably wouldn't be going to home
19 health care nursing, then.

20 A. Right. Sometimes they return to a nursing home.

21 Q. When you have patients return to a nursing home,
22 do you ever communicate with the nursing home as
23 to what the procedure you performed on the
24 patient was?

25 A. We send a report of what we found, and the nurses

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

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

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

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

14 A. I would think that --

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

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

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

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

25 A. If a person had diffuse abdominal pain, absent

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

3 Q. And then going on to --

4 A. Going on to --

5 Q. Septic shock?

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

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

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

17 MR. FRASURE: I think I mucked it
18 up.

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

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

24 A. Yes.

25 Q. Would they be applicable to a delayed perforation

1 that occurs some days after a colonoscopy?

2 A. Yes. And also apply to a spontaneous that
3 occurs --

4 Q. In the absence of any colonoscopy?

5 A. In the absence of any procedure. Right.

6 Q. Very good. If postoperatively nurses became
7 aware of any of these signs and symptoms
8 following your performance of a colonoscopy and
9 you were the patient's attending physician, would
10 you expect to be notified of those conditions
11 that a patient was experiencing?

12 MR. JAMISON: Objection.

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

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

18 - - - -
19 (Thereupon, the requested portion of
20 the record was read by the Notary.)

21 - - - -

22 MR. MOSS: I object.

23 MR. JAMISON: Objection.

24 Q. You can answer.

25 A. I would expect the nurses to notify a physician

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

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

8 A. No.

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

11 A. No.

12 Q. Do you know a Nurse Geraldine Shandt?

13 A. No.

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

17 A. Correct.

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

21 A. No.

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

1 A. No.

2 Q. Were you ever contacted by Dr. Seese?

3 A. No.

4 Q. Do you know who Dr. Seese is?

5 A. Yes. Dr. Gross' partner.

6 Q. Doctor, did you comply with the standard of care
7 at all times during your involvement with the
8 care and treatment of William Guthrie?

9 A. To my knowledge I did.

10 Q. Did you comply with the standard of care during
11 your EGD which you performed on May 24, 2000?

12 A. Yes.

13 Q. Did you comply with the standard of care during
14 your colonoscopy on May 25, 2000?

15 A. Yes.

16 Q. Did you comply with the standard of care during
17 Mr. Guthrie's postoperative period following his
18 May 25, 2000 colonoscopy?

19 A. Yes.

20 Q. And as you indicated before, you were not the
21 doctor responsible for discharging Mr. Guthrie
22 from Massillon Community Hospital on May 27,
23 2000, correct?

24 A. Correct.

25 Q. Did you become involved in the care and treatment

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

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

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

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

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

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

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

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

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

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

8 A. Right. He had renal failure, too.

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

10 MR. MOSS: Objection.

11 MR. JAMISON: Objection.

12 Q. If you know.

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

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

16 A. I did not.

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

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

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

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

7 A. Yes.

8 Q. Do you recall when that was?

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

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

14 A. No.

15 Q. Since the time that --

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

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

25 A. No.

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

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

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

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

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

1 extent of our conversation.

2 MR. FRASURE: Let it all out,
3 Kirk.

4 THE WITNESS: Does that go in the
5 record?

6 MR. MOSS: That is down forever
7 now.

8 MR. FRASURE: Somebody paid the
9 price for that.

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

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

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

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

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

18 A. Yes.

19 Q. Have you had an opportunity to review those?

20 A. Yes.

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

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

25 A. Yes.

1 Q. Am I correct in assuming this May 23, 2000,
2 6:15 a.m. note is your first note in these
3 medical records pertaining to William Guthrie?

4 A. Yes. I had dictated the report prior to this.
5 Then I wrote the progress note.

6 Q. Why don't you read this progress note into the
7 record.

8 A. 5/23/2000, 6:15 a.m., gastroenterology consult
9 done, my impression is anemia with hemoccult
10 positive stools, unknown etiology.

11 My recommendations were that we start a colon
12 cleansing prep over the next 48 hours, check
13 serial H and H, EGD at 7:00 a.m. on Wednesday the
14 24th, and a colonoscopy at 7:00 a.m. on Thursday
15 the 24th -- I put the 24th, it should have been
16 the 25th.

17 Q. And that's your signature?

18 A. That's my signature.

19 Q. The next note would be May 24?

20 A. Right.

21 Q. At 6:40 a.m., correct?

22 A. Right.

23 Q. Why don't you read into the record your progress
24 note at that time.

25 A. EGD with biopsies, and these are my impressions

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

5 My recommendations are discussed with
6 daughter, who is power of attorney, Leona
7 Shaffer, by phone, and explained the findings.
8 Since the hemoglobin was dropping and no active
9 upper GI bleeding or peptic ulcer, et cetera,
10 found, she agrees to proceed with colonoscopy at
11 7:00 a.m. tomorrow.

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

14 Q. The next written progress note would be May 25 at
15 8:00 a.m., is that correct?

16 A. Yes.

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

18 A. Colonoscopy to cecum with polypectomy times ten.

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

22 Q. Are those large or small?

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

25 Diverticulosis with extrinsic stricturing of

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

3 Third finding was hemorrhoids.

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

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

18 Q. And that's your signature?

19 A. Yes.

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

22 A. Not during this hospitalization.

23 Q. The dictated notes would be --

24 MR. FRASURE: Do you have orders?

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

1 2000 -- excuse me. There was a consult note,
2 correct, that you dictated from May 23, 2000,
3 correct?

4 A. Yes.

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

7 A. Correct.

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

11 A. Correct.

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

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

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

17 A. The first order was May 23, 2000, at 6:05 I think
18 it is, or 6:15. I'm not sure. I think it is
19 6:05 a.m.

20 Q. You want to read that?

21 A. And I wrote clear liquid diet plus Ensure, one
22 can p.o., t.i.d.; number two is milk of magnesia,
23 60 cc p.o. at 10:00 a.m. today and 10:00 a.m. on
24 Wednesday; Number 3 is milk of magnesia citrate,
25 ten ounces, p.o., 2:00 p.m. today and 2:00 p.m.

1 on Wednesday.

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

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

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

12 On May 24, 2000, at 6:45 a.m., this was after
13 the EGD, the first was a listing of the
14 medications that were given for the EGD, Demerol
15 35 milligrams IV, Versed one milligram IV, and
16 Sensorcaine.

17 The next one is n.p.o. until 8:00 a.m., then
18 restart clear liquid diet plus Ensure t.i.d. if
19 fully awake. Soap suds enema this a.m. and
20 repeat times one this afternoon. Give milk of
21 magnesia and magnesia citrate today as ordered.
22 Dulcolax suppository times one at 7:00 p.m.
23 today. N.p.o. after midnight, colonoscopy at
24 7:00 a.m. on Thursday by Dr. Elliott, Prevacid,
25 30 milligrams p.o., 8:00 a.m. today and Q 6:00

1 a.m. daily, and I ordered a CBC and Chem 7 at
2 6:00 a.m. on Thursday.

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

6 A. No.

7 Q. Correct?

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

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

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

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

1 were dictated that we didn't read just now.

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

3 MR. FRASURE: They are typed.

4 Q. They are typed.

5 A. Correct.

6 Q. Do patients ever become constipated following a
7 colonoscopy?

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

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

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

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

20 MR. MOSS: Objection.

21 MR. JAMISON: Objection.

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

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

3 MR. MOSS: Objection.

4 MR. JAMISON: Objection.

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

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

13 A. At what point?

14 MR. FRASURE: When you were
15 treating him.

16 A. During the procedure, you mean?

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

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

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

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

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

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

11 MR. MOSS: Objection.

12 MR. JAMISON: Objection.

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

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

1 A. Right.

2 Q. You obviously were not expecting to be contacted
3 by any home health care nurses regarding this
4 patient, correct?

5 A. Correct.

6 Q. And you would expect any type of post surgical
7 conditions which arose to be reported to Dr.
8 Gross first and not yourself, correct?

9 MR. MOSS: Objection.

10 A. Correct.

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

14 MR. FRASURE: Yes.

15 MR. MOSS: I just have a couple.

16 - - - - -

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

18 BY MR. MOSS:

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

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

1 that testimony?

2 A. Yes.

3 Q. And you said typically following a colonoscopy
4 you would recommend that anti-coagulant
5 medication be discontinued for a period of about
6 two weeks, correct?

7 A. Only if polypectomy was performed.

8 Q. I'm sorry. Following a polypectomy, because of
9 the risk of bleeding.

10 A. Right.

11 Q. In this case, however, you believed that there
12 were other risks which outweighed the risk of
13 bleeding, namely, the risks of a further stroke
14 or an MI if the anti-coagulant medication was
15 discontinued, correct?

16 A. That's what Dr. Gross relayed to me --

17 Q. Okay.

18 A. And I agreed with him. It happens frequently
19 that I defer to the cardiologist or to the
20 specialist who is taking care of the patient.

21 Q. Okay.

22 A. For vascular disease.

23 Q. But in your op report for the polypectomy on May
24 25, you say "I feel the risks far outweigh the
25 benefits in this situation and he should continue

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

4 A. By risks --

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

10 A. Okay.

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

13 A. Right.

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

20 A. Yes.

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

1 were not resumed. Is that fair?

