The State of Ohio,
County of Montgomery.
IN THE COURT OF COMMON PLEAS
Sam L. O'Neal, etc.,)
Plaintiff,)Case No.
-vs-)2003-CV-9286
Kettering Medical Center,)
Foundation, etc., et al.,)
Defendants.)
- - - o0o - - -

Videoteleconference deposition of DAVID FALLANG, M.D., a Defendant herein, called by the Plaintiff as if upon cross-examination under the statute, and taken before Luanne Stone, a Notary Public within and for the State of Ohio, pursuant to the agreement of counsel, and pursuant to the further stipulations of counsel herein contained, on Friday, the 27th day of August, 2004 at 2:38 o'clock P.M., at the offices of Tackla & Associates, Ohio Savings Plaza, the City of Cleveland, the County of Cuyahoga and the State of Ohio.

APPEARANCES:

On behalf of the Plaintiff:
Becker & Mishkind Co., LPA, by:
David Kulwicki, Esq.

On behalf of the Defendant,
David Fallang, M.D.:
Adkinson & Associates, by:
Camille Harlan, Esq.

On behalf of the Defendant,
Kettering Medical Center Foundation:
Robert Cowdrey, Esq.

INDEX OF OBJECTIONS

PROCEEDINGS

MR. KULWICKI: Go ahead and swear the witness in, please.

David Fallang, M.D., being of lawful age, having been first duly sworn according to law, deposes and says as follow:

CROSS-EXAMINATION OF DAVID FALLANG, M.D.

BY MR. KULWICKI:

Q Dr. Fallang, my name is attorney Dave Kulwicki. I represent the estate of Mable O'Neal in a lawsuit that's been filed against yourself and Kettering Medical Center.

I'm here today to ask you some questions with respect to your involvement with Mrs. O'Neal, and I'm going to start by having you introduce yourself by stating your full name and spelling your last name, and, if you would, give us your current home address.

A My name is David James Fallang, F-A-L-L-A-N-G, and I live at 4312 Rosedale Road in Middletown, Ohio.

Q Thank you, Doctor. I'm going to begin by asking some background information

about you, and then we'll turn to the facts of this case. If at any time during my questioning, you do not understand a question that I ask you, please stop me, and tell me that you don't understand my question. I will restate it to your satisfaction at that point in time. Okay?
A Okay.
Q And likewise, Doctor, if you -- if -- if you need to take a break at any point in time, we certainly can accommodate that. The final rule is that, if you would, as you've been doing so far, answer verbally as opposed to an uh-huh or an uh-uh or a nod of the head, so that our court reporter on this end can take down your testimony accurately. Fair enough?
A Yes, sir.
Q Thank you. Doctor, do you have any plans to move from the address that you're currently at in the next six months?
A No.
Q And, Doctor, tell me, if you would, the name of your current practice group.
A The Surgical Weight Loss Center.

Q Is that a d.b.a., or is that an incorporated business?
A That is a d.b.a. The incorporated name is Middletown Surgical Associates, Inc.
Q Are you the only principal in Middletown -- I'm sorry, Middletown Surgical Associates, Inc.?
A Yes.
Q Have you at any time had any other physicians practicing under The Surgical Weight Loss Center name or the Middletown Surgical Associates name?
A Yes.
Q Who else has practiced under that?
A Some years back, a physician named Allison Clarey; a little more recently, a physician named Derek Martin.
Q When was the last time Derek Martin was employed by either of those two entities?
A Oh, it was probably about a year and a half to two years ago.
Q Do you know where Dr. Martin is currently practicing?
A I believe at Miami Valley Hospital,

primarily.
Q And, Doctor, were you acting within the course and scope of your employment with Surgical Weight Loss Center when you were providing medical care and advice to Mable O'Neal in 2002 and 2003?
A Yes.
Q Doctor, can you tell me where you currently have staff privileges?
A Riverview Health Institute in Dayton, Ohio.
Q Is that affiliated with Kettering Medical Center?
A No, it's not.
Q And when did your privileges at Kettering Medical Center-Sycamore Hospital, when did that -- those lapse?
A I think they expired in May.
Q And you anticipated my next question which was to understand the nature of the termination of those privileges. You are suggesting that they simply expired?
A That's correct.
Q Was there a conversation at the time that you decided to let them expire between

yourself and administration at Kettering Medical Center that your privileges would not be renewed, and inviting you to allow them to expire, rather than having them revoked?
MS. HARLAN: Objection. You can answer.
THE WITNESS: No.
BY MR. KULWICKI:
Q Why did you let those privileges expire?
A I didn't want them anymore.
Q Okay, and why did you decide that you didn't want privileges at Kettering Medical Center any longer?
A Oh, well, for one thing, they were always trying to get me to take emergency room call, and every -- every time my privileges came up for renewal, we had to go through a little bit -- a little battle about that, and I just didn't want to continue them.
Q Was there anything with respect to this particular litigation or the incidents underlying this litigation that influenced

your decision to allow those privileges to expire?
MS. HARLAN: Objection.
THE WITNESS: No. I never discussed it with any people from the hospital.
BY MR. KULWICKI:
Q Thank you, Doctor. Now, prior to having privileges at Riverview Health System and besides the privileges you had at Kettering Medical Center, have you had privileges at any other hospital, let's say in the last ten years?
A Yes. I had privileges at Middletown Regional Hospital and Grandview and Southview.
Q Where are Grandview and Southview located?
A In Dayton.
Q And can you tell me what the reason was for the privileges at Middletown Regional Hospital terminating?
A Yes. I was having difficulty obtaining malpractice insurance.
Q And how about with respect to

Grandview and Southview Hospitals?
A That was a few years ago, and I just, again, just didn't want to keep those privileges up.
Q All right. Doctor, have you been -- have your staff privileges at any hospital been the subject of any type of disciplinary proceeding?
A No.
MS. HARLAN: Objection.
BY MR. KULWICKI:
Q Has your medical license ever been suspended, revoked or called into question in any respect?
MS. HARLAN: Objection.
THE WITNESS: No.
BY MR. KULWICKI:
Q And, Doctor, has your Board certification by any specialty board been revoked, suspended, limited or called into question in any regard?
MS. HARLAN: Objection.
THE WITNESS: No.
BY MR. KULWICKI:
Q With respect to your Board

certification, are you board certified in surgery?
A I'm Board certified in surgery.
Q Any other Board certifications?
A No.
Q And besides your Board certification in surgery, do you have any other specialty training, any types of certificates?
A You know, I've taken a few courses in bariatrics, and, for example, doing laparoscopic gastric bypasses, very brief courses. I may have a certificate laying around somewhere, but -- but no -- no formal training as in, for example, a fellowship.
Q With respect to your training in bariatrics, do you -- can you -- can you tell me the name of your license or certification?
A Well, no. I mean, like I said, it was -- it was a course -- for example, I think about three years ago at the bariatric meeting in Washington, D.C., I took a course at that meeting, and it was a cadaver lab doing laparoscopic bypass training, so those are typically sponsored by the American

Society for Bariatric Surgery, but I don't know that they have a special name or institutional designation or anything.
Q Okay. Now, at Riverview Health System, will you be performing surgery?
A Yes.
Q And what -- what type of privileges will you have there?
A General surgery privileges.
Q Are you currently spending 50 percent or more of your professional time in the active clinical practice of medicine?
A Yes.
Q Now, Doctor, I want to turn to the facts of this case. Have you had a chance to review your chart with respect to Mrs. O'Neal prior to today's deposition?
A I glanced over some of the pages earlier today.
Q And have you had a chance to look at both your office chart and records from her subsequent treatment?
A Yes.
Q In addition, have you had a chance to review any of the depositions that have

been taken in this matter?
A Yes, I looked at several of those today also.
Q And as I recall, the depositions that have been taken to date involve all operating room personnel that were present on the date of her operation; is that -- is that your recollection as well from what you reviewed?
A I don't know whether it was -- whether it was all of them or not. I just -- I was given some to review, and I reviewed them.
Q All right. Now, in this particular surgery that you performed on Mrs. O'Neal, I understand that you used what we'll call, I guess, surgical towels during the course of the procedure; fair enough?
A That is fair enough.
Q Who provided the towels to you that you used during the -- the surgery?
A The hospital.
Q And what was the purpose for using those towels during this surgery?
A I usually used a towel in the left

upper quadrant for retraction.
Q And can you describe the type of towel that was used in -- in Mrs. O'Neal?
A Well, it was similar to a standard surgical draping towel, but it was different in the respect that the -- the hospital obtained those, as I understood it at least, specifically for me to use in that situation, because they -- they worked very nicely in these very obese patients to help me get good exposure, and the typical hospital draping towel is usually either green or blue. These towels were, I believe, a white or a light cream color with blue, or I think there were actually maroon stripes on them. So, they would be distinguished from a normal surgical draping towel.
Q Now, in -- in your experience, when these white or maroon striped towels became soaked in blood when you were using them for retraction purposes during this type of surgery, did they -- were they indistinguishable from the usual surgical towels, you know, the bluish ones?

A No. They were very distinguishable.
Q Okay, and why were these used instead of the blue towels?
A Well, in order to -- to allow them to be counted, because you have blue draping towels, and they don't count those, and, then, so you don't know how many you start with, how many you end up with or whatever. So, since these towels had a specialized purpose, they -- they brought in different colored towels so that they could be counted.
Q And did you have any discussion with hospital administration about the types of towels that you wanted them to purchase for this purpose?
MS. HARLAN: Objection.
THE WITNESS: I mean, I don't remember specifically, but I -- I sort of have a general recollection -- recollection of talking with the -- it wouldn't be hospital administration, but people who worked in the OR, and they said they could get suitable towels for the purpose that I

wanted.
Q Do you remember who you spoke with?
A No, I don't.
Q If -- if you don't remember the specific person, do you remember what their position would be? In other words, was it a nursing supervisor, or --
A Well, I mean, again, without a specific recollection of a conversation, I can say that it would most likely have been either with Linda Sich who's the OR supervisor or probably with Kyle, who was the -- I don't know her -- what her exact title was, but she was a somewhat lower level supervisor, but, I mean, it might have been that I talked to one of the other nurses, and they went up the chain and discussed it. I really -- you know, it's been three or four years ago.
Q Our sound just cut out. Three or four years ago, would you please restate that?
A Yes. I said it would have been three or four years ago, but I don't

remember specifically who I talked to. It might have been a lower level nurse who then went to her superiors to see if they could accommodate the -- getting the towels that I asked for.

Q Thank you. Doctor, is there any documentation that you're aware of that relates to this whole process that we're talking about, the process by which you requested towels and the hospital then obtained towels? In other words, was there a purchase order form, or a memo or a note or a handwritten memo, any -- anything that you could think of in writing that relates to this topic that we're talking about?

A Well, there isn't any that I know about, but, of course, that would not be typically something that I would know about. I mean, that would be an internal hospital issue in terms of whether or not they had policies which required documentation of special requests or whatever, so I don't know of any.

Q Now, we know now that this particular towel that was involved with

Mrs. O'Neal did not have any radiopaque tagging or -- or threading in it. Did you know at the time of her operation back in January of 2003 that these towels did not have any radiopaque tagging or threading in them?

A I don't think I knew that. I -- I -- I think that I would have assumed that they would have fulfilled all the requirements that such a towel would be expected to fulfill, which would include the radiopaque tagging. I don't have -- I don't specifically remember what I knew at that time three years ago, though.

Q Okay. Do you recall any discussions either before or -- or after this event wherein you discussed with employees, you know, administration or others, from Kettering Medical Center, discussed with them why -- well, first of all, discussing that you needed to have towels or requesting towels that had radiopaque tagging or threading?

A Well, my recollection, again, is somewhat vague, but the initial issue was

that, you know, I -- I told them I like to use towels in this capacity, that they -- they served the purpose that I needed for good closure, and there was -- you know, there was some discussion that, you know, we didn't want to use regular draping towels because they said that they thought they could get towels that would be satisfactory for that purpose. I don't think that there was a specific conversation about whether or not they would have a radiopaque -- radiopaque stripe. I -- again, I -- I presume that at the time I simply assumed that they would.

Q Have you, Doctor, since this incident, have you done any research with respect to surgical towels and, you know, what's available out there on the market?

A No, I haven't. I simply stopped using them.

Q Certainly from the -- your involvement in the Bowlin litigation, you were aware at the time of Mrs. O'Neal's surgery that it can be dangerous to use surgical towels for this particular surgery

that do not have any radiopaque tagging or threading in them, correct?

MS. HARLAN: Objection.

THE WITNESS: Well, I -- I guess I would put it somewhat differently. I mean, we put lots of things inside the abdominal cavity: sponges, laparotomy pads, and in this case, these towels, and anything that's put in that is incorrectly counted: needles, other kinds of devices, instruments, all kinds of things during the course of a whole variety of different operations that the surgeons perform, anything that you put in that is incorrectly counted is dangerous.

The radiopaque striping would have a benefit only at some later time to detect this, but if an -- if an item is retained because of an incorrect count, the radiopaque striping doesn't help you unless somebody somewhere along the line would take an X-ray.

Q Right.

A So, in many situations, it really wouldn't be -- be very helpful.

Q But certainly you understood in January of 2003 that, in the event a -- a piece of, or a towel had been left behind that did not have radiopaque striping, that it made it more difficult for subsequent detection, and that that can pose a hazard to a patient who has retained one of these towels.

MS. HARLAN: Objection.

THE WITNESS: I think there is some additional degree of risk, yes.

BY MR. KULWICKI:

Q Okay.

A That's why we specified getting towels that were only to be used for this purpose.

Q And -- and you said "we." Are you talking about you or -- or are there -- were there other physicians involved in this discussion?

A No. I just -- I just meant myself and -- and the people that I talked to about it.

Q So, your belief would have been, since you were asking them to obtain a towel

that was going to be part of the surgical count --

A Correct.

