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Case no.
226946

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I N D E X

WITNESS: JOEL B. HOLLAND, M.D.

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(FOR KEYWORD AND OBJECTION INDEX, SEE APPENDIX)

JOEL B. HOLLAND, M.D.

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

- - - - -

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Why don't you state your full name, Doctor?

A. Joel Holland, J-o-e-l, H-o-l-l-a-n-d.

Q. Your business address, sir?

A. One Mount Sinai Drive, Cleveland, Ohio
44106.

Q. I'm going to ask you a number of questions
this afternoon. If you don't understand any of
them, tell me and I will happy to repeat or
rephrase any questions you don't understand,

When you response to a question,
please do so verbally. He is going to take down
everything that's said. He can't take a nod of
your head.

Keep your voice up so everybody can
hear you, okay?

A. Do my best.

1 Q. Doctor, do you have a CV?

2 A. We're updating it. We can get it to you.
3 I'll give it to Fred. He can get it to you.

4 MR. FULTON: You're
5 excused,

6 Q. If you would run me through your educational
7 background starting with high school?

8 A. Bowne High School in New York City.

9 Q. B-a-u-m?

10 A, B-o-w-n-e.

11 Q. When did you graduate high school?

12 A, 1969,

13 Q. What did you do after that?

14 A. Went to the University of Rochester in
15 Rochester, New York,

16 Q. What kind of degree did you receive?

17 A. I received a B.A. Degree in 1973.

18 Q. What was your major?

19 A. English,

20 Q. What did you do then?

21 A. I went to University of Rochester Medical
22 School.

23 Q. Graduated?

24 A. 1977.

25 Q. Then after that?

1 A, Went to the University of Chicago, I did a
2 medical internship; then two years of medical
3 residency, and then two years of cardiology
4 Fellowship training.

5 Q. All at the same institution?

6 A. University of Chicago.

7 Q. That brought us up until '82?

8 A, Yes.

9 Q. Now, what did you do?

10 A, Came to Mount Sinai Medical Center in
11 Cleveland, Ohio.

12 Q. In what capacity?

13 A. Director of the Coronary Care Unit.

14 Q. Were you an employee of Mount Sinai?

15 A. Not really, no,

16 Q. Were you in private practice?

17 A. I was employed by a group associated with
18 Mount Sinai called Full-Time Medicine.

19 Q. Where was your office at that time?

20 A. At Mount Sinai.

21 Q. Was that a corporation, Full-Time Medicine?

22 A, I think they were a corporation, They didn't
23 share those kinds of things with me, **so;** but I
24 think they were a corporation.

25 Q. Were you an employee of the corporation?

1 A. Yes.

2 Q. How long did you remain employed by the
3 corporation?

4 A. I would say five years.

5 Q. That brings us up to '87?

6 A, Right,

7 Q. Then what did you do?

8 A, I left that corporation because the
9 principals of that corporation left Mount Sinai,
10 and formed a new entity with another cardiologist
11 here,

12 Q. The name of that entity?

13 A. Drs. Adler and Holland, Incorporated,

14 Q. Are you still employed by that corporation?

15 A, Um-hum.

16 Q. So that's been your form of employment
17 since '87?

18 A, That's correct,

19 Q. Who are the principals in Full-Time Medicine
20 that left?

21 A, Who were they?

22 Q. Yes.

23 A, Joseph Adelstein and Victor Vernes.

24 Q. Have you had any other position at the Mount
25 Sinai Medical Center other than director of the

1 coronary?

2 A. Co-chief of Cardiology with Dr. Adler, he is
3 the other co-chief.

4 Q. What is the Mount Sinai Heart Institute?

5 A, That's a good question, It's an umbrella
6 kind of name that encompasses certain physicians,
7 the cardiologists, the cardiovascular surgeons, and
8 the vascular surgeons,

9 Q. Well, I mean is it a legal entity?

10 A. No, It's not a corporation. I think it's
11 used mostly for marketing purposes by the hospital.

12 Q. We're in a building that's separate from the
13 hospital?

14 A, That's not correct,

15 Q. This is a part of the hospital?

16 A, Absolutely,

17 Q. It's in this building that your offices for
18 private practice are contained?

19 A. This, and another building in Beachwood.

20 Q. What is the address there?

21 A. 26900 Cedar Road,

22 Q. Do you use this office here for private
23 patients or --

24 A. Sometimes. Mostly for administrative and
25 teaching purposes.

1 Q. As relates to your hospital duties?

2 A. Right.

3 Q. So you principally see private patients in
4 your Beachwood office?

5 A, That's correct.

6 Q. Or if they were inpatients, at the hospital?

7 A, Absolutely,

8 Q. Have you authored any articles, sir?

9 A, I have been co-author on several articles,

10 Q. Those are on your CV?

11 A. They would be on my CV somewhere,

12 **a.** What's the most recent article, how long ago?

13 A. Probably five, six years ago.

14 Q. How many articles are we talking about?

15 A. Five, six, something like that.

16 Q. Do you recall the subject matter of the
17 articles?

18 A, Yes.

19 Q. Tell me what they are,

20 A, One was a study in basic cardio-electric
21 physiology, one was a study of survival after
22 myocardial infarction,

23 Q. What's the name of that article?

24 A. It was the Save Study.

25 Q. I'm sorry?

1 A, It was the called the Save Study.

2 Q. You said you were co-author there?

3 A. It's multi-center studies. We were one of
4 the participating centers and I was a participating
5 investigator,

6 There was a study called the CAST
7 Study, which was **also a** multi-center study of
8 survival after myocardial infarction; CAST, Cardiac
9 Arrhythmia Survival Trial. It was a multi-center
10 study, We were one of the centers participating in
11 the study, and in the last few years the kind of
12 research that I get involved in are those kind of
13 things. I don't do laboratory investigation
14 anymore, and the nature of my practice is primarily
15 clinical and teaching,

16 Q. What were the years on those two studies, do
17 you know?

18 A. 1987, 1986. Actually I think these were the
19 year the study took place, but I think the results
20 were published -- I can get that all for you. I
21 have to look that up,

22 Q. These would be on your CV?

23 A. They will, will be on the CV.

24 Q. Do you refer patients to various physicians
25 within your facility; surgeons, for example?

1 A. Sure.

2 Q. What surgeons do you use as referral sources?

3 A. Depends on what the patient's problem is.

4 Q. Well, for a bypass, for example?

5 A, Alan Markowitz and Mark Botham are the two
6 surgeons that I generally refer patients to.

7 Q. Are they together in practice?

8 A. Yes. You probably know them since I think
9 they operated on your father,

10 Q. Who else did they operate on?

11 A, Who else did they operate on?

12 Q. Yes.

13 A. Hundreds of people every year,

14 Q. Give me their names, since you have no
15 difficulty in giving me my father's name,

16 MR. CARMEN: Objection.

17 Q. Is that a privilege between my father and
18 Dr. Markowitz, sir?

19 MR. CARMEN: Objection.

20 MR. FULTON: I don't think,

21 MR. CARMEN: You don't have
22 to answer.

23 MR. KAMPINSKI: Why not?

24 MR. CARMEN: Because I told
25 him not to,

1 Q. Do you think that's privileged, sir?

2 MR. CARMEN: Objection. You
3 don't have to answer.

4 A. I am going to abide by the advice of counsel
5 here.

6 Q. Is he your attorney?

7 MR. CARMEN: I'm the
8 attorney for Dr. Varma, who is in this case
9 representing Dr. Holland's interests.

10 Q. Is there anything else you want to say about
11 my father?

12 MR. FULTON: He didn't say
13 anything about your father.

14 MR. CARMEN: You don't have
15 to answer any of this. When he gets to another
16 question --

17 Q. You are the one that brought it up,

18 MR. CARMEN: He is not going
19 to answer anymore --

20 MR. KAMPINSKI: I am going to
21 ask him. You can tell him not to answer all of
22 these and we'll go to the judge and have the judge
23 decide.

24 Q. If you want to talk about patients, let's
25 talk about all of Dr. Markowitz' patients.

1 A. I can't talk about them with you because
2 he -- they have nothing to do with you.

3 Q. What does my father have to do with me?

4 A, I only meant -- you seemed tremendously
5 offended. I was only saying that because you
6 seemed to be not sure who Dr. Markowitz was. I
7 inferred that by the tone of your voice. I was
8 merely pointing out you'd probably remember him as
9 the surgeon who took care of your father. It
10 wasn't meant --

11 Q. How do you know he took care of my father?

12 A. Because I know all the patients who come
13 through here at one point or another.

14 Q. So you know my father?

15 A. No, I was not his cardiologist, but he was a
16 nice man. That's what I understood, and
17 Dr. Markowitz took care of him. That's all I am
18 going to say about it.

19 Q. You know he was a nice man from whom?

20 A* From the nurses on the floor said --

21 Q. What nurse?

22 MR. CARMEN: You don't have
23 to answer.

24 MR. FULTON: Tell him not to
25 answer.

1 A. I can't remember the names of nurses.

2 MR. CARMEN: You don't have
3 to answer,

4 Q. Do you find this humorous, Doctor?

5 MR. CARMEN: Don't answer
6 that.

7 Q. Do you have a father?

8 MR. CARMEN: Don't answer.

9 Q. Do you?

10 MR. CARMEN: He is not going
11 to answer.,

12 MR. KAMPINSKI: I want to talk
13 about his father's medical background,

14 MR. CARMEN: He is --

15 MR. FULTON: Nobody talked
16 about medical background, Charles.

17 MR. KAMPINSKI: I want to know
18 if his father ever had an operation.,

19 MR. CARMEN: He is not going
20 to answer,

21 MR. KAMPINSKI: Why not?

22 MR. CARMEN: Because it has
23 nothing to do with this case.

24 MR. KAMPINSKI: Maybe you can
25 **explain what my father has to do with this case.**

1 MR. CARMEN: He already
2 explained.

3 MR. KAMPINSKI: No, he hasn't.

4 MR. FULTON: We can sit here
5 and argue all day.

6 Q. Is your father still alive, Doctor?

7 MR. FULTON: Don't answer,

8 MR. CARMEN: Don't answer,

9 Q. How about your mother?

10 MR. FULTON: Don't answer,

11 Q. Do you have any siblings?

12 MR. CARMEN: Don't answer,

13 Q. Are you married?

14 MR. CARMEN: You can
15 answer.

16 A. Yes, I am married.

17 Q. Do you have children?

18 A. No.

19 Q. Who is your wife's doctor?

20 MR. CARMEN: You don't have
21 to answer that. Relax,

22 THE WITNESS: I am relaxed.

23 Q. Answer the question,

24 MR. CARMEN: He is not going
25 to answer.

1 Q. Do you know who treated my mother?

2 MR. CARMEN: He is not going
3 to answer the question. When you get to a new
4 topic, he will.

5 You can tell your questions to the
6 court reporter because the doctor --

7 MR. KAMPINSKI: I am not asking
8 the court reporter the questions. I am --

9 THE WITNESS: Can I confer
10 with my counsel for a minute.

11 MR. KAMPINSKI: So he is your
12 counsel.

13 THE WITNESS: If he continues
14 this, I am going to leave, I have many things to
15 do. I don't want to waste my time.