2 A. Correct.

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

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

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

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

23 A. Correct.

24 Q. And is that paragraph three of your note?

25 A. Yes.

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

9 First, is that what we were just talking
10 about?

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

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

18 A. He said absolutely not.

19 Q. Did he say why?

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

21 Q. Did you believe that?

22 A. Yes, absolutely.

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

25 A. Very small.

1 Q. And that's because of all of his co-morbid
2 conditions?

3 A. Correct.

4 Q. Was that issue of -- was that issue, namely
5 whether or not malignancy was found, whether
6 further surgery would be performed, discussed
7 with Miss Shaffer by you?

8 A. I had told her the results of the endoscopy, what
9 I found, this recommendation of what would be
10 done as far as further x-rays, that sort of
11 thing, basically what I put down here, but to my
12 recollection, I told her that he did not want
13 surgery even if a problem was found.

14 Q. Did Miss Shaffer express any objection to that
15 proposed course, or any disagreement with her
16 father's wishes in that regard?

17 A. No.

18 Q. In terms of the postoperative management of this
19 patient after the polypectomy, what was done to
20 try to look for signs of perforation while he
21 remained in the hospital? Did you order any
22 tests or prescribe any other procedures which
23 would alert the medical staff as to the
24 possibility of perforation in the postoperative
25 period while he remained in the hospital?

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

9 Q. You were checking CBCs after the surgery?

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

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

20 A. No.

21 Q. On May 27. No signs of perforation?

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

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

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

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

6 MR. FRASURE: Percentage-wise?

7 MR. MOSS: Yes.

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

12 Q. Delayed perforations happening within 24 hours.

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

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

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

1 A. Yes.

2 Q. And likewise, if he had sustained a delayed
3 perforation prior to his discharge, you would
4 expect to see signs and symptoms very shortly
5 after the perforation occurred?

6 A. Yes.

7 Q. Are you aware of any studies or literature that
8 talks about the risks of delayed perforation as
9 you move further out following a surgical
10 procedure?

11 A. No.

12 Q. And it's your opinion that Mr. Guthrie sustained
13 a perforation within 24 hours of his readmission
14 to the hospital on June 1, within 24 hours before
15 that?

16 A. That's my opinion.

17 Q. And what's the basis for that?

18 A. The basis is that if there was a perforation,
19 whether it is due to a procedure or whether it is
20 due to spontaneous perforation, diverticulitis,
21 foreign bodies or whatever the reason is,
22 patients rapidly deteriorate. All these things
23 we have discussed earlier occur. Very rapid
24 progression to septic shock, and it is considered
25 a surgical emergency that within just a few

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

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

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

9 MR. MOSS: Okay.

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

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

1 A. No.

2 Q. Would you expect to see --

3 A. Unless it would be blood.

4 Q. I'm talking about --

5 A. Normal bowel movement, no.

6 Q. -- stool. Would you expect to see active bowel
7 sounds in a patient with a perforation?

8 A. No.

9 Q. Would you expect to see a patient with the
10 ability to tolerate food or liquids by mouth with
11 a perforation?

12 A. No.

13 Q. You would expect to see vomiting and inability to
14 tolerate food or liquid, correct?

15 A. Correct.

16 Q. Would you expect a patient who has suffered a
17 perforation to be complaining of abdominal
18 cramping versus severe abdominal pain?

19 A. The description of pain is so subjective on the
20 part of a person, I can't really say how they
21 would describe the pain. It would be severe if
22 they had a perforation.

23 Q. And most patients would not call severe abdominal
24 pain cramping.

25 MR. FRASURE: Objection.

1 MR. CONWAY: Objection.

2 Q. If you know.

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

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

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

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

12 Q. Yes, sir.

13 MR. CONWAY: Objection.

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

18 MR. MOSS: Okay.

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

22 Do you have any --

23 A. During the procedure, you mean?

24 Q. Yes.

25 MR. CONWAY: Objection to the

1 form of that question.

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

4 MR. CONWAY: Whatever.

5 MR. MOSS: Let me try it again.

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

8 MR. MOSS: I know you are.

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

13 MR. MOSS: Is that better?

14 MR. CONWAY: Yes.

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

20 MR. MOSS: That's all I have.

21 Thank you.

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

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

- - - - -

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?

1 A. You mean within 24 hours?

2 Q. You said whatever time. I don't mean to put
3 words in your mouth. It logically follows based
4 on what you said that if there is a perforation,
5 the area becomes infected, peritonitis ensues,
6 correct?

7 A. Right.

8 Q. And when an infection is developing, the person's
9 white blood count becomes elevated, correct?

10 A. It may become elevated. It doesn't always. But
11 it might become elevated. If it does become
12 elevated, and the infection is a very severe,
13 life threatening one, like peritonitis, you would
14 expect it to go higher and higher and higher with
15 time.

16 Q. But it would be a rising white blood cell count,
17 correct, as the infection progresses?

18 A. Correct.

19 Q. So theoretically, before the white blood cell
20 count gets to that highest level, it would have
21 been at lower levels, correct, working its way
22 upward?

23 A. Correct.

24 MR. CONWAY: Okay.

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

1 hypothetical, all right?

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

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

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

14 A. Right.

15 Q. What do you do at that point?

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

18 MR. CONWAY: Yes.

19 MR. MOSS: I would just note an
20 objection.

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

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

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

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

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

13 A. Correct.

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

16 A. One.

17 Q. Were you able to treat it medically?

18 A. No.

19 Q. It had to go directly to --

20 A. Directly to surgery.

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

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

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

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

23 A. You mean procedures?

24 Q. Yes.

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

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

4 Q. Because of his condition, his overall --

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

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

11 A. In Kansas City.

12 Q. And what school in Kansas City?

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

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

19 A. Yes.

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

21 A. Yes.

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

24 A. Since 1984.

25 Q. Have you ever had your privileges revoked or had

1 disciplinary action taken against you in any way?

2 A. No.

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

6 A. Yes.

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

9 MR. MOSS: I just have one
10 question.

11 - - - -

12 FURTHER CROSS-EXAMINATION OF

13 R. KIRK ELLIOTT, D.O.

14 BY MR. MOSS:

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

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

19 MR. MOSS: Overall prognosis.

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

1 two days later as he did before.

2 Q. So still very poor?

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

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

10 A. Correct.

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

13 MR. CONWAY: Objection, asked and
14 answered.

15 MR. MOSS: It may have been.

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

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

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

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

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

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

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

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

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

22 A. Correct.

23 MR. MOSS: That's all I have.

24 Thank you.

25 MR. CONWAY: One last question.

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

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

3 A. Yes.

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

6 MR. MOSS: Nothing further.

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

9 MR. CONWAY: Yes. I do need this
10 because I have to get it out to Dr.
11 Slinger.

12 MR. FRASURE: We'll read.

13

14

R. KIRK ELLIOTT, D.O.

15

16

17

18

19

20

21

22

23

24

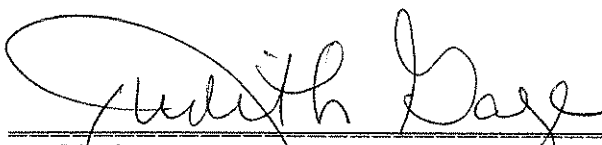
25

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

WORD
INDEX

1

1 21:5, 6, 10, 11, 25; 34:2;
36:23; 37:1; 56:14
1.4 44:12
100 46:23; 47:1
102 46:12
10:00 42:23, 23; 44:18
12 18:1; 45:15
12:51 21:18
1948 4:17
1984 66:24

2

2000 6:1, 10; 9:10, 12;
33:11, 14, 18, 23; 36:23;
37:1; 38:16, 24; 39:1; 42:1,
2, 6, 8, 17; 43:3, 12; 44:9,
23; 59:8; 67:20
23 6:10; 38:24; 39:1;
41:25; 42:2, 17; 67:20
23rd 68:22
24 7:2; 9:10, 24; 10:4, 17;
11:1; 18:1, 5; 21:4, 10, 11,
23; 33:11; 39:19; 42:6;
43:3, 12; 45:15; 55:12;
56:13, 14; 62:1
24th 10:2; 39:14, 15, 15
25 7:3; 8:3, 10; 9:11;
10:10, 17; 11:20; 13:13;
21:21; 23:7, 11; 32:10, 15,
20, 24; 33:14, 18; 40:14;
42:8; 44:9; 49:24; 59:8;
65:19; 67:16
25th 13:17; 39:16
26th 13:24; 14:2
27 27:14; 28:3; 33:22;
44:23; 54:21
27th 55:25
2:00 42:25, 25

3

3 42:24
30 40:12; 41:1; 43:25
31 21:11
35 43:15

4

4 4:17; 43:2
44 45:18; 46:2
48 39:12; 55:5

5

5/23/2000 39:8
50 44:11; 67:3

6

6/1/2000 57:23
60 42:23
6:00 43:7, 25; 44:2, 16
6:05 42:17, 19
6:15 39:2, 8; 42:18
6:40 39:21
6:45 43:12