Q -- and that was going to be used intraabdominally, that you -- you made the assumption that they would obtain a product that was made for that purpose.

A Well, or at least was consistent with current standards for that use, yes.

Q Can -- can we agree that a towel that did not have radiopaque tagging or threading in it was not consistent with the standards for -- applicable to towels that were being used as you were using this towel?

MS. HARLAN: Objection.

THE WITNESS: I think that's -- that's a fair statement, yes.

BY MR. KULWICKI:

Q And with respect to those standards, are you referring to the American Association of Operating Room Nurses standards?

A Yes.

Q Are there any other standards that

you're aware of that specify or discuss the use of radiopaque striping or tagging in towels or sponges or anything else that are going to be used intraabdominally?

A Not that I'm aware of.

Q Doctor, have you used, to your knowledge, towels that had radiopaque tagging or striping or threading in them for purposes of retraction in a bariatric surgery?

A I -- I don't -- I don't recall for sure what they were using in Sycamore. When this occurrence came to pass with Mrs. O'Neal, I just quit using them altogether, and I can't recall whether the hospital on its own began using towels with radiopaque striping prior to that incident coming to light or not. I'm sure somebody in the hospital would know that.

Q Based on your -- your understanding, is there any advantage to using surgical towels that have radiopaque striping, tagging or threading in them versus towels that do not have that?

A Well, not from a surgical point of

view, no.

Q All right. Now --

A The striping, there's typically very tiny threads, and you wouldn't be able to know whether they were in there or not anyway.

Q In performing this surgery without any towel, have you found that it is more dangerous to the patient in any regard?

A Well, the exposure's not as good. I wouldn't go quite so far as to say it's more dangerous, but, you know, everything surgeons do has a degree of risk. The easier that you can make the procedure, the safer it is. So, you know, you can draw your own conclusion from that.

Q Okay. Now, you'll recall from your review of the -- the depositions of the nurses, and I think there was a surgical tech, that there was a discussion about the use of these towels being a change in their -- their usual policy. Do you remember that discussion in the depositions?

A I remember reading about it.

Q Okay. Did you have an understanding that the use of these towels was going to be a change in the normal policy?
A Well, I really didn't know that much about what the policy was. I mean, I knew that they were not using towels like this at that time, and I asked them if -- you know, if we could, and they said they would look into it, and they came up with these towels, but I really -- you know, I don't read those OR policies. That's not my job. That's theirs.
Q Okay. Now, Doctor, with respect to this surgery, you know, backing out the -- the towel issue, can we agree that it was a successful surgery?
A Yes.
Q There were no intraoperative complications, true?
A That is true.
Q And at least for -- until Mrs. O'Neal started having symptoms of this towel, there were no -- there were no postoperative complications for several weeks, correct?

A That is correct.
Q Now, Doctor, with respect to getting informed consent from patients that undergo bariatric surgery, what -- first of all, how do you go about doing that? Do you -- do you just give it to them yourself in person, or do you show them, you know, a film strip that -- that discusses the risks and benefits, or do you provide them something in writing, or all of the three, or something else, if you could just share that with us?
A Well, I -- I do an informational session that usually lasts about four or five hours in length. I go through the -- the history of -- of bariatric surgery, some of the issues involving causation of morbid obesity, procedures that used to be done and have been abandoned, why we're doing what we're doing now. I have a fairly in-depth discussion about the -- the actual performance of the procedure and how we do it, and then I have a pretty detailed discussion about the -- the most common kinds of complications, and that's done in a

group setting with, oh, anywhere from five or ten to sometimes 15 or 20 prospective patients.
Following that, the patients come back to the office later. They meet with my PA where he does another similar kind of a small group session for the patients who are probably a week or so pre-op, answering questions, explaining issues and so forth, and then I meet with the patients individually myself.
I make a special point of discussing the risks and complications and asking them if they have any questions, and -- and if they want to talk about, you know, any other aspects of the procedure, of course, also.
Q Do you provide the prospective patient with anything in writing with respect to the risks of this procedure, either --
A Well, of course, they have to sign a written consent for surgery which includes some mention of risks. I don't remember off the top of my head exactly how those are -- are listed, and we also have some written

information we provide to patients. It's not -- that information is not oriented so much towards surgical risk as much as it is post-operative issues and what patients might run into and -- and need to look for, and what it is they might, you know, want to call us about, and things like that.
Q Now, it's also my understanding that you typically will show a slide show or something during the course of this informational session; is that correct?
A That is correct.
Q And would one of the slides in there list the risks of the procedure?
A I have several slides on the risks, yes.
Q Do you -- do you still have that slide show?
A Yes. It's in my computer.
Q And is there a way that you could print out those portions of it that reference risks?
A Yes.
Q And -- and I think you were trying to explain this, and I -- I didn't quite get

my arms around it. Would the risks that are laid out in your slide show presentation, would those be pretty much the risks of the surgery that you discuss with the patient, or would there be risks in addition to what's set forth in the slide show that you discuss with the patient?

A Well, on our -- on our one-on-one meeting with the patient, other issues may come up that might not have been included in the slide show. The slide show typically has the -- the risks that we most often encounter and discuss, such as leaks and pulmonary emboli, pneumonia, bleeding, infection, issues like that. I mean, obviously, as I'm sure you're aware of, there's no way to include every conceivable risk, but it has -- it has the most common ones associated with this specific kind of surgery. Some of them are generic to all kinds of abdominal surgery like adhesions and bowel obstructions, and some of them are more specifically related to gastric bypass surgery, for example, stomal stenosis.

Q Okay, now, with regard to this

one-on-one meeting that you have with the patient, do you -- first of all, do you specifically recall the one-on-one conversation that you had with Mable O'Neal?

A No, I don't -- I don't think that I do.

Q Do you recall her generally as a patient? In other words, do you have a picture in your mind's eye of what she looks like and who she was?

A Yes, yes, I certainly do. In fact, her patient was a daughter -- or her daughter was a patient of mine as well.

Q That's correct.

A So, I knew the family from that experience also.

Q And to clarify, do you have any specific recollection sitting here today of any risks that you spoke with her about during this one-on-one meeting that were in addition to the risks that were discussed as part of the, you know, the routine informational session with you and your PA?

A No, I don't have any specific recollection.

Q Now, one of the risks of the procedure I think you mentioned is pulmonary emboli.

A Correct.

Q And is that something that's mentioned in the slide show presentation?

A Well, the slide show actually refers to DVT, which is deep venous thrombosis, but in the course of my presentation, I use that to further talk about pulmonary emboli, because the -- the deep venous thrombosis in and of itself is not particularly life-threatening. It's only when a clot breaks free and becomes a pulmonary embolus. So, I always talk about pulmonary emboli --

Q You died down. I think -- I think part of the problem is we lose you every once in a while, and it sounds like it might be somebody shuffling paper nearby the -- the conference or the -- what the hell do you call these things? Nearby this thing.

THE VIDEOGRAPHER: Microphone.

Q The microphone, good work.

A We will -- we will try to minimize that; won't we?

MS. HARLAN: □We certainly will.

BY MR. KULWICKI:

Q I appreciate that, and, Doctor, if you could, maybe we should have the court reporter read back to you where she left off so that you can make sure you've completed this response.

(At this time the answer was read back.)

BY MR. KULWICKI:

Q Do you remember the rest of your response?

A Yes, I said I always talk about pulmonary emboli, even though the slide itself only refers to deep venous thrombosis.

Q Okay, thank you. And, Doctor, with respect to the risk of pulmonary emboli following a bariatric surgery, can you quantitate that? In other words, can you give me a percentage of patients that will suffer that complication?

A Well, the -- I believe my slide has

a -- a figure that I gleaned from the literature about that. I don't remember off the top of my head exactly what it is. It's something like, you know, a half a percent or something like that. I know that in my practice, I've done about 2500 gastric bypasses, and I've only had two documented pulmonary -- pulmonary emboli, and neither one of those was -- was fatal, fortunately. So, my personal experience, I guess you would say, is -- is much better than what -- what is in the literature, but there is a -- there is a number on the slide that I got -- I got out of an article somewhere.

Q Okay, and, Doctor, with respect to the risk of -- of pulmonary embolism, is that increased because the patients that you do the surgery on are -- are obese, and because abdominal surgery's involved, and because the patient is somewhat immobilized following the surgery? Are those the three risk factors that increase the risk of PE in bariatric patients?

A Well, I would agree with the first two risk factors that you mentioned. In my

own practice, I -- I don't know that I would -- that I would include that last risk factor. We routinely do these operations in about one hour. We don't use Foley catheters. We use sequential compressive devices on the legs to create some increased blood flow and -- and turbulence. We use local anesthesia in the abdominal wall at the end of the procedure to enhance the patient's postoperative comfort, and -- and very typically have the patients up and walking within an hour or two of -- of surgery. So, you know, and I -- and frankly, I -- I believe that this aggressive response at limiting the patient's inactivity may account for why we've had an extremely low rate of pulmonary emboli in my own practice. The first two are correct.

Q Okay, thank you. Incidentally, going back to Mrs. O'Neal's surgery, did you encounter any unusual anatomy during the course of her procedure?

A I really do not have a specific recollection of her operation.

Q You talk about --

A From the notes and so forth, it was a pretty routine case.

Q Okay, and you mentioned that routinely, the procedure takes about an hour. Do you remember hers taking roughly about the same amount of time?

A Again, I don't remember for sure. That would be on the operative record someplace.

Q Now, with respect to the risk of PE following bariatric surgery, is -- is there a period of time when the risk is highest?

A Well, I would say it's -- it's in the first several hours, or not -- I'm sorry, the first several days after surgery, yes.

Q Okay.

A It's been well documented that the deep venous thrombi that could eventually result in a pulmonary embolus are most likely to form on the operating table. That's been studied with radioactive fibrinogen, and, so, that's where these blood clots really start, which is one of the reasons why I think it's so beneficial

to the patients to have such a brief operation, but if the clot propagates, then, and -- and that means it grows, then, then, over the next several days, maybe out as far as a week or so, that would be really the period of risk. Anything that happened very much after that, I guess I would say I'd have to question whether it had any direct relationship to the surgery itself.

Q Thank you. Doctor, in this case, have you had a chance to review the autopsy and the death certificate?

A No, I have not.

Q All right. Postoperatively in these patients, is there something that you do via medications to prophylax against PE?

A Yes. We use a standard regimen of fractionated heparin.

Q And how long do you -- and let's just talk about Mrs. O'Neal. If you need to refer to your records, please do. How -- how long did you have her on fractionated heparin?

A Well, I -- it would be my routine to start this preoperatively, usually an hour

or so preoperatively when they're in the preoperative holding room, and then I usually continue this until the patients leave the hospital, so that would be -- I don't know how long she was in the first time. It's usually 20 -- it's usually 48 to 72 hours.

Q And, then, Doctor, with respect to after that point in time, do you give them a prescription typically, or did you give Mrs. O'Neal a prescription for any type of anticoagulant or any other type of medication for --

A No, the heparin is a subcutaneous shot. There are some surgeons -- I've talked to surgeons who use Coumadin which is an oral anticoagulant. In my opinion, Coumadin is -- Coumadin use in this situation is really overly aggressive and -- and not appropriate. Certainly, it would have been in Mrs. O'Neal's case, but -- but just as a routine I -- I would not advocate the use of Coumadin, nor is it standard.

Q Okay.

A There are a few surgeons who use

it.

Q Now, in -- in addition to medical therapy to protect against pulmonary embolism, do you -- as a treating surgeon, do you have sort of in the back of your mind as you talk to the patient that this is a potential risk, and ask questions pertinent to it? In other words, do you ask the patient: Have you had any foot swelling, leg swelling, lower leg pain, et cetera, to -- to find out whether or not they're experiencing anything consistent with a DVT, or likewise ask them about, you know, shortness of breath, or pain in the chest, or any of those other things that might be consistent with pulmonary embolus?

A Well, we certainly take a medical history, and we know what medications they're on. If they have a history of previous DVT or pulmonary embolus, we would hope to elicit that, assuming that, when we ask the question, the patients gave us the right answer. Sometimes people don't remember to tell us, but as far as the things like shortness of breath, most of our

patients have shortness of breath, sometimes severe. It's usually chronic. The same thing applies to distal swelling. It's one of the problems that people suffer from when they're morbidly obese, so those particular findings quite honestly wouldn't be of very much value to us, even though we -- you know, we do a physical exam. We check for swelling, and we ask about those things. Much more helpful to us would be any history of previous DVTs or PEs.

Q I believe Mrs. O'Neal indicated that she had shortness of breath prior to the surgery, but did she have anything that would, in your mind, raise the possibility that she was -- she had a prior history of DVT or PE or even questionably?

A Not that I recall. As I said, I -- I would guess off the cuff that probably at least 90 percent of our patients have shortness of breath. It's part of the problem.

Q Right, and you answered a question, but I'm not sure it was my question. Let me -- let me restate it, and see if maybe I

can get there. After the surgery, in the course of your follow-up visits, and I know you have several that are -- that are planned where you follow up with the patient and ask how they're doing; in the course of those visits, is one of the things in the back of your mind postoperatively that -- to -- to ask the patient about their current -- current condition with an eye towards seeing if they do have any signs or symptoms of DVT or PE?

A Our first postoperative visit is at two weeks post-op, and to be honest, by that time, my concern about pulmonary emboli in these patients is actually quite low.

Q Okay. Thank you. Now, with respect to Mrs. O'Neal's care, did you have an opportunity to review the treatment that she received back home in Mansfield by her primary care doctor and by the physicians at Med Central Health System?

A No, I did not.

Q At the two-week visit, what was your feelings about Mrs. O'Neal's recovery?

A I was -- again, I don't have a

specific recollection, but my -- from reviewing the notes and so forth, she seemed to be doing pretty well; even better at the six-week visit.

