

1 IN THE COURT OF COMMON PLEAS

2 CUYAHOGA COUNTY, OHIO

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5  
6 RICHARD KEITER, etc., )

7 Plaintiff, )

8 vs. )

Case No. 535034

9 FRED KESSLER, M.D., )

10 Defendant. )

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15  
16  
17 DEPOSITION OF:

18 TIMOTHY R. S. HARWARD, M.D.

19 FRIDAY, JULY 15, 2005

20 10:20 A.M.

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22  
23 Reported by:

24 Kathleen E. McCarthy

25 CSR No. 4483

<p style="text-align: right;">Page 2</p> <p>1 Deposition of TIMOTHY R. S. HARWARD, M.D., the  2 witness, taken on behalf of the Plaintiff, on Friday,  3 July 15, 2005, 10:20 a.m., at 1140 West La Veta  4 Avenue, Suite 850, Orange, California, before Kathleen  5 E. McCarthy, CSR No. 4483.  6  7 APPEARANCES OF COUNSEL:  8 FOR PLAINTIFF:  9 FINELLI &amp; MARGOLIS P.L.L.  10 BY: RONALD A. MARGOLIS, ESQ.  11 DANIEL M. FINELLI, ESQ.  12 730 Leader Building  13 526 Superior Avenue  14 Cleveland, Ohio 44114  15  16 FOR DEFENDANT:  17 REMINGER &amp; REMINGER  18 BY: SUSAN M. SEACRIST, ATTORNEY AT LAW  19 1400 Midland Building  20 101 Prospect Avenue, West  21 Cleveland, Ohio 44115-1093  22  23 ALSO PRESENT: KENNETH McNEAL, VIDEOGRAPHER  24  25</p>	<p style="text-align: right;">Page 4</p> <p>1 ORANGE, CALIFORNIA; FRIDAY, JULY 15, 2005  2 10:20 A.M.  3  4 THE VIDEOGRAPHER: Here begins Volume No. 1,  5 videotape number one, in the deposition of Timothy --  6 Dr. Timothy Harward in the matter of Richard Keiter  7 versus Hillcrest Hospital in the Court of Common Pleas  8 of Cuyahoga County, Ohio. The case number is 535034.  9 Today's date is July 15, 2005. The time on  10 the video monitor is 10:20 a.m.  11 The video operator today is Kenneth McNeal, a  12 notary public, contracted by LegaLink of Los Angeles  13 at 16830 Ventura Boulevard in Encino, California.  14 This deposition is taking place at the  15 doctor's office at 1140 West La Veta Avenue, Suite  16 850, in Orange, California, and was noticed by Ronald  17 Margolis of Finelli &amp; Margolis.  18 Counsel, please voice-identify yourselves and  19 state whom you represent for the record.  20 MR. MARGOLIS: Ron Margolis, plaintiff.  21 MR. FINELLI: Dan Finelli, plaintiff.  22 MS. SEACRIST: Susan Seacrist, Fred Kessler,  23 M.D.  24 THE VIDEOGRAPHER: The court reporter today  25 is Kathy McCarthy of LegaLink of Los Angeles.</p>
<p style="text-align: right;">Page 3</p> <p>1 INDEX  2 WITNESS EXAMINATION PAGE  3 TIMOTHY R. S. HARWARD, M.D.  4 Mr. Margolis 5  5  6 EXHIBITS  7 NO. PAGE DESCRIPTION  8 (None)  9  10 INSTRUCTIONS NOT TO ANSWER  11 PAGE LINE  12 55 25  13  14 INFORMATION REQUESTED  15 PAGE LINE  16 (None)  17  18  19  20  21  22  23  24  25</p>	<p style="text-align: right;">Page 5</p> <p>1 Would the court reporter please swear in the  2 witness.  3  4 TIMOTHY R. S. HARWARD, M.D.,  5 having been first duly sworn, was  6 examined and testified as follows:  7  8 EXAMINATION  9 BY MR. MARGOLIS:  10 Q. Good morning, doctor. We have had the  11 opportunity to meet briefly before. My name is Ron  12 Margolis. The gentleman to my right is Dan Finelli.  13 Jointly we represent the Estate of Abigail Keiter.  14 Doctor, one of the things you were asked to  15 bring with you today was your full and complete file  16 relative to your work as an expert witness where you  17 have been identified by Mrs. Seacrist in this case.  18 Did you bring with you today your full and complete  19 file, sir?  20 A. I did.  21 Q. And where is it?  22 A. On the floor right here.  23 Q. Okay. What I would first like to do is start  24 off by indexing everything that you reviewed prior to  25 dictating your report in this case. Okay? So if you</p>

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1 would be kind enough to access the material so that  
 2 you could just kind of give me a list. And again,  
 3 sir, what I'm interested in is all of the information  
 4 prior to you writing your report.  
 5 A. Medical records of Mrs. Abigail Keiter is  
 6 what I reviewed. These records began, I believe, as  
 7 early as January, 1991, up until her autopsy after her  
 8 death in July of 2001, I believe.  
 9 Q. And did those medical records, sir, include  
 0 the chart of her family physician, Dr. Granieri?  
 1 A. Yes.  
 2 Q. And did they include her hospitalization at  
 3 Hillcrest from May -- excuse me -- in November of '01,  
 4 University in November of '01?  
 5 A. Yes.  
 6 MS. SEACRIST: University Hospital?  
 7 MR. MARGOLIS: University, yes.  
 8 THE WITNESS: Yes.  
 9 BY MR. MARGOLIS:  
 0 Q. And December Hillcrest Hospital records?  
 1 A. Yes.  
 2 Q. And the records of Dr. Monica Ray?  
 3 A. Yes.  
 4 Q. As well as the outpatient chart of U.H.  
 5 Gastroenterology?

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1 A. I don't know if I had the outpatient records  
 2 of U.H. Gastroenterology. I can't answer that  
 3 question.  
 4 MS. SEACRIST: I'm going to object because I  
 5 don't think that's the proper title specifically.  
 6 MR. MARGOLIS: Why don't you show me the  
 7 records that you have that are from Dr. Ray.  
 8 THE WITNESS: I'll let you go through and  
 9 find them.  
 10 MS. SEACRIST: I mean there's an index at the  
 11 front of every volume, so you'll be able to see just  
 12 looking at one index everything he reviewed.  
 13 BY MR. MARGOLIS:  
 14 Q. Did you review Dr. Ray's records?  
 15 A. I reviewed what's in here, yes, but what  
 16 volume they're in, I don't know.  
 17 Q. Okay. And if it's not in these one, two --  
 18 A. It's in this one.  
 19 Q. -- three -- so these five volumes would be  
 20 the volumes that you reviewed in this case; is that  
 21 correct?  
 22 A. Six.  
 23 Q. Six volumes? Okay.  
 24 I believe you did have the chart of Dr. Ray,  
 25 by the way.

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1 Did you review any films?  
 2 A. I believe I reviewed the CT scan of December  
 3 7, 2001, from Hillcrest Hospital.  
 4 Q. Anything else? *no deposes*  
 5 A. No.  
 6 Q. Doctor, you were also asked to bring with you  
 7 any correspondence that would have been generated  
 8 either by you or by defense counsel. Did you bring --  
 9 did you ever receive correspondence from defense  
 10 counsel in this case?  
 11 A. Yes.  
 12 Q. And did you bring that correspondence with  
 13 you here today?  
 14 A. No.  
 15 Q. And where is it?  
 16 A. Probably in the Los Angeles landfill.  
 17 Q. You threw out the correspondence?  
 18 A. Yes. I do not normally save them. They're  
 19 nothing more than usually "Enclosed is" such and such  
 20 "document for your review. Call me if you have any  
 21 questions."  
 22 Q. Do you have a specific recollection in this  
 23 case that the only thing you would have received from  
 24 defense counsel would have been transmittal letters  
 25 that say "Enclosed please find"?

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1 A. That's all I remember, yes.  
 2 MR. MARGOLIS: Okay. And just for the  
 3 record, there was a duces tecum that was issued where  
 4 the correspondence was asked to be provided. It's my  
 5 understanding that defense counsel will make that  
 6 available to me at a later date.  
 7 MS. SEACRIST: That's correct.  
 8 BY MR. MARGOLIS:  
 9 Q. Doctor, do you use e-mail?  
 10 A. Yes.  
 11 Q. And was there any e-mail that occurred  
 12 between you and defense counsel in this case?  
 13 A. I think once or twice when I had written this  
 14 document, I sent her a rough draft that I had  
 15 originally written to show her what my ideas were. I  
 16 received a response back that said "Thank you very  
 17 much." Then I basically went through it to correct my  
 18 English and make it sound intelligent and sent it  
 19 back. Nothing else changed.  
 20 Q. So as I understand it, the report that you  
 21 authored in this case -- and I don't think it has a  
 22 date on it, does it, sir?  
 23 A. I don't know that it does or it doesn't. I  
 24 don't normally date them.  
 25 Q. As I understand it, the report that you

<p style="text-align: right;">Page 10</p> <p>1 authored in this case, you did a rough draft, and you  2 then e-mailed that rough draft to Mrs. Seacrist's  3 office?  4 A. Yes.  5 Q. And Mrs. Seacrist then reviewed the rough  6 draft of your report?  7 A. Um-hum, just so she could see what my ideas  8 were.  9 Q. All right. And then did you and  10 Mrs. Seacrist speak over the phone after she had the  11 opportunity to review the rough drafts of your report?  12 A. Yes.  13 Q. And were there any notations that were made  14 contemporaneous or subsequent to that telephone  15 conversation with Mrs. Seacrist?  16 A. No.  17 Q. And as a result of the telephone conversation  18 that you had with Mrs. Seacrist, did you make any  19 changes to the rough draft of your report?  20 A. None.  21 Q. So the rough draft of your report that you've  22 e-mailed to Mrs. Seacrist, other than grammatical  23 changes, is the exact -- is the exact report that you  24 actually submitted setting forth your opinions in this  25 case?</p>	<p style="text-align: right;">Page 12</p> <p>1 Stephen Walters, Marc Groedel?  2 A. I don't know them.  3 Q. Okay. So is it your testimony that this  4 would be the first and only case that you have been  5 retained on as an expert by the law firm of Reminger &amp;  6 Reminger?  7 A. That I remember, yes.  8 Q. Do you keep any records of your expert work  9 that you would be able to review to see if you've been  10 retained by them previously?  11 A. I don't keep very good records after the  12 cases have been completed. I pretty much shred  13 everything, so it's gone.  14 Q. Are there any publications that you're  15 working on that are under submission right now?  16 A. No.  17 Q. Any abstracts that are not listed on your CV?  18 A. Yeah, we have one that we've submitted to the  19 Western Vascular which has been accepted on  20 retroperitoneal approach to repair of the aorta, but  21 other than that, that's it right now.  22 Q. Have your hospital privileges ever been  23 diminished, revoked, or suspended?  24 A. No.  25 Q. What hospitals do you have privileges at?</p>
<p style="text-align: right;">Page 11</p> <p>1 A. Yes.  2 Q. Tell me the logistics of -- do you dictate  3 the report? Do you type it yourself on a computer?  4 How does that work?  5 A. I type it myself.  6 Q. And is it on a computer in the office or a  7 home computer?  8 A. Home computer.  9 Q. Let's talk a little bit, sir, about prior  10 work that you've done for the law firm of Reminger &amp;  11 Reminger. Have you been retained on any present cases  12 other than the Keiter case by the law firm of Reminger  13 &amp; Reminger?  14 A. I don't think so.  15 Q. Have you done work for the law firm of  16 Reminger &amp; Reminger on any case before this case?  17 A. Not that I recall.  18 Q. Have -- have you ever testified in federal  19 court?  20 A. No.  21 Q. Do you know the names of any of the lawyers  22 at Reminger &amp; Reminger that you may have done work  23 for? If I were to say --  24 A. Susan Seacrist.  25 Q. -- the name Susan Seacrist, Bill Meadows,</p>	<p style="text-align: right;">Page 13</p> <p>1 A. Saint Joseph's Hospital here in Orange.  2 Q. And tell me a little bit about Saint Joseph's  3 Hospital. How large is it?  4 A. It's about a 450-bed tertiary hospital here  5 in Orange County situated right in the center of the  6 county. It pretty much does all aspects of medicine.  7 It's associated or affiliated with the Children's  8 Hospital across the street as well.  9 Q. And are you simply a physician that has staff  10 privileges there, or do you have any other position at  11 the hospital?  12 A. I'm the director of vascular surgery, the  13 chief of vascular surgery there, not to downplay just  14 being a staff physician. I have been involved very  15 much so with the administration aspects of being on  16 the Medical Executive Committee for years but recently  17 have given that up, just time constraints.  18 Q. Tell me a little bit about the nature of your  19 present practice. Do you do general surgery as well  20 as vascular surgery?  21 A. No, I do not do general surgery at all. I do  22 strictly vascular surgery. It consists of all aspects  23 of vascular surgery from as small as doing a  24 sclerotherapy or varicose veins ablation to as large  25 as doing both open and endovascular repair of thoracic</p>

4 (Pages 10 to 13)

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1 aneurysms. I'm probably the first person in Orange  
 2 County to do a thoracic aneurysm, put in an endograft.  
 3 Q. Now, doctor, how many revascularizations of  
 4 the mesenteric arteries have you done?  
 5 A. Since I left the University of Florida I sort  
 6 of lost count. I used to keep track of that, but I  
 7 would say probably in the range of 70 to 80.  
 8 Q. When did you leave the University of Florida?  
 9 A. Ten years ago.  
 10 Q. So in the past five years how many  
 1 revascularizations of the mesenteric arteries have you  
 2 done, if you know?  
 3 A. I don't know exactly. If I can estimate, I  
 4 do probably somewhere in the range of two or three a  
 5 year now. I had one year in Florida I did 15 in one  
 6 year. I mean that was what I did academically, but  
 7 here I'm not out searching for those patients like I  
 8 was before.  
 9 Q. So you would agree with me if you do about  
 10 two or three mesenteric artery revascularizations a  
 1 year in the past five years, how many surgeries,  
 2 vascular surgeries, do you do a year?  
 3 A. I don't know the answer to that. It varies  
 4 I'm sure anywhere from -- probably do somewhere in the  
 5 range of 150 major vascular procedures, and then

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1 there's just an awful lot of smaller procedures,  
 2 dialysis shunts, fistulas, pseudoaneurysm repairs for  
 3 the cardiologists, et cetera, that I don't even think  
 4 about that add up.  
 5 Q. So you would agree with me that mesenteric  
 6 artery revascularization is a substantial minority of  
 7 the surgeries that you perform at least over the last  
 8 five years?  
 9 A. I think it's always been the minority of the  
 10 procedures that I perform.  
 1 Q. You are board certified?  
 2 A. I am.  
 3 Q. Passed the test the first time out?  
 4 A. I did.  
 5 Q. With what insurance company do you presently  
 6 carry your liability or malpractice insurance  
 7 coverage?  
 8 MS. SEACRIST: Objection. I'll allow him to  
 9 answer, if you know.  
 10 THE WITNESS: I know.  
 11 It's a physician co-op here in Orange County  
 12 known as CAP-MPT.  
 13 BY MR. MARGOLIS:  
 14 Q. Have you received any information or do  
 15 you -- from your insurance company about serving as an