7

7 44:1
70 46:12
75 44:16
7:00 39:13, 14; 40:11;
43:2, 4, 22, 24

8

80 46:21
84 45:18; 46:1
8:00 40:15; 43:17, 25;
44:9

9

9:30 44:13

A

a.m 39:2, 8, 13, 14, 21;
40:11, 15; 42:19, 23, 23;
43:3, 4, 7, 12, 17, 19, 24,
25; 44:1, 2, 9, 13, 16;
57:19
abdomen 14:5
abdominal 17:25; 18:3;
29:20, 25; 58:17, 18, 23
ability 58:10; 68:18
able 14:14, 17; 15:5;
51:19; 64:17, 22
above 46:22, 23
absence 31:4, 5
absent 29:25
absolutely 12:9, 12;
52:18, 22
accident 50:8
action 67:1
active 14:20; 15:3; 40:8;
41:12; 50:2; 51:13; 54:8;
58:6
actively 11:9
activity 45:9
actual 17:7; 18:19; 20:7
actually 21:2
acute 17:19; 18:7, 22, 24,
25; 30:22; 57:21; 60:11
add 5:15; 37:5
added 41:4; 44:15

addition 10:14
addressed 51:21
advance 44:14
afternoon 21:19; 43:20;
44:21
afterwards 26:8; 29:5
Again 44:10; 45:11; 51:5;
60:5
against 67:1
age 4:1
aggressive 65:6; 68:8,
12
ago 18:16; 37:6
agree 20:25; 54:24
agreed 49:18
agreement 50:15
agrees 40:10
ahead 43:10; 51:9; 63:21;
70:19
air 17:24; 18:17; 19:3, 6;
23:22
alert 53:23
alertness 68:18
along 26:11
although 14:21; 16:6
always 19:23, 25; 29:10;
47:13; 62:10
amazed 37:21
amount 15:24
and/or 67:5
anemia 39:9; 69:23
anemic 54:13
anesthetic 35:4
angulation 23:15
answered 68:14
anti-coagulant 48:24;
49:4, 14; 50:18, 23
anti-coagulants 8:18
antibiotics 63:24; 64:10
anticoagulants 41:7
appetite 45:12
applicable 30:21, 25
apply 31:2
approach 69:13
approximately 52:3
area 19:4; 22:14; 52:5;
62:5; 66:17, 20
areas 12:25; 16:1, 2
arose 48:7
around 23:20
arrival 21:14
arrived 21:15
arriving 21:12
aspirin 8:17; 12:4; 41:6
assume 4:18; 5:9; 7:12;
35:13; 63:2
assuming 39:1
atrophic 40:2
attack 50:25
attending 7:19; 25:17,
24; 28:6; 31:9; 47:14
attorney 4:18; 5:13; 17:1;

38:17; 40:6; 68:24; 70:9,
15; 71:17
attorneys 37:12, 18, 20
autopsy 20:15
available 27:7; 47:13
avoid 64:10
awake 43:19; 44:17, 19
aware 28:1; 31:7; 47:3, 9;
56:7; 57:8, 10; 69:3
away 36:10, 20

B

back 6:1, 10; 8:14, 21;
31:17; 37:6; 45:11, 15;
57:15
barium 12:22; 41:13;
51:8; 52:2; 66:2; 69:11, 15,
17
based 54:15; 59:6; 61:6;
62:3; 65:20
Basically 12:15; 27:5;
28:9; 40:21; 53:11; 54:5
basis 56:17, 18; 57:6
became 14:7; 31:6
become 15:17; 19:20;
20:5, 6; 33:25; 45:6; 62:10,
11, 11
becomes 62:5, 9
begin 22:19
beginning 31:16
belabor 68:6
belief 60:16
below 47:1
benefits 49:25
best 25:13, 19; 26:8;
50:17
better 12:6; 60:13
biopsies 39:25
biopsy 9:23; 42:6
birth 4:16
bit 6:23; 37:6; 66:8, 9;
69:9
blame 38:12
Blankenhorn 44:3
bleed 14:9, 18; 50:22
bleeding 11:8, 8, 9;
12:11; 14:10, 13, 19, 20,
22, 24, 24; 15:2, 3, 6;
29:20; 32:2; 40:9; 41:12;
49:9, 13; 50:2; 51:13; 54:8;
65:10; 69:6
blood 30:6; 32:2; 40:3;
45:17, 24; 46:1, 5, 9, 11,
19, 23; 47:1, 9, 20; 51:13;
58:3; 61:8, 12, 15, 18, 21;
62:9, 16, 19; 69:5, 22
board 66:17, 20
bodies 56:21
both 9:5, 15, 20; 11:22;
12:12
bowel 12:16; 22:18; 30:1;
45:9; 51:4, 14; 57:24; 58:5,
6

break 5:12
breakfast 44:14
breath 30:2
bright 14:21; 51:13
brought 52:15, 17

C

call 10:14, 16; 29:1;
47:15; 58:23; 65:15, 16
called 4:2; 11:2; 21:17,
17, 18; 66:13, 15; 69:4;
70:12, 16
came 21:5, 19; 28:16;
37:13; 57:15; 66:6
can 5:17; 6:23; 15:17;
17:7, 13; 18:25; 19:1; 23:1;
29:7, 9; 31:24; 42:22; 57:1;
61:16, 17; 64:4; 65:7
cancelled 37:20
cancer 52:16; 65:11
candidate 65:2
cardiac 47:21
cardiologist 26:3; 49:19
cardiopulmonary 36:2
cardiovascular 50:8
care 7:11, 12, 14; 8:20;
13:14; 25:15; 26:2, 5, 10;
28:2, 8, 10, 19; 32:7; 33:6,
8, 10, 13, 16, 25; 34:9;
35:25; 47:2; 48:3; 49:20;
51:16; 54:4; 59:16; 71:6,
25
carried 45:23; 69:24
carries 15:14
carry 16:5
case 4:10, 25; 7:18; 8:16,
24; 9:5, 16; 12:5; 15:20;
20:15, 17, 20; 24:25; 25:1;
27:6; 32:5; 37:7; 38:10;
42:13; 48:20; 49:11; 64:9
cases 27:24; 47:17
catastrophic 17:22
cause 15:1, 6; 17:25;
19:6; 20:1; 22:7, 11; 23:3;
61:16; 69:23
caused 14:23; 22:5
causes 18:20; 22:12, 20;
61:15, 18
cauterize 69:22
cautery 19:21, 22
cavity 18:1
CBC 41:11; 44:1, 16
CBCs 54:9
cc 42:23
cc's 43:6; 44:16
cecum 40:18; 42:9
cell 61:8, 13, 16, 19, 21;
62:16, 19
centimeters 41:1
Certainly 46:1
certainty 72:2
certificate 20:17

certification 66:20
certified 4:5
certify 66:17
cetera 40:9; 41:9
chance 19:25
change 67:23
changed 66:13
chart 13:24; 17:1; 42:14;
54:16
charting 38:22; 44:22
chase 23:9
check 39:12; 40:13;
41:11, 11; 52:5
checking 54:9
Chem 44:1
choices 69:10
choose 65:16
chose 69:13
chronic 40:2
circulation 22:22
circumstances 28:1
citrate 42:24; 43:21
City 66:11, 12, 14
Civil 4:4
clarification 48:22
clarify 67:20
cleaned 69:17
cleansing 39:12
clear 42:21; 43:18; 70:3
clearer 68:20
clinical 67:4
closely 41:12; 50:2
co-morbid 53:1
code 65:8
coffee 40:2
cold 37:16
colitis 23:2
College 66:14
colon 12:20, 24; 14:22;
15:17, 20, 23, 25; 16:4, 6,
7; 17:25; 18:14, 15, 18;
19:3, 7, 13, 14, 20, 25;
20:2, 20, 25; 21:2, 6, 23;
22:14; 23:5, 12, 13, 14, 15,
16, 22, 23; 29:8, 13, 19;
30:9, 12; 39:11; 40:19, 24;
41:1; 45:10; 52:2; 61:6, 14,
17; 63:4, 12
colonoscopist 23:16
colonoscopy 7:2, 21;
8:2, 10, 11, 19; 9:11; 10:7,
25; 11:11, 12, 21, 23;
13:18; 15:13, 14; 16:8;
17:8, 12; 23:6; 30:11, 23;
31:1, 4, 8; 32:10, 16;
33:14, 18; 39:14; 40:10,
18; 42:9; 43:4, 23; 44:9,
11; 45:7, 13, 19; 48:25;
49:3; 64:15; 65:19; 69:18
colonoscopy/polypec-
tomy 55:1, 4
colons 64:3
colored 40:3
coming 51:14

common 16:1; 45:8, 14
communicate 9:15;
27:11; 28:22; 29:3; 34:16,
22; 68:18
communicated 13:6;
27:10, 20
communicating 8:11,
13; 26:18
Community 25:19;
27:15; 28:8; 32:6; 33:22;
34:2
compared 15:25; 25:1;
30:15
complaining 58:17
complete 51:19
completely 68:25
complicated 47:18
complication 15:15;
24:7; 70:1
complications 12:11;
17:22; 65:4; 67:24
complied 71:5, 24
comply 33:6, 10, 13, 16
conclusion 57:6
condition 13:1; 18:3;
66:4, 5; 68:3
conditions 31:10; 48:7;
53:2; 65:1
congestive 46:8
conscious 34:20; 65:7
consciousness 30:7
consent 69:19, 19
conservative 66:9
consider 41:13
considered 7:5; 56:24
consistent 70:20
constipated 45:6; 57:20
constipation 22:22
consult 6:15; 26:25; 27:2;
39:8; 42:1; 63:25; 67:21;
68:23
consultant 7:8; 14:8;
28:9
consultation 11:6
consulting 8:24
contact 6:12; 14:1; 47:19
contacted 32:5, 14, 18,
22, 23; 33:2; 37:19; 48:2
continue 8:17; 49:25;
50:17; 51:16
continued 12:10, 12, 18
contribute 22:16
controlled 52:14
conversation 13:12;
17:4; 32:19, 24; 34:18;
36:12; 38:1; 68:25; 69:24
conversations 34:13;
35:14, 17; 37:2
CONWAY 4:8, 9; 18:23;
21:15; 25:22; 27:1; 29:11,
17; 30:19; 31:15; 48:11;
55:20; 59:1, 13, 25; 60:4,
6, 14, 24; 61:4; 62:24;
63:18; 67:7; 68:13; 70:25;