Q Thank you.

A The one -- the one thing I noticed at the -- at the two week was that her weight loss was a little low, but by six weeks she was back within what we would normally expect to see which was 28 pounds of weight loss at six weeks.

MR. KULWICKI: There was some noise immediately before you answered that question, and I just want to ask if either counsel interposed an objection.

MS. HARLAN: No.

BY MR. KULWICKI:

Q Okay, thank you. Now, Doctor, although you haven't had a chance to review the autopsy, you were involved in Mrs. O'Neal's care during her last hospital admission, correct?

A That's correct.

Q And let me read to you the --

MR. COWDREY: David -- David,

this is Bob Cowdrey. I've got the chart with me if you want me to show it to the doctor, what you're referring to.

MR. KULWICKI: Sure, that'd be fine. What I'm looking at is the -- the two-page summary from the postmortem exam, and it's the first two pages that has the coroner's opinion, so that would be page two signed by Dr. Casto and Dr. Lehman.

THE WITNESS: You don't mind if I skim over the first page; do you?

MR. KULWICKI: I do not.

THE WITNESS: Okay, I've looked at both of those pages. You want me to look at page two?

BY MR. KULWICKI:

Q Yes, please, and under the opinion there, it says, "It is our opinion that the cause of Mable O'Neal is pulmonary thromboembolism due to complications of a retained surgical sponge with recent GI bleeding contributing." Do you agree with that?

MS. HARLAN: Objection.

THE WITNESS: I don't think I

understand the question.

BY MR. KULWICKI:

Q Yeah. I'm just wondering if you agree with that opinion, that the cause of her death was PE related to the retained, and they say "sponge," but obviously it was a towel; retained towel with recent GI bleeding contributing.

MR. COWDREY: And I'll object.

MS. HARLAN: If you qualify --

THE WITNESS: I -- I don't think that I have a basis to agree or disagree with that. I mean, they're talking about the findings that they saw at autopsy, and I wasn't there.

BY MR. KULWICKI:

Q Well, okay, then, clinically, Doctor, would you agree that, based on your care and treatment of the patient at the end of her life, that, in your opinion, she died as a result of PE due to complications of the retained towel?

A I don't know that I would agree with that. If she died of a pulmonary embolus as this report suggests, that -- that raises a

question I had never considered before in terms of what was the actual cause of her death, because I guess I assumed it was sepsis. If that was a pulmonary embolus instead, then, the question arises whether that pulmonary embolus had any relationship at all to the retained item.

Q And let me ask you, since this is the only chance I get to talk with you before trial, and I need to understand your opinions, do you have an opinion to a reasonable degree of medical probability as to what was the cause of Mable O'Neal's death as we sit here today?

A Well, as we sit here today, with me seeing this autopsy report for the first time, I would say that the cause of her death appears to be a pulmonary embolism of the saddle type. That saddle type means that it's a large clot which folds over the bifurcation of the pulmonary artery, implying, first of all, it's a very large clot occluding both branches of the pulmonary artery, and making a reasonable presumption that that was the immediate

cause of her death.
The -- the issue, though, that that raises in my mind is: How long had that clot been there? She was five months post-op. It's pretty impossible to -- to -- in my opinion, to relate the origin of that clot to her surgery from January. I know that she had been ill and had bleeding and pneumonia and diverticulitis and things like that, so the question then would be, if she died as a result of this pulmonary embolus, then, was this -- was the clot that broke free and caused the pulmonary embolus something that preceded her most recent hospitalization and illness? It might have been there for several weeks. It's hard to say. I mean, it's impossible to say.
Q Okay. Let me -- let me parse through that.
A Okay.
Q First, with respect to the -- your opinions and -- and that's really what I'm more concerned about, and I'm less concerned about your interpretation of the autopsy, and more concerned about opinions that you

hold to a reasonable degree of probability, and opinions that you feel comfortable based on your training and background in -- in rendering.
A Correct.
Q And -- and what I want to ask you is, again, the same question, is: Do you have an opinion here, and -- and you certainly can say: I don't have an opinion, or I don't feel fully qualified to render an opinion. Do you have an opinion as to what was the direct and proximate cause of Mrs. O'Neal's death?
A Well, it appears that it was a pulmonary embolism.
Q Okay, and you're basing that exclusively on the autopsy report that you've just read during the course of this deposition?
A That's correct. This is a surprise to me.
Q Okay. Now, certainly, we can agree that abdominal surgery increases the risk of pulmonary embolism, true?
A That is true.

Q And we can agree that sepsis increases or can increase the risk of pulmonary embolism, true?
A I think -- I don't know that I would agree with that. That's a much more complicated answer because sepsis has so many metabolic effects. It could, in some situations, actually decrease it, depending on the circumstances. I'm not trying to be evasive. I just -- I just couldn't give a blanket agreement to that statement.
Q Fair enough, but you -- you acknowledge that, based on your medical training, that sepsis can create an inflammatory response within the body that leads to hypercoagulability which can increase the risk of pulmonary embolism?
A That's true. I'm just saying there are situations where it can go in the opposite direction as well.
Q Fair enough, and again those -- the study of that process, the hypercoagulability and -- and -- related to sepsis would be more within the expertise of a hematologist or of an infectious disease

doctor than a surgeon, true?
A I would agree with that, yes.
Q And likewise, we can agree that immobility, say, from sepsis or from inactivity due to weakness and -- and illness can increase the risk of pulmonary embolism, true?
A Yes.
Q Now, with regard to the testimony of the nurses and the surgical tech that were involved in Mrs. O'Neal's operative and -- and postoperative care, immediate postoperative care, they acknowledge or they state in their depositions that it was their responsibility to conduct a count at three different points during the course of that procedure, and would you agree with that?
A Yes, I would.
Q And -- and I believe, and I don't want to misquote; I believe that they further state that it is ultimately their responsibility to ensure that towels that are subject to the count and are placed in the patient are removed, and it's ultimately their responsibility. Would you agree with

that?
A Yes, I would.
Q What is your role with respect to removing towels that are used during the course of this procedure?
A Well, obviously, if there was an object, a towel, a sponge, an instrument or anything else that was known to me to be retained in the abdomen, I would -- I would certainly have a responsibility to -- to remove it.
Q Okay.
A But, of course, the -- you know, the nature of what we're doing and the process is such that no surgeon can keep track of all the things that are put in the abdomen, taken out, put in and taken out during the course of an operation, so that the procedures have been established for these counts, and surgeons, of course, rely on them.
Q Well --
A I guess -- I guess I don't -- I don't mean to be jumping ahead, but I don't believe that I have an independent

responsibility to go searching for things once I've been told that the count's correct. I think that would be -- that would be dangerous. It would be meddlesome, and it would be inappropriate. You could -- you could cause harm by searching all over the thing -- all over the abdominal cavity when you've already been informed that the counts are correct.
Q Well, ultimately, it's you that places the towel there, correct?
A It's me that places the towel there; that's correct.
Q And I think you said earlier that you just use one towel; is that true?
A There have been times in the past where I've used two. Sometimes I would use -- I -- I typically use one in the left upper quadrant. There have been times when I used a second one. I really pretty much quit using the second one several -- a few years ago. I don't remember exactly when. At this time it would have been my routine to only use one towel.
Q And you would be the one who removes

the towel too, right?
A That is correct.
Q Okay, and do you keep track of -- of sponges or towels in any way during the course of a procedure?
A No, unless there's one that's obviously there.
Q Okay.
A But, you know, I've been doing this for a very long time. I've seen many, many situations where laps, towels, sponges or whatever, were hidden from view, not easily palpated, and that's why we do the counts.
Q After you are done with the bypass procedure itself, is it your routine to conduct a thorough inspection of the peritoneum before closure?
A No. That's what I just said. I believe that that could be potentially dangerous. It's certainly meddlesome. It's unnecessary, and I don't think it's good care. Any fragile areas that can be damaged by poking your hands all over the place, you just have to be careful and not do more than you need to.

Q Okay. Now, Doctor, with regard to the Bowlin litigation, my understanding from your testimony in that case is that there was also a change in policy at Middletown hospital while you were there wherein they went from using the blue towels to white towels; is that true?
A That is my recollection, yes.
Q And do you know what the purpose was for that change? Is that so that they -- the white ones were counted, and the blue ones were not counted? Is that so they'd become part of the count?
A That's my understanding, yes.
Q Okay, and likewise, at Kettering Medical Center, your understanding was that the reason why they used white towels was so that they would be part of the -- the count?
A Correct.
Q Okay. Doctor, have you had any discussions with the administration at Kettering Medical Center with respect to this particular incident?
MS. HARLAN: Objection.

THE WITNESS: None other than immediately after this with the people in the operating room, but nobody at a higher administrative level.

BY MR. KULWICKI:

Q And whom did you speak with in the operating room about this?

A Well, I don't remember for sure. I -- I -- I think, you know, I have -- I recall, I believe, having a conversation with Linda Sich. You know, it wasn't so much in terms of the policy and procedures of the hospital as much as it was everyone's distress over the -- the misfortune that had befallen Mrs. O'Neal and her family.

I think I've talked to Mr. Kintz who I believe was the scrub nurse on this case, trying to figure out how we could have a correct count and, yet, have a retained towel.

Q And -- and let me ask you about those, but before I do, can you tell me were these conversations -- were these one-on-one conversations, one with Mr. Kintz and then one with Mrs. Sich?

A Well, I mean, these weren't formal appointments or anything. These were informal conversations within the -- the -- the confines of the operating room or the hallways immediately adjacent where we would run into each other, and, for example, I think I ran into Linda at one point, and she said: well, how's Mrs. O'Neal doing, and I said: well, not very well, and, you know, sort of, I don't know how you describe it; a mutual consolation. Everybody was pretty upset about this.

Q Tell me if, during that conversation with Linda Sich, whether she made any overture to you or made any assurance to you that the hospital would accept responsibility for this; that, in essence, it was their responsibility rather than yours.

MR. COWDREY: Object.

THE WITNESS: I don't remember talking -- I mean, we -- we may have discussed that. It would be wonderful for me to say: oh, yeah, I remember that conversation. I really don't.

BY MR. KULWICKI:

Q Okay.

A I don't remember us saying that, or her saying that; I'm sorry.

Q Now, with regard to Mr. Kintz, you indicated that you had a conversation about how could there have been a correct count, and then missed this towel. Do you remember what -- how that conversation went or what the subject matter of that conversation was?

A I mean, it's sketchy. The only -- you know, I mean, this is very difficult for us to comprehend. The only thing that -- that I recall him saying was that, and this is -- I'm trying to recall what he said to me, you know, some, a couple of years ago, but it seems like he said something like these towels came in packs of two, and he was speculating, of course, but I think he speculated in terms of whether or not these towels could have been somehow folded together so that they counted one towel whereas there were actually two. They could have given me the towels which I placed as

packing, and then when I removed the towel -- the towel is actually located in -- in a position where it's not easily viewable. It's not visible. So, if I saw -- if I pulled down and saw the corner of the towel, and pulled the towel out, gave them the towel, and that created a correct count, if they had miscounted at the beginning and counted one towel instead of two, that could have left a towel in its -- in its -- inside the abdomen. When I thought I took it out, they thought we had a correct count, but he thought that could have occurred if the two towels that came in the pack were incorrectly counted as one. Does that make sense to you?

Q It does.

A And that's speculation. We don't know what happened, really.

MR. COWDREY: And I'll object and move to strike since the doctor's indicated that it is speculative.

BY MR. KULWICKI:

Q But, again, it would be the -- the hospital personnel that are assisting you in

the operating room, it would be their responsibility to make sure that they were counting the towels before they gave them to you accurately in order that they can have an accurate count at the end of the procedure, correct?

A Well, obviously, if the count at the -- before the procedure begins is incorrect, then, the subsequent counts are not reliable.

Q And what I'm asking, Doctor, is more a question of responsibility. That would be the responsibility of the hospital personnel to make sure that the -- the equipment or, in this case, towels are counted properly before they hand them to you, correct?

A Yeah. I mean, that's not only correct, but all these counts are the hospital's responsibility. Don't forget that there are additional items added to the count during the procedure. So, while the surgeon is -- is physically performing an operation, if additional lap packs are opened, or needles added, or maybe an instrument is brought in that is needed

for -- brought in from the outside, those are all added to the -- to the written count by the hospital personnel.

The surgeon doesn't have any opportunity to -- to be involved in any of those, and the preoperative counts are done while I'm sitting out in the surgeon's lounge waiting for the case to begin. So, I mean, I'm not trying to dump on the hospital, but those are counts that I don't have any ability to interact with, and, therefore, I don't think I have any responsibility for them.

Q And, Doctor, with respect to -- to this whole issue, did anyone from the hospital admit to you or acknowledge to you that the hospital was responsible for what happened to Mrs. O'Neal?

MR. COWDREY: Object.

THE WITNESS: Well, I think that came up in the conversation with Matt.

BY MR. KULWICKI:

Q Tell me --

A But, I mean, he was -- he was stating the obvious. I mean, people who

work in operating rooms know that surgeons don't do counts. It would be impossible to imagine at the end of a case a surgeon stopping the operation, and getting down on his hands and knees and doing the count while the patient's laying there on the operating room table, not to mention what I've already said, which is that, if the original count weren't accurate, the other counts aren't reliable.

So, in order to hold the surgeon responsible, the surgeon would have to do all three counts himself or herself, and the surgeon would also have to keep track of all the additional items added to the count during the course of the procedure. I mean, it's just -- it's just impossible to imagine that happening.

Q And you took that away from the conversation with Mr. Kintz?

A Yes.

Q Okay. Now, Doctor, let's go back in time, and with respect to the Bowlin case, as I understand there were actually two towels that were left behind in that

particular patient.

A Yes. As I said for -- for a time, I -- I was using two.