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1 expert witness in medical malpractice cases?  
 2 A. No.  
 3 MS. SEACRIST: Objection.  
 4 BY MR. MARGOLIS:  
 5 Q. Are your premiums at all diminished by virtue  
 6 of you being willing to review cases on behalf of an  
 7 insurance company?  
 8 MS. SEACRIST: Objection.  
 9 THE WITNESS: No.  
 10 BY MR. MARGOLIS:  
 11 Q. How long have you been doing medical/legal  
 12 work, sir?  
 13 A. About 16 or 17 years now.  
 14 Q. Have you ever advertised your services?  
 15 A. No.  
 16 Q. How many depositions do you give a year,  
 17 let's say in the last five years?  
 18 A. Anywhere from about five to ten a year.  
 19 Q. And how many times over the last five years  
 20 have you gone to court to testify?  
 21 A. Not very often. I don't like going to court.  
 22 It interrupts my schedule at home. Probably on the  
 23 average of once a year. Some years you don't go at  
 24 all; some cases you'll go twice.  
 25 Q. How many medical/legal cases do you review or

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1 a yearly basis?  
 2 A. It varies from year to year. On the average  
 3 I would say somewhere between probably about ten. The  
 4 busiest year, I think, was two or three years ago I  
 5 did 17 or 18 in one year.  
 6 Q. What is the split, sir, between instances  
 7 where the patient has engaged your services to review  
 8 a medical case versus the physician engaging your  
 9 services to defend a medical case?  
 10 A. It has changed a lot over the years. When I  
 11 started doing this at the University of Florida, I did  
 12 only defense.  
 13 Q. How many years was that, sir?  
 14 A. Sixteen, seventeen years ago.  
 15 Q. I mean how many years did you only do  
 16 defense?  
 17 A. The years I was at the University of Florida.  
 18 Q. And how many years was that?  
 19 A. Six or seven years.  
 20 Q. And why is it over the six- or seven-year  
 21 period you only would review defense cases?  
 22 A. Because I worked for the state university.  
 23 Q. What does that mean?  
 24 A. It means I got my referrals from the  
 25 physicians around the state, so I defended all the

<p style="text-align: right;">Page 18</p> <p>1 people around the state.</p> <p>2 Q. So it was just by virtue of those were the</p> <p>3 types of cases that came to you.</p> <p>4 A. Right. That's what came.</p> <p>5 Q. Okay.</p> <p>6 A. And once I left the university and as the</p> <p>7 defense attorneys got a little older, because defense</p> <p>8 attorneys sometimes tend to be a little younger, many</p> <p>9 of them moved out into the plaintiff world, and I was</p> <p>10 no longer at the university. The practice has changed</p> <p>11 a little bit. I still do more defense than I do</p> <p>12 plaintiff. I think that last count, which was</p> <p>13 probably six months ago, I was somewhere in the range</p> <p>14 the best I can -- I mean I estimate it's around</p> <p>15 60 percent defense now. I'm doing more plaintiff than</p> <p>16 I used to just because I'm more accessible.</p> <p>17 Q. Do you remember a case that you recently</p> <p>18 testified in the last couple of years in Philadelphia</p> <p>19 dealing with vascular surgical issues?</p> <p>20 A. No, because I don't think I have ever had a</p> <p>21 case in Philadelphia.</p> <p>22 Q. Okay.</p> <p>23 A. If I have, you'll have to refresh my memory</p> <p>24 on that.</p> <p>25 Q. I will.</p>	<p style="text-align: right;">Page 20</p> <p>1 Q. Okay. And how much, sir, is your hourly rate</p> <p>2 for review of records?</p> <p>3 A. It depends on what the person requests. If</p> <p>4 it's a routine review, it's \$400 an hour. If it's an</p> <p>5 urgent review, which means within two weeks, it's \$500</p> <p>6 an hour, and if they need it yesterday, it's usually</p> <p>7 \$600 an hour.</p> <p>8 Q. Are there any plaintiffs cases where you have</p> <p>9 been retained as an expert dealing with issues of</p> <p>10 mesenteric ischemia?</p> <p>11 A. You know, I'm sure there have been, but I</p> <p>12 don't recall right off the top of my head. I don't</p> <p>13 have any actively going right now.</p> <p>14 Q. Do you have any of the reports that you would</p> <p>15 have written on the plaintiffs cases where you were</p> <p>16 retained and the issue was mesenteric ischemia?</p> <p>17 A. No. I don't save any of those. Everything</p> <p>18 is shredded.</p> <p>19 Q. To the best of your knowledge, sir, in the</p> <p>20 last five years have you served as an expert on behalf</p> <p>21 of a plaintiff where the issues of the case dealt with</p> <p>22 mesenteric ischemia.</p> <p>23 A. I'm sure I have.</p> <p>24 Q. The computer that you're using, sir, to write</p> <p>25 your reports on --</p>
<p style="text-align: right;">Page 19</p> <p>1 It's my understanding that your charge for</p> <p>2 this deposition today is a flat fee of \$2,000?</p> <p>3 A. That is correct.</p> <p>4 Q. And if we're here a half hour or four hours,</p> <p>5 it's \$2,000.</p> <p>6 A. That is correct.</p> <p>7 Q. And what is the charge, doctor, for you to</p> <p>8 come to court to testify?</p> <p>9 A. It will be \$5,000 a day plus expenses of</p> <p>10 travel and stay.</p> <p>11 Q. You were also asked to bring with you today</p> <p>12 your bill for work that you've done on Mrs. Seacrist's</p> <p>13 request up to date. Do you have that, sir?</p> <p>14 A. I do.</p> <p>15 Q. May I see that, please.</p> <p>16 Thank you, sir.</p> <p>17 If I'm interpreting this accurately, up</p> <p>18 through June 8 of '05 you've billed and were paid</p> <p>19 \$14,031.35?</p> <p>20 A. If that's what it says.</p> <p>21 Q. Okay. And are these minutes, sir, these</p> <p>22 numbers?</p> <p>23 A. Yes.</p> <p>24 Q. Okay.</p> <p>25 A. There's been no bill submitted.</p>	<p style="text-align: right;">Page 21</p> <p>1 A. Um-hum.</p> <p>2 Q. -- have you been using that same computer for</p> <p>3 three or four years?</p> <p>4 A. No. We actually had a hard disk crash.</p> <p>5 Bought a new computer I think sometime within the last</p> <p>6 year.</p> <p>7 Q. Did you download the information from your</p> <p>8 old computer into the new computer?</p> <p>9 A. No.</p> <p>10 Q. Do you know the name of any plaintiff's</p> <p>11 lawyers who you have worked for in the last five</p> <p>12 years?</p> <p>13 A. Yes.</p> <p>14 Q. May I please have those names, sir.</p> <p>15 A. Well, let's see here. There's Robert</p> <p>16 Spector, who is in Fort Lauderdale, Florida.</p> <p>17 MS. SEACRIST: This is any case, not just</p> <p>18 mesenteric ischemia cases?</p> <p>19 MR. MARGOLIS: Correct, any plaintiff's</p> <p>20 lawyer.</p> <p>21 MS. SEACRIST: Okay.</p> <p>22 THE WITNESS: There's the firm of Babbit,</p> <p>23 Johnson, La Claniche, Osborne, and I've done three or</p> <p>24 four cases for that firm with La Claniche, one with</p> <p>25 Osborne, and one with Johnson, I think.</p>

6 (Pages 18 to 21)

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1 There's a young lady I think in Miami named  
2 Lisa Levine. I haven't worked with her for quite some  
3 time, but it probably would have been in the past five  
4 years.  
5 There was a case in Clearwater, Florida, with  
6 a fellow by the name of Joe Magri.  
7 I'm sure there are others that just don't  
8 come to mind.  
9 BY MR. MARGOLIS:  
10 Q. Doctor, do you have a copy of your bill, sir?  
11 A. That's all I have.  
12 Q. Okay. If you would look on 4-26, you say  
13 "affidavit revision." Do you refer to your report as  
14 an affidavit?  
15 A. Yes.  
16 Q. Okay. You had testified earlier that there  
17 were no changes made in the report. What was it that  
18 you revised that in April you submitted a 30-minute  
19 bill for?  
20 A. Took me about 30 minutes to correct most of  
21 the grammar mistakes that I had made and go through  
22 spell check.  
23 Q. Okay.  
24 A. Spell check is wonderful.  
25 Q. Any other plaintiff's attorneys that you

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1 recall doing work for?  
2 A. Not off the top of my head, no.  
3 Q. And as I understand it, you have no means by  
4 which to assess prior cases where you have served as  
5 an expert for a plaintiff and the issue was mesenteric  
6 ischemia.  
7 A. No.  
8 Q. Did you ever give plaintiff a positive  
9 opinion on cases where you were asked to review  
10 involving the medical issue of mesenteric ischemia?  
11 A. What do you mean by "positive opinion"?  
12 Q. Well, if a plaintiff asked you to review a  
13 case and you felt that the case had merit.  
14 A. I'm sure I have.  
15 Q. Okay. Do you recall any of the facts of  
16 those cases?  
17 A. No.  
18 Q. Do you recall what states?  
19 A. No, because -- but I can tell you that the  
20 majority of what I do is somewhere in the southeast,  
21 large number of it in Florida.  
22 Q. Okay.  
23 A. But other than that, I don't think I could  
24 tell you any further than that.  
25 Q. Thank you very much.

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1 Do you know how it is Mrs. Seacrist obtained  
2 your name in this case?  
3 A. I have no idea.  
4 Q. How were you first contacted? Was it by  
5 telephone? By e-mail?  
6 A. No. What happened initially, as happens in  
7 most of my cases, somebody in her office called and  
8 talked to the secretary in this office and asked if I  
9 would be interested in reviewing the case, nothing  
10 more, nothing less, and I said yes, and with that came  
11 a box of records and basically said, you know,  
12 "Enclosed are these records. Would you please review  
13 these and give us your opinion."  
14 Q. Did you know at the time when you received  
15 the records in this case that Mrs. Seacrist was  
16 representing Dr. Kessler, the defendant?  
17 A. I had no idea, actually. She and I have  
18 actually talked about that because I just sat down and  
19 read the records, and I wasn't sure if I was reading a  
20 defense case or a plaintiff case. Pretty much the  
21 report I generated was along those same lines. It  
22 wasn't trying to give a positive opinion whether this  
23 was a good defense case or whether it was a good  
24 plaintiff case. It was just what my opinions were --  
25 Q. Fair enough.

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1 A. -- after having read the records.  
2 Q. Fair enough.  
3 A. That's why I say it's not uncommon. A lot of  
4 times I'll read depositions before they ask me to read  
5 an affidavit. This was records came. "Tell us what  
6 your opinion is."  
7 Q. You also reviewed depositions before you  
8 authored your report?  
9 A. No.  
10 Q. So you reviewed absolutely no depositions in  
11 this case?  
12 A. Not before I wrote the report. I don't think  
13 so.  
14 Q. Okay.  
15 A. That's my recollection. It was -- these  
16 opinions were generated from the medical records and  
17 the medical records alone.  
18 Q. All right. Do you believe that there would  
19 have been any information contained in Dr. Kessler's  
20 deposition which you would have wanted to know before  
21 you authored your expert report?  
22 A. No, I don't think so. The only thing that I  
23 really was interested, he verified something that as I  
24 read the records I sort of read between the lines and  
25 thought that some of his comments meant.

7 (Pages 22 to 25)

1 MS. SEACRIST: He has read depositions since  
2 then. They're here. I want you to know that.

3 MR. MARGOLIS: I understand that.

4 Q. I'm sorry, doctor. You had indicated that  
5 Dr. Kessler verified something that you believed --

6 A. Right. When I read through his notes, it was  
7 my impression that what he was concerned about was an  
8 acute mesenteric problem, that he didn't think that  
9 was the situation, and that is what I took home from  
10 the records, and he verified that in his deposition,  
11 that that's what he was concerned about at the time.  
12 He did not feel that's what Mrs. Keiter had.

13 Q. So it's your testimony that by virtue of your  
14 review of the medical records in this case, prior to  
15 reading the deposition of Dr. Kessler, that you  
16 believed Dr. Kessler by virtue of the medical records  
17 was concerned about acute mesenteric ischemia.

18 A. Correct.

19 Q. Okay. Can you point to me any medical record  
20 that supports that opinion on your behalf?

21 A. You'll have to define that a little better.

22 Q. Sure, sure.

23 You indicated that before you authored your  
24 report in this case -- and let me back up here. You  
25 understood when you authored your report that it was

1 that to be so.

2 Q. Okay.

3 A. And his deposition helped solidify my  
4 assumption that that's what he thought.

5 Q. Were there any other assumptions that you  
6 made in this case?

7 A. I wouldn't remember.

8 Q. Okay. Would you please refer to me -- to the  
9 medical records in the Hillcrest chart that support  
10 your opinion that Dr. Kessler had a concern about this  
11 patient having acute mesenteric ischemia.

12 A. I don't think there's any objective evidence  
13 in that chart one way or the other. That's why it was  
14 an assumption. In his first consultation he makes  
15 mention that he doubts this is mesenteric ischemia. A  
16 patient comes through the emergency room with this  
17 kind of presentation, it's usually the thinking of the  
18 physicians involved whether this is an acute process.  
19 That's where that assumption came from.

20 Q. Okay. And then when you read Dr. Kessler's  
21 deposition after you wrote your report, Dr. Kessler  
22 testified that it was his concern, at least in the  
23 first 24 to 36 hours of Mrs. Kessler's hospitalization  
24 from his initial consult, that he had a concern that  
25 she had acute mesenteric ischemia.

1 going to be relied upon by others; correct?

2 A. Correct.

3 Q. And you take your responsibility as a medical  
4 expert in these cases, I'm sure, very seriously;  
5 correct?

6 A. Correct.

7 Q. And you want to be as accurate and objective  
8 as you can; correct?

9 A. Correct.

10 Q. And you will agree with me that the accuracy  
11 of the opinions that you arrive at is to a certain  
12 extent dependent upon the completeness of the  
13 information that you receive.

14 A. Correct.

15 Q. It's my understanding, and tell me if I'm  
16 wrong because I'm always usually the least intelligent  
17 person in the room on these things, that you were able  
18 to discern from review of the medical chart of  
19 Hillcrest Hospital that Dr. Kessler was concerned  
20 about the patient having acute mesenteric ischemia;  
21 correct?

22 A. That was my assumption, yes.

23 Q. And that you knew that to be so prior to you  
24 reviewing Dr. Kessler's deposition.

25 A. No, I didn't know that to be so. I assumed

1 A. Correct.

2 Q. Okay. Now --

3 A. Let me back up for a second. No, it wasn't  
4 that he had a concern. It was part of his  
5 differential diagnosis, and he didn't think that's  
6 what she had.

7 Q. And I'm not going to -- and I want to be  
8 respectful to you throughout as you have been to me.  
9 Didn't Dr. Kessler testify in his deposition that he  
10 was concerned for the first 24 or 36 hours that she  
11 may have acute mesenteric ischemia? Weren't those his  
12 words --

13 MS. SEACRIST: I object.

14 THE WITNESS: I don't remember --

15 BY MR. MARGOLIS:

16 Q. -- per your memory?

17 A. I don't remember exactly what those words  
18 were. I think he had -- his deposition is very clear  
19 that he formulated a differential diagnosis from what  
20 he learned from a history and physical exam, what he  
21 learned from what had gone on previously at University  
22 Hospital, and that one of the items in that  
23 differential diagnosis would be acute mesenteric  
24 ischemia. In his mind he had doubted that's what she  
25 had.