71:4, 11, 16; 72:4, 9
COPD 35:3
copy 9:24
corners 23:21
correction 37:5
count 61:8, 13, 16, 19,
22; 62:9, 16, 20
couple 12:23; 34:7;
48:15; 51:12
course 53:15
court 4:13; 5:18
coverage 34:10
covering 34:4; 36:18
CPR 70:6
cramping 58:18, 24
cross-examination 4:3,
7; 48:17; 61:2; 67:12; 71:2
current 50:1
custom 11:15
cutting 23:9
CVA 41:9; 50:16

D

D.O. 4:1, 7; 48:17; 61:3;
67:13; 71:3; 72:14
D5 43:5
daily 44:1
dangerous 12:13
date 4:16; 9:24, 25; 36:23;
37:2
daughter 11:2; 16:14;
17:5; 40:6; 70:13
David 26:12; 27:4
day 10:2, 22; 28:17; 34:4,
6; 37:15; 40:13; 45:8; 47:5;
54:10; 55:8; 59:11, 11;
63:8
days 26:19; 31:1; 34:7, 8,
17; 35:20; 36:10, 19;
45:10, 18; 46:6; 55:10;
57:11, 20; 68:1, 20, 20, 21;
69:17
DC 44:18
deal 63:10
dealing 16:13, 21
dealt 16:18
death 18:4; 20:17; 50:8;
57:2
decrease 45:12
deeper 20:1
defer 49:19
definitively 15:5
degree 25:3; 64:5; 71:7;
72:1
delayed 17:12, 13; 18:21;
20:4; 22:2, 5, 7, 17; 30:25;
55:12, 13, 15; 56:2, 8;
59:19; 60:11, 17
delete 5:15
Demerol 43:14; 44:11
demonstrating 54:17
depend 45:22; 64:5

deposed 4:5
deposition 4:11, 20, 22;
5:17, 21; 27:18; 37:10, 18,
25; 48:20
describe 58:21
described 18:16; 30:9
description 27:17;
58:19; 59:3
desire 52:6
despite 12:18
detail 8:8
detect 54:5
deteriorate 56:22
deterioration 18:2; 57:4
determine 14:12, 14, 17;
15:1, 5
determined 63:3
developing 62:8
devoted 67:4
diagnostic 66:2
diameter 23:18; 40:20
dictated 10:3, 9; 39:4;
41:23, 25; 42:2; 44:24;
45:1
dictating 8:12; 13:5
died 26:3; 36:6
diet 8:15; 12:14; 41:5;
42:21; 43:18; 44:14, 15
difference 57:1
different 15:17; 16:15;
35:22; 47:21; 55:2; 59:4;
69:6
differently 15:11
difficult 12:24; 23:7, 10,
20, 24; 24:4, 6, 15, 22, 25;
25:2, 4
difficulty 25:3; 27:18;
65:21
diffuse 29:25; 40:1
direct 14:1; 15:1
directed 70:12
directly 18:25; 27:8; 29:1;
64:19, 20
disagreement 53:15
discharge 27:13; 28:2,
13; 44:23; 54:19; 56:3
discharged 28:7; 55:25
disciplining 33:21
disciplinary 67:1
discontinuance 48:24
discontinued 49:5, 15
discovered 69:22
discuss 29:1; 36:21; 64:1
discussed 8:16; 11:3, 4;
12:2, 19; 27:6; 36:24; 40:5;
50:14; 53:6; 56:23; 69:1;
70:16, 17
discussing 37:7
discussion 11:5; 37:8;
68:5; 71:20
discussions 16:15
disease 22:23; 35:2;
49:22; 50:6

diverticulitis 56:20
diverticulosis 12:21;
22:13, 21; 40:25
DNR 70:8, 11
doctor 4:9; 22:6; 33:6, 21;
38:14; 48:11; 60:25;
62:25; 71:23
doctors 27:12
done 13:18; 26:22; 39:9;
52:14; 53:10, 19; 54:1;
63:5; 71:12
double 52:4
down 6:23; 38:6; 45:9;
53:11; 69:1
Dr 8:20; 9:16, 19; 10:1,
13, 16, 17; 11:1, 4, 13, 19;
13:1, 8, 12; 25:14, 17, 24;
26:1, 9, 11, 12, 12, 14, 15,
18; 27:3, 4, 6, 20, 22; 28:3;
32:18, 23, 24; 33:2, 4, 5;
34:3, 9; 35:17, 24; 36:1,
12, 17, 21, 21, 24; 37:7,
14; 43:5, 24; 44:3; 47:19;
48:7, 19, 20; 49:16; 50:14;
51:16; 59:6; 64:24; 72:10
drop 12:18; 30:6; 32:1;
47:9
dropped 13:20; 37:24;
47:6; 69:9
dropping 14:12; 40:8;
69:4
due 19:3; 22:10; 56:19, 20
Dulcolax 43:22
duly 4:4
duodenitis 40:4
during 7:5; 17:7, 11, 19;
18:8; 19:16; 20:6, 6; 25:22;
26:19, 19; 30:22; 33:7, 10,
13, 16; 34:14, 20; 35:15,
18; 41:22; 46:16, 17, 17,
20, 22, 23; 47:3; 55:14, 22;
57:11; 59:23; 60:12;
63:12; 64:15; 65:9, 14;
70:2, 6

E

E-I-I-o-t-t 4:15
ear 71:10
earlier 35:1; 46:21; 54:6;
56:23; 64:21
easier 6:24
easy 23:19
effect 5:22
EGD 7:1; 9:8, 23; 11:1, 3,
5, 6, 7, 22; 33:11; 39:13,
25; 42:6; 43:3, 7, 13, 14
either 18:10, 25; 21:11;
36:21; 44:4; 67:24
elderly 51:11
elect 65:16
electric 19:22
electrocautery 20:1
elevated 61:12, 15, 19,
21; 62:9, 10, 11, 12

ELLIOTT 4:1, 7, 14; 43:5, 24; 48:17, 19; 59:6, 61:3; 67:13; 71:3; 72:14
else 36:3; 37:12, 17
Emergency 21:5, 24; 56:25; 57:16, 17, 18, 22; 63:22
emphasize 5:1
empty 45:9, 10
EMS 21:17, 17
endoscopic 59:21; 69:13
endoscopically 52:15
endoscopy 9:9; 53:8; 54:2; 55:14; 66:2, 3; 67:18; 69:3, 12, 19; 70:19
enema 12:22; 41:13; 43:19; 51:8; 52:2; 69:15
enough 8:23; 66:1, 7
ensues 62:5
Ensure 42:21; 43:18
entailed 8:13
entire 19:23; 40:23
especially 47:17
et 40:9; 41:9
etiology 39:10
even 11:23; 23:19; 41:16; 53:13; 59:20
event 55:14, 15; 65:9
events 18:12
everybody 65:6
evident 20:6, 6
exacerbating 64:11
exact 22:7; 23:3; 36:9
examined 14:5
excuse 21:17; 41:11; 42:1
expect 18:2; 31:10, 25; 48:6; 56:4; 57:14, 24; 58:2, 6, 9, 13, 16; 61:21; 62:14
expectancy 59:8
expectations 47:24
expected 55:23
expecting 48:2
experiences 45:17
experiencing 31:11
explained 16:10; 40:7
explaining 17:2
express 53:14
extensive 12:21
extent 38:1; 43:8; 44:22
extreme 55:15
Extremely 20:11; 35:23; 51:10; 67:16
extrinsic 40:25