Q And neither of them had any radiopaque tagging, striping or threading in them, correct?

A Well, that is correct.

Q And, then, as I understand it, you had one other incident where a sponge was left behind in a patient inadvertently and discovered later?

A Yes. That was approximately 20 years ago.

Q Any -- any other situations like this where some instrumentation or a sponge or other piece of equipment was left behind in a patient that -- that you were the attending surgeon for?

A There -- there is another situation that occurred at Middletown that we found out about several years after -- after it occurred that is currently in litigation.

Q Do you know the patient name in that case?

A Yes, I do.

Q Can you share that with us?
THE WITNESS: Can I share that with him? That's confidential information.
MS. HARLAN: It's a filed case.
THE WITNESS: Okay. Yeah, his name is Coleman, and I can't remember. I want to say his first name is Ronald, but I think that's a movie star, and I'm blocking on his name, so -- but his last name is Coleman.
BY MR. KULWICKI:
Q Is that filed in -- do you know if that's in Butler County or in Montgomery County?
A I think it's in Butler County. I'm pretty sure it is.
Q All right. Doctor, back at the time that you were doing Mrs. O'Neal's surgery, and throughout the course of your staff privileges at -- what's the name of the hospital? Kettering Medical Center, what percentage of your time was spent doing bariatric surgery?
A Most of it.
Q Ninety-five, 99 percent? Can you

give me a percentage?
A Probably -- probably 90 to 95.
Q Okay. Now, let's turn to the chronology of events as they transpired with Mrs. O'Neal. I have here that you had a visit with her in July of '02 which was to assess, you know, to discuss the surgery. This is a pre-op meeting, and on that same date she had a psychiatric evaluation. I want to ask you: Was -- was it your standard practice to have a psychiatric evaluation for your bariatric patients?
A No.
Q Why did you get one in her case?
A I don't remember specifically, but I can tell you that, generally speaking, the only reason we would get one is if the patient's insurance company required it. My opinion is that they're pretty much a waste of time.
Q Was there anything in her history that made it necessary for her to have a psych evaluation as opposed to it being done as a matter of routine by an insurance company that required it?

A Not that I recall again. As a general rule, some insurance companies require it; some don't. We -- we typically view this as an insurance company tactic to try to discourage people from having surgery for financial reasons, quite honestly.
Q Sure. And, then, I have that the surgery took place on January 3 of 2003 at Sycamore Hospital, and Mrs. O'Neal was discharged three days later on January 6th of 2003. Is that a typical period of stay following this type of procedure?
A It is for my patients.
Q And, then, Doctor, I have that you performed your two-week follow-up visit on January 20 of 2003, and that Mrs. O'Neal was recovering as -- as planned, and had no complaints; is that true?
A I think that's what my review of the records indicates.
Q Now, I've got a note here from January 29 of 2003 where Mrs. O'Neal contacted you complaining of left -- left-sided pain noted to be deep, and that radiated into the shoulder and back. First

of all, do you recall this particular phone call?
A No. I think my -- my PA talked to her and then discussed it with me later.
Q Okay. And, then, the next visit I have is or contact is February 3 of 2003 wherein you or your office called Mrs. O'Neal to follow up about her complaints of left-sided pain; is that correct?
A I believe that that was also Troy Miller, my PA, that did that follow-up call, yes.
Q And she noted that her left-sided pain was better, but it was aggravated by coughing, and you suggested that she should see her primary care doctor, a GI specialist, correct?
A I believe that is correct.
Q All right, and I think you tried to call her, or your office tried to call her on February 3, but that actual instruction was actually communicated on February 4, the following day of 2003, correct?
A Yeah. I mean, I don't have these

records in front of me, but I -- I looked at them, and that sounds about right.

MR. COWDREY: Doctor, I believe -- David, Bob Cowdrey again.

I believe Dr. Fallang's records are part of this big binder I have here. It should be probably the last thing.

MS. HARLAN: Yeah. Yeah.

THE WITNESS: Here we go.

BY MR. KULWICKI:

Q Okay.

A I'm with you.

Q Good, thank you. And, then, the next contact I have is February 21 of 2003, and -- and you note that she's doing very well at that time, correct?

A Yes.

Q And, then, the next contact would be March 6 of 2003, and it appears to me that you were notified at that time that Mrs. O'Neal was admitted to her local hospital up in -- up in Mansfield, correct?

A I believe that was May the 6th. I think you said March the 6th.

Q Yeah. I actually do have March the 6th. Oh, I'm sorry. That wasn't communicated to you. My apologies. I'm reading from a chronology I have here, and this is the whole case, not just your care. So, I apologize.

A Okay.

Q I do have, however, that on March 10 of 2003, that you were advised that she had a CT scan performed during this hospitalization in Mansfield. Do you -- do you have anything indicating that in your chart?

A No. I have a note that says 3/10/03, "patient called, returned call to hospital room. Patient evaluated for diverticulitis." Complains -- "Complaint of pain. Will request pain meds from attending physician." That's all we have on that.

Q Okay.

A It doesn't say anything about a CAT scan.

Q Thank you. Doctor, what's your next contact according to your notes with Mrs. O'Neal?

A It's April the 7th.

Q And it appears that she contacted you on that occasion complaining of left-sided abdominal pain, correct?

A That is correct. It says, "patient called regarding pain in left side consistent with previous diagnosis of diverticulitis. Patient explains pain is similar to pain she had with diverticulitis for which she was hospitalized. See 3/10/03 progress note."

Q Now, it goes on to say something, "pain is located in the left lower quadrant and is moderate to severe at times." Do you have that charted?

A Let me see. It says, "no blood in stool this time," though. "Pain is in left mid to lower quadrant, and moderate to severe at times." Yes, it does say that.

Q And, Doctor, is that -- is that where the -- the towel was ultimately located?

A The towel, I would say, was in the mid to upper --

Q Okay.

A -- left abdomen, so it's -- it's close.

Q And, then, when's the next contact that you had with Mrs. O'Neal?

A 5/2/03. This isn't with her. This is with Dr. Paul, who I presume to be her physician in Mansfield.

Q That's correct, and what do you have recorded for that visit?

A It says, "Dr. Paul called. Would like to talk to Dr. Fallang about patient. Would like to transfer patient to Sycamore tomorrow, Saturday, 5/3. Paged Dr. Fallang" with cell number.

Q And this is after they had detected the towel in the abdomen via CT, correct?

A I believe that is correct.

Q Do you think it was appropriate for Dr. Paul to ask you to take over the patient at this point in time?

A Probably.

Q Was there anything --

A I mean, I didn't see her in Mansfield, so it would be hard for me to answer that question, not knowing how she

looked up there.
Q Okay. Based --
A But I did see her when she arrived at Sycamore, and I mean, she was reasonably stable at that point.
Q Okay. So, based on the contacts you had with Dr. Paul, and based on her condition on arrival at Sycamore Hospital, you felt it was reasonable for him to transfer her back to your care at that point in time, true?
A I -- I think so, yes.
Q All right, and, then, you took her to surgery on May 3 of '03; is that correct?
MR. COWDREY: I think the records from the subsequent records are in that binder.
THE WITNESS: That is correct.
BY MR. KULWICKI:
Q Now --
A My recollection is she was transferred down on a Saturday, and I took her back to surgery that same day.
Q And it indicates in -- in the op

note that you both removed the towel, and you drained the left upper quadrant abscess. Can you give us some sign -- some idea about how big that abscess was?
A This was a -- this was a somewhat difficult situation because of her anemia at that time, and being a Jehovah's Witness, I knew that we would not be able to give her any blood. So, what I did at the time of that exploration is, as carefully as I -- as I was able to, get straight to the towel, and the abscess that I described describes the encapsulated towel space itself. In other words, the towel was -- was encapsulated in -- in five months' worth of scar tissue, had some cloudy fluid around it. I tried to gently slip the towel out, put a small drain or a -- a drain. I forget what -- I think I used a Jackson-Pratt; put some kind of a drain into that pocket where that towel was, and then closed. I did not do a full exploration which I felt at the time, and of course in retrospect would continue to feel, would be very dangerous in a patient unable to receive blood.

Q Could you get --
A The larger abscess cavity was only where the towel was enclosed.
Q Could you get a sense about the size of the capsule that was around the towel based on the limited exploration that you did?
A It was exactly the size of the folded towel. If we had a towel and folded it up, I guess I could take a ruler and estimate that. It was the same shape. In other words, it was rectangular. It was flat, just like a small, folded-up towel.
Q With respect to the abscess, was it your feeling or observation that the abscess extended beyond the capsule?
A It was my impression that it did not, but -- but again, I did not do a wider exploration.
Q Now, you mentioned her anemia, and did you have a sense or do you now have a sense about what was causing her anemia at the -- prior to this operation?
A Well, we were informed that she had had a diverticular bleeding in Mansfield,

and that we -- I think she had a confirmation of diverticulosis, and, of course, diverticular bleeding is intraluminal, so that the blood comes out the lower GI tract.
Q Right.
A Now, of course, that doesn't prove it's from -- from diverticular disease. You can have the same thing from an ulcer or something like that, but we were not involved in that diagnostic effort. So, we were informed that she'd had diverticular bleeding, had been in the hospital. The bleeding had stopped, and they were giving her iron to try to get her blood counts built back up, and that was my understanding of why her blood counts at that time were so low.
Q Were -- were you informed of that by Mrs. O'Neal, or did you -- were you informed of that by medical records or by your conversation with Dr. Paul or a combination of any of those or something else?
A Well, I think it was a combination. I mean, most -- most of that I believe I

would have probably been informed of by Troy.
Q Troy is your PA?
A Troy Miller is my PA, and he actually is the person who talked to her on most of these occasions, and, then, noted those conversations in the -- in the chart, and, then, our practice is then, when Troy has a discussion like that with a patient, then he comes to me and says: Well, this is -- I had a phone call from -- from a patient. This is what's going on, and so forth. So, that's where I would have gotten that information.
Q Do you know if you --
A Of course, at the time it didn't seem particularly ominous to us.
Q Did -- did you know -- well, strike that.
Do you know if -- at the time in -- in early May of 2003, did you have access to Mrs. O'Neal's medical records from her earlier hospitalization at the hospital in Mansfield?
A No, we did not.

Q Okay. Now, with respect to this diverticula, were you informed or were you aware when you cared for Mrs. O'Neal during the first week or eight days of May of 2003 that her diverticula were not bleeding and were thought by her GI consultant to not be the cause of her rectal bleeding?
A I do not believe that I knew that.
Q And, incidentally, Doctor, by the way, had you known back in March of 2003 that Mrs. O'Neal had left, mid to lower quadrant pain, and assume that the CT scan at that point in time had shown or disclosed evidence of a retained object, if that had been the facts back in March of '03 when Dr. Paul contacted you or when the patient contacted you, would you have advised her to come down so that you could do further investigation at that point in time with respect to --
MS. HARLAN: Objection.
BY MR. KULWICKI:
Q -- these left lower quadrant pain -- complaints?
MS. HARLAN: Objection.

THE WITNESS: Can I -- can I ask you a clarify -- clarifying question? Are you asking me what I would have done had I known in March that there was a retained towel?
BY MR. KULWICKI:
Q Yes, absolutely.
A I would -- I would have requested that she come back so that we could take it out, yes.
Q And --
A No question whatsoever.
Q Would time be of the essence, that -- in your mind, that you get that towel out?
A I was going to say it's a complicated question. It's actually a simple question, but I think the answer may be complicated.
I would not have delayed. There would be no point in delaying, but I must honestly tell you that a sterile towel that simply is residing within an encased framework of scar tissue in the abdomen would not, in my opinion, constitute an

emergency. There's no point in delaying. There's no reason not to go in and take it out right away. I can't think of anything good that would happen, but I wouldn't consider that to be a surgical emergency. I would do it expeditiously, but not on an emergent basis.
Q Doctor, before you saw the autopsy report in this case, did you have a different opinion as to what was the cause of her death? In other words, did you feel like her death was probably related to sepsis?
A Well, sepsis, acidosis, anemia, all acting in concert.
Q And did you have -- do you hold the opinion that her sepsis was related to this towel?
A My -- my feeling at the time, and I remember fairly clearly thinking about this, was that I could not understand why, with a completely encapsulated towel with -- although I did not do a full exploration, with no evidence of any widespread abdominal sepsis or abscessed cavity, and with a drain

in this pocket where the towel had been, I could not understand why she would become septic. I was very confused. I didn't know if this was as a result of her anemia, her overall generalized debilitated condition, and so forth.

So, you know, my current opinion, having looked at this autopsy report, is that she did not die from sepsis but rather she died from a pulmonary embolus.

At the time I was caring for her on her second admission, I was perplexed at how she could be septic when I got a drain. In fact, I remember discussing that issue with some of the nurses caring for her, going like: How can she be septic? She's got a drain in place. I think this was after she suffered her respiratory or cardiopulmonary arrest.

In retrospect, it appears to me now highly likely that she instead had a pulmonary embolus which was the cause of her death, and that she did not, in fact, die of sepsis.

Q I understand that, but with respect

to, you know, obviously, she could have sepsis at the same time that she had the pulmonary embolism, correct?

A That is true.

Q And sitting here today, even in retrospect, do you -- do you maintain the opinion that she probably had sepsis at the time of her death in May of 2003?

A No, I do not believe that.

Q Well, did you -- did you look? I -- I -- excuse me. I'm -- I'm confused. I thought you said that, when you performed this surgery in May of 2003, that you located an abscess.

A There was -- as I said, there was a pocket of scar tissue encapsulating the towel.

Q Yes.

A There was a small amount of cloudy fluid around it, and, you know, I can't remember of the top of my head whether we cultured that, and it grew anything or -- or whatever, but I put a drain in it, and, of course, we were treating her with antibiotics too.