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1 Q. Do you make any distinction, sir, between him  
2 being concerned that she may have acute mesenteric  
3 ischemia versus acute mesenteric ischemia being part  
4 of her differential diagnosis?  
5 A. Sure, I do.  
6 Q. What distinction do you make, sir?  
7 A. Well, he's concerned that she's got a  
8 problem, but it's way down on his list of a  
9 differential diagnosis. And I don't want to put words  
10 in Fred Kessler's mouth, but I'm sure that he's no  
11 different than I am when I do my differential  
12 diagnosis for a patient's problems. I rank them in  
13 order of what I think is more realistic that they have  
14 and don't have, and his statement that he doubts that  
15 she had mesenteric ischemia puts it almost at the  
16 bottom of the list if that's even there. Now,  
17 semantics of the word "concerned," is it concern on a  
18 one-to-ten scale of ten or one? It's still in his  
19 differential diagnosis, but he doesn't think that's  
20 what she's got. So I'm having troubles with the word  
21 "concerned."  
22 Q. I asked you and you said you would make a  
23 distinction between if Dr. Kessler was concerned that  
24 she had acute mesenteric ischemia versus acute  
25 mesenteric ischemia being one of the list of her

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1 differential diagnosis. That's what you testified to.  
2 A. Sure.  
3 Q. I'm trying to learn from you what is the  
4 distinction as to whether he is concerned that she has  
5 acute mesenteric ischemia versus it being one on the  
6 list of the differential.  
7 MS. SEACRIST: Objection. Asked and  
8 answered.  
9 THE WITNESS: I don't think there's a  
10 difference. I don't think you can differentiate  
11 between them. He's concerned he's got a sick patient  
12 and he doesn't know what's wrong with her, and he's  
13 trying to sort that out. I think he's concerned  
14 about, if you use those definitions, he's concerned  
15 that she's got disease processes he hasn't even  
16 thought of yet. So I mean I think the word "concern"  
17 when you're talking about a physician is a difficult  
18 word to define.  
19 BY MR. MARGOLIS:  
20 Q. And I'm not trying to barb with you. I'm  
21 just trying to understand -- the words that came out  
22 of your mouth was that you drew a distinction whether  
23 he was concerned about acute mesenteric ischemia  
24 versus it being one on the list of the differential.  
25 I'm trying to understand what that distinction is.

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1 That's my question.  
2 A. That distinction --  
3 MS. SEACRIST: Objection. Asked and  
4 answered.  
5 THE WITNESS: Those distinctions are  
6 essentially degrees of concern --  
7 MR. MARGOLIS: Okay.  
8 THE WITNESS: -- I think is probably what you  
9 and I are battering back and forth about. It's the  
10 semantics of the word of "concern." There's no  
11 adjective to describe his level of concern, I think is  
12 what we're talking about.  
13 BY MR. MARGOLIS:  
14 Q. Okay. Now, doctor, when you were first  
15 contacted in this case, you did not -- strike that.  
16 Before you wrote your report, you did not  
17 have the benefit of the actual film of the 8-13-01  
18 ultrasound that was performed, did you?  
19 A. I have never had the film.  
20 Q. Okay.  
21 A. I have had the Xerox copy.  
22 Q. The report?  
23 A. No. I had Xerox copies of the pictures of  
24 the tracings that were obtained.  
25 Q. But not the entire film of the study.

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1 A. You have to define what "the entire film of  
2 the study" was. What I have are pictures of the  
3 films, the hard-copy films that were made by the  
4 technologist doing the study at that time.  
5 Q. You haven't reviewed a film of the ultrasound  
6 in real time?  
7 A. You're talking about a tape?  
8 Q. Yes, sir.  
9 A. No. That's what we tried to do this morning.  
10 Q. Fair enough.  
11 What else is in your file that you have not  
12 produced thus far relative to my questioning?  
13 Anything? Is there anything else in your file we  
14 haven't gone over yet?  
15 A. You mean my personal file in this case.  
16 Q. Your file in this case, yes, sir.  
17 A. There's not much of anything in the file  
18 other than these notes that we talked about --  
19 Q. Okay.  
20 A. -- the affidavit that I authored, and the  
21 reason I have this correspondence is because it came  
22 to the office yesterday about us being here today.  
23 Q. All right. Can I see that correspondence?  
24 A. Sure.  
25 Q. And while I'm looking at this, would you be

<p style="text-align: right;">Page 34</p> <p>1 kind enough to identify the depositions that you have 2 reviewed. 3 A. Sure. I can do that. 4 I don't know if they're in any particular 5 order here. 6 The depositions of Dr. Jeffrey Katz; 7 Dr. Monica Ray; Dr. Eric Shapiro; Dr. Joel Feinstein; 8 Dr. Fred Kessler; Dr. Jay Schapira, S-c-h-a-p-i-r-a; 9 Dr. Jeffrey Brown; Dr. Louis Adler; and Dr. Patrick 10 Dean. 11 Q. And all of these depositions you would have 12 reviewed after you wrote your report. 13 A. Yes. 14 Q. Did you review the deposition of Dr. Rockne? 15 A. No. I don't know who Dr. Rockne is. 16 Q. Were you provided with the affidavit of a 17 Ms. Bouser -- Bower? 18 MS. SEACRIST: I can answer that. No, he was 19 not. 20 THE WITNESS: I don't remember. 21 BY MR. MARGOLIS: 22 Q. Were you ever provided with the deposition of 23 a Dr. Pikorny? 24 A. I don't remember. 25 Q. It's not here. I'm assuming you weren't</p>	<p style="text-align: right;">Page 36</p> <p>1 A. Is it independent of my clinical business 2 here in the office? 3 Q. Yes, sir. 4 A. Yes. 5 Q. And is it incorporated? 6 A. No. 7 Q. What is the name of the business that 8 utilizes -- that you use for your medical/legal 9 reviews? 10 A. There's no name for it. 11 Q. Okay. It's just -- 12 A. Just it is. 13 Q. Okay. And do you have a separate federal tax 14 I.D. number for that business? 15 A. No. 16 Q. Okay. 17 A. We don't want to make it that complicated. 18 Q. What percentage of your total income does the 19 medical/legal work account for? 20 MS. SEACRIST: Objection. 21 You can answer. 22 THE WITNESS: Yeah, probably about ten 23 percent. It varies from two to three percent some 24 years to 10 to 15 percent in other years. 25 BY MR. MARGOLIS:</p>
<p style="text-align: right;">Page 35</p> <p>1 provided. 2 A. I don't -- yeah, I don't think so. 3 Q. Okay. 4 Did you ever review the deposition of 5 Mrs. Keiter's husband? 6 A. No. 7 MS. SEACRIST: I do intend to send that to 8 him before trial. That was an omission on my part. I 9 will send that to him. 10 BY MR. MARGOLIS: 11 Q. Were you provided with copies of plaintiff's 12 expert witness reports in this case? 13 A. You know, as you were asking that question, I 14 believe I was, and I'm trying to for the life of me 15 remember. It was quite some time ago. I think there 16 were two of them. 17 Q. A lot more than two. 18 A. I'm sure -- I could figure there were a lot 19 more from reading depositions, but I only remember, I 20 think, seeing two, and I'll be doggone if I can 21 remember who they were. 22 Q. Okay. Do you have a separate business that 23 you utilize for your expert witness review? 24 A. Meaning? 25 Q. Well, I don't know. Some --</p>	<p style="text-align: right;">Page 37</p> <p>1 Q. Have you spoken with anybody about the work 2 you have done in this case other than defense counsel? 3 A. No. 4 Q. How many times have you met with defense 5 counsel? 6 MS. SEACRIST: Objection. I think that's 7 work product. 8 MR. MARGOLIS: I'm not asking him what the 9 two of you discussed. I'm asking him how many times 10 he met with you. And your objection is noted, but I 11 respectfully would request that you permit him to 12 answer that. 13 MS. SEACRIST: The number of personal 14 meetings you're asking about; right? 15 MR. MARGOLIS: Yeah. 16 MS. SEACRIST: Okay. Objection. 17 You can answer. 18 THE WITNESS: Twice. 19 BY MR. MARGOLIS: 20 Q. And how many times have you spoken with 21 defense counsel? 22 A. Oh, boy. I don't know the answer to that 23 one. 24 MS. SEACRIST: Object as well. 25 THE WITNESS: More than twice.</p>

10 (Pages 34 to 37)

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1 MR. MARGOLIS: Okay.

2 Q. Would there be two meetings that you met with

3 Mrs. Seacrist prior to today, or does today involved

4 the second meeting?

5 A. Today is included.

6 Q. Today is included.

7 Have you received correspondence from anyone

8 other than Mrs. Seacrist's office?

9 A. No.

0 Q. Have you had any discussions with Dr. Fred

1 Kessler?

2 A. No.

3 Q. Have you reviewed any summary of the medical

4 records that have been prepared by anyone else?

5 A. No.

6 Q. When you wrote your report, were you

7 comfortable that you had been supplied with all the

8 information necessary for the opinions that you

9 articulated?

0 A. Yes.

1 Q. Please tell me how you define "standard of

2 care."

3 A. Standard of care is the usual treatment that

4 any prudent physician would provide. Custom --

5 that's -- what's the word? Consistent with what is

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1 the accepted practice in the community of their

2 specialty.

3 Q. Do you know if you were the only vascular

4 surgeon that was contacted by defense counsel to give

5 an opinion in this case?

6 A. I have no idea.

7 Q. Have you ever been sued for medical

8 malpractice?

9 A. Twice.

0 Q. Have any payments ever been made out on your

1 behalf?

2 A. No.

3 MS. SEACRIST: Objection. Continuing

4 objection, please.

5 BY MR. MARGOLIS:

6 Q. Did any cases go to trial against you?

7 A. No.

8 Q. Were there instances where you were sued and

9 the cases were subsequently dismissed?

0 A. Yes.

1 Q. Are there any pending cases?

2 A. No. At least not that I know of.

3 Q. Are you familiar with a physician by the name

4 of Dr. Louis Adler?

5 A. Only through the depositions.

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1 Q. Did you know him by reputation at all? He

2 used to practice at Cedars-Sinai for many years.

3 A. It's a long ways from here. I don't have a

4 clue who he is. Not to hurt his feelings, but he

5 doesn't know me either, I'm sure.

6 Q. If I wanted to -- if I was a resident under

7 your tutelage in vascular surgery and you wanted to

8 refer me to a textbook on vascular surgery, would you

9 please tell me what textbooks you would refer me to?

10 A. Well, it's pretty standard that the major

11 textbook that people read in vascular surgery is

12 Rutherford's Textbook on Vascular Surgery I think only

13 because it's the largest, the heaviest, but it's the

14 one that seems to be revised every couple three years.

15 It's stood the test of time.

16 Q. Have any items been removed from your file

17 today by you or anyone else?

18 A. No.

19 Q. Doctor, what I'm going to do is kind of

20 headnote the subject areas I'm going to be talking

21 about as we get into the medicine a little bit to

22 hopefully streamline things.

23 Would you agree with me that atherosclerotic

24 disease is also known by laymen as hardening of the

25 arteries?

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1 A. Yes.

2 Q. Would you agree with me that atherosclerotic

3 disease of the mesenteric vasculature is a chronic,

4 progressive condition?

5 A. No, I probably wouldn't.

6 Q. Tell me why.

7 A. In some patients it would be. In some people

8 they just have atherosclerosis and it's not

9 progressive. It's the word "progressive" that I don't

10 agree with.

11 Q. What majority -- what percentage of patients

12 who have atherosclerotic disease of their mesenteric

13 vasculature would that disease be not progressive?

14 A. I don't think you can answer that because you

15 don't know the denominator of that number, so I mean

16 you would only be speculating. We just know from

17 vascular pathology that some people's disease doesn't

18 progress. Atherosclerotic arterial occlusive disease

19 is a disease of getting older. Not everybody gets it

20 because they smoke. Not everybody gets it because

21 their cholesterol level is too high or they're

22 diabetic. They get it because they're older. And we,

23 unfortunately, as physicians have a very skewed view

24 of what this disease does because we don't see the

25 ones that progress. We don't see what happens with

<p style="text-align: right;">Page 42</p> <p>1 the other people out there.</p> <p>2 Q. Based upon your experience as a vascular</p> <p>3 surgeon, what percentage of the patients that have</p> <p>4 atherosclerotic disease is progressive versus</p> <p>5 nonprogressive in nature?</p> <p>6 A. In the mesenteric arteries or in all comers?</p> <p>7 Q. Let's say all comers, and then we'll go to</p> <p>8 the mesenteric.</p> <p>9 MS. SEACRIST: Objection.</p> <p>10 THE WITNESS: Again, I'm going to have to</p> <p>11 tone that down a little bit.</p> <p>12 In diabetic patients it tends to be a little</p> <p>13 more progressive than the general population. It</p> <p>14 doesn't tend to be as progressive. Probably the</p> <p>15 literature would argue this number, anywhere from 50</p> <p>16 percent of the people it would be progressive to some</p> <p>17 patient papers would say only 15 to 20 percent would</p> <p>18 it be progressive.</p> <p>19 BY MR. MARGOLIS:</p> <p>20 Q. What about in the mesenteric vasculature?</p> <p>21 A. I don't know that anybody has been able to do</p> <p>22 a natural history study of that disease mostly because</p> <p>23 the disease is not that common, and only within the</p> <p>24 last ten to 15 years have we had any kind of means to</p> <p>25 study these people outside of invasive testing with</p>	<p style="text-align: right;">Page 44</p> <p>1 me, the way I interpret that, is a steady, chronic</p> <p>2 process, and we know that atherosclerotic disease may</p> <p>3 not progress in a steady, chronic process. Sometimes</p> <p>4 it progresses in a very rapid progress -- process. We</p> <p>5 don't know what happened to Mrs. Keiter.</p> <p>6 Q. Do you have an opinion as to whether the</p> <p>7 atherosclerotic disease in Mrs. Keiter's mesenteric</p> <p>8 arteries was a chronic, long-standing condition?</p> <p>9 A. Well, I do have an opinion, and that's why</p> <p>10 you're here today.</p> <p>11 Her autopsy showed something somewhat</p> <p>12 unusual, what they call Dunbar syndrome, and I must</p> <p>13 admit I have never heard the word "Dunbar syndrome,"</p> <p>14 but I have seen patients and read about patients that</p> <p>15 have entrapment of their celiac axis, a-x-i-s, with</p> <p>16 the arcuate ligament of the diaphragm.</p> <p>17 Arcuate.</p> <p>18 Q. A-r-c- --</p> <p>19 A. Go ahead. You're doing good.</p> <p>20 Q. A-r-c-u-a-t-e?</p> <p>21 A. Yes.</p> <p>22 And I have actually seen two patients through</p> <p>23 my years that also had a high takeoff of this superior</p> <p>24 mesenteric artery and were trapped. That situation is</p> <p>25 a little different. I found Mrs. Keiter's pathology</p>
<p style="text-align: right;">Page 43</p> <p>1 arteriography. I think if I had to speculate on it, I</p> <p>2 have an awful lot of people that I see that have</p> <p>3 vascular problems in their mesenteric arteries that</p> <p>4 never come to needing any kind of surgical procedure</p> <p>5 done, and I think that's the only way one can say are</p> <p>6 they progressive or not because we do not have testing</p> <p>7 that's accurate enough to follow those blockages in</p> <p>8 those arteries enough to tell you, you know, is it</p> <p>9 going from 50 to 60, 60 to 70, 70 to 80 percent.</p> <p>10 Q. Was Mrs. Keiter's -- first thing, did</p> <p>11 Mrs. Keiter have atherosclerosis in her mesenteric</p> <p>12 arteries?</p> <p>13 A. I think her autopsy and pathology slides</p> <p>14 clearly showed that she had atherosclerotic disease.</p> <p>15 Q. Do you have an opinion as to whether her</p> <p>16 atherosclerotic disease in the mesenteric arteries was</p> <p>17 progressive in nature?</p> <p>18 A. Well, it had to have been progressive to</p> <p>19 reach the point that it did.</p> <p>20 Q. So we can agree that the atherosclerotic</p> <p>21 disease in Mrs. Keiter's mesenteric arteries was</p> <p>22 progressive in nature; correct?</p> <p>23 A. I have a little problem with the word</p> <p>24 "progressive." We know it progressed. We don't know</p> <p>25 whether -- the word "progressive" -- "progressing" to</p>	<p style="text-align: right;">Page 45</p> <p>1 very interesting because clearly this is a process</p> <p>2 that I find very interesting anyway, having spent all</p> <p>3 the years and academics studying it. From a</p> <p>4 progressive nature, if indeed she has arcuate ligament</p> <p>5 syndrome which has trapped both of those arteries,</p> <p>6 then over time she would have developed a chronic</p> <p>7 fibrotic process of narrowing of the arteries. We</p> <p>8 know that that happens from the repetitive motion of</p> <p>9 the diaphragm moving up and down the arcuate ligament</p> <p>10 entrapping the artery. We see it much more common</p> <p>11 with celiac axis compression, but there's no reason to</p> <p>12 think that the same thing wouldn't happen with the</p> <p>13 superior mesenteric artery.</p> <p>14 My opinion is that indeed occurred, but I</p> <p>15 think she also developed an atherosclerotic process,</p> <p>16 whether it was related to the chronic injury of the</p> <p>17 artery by the arcuate ligament or whether she</p> <p>18 developed that de novo totally separate and would have</p> <p>19 felt that anyway if she didn't have the anatomic</p> <p>20 process.</p> <p>21 Would you do me a favor. When I'm talking,</p> <p>22 let me finish my statement, and then you can talk to</p> <p>23 him. It's very bothersome.</p> <p>24 MR. FINELLI: I apologize.</p> <p>25 THE WITNESS: It's okay. I understand.</p>