16 MR. KAMPINSKI: You started
17 this, and you started it for a reason, okay.

18 MR. CARMEN: Don't respond
19 to him.

20 MR. KAMPINSKI: Don't you play
21 games, We can play as many games as you want to
22 play, sir,

23 MR. CARMEN: He gave you the
24 reason,

25 MR. KAMPINSKI: ~~We~~ didn't give

1 me the --

2 MR. FULTON: Why don't you
3 call the judge now if you're so concerned.

4 BY MR. KAMPINSKI:

5 Q. What did you review in this case, Doctor?

6 MR. CARMEN: That, you can
7 answer.

8 A, Good. I reviewed many documents,

9 Q. Where are they?

10 A, They're sitting in my office.

11 Q. Why don't you get them along with the copy of
12 your CV, if you would, please.

13 MR. CARMEN: The CV, as
14 reported to you, is being updated,

15 MR. KAMPINSKI: I'd like the
16 old one then.

17 THE WITNESS: I'll ask my
18 secretary

19 -----

20 (Recess had.)

21 -----

22 BY MR. KAMPINSKI:

23 Q. How long have you lived on Shelburne?

24 A. I think next month it's going to be
25 three years.

1 Q. Where did you live before that?
2 A, Calverton Road.
3 Q. The address?
4 A, 22000 Calverton Road.
5 Q. Where is that at?
6 A, Shaker Heights, Ohio.
7 Q. How long did you live there?
8 A, About a year and a half, I think.
9 Q. Where did you live before that?
10 A, 19501 VanAken, also in Shaker Heights.
11 Q. How long did you live there?
12 A. Two years,
13 Q. Before that?
14 A. 2687 Rockland Road, Shaker Heights, Ohio,
15 Q. How long did you live there?
16 A, Five years.
17 Q. And before that?
18 A. Something, something Blackstone Road,
19 Chicago, Illinois, 53525 or -- I can get that for
20 you.
21 Q. The two reports you referred to, the CAST
22 report, the last one, that's set forth on your GV?
23 A, Yes.
24 Q. And the other one, is that on there?
25 A. No.

1 Q. Where would that be found, the Save Study?

2 A. I said it was published in the New England
3 Journal. We were one of the participating
4 centers,

5 Q. Is there a reason it's not on your CV?

6 A. Yeah, because it hasn't been updated. It was
7 published in the last few years.

8 Q. Have you been sued, sir?

9 A. Yes.

10 Q. When?

11 A. 1983.

12 Q. Here in Cleveland?

13 A. Yeah,

14 Q. For what?

15 A. Patient who Dr. Markowitz operated on when --
16 who unfortunately died after the surgery, and the
17 physicians here at the hospital taking care of her
18 were sued.

19 Q. What was the result of that lawsuit?

20 A. Settled out of court,

21 Q. Who were you represented by?

22 A. Jacobson, Maynard.

23 Q. Which attorney?

24 A. Steven Charms,

25 Q. Were you **deposed** in that case?

- 1 A, Yes, I think so.
- 2 C. Who was the plaintiff's attorney?
- 3 A. I don't even remember,
- 4 Q. Any others?
- 5 A, Another similar case, probably 1984.
- 6 Q. -- Markowitz operated on that person too?
- 7 A. Yes.
- 8 Q. This would have been a patient of yours that
- 9 you had referred to him?
- 10 A, Yes, both were. Yes.
- 11 Q. What firm represented you in that case?
- 12 A. Same firm.
- 13 Q. What attorney?
- 14 A. Steve Charms.
- 15 Q. What was the result of that case?
- 16 A. It was dropped.
- 17 Q. Were you deposed in that case?
- 18 A, I think so, as well.
- 19 Q. Who was the attorney that represented the
- 20 plaintiff?
- 21 A, A Weisman, is that a familiar name.
- 22 Q. Any other cases?
- 23 A. No, that would be it.
- 24 Q. Have you testified in any cases?
- 25 A, In what manner?

1 Q. Any capacity.
2 A. Yes,
3 Q. Expert, witness?
4 A. Yes.
5 Q. How many times have you testified as an
6 expert?
7 A. I would say five times or less,
8 Q. Who did you testify for on those occasions,
9 who were the attorneys?
10 A. Charms, and I'm trying to think of the other
11 guy. Gary --
12 Q. Goldwasser?
13 A. Right,
14 Q. Anybody else?
15 A. Yes, there's another person at Jacobson, but
16 I don't think -- I haven't given a deposition, so
17 in terms of depositions, those are the two,
18 Q. I don't want to be confused,
19 Are you saying you're including in
20 the five or less, deposition testimony --
21 A. Right,
22 Q. -- and courtroom?
23 A. As opposed to reviewing a case, for example.
24 Q. How many times would it have been in court?
25 A. I never testified in court,

1 Q. So all five of these times, as I understand
2 **at least**, the attorney that you are telling me
3 about would have been for the defendant then?

4 A. Right.

5 Q. Do you review cases often for Jacobson,
6 Maynard?

7 A. Couple times a year they ask me to look at
8 something.

9 Q. How about for Reminger's firm?

10 A. Reminger's, occasionally.

11 Q. Any others?

12 A, No.

13 Q. How many times a year would **you** say for
14 Reminger's firm?

15 A. I'd say I've done it probably twice.

16 Q. Do you have a list of the cases that you have
17 been an expert in --

18 A. No.

19 Q. -- for these firms?

20 A. No,

21 Q. Are some of them still pending?

22 A. Yes.

23 Q. How many?

24 A, Probably **just** one.

25 Q. **Do** you remember the names of the attorneys

1 that would have taken your depositions in these
2 five cases?

3 A. No.

4 Q. Within what time frame are we talking, last
5 year, last two years, five years?

6 A. This -- these five cases would be in the last
7 ten years.

8 Q. Would you have any record that would reflect
9 who the attorneys would have been in those cases
10 for the plaintiffs?

11 A, No. Usually after the case is concluded in
12 one way or another I just depose of all the
13 documents, so if you gave me a list I might be able
14 to recognize say a name. I can't come up with them
15 off the top of my head.

16 Q. Do you recall the subject matter that you
17 were asked to testify in these five cases?

18 A. Usually someone who had some kind of heart
19 surgery or had a heart attack, had a bad outcome,
20 That's generally what they are about.

21 Q. You are not a surgeon?

22 A. No.

23 Q. So that would not be something you render
24 your expert advice on?

25 A. No.

1 Q. ~~It would~~ be the medical aspect surrounding
2 the surgery?

3 A. Yes.

4 Q. Either before, during, or after?

5 A. Absolutely.

6 Q. Have you done work for Mr. ~~Carmen~~ or his firm
7 or Mr. Fulton or his firm or Mr. Coyne or his firm
8 in the past?

9 A. Never,

10 Q. How is it you got involved in this case?

11 A. I think Mr. Carmen called me.

12 Q. Do you know how he obtained your name?

13 A. Probably from his client, Dr. Varma,

14 Q. How do you know Dr. Varma?

15 A. Dr. Varma was a resident here for a year or
16 so.

17 Q. When was that?

18 A. Let's see, Prem finished about this time last
19 year, so that would be '91, '92, something like
20 that.

21 Q. Was he someone you trained?

22 A. Well, to the extent that he was here for a
23 year, we worked together, I guess you would say
24 that.

25 Q. Did you have anything to do with his coming

1 here as a resident?

2 A. Absolutely nothing.

3 Q. When he was here as a resident, did he work
4 in the cardiology department?

5 A, I think for several months, so I worked with
6 him personally for some of that time.

7 Q. Were you aware of this case when he was a
8 resident here?

9 A, I was aware there were problems. I didn't
10 know it was a case.

11 Q. What were you aware of?

12 A, I was aware there was an incident at
13 Saint Vincent that caused a problem for him and led
14 to his leaving the Cleveland Clinic residency
15 program and seeking a position somewhere else, I
16 was not aware that it was a case, per se.

17 Q. Well, how did you become aware of this?

18 A, He told me,

19 Q. What did he tell you?

20 A, He told me -- this may be a little foggy -- I
21 think he asked me for a letter of recommendation so
22 he can pursue further training, he felt he needed
23 to explain why he left the Cleveland Clinic and so
24 he told me there had been a problem and they --
25 there had been some problems with his continuing

1 there, and things of that nature.

2 Q. I guess what I am asking you is to give me as
3 best you can specifically what he told you, at
4 least what your understanding of the incident was
5 before reviewing the records?

6 A. I'll do the best I can.

7 Q. Fine.

8 A. That there had been a patient in the
9 intensive care unit and that there had been
10 some complications surrounding the placement of a
11 catheter, and that he felt that he had been blamed
12 unfairly for what had happened; but the bottom line
13 was that they had asked him to find someplace else
14 to work.

15 Q. What is it that he felt he had been blamed
16 unfairly about?

17 A. I really didn't explore his feeling at that
18 time. I think I told him that he would be given a
19 fair chance here, we'll evaluate him on -- based on
20 what he did here. This was after he had done one
21 or two rotations with me and I was satisfied with
22 his work, so I left it at that. I didn't really
23 explore it.

24 Q. Did you have anything to do with -- and I
25 apologize if I asked this already -- with his

1 coming here as a resident to begin with?

2 A. No.

3 Q. As part of the rotation through cardiology,
4 that would have been the normal rotation of a
5 resident?

6 A. Sure.

7 Q. That's how you came into contact with him?

8 A, Absolutely.

9 Q. How many residents would rotate through your
10 department at any given time?

11 A. In any month there could be four, five in the
12 CCU, two or three on another service; could be a
13 busy month and you have a lot of residents,
14 anywhere from five to seven a month come through.

15 Q. How long did the rotation last?

16 A, One month.

17 Q. How many rotations did he do with you?

18 A. My recollection is he did probably two. The
19 program is small enough they rotate on the weekends
20 and change the coverage so you wind up spending a
21 fair amount of time with these people anyway; my
22 recollection is I spent -- Prem was interested in
23 cardiology,, and so during the time he was here I
24 wound up spending a fair amount of time with him.

25 Q. The box that you brought in here, Doctor,, are

1 these all of the records you reviewed?

2 A. Yes.

3 Q. Has anything been removed from the records,
4 that you removed?

5 A. No, these are all the records.

6 Q. Is the first time that you received these,
7 would that be January 22, I am looking at the
8 letter here signed by Lynn Moore?

9 A. Yes,

10 Q. It's sent by messenger to you, that's when
11 you would have received these materials?

12 A. Let me see,

13 Q. Sure.

14 A. I think so. I think I had a brief meeting
15 with Lynn and maybe Fred, and then they -- we
16 talked about it briefly. They said they will send
17 the records, and then the next day they came in
18 that box.