Remember what sepsis is. Sepsis is sometimes used as a hazy term or an inexact term, but really what sepsis is, is -- is a bacterial invasion of the bloodstream; in other words, widespread infection. An abscess is not sepsis.

Q I understand.

A So, sepsis is the widespread infection, and I was -- and I was -- I could not understand at the time why she would have that when we -- when we had taken out the towel. There wasn't that much pus in there, and I put in a drain. So, my -- my opinion when she had the cardiopulmonary arrest was that she was probably septic. Knowing now that she had a large saddle pulmonary embolus, I don't believe that anymore.

Q Okay, but she --

A Does -- does that answer your question?

Q It does, but she did have an abscess in her belly, correct?

MS. HARLAN: Objection.

THE WITNESS: She -- she had a

pocket. Once again, I'm not -- I'm not trying to -- to debate or -- or be evasive, you know. An abscess can be a pocket filled with fluid. There are things that we in surgery call cold abscesses, a pocket of purulent fluid where nothing ever grows. Those used to be seen with tuberculosis. Those are occasionally still seen in situations like cat scratch fever. So -- so, I think you could call what she had around this towel an abscess. That does not automatically imply that it had bacteria in it, but it very well may have. I mean, I don't remember if we cultured it or not.

Q And when you talk about an abscess, that is indeed -- that's an infection, correct?

A That's why I'm saying, not -- that is not necessarily the case. I guess I'd have to get out a medical dictionary to see if there's an official definition. We normally think of an abscess as being an infected pocket of fluid, but, you know, this is a very complex case, and I've learned something today I didn't know

before. I'm not trying to parse this on you. I'm just saying: Just because this towel was encapsulated in a pocket does not automatically mean the pocket was infected. You could call it a cold abscess; in other words a fluid collection without infection, and -- and the way to know that would be to look back at the record and see if I -- if I did any cultures.

Q Why don't we do that now, if we could, and I'm certain there was. As I recall, it grew out strep aureus.

A Oh, that -- that is not an -- an organism.

Q Or, I'm sorry, what is it? Staph -- staph aureus.

A Staph aureus, okay. I see, let's see. The date of this is 5/3.

Q It's actually a strep constellatus; is that right?

A Just a minute. I'm -- I'm seeing -- I see two different reports, is what I'm looking at. I have two pages here that demonstrate -- that -- that indicate they are from specimens collected on 5/3. That

would have been at the time of her surgery. They have moderate gram positive rods on gram stain; moderate gram negative rods; moderate gram positive cocci; and a culture result that shows heavy porphyromonas species NOS. I think that means not otherwise specified. And, it says, "see aerobic culture for identification of gram positive cocci. Some organisms on gram stain may have been overgrown on culture." I don't honestly know what they mean by that. I think the -- the gist of this is that that fluid was, in fact, infected.

Q Okay.

A That's what we were trying to determine, correct?

Q Yes. And, Doctor, if we could, just look at the -- the radiology from the -- the May, 2003 admission to Sycamore Hospital. Was there -- I thought you mentioned or I read that -- was there a CT performed at Sycamore Hospital during this admission?

A No, not that I recall.

Q Yeah, I don't have one, but, I mean, I have a CT -- CT of the head.

A No, that's different. I thought you meant an abdominal CT.

Q Right, I did, I did, and that's why I was asking about if there was an abdominal CT.

A I don't believe so.

Q Okay, thank you.

A In other words, it's fair to call this a true abscess with infection.

Q Thank you. Now, you talked about the -- that this is different from sepsis, but certainly an abdominal infection can beget sepsis, true?

A That is true.

Q And the definition of sepsis, how -- how do you define that?

A Well, there are more than -- there's more than one definition. Normally, I would -- I guess I would define sepsis as an overwhelming systemic infection. Well, let me just say -- let's delete the word "overwhelming;" as a systemic infection, and the typical way of making a diagnosis of sepsis is with a positive blood culture, but -- but, quite honestly, physicians in

normal practice sometimes use the term somewhat loosely and say: Well, this patient is septic, or that patient is septic, and they're referring to a constellation of symptoms, and signs, and so forth and so on, indicating their -- their belief that this patient has infectious problems that may not show up on a positive blood culture.

Q Doctor, are you aware of a phenomenon whereby the body has an inflammatory response to foreign objects that are left within the body, say, through surgery?

A Well, the body frequently responds to foreign objects by an inflammatory response, yes.

Q Okay, and are you aware or would you agree that that inflammatory response can, just like an inflammatory response to sepsis, can create a hypercoagulable state?

A I don't know the answer to that. I don't think I've ever read about that.

MR. KULWICKI: All right. You

know, I am done with everything except some issues about credentialing. I note here that defense counsel has some exhibits that he wanted to ask you about, and they appear at first glance to have to do with credentialing.

Let -- let me suggest this, and -- and you all there can veto this, but let me suggest that we allow the hospital's counsel to go forward, Mr. Cowdrey to go forward with his examination. I can then have the opportunity to review what came over on the fax which I haven't had a chance to really read in detail, and, then, I may or may not have any additional questions depending on where Mr. Cowdrey goes with his examination, and if that's offensive to you, tell me, and I'll be happy to continue with -- with -- with my questions.

MS. HARLAN: That's fine with me.

MR. COWDREY: Okay. Yeah, that's fine with me, David. What I'll do is, I'll go through some questions. Doctor, do you want to take a break?

MS. HARLAN: No.

MR. COWDREY: And, then, we'll probably take a break at that point, and I'll see whether or not I need to ask any additional questions, and, then, if you have some additional questions, feel free to ask them, okay?

MR. KULWICKI: I appreciate that. Thank you.

CROSS-EXAMINATION OF DAVID FALLANG, M.D.

BY MR. COWDREY:

Q Doctor, my name's Bob Cowdrey, and I represent the hospital in this litigation. I'd like to follow up with some of the questions that Mr. Kulwicki asked you, and then I am -- I will ask you some questions about credentialing and insurance.

Middletown Surgical Associates, Inc. is a professional corporation; is that right?

A Right.

Q And when -- when was that professional corporation formed?

A 1981.

Q Okay, and it's still in existence as we sit here today?

A Yes.

Q Okay, and are you the sole shareholder of that corporation?

A Yes.

Q Okay. I take it you're an officer of the corporation?

A Yes.

Q As -- as we sit here today, are there any other officers of the corporation?

A Frankly, I don't remember.

Q And you mentioned that in the past, Dr. Clarey and Dr. Martin had worked for Middletown Surgical Associates, Inc.; is that correct?

A Yes.

Q But they were never shareholders of that corporation?

A No.

Q Riverview Health Institute, where's that located?

A In Dayton.

(Inaudible.)

MR. KULWICKI: Hang on one second. Hang on. We're having problems hearing you

over here. Let me have the court reporter talk to you. Just tell him what you did or did not hear.

THE REPORTER: I did not hear the last question.

BY MR. COWDREY:

Q Okay. Doctor, Riverview Health Institute, where's that located?

A Dayton.

Q And that's over next to the old St. E's Hospital?

A Yes.

MR. COWDREY: Do you hear me all right now?

MR. KULWICKI: Yes.

BY MR. COWDREY:

Q The -- how long have you been at Riverview?

A Oh, about seven months.

Q And -- and who owns that institute?

A A variety of business entities.

Q Okay, are you an owner of that -- a part owner of that institute?

A Yes, sir. Five percent.

Q Okay, and you say you've been -- you've been practicing there for the past seven months?
A Yes.
Q And do you do bariatric surgery at Riverview?
A Yes.
Q And -- and when did you actually start performing bariatric surgery? What -- what year?
A Oh, in 1997.
Q And the bariatric surgery, how's that defined? What -- what do you consider to be bariatric surgery?
A It's surgery intended to induce weight loss.
Q And that involves a Roux-en-Y procedure?
A Well, there's a variety of different procedures. I perform Roux-en-Y procedures -- Roux-en-Y gastric bypasses pretty much exclusively, but there are other procedures that can be performed.
Q I believe Mr. Kulwicki had asked you some questions about the coroner's report.

As you sit here today, is -- is there a question that has now arisen in your mind as to whether this pulmonary embolism that was seen on autopsy predated or preceded her admission to the hospital at Kettering in May of 2003?
A Yes, I would have a serious question about that.
Q And why do you believe that?
A Well, for one thing, a large pulmonary embolus takes a while to develop, but probably more than that is, it -- it appears quite obvious to me now that she died of a pulmonary embolus rather than of sepsis. The pulmonary embolus results from the breaking loose of a clot. Frequently these clots are in the pelvic veins, and the issue is that the age of this clot may not be able to be determined. I mean, I think it almost certainly at this stage in time cannot be determined. We can only guess about it, but in -- in my estimation, it certainly could have predated her admission to -- her second admission to Sycamore.
Q And in that circumstance, would --

would that pulmonary embolism, if, in fact, it predated her admission to the hospital in May of 2003, be related to --
MR. KULWICKI: We can't hear you. You're shuffling papers. We can't hear.
BY MR. COWDREY:
Q I'm sorry. Let me -- let me repeat it. With -- with respect to the pulmonary embolism and its predating her admission to the hospital in May of 2003, would that be, in your opinion, unrelated to the retained towel?
MR. KULWICKI: Objection.
THE WITNESS: I mean, the problem is that I don't know that it's possible to determine what was the originating factor behind the pulmonary embolism or -- or, in other words, the deep venous thrombosis. Certainly, the retained towel would have created additional risk factors, but she already had other risk factors. I -- I don't think it's possible to know. It's certainly possible that it could have been unrelated to the retained towel.
Typically, these clots occur; that

is to say, they first form in the pelvic veins. All -- all the inflammatory processes that -- that existed in this patient, to my knowledge, were in the left upper quadrant. It may not be, you know, miles away, but, I mean, anatomically and physiologically, that makes a difference.
If you have an inflamed mass sitting on top of a pelvic vein, such as what you might see in Crohn's disease, that vein is certainly at risk. If you have an inflamed mass sitting elsewhere that's not contiguous, then, possibly there are some systemic inflammatory factors, but it becomes a very difficult question to answer with any degree of certainty.
Q With respect to this individual, Mrs. O'Neal's religious beliefs and her attitude toward not taking blood products, did that complicate or cause any problems for you in -- in treating her in May of 2003 when you did the surgery to remove the towel?
A Very much so.
Q And in -- in what way was that a

complicating situation?
A Because she was extraordinarily anemic, and we couldn't give her any blood, and that affects hemodynamic function. It affects physiologic function in terms of hypoxia, anaerobic metabolism which results in lactic acid, cardiac function. There's a whole range. You don't have to be a doctor to know that your body needs oxygen, and most people understand that red blood cells -- the hemoglobin inside the red blood cells carries the oxygen. Without them, and I fully respect her religious beliefs, but it is a simple, scientific fact that, without the ability to give her red blood cell transfusions, her physiologic status was severely compromised. I believe that she had a hematocrit noted in one of the progress notes of 16. It's extraordinarily low. I had several discussions with her family about this to -- to make sure that -- that they would not change their mind. I discussed this with the family in conjunction with their spiritual counselor, their minister or what have you to make sure

they understood the gravity of the situation, and that they -- that they did not have any change of heart about it.
Q Doctor, at this point, I want to discuss with you the -- your application for privileges to practice at Kettering. It's my understanding that you first applied for privileges at Kettering and Sycamore in 1997; is that accurate?
A That is my recollection.
Q And you were provided -- when you applied for -- for staff privileges, did they provide you with bylaws of the hospital?
A I think so.
Q And were you aware that your application for privileges would be on a two-year basis, in -- in the sense that, if you wanted to renew your privileges, you'd have to ask for a renewal every two years?
A I think I recall that.
Q And -- and were you also provided, in addition to the bylaws, also provided with a credentials manual?
A I assume so. I mean, I don't

recall. It was seven years ago.
Q I'm going to show you what's been marked as Exhibit 3.
(At this time Defendant's Exhibits 1 to 13 were marked for identification purposes.)
BY MR. COWDREY:
Q And that -- that is page 12 of the credentials manual; at least, that's as -- as it sits in front of you. It's titled at the bottom; is that correct?
A That's what it says.
Q Okay.
A Updated 4/24/03.
Q Okay.
A So, this is not the copy that I would have received seven years ago.
Q I understand that, but were you aware that you were to provide evidence to the hospital of malpractice coverage?
A That would be typical, yes.
Q And -- and on Exhibit 3 under Subsection E, it indicates, at least as of the date April 24th, 2003 when this was published, that you were to advise the

hospital of any changes in your professional liability coverage; is that correct?
A That's what it says.
Q Now, when you first applied for privileges at -- at Kettering, did you apply for general surgery privileges?
A I believe so.
Q Okay. Did you apply for bariatric privileges the first time you applied in 1997?
A I don't recall.
Q Okay. Were you doing any bariatric surgery in 1997?
A Yes.
Q And that was -- you were doing that down at Middletown?
A Well, I was doing it at Sycamore also, Middletown and Sycamore.
Q So --
A And -- and Southview and Grandview and a couple of cases at Kettering.
Q Is it your testimony that in 1997 -- well, let me ask you, first of all: When you applied for privileges at Kettering, that also involved the satellites Sycamore,

Grandview and Southview, correct?
A Well, Grandview and Southview were not affiliated at that time. It included Sycamore.
Q Okay.
A Grandview and Southview were separate.
Q So, when you applied for privileges at Kettering in 1997, you were doing bariatric surgery at Middletown Regional Hospital?
A Yes.
Q You were doing bariatric surgery at Grandview and Southview?
A Yes.
Q Okay, and are you sitting here today telling me that you -- when you applied for privileges at Kettering in 1997, you asked for bariatric surgery privileges in addition to general surgery privileges?
MS. HARLAN: Objection. I think he said he doesn't recall.
THE WITNESS: That is correct. I don't recall how I filled -- actually, I usually -- I didn't fill those forms out.