12 (Pages 42 to 45)

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1 MR. FINELLI: I wasn't familiar with --  
 2 THE WITNESS: It is. But it really disturbs  
 3 what I'm trying to say.  
 4 MR. FINELLI: I apologize.  
 5 THE WITNESS: It's fine to talk to him. I  
 6 mean it's your right.  
 7 MS. SEACRIST: You were talking about  
 8 atherosclerotic disease, whether it was a separate  
 9 process or a related process to the celiac axis.  
 10 THE WITNESS: In Mrs. Keiter there's no way  
 11 we're ever going to know, but it's pretty clear that  
 12 she had atherosclerotic disease. Pathology slides  
 13 showed that, and there's nothing more definitive than  
 14 an autopsy and pathology slides.  
 15 BY MR. MARGOLIS:  
 16 Q. We're going to get to the celiac axis  
 17 compression syndrome issues.  
 18 A. Right.  
 19 Q. I'm trying to at this point to focus in on  
 20 your opinions based upon your review of the  
 21 literature, the medical records, your skill and  
 22 expertise, your education.  
 23 We know that at the time of her death she had  
 24 severe atherosclerotic disease of her celiac, SMA, and  
 25 IMA arteries. Do you agree with that?

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1 A. I would agree with that.  
 2 Q. All right. Would you believe that the  
 3 atherosclerotic disease in the mesenteric arteries --  
 4 and can we have an understanding between us when I use  
 5 the word "mesenteric arteries" I'm meaning celiac,  
 6 SMA, and IMA?  
 7 A. Sure.  
 8 Q. Okay. Can we agree that the atherosclerotic  
 9 disease that she had at her autopsy in her mesenteric  
 10 arteries which was severe was a long-standing, chronic  
 11 disease process?  
 12 A. Before I answer that, let me make one  
 13 statement. Then I'll answer your question.  
 14 The disease process of the celiac axis in the  
 15 superior mesenteric arteries is a different disease  
 16 process than the inferior mesenteric arteries, so you  
 17 can't group the three of them together.  
 18 Q. Fair enough.  
 19 A. But in my opinion, she had atherosclerotic  
 20 disease for some time, long standing. I don't know  
 21 that I can defined "long standing." We do know that  
 22 when she had her CT scan done December of 2001, which  
 23 is the one I looked at, she had some calcifications in  
 24 her aorta. Consequently, we know that she's got  
 25 atherosclerotic disease at that time. Whether she has

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1 got long-standing atherosclerotic disease in her  
 2 celiac and superior mesenteric artery is harder to  
 3 tell, in my opinion.  
 4 Q. Were there any findings in the December 7,  
 5 '01, CT scan of atherosclerotic -- strike that.  
 6 Were there any findings in the December 7  
 7 abdominal CT scan of Mrs. Keiter that were abnormal  
 8 findings of her celiac artery?  
 9 A. Boy, that's a bone of contention. You've got  
 10 several experts that say there were. I looked at that  
 11 CT, and as I looked at it and read through the  
 12 depositions, it's very clear that the newer studies of  
 13 CTAs have clearly influenced how we look at plain CT  
 14 scans. I can look at those and convince myself  
 15 retrospectively that there's a problem with the  
 16 superior mesenteric artery and questionably the origin  
 17 of the celiac axis, and I use the word  
 18 "questionably" -- the celiac axis is a lot harder to  
 19 identify. Over all the years that we've looked at CT  
 20 scans in these people, because we've gotten a lot of  
 21 CT scans, we have never been able to say definitively  
 22 from a plain, routine CT scan that a patient had a  
 23 definitive stenosis or occlusion with the superior  
 24 mesenteric or celiac axis. The CTA has changed that  
 25 dramatically. There's no question of that.

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1 But in retrospect, looking at that, I can  
 2 sort of convince myself that there might have well  
 3 been some problems with those arteries, but it's not  
 4 clear-cut to me.  
 5 Q. So my question is: based upon the findings  
 6 of the CT scan of the SMA and the celiac -- and for  
 7 purposes of accuracy I'm going to split them off.  
 8 Let's first talk about the SMA.  
 9 Based upon the autopsy findings, based upon  
 10 your review of the medical records, and based upon the  
 11 12-7-01 CT scan, is it your opinion that there was an  
 12 atherosclerosis that Mrs. Keiter had in the SMA in  
 13 December of '01? And also you can include the autopsy  
 14 notes that you reviewed.  
 15 A. I think she had some atherosclerosis in those  
 16 arteries. I don't think they were normal.  
 17 Q. When you say "those arteries," we're talking  
 18 about the celiac --  
 19 A. The mesenteric, celiac.  
 20 Q. Okay. You would agree with me, then, would  
 21 you not, that if an ultrasound would have been --  
 22 first thing, I've read your articles. You've done a  
 23 lot of research and writing on ultrasound and study of  
 24 mesenteric vasculature, have you not?  
 25 A. I have.

<p style="text-align: right;">Page 50</p> <p>1 Q. You would agree with me that an ultrasound is  2 a pretty accurate test for screening purposes of the  3 mesenteric vasculature; correct?  4 A. I never thought about it as a screening test.  5 Yes, it's very accurate.  6 Q. Okay. And let's exclude the word I used of a  7 screening test. Is it your opinion that an abdominal  8 ultrasound is an accurate diagnostic test to identify  9 abnormalities of the mesenteric arteries?  10 A. I don't believe that an abdominal ultrasound  11 is, no. I believe a duplex scan is. There's a major  12 distinction between the two.  13 Q. Okay. Is a duplex scan an accurate test at  14 diagnosing abnormalities of the mesenteric arteries?  15 A. Yes.  16 Q. Are there any risks to the performance of a  17 duplex scan?  18 A. None.  19 Q. What is the sensitivity of a duplex scan in  20 diagnosing abnormalities of the mesenteric arteries?  21 A. I would say it's probably in the range of 95  22 percent.  23 Q. What is the specificity of a duplex scan in  24 diagnosing abnormalities of the mesenteric arteries?  25 A. I should have read my own paper. I don't</p>	<p style="text-align: right;">Page 52</p> <p>1 they might have find an abnormality, but they just as  2 easily could have found that there was normal flow  3 through those arteries because the test of duplex  4 scanning, when a patient has compression by the  5 ligament, so the diaphragm -- as the diaphragm moves  6 up and down and the aorta moves, those signals can go  7 from being markedly abnormal to normal.  8 Q. The inspiration and expiration.  9 A. Exactly. And that is the positive nature of  10 the test. The component of duplex scanning that a lot  11 of people do not understand, and that's why I  12 corrected you about abdominal ultrasound, it is not a  13 test to so much look at the artery as it is a test to  14 evaluate the blood flow through the artery, and the  15 ultrasound is nothing more than looking, whereas a  16 duplex scan looks to find the flow, to evaluate the  17 flow, and in this situation it's very difficult to  18 determine the degrees of atherosclerotic obstruction  19 by looking at the plaques.  20 And that's why I say I think Mrs. Keiter had  21 two processes going on here, and that's what makes it  22 difficult to know and to predict what was going on in  23 December and correlate with what we know happened in  24 July.  25 Q. So as I understand your testimony, it is your</p>
<p style="text-align: right;">Page 51</p> <p>1 know that I can remember the numbers. It's over 90  2 percent.  3 Q. Now that we have identified that there was  4 atherosclerosis present in Mrs. Keiter's celiac and  5 SMA arteries in December of '01, are you able to offer  6 an opinion as to the extent of the atherosclerotic  7 disease present at that time?  8 A. No.  9 Q. When you're talking about the degree or the  10 extent of atherosclerotic disease in mesenteric  11 vasculature, do you grade it as mild, moderate,  12 severe, occluded, or is it just percentages?  13 A. I tend to believe in percentages.  14 Q. Okay. Had a duplex scan been done of  15 Mrs. Keiter's mesenteric arteries in December of '01,  16 do you believe it would have been positive for  17 abnormal findings of the celiac artery?  18 A. Yes, I do.  19 Q. Do you believe if a duplex scan would have  20 been performed in December of '01, whether it would  21 have been positive for abnormalities of the SMA in  22 Mrs. Keiter?  23 A. I do. And let me explain why, because I do  24 believe she had compression syndrome, and if the  25 technologist was astute enough to be looking for it,</p>	<p style="text-align: right;">Page 53</p> <p>1 opinion that Mrs. Keiter had atherosclerotic disease  2 in December, '01, of her celiac and SMA and in  3 addition thereto had celiac axis compression syndrome.  4 A. Correct.  5 Q. And had a duplex scan been done in December  6 of '01, it would have diagnosed those conditions.  7 A. Could have, yes.  8 MS. SEACRIST: Objection.  9 THE WITNESS: I don't know that it would  10 have, but it could have.  11 BY MR. MARGOLIS:  12 Q. Do you have an opinion as to whether it's  13 more likely than not, because you told me earlier you  14 don't know the amount of ASO that would have been  15 present and that there's 95 percent specificity and  16 sensitivity.  17 A. I have to ask you a question. What does  18 "ASO" stand for?  19 Q. Atherosclerotic disease.  20 A. Okay.  21 Q. But I tend to always -- atherosclerosis.  22 A. I figured that's what you meant. We're on  23 the same page.  24 More likely than not, they would not have  25 found an abnormal duplex scan. My experience with</p>

14 (Pages 50 to 53)

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1 looking at patients that have celiac axis compression,  
2 unless we're really astute, we will miss it because  
3 doing duplex scanning of mesenteric arteries is not  
4 the easiest of exams to do, and a lot of times you  
5 catch the artery as it passes through the field of the  
6 ultrasound, and if you happen to be looking in the  
7 particular field where the artery is open, you will  
8 miss the problems.  
9 Q. My question, Dr. Harward, is this.  
10 Did I pronounce the name properly?  
11 A. Excellent.  
12 Q. Okay.  
13 You have testified previously, and correct me  
14 if I'm misstating anything, that it is your opinion  
15 that she did have some atherosclerotic disease in her  
16 SMA and celiac artery in December of '01; true?  
17 A. Correct.  
18 Q. You could not quantify for me the amount of  
19 that disease.  
20 A. That is correct.  
21 Q. Assuming that the amount of the  
22 atherosclerotic disease in her SMA in December of '01  
23 was such that the artery was 70 percent narrowed,  
24 would that have been picked up by a duplex scan?  
25 A. Should have been, yes.

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1 Q. Assuming that her atherosclerotic disease in  
2 her celiac in December of '01 was such that that  
3 artery was 70 percent narrowed, would that have been  
4 picked up by a duplex scan?  
5 MS. SEACRIST: Objection to the hypothetical.  
6 Go ahead.  
7 THE WITNESS: I believe it would have been.  
8 BY MR. MARGOLIS:  
9 Q. Doctor, I want you to assume for a moment  
10 that the 8-13-01 duplex scan -- and no fault of your  
11 own. You have not had the opportunity to see that  
12 study. We have tried to make it available today, but  
13 because of technical issues, we could not. Assume  
14 that the PSV of the -- I want to get this right. I  
15 want you to assume that the 8-13-01 study of the  
16 celiac artery had a PSV of 327 and an EDV of 111.  
17 Assuming that to be the case, what does that tell you?  
18 MS. SEACRIST: I'm going to object to any  
19 questions about the August, 2001, ultrasound on the  
20 basis that this doctor has not had an opportunity to  
21 review it, and now you're taking information and  
22 asking him to assume certain things. So I'm going to  
23 object to any line of questioning on this ultrasound  
24 until he has an opportunity to review the film. I  
25 think it's unfair. I'm not going to allow him to

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1 answer questions about the ultrasound. I think that  
2 was our agreement coming in.  
3 MR. MARGOLIS: Yeah, let me ask the question  
4 this way. You're right. You're right. We had  
5 discussed that, and I made it applicable to her, and I  
6 should not have.  
7 Q. What does it indicate to you as a vascular  
8 surgeon who is very well written on duplex  
9 ultrasonography of the mesenteric vasculature if a  
10 celiac on a duplex scan has a PSV of 327 and an EDV of  
11 111, not specific to this patient, just in general?  
12 MS. SEACRIST: Same objection. If he can  
13 answer that in a vacuum, I'll let him answer that  
14 question.  
15 THE WITNESS: It's clearly an abnormal peak  
16 systolic velocity.  
17 BY MR. MARGOLIS:  
18 Q. Where is the cutoff? 250?  
19 A. It depends on the machine, the laboratory,  
20 the criteria used by each lab. But no matter which  
21 machine you use, 327 is abnormal.  
22 Q. Okay.  
23 A. And all I can use is the experience we have  
24 in our laboratory, and we use a Siemen's machine, and  
25 it probably would represent about a 70 percent

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1 blockage.  
2 Q. Okay.  
3 Let me try to take the dive this way before I  
4 get my notes on celiac axis compression.  
5 Give me the basis, please, of all of the  
6 factors in this case that support your opinion that  
7 Mrs. Keiter suffered from celiac axis compression.  
8 A. I think there's really only one basis, and  
9 you have an autopsy report, which is the definitive  
10 test, that that's what the pathologist found.  
11 Q. Okay. And the same question applicable to  
12 the SMA?  
13 A. Same answer.  
14 Q. Okay. Do you agree with the statement that  
15 celiac axis compression is a concept that is in  
16 dispute in medicine? I'm probably not using the best  
17 word. I'm just --  
18 A. I understand where you're coming from,  
19 though.  
20 Q. A controversial --  
21 A. Yeah, you know, I'm going to answer that yes,  
22 I understand that there are people out there that  
23 don't believe that entity exists, but they're usually  
24 people that don't have enough experience or seen  
25 enough of these patients. There are an awful lot of