19 Q. Did you receive any additional records after
20 these that are set forth in this January 22nd
21 letter?

22 A. Not that I am aware of, no,

23 MR. FULTON: What are you
24 looking at?

25 MR. KAMPINSKI: Records that

1 were sent to him. I'll have him identify them in a
2 second.

3 MR. FULTON: In Florida you
4 took out the personal correspondence.

5 MR. KAMPINSKI: I didn't know I
6 was there.

7 MR. FULTON: I just thought
8 I would advise you,

9 MR. KAMPINSKI: My spirit.

10 MR. FULTON: Your spirit was
11 there

12 - - - - -

13 (Dr. Holland Deposition Exhibits 1 and 2
14 marked for identification.)

15 - - - - -

16 BY MR. HAMPINSKI:

17 Q. Doctor, I'm going to ask you to identify
18 these exhibits we have been discussing.

19 What's been marked Dr. Holland
20 Exhibit 2 -- and I looked through the depositions
21 and I assume that what's loose in here is the
22 chart, correct, in the box?

23 A, Pretty much. I can't verify that completely,

24 Q. Number 3 referred to on Exhibit 2 is a letter
25 dated May 14th from Fred Carmen to Michael Meehan,

1 do you know why that has been removed from your
2 file?

3 w e I don't remember ever seeing that. I don't
4 know what would be in that letter. I mean, I don't.
5 know what it is, I mean, if someone could tell me
6 what the contents were, I can tell them whether
7 I've seen it or not. I don't know what the letter
8 is,

9 Q. So it's not something you remember looking
10 at?

11 A, No.

12 Q. It's not something that you know the
13 whereabouts about today? You take your time, you
14 can look.

15 A. No, I don't know what that is, If someone
16 wants to tell me what it is, I can tell whether I
17 have a recollection of seeing --

18 Q. Dr. Holland, I didn't send it to you.

19 A. I know. I don't know the rules here, If
20 someone can tell me what it is.

21 MR. CARMEN: Just if you
22 think that it's in here, if you've seen it, take a
23 look; if you can't, fine.

24 A, These I'm pretty sure are the records from
25 here, Saint Vincent, and the -- what's the other,

1 Ashland Hospital, hospitalization.

2 I don't think it's in here.

3 Q. Can you tell me what happened to it?

4 A. No, I can't tell because I don't know what it
5 is,

6 Q. Did you remove it from your file?

7 A. No.

8 Q. Did Mr. Carmen remove it from your file?

9 A. That -- nobody removed it. If you want me to
10 go back there, I'll tell you the things that are
11 under my desk and it may be somewhere else. You
12 want me to go back and look, see if I can -- I
13 don't know what it is. I don't know where it is,

14 Q. Why don't you try to find it, Doctor,

15 A. Okay,

16 MR. FULTON: Why don't you
17 tell him what it is,

18 MR. KAMPINSKI: You sent it to
19 him, Fulton, why don't you tell him what it is,

20 MR. FULTON: I didn't send
21 it. Is my name on that?

22 MR. KAMPINSKI: Yes, it is.

23 MR. CARMEN: Do you want to
24 go see.

25 THE WITNESS: I don't know

1 what it is but I'll look for it.

2 MR. CARMEN: If you see it,
3 bring it in; if you don't bring --

4 MR. COYNE: Either way,
5 come back,

6 -----

7 (Recess had.)

8 -----

9 THE WITNESS: It's there
10 under the desk, I have to say I have not read
11 this, so.

12 BY MR. KAMPINSKI:

13 **a.** Is there anything else there under the desk?

14 A. Well, there's one other case,

15 Q. Pertaining to this case, Doctor?

16 A, No.

17 Q. So it's your testimony even though he sen%
18 this, it wasn't in your material but was under your
19 desk and you didn't look at it?

20 A. I did not look at it, no.

21 - - - - -

22 (Dr. Holland Deposition Exhibit 3
23 marked for identification,)

24 - - - - -

25 Q. Why don't you identify what Exhibit 3 is for

1 the record, please?

2 A. This is a letter to Mr. Michael Meehan, who
3 is at the Cleveland Clinic, and from Fred Carmen.

4 Q. That's the May 14th letter referred to --

5 A. Yes.

6 Q. -- in Exhibit 2 --

7 A. Yes.

8 Q. -- the letter from Gallagher, Sharp, sending
9 you the materials they wanted you to review for
10 purposes of preparing a report?

11 A. Right.

12 Q. You received another letter prior to that,
13 Doctor, that I marked as Exhibit 1, would you
14 identify that, please?

15 A. This is a letter to me from Sanjay Varma from
16 December 24, 1992.

17 Q. Apparently he provided you with various
18 materials as well?

19 A. Correct.

20 Q. And the purpose of that was what?

21 A. I believe this was right after I was
22 contacted by telephone to see whether I would
23 assist in this case, and then following a
24 conversation he sent me these materials.

25 Q. In looking at the two letters apparently you

1 were sent the record by Sanjay Varma, I mean he
2 refers to sending the medical record; and in the
3 letter from Gallagher, Sharp they sent the
4 Samaritan record; he didn't apparently send the
5 Saint Vincent record because you already had it?

6 A. That's probably the case.

7 Q. He sent you -- "he" being attorney Sanjay
8 Varma --

9 A. Yes.

10 Q. -- For your review a number of internal
11 memoranda, and some Journal articles, right?

12 A. Yes.

13 Q. Then asked you a number of questions?

14 A. That's correct,

15 Q. Is that what you perceived your function to
16 be in this case in terms of your retention, that is
17 to respond to these questions?

18 A. Well, that's clearly what he seemed to be
19 interested in, yes, I would agree with that,,

20 Q. I'm sorry?

21 A. I would agree with that,

22 Q. The third question that he asked is, "What
23 precisely occurred during the February 26, 1991
24 procedure during which Dr. Varma placed the
25 arterial line in this patient, and the subsequent

1 procedures during which the wires were removed"?

2 A, Yes .

3 Q. What is the answer to the first part of that
4 question, what precisely occurred during the
5 February 26, 1991 --

6 A. I have to say I don't know for sure. I don't
7 know

8 Q. Well, what is your opinion based on your
9 careful review of all, the records as to what
10 occurred on February 26, 1991 during Dr. Varma
11 placing the arterial line?

12 A. Well., I can say that an arterial, line was
13 attempted and the end result was that there were
14 two full intact guide wires left in the patient.

15 Q. Did you understand my question? That's the
16 result. I'm asking what occurred,

17 Who put them in --

18 MR. FULTON: Objection.

19 Q. -- in your opinion?

20 MR. CARMEN: Same.

21 A, I don't know.

22 Q. Did you review Dr. Steele's deposition?

23 A. I have reviewed all of the depositions. I
24 have to say I don't know after reviewing all the
25 information.

1 Q. Don't have a clue?

2 MR. CARMEN. Objection.

3 Asked and answered.

4 A. I don't know.

5 Q. Well, do you think Dr. Varma put two guide
6 wires into Mrs. Weitzel?

7 MR. CARMEN: Objection. You
8 can go ahead, if you know.

9 A. I don't know. It's a possibility, but I have
10 to say that my answer is I don't know.

11 Q. It's a mystery to you then?

12 A. It really is, yes.

13 Q. Is it? Well, I mean, is it also possible
14 someone's running around the hospital putting guide
15 wires into people?

16 MR. CARMEN: Objection. You
17 can go ahead and answer.

18 A. Anything is possible. That doesn't seem
19 likely but --

20 Q. So is that a part of your differential in
21 terms of figuring out the answer to question
22 number 3?

23 A. I don't know what you mean "differential"?
24 It's not a medical problem. It's sort of a
25 detective case, as I understand it.

1 Q. You were given this task, so I want to know
2 how it is that you would go about in determining
3 that or what are the -- if one of the possibilities
4 is Dr. Varma putting it in, what are other
5 possibilities?

6 A. Other physicians who participated in that
7 procedure.

8 Q. Who would that be based on your careful
9 review of the record?

10 A. There were several other physicians who
11 attempted to put lines in there.

12 Q. In the femoral artery? If that's your
13 testimony, who were they?

14 A. I don't know their names. I can go through
15 the record.

16 Q. Sure. Please. Any time you need to refer to
17 your record, go ahead.

18 A. It may take a while.

19 Q. Whatever.

20 A. Okay.

21 THE WITNESS: Do you have a
22 chart where things are better organized?

23 MR. CARMEN: No.

24 THE WITNESS: This is it, is
25 not going any further.

1

MR. CARMEN: Okay. Take

2

your time.

3

THE WITNESSES: Yes.

4

MR. JACKSON: We have a

5

tabulated chart, Doctor.

6

THE WITNESS: That will help.

7

MR. SEIBEL: It's not full.

8

THE WITNESSES: What day is

9

this?

10

MR. COYNE: 28th or 2-28, I

11

mean.

12

THE WITNESS: Mr. Jayne,

13

here.

14

BY MR. KAMPINSKI:

15

Q. Did she attempt to insert a femoral line?

16

A. The nurse note, 4:00 p.m., Dr. Varma and

17

Dr. Jayne here^a to insert femoral something.

18

Q. Did you read Dr. Varma's testimony about

19

Mr. Jayne's involvement?

20

A. I did. I don't recall the details.

21

Q. Well, I mean, as someone trying to figure out what happened on February 26, would^a the details be somewhat important?

22

24

A. Absolutely.

25

Q. But you don't recall?

1 A. No. I can look that up. I'd be happy to
2 review that with you,

3 Q. Well, if it assists in trying to answer my
4 question, go ahead,

5 A, Are you going to tell me where it is or do
6 you want me to rummage through it? I will be happy
7 to go through it.

8 Q. Do whatever you have to do to try to answer
9 the question.

10 A, Fine,

11 MR. JACKSON: May I see that,
12 please?

13 MR. FULTON: I think this is
14 attached to the Complaint. Where is that other
15 exhibit, the letter?

16 MR. OKADA: This is it.

17 MR. JACKSON: Can't you just
18 tell him what he said,

19 MR. KAMPINSKI: Keep everything
20 on the record,

21 THE WITNESS: Do you want me
22 to keep going? If you want to show me.

23 MR. JACKSON: We're going to
24 wait until someone passes out; is that it?

25 THE WITNESS: I still don't

1 see where that says who did what.

2 This is stuff about who wrote the
3 procedure note, all of that.

4 MR. CARMEN: Flip here.

5 THE WITNESS: This is -- she
6 said that he pulled the guide wire out.

7 MR. CARMEN: There is one
8 other.

9 Is that enough or do you want more?
10 That may be the biggest piece.

11 THE WITNESS: I can't find
12 it. I can't conclude from the review of Prem
13 Varma's deposition who did what during the
14 procedure.