My office staff typically did that.
BY MR. COWDREY:
Q And -- and at the time you applied for privileges at Kettering-Sycamore in 1997, your active staff privileges were at Middletown Regional and Grandview, Southview?
A Well, I had privileges in Middletown since 1981. My recollection is that I applied at Grandview, Southview and at Kettering-Sycamore at approximately the same time.
Q Now, when you applied for privileges, or while -- while you were on staff and a privileged -- and having privileges at Middletown Regional Hospital, did they require you to maintain professional liability coverage?
A Yes.
Q Did -- did they require you to maintain professional liability coverage for a certain amount?
A Yes.
Q And do you remember what -- what amount Middletown required you to have?

A One million, three million.
Q One million per incident?
A Per incident, three million per year.
Q Now, when -- when you applied for privileges at Kettering in 1997, what company did you have professional liability insurance with?
A I don't recall.
Q Do you recall what your limits of liability were in 1997 when you applied for privileges at Kettering?
A I assume they were one million, three million.
Q Now, and when I ask -- when I say "you," I'm meaning you as opposed to the professional corporation. Did the professional corporation, Middletown Surgical Associates, Inc., also have a separate policy of professional liability coverage?
A No. I believe it was encompassed in the same policy.
Q My understanding is that you were provided privileges in 1997 at Kettering and

Sycamore; is that correct?
A That's my recollection.
Q Okay, and did you provide Kettering with any proof of professional liability insurance?
A I suppose so.
Q For 1997?
A I suppose so. Again, I didn't do that stuff. My office people did all that.
Q And who in your office was responsible for providing that information to the hospital?
A In 1977?
Q 1997.
A I'm sorry, 1997. I can't remember exactly who was working there then.
Q How -- how many people did you have in the office that worked in the office for you in 1997?
A There's been a lot of changes since then; probably three or four.
Q Was there one particular person that -- that you would have involved in making sure that appropriate information was given to the hospital when you were applying

for privileges? Did you have, like, a designated office manager that -- that would fulfill those duties?
A Yeah, basically, that's correct.
Q Okay.
A She left in '97, and I'm trying to remember when. It would have been a girl or a woman named Sara Graham, G-R-A-H-A-M. I believe that she's the one that probably would have done that, or at least overseen the process.
Q Now, my understanding is, and if your recollection is different, tell me, that you voluntarily resigned your privileges at Kettering in 1999; is that accurate?
A More or less.
Q And, then, you reapplied for privileges in -- in 2000, in I believe 2000 -- February of 2000.
A That sounds right.
Q Do you remember -- let me show you what's been marked as -- showing you what's been marked as Exhibit 4, and that describes privileges that you're requesting; is that

correct?
A I think so.
Q And that -- that's your signature on the --
A Yes.
Q -- the bottom there?
A Yes.
Q And that indicates what privileges are you asking for?
A Well, this is page two, so I assume there's a page one, but on this page, it says, "laparoscopy and laparoscopic surgery," and "other," it says "Roux-en-Y gastric bypass, open and laparoscopic," and that has a date notation of 3/26/01.
Q And -- and your initials are next to that date; is that correct?
A Yes.
Q Okay. The initial page, which is Exhibit 4, was signed by you February 25th of 2000, correct?
A That's what it says.
Q And, then, you added the request for additional privileges involving the Roux-en-Y gastric bypass and the open and

laparoscopic procedures?
A It looks that way.
Q And that would have been done in March of 2001.
A Yes.
Q And in March of 2001, can you tell me who was your professional liability carrier?
A I can't remember. Three of them have gone bankrupt.
Q I'm going to show you what's been marked as Exhibit 5.
A Uh-huh.
Q And that -- that appears to be a certificate of liability insurance which is dated at the top March 26 of 2000, correct?
A May 26th.
Q Is that correct?
A May 26th.
Q Yeah, May 26th of 2000 is the date on that certificate of liability insurance?
A That's what it says.
Q It shows you as an insured, David J. Fallang, M.D., correct?

A Yes.
Q The insurance company is American Equity Insurance Company; is that correct?
A Yes.
Q It shows your coverage, $1 million each occurrence, $3 million annual aggregate with a $10,000 deductible, correct?
A Correct.
Q And it shows effective dates of the policy, May 24, 2000 to May 24, 2001; is that correct?
A Correct.
Q This -- this certificate of liability insurance, did you give this or have someone from your office give it to someone at the hospital?
A I presume so.
Q And who would have been your -- who would have been the person in your office responsible for providing this certificate of insurance to the hospital?
A What -- what -- when was this done?
Q In May of 2000.
A I believe that would have been my wife.

Q And your wife's name?
A Is Teresa Fallang.
Q And this policy of insurance that -- that was written by American Equity Insurance Company, did it provide coverage for bariatric surgery?
A As far as I know, but I don't have the policy in front of me. I think it did.
Q Did -- did you ever actually review the policy of insurance that American Equity provided to you to -- to determine whether or not it did provide coverage for your bariatric surgery?
A Probably not.
Q I'm going to show you what's been marked as Exhibit 6, and that is a letter from Mr. Manchur at Kettering Medical Center indicating that you had been -- your privileges had been approved?
A Uh-huh.
Q Is that correct?
A That's what it says.
Q Okay, and that -- that letter is dated May 4, 2001?
A Okay.

Q Is that right?
A It says.
Q And -- and, so, you're aware that, when the spring of 2003 rolls around, you're going to need to apply for -- for renewal privileges, correct, since it was over two years?
A Okay.
Q Is that right?
A Yeah, as far as I know.
Q With respect to the insurance policy that was written by American Equity, were you aware of any restrictions or exclusions on that policy when it came to your ability to perform surgery, whether it be general surgery or bariatric surgery?
A Not to my knowledge.
Q And I'm going to show you what's been marked as Exhibit 7, and that appears to be another certificate of insurance; is that correct?
A It appears to be.
Q And -- and who is the insured on that?
A Myself as well as Middletown Surgical Associates.
Q It says "David J. Fallang M.D., d.b.a. Middletown Surgical Associates"; is that right?
A Yes.
Q And it's -- it's hard to read, but it appears as if the company that's providing the insurance is Admiral Insurance Company.
A Yes.
Q And -- and that shows a date, effective date of the policy as being July 25th, 2001 through July 25th, 2002; is that right?
A Yes.
Q And I guess what I'm interested in is, if you look at the previous certificate of insurance which had American Equity as the company -- do you see that?
A Yes.
Q If you compare those two certificates, you have one certificate which shows coverage up through May 24th of 2001, and then the next certificate indicates your coverage starts on July 25th, 2001; is that right?
A It looks like it.
Q Did you have another insurance policy that provided coverage for that gap between May of 2001 and July of 2001?
A I don't think so.
Q So, you -- you were uninsured for some period of time, then?
A It looks that way.
THE VIDEOGRAPHER: Mr. Cowdrey, you've got a little less than five minutes left on this tape.
BY MR. COWDREY:
Q The -- your office manager in 2001, would that have still been Teresa Fallang?
A Yes.
Q And would she have been the person that you would have designated to provide this type of information, insurance information to the hospital?
A Yes.
Q All right, and with respect to this Exhibit 7 which shows Admiral Insurance Company as being the insurance company providing insurance, professional liability

insurance to you, was there any particular restriction or exclusion issued by Admiral concerning the performance of bariatric surgery?
A It doesn't say so. I don't recall, you know, the text of the policy. I mean, this is the binder, and it doesn't have any exclusions on it.
Q Do you -- do you happen to have these policies somewhere that were issued by the various insurance companies?
A I assume so. They're not in my car. I don't know where they are. I don't do this stuff. Yeah, I assume they're at the office someplace.
Q Who's your office manager now?
A The same person.
Q Teresa?
A Uh-huh.
Q Okay. Would Teresa be the individual that would have the actual policies of insurance that -- that were issued by these various companies for your professional liability?
A That's my best guess, yes.

Q So, as -- as you sit here today, with respect to this policy issued by Admiral Insurance Company, you're not aware that there was any restriction or exclusion on that particular policy concerning the performance of bariatric surgery?
A No. They usually put the exclusions and restrictions on the binder.
THE VIDEOGRAPHER: Mr. Cowdrey, you only have about a minute left on this tape.
MR. COWDREY: Do you just want to stop now.
THE VIDEOGRAPHER: Unless you --
MR. COWDREY: Let's go ahead and stop.
THE VIDEOGRAPHER: The time is 4:36 p.m. We're going off the record. This is the end of tape one.
(At this time a short recess was had.)
THE VIDEOGRAPHER: The time is 4:45 p.m. We're going back on the record. This is the beginning of tape 2.
BY MR. COWDREY:
Q Thank you. Doctor, when it comes to

purchasing the -- the professional liability coverage for yourself, it also provides coverage for your professional corporation. Is that paid -- paid for by a check?
A Usually.
Q Okay, and Teresa Fallang is your office manager. Does she have the ability to write checks and sign checks, or is -- or are the checks signed by yourself?
A I don't remember signing any particular check.
Q Well, does Teresa have the ability to actually sign a check?
A Yes.
Q On behalf of yourself?
A I don't know on behalf of myself. It's on behalf of the business.
Q Well, for example, if we looked at Exhibit 7 and the coverage afforded by Admiral Insurance Company, would -- would a check have been written from a personal account, David Fallang, or from the corporate account?
A From the corporate account.
Q And your testimony is Teresa would

have had the authority to sign that check?
A Yes.
Q Okay. Would you have known back in July of 2001 as to how much your insurance premiums were for coverage through Admiral Insurance Company?
A I guess I don't know.
Q Well, let me ask you this.
A Would I have known back then? Well, I don't --
Q Let me ask you this. When you were looking for insurance coverage, professional liability coverage, did you shop around for coverage when it came to the insurance companies and how much your premiums were?
A Yes.
Q And did you have anybody in the office doing that for you, or did you do that yourself?
A She did most of that.
Q So, Teresa would have been the person who, for lack of a better word, solicited insurance companies, and what type of coverage they would provide you, and how much that coverage would cost?

A After millions of phone calls, lots of forms to fill out, applications to fill out. I mean, it's just an unbelievable nightmare.
Q And I guess my question to you is: You -- you delegated that responsibility to -- to Teresa to shop around for insurance coverage, and how much it would cost?
MS. HARLAN: Objection.
THE WITNESS: Yes.
BY MR. COWDREY:
Q And who ultimately determined what insurance company you would buy coverage through?
A I don't know how to answer that question.
Q Well, I mean, did you --
A What ultimately determines whether you're going to buy a new car? If your wife wants a new car, you get a new car.
Q Not so in my family, but go ahead. What I'm interested in then is, with respect to your professional liability coverage, did you make the ultimate decision as to what insurance company you would go with?

A I mean, I guess as the president of the corporation, I had the authority to say no, but in reality, it was so difficult to find any coverage at all, and it was so complicated, and like I said, I mean, this stuff has turned into a nightmare that -- and it kept getting increasingly worse as time went on, that sometimes any coverage at all determined what company we picked.
Q And -- and --
A Three of my companies went bankrupt.
Q And which companies were those? Do you remember?
A Well, PICO was one of them. PHICO was another one, and I believe Frontier. I had PICO for many years. That's the company I started in practice with.
Q Is it -- is that the one out of Columbus?
A Oh, I don't remember. I -- it might have been.
Q The PHICO is a different company than PICO, correct?
A That's correct. I don't remember

for sure. I think that they were from Pennsylvania or something, but I don't know where these guys are from.
Q Okay, as -- as things went along, did it become more difficult to obtain insurance coverage for bariatric surgery?
A Everything. Bariatrics is very difficult, yes.
Q And why is that?
A Because people like our friend in Cleveland keep suing us. It is well known -- that was a flip answer.
It is well known, and I cannot explain to you the reasons why, but it is well known that bariatrics is probably the worst specialty as far as medical malpractice, and -- and I believe that the -- there's -- there was a guy that spoke at the American Society -- Society for Bariatric Surgery, and I believe he said that the average full-time bariatric surgeon gets sued something like 2.3 times per year, whereas the average obstetrician/gynecologist gets sued something like 2.5 times per career. It's just horrible.

Q And -- and I take it that one of the reasons for that is because you're dealing with high risk patients?
A I assume that to be true, but I -- I must tell you, this is what I do for a living. I've done it for some time. I love it, and I don't understand it. I mean, we do a lot of good, but it may be that. It may be high expectations. I -- I really don't get it.
MR. COWDREY: Do you want to show him Exhibit 8?
MS. HARLAN: I did.
BY MR. COWDREY:
Q Doctor, I've put in front of you Exhibit 8, which is, again, the second page of a document for signature on it, and it's dated April 19, 2003; is that correct?
A Yes.
Q And that appears to be a request for privileges that you signed; is that correct?
A That's what it appears to be.
Q Okay, and this involves, again, a request for a Roux-en-Y gastric bypass

cholecystectomy; is that correct?
A Yes.
Q And that would involve laparoscopic -- a request for laparoscopic procedures with respect to Roux-en-Y?
A Yes.
Q And, then, also a request for open Roux-en-Y gastric bypass, correct?
A Yes.
Q Okay, and showing you what's been marked as Exhibit 9, this is an agreement that you signed with the hospital on April 19, 2003 concerning malpractice coverage; is that correct?
A Yes.
Q And that indicates that if -- if your current coverage is cancelled, terminated or restricted in any way, you would notify Kettering Medical Center of that.
A Yes.
Q Showing you what's been marked as Exhibit 10, this is a certificate of insurance dated at the top, right-hand side July 25th of 2002; is that correct?