<p style="text-align: right;">Page 58</p> <p>1 patients that come that have this anatomic problem,  2 but are totally asymptomatic from it, but there are  3 also a smaller percentage of patients that come that  4 do have this anatomical problem that have their own  5 certain set of clinical problems and presentation that  6 when you relieve the obstruction to the celiac axis,  7 the problem goes away. And it all stems from the  8 collateral network of circulation and communications  9 between all three of the various blood vessels because  10 not everyone has a wonderfully developed collateral  11 network.  12 Q. Okay. Do you agree with me that there is a  13 distinction between a high origin of the takeoff of a  14 celiac and celiac axis syndrome?  15 MS. SEACRIST: Can you repeat that? I'm  16 sorry.  17 THE WITNESS: I'm not sure I understand your  18 question.  19 BY MR. MARGOLIS:  20 Q. Sure. I guess my question is simply because  21 the celiac has a high takeoff from the aorta, that  22 does not in and of itself meet the criteria for Dunbar  23 syndrome, celiac axis syndrome, median arcuate  24 ligament syndrome, does it?  25 A. The answer is probably -- and every different</p>	<p style="text-align: right;">Page 60</p> <p>1 can't have the anatomic abnormality without the  2 compression. You definitely can't have the clinical  3 presentation without the compression.  4 Q. And isn't celiac axis compression syndrome a  5 condition which will be picked up by the lateral view  6 of angiography?  7 A. It can be.  8 Q. In this case did the angiography of July 7,  9 '02, have a finding of celiac axis compression  10 syndrome?  11 MS. SEACRIST: Objection. We don't have that  12 film. That's the nature of my objection.  13 MR. MARGOLIS: Okay. We have the report.  14 You reviewed the report.  15 MS. SEACRIST: Someone else's interpretation.  16 THE WITNESS: If the disease has progressed  17 to the point that the artery is completely occluded,  18 you can't make that diagnosis.  19 BY MR. MARGOLIS:  20 Q. Okay. In your report you make reference to  21 the fact that -- let me get the report so I'm not  22 misquoting.  23 Doc, if while I'm looking for your report  24 language, if you would be kind enough to pull out the  25 autopsy.</p>
<p style="text-align: right;">Page 59</p> <p>1 physician has got a different interpretation of that,  2 so I'll give you my interpretation. I think it will  3 answer your question.  4 The anatomic presence of the problem, some  5 people would say that means they have an arcuate  6 ligament syndrome. Anecdotally, just like people that  7 have reverse flow in their vertebral artery because  8 they have an obstruction to their subclavian artery,  9 they have subclavian steal syndrome. But do they have  10 clinical manifestations of that anatomical problem,  11 and the answer to your question is there are a lot of  12 people that have the anatomical problem that never  13 present with the clinical presentation, but -- and  14 that's why there's a dispute out there because some  15 physicians do not believe that this is a clinical  16 entity. It's an anatomical entity. But there are a  17 small number of patients out there who definitely  18 present with clinical symptoms from celiac axis  19 compression syndrome and/or Dunbar syndrome.  20 Q. In order for Dunbar/celiac axis syndrome to  21 exist, doesn't there actually have to be compression  22 of the celiac artery by the arcuate ligament?  23 A. By definition, that is the disease.  24 Q. Okay.  25 A. You can't have either the anatomic -- you</p>	<p style="text-align: right;">Page 61</p> <p>1 MS. SEACRIST: I can pull that out pretty  2 easily.  3 THE WITNESS: It's not hard to find.  4 MS. SEACRIST: I think it's going to be in  5 Volume 4.  6 THE WITNESS: Is that where it is?  7 MS. SEACRIST: Um-hum.  8 THE WITNESS: It might be there.  9 MS. SEACRIST: This is 5 and 2.  10 THE WITNESS: This is 4.  11 MS. SEACRIST: Okay.  12 THE WITNESS: I got to keep from pulling this  13 cord off the table here. That's all right.  14 Okay. I have it.  15 BY MR. MARGOLIS:  16 Q. Okay. On page 5 of your report I'm going to  17 read you a sentence that is the last sentence of the  18 last paragraph.  19 "Rather than the usual  20 atherosclerotic occlusive disease  21 [sic] seen in patients with this  22 disease process, it was noted that  23 both arteries were entrapped by the  24 arcuate ligament of the diaphragm."  25 What do you mean when you -- in that context</p>

16 (Pages 58 to 61)



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1 does "entrap" also mean "compressed"?  
 2 A. Well, yes. They have to be entrapped to be  
 3 compressed.  
 4 Q. Okay. So tell me how -- in that context how  
 5 you use the word "entrapped." That there's some  
 6 physical touching, if you will, of the arcuate  
 7 ligament on the celiac --  
 8 A. Yes.  
 9 Q. -- artery?  
 10 Okay. Would you please show me in the  
 11 autopsy report where there is a physical finding that  
 12 the arcuate ligament was actually entrapping the  
 13 celiac artery.  
 14 And Kenny, if you would like, we can go off  
 15 the record so the doc can take his time and look at  
 16 it.  
 17 THE VIDEOGRAPHER: Sure.  
 18 The time now is 11:29. We're going off the  
 19 record.  
 20 (Pause in proceedings.)  
 21 THE VIDEOGRAPHER: The time now is 11:31.  
 22 We're back on the record.  
 23 BY MR. MARGOLIS:  
 24 Q. Doctor, the question that is pending was  
 25 would you please show me in the autopsy report where

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1 there is a physical finding that the arcuate ligament  
 2 was actually entrapping the celiac artery.  
 3 A. While we were off camera there, I have sat  
 4 here and looked through the autopsy report, and  
 5 there's nowhere does it give the actual term of  
 6 "entrapment." I believe that I'm probably  
 7 interpreting what our pathologist has said in his --  
 8 in his comments of the autopsy, stating that the  
 9 patient had high takeoff of both celiac axis and  
 10 superior mesenteric artery and that he found what was  
 11 called Dunbar syndrome, which is basically by  
 12 definition entrapment of these arteries by the arcuate  
 13 ligament of the diaphragm.  
 14 Q. And if I can interrupt you a moment, let's  
 15 look at exactly what the pathologist says. Are you  
 16 reading the "Summary" and "Comment"?  
 17 A. I wasn't reading anything actually at the  
 18 time.  
 19 Q. I think you answered my question by saying he  
 20 found this Dunbar syndrome, which is defined as  
 21 entrapment of the celiac artery by the arcuate  
 22 ligament. I guess what I'm just trying to find out is  
 23 it seems to me that the pathologist is talking about  
 24 this high origin and then goes on to a discussion of  
 25 the medical literature and talks about Dunbar syndrome

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1 and then gives a definition "This is when the high  
 2 arteries are compressed by the median arcuate ligament  
 3 of the diaphragm." But at no point in the autopsy  
 4 does he actually make the gross physical finding that  
 5 there is compression of the celiac axis by the median  
 6 arcuate ligament. Would you agree with that?  
 7 A. No. I think that's your interpretation. A  
 8 lot of times things are found at autopsy, and he's not  
 9 describing word for word what he found.  
 10 Unfortunately, we don't have photographs here. You're  
 11 right. I would like to have a very detailed  
 12 description of as he cut the diaphragm and the arcuate  
 13 ligament what happened, but I don't expect to see that  
 14 from a pathologist.  
 15 Q. Would it totally change your opinion that  
 16 this woman suffered from celiac axis compression  
 17 syndrome if the pathologist were to say that he did  
 18 not find any compression of the celiac artery by the  
 19 arcuate ligament of the diaphragm?  
 20 MS. SEACRIST: Objection.  
 21 BY MR. MARGOLIS:  
 22 Q. You may answer.  
 23 A. You mean if he comes along and tells us that  
 24 he lied in his report here?  
 25 Q. No. If he comes along and says that the way

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1 you, sir, are interpreting his report is not accurate.  
 2 MS. SEACRIST: Objection.  
 3 BY MR. MARGOLIS:  
 4 Q. That's another possibility other than him  
 5 lying, isn't it?  
 6 A. No, I don't think so. When he describes  
 7 compression-type syndrome problems, that's what it is.  
 8 It's a black-and-white issue. It's not a "maybe it  
 9 was." It's like being a little bit pregnant. Either  
 10 you are or you aren't.  
 11 Q. My question, sir, is this. If Dr. Hoffman  
 12 were to be deposed in this case and Dr. Hoffman were  
 13 to testify under oath that he did not find compression  
 14 of the celiac artery at autopsy by the arcuate  
 15 ligament, would that change your opinion that this  
 16 patient suffered from celiac axis compression  
 17 syndrome?  
 18 MS. SEACRIST: Objection.  
 19 THE WITNESS: Yeah, I guess I would probably  
 20 have to say it would because that would mean that the  
 21 patient had normal anatomy. If that's what you're  
 22 telling me, that the patient had absolutely  
 23 stone-cold, normal anatomy, then that would mean that  
 24 that autopsy report would read totally different than  
 25 it does.

<p style="text-align: right;">Page 66</p> <p>1 BY MR. MARGOLIS:</p> <p>2 Q. And if that were the case, sir, and if the</p> <p>3 August ultrasound shows a 70 percent occlusion of the</p> <p>4 celiac artery, you would then attribute that stenosis</p> <p>5 of the celiac to atherosclerotic disease?</p> <p>6 MS. SEACRIST: Objection to the foundation of</p> <p>7 the hypotheticals.</p> <p>8 BY MR. MARGOLIS:</p> <p>9 Q. You may answer.</p> <p>10 A. I think you would have to attribute it to the</p> <p>11 atherosclerotic disease.</p> <p>12 Q. Fair enough.</p> <p>13 Would you please go to the "Abdomen" portion</p> <p>14 of the autopsy under the "Gross Description."</p> <p>15 A. What page?</p> <p>16 Q. I think, sir, that's on --</p> <p>17 MS. SEACRIST: Page 4.</p> <p>18 MR. MARGOLIS: It's -- yeah, page 4.</p> <p>19 MS. SEACRIST: Under "Internal Examination."</p> <p>20 THE WITNESS: Okay.</p> <p>21 BY MR. MARGOLIS:</p> <p>22 Q. Under the portion of it that says "Abdomen,"</p> <p>23 wouldn't that be the portion that you would expect</p> <p>24 there to be a description if there was actually</p> <p>25 arcuate ligament compression of the celiac</p>	<p style="text-align: right;">Page 68</p> <p>1 Q. Okay. Well, I need to pull them because I</p> <p>2 don't remember.</p> <p>3 A. Okay.</p> <p>4 Q. Is it your testimony, sir, that the surgical</p> <p>5 procedure performed by Dr. Pinault, the exploratory</p> <p>6 laparotomy right iliac artery to SMA retrograde bypass</p> <p>7 with reversed saphenous vein, that in the performance</p> <p>8 of that surgery he would not have dissected the area</p> <p>9 where the median arcuate ligament comes over the</p> <p>10 celiac artery?</p> <p>11 A. Not even close.</p> <p>12 Q. Okay. Was there a point in that procedure</p> <p>13 where after the dissection of the location of the</p> <p>14 celiac artery that he checked to see a blood flow in</p> <p>15 that area with a -- intraoperatively with a Doppler</p> <p>16 ultrasound, I think?</p> <p>17 A. No, he didn't. There's no description in his</p> <p>18 op report listening to the celiac axis.</p> <p>19 Q. What about the SMA?</p> <p>20 A. There's no description of listening to the</p> <p>21 SMA. He feels for a pulse in the root of the</p> <p>22 mesentery.</p> <p>23 Q. Okay. If the celiac artery were compressed</p> <p>24 by the arcuate ligament, with the procedure that</p> <p>25 Dr. Pinault did, would the dissection cause the</p>
<p style="text-align: right;">Page 67</p> <p>1 artery?</p> <p>2 MS. SEACRIST: I'm going to object. He's not</p> <p>3 a pathologist. He didn't write the report.</p> <p>4 THE WITNESS: I don't know how these reports</p> <p>5 are generated. I don't know where you would put it.</p> <p>6 That's up to the pathologist.</p> <p>7 BY MR. MARGOLIS:</p> <p>8 Q. Have you reviewed autopsy reports prior to</p> <p>9 today?</p> <p>10 A. Not very often. Probably ten in my life.</p> <p>11 Q. Now, you reviewed the op notes in this case</p> <p>12 of Dr. Pinault and Dr. Shuck; correct?</p> <p>13 A. I did.</p> <p>14 Q. Anywhere in the op notes in the physical</p> <p>15 findings do they discuss a finding of arcuate ligament</p> <p>16 compressing the celiac --</p> <p>17 A. They didn't look.</p> <p>18 Q. -- artery?</p> <p>19 Is it --</p> <p>20 A. There's no description of it because they</p> <p>21 didn't look.</p> <p>22 Q. Okay. Let's pull the op notes. First --</p> <p>23 A. I don't need to pull the op notes. I read</p> <p>24 the op notes. There's no reason to even go up there</p> <p>25 and look.</p>	<p style="text-align: right;">Page 69</p> <p>1 compression if it existed to be remedied?</p> <p>2 A. No.</p> <p>3 Q. Why not?</p> <p>4 A. He's about three inches away from it.</p> <p>5 Q. What about the same question applicable, sir,</p> <p>6 to the SMA?</p> <p>7 A. No.</p> <p>8 Q. Why not?</p> <p>9 A. It's about three inches away from the</p> <p>10 diaphragm.</p> <p>11 Q. Okay. So as I understand your testimony,</p> <p>12 there is nothing in the op notes of Dr. Pinault or</p> <p>13 Dr. Shuck which would shed any light on whether or not</p> <p>14 she suffered from celiac axis compression syndrome.</p> <p>15 A. Nothing.</p> <p>16 Q. Okay. Same question, sir, applicable to</p> <p>17 compression of the SMA.</p> <p>18 A. There's no way from the dissections that they</p> <p>19 did -- the only thing that Dr. Shuck does describe is</p> <p>20 going into the lesser sac and feeling for the superior</p> <p>21 mesenteric artery, which is, in my opinion, impossible</p> <p>22 to feel to the lesser sac without moving the pancreas</p> <p>23 away from the artery, and it's absolutely the wrong</p> <p>24 place to feel for the artery. Dr. Pinault was quite</p> <p>25 right into feeling for the artery in the root of the</p>

18 (Pages 66 to 69)