15 BY MR. KAMPINSKI:

16 Q. Did you ask for Dr. Jayne's deposition?

17 A. No. I don't think I've seen Dr. Jayne's
18 deposition. I don't know that I knew a Dr. Jayne
19 was even deposed.

20 a. So as you sit here today you don't know what
21 Dr. Jayne did or didn't do as it related to
22 attempted insertion of the femoral line?

23 MR. FULTON: You mean what
24 she did, she said she did or didn't do?

25 A. Well, I don't know what she did or did not

1 do, that's correct,

2 Q. Or what she said she did or didn't do?

3 A. I do not know what she said or didn't do.

4 Q. In your own mind she is a possible individual
5 who could have placed one or more arterial lines or
6 arterial lines into the femoral artery of
7 Mrs. Weitzel?

8 A, You mean arterial wires?

9 Q. Yes. Guide wire?

10 A, Yes.

11 Q. Anybody else?

12 A. There was another, Dr. Mahlay, who seemed to
13 be involved at that point, and the documentation is
14 not clear what exactly he did or did not do.

15 Q. Before you referred to the nurse note, wasn't
16 the nurse's note clear as to what he did or didn't
17 do?

18 A. Right, But the nurse note said he was there
19 to insert an internal jugular line.

20 Q. Is that what it said?

21 A, That's what it said,

22 Q. Assuming your careful review of the chart is
23 reflective of what the record shows, then that
24 would not be the same as a femoral arterial line?

25 Am Femoral, right, that's correct,

1 Q. So then why is he potentially a culprit?

2 MR. FULTON: Objection to
3 that. We didn't say he was a culprit.

4 Q. Or potential individual who placed a guide
5 wire into the artery?

6 A, It's a possibility. Frequently when one is
7 unsuccessful in putting a line somewhere, you will
8 try another site, and it's not always -- the nurses
9 don't always document what goes on.

10 I mean, I am not saying it's a
11 likely possibility and I am not -- I don't know,
12 That's what I told you several times,

13 MR. CQYNE: Show an
14 objection to what is possible.

15 Q. Did you read Dr. Mahlay's deposition?

16 A, No.

17 Q. Were you aware that he was deposed?

18 A, No.

19 Q. Did you request any additional information
20 from any of the attorneys that retained you?

21 A, No.

22 Q. Just assuming, Doctor, that the testimony has
23 been that Dr. Jayne did not attempt an insertion of
24 the femoral arterial line and that Dr. Mahlay did
25 not attempt the insertion of a femoral arterial

1 line, assuming those facts to be true, do you have
2 an opinion as to who it is that placed the
3 two guide wires into the femoral artery of
4 Mrs. Weitzel on the 26th of February?

5 MR. CARMEN: Objection.

6 MR. FULTON: He doesn't have
7 to speculate. Are you asking on reasonable medical
8 certainty?

9 MR. KAMPINSKI: Absolutely.

10 MR. FULTON: He doesn't have
11 to speculate.

12 A. It's not a medical question.

13 Q. It's a question that you are asked by the
14 attorneys that retained you in this case, and I am
15 asking you to assume certain facts to be true;
16 obviously if the facts don't exist, the answer
17 wouldn't be applicable.

18 A. Right. And I said I do not know,

19 Q. Based on those assumptions you still don't
20 know?

21 A. I don't know.

22 Q. Well, what if just for the sake of argument
23 Dr. Varma placed the two guide wires into the
24 femoral artery of Mrs. Weitzel, under those
25 circumstances, assuming that to be the **fact**, do you

1 have an opinion to a reasonable degree of medical
2 certainty as to whether or not that action by
3 Dr. Varma deviated from the appropriate standard of
4 care required of a physician?

5 A. Yes.

6 Q. Yes, you have an opinion?

7 A, Yes.

8 Q. What is your opinion?

9 A, That that would be below the standard of
10 care,

11 Q. If in fact he didn't tell anybody about it
12 for a number of days, how would you characterize
13 that?

14 MR. FULTON: Objection to
15 "number of days." What do you mean "A number of
16 days"?

17 a. Let's say ten or let's say he never told
18 anybody --

19 MR. FULTON: That isn't so.

20 Q. -- and that it was found out by somebody
21 else, how would you characterize that?

22 A, That would also be well below the standard of
23 care.

24 Q. Criminal?

25 MR. CARMEN Objection. IS

1 he a lawyer?

2 A. I don't know the criminal statutes, so I
3 couldn't tell you.

4 Q. How about unethical from a medical
5 standpoint?

6 MR. FULTON: Should be noted
7 March 8 he indicated perhaps there was a
8 possibility that it occurred,

9 MR. CARMEN: Objection. You
10 can answer,

11 A. If he knew and he was withholding that
12 information from the other physicians, certainly.

13 Q. Have you put guide wires into patients?

14 A. Yes,

15 Q. For the purpose of putting catheters in?

16 A. Yes.

17 Q. Can you use a guide wire for the placement of
18 a catheter, have it go into an artery and not know
19 that it's in the artery and that it is still there
20 when you're done with the procedure?

21 A. I don't see how you could do that,

22 Q. That would be doubly true of two of them,
23 wouldn't it?

24 Ae I guess so.

25 Q. So your qualification as to that answer

1 earlier, "if he knew," certainly anybody that put a
2 guide wire in, left it there, would^d know, wouldn't
3 they?

4 A, That would be correct. Yes.

5 Q. Did the possibility of Dr. Varma having done
6 that occur to you in your careful review of this
7 record?

8 A. Yes.

9 Q. Did that concern you at all as a Physician?

10 A, Yes.

11 Q. Was he still training under You at that time?

12 A, No.

13 Q. Did you write any letters on his behalf as he
14 requested you to do?

15 A, Yes.

16 Q. When was that?

17 A. Probably, oh, a little over a year ago.

18 Q. It was prior to looking at this case in the
19 context of an expert?

20 A, Certainly,

21 Q. Since you looked at it, knowing that
22 possibility, have you contacted the people that you
23 wrote to, to make them aware of what you found out?

24 MR. FULTON: Objection.

25 MR. CARMEN: Same.

1 A. I have not contacted any of the places I
2 wrote letters to,

3 Q. Who did you write letters to?

4 A. Number of hospitals in the United States.

5 Q. Who?

6 A. I couldn't tell you.

7 Q. Why not?

8 A. Because I don't recall.

9 Q. Do you have a file that would reflect that?

10 MR. FULTON: I am going to
11 object until it's determined he has to turn it
12 over, if he does have a file,

13 A. We probably don't have a file. My secretary
14 may have it on her computer disk,

15 Q. Did you feel any need to contact these people
16 and let them know what you found out?

17 A. Well, I didn't feel that I found anything out
18 that would change my opinion of Dr. Varma.

19 Q. In other words, if he put the two guide wires
20 in and didn't tell anybody about that, it wouldn't
21 change your opinion?

22 MR. FULTON: Objection,

23 MR. CARMEN: Objection,

24 A. That's not what I found from reading the
25 record, That's what you found,

1 Q. So you don't believe that occurred?

2 A. I guess my feeling is people are innocence
3 until we prove them guilty, and we haven't proven
4 anybody guilty here.

5 Q. Who is it that proves them guilty, is it
6 people in the medical community that review the
7 record to determine what happened?

8 A. Those would be some of the people, yes,

9 Q. Did you read Dr. Steele's deposition?

10 A. Yes.

11 MR. CARMEN: Objection.

12 Asked and answered.

13 MR. KAMPINSKI: You are right.

14 A. I did.

15 MR. KAMPINSKI: You are right.

16 Q. What did Dr. Steele say about what happened?

17 A. My recollection is that he felt Dr. Varma put
18 them in.

19 Q. Do you not believe him?

20 A. It's not a question of belief. It comes back
21 to the same answer, do I feel that you can conclude
22 unequivocally that Dr. Varma put them there, and I
23 can't, and --

24 Q. Is that what's necessary in your mind, an
25 unequivocal determination?

1 A. Pretty much, for me to do what you suggested
2 that I do.

3 Q. And what percent is unequivocal?

4 MR. CARMEN: Objection.

5 Q. 100 percent?

6 A. I don't think that way, in terms of
7 percentages.

8 Q. Who makes decisions regarding whether or not
9 a post MI patient should have surgery, is it the
10 medical doctor or is it the surgeon or is it both?

11 A. I would think it depends on what kind of
12 surgery we're talking about, of course, but I think
13 that would be a collaborative decision between all
14 the physicians caring for the patient, putting
15 their input into the situation, that would make the
16 most sense to me.

17 Q. When you say "All the physicians," if there
18 is an attending who has been responsible for
19 obtaining consults --

20 A. Yes.

21 Q. -- I assume you are including him?

22 A. Certainly.

23 Q. Would you include the consults in that?

24 Ae Depends on what their -- if their consult **was**
25 relevant to the surgery being performed.

1 Q. Well, in this particular case based on your
2 careful review of the record whose decision in your
3 opinion to a reasonable degree of medical certainty
4 should it have been in terms of operating on
5 Mrs. Weitzel on March 14?

6 A, I would say certainly the cardiologist.

7 Q. Dr. Steele?

8 A, Yes.

9 Q. Who else?

10 A, There was a pulmonologist, a chest physician,

11 Q. Dr. Sopko?

12 A. I would say he -- his input would be
13 important, as well as --

14 Q. Okay.

15 A. -- an infectious disease disease consult, I
16 think there was one,

17 Q. Dr. Chmielewski?

18 A. His input would be important, and certainly
19 their input plus the input of the surgeon who would
20 understand the risks of the surgery,

21 Q. Dr. Moasis?

22 A. Right. And it's certainly not unreasonable
23 to have an anesthesiologist get involved, since,
24 you know, he's going to be putting the Patient to
25 sleep.

1 So I think it's a collaborative
2 decision. I don't think it rests on any one
3 particular person.

4 Q. In this particular case Dr. Steele didn't
5 seek the assistance of either Dr. Sopko or
6 Dr. Chmielewski, was he wrong in not seeking
7 their assistance?

8 MR. JACKSON: objection. I'm
9 objecting for the record.

10 THE WITNESS: You are not
11 silencing me?

12 A. I don't know. I was told that was wrong. I
13 certainly would in that case.

14 Q. Did he fall below the standard of care --

15 MR. JACKSON: Objection.

16 Q. -- in your terminology?

17 A. We'll put it a different way. I am not
18 trying to be oblique.

19 Q. Of course not.

20 A. Different physicians have different levels of
21 confidence and feeling comfortable with making
22 decisions.

23 If he feels -- I don't know
24 Dr. Steele personally -- if he feels that the
25 infectious disease aspect on the case was stable,

1 he has a good understanding of them; pulmonary
2 components are stable, he has a good understanding
3 of them; he feels comfortable with these kinds of
4 things, nothing is wrong with him going ahead and
5 saying, you know, I factored those things in and my
6 opinion is proceed.