F

fact 5:9; 9:19; 10:3; 11:12; 12:2, 19; 47:9
failure 35:8; 46:8; 70:2
fair 5:10; 8:23; 51:1; 59:15

fairly 18:5; 45:13, 16
familiar 64:24
family 4:10; 16:11, 21, 24; 35:15; 37:3; 64:2
far 8:17; 13:3, 14; 15:23; 16:3; 23:10; 24:15; 49:24; 53:10; 54:6
father 70:21
father's 53:16
fecal 18:17
feed 63:24
feeding 64:11
feel 5:13; 12:15; 47:23; 49:24; 50:7; 65:25
felt 9:2, 5; 12:8, 11, 13; 27:10; 54:2; 64:24; 67:15, 21
fever 18:3; 29:20; 30:1; 32:1; 54:8; 61:11
few 36:10; 45:10; 48:21; 56:25; 60:24
field 47:16
fifteen 40:20
filed 37:10
find 24:14; 69:15
finding 41:3
findings 8:13; 9:15; 40:7
finds 23:16
finish 6:20
finished 26:17; 60:2
first 4:4; 6:11; 8:12; 34:4, 6; 37:15; 39:2; 40:19; 42:17; 43:13; 48:8; 52:9; 63:10, 21
five 40:20; 45:18
flecks 40:3
flexible 23:18
floor 29:5; 54:3
fluctuate 68:19
fluctuated 46:19
fluid 17:24; 18:17
fluids 63:25
follow 7:11, 20; 8:21; 18:7, 10; 24:1, 5
followed 35:21
following 8:9, 11; 11:5, 12, 20; 13:12; 31:8; 32:18; 33:17; 44:25; 45:6, 12; 47:6; 49:3, 8; 50:11, 18; 54:10, 25; 55:4; 56:9; 59:21; 61:20; 65:18; 67:16
follows 4:6; 18:13; 62:3
food 58:10, 14; 64:12
foreign 56:21
forever 38:6
forget 34:7
form 7:22; 60:1
forward 66:6
found 11:7, 25; 28:25; 29:4; 40:10; 41:16; 52:13, 16; 53:5, 9, 13; 69:5, 20, 21, 25
frail 51:11

frame 26:19
FRASURE 7:23; 10:22; 17:16; 18:21; 21:13; 24:19; 26:24; 29:9, 15; 30:17; 31:13; 37:21; 38:2, 8, 12; 41:24; 45:3; 46:14; 48:14; 51:8; 55:6; 57:7; 58:25; 59:9, 14; 61:24; 67:17; 68:16; 71:9, 14; 72:7, 12
free 5:13; 20:3
frequency 16:3
frequently 49:18
Friday 13:19; 44:16
front 5:23; 20:23; 21:16; 38:14
full 4:12; 20:2; 44:14
fully 23:21; 43:19; 44:17, 18; 52:4
further 13:13; 48:12; 49:13; 51:19; 53:6, 10; 56:9; 61:2; 65:21; 66:1, 3; 67:8, 12; 69:24; 71:2; 72:5, 6

G

gastritis 14:21; 40:2
gastroenterologist 6:2; 8:24; 66:23
gastroenterology 6:15; 28:14; 39:8; 66:18
gastrointestinal 14:13; 66:1
gave 13:9; 37:24; 52:13; 70:18
general 17:16, 18; 26:4; 29:16; 30:9; 60:16
gentleman's 12:25
Geraldine 32:12
GERD 40:1
gets 15:11, 24; 62:20
GI 9:9; 14:9, 17; 40:9
given 12:25; 43:14; 44:10; 69:18
giving 27:17; 51:17
glad 5:5
goes 21:24
good 30:19; 31:6
greater 16:6; 23:25; 25:9
Gross 8:20; 9:16, 19; 10:1, 13, 16, 17; 11:1, 4, 13, 19; 13:1, 8, 12; 25:14, 17; 26:1, 9, 14, 15, 18; 27:6, 20, 22; 28:3; 32:18, 23, 25; 33:5; 35:18; 36:1, 12, 21, 24; 37:7, 14; 47:20; 48:8, 20; 49:16; 50:14; 51:16; 64:24
ground 40:2
group 27:5
Guthrie 6:7, 12, 15, 25; 7:20; 8:2, 6, 10; 13:14; 16:14, 19; 17:3; 20:20; 24:16; 27:14, 19; 33:8, 21;

34:1, 14; 35:18; 36:6, 24; 37:4; 39:3; 44:22; 45:23; 56:12; 63:3, 11; 72:1
Guthrie's 4:10; 23:11; 25:14, 17; 26:9; 33:17; 35:19; 38:15; 67:15; 68:7

H

H 39:13, 13; 40:13, 13
half 43:6
handles 28:10
happened 57:10; 70:7
happening 55:12
happens 18:14; 19:10; 49:18; 70:1
happy 47:16
hard 23:21
head 29:3
healed 41:6, 15; 52:4
health 28:2, 8, 19; 32:7; 48:3; 52:6; 66:16
heart 13:3; 35:2; 46:8, 8; 50:25; 70:1
heavy 65:10
hemocult 39:9
hemoglobin 12:17; 14:11; 40:8; 54:14; 69:4, 9
hemorrhoids 41:3
hereinafter 4:5
hernia 40:1
Hi 4:9
hiatal 40:1
high 25:6, 7; 30:1; 41:8; 54:8; 61:7; 65:3
higher 62:14, 14, 14
highest 62:20
history 47:18; 50:16
hole 20:1, 3
home 28:2, 8, 18, 20, 21, 22; 29:1; 32:6; 48:3; 57:10
honest 24:18; 55:13, 17; 70:10
Hopefully 23:15
hospital 10:5, 12, 19; 13:19; 21:12; 25:19; 26:13; 27:15; 28:8; 32:3, 6; 33:22; 34:2, 4, 10; 36:18; 46:7; 53:21, 25; 56:14; 57:12, 16
hospitalization 34:5, 11, 15, 21; 35:15, 19; 38:15; 41:22; 57:11
hospitalized 25:18
hour 43:6; 44:17
hours 18:1, 5; 21:4, 10, 11, 24; 37:11, 14, 17; 39:12; 45:15; 55:5, 12; 56:13, 14; 57:1; 62:1
hundred 43:6; 55:18
hypothetical 31:14; 63:1
Hypothetically 63:11

I

idea 55:19; 65:13
ideally 41:6
immediately 63:2, 12; 65:18
important 27:11
impossible 59:3
impressed 14:6
impression 39:9; 40:4, 19
impressions 39:25
in-patient 7:10; 10:6
inability 58:13
incidence 17:13
included 17:3
including 44:24; 45:23; 61:16
increase 24:2, 7, 11
increased 12:10; 24:3
increases 22:19
indicate 5:5
indicated 9:2, 6; 33:20
indication 61:13
indications 61:14
individual 45:22
infarction 41:9
infected 62:5
infection 17:25; 61:16, 17, 20; 62:8, 12, 17; 63:23
inflammation 22:20
information 36:20; 60:10; 65:8; 66:6
informed 11:22
initiate 63:22
inpatient 54:5
input 13:9; 27:13
instructions 70:20
instrument 19:12
insufflate 23:22
insufflation 19:3
intensive 34:8; 35:25
interim 35:7
intermittent 14:24
internally 69:7, 23
internist 26:4
internists 26:12; 27:3
interpreted 15:11
intestinal 18:11; 22:10
into 21:24; 27:13; 39:6, 23; 40:17
intraoperatively 63:17
intravenous 63:25
introduced 48:19
introducing 19:2
involved 14:7; 16:15; 26:12; 33:25; 38:10, 16; 47:2
involvement 4:25; 13:13; 28:12; 33:7; 59:7
ischemic 23:2

issue 51:21; 53:4, 4
issued 42:12
IV 43:5, 15, 15; 44:12, 12,
16, 18

J

JAMISON 31:12, 23;
35:11; 45:21; 46:4; 47:12;
60:22; 61:23
judge 5:23
judgment 12:8
June 21:5, 6, 10, 11, 25;
34:2, 15, 20, 24; 35:15, 19,
23; 36:23; 37:1; 56:14
jury 5:23

K

K-i-r-k 4:14
Kansas 66:11, 12, 13
KIRK 4:1, 7, 14; 38:3;
48:17; 61:3; 67:13; 71:3;
72:14
knew 37:20
knowledge 25:14, 20;
26:9; 33:9
known 22:23; 26:1, 15
knows 12:6

L

large 40:22
last 4:13; 37:9; 40:3, 12;
43:5; 44:8; 70:25
later 12:23; 36:10; 37:14;
47:5; 55:11; 68:1
lawful 4:1
lawyer 37:22
laxatives 69:17
layers 19:24
lead 61:17
leading 18:4; 29:21; 57:4
leakage 17:24; 18:17
learned 36:5
least 24:18
leave 12:8; 13:1
left 12:20; 22:14; 28:17
Leona 16:14, 25; 17:4, 6;
40:6
less 59:20; 60:16
level 62:20
levels 62:21
life 41:8; 57:1; 59:8; 62:13
likelihood 23:25; 55:3
likely 47:19; 60:17
likewise 56:2
limited 35:23
lining 19:24; 22:10
liquid 42:21; 43:18;
44:14; 58:14

liquids 44:18, 19; 58:10
list 29:7
listed 40:1; 44:10; 57:14
listing 43:13
literature 56:7
little 6:23; 37:6; 66:8, 8;
68:20
live 52:20
localized 23:1; 64:7
located 10:20
logically 62:3
long 26:1; 66:22
look 53:20
loss 30:6
lot 35:5; 37:13
loud 6:19
low 25:6; 41:4; 44:15;
45:24; 46:1, 9, 20
lower 62:21
lucid 68:23
lumen 41:2
lunch 44:15
lung 70:2
lungs 13:3