<p style="text-align: right;">Page 70</p> <p>1 mesentery. Celiac axis compression syndrome is up  2 under the diaphragm, and for them to have even thought  3 about it at the time would be remarkable. And the  4 only reason that one would even consider being up in  5 that region is if one was going to do a bypass off the  6 superceliac aorta, which would not be indicated in  7 this situation. I mean the operation that Dr. Pinault  8 did was an appropriate operation for the situation  9 that he found the patient in.</p> <p>10 Q. Okay. So the total evidence that supports  11 your opinion of celiac compression or SMA compression  12 by the median arcuate ligament in this case would be  13 the autopsy.</p> <p>14 A. Correct.</p> <p>15 Q. Okay. Unfortunately, despite the best  16 efforts of Mrs. Seacrist and myself and Dan, we have  17 been unable to have the July 7 angiography film  18 reproduced, so we're stuck with just going with the  19 dictated report.</p> <p>20 A. I understand.</p> <p>21 Q. You have had the opportunity to review that  22 report?</p> <p>23 A. I understand that, and yes, I did.</p> <p>24 Q. Are there any findings on that report which  25 are confirmatory of celiac axis compression syndrome?</p>	<p style="text-align: right;">Page 72</p> <p>1 is not uncommon that two of the three arteries are  2 severely diseased, and as the third artery becomes  3 more diseased, they get in trouble because the  4 collateral connections between the three arteries are  5 such that it's not uncommon to see an arteriogram for  6 any reason that total occlusion of the artery -- of  7 the celiac axis and the superior mesentery artery are  8 present, the patient is totally asymptomatic.</p> <p>9 BY MR. MARGOLIS:</p> <p>10 Q. Because of the collateral?</p> <p>11 A. But you see a large, meandering artery  12 connecting between the left colic, and they're  13 basically living off of that artery.</p> <p>14 Q. Is that the Circle of Drummond?</p> <p>15 A. No. It's the Arc of Riolan, R-i-o-l-a-n.  16 And as the disease process progresses, whether it be  17 rapidly, usually that's what happens. Something  18 acutely occurs or rapidly changes that gets them in  19 trouble.</p> <p>20 Q. Okay. So as I understand it, it's your  21 opinion that retrospectively Mrs. Keiter had  22 mesenteric ischemia in December of '01 secondary to  23 disease of the celiac, SMA, and IMA to some extent.</p> <p>24 A. Correct.</p> <p>25 MS. SEACRIST: Objection.</p>
<p style="text-align: right;">Page 71</p> <p>1 A. None.</p> <p>2 Q. What is the percentage of patients that have  3 both the celiac artery and the SMA compressed by the  4 median arcuate ligament? Do you know?</p> <p>5 A. No. It's very rare.</p> <p>6 Q. Did Mrs. Keiter suffer from mesenteric  7 ischemia in December of '01 --</p> <p>8 MS. SEACRIST: Objection.</p> <p>9 BY MR. MARGOLIS:</p> <p>10 Q. -- based upon your skill, your expertise, and  11 all the material you have had to review?</p> <p>12 A. I think if we retrospectively review this  13 case, I think she probably did.</p> <p>14 Q. Okay. And would that be secondary to disease  15 in the celiac and SMA?</p> <p>16 MS. SEACRIST: Objection.</p> <p>17 BY MR. MARGOLIS:</p> <p>18 Q. Let me ask the question this way.  19 Which of the mesentery arteries would have  20 been responsible for her suffering mesenteric ischemia  21 in December of '01?</p> <p>22 MS. SEACRIST: Objection.</p> <p>23 THE WITNESS: Well, most commonly it's all  24 three. As I put this together, Mrs. Keiter had a very  25 unusual presentation of this disease process, but it</p>	<p style="text-align: right;">Page 73</p> <p>1 BY MR. MARGOLIS:</p> <p>2 Q. If an MRA would have been done in December of  3 '01, do you have an opinion as to whether or not it  4 would have been normal or abnormal with results to  5 findings of the mesenteric arteries?</p> <p>6 A. You know, I don't know quite what an MRA  7 would have shown. I don't particularly like MRA.  8 They're small. They don't have very good resolution.  9 Some places they're excellent. My hospital, they're  10 terrible. I was very not surprised at all when I read  11 Dr. Kessler's comments that they had MRA at their  12 hospital, but they just weren't used very often.  13 They're very specific to institution to institution.  14 So I mean I don't know if I can tell you whether they  15 would have shown something proper or not. I think an  16 arteriogram might have shown something.</p> <p>17 Q. And at no fault of yours, Dr. Harward, you  18 were not aware because defense counsel chose not to  19 give you this information, but a deposition was taken  20 of Dr. Rockne, who is the chief of interventional  21 radiology at Hillcrest Hospital, and he has testified  22 that they had a very high-quality MRA scanner; that it  23 had been in use at the hospital since 1998; they were  24 doing numerous abdominal studies of the mesenteric  25 arteries with very good results. And I understand,</p>

19 (Pages 70 to 73)

<p style="text-align: right;">Page 74</p> <p>1 sir, you didn't have that information, and --</p> <p>2 A. Well, whether I had that information or not,</p> <p>3 having a high-quality scanner is not the important</p> <p>4 aspect. It's whether it can be used clinically. We</p> <p>5 have a very high-quality scanner at our hospital. We</p> <p>6 just don't have radiologists who are very skilled at</p> <p>7 providing the information we need. We have had more</p> <p>8 false positives and false negatives of our scans that</p> <p>9 we end up arteriogramming everybody that gets an MRA</p> <p>10 by one of our good referring physicians. So I don't</p> <p>11 know that that tells me a whole lot about whether they</p> <p>12 had good MRA results or not.</p> <p>13 Q. I want you to assume, sir, in this case</p> <p>14 Dr. Rockne has testified and it has not been</p> <p>15 controverted by anyone that the quality of his</p> <p>16 interpretation of abdominal MRAs was very good.</p> <p>17 A. Might have been.</p> <p>18 Q. Does that at all change your opinion as to</p> <p>19 what an MRA would have demonstrated in December of '01</p> <p>20 had one been done of the mesenteric vasculature of</p> <p>21 Mrs. Keiter --</p> <p>22 MS. SEACRIST: Objection.</p> <p>23 BY MR. MARGOLIS:</p> <p>24 Q. -- at Hillcrest Hospital?</p> <p>25 A. It's hard to know what it would have shown.</p>	<p style="text-align: right;">Page 76</p> <p>1 an interesting finding to see. If indeed she has got,</p> <p>2 which I think she does, compression of the celiac and</p> <p>3 superior mesenteric arteries, if they catch it in the</p> <p>4 wrong phase of breathing, it might be open; it might</p> <p>5 be occluded. It's the same problem you're going to</p> <p>6 have when you do a duplex scan for that disease</p> <p>7 process.</p> <p>8 BY MR. MARGOLIS:</p> <p>9 Q. I want you to assume that she had</p> <p>10 atherosclerotic disease in her mesenteric vasculature</p> <p>11 of the celiac, SMA, and IMA in December of '01. Had</p> <p>12 an MRA been done, would it have been diagnostic for</p> <p>13 occlusive or stenotic findings?</p> <p>14 MS. SEACRIST: Objection.</p> <p>15 THE WITNESS: It depends on the degree of the</p> <p>16 atherosclerotic process.</p> <p>17 BY MR. MARGOLIS:</p> <p>18 Q. I want you to assume that the celiac had 70</p> <p>19 percent stenosis.</p> <p>20 A. Well, we can only assume it would have shown</p> <p>21 that.</p> <p>22 MS. SEACRIST: Objection to the basis of that</p> <p>23 hypothetical.</p> <p>24 BY MR. MARGOLIS:</p> <p>25 Q. When an MRA is done, don't they do serial</p>
<p style="text-align: right;">Page 75</p> <p>1 I mean I don't have any reason one way or the other to</p> <p>2 say it would have shown something bad or something</p> <p>3 good. I mean my gestalt is that she probably would</p> <p>4 have had something on that MRA.</p> <p>5 Q. And "something" means some abnormal finding</p> <p>6 of the mesenteric vasculature?</p> <p>7 A. I think she probably would have because I</p> <p>8 believe his autopsy indeed demonstrated there was some</p> <p>9 entrapment of those two arteries, so I expect the MRA</p> <p>10 is going to show something.</p> <p>11 Q. Would it show more likely than not some</p> <p>12 atherosclerotic disease of her mesenteric vasculature?</p> <p>13 A. I don't think you can see that on an MRA.</p> <p>14 It's not enough -- it does not define the disease</p> <p>15 process. What it's going to define are obstructions</p> <p>16 of the artery, and it's unfortunately our job as</p> <p>17 physicians to figure out what's causing the</p> <p>18 obstructive process.</p> <p>19 Q. Would you agree that had an MRA been done in</p> <p>20 December of '01 of the mesenteric vasculature of the</p> <p>21 celiac, the SMA, and the IMA, that it would have been</p> <p>22 positive for occlusive or stenotic findings?</p> <p>23 MS. SEACRIST: Objection.</p> <p>24 You can answer.</p> <p>25 THE WITNESS: You know, I think it would be</p>	<p style="text-align: right;">Page 77</p> <p>1 cuts over a period of time so it would include both</p> <p>2 phases of inspiration and expiration?</p> <p>3 A. Serial cuts over time. I'm not a</p> <p>4 radiologist, so I can't tell you exactly how they do</p> <p>5 them. So I'm not going to answer that. I don't know</p> <p>6 that I can answer that.</p> <p>7 Q. Okay.</p> <p>8 A. I would be guessing if I answered that for</p> <p>9 you.</p> <p>10 Q. And offering no disrespect to you, sir, but</p> <p>11 given the fact that you're not a radiologist, you</p> <p>12 don't want to guess on that issue, you still feel</p> <p>13 comfortable opining as to what an MRA would or would</p> <p>14 not have shown on Mrs. Keiter in December of '01 if it</p> <p>15 had been done of her mesenteric vasculature?</p> <p>16 A. I feel pretty comfortable of it. I can tell</p> <p>17 you about the study. I couldn't tell you how the</p> <p>18 machinery works. I'm probably better at interpreting</p> <p>19 these things than the radiologists are.</p> <p>20 Q. Okay. If an angiogram would have been done</p> <p>21 in December of '01, do you have an opinion as to what</p> <p>22 it would have shown of the mesenteric vasculature of</p> <p>23 Mrs. Keiter?</p> <p>24 MS. SEACRIST: Objection. It's been asked.</p> <p>25 Go ahead.</p>

20 (Pages 74 to 77)

1 THE WITNESS: The only thing I'm certain it  
2 would have shown is compression syndrome of the celiac  
3 and superior mesenteric artery. I don't know from the  
4 information that I have the degree of narrowing of  
5 those arteries. I've seen an awful lot of  
6 arteriograms on people with compression syndrome, and  
7 if you catch them at the right time, they're wide  
8 open, and if you catch them in the right cycle,  
9 there's a high-grade stenosis in the artery.

10 BY MR. MARGOLIS:

11 Q. Assume, sir, that in August of '01 a duplex  
12 ultrasound was positive for 70 percent stenosis of the  
13 celiac artery. Do you have an opinion if that  
14 information were true as to what the finding of an  
15 angiogram of the mesentery vasculature in Mrs. Keiter  
16 would have been in December of '01?

17 MS. SEACRIST: Objection.

18 THE WITNESS: I'll give you the same answer  
19 because the duplex scan ultrasonographer may have just  
20 caught that artery in the right phase and not gone any  
21 further to investigate it with inspiration and  
22 expiration movements.

23 BY MR. MARGOLIS:

24 Q. Assume for a second, sir, that you are  
25 correct and that she suffered from this compression

1 A. Well, if all they have is celiac axis and  
2 superior mesenteric artery compression, the natural  
3 history is they're going to do fine. They probably  
4 will not have symptoms.

5 Q. Okay. So if I understand your testimony,  
6 assuming that you are correct and she had this  
7 compression syndrome of the SMA and celiac, it was no  
8 causative factor in her ultimate death.

9 A. No, that's not what I said.

10 Q. That's why I'm here, to learn.

11 A. I understand that.

12 It contributes to her death, but as we talked  
13 about earlier, this -- it is as the third artery gets  
14 in trouble from some other process, as in this case  
15 she developed severe atherosclerotic occlusion of the  
16 takeoff of the inferior mesenteric artery that got her  
17 in trouble because then her collateral networks are  
18 not able to provide the blood flow she needs to  
19 maintain viability of her intestines.

20 Q. Meaning no disrespect, how does that  
21 correlate with the finding of the celiac and SMA with  
22 severe atherosclerotic disease per the autopsy slides?

23 A. I'm not sure that -- you didn't ask -- that  
24 was not the question you asked. Now, if you want to  
25 ask if she had developed severe atherosclerotic

1 syndrome. Did it affect just the celiac or the celiac  
2 and the SMA?

3 A. Well, the autopsy suggested it affected both.

4 Q. Okay. Assume, sir, that you are correct and  
5 that she suffered from this compression syndrome. You  
6 would have expected that condition to have been  
7 diagnosed in December of '01 had a duplex study or an  
8 MRA study been done?

9 A. No, I'm not going to say I would have  
10 expected it because it's a difficult diagnosis to  
11 make.

12 Q. Would an MRA study, assuming it was an  
13 accurate MRA study appropriately interpreted, in  
14 December of '01 in your opinion of this patient been  
15 diagnostic for arcuate ligament compression syndrome  
16 of her SMA and celiac?

17 A. I think it probably would have if  
18 appropriately performed and appropriately interpreted.

19 Q. Assuming, sir, that she had compression of  
20 her SMA and celiac secondary to median arcuate  
21 ligament, can that condition in and of itself cause  
22 mesenteric ischemia?

23 A. Yes.

24 Q. If that condition is left untreated, what is  
25 the evolution?

1 disease in her superior mesenteric artery. Your  
2 question was whether she had entrapment or compression  
3 syndrome.

4 Q. Is it your opinion in this case that the  
5 arcuate ligament compression diminished and eventually  
6 cut off the blood supply to the celiac and SMA and  
7 then because of atherosclerotic disease of the IMA,  
8 her blood flow to her gut stopped?

9 A. I don't think we know. I think we speculate.  
10 But as I said when we started this deposition, it's  
11 awful hard to dispute what the autopsy found. She's  
12 got atherosclerotic arterial occlusive disease of her  
13 celiac axis and superior mesenteric artery. Now, how  
14 those two interacted, i.e., the atherosclerotic  
15 process and the compression syndrome, we will never  
16 know.

17 Q. Doctor, assume that you are correct and she  
18 had this compression syndrome of the celiac and SMA  
19 which would have been diagnosed in December of '01.  
20 Do you follow these patients to see if they become  
21 symptomatic?