7 On the other hand, other physicians
8 my feel, gee, I don't feel comfortable, I am going
9 to seek out my chest physician, ask him what he
10 thinks.

11 There's certainly room for
12 different physicians to behave differently and
13 still fall above the standard of medical care,
14 Q. So you don't believe that he deviated from
15 the acceptable standard of care in not consulting
16 with Dr. Chmielewski and Dr. Sopko prior to
17 allowing Dr. Moasis to perform surgery?

18 A. I think that's correct,

19 Q. So that then amends your previous answer
20 where you said that you believe that the people
21 should have been involved were these other
22 individuals?

23 A, I am kind of speaking for myself.

24 Q. I don't know if you practice in accordance
25 with the standard of care or not, quite frankly,

1 and you are here as an expert. I assume that you
2 are expert on the standard of care, whether or not
3 you operate under the standard of care or above the
4 standard of care, really isn't relevant.

5 How you would do it may be
6 interesting to you, it's not all that interesting
7 to me

8 MR. FULTON: Let's move on,
9 Strike all, that baloney.

10 Q. I want to establish the ground rules, when
11 you tell me you do something or you wouldn't do
12 something, if what you do is the standard of care,
13 that's fine --

14 MR. CARMEN: Answer the way
15 that you answered,,

16 Q. Is that how you perceive the standard of
17 care, what you do, sir?

18 A, No, I think you have a misunderstanding about
19 the standard of care.

20 Q. Why don't you straighten me out.

21 A. I am not going to straighten you out. I am
22 going to point out not every situation can be
23 handled or should or needs to be handled the same
24 way by every physician. There are different ways
25 good physicians who practice good medicine can

1 handle a situation, and I merely pointed there's
2 different ways to handle it and they can be right;
3 and if that's not something you are comfortable
4 with, I mean, that's kind of how medicine is
5 practiced.

6 Q. Does the standard of care require medical
7 approval for surgery in a patient such as
8 Mrs. Weitzel by the pulmonologist and infectious
9 disease specialist?

10 A. It requires that a physician knowledgeable
11 about the patient and knowledgeable about her
12 medical problems clear her.

13 Q. And in this case you're comfortable with
14 Dr. Steele had that knowledge, based on your review
15 of the chart?

16 MR. FULTON: He didn't say
17 that.

18 MR. CARMEN: Do you know?

19 A, I don't know Dr. Steele, I can't say. I
20 can't answer that question.

21 Q. You don't know?

22 A, It appeared that he felt he did, and I will
23 go along with that, I do not know Dr. Steele to
24 answer.

25 Q. The question is: Did you feel in your

1 opinion that he did?

2 MR. CARMEN: Objection. He

3 already --

4 MR. FULTON: He already

5 answered.

6 A. In the event Steele had consulted with the
7 people who are appropriate and had made himself
8 comfortable with the level of input that he thought
9 was appropriate, he told you what he would do.

10 Q. Well, did he?

11 MR. CARMEN: If you know.

12 A. I do not know what he did. He may have
13 called a pulmonologist and said I am going to send
14 Mrs. Weitzel to surgery, what do you think.

15 Q. Whatever he did is okay with you?

16 MR. CARMEN: Objection.

17 A. That's not what I said.

18 Q. Well, based on your careful review of the
19 record and his deposition, what did he do?

20 A. I can tell you that he apparently approved
21 her for surgery. What process he went through to
22 arrive at that point and what input he got from
23 other physicians, I can't comment on.

24 Q. Wasn't the correct decision in your

25 opinion --

1 A. No.

2 Q. -- to a reasonable degree of medical
3 certainty?

4 A. No.

5 Q. You believe he fell below the standard of
6 care in making that decision then?

7 A, I believe so.

8 Q. Did that failure contribute to cause
9 Mrs. Weitzel's death?

10 A, I believe so.

11 Q. Did Dr. Moasis' input in a collaborative
12 effort, I guess with Dr. Steele, in deciding to do
13 the surgery fall below the standard of care in
14 Mrs. Weitzel's case?

15 A, I believe so. I would qualify that with I am
16 not a vascular surgeon, so I mean -- but I think
17 between the two of them, I think the fact that she
18 underwent surgery under those circumstances fell
19 below the standard of care.

20 Q. Did that contribute to cause her death?

21 A. Yes,

22 Q. Did Dr. Varma in his -- assuming he put the
23 wires into Mrs. Weitzel -- contribute to cause
24 Mrs. Weitzel's death?

25 A. I don't believe so,

1 Q. Do you believe that the --

2 MR. FULTON: Your own expert
3 says that.

4 MR. KAMPINSKI: You got
5 anything else to say, Mr. Fulton? I mean, you
6 think this is all very entertaining, that's
7 terrific. You want to say something to me, say **it**,
8 get it out of your system and we'll continue with
9 my examination.

10 MR. FULTON: Thank you,
11 I'll abide by your --

12 MR. KAMPINSKI: It's not a
13 question of abiding.

14 MR. FULTON: And you're
15 overruled. You enjoy playing these games, there's
16 no reason for it, I guess I've been around you too
17 long.

18 MR. KAMPINSKI: You taught me.
19 If this is the way you want to proceed, go ahead.

20 MR. CARMEN: Why don't we
21 just proceed,

22 MR. KAMPINSKI: I'd like to,

23 MR. CARMEN: Good.

24 BY MR. KAMPINSKI:

25 Q. How about the hospital personnel subsequent

1 to the surgery, did they adhere to the appropriate
2 standard of care required of them --

3 MR. CARMEN: Objection.

4 What hospital personnel?

5 MR. KAMINSKI: I'm referring
6 now -- let me finish my question, then you can
7 object.

8 MR. CARMEN: Just didn't
9 know you were going on.

10 Q. Referring to the nurses that attended
11 Mrs. Weitzel after the surgery and/or the resident
12 who was on duty that evening?

13 A. I would say so. I think they were a little
14 slow in recognizing that things were going badly
15 for her after surgery.

16 Q. You will say what, so I understand?

17 A. That they fell below the standard of care.

18 Q. Did that contribute to cause Mrs. Weitzel's
19 death as well?

20 A. Probably to an extent it did, yes.

21 Q. Would you show me, please, where in the
22 records you find that Mrs. Weitzel had an abnormal
23 mental status related to anoxic brain damage; would
24 you show that to me, please?

25 A. I'll try.

1 Moves arms in her --

2 ~~2.. Just refer to the date.~~

3 Am This is her admit note from 2-11-91 where the
4 exam of -- I presume this is a resident -- moving
5 arms and legs in decerebrate posturing.

6 Q. That was the admit note?

7 A. Coldness of both feet, no Plantar reflex,
8 VTR's, three plus; hyperactive reflex and
9 decerebrate posturing.

10 Q. That was on the day of admission?

11 A. Yes.

12 Q. Anything else?

13 A. Another note continues, unresponsive --

14 Q. Please tell me the dates.

15 A. 2-11.

16 Q. Same day?

17 A. Later in the same day.

18 Q. Later or at the same time?

19 A. No, that was later.

20 Q. What did that note say? Whose note was it?

21 A. Another resident, 6:00 p.m., later the same
22 day.

23 Continues unresponsive.

24 Q. Okay.

25 A. Let me see here. I'll use this.

1 MR. SEIBEL: You may not
2 find the earlier records in those notes, Doctor.
3 A, Patient on 2-23 lethargic, sleepy.
4 Q. I'm sorry, What was the date?
5 A, February 23rd.
6 Q. Lethargic and sleeping?
7 A. Yes.
8 Q. Wait a minute. I mean, is that evidence of
9 abnormal mental status related to anoxic brain
10 damage?
11 A, It is definitely related to an abnormal
12 mental status,
13 Q. And was she on any medication at that time,
14 sir?
15 A. On lots of medication,
16 Q. Was she on any medication that would account
17 for her being lethargic?
18 A, I can't tell you from this note.
19 Q. Well, I mean, what part of the chart would
20 assist you in telling whether or not she was on any
21 medication?
22 A. Here are the medications, actually,
23 At that point she was on s.cut,
24 Heparin, Unisom, aspirin, Nitro paste, Digoxin,
25 Vancomycin, Erythromycin, Tobramycin, Amantadine,

1 Flagyl, and Lopressor. I don't know. I can't read
2 that.

3 Here we got Flagyl, Lopressor,
4 Peri-Colace.

5 a. Anything else?

6 A. She was intubated. These patients at times
7 get morphine, Adapin, other things.

8 Q. Versed?

9 A. Versed is certainly one of them.

10 Q. Was she getting it?

11 A. I don't know if she was getting it at the
12 time that this note was written.

13 Q. What does Versed do to a patient?

14 A. It depresses their mental status.

15 Q. Well, would that explain her lethargy if in
16 fact she was getting Versed?

17 A. It would be an explanation, yes.

18 Q. By the way, Doctor, what are you leafing
19 through, the progress notes?

20 A. Yes.

21 Q. Do you see any progress notes between
22 the 11th and 23rd regarding her mental status that
23 would suggest to you that she did not have an
24 abnormal status related to anoxic brain damage?

25 A. No.

1 Q. How about the nurses' notes, in your careful
2 review of the record prior to writing this report
3 did you see any nurses' notes --

4 A. I saw many.

5 Q. Let me finish.

6 -- that would indicate to you that
7 she did not have abnormal mental status related --
8 and did not have anoxic brain damage; do you see
9 any of these?

10 MR. FULTON You mean a note
11 that she is -- she did not have anoxic brain
12 damage?

13 A. They don't write notes like that.

14 Q. That's Mr. Fulton's question.

15 My question was: Were there any
16 notes that would lead you to the conclusion that
17 she did not have abnormal mental status related to
18 anoxic brain damage, sir? For example,
19 communicating, alert, aware, things of that nature?

20 A. Let me just say something. May I answer your
21 question?

22 Q. Please do.

23 A. Okay. Thank you. I appreciate it.

24 It's really impossible to evaluate
25 someone else's mental status very well when they're

1 on a ventilator, even the patient who follows one
2 step commands does not give you an idea of what
3 someone's mental status is when they're ventilated,
4 and so there's certainly notes where they said
5 she's awake where she follows commands, but that's
6 far from saying that her mental status is normal.

7 It would -- may I finish?

8 Q. Absolutely.

9 A, And it would be unusual that someone who
10 underwent the kind of trauma that she did prior to
11 her coming to the hospital, if one was able to do
12 formal mental status testing with psychological
13 testing, that her mental status would be normal.

14 Q. Well then, if there is this much difficulty
15 in the nurses who were there seeing her every day
16 doing this, how in the world did you evaluate it in
17 your report?

18 A. Based on her admission she had classic signs
19 when she came in for anoxic encephalopathy. Doesn't
20 mean that it can't resolve, Sometimes it did
21 resolve, but there is no way at this point in time
22 to know where she stands on that curve of
23 resolution; but without a doubt when she came to
24 that hospital she had classical signs of anoxic
25 encephalopathy.