M

magnesia 42:22, 24;
43:21, 21
mainly 54:12
major 35:4; 70:1
making 35:22
malignancy 41:16; 53:5;
68:9
man 22:23
managed 64:4
management 53:18
managing 27:8; 35:25;
36:1; 47:21
many 7:10; 27:24; 34:7;
61:15, 18
marked 41:1
Massillon 25:18; 27:14;
28:7, 10; 32:6; 33:22; 34:2
material 18:17
maximum 20:13
May 6:1, 10, 18; 7:2, 3, 10,
12; 8:3, 10; 9:10, 11, 24;
10:4, 10, 17, 17; 11:1, 20;
13:12; 20:13; 21:11, 21;
23:7, 11; 27:14; 28:3;
32:10, 15, 20, 24; 33:11,
14, 18, 22; 35:1, 5; 38:16,
24; 39:1, 19; 40:14; 41:25;
42:2, 6, 8, 17; 43:3, 12;
44:9, 23; 49:23; 54:21;
59:8; 62:10; 64:8; 65:15,
19; 67:16, 20, 20; 68:15
Maybe 55:17
mean 23:14; 26:25;
46:16; 59:23; 62:1, 2;
65:23
means 23:15

mechanically 19:19
medical 12:7; 20:22, 23;
27:5, 8; 39:3; 51:16; 53:23;
65:1, 3; 66:10; 71:7; 72:2
medically 9:2, 6; 64:4, 8,
17
medication 48:25; 49:5,
14; 50:23
medications 43:14;
44:10; 47:22; 50:1, 18, 25
Medicine 66:14; 67:4
Medium 40:23
meet 4:19
members 16:22, 24;
35:14; 37:3
mental 68:18
mentioned 51:3; 68:5
Meshekow 35:24; 36:21
Mi 49:14; 50:8, 16
midnight 43:2, 23
might 50:21; 62:11
Mild 40:1, 4
milk 42:22, 24; 43:20
milligram 43:15
milligrams 40:13; 43:15,
25; 44:11, 12
millimeters 40:20
million 55:18
misheard 61:12
Miss 53:7, 14
modify 5:16
moment 18:16; 71:17
monitor 41:12
monitoring 54:1
months 12:23; 41:14;
52:3
morbidity 65:4
more 16:1; 17:21; 23:24;
25:2, 8; 29:21, 23; 41:20;
47:16, 18; 66:6, 9; 67:3;
69:20
morning 13:19; 43:8
mortality 65:4
MOSS 7:22; 18:9; 24:20;
25:21; 26:16, 23; 31:22;
35:10; 38:6; 45:20; 46:3;
47:11; 48:9, 15, 18; 55:7;
57:9; 59:18; 60:2, 5, 8, 13,
20; 61:7; 63:16, 19; 65:20;
67:9, 14, 19; 68:15; 70:23;
72:6
most 20:14; 27:7; 47:17;
58:23
mouth 58:10; 62:3
move 55:20; 56:9
movement 57:24; 58:5
much 36:3; 60:16
mucked 30:17
myocardial 41:9
myself 21:4

N

n.p.o 43:2, 17, 23; 44:13
name 4:9, 12, 13; 6:7;
66:13
namely 49:13; 53:4
names 16:24
narrowing 23:12; 41:2
necessary 12:9
need 38:21; 65:15; 70:15;
72:9
needs 36:2
neither 8:17
next 12:17; 39:12, 19;
40:14; 43:3, 11, 17; 52:8
nice 60:7; 71:15
none 37:12; 57:13
norm 46:9
normal 25:1, 6; 43:6;
45:16; 54:1, 4; 58:5
normally 12:22; 52:2
Notary 31:20
note 13:24; 39:2, 2, 5, 6,
19, 24; 40:14; 42:1, 5, 8;
51:22, 24; 63:19
notes 9:20; 38:23; 41:20,
23, 25; 44:24; 68:17
notified 31:10; 36:11;
47:5
notify 31:25
November 4:17
number 42:22, 24; 43:2;
44:13
numbers 25:5
nurse 29:4; 32:12, 14
nurses 28:25; 29:3; 31:6,
25; 47:14; 48:3
nursing 13:21; 28:2, 8,
19, 20, 21, 22; 29:1; 47:5;
54:4; 70:13

O

oath 5:22
Object 7:22; 31:22
Objection 18:9; 26:23;
31:12, 23; 35:10, 11;
45:20, 21; 46:3, 4; 47:11,
12; 48:9; 53:14; 55:20;
57:7; 58:25; 59:1, 13, 25;
61:23; 63:20; 68:13
observation 29:6
Obviously 16:18; 23:24;
25:8; 27:17; 35:3; 48:2;
63:24
occult 14:19
occur 17:7, 19, 23; 18:25;
19:1, 11, 16, 19; 20:6, 12,
13; 55:8; 56:23; 65:9, 10
occurred 21:4; 23:4; 56:5
occurrence 20:9
occurring 55:4; 63:6

occurs 17:15; 18:11, 19;
30:22; 31:1, 3
off 37:16; 63:23; 71:20
office 10:17; 32:22, 23
one 16:1; 17:21; 18:10;
20:5; 21:22; 22:11; 26:18,
21; 27:2; 36:16; 37:5, 12,
17, 18; 40:12; 42:21;
43:15, 17, 20, 22; 44:4;
54:10; 55:17, 18; 59:4;
60:18; 61:5, 13, 16, 18;
62:13; 64:16; 67:9; 69:10,
11, 11; 70:25
ones 25:2
Only 28:16; 37:8; 49:7
op 9:20; 49:23
operative 42:5, 8; 51:21
operatively 7:16
operator 10:19
opined 64:21
opinion 22:1, 2, 6; 56:12,
16; 59:6; 64:22; 65:1, 19
opinions 71:5, 6, 24
opportunity 4:19; 6:11;
20:24; 28:5; 38:19
options 69:1, 14; 70:17,
18
order 42:17; 43:11;
53:21; 63:22; 70:8
ordered 28:3; 43:21;
44:1; 54:10
orders 29:4; 41:24;
42:12, 14, 15; 43:8, 10;
44:8
ordinary 23:10
original 14:7
originally 37:9
Osteopathic 66:14, 17
otherwise 52:6
ounces 42:25
out 6:19; 10:4, 5, 12; 14:8;
23:9; 38:2; 56:9; 69:17;
72:10
outpatient 28:16
outside 17:24; 18:18;
37:16
outweigh 49:24
outweighed 49:12; 50:23
over 4:18; 27:25; 39:12;
45:18; 46:2, 12; 52:7;
68:19
overall 35:1; 66:4, 5;
67:17, 19, 21; 68:3
own 65:5

P

p.m 21:18; 42:25, 25;
43:22
p.o 42:22, 23, 25; 43:25;
44:17, 19
paged 10:19
paid 38:8
pain 18:3; 29:20, 25; 32:1;