22 MS. SEACRIST: Objection. I don't think  
23 that's what he said.

24 MR. MARGOLIS: It's a question.

25 MS. SEACRIST: You said "assume you are

<p style="text-align: right;">Page 82</p> <p>1 correct," and that's my objection.  2 You can answer.  3 BY MR. MARGOLIS:  4 Q. Do you understand what I asked, sir?  5 A. Yes, I do follow you.  6 Q. Why?  7 A. Because they have a process that's abnormal  8 and their artery is slow.  9 Q. What is the purpose of following them, sir?  10 A. In case they get in trouble.  11 Q. When you say "get in trouble," what do you  12 mean?  13 A. Develop symptoms.  14 Q. And assuming they develop symptoms and you  15 have this information of the abnormality of the  16 arteries, i.e., the compression, what significance is  17 that to you in the management of the patient's  18 condition who now becomes symptomatic?  19 A. It means they need a bypass or some way to  20 remedy their poor perfusion to their bowel.  21 Q. In Mrs. Keiter's case, had the compression  22 syndrome been diagnosed of the celiac and SMA and she  23 had the same symptoms that she did and this was known  24 in December of '01 by her physicians, do you believe  25 it would have impacted her outcome?</p>	<p style="text-align: right;">Page 84</p> <p>1 Q. Would you believe that the more important  2 factor in the overall approach to treating a patient  3 with acute mesenteric ischemia is early diagnosis and  4 aggressive management of the condition?  5 A. Sure. I may be a fool not to agree with  6 that.  7 Q. Would you agree that with acute mesenteric  8 ischemia that a clinical profile of pain out of  9 proportion to clinical findings is a classical  10 description of patients with acute mesenteric  11 ischemia?  12 A. Early on, yes.  13 Q. Would you agree that intraoperatively a test  14 to determine intestinal viability is fluorescein that  15 is then exposed to a Wood's lamp?  16 A. I've done a lot of those. I've never -- I  17 tend to think more -- I'm going to try to answer your  18 question in a little bit of a roundabout way, because  19 what fluorescein does is it tells you is there  20 circulation to the smaller blood vessels of the bowel,  21 and that usually correlates with viability. So I  22 think that yes, you would use that, but it's not a  23 test that will tell you absolutely you have a viable  24 bowel. It tells us that you've got blood flow into  25 the smaller circulation. So 99 percent of the time,</p>
<p style="text-align: right;">Page 83</p> <p>1 A. We could speculate on that all day. The  2 biggest concern is that her presentation for  3 mesenteric ischemia was not typical. It's somewhat  4 atypical. It was quite some time after that December  5 admission that she eventually began to complain of  6 what I call postprandial discomfort because these  7 people don't complain of pain. It's a different  8 sensation than just pain, and she was not complaining  9 of that at the time. There were -- from what I can  10 tell from gastroenterology colleagues that I've dealt  11 with over the years, there are a number of conditions  12 that will present just like this.  13 MR. MARGOLIS: Doctor, I would like to take a  14 break at this moment for about five minutes if I can.  15 THE WITNESS: Sure.  16 THE VIDEOGRAPHER: The time now is 11:57.  17 We're off the record.  18 (A recess was taken.)  19 THE VIDEOGRAPHER: The time now is 12:09.  20 We're back on the record.  21 BY MR. MARGOLIS:  22 Q. Doctor, I'm switching gears a little bit  23 here. I am going to talk about acute mesenteric  24 ischemia.  25 A. Go for it.</p>	<p style="text-align: right;">Page 85</p> <p>1 yes, I would agree with that statement.  2 Q. Is it your opinion, sir, based upon your  3 review of the records in this case that Dr. Shuck was  4 of the opinion that Mrs. Kessler's bowel was viable at  5 the time of his first surgery?  6 A. Yes, that was my opinion.  7 Q. Would it surprise you to learn if Dr. Shuck  8 were to testify that he did not have an opinion one  9 way or the other whether the bowel was viable or not  10 viable at the time of his first surgery?  11 A. That would shock me.  12 MS. SEACRIST: Objection.  13 BY MR. MARGOLIS:  14 Q. Okay. Why?  15 A. If he did not -- it's kind of hard to  16 believe. He's the surgeon in charge who is taking a  17 patient to the operating room with the concern of some  18 intra-abdominal catastrophe. His description is  19 dusky, but viable-appearing bowel. He either went  20 brain dead after making that observation or he had to  21 have had an opinion whether that bowel was viable or  22 not because if it was not viable, as in his second  23 operation, he'd just close, make the patient  24 comfortable, and let them expire.  25 Q. Would you agree with the statement that the</p>

22 (Pages 82 to 85)

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1 primary clinical use of duplex ultrasonography of the  
 2 mesenteric vasculature is to detect stenosis in the  
 3 celiac or SMA and that where the findings suggest a  
 4 stenosis, that contrast angiography should be  
 5 performed?  
 6 A. I would agree with the first part of that in  
 7 that its primary objective is to determine the  
 8 presence or absence of significant disease or  
 9 obstruction of those arteries, whatever the process  
 10 is. It's also very good for determining total  
 11 occlusion. But I don't know that I can agree that  
 12 just because you found that, that you need to go get  
 13 an arteriogram.  
 14 Q. Do you agree with the statement that patients  
 15 presenting with a clinical suspicion by their  
 16 physician of acute mesenteric ischemia should always  
 17 undergo an abdominal aortogram to look for mesenteric  
 18 artery disease?  
 19 MS. SEACRIST: Objection.  
 20 THE WITNESS: No, I don't agree with that  
 21 either. Suspicions of it, again, it depends on how  
 22 highly suspicious you are. If you were to send a  
 23 patient off to get an arteriogram for an acute  
 24 mesenteric event, it's got to be the number-one thing  
 25 on your list of differentials.

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1 BY MR. MARGOLIS:  
 2 Q. Same question, the only change is instead of  
 3 an angiogram is the test, a duplex ultrasound.  
 4 A. Duplex ultrasound is not usually used in  
 5 patients for acute mesenteric ischemia.  
 6 Q. Okay.  
 7 A. That has not been the standard of care  
 8 usually because duplex scanning is more of an elective  
 9 procedure. Some people believe that you need to  
 10 pretreat the patient to get rid of intestinal gas,  
 11 those sort of things. We have used them emergently  
 12 here for other reasons, but that's not usually the  
 13 standard of care how we use it.  
 14 Q. Would you agree that 75 percent of the  
 15 patients with chronic mesenteric ischemia give a  
 16 history of weight loss, significant weight loss?  
 17 A. No. I think it's probably higher than that.  
 18 In my experience of seeing patients that truly have  
 19 this disease, almost a hundred percent of them have  
 20 lost weight and have postprandial discomfort of some  
 21 sort. Not a hundred percent, but it's pretty doggone  
 22 close to a hundred percent.  
 23 Q. Would you expect a gastroenterologist to know  
 24 that the majority of patients with chronic mesenteric  
 25 ischemia have a history of significant weight loss?

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1 A. I would expect them to know that, yes.  
 2 Q. Would you agree that surgical  
 3 revascularization of a patient with mesenteric  
 4 ischemia prior to infarction of the bowel has about a  
 5 90 to 95 percent success rate?  
 6 A. Define "success rate" to me.  
 7 Q. It cures the underlying condition and the  
 8 patient lives.  
 9 A. No, I wouldn't agree with that number.  
 10 Q. What numbers would you use, sir?  
 11 A. A hundred percent.  
 12 Q. Thank you.  
 13 And would you agree that the mortality rate  
 14 of acute mesenteric ischemia is around 90 percent if  
 15 the diagnosis and treatment is not initiated prior to  
 16 intestinal infarction?  
 17 MS. SEACRIST: I'm sorry. Would you repeat  
 18 that? I just lost you.  
 19 MR. MARGOLIS: Sure.  
 20 Could you read that back, please?  
 21 (The record was read.)  
 22 MS. SEACRIST: Objection. Relevance.  
 23 THE WITNESS: I'm going to agree with that.  
 24 I would think that number would be a little higher  
 25 than 90 percent as well because once bowel infarction

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1 occurs, most of these people are going to expire, but  
 2 I'm sure there's always somebody out there that  
 3 survives.  
 4 BY MR. MARGOLIS:  
 5 Q. When you say most of them, would you say  
 6 greater than 80 percent?  
 7 A. I would say greater than 90 percent. I mean  
 8 acute mesenteric ischemia is a catastrophic problem  
 9 that's so difficult to diagnose --  
 10 Q. I'm listening, sir.  
 11 A. I'm thinking -- that because its presentation  
 12 is so unusual and usually the patients come with other  
 13 co-morbid problems that -- they're sick when you see  
 14 them. You're not quite sure where you're going with  
 15 your diagnosis, but by the time you make that  
 16 diagnosis, the bowel has already infarcted. It's one  
 17 of those disease processes that goes a little bit  
 18 against everything we're taught in medical school, is  
 19 to, you know, depend on your history and physical  
 20 examination. And as you said, it's one of those where  
 21 the physical exam doesn't help you a whole lot.  
 22 Q. And so the history is very important?  
 23 A. No. Frequently there's no history at all.  
 24 There's not much of anything.  
 25 Q. Okay.



1 A. The patients usually show up with no history.  
2 They've got sudden onset of severe -- it's not a  
3 little pain. It's severe pain. I've always likened  
4 it to the patient that rolls in the door with a kidney  
5 stone.

6 Q. That's terrible. I've had that.

7 A. They're all over the bed. They're all over  
8 the room. They can't hold still. They look sick as  
9 they can be. But then you go to palpate their  
10 abdomen, and their abdomen is soft. They've got bowe  
11 sounds. You can't figure out what's going on.

12 Q. Would you agree with the statement that acute  
13 mesenteric ischemia is more common than chronic  
14 mesenteric ischemia?

15 A. I don't know that we can answer that question  
16 either. I think that's one of those questions in life  
17 that we will never know the answer because you don't  
18 know the denominator of that number. We have a little  
19 better handle on acute mesenteric ischemia because  
20 it's such a dramatic presentation whereas chronic  
21 mesenteric ischemia is not very dramatic until you  
22 reach the very end point.

23 Q. Would you agree that patients with acute  
24 mesenteric ischemia, about three quarters of them have  
25 leukocytosis, which I'm defining as a white blood cell

1 count greater than 15,000?

2 A. Sure.

3 Q. They frequently will have an elevated amylase  
4 level?

5 A. They may; they may not.

6 Q. Do doctors see acute mesenteric ischemia more  
7 frequently than chronic mesenteric ischemia?

8 A. I don't think we can answer that either  
9 because I think a lot of doctors don't recognize when  
10 they see mesenteric -- chronic mesenteric ischemia.  
11 Acute mesenteric ischemia is recognized because the  
12 patient frequently dies before you get a chance to do  
13 anything.

14 Q. Would you agree that a normal CT will not  
15 exclude the diagnosis of acute mesenteric ischemia?

16 A. It depends on the timing of your CT scan. If  
17 you get your CT scan very, very, very early on in the  
18 process, it may be normal, but soon thereafter it will  
19 not be normal.

20 Q. You would agree that a normal K.U.B. will not  
21 exclude the diagnosis of acute mesenteric ischemia?

22 A. I would agree with that.

23 Q. And bear with me. I'm just kind of reviewing  
24 this because I don't want to repeat what I've already  
25 said.

1 Would you agree that it's important to  
2 consider and pursue the diagnosis of acute mesenteric  
3 ischemia in a patient who has the classic early  
4 finding of severe abdominal pain out of proportion to  
5 physical findings?

6 A. I think the key word there is "severe." And  
7 if it is severe on a ten out of ten basis, not by the  
8 patient's explanation, but by the doctor's, that it  
9 came on suddenly with no preceding symptoms, then I  
10 think yes, you would consider that.

11 Q. Are you aware that in this case at some point  
12 during the emergency room when Mrs. Keiter's abdomen  
13 was examined, she jumped off of the gurney?

14 A. No, I'm not aware of that.

15 Q. Would that be an example of a patient's  
16 reaction to severe pain?

17 MS. SEACRIST: Objection.

18 THE WITNESS: I don't know that I can answer  
19 that either. It could be a reaction to cold hands.  
20 I've had patients do that.

21 BY MR. MARGOLIS:

22 Q. Could it also be a reaction caused by severe  
23 pain?

24 A. No. Usually patients with severe pain won't  
25 move.

1 Q. Okay.

2 A. You know, they don't want to do anything.  
3 They'll grab at you, but they won't hop off the bed  
4 and run down the hall on you.

5 Q. What, if any, is the significance in a  
6 patient that you think may have acute mesenteric  
7 ischemia if there is a finding on the CT of bowel wall  
8 thickening?

9 A. Make sure I understand. What is the  
10 significance of bowel wall thickening in acute  
11 mesenteric ischemia? Is that what you're asking?

12 Q. Yes, as demonstrated by CT.

13 A. To me, the significance would depend on the  
14 location of the bowel wall thickening. If the  
15 majority of the small bowel is thickened, which is  
16 usually the case with acute mesenteric ischemia, in  
17 the context of the history of this going on for a  
18 while, I think it would be significant, something I  
19 would be concerned about.

20 Q. And what would its presence indicate to you  
21 in the context?

22 A. I'm not sure it would indicate anything to me  
23 in and of itself if it was the only finding. At that  
24 point in time I would expect to see some of the other  
25 findings if we're worried about acute mesenteric



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1 ischemia, potentially gas in the portal vein system,  
 2 pneumatosis of the bowel walls, air fluid levels in  
 3 the bowel, or large, dilated bowels that are full of  
 4 fluid.  
 5 Q. What is the significance of large, dilated  
 6 bowels full of fluid in this context? What does that  
 7 mean to you?  
 8 A. It usually means that the bowel is pretty  
 9 sick.  
 10 Q. And that included the small bowel?  
 11 A. That's what I'm mostly talking about, is the  
 12 small bowel.  
 13 Q. Okay.  
 14 A. Acute mesenteric ischemia from the context of  
 15 what we're talking about normally does not involve the  
 16 colon. I shouldn't say that. It can involve the  
 17 colon, but not alone. It's not just colon, although I  
 18 can sit here and give you instances where that well  
 19 might be the case, where you have a small embolus that  
 20 goes out into the ileocolic branches, ileocolic  
 21 branches, but that's a very rare bird.  
 22 Q. Okay. What, if any, is the significance in  
 23 the context of what we're talking about of a patient  
 24 comes in and the differential is acute mesenteric  
 25 ischemia and on the CT there are findings of bowel

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1 wall thickening? And you said "that may be  
 2 significant to me."  
 3 A. Well, actually, none of these individually  
 4 are significant.  
 5 Q. I agree, but I'm talking over --  
 6 A. They're all in the context of everything. If  
 7 the patient's clinical presentation doesn't strongly  
 8 suggest acute mesenteric ischemia, then the CT scan is  
 9 not going to make that diagnosis for you. Acute  
 10 mesenteric ischemia is a diagnosis that's usually made  
 11 clinically and then verified by some type of testing.  
 12 Q. Fine.  
 13 A. And it's not uncommon that patients will even  
 14 be taken to the operating room for the, quote unquote,  
 15 old, classic exploratory laparotomy because no one can  
 16 figure out what's going on.  
 17 Q. Is bowel wall thickening reflective of  
 18 submucosal edema and hemorrhage in this context?  
 19 MS. SEACRIST: In the context of acute  
 20 mesenteric ischemia?  
 21 MR. MARGOLIS: Yes.  
 22 THE WITNESS: It probably is, particularly  
 23 the edema.  
 24 BY MR. MARGOLIS:  
 25 Q. Would you agree that acute mesenteric

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1 ischemia is an intra-abdominal catastrophe almost as  
 2 lethal today as it was 50 years ago?  
 3 A. Yes. I don't think we've made any progress.  
 4 Q. And that making the diagnosis of acute  
 5 mesenteric ischemia prior to bowel infarction is  
 6 probably the most important factor to improve patient  
 7 outcome?  
 8 A. Correct.  
 9 Q. Do you agree with the statement that  
 10 improvement in the survival of patients with  
 11 mesenteric ischemia will only be achieved when it is  
 12 recognized that waiting for definite physical signs,  
 13 i.e., the development of acute abdomen, is equivalent  
 14 to waiting for ischemia and viable bowel to infarct?  
 15 THE WITNESS: Read that again. I'm just  
 16 curious to hear that.  
 17 (The record was read.)  
 18 MR. MARGOLIS: Let me ask it again because I  
 19 did a pretty inartful job.  
 20 THE WITNESS: Go for it.  
 21 BY MR. MARGOLIS:  
 22 Q. Would you agree that in order to improve  
 23 survival of patients with acute mesenteric ischemia,  
 24 physicians must recognize the waiting for definite  
 25 physical signs, i.e., the development of an acute

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1 abdomen, or radiological signs is equivalent to  
 2 waiting for viable bowel to infarct?  
 3 MS. SEACRIST: Objection.  
 4 THE WITNESS: I don't think it's equivalent  
 5 to waiting for bowel to infarct because by the time  
 6 you have physical findings does not always equate with  
 7 bowel infarction. What it equates with is  
 8 transmigration of intestinal fluid and bacteria into  
 9 the peritoneal cavity to irritate the peritoneal  
 10 lining and give you signs and symptoms of an acute  
 11 abdomen. If you wait long enough, there's no question  
 12 you'll wait -- you'll develop bowel infarction, but  
 13 you have to have constant, vigilant observation to  
 14 make that observation to take the patient to the  
 15 operating room and interact. You can't just say we'll  
 16 send the patient home. Come back and see me in a  
 17 couple of days, if that answers your question.  
 18 MR. MARGOLIS: Yes, sir.  
 19 Q. In December of 2001 if you wanted to do a  
 20 work-up on a patient to exclude acute mesenteric  
 21 ischemia, what would you have done?  
 22 MS. SEACRIST: Objection.  
 23 THE WITNESS: Well, I think you got two  
 24 options there. One, you go to the operating room and  
 25 exclude it, or -- and that's really the only way you

1 can exclude acute mesenteric ischemia. What  
2 frequently happens is that the diagnosis is made or  
3 suspected and one goes and gets an arteriogram, and  
4 what you find is an artery that's obstructed, and then  
5 you logically, but not always correctly, but most  
6 times logically, assume that point A and point B go  
7 together and then you take them to the operating room  
8 and you fix it, because the majority of those patients  
9 present from an embolic phenomenon, not a thrombotic  
10 process. The embolic process has a very distinct look  
11 on the arteriogram. You can also make that diagnosis  
12 in the operating room by the way the bowel looks,  
13 whether it's embolic or thrombotic.