A Yes.
Q That shows a new insurance company providing coverage for Middletown Surgical Associates and Dr. David J. Fallang, correct?
A Yes.
Q That new insurance company is Evanston; is that right?
A Yes.
Q That's a claims made policy?
A That's what it says.
Q Okay, and did you, or do you, as you sit here today, understand the difference between a claims made policy and an occurrence policy?
A I think I do, yes.
Q All right, and what's your understanding of that difference?
A An occurrence policy covers any adverse event or allegation of adverse event that occurs during the policy period. Even if the policy changes, expires or whatever, any claim ever made for any situation or any -- any incident that -- that occurred during that policy period would be covered

forever, assuming, of course, the insurance company didn't go bankrupt.
The claims made policy only covers claims made during the policy period or an incident that you might notify the insurance company of. So, if something bad happened, and you called your insurance company and said: You need to know about this, that would be equivalent to having the claim -- a claim reported, I guess you could say.
Q And Exhibit 10 shows that you have coverage with Evanston under policy number MM-4025 with a policy period of July 25, 2002 to July 25, 2003, correct?
A That's what it says.
Q And it shows a certificate of holder at the bottom being Kettering Medical Center; is that right?
A That's what it says.
Q And -- and would Teresa have provided this certificate of liability insurance to the hospital?
A I assume so.
Q Well, did you personally provide this certificate to -- to the hospital?

A No. Sometimes -- I think sometimes the insurance broker provides it. Again, I mean, I didn't do this stuff, but I think sometimes it comes directly from the broker, or if not, then it comes, I guess, from our office.
Q And -- and how would the broker know who to provide this certificate of insurance to?
A I don't know. I guess somebody would have to tell him.
Q Now, this certificate, Exhibit 10, indicates in the space under description of operations, et cetera, it says, "coverage extends to David J. Fallang, M.D. while performing services on behalf of the named insured." Is that what it says?
A Yes.
Q Were there any restrictions that you were aware of under this -- under this insurance policy issued by Evanston concerning bariatric surgery?
A Not that I remember.
Q This policy of insurance, do you still have -- do you actually still have --

strike that.
Would Teresa still have the policy of insurance that Evanston issued for this policy year?
A I guess so. I don't know that as a fact.
Q If you'll look at Exhibit 12, skip over Exhibit 11, Exhibit 12 is another certificate of liability insurance which is dated July 8th of 2003; is that correct?
A Yes.
Q And that shows the insured as David J. Fallang, M.D.; is that correct?
A Yes.
Q And the certificate holder on the bottom, left-hand side is Sycamore Hospital?
A Yes.
Q And, again, do you know whether Teresa would have provided this to the hospital?
A I think so.
Q And this shows a different malpractice policy number being MM 807001 with an effective date May 7, 2003 to May 7,

2004; is that right?
A That's what it says.
Q And what was the reason why the policy number changed? Do you know?
A No.
Q You had the same coverage; is that correct?
A It looks like it to me.
Q Was there any restriction or exclusion of coverage under this policy number MM 807001 with respect to bariatric surgery that you were aware of?
THE REPORTER: You know what? I can't hear you again.
THE WITNESS: I'm sorry. I said it does -- it has no restrictions on the -- on the certificate, but it's my recollection that this did not cover bariatrics.
Q And -- and you indicated that this particular policy of insurance which is noted by the certificate of Exhibit 12, your recollection is this did not afford coverage for bariatric surgery?
A I think that's the case.
Q And -- and did you advise Kettering

hospital that this policy of insurance issued by Evanston with a date on the certificate of liability insurance of July 8, 2003 that you did not have coverage for bariatric surgery?
A (At this time the witness shook his head.)
Q Why not?
A I don't know.
Q Weren't you required to do that?
A Well, you've given me a previous document that said so, but we get -- we get lots of things to sign. We have these huge packets of bylaws and all those kinds of things, and I don't recall what all of those things say.
Q But you acknowledge that you did sign an agreement on April 19, 2003 where you indicated to the hospital that, if your coverage was changed, restricted, you would certainly notify the hospital of that, correct?
A Correct.
Q And as you sit here today, you did not, in fact, notify the hospital of the

change in coverage with respect to your professional liability coverage; is that right?
MS. HARLAN: Objection.
THE WITNESS: That appears to be true.
BY MR. COWDREY:
Q And the last exhibit that I'll show you, Exhibit 13, indicates that you submitted a resignation from the medical staff of Kettering Medical Center dated May 5th of 2004; is that right?
A That is correct.
Q So, you -- you'd earlier testified about your privileges lapsing. As it turned out, you actually resigned your privileges, correct?
A Yes. They were about to lapse.
Q And -- and when you say they were about to lapse, what do you mean by that?
A Well, the -- the renewal period was coming up, and as I previously stated, I chose not to continue having privileges there.
Q With respect to the certificate of

insurance which has been marked as Exhibit 12, since -- since it's your understanding that this insurance policy issued by Evanston did not provide coverage for bariatric surgery, I take it your premiums were significantly different than the premiums you'd paid in the past.
A Significantly higher.
Q Significantly higher or lower?
A My recollection is that these were about $180,000 a year. I mean, they just -- they just have kept going up and up and up over the last six or seven years.
Q Okay. I guess my question to you is: When you obtained this policy of insurance through Evanston which had -- which is noted by their certificate on Exhibit 12, was this policy of insurance, since it did not provide coverage for bariatric surgery, cheaper than the previous policies of insurance that you'd had providing professional liability coverage?
A Not that I recall. I mean, you had so many applications out there with quotations all over the place, it's -- it's

very difficult to remember.
Q With respect to this particular lawsuit, the O'Neal lawsuit, did you notify the Evanston Insurance Company of this potential claim?
A I believe we did, yes.
Q Do you remember when you first notified them of the claim?
A I don't remember, no.
Q Did you notify them of the claim before the lawsuit was filed?
A I don't think so.
Q So, your recollection is, when you got served with the suit papers from the court is when you would have submitted the claim to Evanston?
A I mean, I think we just turned that over to the attorneys, and they do it.
Q Did you get a letter from Evanston denying coverage for this claim?
A I believe so.
Q Okay, do you have a copy of that somewhere?
A The same as all the other places. I don't keep it myself, but I believe it's

probably in the office.
MR. COWDREY: Okay. Why don't we take a break for a couple minutes here, David, if you don't mind, and let me kind of collect my thoughts. Is that all right?
MR. KULWICKI: No problem.
MR. COWDREY: Okay.
THE VIDEOGRAPHER: The time is 5:04 p.m. We're going off the record.
(At this time a short recess was had.)
THE VIDEOGRAPHER: The time is 5:08 p.m. We're going back on the record.
BY MR. COWDREY:
Q Doctor, just a follow-up question. I -- I know I asked you a question as to whether or not you ever notified anybody from the hospital about the fact that your insurance policy with Evanston did not provide coverage for bariatric surgery. Did you ever have any in -- informal discussions with anybody at the hospital about the fact you didn't have coverage for bariatric surgery?
A Not about that fact, no.

Q What -- what -- did you have informal discussions with anybody at the hospital about malpractice insurance in general?
A Oh, yes.
Q Who did you talk with?
A I talked with -- well, who's the CEO? I'm locking on it.
Q Mr. Perez?
A No, not Perez. The guy --
Q Fred?
A Fred Manchur and Richard Haas. Richard Haas is the VP in charge of Sycamore, and we had a number of discussions about the crisis and the problems. There were meetings that many of the medical staff attended. I voiced my opinions about what I thought people should do, and we had a lot of discussions. It's a very difficult problem, as you may know.
Q What -- what -- what particular opinions did you express to those individuals?
A I expressed the opinion that I thought the hospital should either,

preferably, drop the requirement for malpractice insurance, or at minimum lower it. I know a number of surgeons, first of all, surgeons who've gone out of business. The guy in Middletown I shared office space with for 17 years is 49 years old. He had to quit. He couldn't -- he couldn't -- he went to managed health care, and with the increasing malpractice premiums, he couldn't stay in business. I mean, this guy's got a, you know, a kid in the sixth grade or thereabouts, and he's less than 50 years old, and he had to quit practicing surgery.

I know that Mike Keller at Sycamore, a general surgeon, expressed to me that he wasn't sure he was going to be able to continue in practice. John Bullmaster told me if Kettering would allow it, he would -- he would drop his insurance, particularly after they passed the so-called tort reform where they eliminated the joint and several liability requirements.

I -- I opined that I thought that the hospital, certainly the medical staff but also the hospital would be better off if

they just didn't require it for medical staff privileges. I was told that they -- Kettering was -- being a Seventh Day Adventist hospital had not only Fred Manchur and Richard Haas's Frank Perez's opinions to consider, but also Board members from the Seventh Day Adventist community outside of the state, and, you know, that that wasn't going to happen, and, you know, my opinion is that, just as in other parts of the country, we're facing a huge crisis. There's going to be a crisis of physician availability. I've been, you know, certainly feeling as though my entire career in the last several years has been threatened with extinction, and, you know, one of my -- one of my friends at Sycamore told me that they'd done an investigation into the -- some of the stuff revolving around bariatrics, and that I had the lowest complication rate of any surgeon on the staff doing these procedures, and, yet, you know, these people are trying to drive me out of business.

So, you know, that's my personal

opinion, and I guess you could call it a political opinion, if -- if you will, but we -- Fred and Richard and I had many -- a number of discussions about these issues. Who knows -- who knows what's going to happen next.

Q At least as of May 5th, 2004 when you submitted your resignation from the medical staff at Kettering Medical Center, the hospital still had a requirement that you have professional liability coverage for a million dollars and $3 million?

A Which I indeed had.

Q Except you didn't have coverage for bariatric surgery?

A I believe that that is true.

MR. COWDREY: Thanks. David, you can ask some questions if you want to follow up.

MR. KULWICKI: I do.

RECROSS-EXAMINATION OF DAVID FALLANG, M.D.

BY MR. KULWICKI:

Q Doctor, are you suggesting that you concealed the fact that you didn't have coverage for bariatric surgery from the

folks at Kettering Memorial Hospital or Medical Center?

MS. HARLAN: Objection.

THE WITNESS: I don't believe I was suggesting that, no.

BY MR. KULWICKI:

Q Did you just feel that the right questions weren't asked of you by the Kettering Medical Center credentialing people?

A I filled out my credentialing paperwork as I believed, and again, I didn't do it personally, but through my office, we filled that out, and we sent them what was -- what we understood to be required, and we didn't -- we didn't volunteer any extraneous information, and that was it.

Q With respect to the credentialing process, did you also submit information with respect to litigation that you had been the subject of?

A As far as I know, we submitted it. If it was required in their admission packet, again, I never personally filled any of these out, but I assume, if it was

requested, we submitted whatever was requested.

Q And do you know if the case that you spoke of today, the Coleman case, do you know if that had been filed -- well, do you know when that had been filed?

A I don't recall, no.

Q All right. The Exhibit 13 that you looked at, a copy of your resignation letter, it appears to me that there's a substantial gap between the first sentence and the last sentence. Do you recall whether or not the original of this had more language in there?

A Your question implies that there is an original that's someplace. Oh, you mean like the -- the one with the ink signature? No, I mean, no, we haven't, like, you know, erased anything or whited it out or anything. Again, I mean, I just signed this stuff. I assumed that they put that space in there so that the letter looks better.

Q Well, who prepared this document?

A It's signed "TLF" which I assume stands for Teresa Lynn Fallang, who is my

wife.

Q Okay. So, you're not aware of any information that's been redacted or removed from this -- this exhibit?

A Or concealed, no.

Q A couple of questions. Going back to the medical record, if you could take a look at that, there are a couple of consultations that took place during Mrs. O'Neal's May, 2003 admission. One of them appears to be by a Dr. Iberico, I-B-E-R-I-C-O. What specialist --

A Mariano Iberico.

Q I'm sorry?

A Mariano Iberico, he is a pulmonologist and intensivist.

Q Okay, and that was my question, his specialty. There also appears to be a consultation by Dr. Schoonover, S-C-H-O-O-N-O-V-E-R. What specialty of medicine is he?

A I -- I don't know him. Dr. Iberico asked him to consult, but I believe that he's a neurologist.

Q It appears that he consulted after

Mrs. O'Neal had already arrested, correct?

A That appears to be the case, yes.

Q Now, also, so I understand these records, there is a Discharge Summary in here, and I'd like you to find that, if you could, Doctor.

A Okay.

Q As I look through the chart, I find only one document that appears to be a Discharge Summary from the May, 2003 admission, and it appears to have the word "Discharge Summary" at the bottom. It's signed by you, and it appears to be dictated on September 15 of 2003 and transcribed that same day. Is that -- is that what you consider to be the Discharge Summary?

A Yes.

Q Is it unusual for you to wait roughly, like, four months to dictate a Discharge Summary?

A Well, first of all, I don't typically dictate the discharge summaries; my PA does, and the Discharge Summary cannot usually be completed until the chart's available, and sometimes the charts are out

to other physicians to sign. In this case, this chart may have been held up someplace waiting for the autopsy report. It may have been in risk management, so it -- it would be a little unusual. I think I'd get in trouble with the medical records people if all my discharge summaries were four months after discharge, but, of course, this was an unusual situation, so my guess is that this chart was off someplace else being held and perused and completed.

Q Even though the physician's assistant dictates the -- the discharge note, you signed it, correct?

A That's correct.

Q And that would indicate that you agree with it, fair enough?

A No. It would indicate that I signed it.

Q Well, do you disagree with it?

A I haven't read it.

Q Ever?

A I don't know if I read it back then. I probably did. I haven't read it recently.

Q Okay. Well, why don't you read it

now, if you would.
A Okay.
Q To yourself.
A Okay. Okay, I've read it.
Q Is there anything in it that you consider to be inaccurate?
A There's nothing that I could point out as being accurate -- as being inaccurate, sorry.
Q Now, in the text of the Discharge Summary, there's a notion or a mention of "blood culture did note hemolytic strep which would explain the continued decrease in the hematocrit." Did I read that correctly?
A Yes.
Q What does that mean, hemolytic strep?
A Well, it's a classification of streptococcal bacteria, beta -- they're typically called beta hemolytic strep.
Q And the term, hemolytic, means that the strep is actually, in a sense, eating blood cells?
A I wouldn't say that, no.