54:7; 57:18, 20; 58:18, 19, 21, 24; 59:4 paragraph 51:24 parameters 61:25 Pardon 71:8 parking 37:13 part 16:4; 18:14; 19:7; 58:20 particular 7:18; 8:16; 9:16; 12:5; 15:20; 32:5; 42:12; 47:25; 50:17; 51:10; 64:9 partner 33:5; 34:3, 9 partners 36:16 parts 15:17, 25 passed 36:10, 20 pathology 19:5 patient 6:7, 25; 7:5, 14; 8:21; 12:6, 14, 16; 16:10, 14; 28:6, 7, 24; 29:2; 31:11; 32:3, 9; 41:8, 15; 45:17, 22; 47:17, 24; 48:4; 49:20; 50:17, 21; 51:4, 6, 10; 53:19; 54:17, 24; 57:25; 58:7, 9, 16; 59:7; 63:24; 64:10, 21 patient's 18:3; 31:9; 50:6, 12, 16; 52:5 patients 28:13, 21; 45:6, 23; 56:22; 58:23; 64:14 pediatric 23:17, 19 people 23:1; 55:10 peptic 40:9 per 44:17 percent 67:3 percentage 55:9, 16, 19 Percentage-wise 55:6 perforate 19:13 perforated 15:18, 24; 16:7; 18:15; 19:20; 20:20, 25; 21:3, 6, 23; 29:8, 13, 18; 30:9, 12; 61:5, 14, 17; 63:4, 11; 64:3, 15 perforation 15:15; 16:1, 2; 17:7, 10, 12, 14, 20, 21, 23; 18:7, 11, 19, 20, 24, 25; 19:6; 20:3, 5; 22:3, 5, 8, 17; 23:4, 25; 24:11; 25:10; 30:11, 15, 16, 22, 25; 53:20, 24; 54:18, 21, 23, 25; 55:3, 8, 10, 13, 14, 15, 22, 24; 56:3, 5, 8, 13, 18, 20; 57:15, 25; 58:7, 11, 17, 22; 59:17, 19, 20; 60:11, 12, 17; 61:20; 62:4; 63:5, 8; 64:5, 6, 7; 65:11 perforations 55:12 perform 6:14; 7:8; 8:14, 25 performance 31:8 performed 7:2, 3; 8:2; 9:10, 11, 23; 10:2; 12:23; 23:7; 25:12, 23; 26:7; 27:19; 28:14, 23; 33:11; 49:7; 53:6; 70:6 perhaps 29:21; 30:1;	50:25 period 7:6; 25:23; 29:6; 33:17; 35:19; 45:14; 49:5; 53:25; 65:18 peritonitis 29:22, 24; 62:5, 13 permission 52:13; 70:18, 19 Perry 26:12; 27:4 person 29:25; 58:20; 59:5 person's 62:8 personal 10:14 personally 27:7, 22, 24; 35:20 perspective 13:5 pertaining 39:3 phone 40:7 Physically 18:14; 19:12 physician 7:12; 8:14, 20, 20; 11:16; 25:15, 18, 24; 26:6, 10; 28:6, 10; 31:9, 25; 47:15; 57:18 physician's 7:19 physicians 7:10; 64:25 picked 45:15 picking 45:11 place 10:16 Plaintiffs 4:2 Plavix 8:17; 12:4; 41:6 please 4:12 plenty 63:25 plus 42:21; 43:18; 65:4 point 12:15; 36:5; 46:13; 48:13; 51:15; 52:16; 54:19; 63:15; 65:25; 66:7, 9 points 46:19 polyp 19:1, 17, 21, 23; 22:15; 69:16, 20 polypectomies 22:10 polypectomy 24:14; 40:18; 41:5, 15; 42:9; 49:7, 8, 23; 50:12; 51:7; 52:4; 53:19 polyps 8:18; 12:2, 5, 19; 14:22; 24:22; 25:5, 8, 10; 40:19; 69:21 poor 12:25; 22:22; 34:25, 25; 52:6; 65:2; 67:16, 22; 68:2, 3, 4 portion 22:18; 31:19 positive 14:11; 39:10 possibilities 14:19 possibility 53:24 possible 22:11, 12; 23:19; 29:12; 64:1, 2; 65:17 possibly 22:16 post 7:14, 20; 43:2; 44:9; 48:6 postoperative 7:6; 8:5, 8; 33:17; 35:24; 53:18, 24; 54:1	postoperatively 7:11; 13:15; 31:6; 34:3, 17; 41:7; 50:22; 54:18, 25; 63:3 potentially 19:11 power 16:25; 40:6; 68:24; 70:8, 14 practice 11:15; 67:4 practicing 66:22 preceding 21:10 predecessor 38:13 prep 39:12 prescribe 53:22 presence 54:7, 7 pressure 22:20; 30:6; 32:2; 45:18, 24; 46:1, 9, 11, 19, 23; 47:1, 10, 20 pressures 46:6 pretty 14:21; 36:3; 45:2 Prevacid 40:12; 43:24 previous 11:5; 50:5 previously 5:16 price 38:9 primarily 35:24; 48:21; 54:11 primary 7:11; 8:19, 20; 25:14; 26:5, 9; 28:10 prior 4:19; 11:6; 39:4; 44:22; 50:16; 56:3; 63:6 privileges 66:25 probability 71:7 probably 16:5; 28:18 problem 53:13 problems 12:7; 13:22; 14:6; 32:4; 35:2; 54:12; 65:3; 68:9 procedural 30:15; 44:24 Procedure 4:4; 8:13; 9:25; 10:6; 11:17; 16:8; 17:2, 8, 11, 20, 22; 18:8; 20:7, 14; 21:21; 23:7, 11, 24; 24:4, 6; 27:19; 28:14, 23; 29:18; 31:5; 43:9; 46:16, 18, 20, 22, 24; 47:3, 4, 7; 55:5, 9, 23; 56:10, 19; 57:12; 59:11, 21, 23; 60:12, 19; 63:5, 9, 12; 65:10; 67:16, 25; 70:2, 7 procedures 7:7, 9; 8:25; 9:6, 16, 20; 13:8; 24:15; 25:12, 23; 26:8, 22; 34:19; 44:4, 25; 45:24, 25; 53:22; 63:22; 65:23; 67:22 proceed 11:10; 40:10 professional 67:3 professionally 27:23 prognosis 34:23; 67:15, 17, 19, 21; 68:4 progress 38:23; 39:5, 6, 23; 40:14; 41:20 progresses 62:17 progression 56:24 proposed 53:15 provided 4:3; 38:17 providing 7:14	purpose 4:2 purposes 7:1 put 39:15; 51:17; 53:11; 55:16; 61:24; 62:2 putting 19:6	Q Q 40:13; 43:25 quick 71:23 quickly 18:5 quite 69:9	R R 4:1, 7; 48:17; 61:3; 67:13; 71:3; 72:14 range 46:12 rapid 18:2; 56:23; 57:3 rapidly 56:22 rare 17:13; 20:9, 11; 55:14 rarer 16:2 rate 15:23 re-hospitalization 57:5 read 20:15; 31:16, 20; 39:6, 23; 40:17; 42:20; 45:1, 2; 57:16; 72:12 reading 20:22 readmission 56:13 readmitted 34:1 real 71:23 really 58:20 reason 14:7; 29:16; 56:21 reasonable 71:6; 72:1 reassess 51:17 recall 10:18; 11:2, 19; 16:13, 16, 21, 24; 35:17; 36:8, 9, 16; 37:3; 48:25 receives 54:5 recent 12:7; 50:6 recheck 41:14 recognize 67:24 recognized 15:14; 16:7; 29:12; 63:8, 13, 17 recollection 53:12; 54:15 recommend 49:4; 52:2 recommendation 51:5, 15; 53:9 recommendations 8:15; 12:3; 13:9; 39:11; 40:5; 41:4; 44:25; 48:23 recommended 12:1, 21 record 4:12; 5:18; 9:8; 21:16; 31:20; 38:5; 39:7, 23; 40:17; 57:16, 17; 71:21 records 20:22, 23; 38:14, 15; 39:3; 57:8; 59:10, 16 recovery 47:4 recurrent 50:7	red 14:21; 51:13 refer 17:10; 68:17 reference 21:13 referring 7:9; 11:16; 37:4 regard 8:9; 48:24; 53:16; 68:11 regarding 4:24; 8:6; 23:10; 27:18; 32:7, 9; 35:18; 44:4; 47:24; 48:3; 60:10 regardless 52:12; 70:4 regards 24:15 rehab 13:20; 27:9; 29:3 rehabilitation 25:25 rehospitalization 36:22 related 8:21 relative 60:10 relay 65:7 relayed 36:19; 49:16 rely 5:9 remainder 34:11 remained 53:21, 25; 54:14 removal 12:5, 18; 19:17; 25:10 remove 19:22, 23; 24:22, 25; 69:20, 21 removed 8:18; 12:2; 14:23; 19:21; 22:15; 25:6; 40:24 removing 19:1; 25:8 renal 35:8 rendering 13:14 repair 63:5 repeat 5:6; 43:20 repeatedly 14:11 rephrase 5:6; 8:1 report 8:12; 10:1, 9; 11:24; 13:6; 28:25; 39:4; 49:23; 57:23 reported 48:7 reporter 4:13; 5:18 represent 4:9; 48:20 request 7:9 requested 6:14; 8:14; 26:21, 24; 27:2; 31:19 require 65:12 residue 41:4; 44:15 response 11:20 responsibilities 8:9, 23 responsibility 7:19, 20; 8:5; 9:14 responsible 33:21; 41:21; 42:16 restart 43:18 result 35:9 resulting 17:12 results 9:25; 11:22; 13:6; 30:11; 53:8 resume 50:18 resumed 51:1 resuscitated 70:5 return 28:20, 21
---	--	---	--	---	--	---

returned 10:21; 29:5;
54:3; 70:13
review 20:24; 38:19;
54:16
reviewed 46:5; 59:10, 16
revoked 66:25
Richard 4:14
right 5:19; 7:15, 17; 9:1,
10; 15:12; 16:3, 20; 19:15;
21:9, 22; 22:24; 23:6;
28:20; 29:17; 31:5; 35:8;
39:20, 22; 48:1; 49:10;
50:13; 60:23; 62:7; 63:1,
14; 71:15
rising 62:16
risk 12:10; 15:15; 16:6, 7;
24:7, 11; 25:9; 41:8; 49:9,
12; 50:7, 21, 24; 59:19, 20;
65:3
risks 17:2; 24:10; 49:12,
13, 24; 50:4, 14; 52:23;
56:8; 60:11
role 27:13; 35:23
room 14:3; 21:5, 24; 47:4;
57:16, 17, 18, 22
rotate 34:10
rounds 35:22
routine 54:4
row 34:8
rude 15:10
rule 14:8
Rules 4:3
running 30:1
rupture 19:10

S

sake 21:14
saline 43:6
salt 41:4; 44:15
same 5:22; 10:2, 8; 17:18;
18:12; 27:4; 28:17; 30:10,
13; 32:4; 67:25; 70:17
sat 37:13; 69:1
Saturday 37:11, 16
saw 14:3; 23:1; 26:20;
34:7, 10, 14, 17, 20, 24;
35:1, 5; 37:14; 59:11
saying 15:10; 21:23;
24:5; 55:8; 57:5, 11
Scattered 40:23
scenario 31:14
Scheatzle 25:24
scheduled 43:4
Schirack 34:10; 36:17
school 66:10, 12
Sciences 66:16
scope 14:25; 19:2, 2;
23:17, 18, 20; 29:16; 52:13
scoped 14:20; 15:4
screw 37:19
search 69:12
seated 4:18

second 6:19
sedative 65:15
seeing 13:15; 27:12
seemed 27:7; 66:7; 67:25
Seese 33:2, 4
Semi-conscious 34:22
send 9:19, 24; 10:1;
28:25
sense 24:16; 63:7
Sensorcaine 43:16
sent 10:4, 5, 12
sentence 31:16; 50:5
sepsis 18:4
septic 29:22; 30:5, 6;
35:6, 9; 56:24; 63:6
sequence 18:12
serial 39:13; 40:13;
41:11, 11
serious 65:11
several 14:19; 46:19;
69:10
severe 14:21; 17:25;
22:13; 29:22, 23; 32:1;
35:3; 46:7; 50:6; 57:18, 20;
58:18, 21, 23; 62:12
Shaffer 16:15, 25; 17:4,
6; 40:7; 53:7, 14
Shandt 32:12, 14
sharp 23:15, 20
Shay 34:4
shock 18:4; 29:22; 30:5,
6; 35:6, 9; 56:24; 63:6
short 45:14
shortly 37:24; 56:4
shortness 30:2
showed 37:11, 12, 17
side 12:20; 16:4; 22:14
sidelines 36:4
sigmoid 15:20, 23; 16:6,
7; 18:15; 23:5, 13, 23;
41:1, 14; 52:1
sign 50:2
signature 39:17, 18;
41:17, 18
significance 45:19; 69:8
significant 67:23
signs 29:8, 12, 12, 19, 22,
23; 30:8, 10, 14, 21; 31:7;
41:12; 51:13; 53:20;
54:17, 21, 22; 55:23; 56:4;
57:13; 61:5; 64:6
site 11:8; 69:12
sites 41:5, 15; 52:4
situation 12:22; 13:4;
17:15; 47:25; 49:25;
57:22; 63:10; 64:11; 67:25
six 51:18; 52:8
size 40:23
Slanger 72:11
sleepy 65:14
slow 45:9
slowly 44:12
small 12:16; 40:1, 22;