1 Q. You didn't say in your report that that's how
2 she presented, that you couldn't analyze and
3 determine what it was throughout her hospital stay;
4 that's your testimony, though?

5 MRe FULTON: Objection.

6 MR. CARMEN: Objection.

7 A. That's what I say. That's why we're all
8 here, to clarify that report,

9 Q. All right. You mean you write a report that
10 needs to be clarified? Why wouldn't you write it
11 clear in terms of what you're saying, what you
12 mean?

13 MR. CARMEN: Objection.

14 That's not what he's saying.

15 Q. I'm asking you the question, not your
16 lawyer.

17 A. He's not my lawyer. You have made that very
18 clear at the beginning.

19 Q. Why don't you answer my question.

20 A. The report was prepared for them. It's a
21 summary of the case. I was not asked to prepare
22 100 page report detailing every little thing; and
23 my impression, correct me if I am wrong, the reason
24 you wanted to talk to me is kind of to get more
25 things that **may** not be in a **report**.

a Well, go ahead, you can ask
2 whatever you want. I'm sorry if it wasn't clear to
3 You. I -- I didn't prepare it for you. You didn't
4 ask me to prepare it. I did what I thought was a
5 good job. If you don't feel that way, you're
6 certainly entitled to your opinion; if you don't
7 think my writing is clear enough, that's your
8 opinion, too,
9 Q.

10 I want to make sure you're done with your
11 answer; are you?

12 A. Yes.

13 Q. So that I am clear, it is your opinion that
14 you don't have an opinion with respect to her
15 neurological status subsequent to her admission; is
16 that a fair statement?

17 A. Let me say it again and I will try to make it
18 clearer because I want you to understand what I am
19 saying.

20 When she came to Saint Vincent
21 Hospital she had very obvious anoxic
22 encephalopathy, she clearly during the subsequent
23 days made recovery from that condition; the extent
24 of the recovery is not possible for me to determine
25 based on my careful review of the chart, largely
because the patient remained on a ventilator during

1 that time, where most of the -- one's ability to
2 determine the patient's mentation is based on a
3 verbal interchange between the Physicians and the
4 patient, asking them to remember things, and then
5 several minutes later asking them to recall them,
6 which you cannot do with a patient on a ventilator;
7 so how much recovery she made, I cannot give you a
8 good answer to,

9 Q And looking at the reverse aspect, in terms
10 of how much damage if any was permanent, that you
11 can't tell us either?

12 A. That's also correct,

13 Q. But you can tell there was some recovery
14 based on what is set forth in the nurses' notes?

15 A. That is correct,

16 Q. Did you have an opportunity to read
17 Mr. Weitzel's testimony?

18 A. I don't believe so.

19 Q. Did you ask for it?

20 A. I don't think I did, no,

21 Q. would it matter to you in terms of a
22 neurological evaluation or trying to determine how
23 far she had progressed in her neurological
24 recovery -- let me finish and I will let you
25 finish?

1 A. Okay. It's a deal.

2 Q. -- in terms of what his interplay with her
3 was, in light of the fact that he was there day and
4 night every day?

5 a. No.

6 Q. Does that matter?

7 A. May I answer?

8 Q. Please,

9 a, No. I think since he has the closest
10 relationship with the woman, obviously he might
11 gain some insight by her expressions that some of
12 the other people might not; but often families are
13 often seeing things that aren't there as well,
14 It's sort of a double-edged sword.

15 Q. And you're not a neurologist?

16 A, No, not at all,

17 Q. But that doesn't mean you can't assess and
18 analyze someone's neurological status as part of
19 your duties as a cardiologist, because you can, I
20 take it?

21 A. As a general physician I think it's probably
22 as good as most general physicians, but not
23 certainly the level that a neurologist would be.

24 Q. You go on in your report to say, "However,
25 the most life-threatening problem was the patient's

1 adult respiratory distress syndrome, which was
2 present basically from the beginning of the
3 hospitalization"?

4 A. Yes.

5 Q. Did you read Dr. Sopko's testimony?

6 A. No.

7 Q. Well, if this was the most Life-threatening
8 problem and he was the one that was dealing with
9 that and you are trying to analyze as part of what
10 you are asked to do --

11 MR. FULTON: Just an extra
12 COPY.

13 MR. CARMEN: Do you mind if
14 he looks at this copy of his opinion?

15 MR. KAMPINSKI: No. Absolutely
16 not. Not a hidden ball trick.

17 Q. Wasn't it important to know what the
18 pulmonologist had to say about her condition?

19 Am I am certainly sure that his opinions are
20 important. I think there's a misunderstanding here
21 that I'd like to clarify.

22 I was asked to review the chart and
23 give my impression, and certainly there is some
24 merit in a physician doing that. I mean, there is
25 the next step or a possible next step is looking at

1 the chart and also integrating other people's
2 opinions, okay, other physicians' opinions, but I
3 was not asked to do that. I was asked to review
4 this hospital chart and give my opinion.

5 Q. Time out, sire Time out,

6 That's not a totally fair response
7 to me because you are given certain depositions of
8 Dr. Steele, and Dr. Varma, so certainly you were
9 asked to integrate what they had to say with the
10 chart, and I assume you did?

11 A, And I was asked to do that and I did what I
12 was asked to do.

13 Q. My point is, and you can correct me if I am
14 wrong --

15 A, Okay,

16 Q. -- to the extent that you are going to
17 comment upon the condition being the most
18 life-threatening condition, that is the ARDS, it
19 seems to me that you would want to integrate the
20 testimony of the person taking care of her for that
21 condition to reach that conclusion; am I wrong
22 about that?

23 Ae You are not wrong, and I am not wrong
24 There's different ways to approach it.

25 I was asked to review the hospital

1 record as a complete outsider who had no first-hand
2 knowledge of this case, that's not an easy thing to
3 do, as you can imagine, you people do it all the
4 time, render an opinion as to what I thought was
5 going on.

6 I am not saying that Dr. Sopko's
7 opinions are not valuable. I am merely saying that
8 I was not asked to do and I did not do it.
9 That's --

10 Q. Are you here as an expert to render an
11 opinion on her ARDS condition?

12 A. No.

13 Q. Now, to the extent that that impacts upon
14 your opinion, does it matter to you that
15 Dr. Sopko testified that he anticipated weaning her
16 from the ventilator within a few weeks of the time
17 that this operation occurred; does that matter one
18 way or the another to any of your opinions?

19 A, It **doesn't** surprise me. Patients with
20 A.R.D.S., some of them are weanable. I find no
21 problem. In fact, I would expect Dr. Sopko to say
22 just that, It's his specialty and I would hope he
23 would be optimistic about the chances of weaning,
24 We have a relatively young woman with A.R.D.S. I
25 would feel badly for her if he was extremely

1 pessimistic about it. So there's nothing there
2 that's surprising or worrisome.

3 Q. That doesn't change of course your opinion
4 with respect to whether or not the surgery was
5 untimely?

6 A. No. No.

7 Q. You also indicate that she had
8 superinfection. I am now on the next line --

9 A. Yes.

10 Q. -- of your report.

11 What is superinfection as opposed
12 to just infection?

13 A. Well, patients who have A.R.D.S. develop
14 fluid in their lungs for reasons that have to do
15 with changes in permeability of the membranes and
16 vascular tone of the small vessels in the lung, but
17 the net effect is fluid becomes -- flows into the
18 space of the lungs and unfortunately this fluid is
19 an excellent culture medium for bacteria. The
20 bacteria become colonized in the back of the
21 throat, and you can imagine, drips down into the
22 lungs and causes infection.

23 So superinfection is an infection
24 but it in the medical context usually refers to
25 somebody has some kind of superinfection in the

1 lungs, at least has some kind of pulmonary process,
2 usually heart failure or A.R.D.S., and then on top
3 of that the lungs become infected.

4 Q. To your knowledge and your careful review of
5 the record, was she removed from antibiotics at any
6 point in time?

7 A, I don't know. My review of the record she
8 was pretty much on antibiotics most of the time,

9 Q. Next sentence goes on and you do comment
10 about February 26, and you say, "It appears
11 two guide wires used for introducing arterial
12 catheters were inadvertently introduced"?

13 A, Yes.

14 Q. You're not suggesting that whoever introduced
15 them didn't know they were introduced, you are
16 suggesting that they weren't put there on purpose;
17 do I read that correctly?

18 A. That's absolutely correct,

19 Q. Then you go on to say, "There was no
20 indication whatsoever from the hospital notes that
21 the patient suffered any ill effects from the
22 presence of these wires."

23 Well, the fact of the matter is --
24 and I apologize for being repetitive at all --
25 there was no indication in the hospital notes until

1 March the 8th that the wires were even there; isn't
2 that right?

3 A. That's correct.

4 Q. so --

5 MR. FULTON: Wait a minute.
6 You're talking about x-rays finding or what?

7 A. I believe you said the Progress notes.

8 Q. Yes.

9 A. That's what I'm talking.

10 MR. FULTON: so we
11 understand that.

12 MR. KAMPINSKI: Is that an
13 objection, Mr. Fulton?

14 MR. FULTON: No. It's a
15 statement to clarify the record. You used the
16 word, I wanted to be sure it's medical records and
17 it doesn't include x-ray and x-ray reports.

18 MR. KAMPINSKI: I was curious
19 whether that was an objection or coaching, exactly
20 what that was. I am not as sharp as you.

21 MR. FULTON: What does
22 "coaching" mean?

23 MR. KAMPINSKI: I don't know.

24 Q. So what you're saying is that there was no
25 reason for concern about the existence of these

1 wires in terms of them causing any harm based on
2 anything that you saw in the chart?

3 A. That's not what I said. I said there was no
4 evidence that they have caused any harm.

5 I think all physicians would be
6 concerned about them, but that's not what I said.

7 Q. That's fair. I didn't mean to be misleading
8 in that regard.

9 A. I just want to clarify what I said.

10 Q. But the concern should not have risen to the
11 level of extricating them in a post M_I patient this
12 soon after the M_I, correct?

13 A* That's -- no, I would not, and I think this
14 comes to the crux of the case. I would not. I
15 think what Dr. Steele did was perfectly
16 appropriate. I think that's a minimally invasive
17 technique.

18 Q. The percutaneous removal?

19 A. Right. Really presents extremely little risk
20 to the patient, and if you can snare them with that
21 technique, then it's perfectly appropriate; but I
22 think that the next measure that was taken was a
23 bit more than the patient could handle at the time.

24 a. Have you removed wires such as this
25 percutaneously?

1 A. On one occasion.

2 Q. Is that a difficult procedure?

3 A. I did it with a radiologist who had extensive
4 experience in doing the procedure. I had had
5 really minimal experience previously and asked him
6 to help and kind of assisted him, I will say, would
7 be most appropriate. He kind of showed me.
8 Fortunately I have not had occasion to have to do
9 it.