14 MR. MARGOLIS: Gotcha.

15 THE WITNESS: And the most common times that  
16 we're called by the general surgeon who is in the  
17 operating room with a patient he has no idea what's  
18 wrong with them, he just knows they're sick, and they  
19 call and say "The bowel looks bad. Can you come  
20 look." Then we get in there and figure out what's  
21 going on and deal with it.

22 BY MR. MARGOLIS:

23 Q. What do abdominal bruits tell you as a  
24 vascular surgeon?

25 A. They tell me a little different than most

1 people because needless to say I'm very focused in on  
2 mesenteric disease, abdominal bruits can be anything  
3 from just functional disturbances in flow. The best  
4 example would be the 15-year-old who wants to play  
5 football, goes and has a physical and the doctor hears  
6 a heart murmur. There is absolutely nothing wrong  
7 with him. It's just that the flow is a little  
8 different.

9 You can have bruits in the abdomen due to  
10 stenoses of any artery, tortuous artery, anything.  
11 It's just -- it tells you that there's a disturbance  
12 in the flow. Whether it's significant or not, you  
13 don't know.

14 MR. MARGOLIS: We're going to change the  
15 tape, please.

16 THE VIDEOGRAPHER: Thank you.

17 The time now is 12:30. This the end of tape  
18 number one. Going off the record.

19 (Pause in proceedings.)

20 THE VIDEOGRAPHER: The time now is 12:33.  
21 This is the beginning of tape number two. We're back  
22 on the record.

23 BY MR. MARGOLIS:

24 Q. Doctor, do you agree that you cannot  
25 definitively rule out acute mesenteric ischemia by

1 physical exam alone?

2 A. Boy, that's a good question. I think I'd  
3 probably have to say -- I think I would probably say  
4 no, I wouldn't agree with that. I think that you can  
5 rule it out by physical exam and history, but it's  
6 tough to always rule it in --

7 Q. Okay.

8 A. -- I think if one comes from that direction.  
9 You're dealing with a disease process that's been one  
10 of the mysteries of vascular surgeons and general  
11 surgeons for ages. There is no definitive anything.  
12 That's why a lot of times the patients go straight to  
13 the operating room because you really can't tell  
14 what's going on.

15 Q. Do you agree with the statement that you  
16 cannot definitively rule in acute mesenteric ischemia  
17 by physical exam alone?

18 A. I would agree with that, with physical exam  
19 alone. You need the history to go with it.

20 Q. Per your review of the records in this case,  
21 did any physician other than Dr. Kessler and  
22 Dr. Moreno -- strike that.

23 Per your review of the records in this case,  
24 did any physician other than Dr. Kessler have acute  
25 mesenteric ischemia in their differential diagnoses of

1 Mrs. Keiter?

2 A. You know, I would hope they did, but only one  
3 wrote it down.

4 Q. Per your review of the information in this  
5 case, inclusive of the depositions, did anybody other  
6 than Dr. Kessler have acute mesenteric ischemia in  
7 their differential diagnosis of Mrs. Keiter?

8 MS. SEACRIST: I mean at what point? As of  
9 July 7, obviously.

10 MR. MARGOLIS: At the point prior to the  
11 angiogram of July 7.

12 MS. SEACRIST: Prior to July 7.

13 MR. MARGOLIS: Let me ask the question again.

14 Q. Doctor, based upon all the information you  
15 reviewed in this case, including the depositions which  
16 were supplied to you after penning your report, did  
17 any physician have in their differential diagnosis  
18 prior to the July 7 angiogram acute mesenteric  
19 ischemia of Mrs. Keiter other than Dr. Kessler?

20 A. No.

21 Q. I probably will mispronounce this, and please  
22 help me.

23 Once a patient has pneumonitis --

24 A. Pneumatosis --

25 Q. -- pneumatosis --

<p style="text-align: right;">Page 102</p> <p>A. -- intestinalis.</p> <p>Q. -- intestinalis from acute mesenteric ischemia, what is their chance of survival with revascularization surgery?</p> <p>A. I don't know the answer to that.</p> <p>Q. Less than 50 --</p> <p>A. You've asked two very good questions. I don't know that that -- it is a significant finding. There's no question that there is significant bowel pathology or ischemia. And I think when I came out of my surgical training, I would probably have told you the answer to that was they had no chance of survival, but I've seen patients survive with that, and I have also seen patients present with pneumatosis that have mesenteric venous thrombosis, and those patients you don't normally treat surgically. You treat them medically, and they do fine.</p> <p>So I think we've learned a little bit more because it's usually a diagnosis -- it used to be a difficult diagnosis to make on plain x-rays. CT scans is where you really make it nowadays, and if you catch them early enough, you can still salvage those people, but the bowel is truly in trouble at that point.</p> <p>Q. Would you agree with the statement that</p>	<p style="text-align: right;">Page 104</p> <p>1 can say it's less than 50 percent now. I would have 2 earlier on in my career. I would have agreed 100 3 percent with that statement, but now I don't think I 4 would agree with that.</p> <p>5 Q. Let me ask the question this way, sir. 6 In a patient with acute mesenteric ischemia 7 who has pneumatosis intestinalis, air in the portal 8 vein, isn't it more probable than not that that 9 patient will not survive a revascularization procedure 10 and succumb to the disease?</p> <p>11 A. I don't know that we know the answer to that 12 either because the majority of times in the past, 13 pneumatosis and portal vein gas were associated with 14 totally gangrenous bowel. You have a case right here 15 where you have pneumatosis and portal vein gas and a 16 viable bowel. So it's the viable bowel overcedes what 17 you saw in your radiologic picture. So I don't think 18 that you can look at those findings and say, "Well, 19 because of that, this woman was going to die," and the 20 next leap of faith is, "Well, we shouldn't have taken 21 her to the operating room and tried to do anything." 22 That's exactly what we used to do 10 to 15 years ago 23 when CTs first got used a lot for this, is you would 24 see that and you'd go "Well, this is a nonsalvageable 25 situation." That's not the case now.</p>
<p style="text-align: right;">Page 103</p> <p>patients with acute mesenteric ischemia who have pneumatosis intestinalis and air in their portal vein, that the chance of survival is less than 50 percent?</p> <p>A. Again, I think I would have to go back and say earlier in my career I would have said their chances are survival are less than 50 percent, but I think what overcedes that is when you get to the operating room and you see viable bowel, the question -- a better way of looking at that question would be do they have a chance of salvaging all the bowel or enough bowel to salvage their life, and I don't know that any of us know the answer to that.</p> <p>But I do know this, is that we've done CT scans earlier and earlier and earlier in people's presentations. We're seeing things that before we saw late in presentations, and in the late clinical presentation the patient didn't have a chance, so they were assumed to be indicators of nonsalvageability whereas we're finding we're seeing those findings earlier on, and patients are being salvaged because we more rapidly progress to deal with the problem.</p> <p>But as I say, I don't know if I can give you a definitive answer. I think my roundabout answer hopefully answered your question. I don't know that I</p>	<p style="text-align: right;">Page 105</p> <p>1 Q. And I understand that. The question is if 2 you have a hundred patients hypothetically, a hundred 3 Mrs. Keiters, given her condition of July 7 with the 4 pneumatosis intestinalis and air in the portal vein, 5 if a hundred of those people are taken in the 6 operating suite, are you telling me that more than 50 7 of them are going to survive?</p> <p>8 A. Yes.</p> <p>9 Q. And what's the basis for that opinion?</p> <p>10 A. My experience.</p> <p>11 Q. Is there any literature?</p> <p>12 A. I don't think those people -- well, I think I 13 probably ought to ask you what are they going to die 14 from?</p> <p>15 Q. From complications secondary to their acute 16 mesenteric ischemia, whether it's sepsis or any of the 17 other hosts of medical conditions that will occur when 18 your gut dies.</p> <p>19 A. So you're assuming that the gut is dead.</p> <p>20 Q. I'm assuming --</p> <p>21 A. That's what I hear you telling me anyway.</p> <p>22 Q. That's a correct statement based upon what I 23 said. I'm assuming -- let me ask the question this 24 way. 25 What are the complications that will occur in</p>

27 (Pages 102 to 105)

<p style="text-align: right;">Page 106</p> <p>1 a patient with acute mesenteric ischemia who has  2 pneumatosis intestinalis and air in the portal vein?  3 What does that tell you about the patient's condition  4 as a vascular surgeon?  5 A. It tells me the patient's bowel is in  6 trouble.  7 Q. Does this --  8 A. I think it's a major distinction in my mind  9 your question whether the bowel is salvageable or not.  10 If the bowel is not salvageable when you get to the  11 operating room, then a hundred percent of those  12 patients are going to die because you're going to  13 close them up and leave them basically with an  14 intestinal abscess in their peritoneum and they're  15 going to die from overwhelming sepsis. If the bowel  16 is viable, then you get into a whole different kettle  17 of fish because if you've read the things that I've  18 written, you know quite well what I believe in, is  19 that a large number of these people will die, but they  20 won't die without -- with necrotic bowel. They'll die  21 from all the sequelae of being sick.  22 Q. Right. That's my question.  23 A. I don't know which one of those patients are  24 going to survive and which ones aren't, and I don't  25 think anybody will be able to give you a number of</p>	<p style="text-align: right;">Page 108</p> <p>1 (A recess was taken.)  2 THE VIDEOGRAPHER: The time now is 12:46.  3 We're back on the record.  4 BY MR. MARGOLIS:  5 Q. Would you expect to see more likely than not  6 rectal bleeding in patients with acute mesenteric  7 ischemia early on?  8 A. No.  9 Q. Would you expect more likely than not to see  10 a distended abdomen in patients with acute mesenteric  11 ischemia early on?  12 A. No.  13 Q. Would you expect to see vomiting in patients  14 with acute mesenteric ischemia early on?  15 A. Yes.  16 Q. Given Dr. Kessler's following of Mrs. Kessler  17 during the Hillcrest hospitalization --  18 MR. FINELLI: Keiter.  19 MR. MARGOLIS: I'm sorry.  20 Q. Given Dr. Kessler's following of Mrs. Keiter  21 during the Hillcrest hospitalization, would you have  22 expected him to ever contact her personal family  23 physician?  24 MS. SEACRIST: Objection.  25 THE WITNESS: No, I actually wouldn't. I</p>
<p style="text-align: right;">Page 107</p> <p>1 less than or greater than 50 percent because I don't  2 know that anybody has ever done a hundred of those  3 people to be able to derive that number. So I would  4 only be speculating or even guessing at what you're  5 asking.  6 Q. In your experience in patients with these  7 conditions, acute mesenteric ischemia that has  8 progressed to pneumatosis intestinalis, air in the  9 portal vein, what percentage of those patients will  10 die from either the condition or the sequelae of their  11 condition subsequent to revascularization? Greater or  12 less than 50 percent?  13 A. I still think less than 50 percent, but it  14 will be a significant number. I mean --  15 Q. 55 percent?  16 A. No. Less than 50 percent will die.  17 Q. 45 percent?  18 A. I don't know the answer to that. I don't  19 think anybody knows the answer to that.  20 Q. It would be a guess.  21 A. It would totally be a guess.  22 Q. Thank you.  23 Take a two-minute break, please.  24 THE VIDEOGRAPHER: The time now is 12:43.  25 We're going off the record.</p>	<p style="text-align: right;">Page 109</p> <p>1 don't see any reason to.  2 MR. MARGOLIS: Okay.  3 Q. Would you have expected Dr. Kessler to want  4 to have knowledge of any other forms of Mrs. Keiter's  5 vascular disease as information that he would have  6 wanted to have known given his care of her during the  7 Hillcrest admission?  8 A. No, I don't see any reason to.  9 Q. Did Dr. Kessler do anything to try to work up  10 a cause of Mrs. Keiter's abdominal bruits?  11 A. No, I don't think he needed to. I don't  12 think there was any indication to do that.  13 MR. MARGOLIS: Okay. Sir, we are going to  14 suspend the deposition at this point and put on the  15 record what I believe to be the agreement that Susan  16 and Dan and I have arrived at, which is that I will  17 obtain a VHS format of the ultrasound -- duplex  18 ultrasound study that was done at 8-13-01. I will  19 provide that to Susan. She will then provide it to  20 you for your review. We will reconvene the deposition  21 on the sole, exclusive, and limited purpose of what  22 your interpretation of that study has demonstrated.  23 Susan, does that accurately reflect our  24 agreement?  25 MS. SEACRIST: It does.</p>

MR. MARGOLIS: Doctor, Dan and I want to thank you for your time. You have been a professional and a gentleman, and thank you very much.

THE WITNESS: Thanks for coming.

THE VIDEOGRAPHER: This concludes the deposition today of Dr. Timothy Harward. The total number of tapes used was two. The original videotapes will be retained by Rennillo Court Reporting Services in Cleveland, Ohio.

Going off the record. The time now is 12:50.

(The deposition was adjourned at 12:50 p.m.)

1 STATE OF CALIFORNIA )

2 ) ss.

3 COUNTY OF LOS ANGELES )

4 I, Kathleen E. McCarthy, Certified Shorthand  
5 Reporter No. 4483 for the State of California, do  
6 hereby certify:

7 That prior to being examined, the witness named in  
8 the foregoing deposition was duly sworn to testify the  
9 truth, the whole truth, and nothing but the truth;

10 That said deposition was taken down by me in  
11 shorthand at the time and place therein named and  
12 thereafter reduced by me to typewritten form and that  
13 the same is a true, correct, and complete transcript  
14 of said proceedings.

15 I further certify that I am not interested in the  
16 outcome of the action.

17      Witness my hand this 20th day of July, 2005.

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Kathleen E. McCarthy / RRS  
Kathleen E. McCarthy, Certified  
Shorthand Reporter No. 4483  
for the State of California

STATE OF CALIFORNIA )

) SS.

COUNTY OF LOS ANGELES )

I, TIMOTHY R. S. HARWARD, M.D., declare under the penalties of perjury under the State of California that the foregoing is true and correct.

Executed this      day of      ,  
2005, at      , California.

TIMOTHY R. S. HARWARD, M.D.



A				
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