51:4; 52:24, 25; 64:7
smallest 23:18
snare 19:22
Soap 43:19
soft 12:14; 23:18
Somebody 38:8
somehow 5:4
Someone 7:13, 13
sometime 21:6, 10
sometimes 15:10; 28:20
somewhat 24:3
soon 64:1, 2
sorry 49:8; 51:9
sort 17:18; 53:10
sounded 57:21
sounds 30:1; 58:7
source 14:13, 17
spasm 23:22
speak 44:3
speaking 6:20
specialist 49:20
Specialties 27:5
specific 42:15
specifically 70:11
specifics 60:15
spelling 4:13
spent 37:15
spontaneous 30:14;
31:2; 56:20
stable 54:3, 14; 66:7
staff 13:22; 53:23
standard 11:15; 33:6, 10,
13, 16; 71:5, 25
standpoint 27:9
Stark 27:5
start 11:7; 29:18; 39:11;
43:5; 45:11; 63:23
started 57:18, 21
state 4:12
states 41:15
station 70:14
statistics 60:10, 15
status 22:24; 65:8
stave 63:23
stenotic 50:6
step 12:17
stick 19:12, 13; 26:5
still 6:5; 37:22; 65:14;
68:2
stomach 11:9; 40:3
stool 17:24; 58:6
stools 14:10; 39:10; 69:5
stop 11:9; 12:13; 14:16;
41:6, 10; 51:15
straight 23:16
stretch 19:9
stricture 12:20; 23:23;
41:14; 52:1
stricturing 40:25
strike 15:13; 55:21
stroke 12:7; 13:3; 35:2;

49:13; 50:7, 24; 51:12
strong 65:25
stronger 51:19
studies 56:7
subjective 58:19
subsequent 32:9, 15;
45:18
subsequently 25:13
subtract 5:15
sudden 50:8
suds 43:19
suffer 50:24; 55:10
suffered 20:20, 25; 22:2;
35:6; 51:11; 58:16; 63:4
suffers 54:24; 63:11
suggests 54:16
superficial 19:24
supposed 37:10
suppository 43:22
sure 6:18; 10:20; 11:3, 4;
16:3; 35:13; 42:18; 54:13;
55:16
surgeon 35:25; 64:1;
65:12, 15, 16
surgery 34:6; 35:4;
41:16; 50:19; 52:7, 12, 20,
24; 53:6, 13; 54:9, 10;
64:20, 23; 65:12, 22; 70:4
surgical 9:19; 48:6; 56:9,
25; 65:2
surgically 64:4
surrounding 28:1
survival 13:2
survive 64:22
surviving 52:23; 65:21
suspected 54:11
sustained 55:22; 56:2,
12
sworn 4:4
symptoms 17:19; 29:8,
13, 19; 30:8, 10, 14, 21;
31:7; 54:17; 55:24; 56:4;
57:13; 61:5; 64:6
Systolic 46:22; 47:1

T

t.i.d 42:22; 43:18
tachypneic 51:11
talk 5:12; 11:1, 12, 16;
14:4; 20:4; 50:5; 70:15
talked 14:5; 48:23; 54:6;
68:7, 19, 22; 69:2
talking 10:23; 24:10;
52:9; 58:4; 63:16
talks 56:8
teaching 67:5
technically 24:3, 6;
25:25; 27:2
telephone 10:14, 16;
17:5; 70:18
ten 8:18; 12:2, 18; 14:22;
24:14, 23; 25:6, 7; 40:18,

19; 42:10, 25
terms 53:18
test 14:25; 28:17
testified 20:9; 44:21; 61:6
testifying 5:23
testimony 49:1
tests 53:22; 66:2
theoretically 62:19
therapeutic 69:14
therapeutically 14:15
thereafter 8:22; 37:24
Thereupon 31:19; 71:20
thickness 20:2
thin 22:18
thinnest 16:4
Third 41:3
though 11:23
thought 65:19; 71:11, 14
thousand 55:18
threatening 41:9; 62:13
three 34:8; 35:20; 37:11,
13, 17; 41:13; 51:24;
57:20; 69:6
throughout 40:23
Thursday 13:17; 39:14;
43:4, 24; 44:2
times 7:10; 15:24; 24:14;
33:7; 35:22; 40:18, 19;
42:10; 43:20, 22; 69:6
tip 19:2
tissue 19:9
today 42:23, 25; 43:21,
23, 25; 57:21
today's 36:23; 37:1
together 27:24
told 10:19; 11:19; 12:1, 3;
13:21; 20:21; 23:4; 36:17;
52:11; 53:8, 12; 70:21
tolerate 58:10, 14; 69:16
tolerated 44:16
tolerating 44:17, 19
Tom 4:9; 72:8
tomorrow 40:11
took 26:2
tortuous 23:12, 14, 15
touched 68:6
tract 18:12
transcribed 10:3, 9
treat 64:10, 17
treated 18:6; 64:3, 8
treating 46:15, 17, 25;
64:25
treatment 7:14; 13:15;
33:8, 25; 47:2; 71:25
trick 21:20
truck 37:16
try 14:15; 19:22; 53:20;
60:5; 69:12, 21
trying 14:8; 21:20; 47:23;
60:6, 9
turn 27:11
turns 23:21

twice 57:17, 19
two 7:7, 8; 12:4; 20:14;
26:19; 34:5, 6, 7; 35:20;
41:5, 7, 13; 42:22; 44:13;
45:8; 49:6; 52:3; 55:10;
57:11, 20; 67:22; 68:1, 20;
69:16
type 17:15; 28:14; 48:6;
57:22; 63:4; 65:21
typed 45:3, 4; 72:8
typical 45:13; 51:5
typically 12:3; 17:21, 23;
18:1, 12; 28:12; 49:3

U

ulcer 11:8; 40:9
under 5:22; 20:19
undergo 12:16; 51:4;
66:1; 69:15
undergone 51:7
understood 5:9; 24:19;
26:2; 68:25; 70:17
underway 17:20
unit 13:20; 26:1; 27:9;
29:3; 34:9; 36:1; 54:2
University 66:15
unknown 39:10
Unless 58:3; 66:5
up 12:8; 13:1; 21:23; 29:5;
30:18; 36:23; 37:1, 11, 12,
17, 19; 45:11, 16; 52:15,
17; 54:18; 57:4
upon 5:9; 45:22; 54:15;
59:6; 61:6; 64:5; 65:20
Upper 9:9; 40:9
upward 62:22
use 19:21; 26:5
used 23:17
usually 18:4, 5; 45:15;
47:16, 19

V

vascular 22:23, 24; 49:22
ventilator 36:2; 70:6
verbally 16:19, 22
Versed 43:15; 44:12
versus 18:21; 58:18;
60:11
vessel 69:22
vicinity 22:20
view 12:24; 52:1, 5
vomiting 29:21; 32:2;
54:8; 58:13

W

wait 52:7
wall 20:2; 22:18
warrant 66:6
watch 66:8

watched 50:1
way 6:23; 19:16; 30:20;
48:22; 55:2; 62:21; 67:1
weak 46:8
weakened 19:4, 7
weakening 22:9
Wednesday 39:13;
42:24; 43:1, 3, 7
week 20:14; 21:22; 22:25;
37:14
weeks 12:4; 41:5, 7; 49:6;
51:12, 18; 52:8
weight 13:10
welcome 68:16

What's 31:13; 56:17
Whenever 18:11
whisper 71:10
white 61:7, 12, 15, 18, 21;
62:9, 16, 19
wife 26:2
William 4:10; 6:7, 12, 15,
25; 8:2, 6, 10; 13:14;
16:13, 19; 17:3; 20:19;
27:14; 33:8; 34:13; 35:18,
19; 36:6, 24; 37:4; 39:3;
44:22; 71:25
wishes 53:16
within 18:1, 5; 20:13;
21:4, 10, 11; 27:4; 55:5,
12; 56:13, 14, 25; 62:1
WITNESS 7:25; 10:24;
37:23; 38:4; 71:13
words 50:21; 62:3
work 28:9
worked 27:24
working 62:21
workup 51:20
worse 35:3, 5
worsening 63:23
worst 69:25
write 29:4
written 11:24; 40:14;
41:20
wrote 38:22; 39:5; 42:14,
21

X

x-ray 12:16, 22; 41:13;
51:4; 52:3; 69:15
x-rays 53:10; 66:2; 69:11

Y

year 37:9
years 27:25