10 Q. Was that here at this hospital?

11 A. Yes.

12 Q. How long ago was that?

13 A. I'd say that was seven or eight years ago.

14 Q. Prior to Dr. Varma being here?

15 A. Yes.

16 MR. KAMPINSKI: Just curious.

17 MR. FULTON: I'm glad you're
18 being fair.

19 THE WITNESS: Sorry.

20 MR. FULTON: I meant

21 Mr. Kampinski being fair.

22 MR. KAMPINSKI: I want to
23 clarify the record, Mr. Fulton, to make sure.

24 Q. What is it that causes you to refer to -- I'm
25 now really near the end of your report, Doctor --

1 you make the statement that, "I would doubt that an
2 experienced vascular surgeon like Dr. Moasis,"
3 then you go on.

4 What knowledge do you have of
5 Dr. Moasis and his experience?

6 A. I read his deposition and I guess -- maybe
7 did you take it, I don't remember who took it --
8 but somebody questioned him rather extensively
9 about his credentials, where he obtained them, what
10 he did.

11 Q. I didn't,

12 A. He seems **like** he had a lot of experience.

13 Q. Were you impressed with the number of
14 experiences he had, the different places where he
15 had practiced?

16 A. No. It seemed like it was the Clinic, which
17 is a very good place, I know, say they do a lot of
18 cases. He was at some other place.

19 At least to my review of them or
20 knowledge it seemed like tertiary places where a
21 resident would be fairly busy.

22 Q. That's what you meant?

23 A. Yes.

24 Q. You weren't commenting on whether he was good
25 or bad?

1 A. I don't know Dr. Moasis at all. I can't
2 comment on his skill at all.

3 Q. You said you didn't know Dr. Steele, do you
4 know Dr. Rollins or Dr. --

5 MR. CARMEN: Kitchen.

6 Q. -- Kitchen?

7 A. I know Dr. Rollins.

8 Q. How do you know him?

9 A. How do I know Mike Rollins, through some --
10 actually some mutual friends. I know him more on a
11 social basis than any other basis.

12 Q. Are you in any organizations with any of
13 these three physicians?

14 A. Well, I am a member of the American College
15 of Cardiology. Although I haven't looked at the
16 rooster, I presume they probably are as well, as
17 it's a professional organization.

18 I belong to the American Heart
19 Association that they probably belong to that; but
20 I mean, nothing more intimate than that.

21 Q. You don't have any professional
22 inter-relationship with --

23 A. I never met Dr. Kitchen or Dr. Steele.

24 Q. Were you provided with any of the other
25 expert reports other than Dr., I think you got

1 Dr. Pitluk, didn't you?

2 A. And Paul Kohn.

3 Q. Were **you** provided with Dr. Mazal; do you
4 recall?

5 A. I don't think so. If I was, I don't recall
6 **that.**

7 MR. FULTON: What's the date
8 on that letter?

9 MR. KAMPINSKI: This one is
10 **your** January 22nd, the one you sent, of '93; and
11 one that Mr. Varma sent was December of '92.

12 Q. Have you received subsequent --

13 A. This is it.

14 Q. -- reports or records?

15 A. This is **it.**

16 I don't know if those depositions
17 came with this. They may have come separately. I
18 don't remember.

19 Q. I think they did.

20 A. Did they? You know better.

21 Q. According to these letters they did.

22 A. Okay, I don't remember. I don't keep track
23 of these things.

24 Q. Neither of these referred to Dr. Pitluk's
25 report?

1 A, Well, it was there, I read it.

2 Q. Do you know how you got it?

3 A. Somebody sent it, either this firm or what --

4 Q. "This firm," the record won't get that.

5 A, Chattman, Sutula, et cetera, et cetera:

6 Q. Or?

7 A. Gallagher, Sharp sent it to me. That's the
8 only way I've gotten any records on this case.

9 Q. Are there other correspondence that you
10 removed then from your file?

11 MR. JACKSON: Those reports
12 you are referring to are attached.

13 MR. KAMPINSKI: To the December
14 letter?

15 MR. JACKSON: To the thick
16 one, I believe they are.

17 MR. KAMPINSKI: Okay,

18 Q. Mr. Jackson's correct, They're not referred
19 to in the letter but apparently it's attached to
20 the letter that you received from Mr. Varma?

21 A, That must be where I saw it,

22 Q. Did you receive any other expert reports
23 subsequently?

24 A, No.

25 MR. KAMPINSKI: If you need

1 to make a call.

2 THE WITNESS: Yes, I'm going
3 to make a call.

4 -----

5 (Recess had.)

6

7 (Record read.)

8 -----

9 BY MR. KAMPINSKI:

10 Q. Do you agree with the following statement:

11 That the removal of the Guide wire by Dr. Moasis
12 was merely a completion of the procedure that had
13 been initiated by Dr. Steele; do you agree with
14 that?

15 A. No .

16 Q. Do you agree that once Dr. Steele had removed
17 the one guide wire, that it was difficult to
18 justify leaving the other one in place?

19 A. Not at all .

20 Q. So that this maybe a little repetitive of
21 what I just said, but you would disagree then with
22 the statement that Dr. Moasis completed a procedure
23 that was initiated prior to his exploration?

24 MR. SEIBEL: Chuck, why
25 don't you show him that,

1 Q. Do you agree with that?

2 A. That the -- they were basically one
3 procedure; is that what you are saying?

4 Q. That's right.

5 A. No, they were two completely different
6 procedures.

7 Q. Do you believe that her hemodynamic problems
8 that occurred subsequent to Dr. Moasis' surgery was
9 due to blood loss or cardiac irritability?

10 A. A combination of factors, probably both were
11 important.

12 Q. So anyone that said it was due to blood loss
13 as opposed to cardiac irritability you would
14 disagree with?

15 A. I would agree with them in the sense that
16 we're kind of splitting hairs, but I mean, I would
17 agree with them to the extent blood loss was a
18 factor, but if we did that to you, for example, and
19 you hemorrhaged after that kind of procedure, you
20 were otherwise healthy, I don't think you would
21 have died, you would have survived.

22 It's a combination of a certain
23 event happening in a patient who had other serious
24 problems going on.

25 Q. I didn't mean it to be a confusing question.

1 A. I'm confused.

2 Q. The following statement was made and I want
3 to know if you agree with it, referring to her
4 developing hemodynamic problems: This was due to
5 blood loss, not cardiac irritability; do you agree
6 or disagree with that?

7 A, To an extent, yes, blood loss sets off the
8 chain of events probably; but what I am saying is
9 that you could -- to set off the chain of events --
10 I hope I am not being too complicated here -- but
11 you cannot set off that chain of events in someone
12 who was -- did not have the problems that this
13 woman had.

14 Q. I understand.

15 A, Okay.

16 Q. But I am not sure you answered me whether you
17 agree with that statement or disagree.

18 MR. FULTON: Maybe he can't,

19 A, I partially agree,

20 Q. Does that mean you partially disagree with
21 it?

22 A. Right.

23 Q. You agree with the part that the hemodynamic
24 problems were due to the blood loss, you disagree
25 with. the part that says the hemodynamic problem

1 were cause^d or when he said they were not caused by
2 cardiac irritability?

3 A. They were all inter-related. It's not one
4 occurs, everything else just stays the same.

5 Q. I understand.

6 Her white count throughout the
7 hospital stay was elevated --

8 A. That's my recollection.

9 Q. -- was it not?

10 A, Yes.

11 Q. And was that elevation attributable in your
12 opinion to steroid administration?

13 A, In part, Again, it's a multi-factorial
14 problem, many reasons, one of which is steroid
15 administration.

16 Q. Do you believe that the patient -- once again
17 I apologize, I think you answered this a couple
18 times,

19 A. Go ahead,

20 Q. But do you believe that this patient was
21 stable enough for the surgery that occurred on
22 the 14th?

23 A. Absolutely not. Let me just clarify that,
24 I mean "stability" is a relative
25 team. For a life-threatening problem, then you

1 accept the risk, if you don't do the surgery, you
2 lose the patient. Obviously you wouldn't do a
3 herniorrhaphy, repair of the hernia, on a very sick
4 patient.

5 There's no such thing as clearing
6 patients for surgery. It's risk versus benefit.
7 You have to assess the risk of doing the procedure
8 versus the benefit accrued to the Patient from
9 doing it. That's what we're dealing with.

10 Q. And you're saying that in this case the risk
11 of doing the surgery certainly outweighed any
12 potential benefit?

13 A. Very strongly.

14 MR. FULTON: It's tough,

15 Q. Were you told what any of the other experts
16 had to say as opposed to receiving their reports?

17 A. The other experts being -- let's go over
18 this.

19 Q. Well, there's about ten of them.

20 Let me start with, are you aware of
21 the fact that both Dr. Pitluk and Dr. Mazal have
22 been deposed in this case?

23 A. Pitluk, yes. I don't even know who Dr. Mazal
24 is.

25 Q. You didn't get his report?

1 A. Right ,

2 Q. Were you provided any type of summary of what
3 he testified to?

4 A, No. As I said, I never heard of this
5 Dr. Mazal.

6 Q. I'm talking about Dr. Pitluk.

7 A, I got in one of the exhibits there, says
8 letter,

9 Q. So did you receive any kind of --

10 A. No.

11 Q. -- report or summary of what he testified?

12 MR. CARMEL: Wait until he
13 finishes.

14 Q. What he testified to in deposition?

15 A. No.

16 Q. Other than Dr. Kohn, Dr. Pitluk, have you
17 even been informed of who the other experts are?

18 A. I don't think so, no. If I was, I don't
19 recall.

20 MR. KAMPINSKI: That's all I
21 have.

22 Anybody else have any questions?

23 MR. OKADA: I don't have
24 any questions for the Doctor.

25 MR. COYNE: Do you have

1 any?

2 MR. SEIBEL: I am Bob Seibel
3 from Jacobson, Maynard. I represent Dr. Moasis in
4 this case.

5 -----

6 CROSS-EXAMINATION

7 BY MR. SEIBEL:

8 Q. Do you have your report in front of you?

9 A. Yes.

10 Q. On the first page midway down I have a
11 question about a couple sentences.

12 Let me read the sentence to you,
13 says, "There was no indication whatsoever from the
14 hospital notes that the patient suffered any ill
15 effects from the presence of these wires, there was
16 no evidence for thrombosis of any arterial vessel,
17 no evidence for any embolization from the wires, no
18 evidence that they caused any kind of circulatory
19 insufficiency."

20 What's the time frame for those
21 comments?

22 A. During the time the wires were in, from
23 the -- her: death.

24 Q. Until surgery and the postoperative?

25 A. Until they were taken out, that's when she

1 had problems.