Q Well, when a --
A It's a classification of -- of bacteria. Quite honestly, I mean, I'm a general surgeon. You would have to, I guess, ask an expert in microbiology where that name came from. I mean, hemolysis means destruction of red blood cells; that is correct, but that wasn't your question. If you're asking me whether beta hemolytic strep eat red blood cells, I -- I don't think that is the case, but, you know, that's -- that's not an area in which I am an expert.
Q Okay. In any event, with respect to the decrease in hematocrit, that would be a drop in -- in the red cell production due to the strep; is that -- is that what that's saying?
A Well, I wouldn't particularly agree with that connection. That's what it says, yes.
Q Okay.
A I don't -- I don't know that the beta hemolytic strep has anything to do with the drop in hematocrit levels.

Q Well, what do you think was causing her decline in hematocrit levels during the May, 2003 admission?
A Well, I stated in my -- in my progress note that I thought it was probably due to hemodilution from giving her IV fluids. It's also been my experience in caring for -- for seriously ill patients that even relatively small amounts of blood drawn for testing purposes, to get a CBC and so forth, over time in a sick patient particularly can gradually result in -- in a decrease in their -- their overall count.
In a patient like this, of course, with -- with everything being so complex and -- and interwoven, I mean, it's really hard to say whether this decrease in her hematocrit is all due to hemodilution, or, you know, 83 percent due to hemodilution, and two percent due to hemolysis, and five percent due to blood draws. I mean, there's just no way to know.
Most of the time, sick patients in the Intensive Care Unit who are getting blood drawn have a gradual decrease over

time in their -- in their hematocrit until they begin to improve, and, then, things get better. My opinion is that most of her decrease in hematocrit was due to hemodilution from giving her fluids because we couldn't give her red cells. We had to give her something to try to maintain her -- her intravascular volume.
Q So, in other words, she still had the same amount of red blood circulating; it just was diluted by saline or whatever else was given to her?
A Right. The same amount or -- or a similar amount. In other words, we -- we did not note any blood loss from anywhere. She wasn't bleeding from her colon. She wasn't bleeding from her nose or her ears, like someone, for example, with DIC; that is disseminated intravascular coagulopathy, might have. So, there was no obvious source of blood loss, and again, I mean, you know, it's possible that, if she had a hemolytic -- a beta hemolytic streptococcal blood-borne infection, that that could result in some hemolysis. You know, I'm --

I'm not really sure. You'd have to ask somebody more expert in that area.
Q And -- and likewise, Doctor, with respect to the issue of expertise, with regard to dating the blood clots that were found in her lungs, again, would that be a matter that would be more within the specialty of a pathologist as opposed to a surgeon such as yourself?
A Well, I -- I think so. I mean, you -- you -- there's a lot of ways to date things. You can date it by inference clinically, but, obviously, a -- you know, some other kind of analysis might be more accurate. I -- I don't -- you know, I don't know that much about how they date blood clots.
Q Now, with respect to Mrs. O'Neal's religion and -- and her refusal of blood products, did you know that she was a Jehovah's Witness before the original bariatric surgery, the -- whenever that was, the gastric bypass of January 3 of 2003?
A Yes, I did.
Q And that was an elective procedure,

true?
A Yes.
Q Elective on her part, but also elective on your part; in other words, you had the legal right to refuse to undertake surgery on that particular patient if, you know, you felt like it was too dangerous because she was a Jehovah's Witness, right?
MS. HARLAN: Objection.
THE WITNESS: That -- that is true, and many -- and many surgeons would refuse to offer these patients the care that they need.
BY MR. KULWICKI:
Q And, now, with regard to the refusal of blood products, there are other patients, other than Witnesses, that refuse blood products, true?
A Not many.
Q Well, there are --
A I'm sure there must be. There must be some. Well, you answer the question, then. I mean, there must be some somewhere. I don't know that I've ever ran -- run into any, particularly when they're in dire

straits.
Q Now, I've heard about this, or you mentioned this Adventist or Seventh Day Adventist. I'm not familiar with that particular religion. Do they have any prohibitions against use of blood products?
A No, they don't, but they don't believe in eating meat. They're vegetarians. I -- I assume Charles F. Kettering was a Seventh Day Adventist.
Q Have you had the opportunity to review the blood labs from the admission to the Mansfield hospital?
A No.
Q Did you detect any bleeding at any time during the May 3 admission, whether rectally from diverticula or otherwise?
A I don't believe so, no.
Q Can you estimate --
A Only a small amount of blood loss during the surgical procedure.
Q That was my next question.
A Oh.
Q I don't see you having estimated

that in your op note. Maybe we should revisit that. Do you give an estimate of blood loss during that -- that procedure?
A I -- I normally don't estimate it. That's usually something that the anesthesia personnel do, but I do recall the case, you know, reasonably well, and I -- I know I was being as -- as careful as I humanly knew how to be to minimize my dissection, minimize any bleeding, and I would describe her blood loss during surgery as minimal.
Q Tell me, if you would, Doctor, in your opinion, what role, if any, you felt that her refusal of a transfusion had in her ultimate outcome, now that you know that it was a PE that killed her.
A It may have had a very significant role. The reason I say that is because she suffered a cardiopulmonary arrest, which, in retrospect, I think is most likely the direct result of the pulmonary embolus, but she didn't die immediately. Some people will have an acute catastrophic outcome from a large pulmonary embolus like that and simply die on the spot. This patient did

not. She survived for a period of some hours afterwards, but with a very compromised hemodynamic state, because this blood clot was occluding blood flow to the lungs, thus further diminishing her capacity to oxygenate what few red blood cells she had left.

Had she been willing, and again, this is not a criticism of her religion; it's just my opinion about the -- the facts of the case, but had she been willing or her family been willing to decide for her to receive red blood cells, then, she would have had a much improved hemodynamic condition, first of all, in terms of intravascular blood volume, but secondly, and possibly more importantly, a much improved state of oxygen-carrying capability, so that when people suffer from anoxia or hypoxia from some condition like sepsis or like a pulmonary embolus, and their body tissues, their brain, their kidneys are not receiving enough oxygen, maximizing their oxygen-carrying capability is extremely important.

So, had this patient been able to receive red blood cells, her outcome might have been dramatically different.

Q It's possible?

A In fact, you may notice in my progress notes, somewhere in there, I believe I read that I thought this patient was actually improving significantly on the 6th. I believe she was awake. She was sitting up, I think in a chair in the Intensive Care Unit. We had a little conversation, and then some time either later that night or in the middle of the night on the 7th or something, I think is when this -- this cardiopulmonary arrest occurred, which -- which contributed to my bewilderment as to how she could suddenly become so septic when I had just seen her, and I thought, you know, she was getting better, and frankly, I was beginning to have a little optimism, even though her hematocrit had drifted down to about 16, that we -- you know, that we might be able to slip by this -- this -- you know, this horribly dangerous situation and -- and that

she would survive.

Now, in retrospect, it seems clear to me that what happened is that she threw this pulmonary embolus, but had she had good oxygenation with normal red cell numbers and hemoglobin with oxygen-carrying capability and hemodynamics in terms of the force of blood passing through the heart over these blood clots and into the lungs, she may very well have survived this large pulmonary embolus.

Q It -- it's possible; is that what you're saying?

A It's possible.

Q Okay.

A It is possible, yes.

Q Now, with respect to the refusal to obtain or accept a transfusion, you've related to me that it was a contributing factor or may have been a contributing factor to her death after the arrest. Was it a factor before the arrest?

A Probably so. Again, I mean, we're -- we're really out in an area where no one can ever know the truth for sure, but

certainly her overall condition and stability, I think, would have been improved had she had normal oxygen-carrying capability. It's just, all the physiological functions that you can think of that the body carries out require energy, and energy requires oxygen, and, so, there's just such a panoply of -- of misalignments of the physiology that occur because of hypoxia and -- and -- which would be certainly the case with somebody with a hematocrit of 16. I don't see a direct connection between that and the pulmonary embolus, but certainly her overall physiological condition would have been much better.

Q Okay, and, again, with regard to your opinion and characterizing your opinion, is it fair to say that it's your opinion that it's possible that, had she had a transfusion before the arrest, that she may have had a better outcome?

A Yes.

Q Okay. Now, with respect to the chronology of events in this case, we know

that the patient in January of 2003 had a surgery, and that a towel was left at that point in time, that she complained of pain in the area of the towel -- in the area of the retained towel, meaning the left mid to lower quadrant. She complained of pain in that area beginning in the end of January of 2003, and on a few occasions leading up to her admission in May of 2003, at which time the towel was discovered as well as an abscess in the area of the towel.

Can we agree that, in all likelihood, that if Mrs. O'Neal did not have a towel in her belly, that she would not have needed to be hospitalized in May of 2003 for surgery?

MS. HARLAN: Objection to the chronology of events which is different, I think, than even the question was.

MR. KULWICKI: Well, you know what?

THE WITNESS: I'm not sure what I'm supposed to answer.

MS. HARLAN: I don't think he asked you to agree -- I don't think he asked you to agree with that chronology. He then went

on to another question.

THE WITNESS: Okay.

MS. HARLAN: But my objection is to the stated chronology of events.

MR. KULWICKI: Fair enough.

THE WITNESS: Someone tell me what to do.

BY MR. KULWICKI:

Q Well, here -- here, let me take over. I'll withdraw the question, and let me ask you a different one.

Doctor, can we agree that, if Mrs. O'Neal did not have a retained towel, that she would not have needed to undergo surgery in May of 2003?

A Yes, or at least she wouldn't --

MS. HARLAN: Objection.

THE WITNESS: She would not have needed to undergo surgery to remove the towel. The exact timing of it is a different issue.

MS. HARLAN: Or other type of surgery.

THE WITNESS: It might not have been discovered for three years. You never know.

BY MR. KULWICKI:

Q And can we agree that the reason that it was discovered in all likelihood is because the patient was having symptoms related to that towel?

MS. HARLAN: Objection.

THE WITNESS: Well, I mean, you know, it's possible, but the problem is, I wasn't in Mansfield. They diagnosed her as having diverticulitis which also causes symptoms in that same area. I'm not in a position to say that their diagnosis was incorrect, and that it, in fact, was the towel that was causing her symptoms. It's certainly possible, and I think it lends itself to -- to immediate speculation, but there's no way for me to know that that's true. How do we know that she didn't also have diverticulitis and that that was the cause of her lower abdominal pain?

BY MR. KULWICKI:

Q Well, I mean, I'm looking at the Discharge Summary, Doctor, from -- from this admission, and it says, "The patient was admitted with a diagnosis of retained

foreign body with possible abscess in the left upper quadrant," and, I mean, in fact, you agree that she had an abscess. You -- you tested that fluid, and she did have an abscess, true?

A I agree with that.

Q And she was having symptomatology in that area when she arrived at Kettering Medical Center in -- in May of 2003, true?

A That is true.

Q And the reason why she was transferred to you is because the physicians in Mansfield determined that she had a retained towel that was, you know, causing her some difficulty, true?

A Well, determined -- they determined that she had a retained towel, and -- and no one could blame them for not wanting to deal with the consequences of that retained towel. All I'm saying is that, we don't know -- I mean, I'm not saying you're wrong. I'm just saying I don't know that she also did not have, or that she did not also have diverticulitis as they diagnosed. I mean, it's not a -- it's not an illogical

conclusion to say: Well, the diverticulitis diagnosis, you know, maybe that was wrong, but I'm just saying I'm not in a position to say so.

Q Now, as a general --

A Obviously -- they obviously made that diagnosis and felt that they had a reason for making it. Were they incorrect? Possibly, but I -- I can't say that they were.

Q All right. You don't have any criticisms of those physicians, true?

A I do not. I've never seen their records. I don't know what they did.

Q With respect to diverticula as a general surgeon, would you expect that diverticula in the lower descending colon or the sigmoid colon would generate pains in the left side?

A Oh, absolutely. That's -- that's the classic location for symptoms of diverticulitis, but you must also remember, diverticulosis, which is the condition in which these small outpouchings of colonic mucosa protrude through the muscular wall of

the colon, diverticulosis can occur throughout the entire colon. The most common area for diverticulosis or for diverticulitis to occur is in the left side, and that would create an elevated white blood cell count, left mid and lower abdominal pain, and -- and similar symptoms to what Mrs. O'Neal had described.

Q Well, the fact is, is that merely having diverticulosis doesn't mean that a patient's having diverticulitis, correct?

A That is absolutely correct.

MR. KULWICKI: Okay. I think we've beaten this horse long and hard. I'm done. If Mr. Cowdrey has any questions, I -- I cede the floor.

MR. COWDREY: I don't have any questions, and I just want to make sure the court reporter up there has my name, address, phone number and stuff like that.

(At this time a discussion was held off the record.)

MS. HARLAN: □□He'll read.

THE VIDEOGRAPHER: What about viewing the videotape?

MS. HARLAN: We don't need to view the videotape.

THE VIDEOGRAPHER: Thank you very much.

MS. HARLAN: Thanks.

THE VIDEOGRAPHER: It's 5:40 p.m. We're going off the record. We're off the videotape.

- - - o0o - - -

C E R T I F I C A T E

STATE OF OHIO SS:
COUNTY OF CUYAHOGA}

I, Luanne Stone, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, DAVID testify to the truth, the whole truth and nothing but the truth in the case aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotype in the presence of said witness; afterwards transcribed; and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio this -------- day of ---------, A.D., 2004.

_____

Luanne Stone - Notary Public
In and for the State of Ohio
My commission expires 3/27/08

U