2 Q. On the second page of your letter?

3 A, Sure.

4 *a** Second paragraph on page 2 you say that --
5 you say, "Although the surgery appeared to go
6 uneventfully" --

7 MR. FULTON: Hold on.

8 MR. SEIBEL: You have a
9 different type.

10 MR. KAMPINSKI: Where is that,
11 that you're reading? Is there more than one
12 report?

13 MR. SEIBEL: I have one
14 report dated January 28,

15 MR. KAMPINSKI: Right here,
16 Where is that?

17 THE WITNESS: Third
18 paragraph.

19 MR. SEIBEL: Second
20 paragraph on my version.

21 MR. COYNE: Here.

22 MR. KAMPINSKI: Okay.

23 MR. SEIBEL: Is it the
24 second paragraph on your version, too,

25 MR. KAMPINSKI: Yes.

1 Mr. Fulton apparently has a different report. He
2 has four paragraphs.

3 MR. SEIBEL: We can take
4 Mr. Fulton's deposition.

5 MR. KAMPINSKI: We'll continue
6 with the Doctor and we'll find the other version of
7 the report, whatever was omitted by you.

8 MR. SEIBEL: I'll leave that
9 to you.

10 BY MR. SEIBEL:

11 Q. Were you able to detect from the records any
12 intra-operative complications?

13 A. None.

14 Q. When postoperatively did Mrs. Weitzel
15 evidence any hemodynamic instability?

16 A. It seemed to occur all very quickly, and the
17 documentation in the chart was by the nurse
18 predominantly. It kind of -- it seemed like a
19 drop in her blood pressure, she got tachycardic,
20 diaphoretic, started having a lot of ventricular
21 ectopy.

22 Q. When after the surgery did this start?

23 A. I would say -- I don't mean to -- it seemed
24 like at ten o'clock.

25 I can refer to the record.

1 Q. Could you. You have my copy in front of
2 you.

3 A. Only place it's really documented in my
4 recollection is the nurses' notes. As you can
5 imagine, when things get going in there,
6 documentation gets kind of sparse, but it was at
7 the end, very end.

8 Q. First question I want you to answer, keep
9 this in front, when did she -- when was her first
10 evidence of hemodynamic instability
11 postoperatively?

12 A. I am trying to find it. I'm not successful
13 here.

14 The day of her death was -- is
15 when, can you --

16 Q. Early in the morning hours of March 15th,
17 surgery was on March 14th.

18 A. so --

19 Q. It would be at the very end of the nurses'
20 notes?

21 A. Right. That's what I am trying to find. We
22 got it here.

23 At 9-1 there's a note she had
24 increased her oxygenation support; but quite
25 frankly, in someone who's just been in surgery, all

1 kinds of thing, I wouldn't find that physically out
2 of the ordinary.

3 MR. KAMPINSKI: Are you looking
4 at the nurse note or are you looking at the graphic
5 chart?

6 THE WITNESS: Nursing
7 progress notes.

8 MR. KAMPINSKI: We started --

9 THE WITNESS: I'm looking at
10 the last notes on a certain page, says 9-14.

11 MR. KAMPINSKI: I'm sorry. I
12 apologize. What 9-14 note?

13 THE WITNESS: Down at the
14 bottom.

15 MR. KAMPINSKI: That's
16 nine o'clock.

17 MR. COYNE: You mean 9:30.

18 THE WITNESS: It's looks like
19 3914 to me.

20 MR. KAMPINSKI: Have you
21 reviewed the eight o'clock note in answer to his
22 question.

23 THE WITNESS: Yes. She was
24 tachycardic, I guess. Let's go back to that. But
25 **she was** oxygenating well. She was tachycardic.

1 These I.C.U. patients, it's -- they sometimes they
2 just become tachycardic. They get a bronchial
3 plug, they get agitated for whatever reason. So I
4 mean it's something obviously a resident or nurse
5 needs to keep an eye on. I wouldn't hit the panic
6 button because someone was tachycardic, but they do
7 have swings, if it was -- were a consistent trend,
8 yes; but that alone, no.

9 Puts us somewhere back to 9-14, but
10 I don't know what time this is. I can't see it.
11 Is it 10:00, is it 11:00. It's the first notes on
12 that next page.

13 MR. KAMPINSKI: That one is
14 10:00.

15 THE WITNESS: Then I would be
16 concerned. I mean, it seemed like things are
17 continuing, she's diaphoretic. So I mean,
18 intensive care patients, especially someone like
19 this, very sick, trends are more important than
20 single events.

21 By this, is this ten o'clock?

22 MR. KAMPINSKI: Yes. That
23 nurse note is 10:00.

24 THE WITNESS: By 10:00 I
25 would be concerned.

1 MR. KAMPINSKI: Do you want to
2 look at the critical care flow sheet to answer his
3 question?

4 MR. SEIBEL: You can,

5 THE WITNESS: If you're going
6 to let me look at it.

7 She has persistent tachycardia.

8 MR. SEIBEL: From what
9 time?

10 THE WITNESS: 1600 hours,
11 which is eight o'clock, right. Nope,

12 MR. CARMEN: 4:00.

13 THE WITNESS: Four o'clock.
14 Sort of tachycardic, the trend is certainly
15 increasing by eight o'clock. It's 141 by
16 ten o'clock, it's 140, she was not febrile, her
17 blood gasses were -- some hypoxemia, I would be
18 concerned,

19 BY MR. SEIBEL:

20 Q. At what time would you become concerned?

21 A. I would have had some level of concern at
22 eight o'clock, certainly by 9:00; and ten o'clock I
23 would have been very concerned, figuring that
24 something is going on with this lady.

25 Q. What is the least likely cause for her

1 hemodynamic instability postoperatively?

2 A. That's a tough one,

3 Q. Do you have an opinion one way or the other?

4 A. I have a number of opinions. I will tell you
5 what my thinking would be.

6 She lost blood, obviously she had
7 surgery, One would have to look at blood loss as a
8 factor. She developed a new infection related to
9 going into her retroperitoneal space, she's septic,
10 she's hypoxic, which she is, but not alarming so,
11 but some hypoxic; the surgery and these particular
12 fluid shifts have caused a myocardial dysfunction,
13 I think all of these need to be considered,

14 Q. Do you have an opinion as to the most likely
15 cause of her hemodynamic instability which begins
16 at eight o'clock?

17 A. I have an opinion based on what I know about
18 the case; is that what you want?

19 Q. Sure.

20 A. She was bleeding, she had serious
21 retroperitoneal bleed. It's not obvious to a
22 resident coming on a floor.

23 Q. I didn't ask that,,

24 A, That's not what you meant?

25 Q. I didn't ask that.

1 How long does it take of a blood
2 loss to reflect these kind of hemodynamic changes?

3 A. Depends on the rate of blood loss. If it's
4 fast and happened quickly, you know, also depends
5 on the patient; healthy person can sustain quite a
6 bit of blood loss, not show much of anything; very
7 sick, small amount of blood loss can be reflected
8 more quickly.

9 Q. would Mrs. Weitzel's condition make it more
10 likely that she would show quicker complaints --

11 A. Sure.

12 Q. -- due to blood loss?

13 A. Yes.

14 Q. What were the risks to Mrs. Weitzel for
15 leaving the wire in?

16 A. Short term, long term?

17 Q. Let's include them all.

18 MR. KAMPINSKI: Doctor, do you
19 need that anymore?

20 THE WITNESS: No. Here you
21 go.

22 A. I don't believe the risk of the -- we have
23 short and intermediate term -- is much. The real
24 risk in the arterial tends to be the flow states,
25 some then develop thrombus, very often become

1 infected. Really no one -- well, really, wires
2 have been left in people's lungs, for example,
3 forever, and they seem to do well.

4 So the presence of a wire in and of
5 itself, not doing anything, in my opinion is not
6 anything to be too concerned about in this
7 setting.

8 Q. How long is the intermediate term, you said
9 an intermediate term?

10 A. Three to four months.

11 I guess what I am saying, I would
12 not have -- I said I wouldn't have gone in a
13 patient this ill at this time. ~~LIE~~ she made a great
14 recovery, she was up on the floor walking around,
15 we're thinking about sending her home, I'd say we
16 got to get that other wire out, this would be a
17 good time to do it.

18 Q. Would the remaining wire have to come out at
19 some point?

20 A. Well, there is no series, and you know, there
21 is no gospel on this,

22 I think most physicians would feel
23 uncomfortable leaving that wire in indefinitely in
24 a young woman. I think the feeling is at some
25 point it would cause a problem.

1 Q. What kind of problem could be probably caused
2 that could --

3 A. Could be the nidus for thrombus and cause
4 clotting off of arteries. Probably wouldn't cause
5 anything prohibitive and you could leave it there
6 forever, but nobody does, nobody studies this.

7 Conventional wisdom is that a
8 foreign body, if it can be removed safely, should
9 be removed.

10 Q. Was there risk of perforation?

11 A. Not with these wires. The tips tend to be
12 very soft and the artery tends to be very thick
13 walled, so I think whatever risk of perforation
14 occurs earlier on, and not later on.

15 Q. Assuming that Mrs. Weitzel would have --
16 assuming she had no significant neurological
17 impairment and that she began to recover from her
18 illness, would her activity be restricted in any
19 way with the wire in?

20 A. I don't think so. I can't think of anything
21 that I would advise such a patient not to do.

22 Q. At the time Mrs. Weitzel became
23 hemodynamically unstable postoperatively what
24 should have been done for her?

25 A. Well, you got to figure out what's wrong,

1 that's the first step, you got to study the
2 hematocrit, it should have been sent off to see
3 what her hematocrit was,

4 The other thing we were concerned
5 about was her hemodynamic instability related to
6 her heart, One thing you can do is put in a
7 Swan-Ganz catheter, she had it intermittently
8 during the hospitalization, and see what her
9 cardiac output was, what her wedge pressure was,
10 what her right atrial pressure was, what her
11 pulmonary artery saturation was, figure out what is
12 going on, If her crit is -- hematocrit is
13 significantly lower than it was preoperatively,
14 then you got to call the O.R. people and re-explore
15 her; if that's fine, then you -- whatever the
16 problem is, fix the problem,

17 Q. If this was a bleeding problem that had been
18 detected postoperatively and successfully treated,
19 would she have survived?

20 A. That, I can't say, I mean, it's such a
21 complicated case with so many things going on, I
22 can't say that she would survived.

23 Q. You don't have an opinion one way or the
24 another?

25 A, Well, you know, you guys like to hear

1 percentages and I can't give you percentages.

2 It is a long shot, If a lady like
3 this survived to walk out of the hospital, not
4 going to a nursing home, return to her family,
5 return to work, it's a long shot. It happens, and
6 I have seen it. I'm Proud to say I have
7 participated in many cases, but I mean there's many
8 who don't make it, So it's just she's sort of in
9 the period of time where she could go either way.

10 Q. What period of time could she go one way or
11 the other?

12 A, I'd say in the next few weeks it would have
13 been clear, If she is extubated and if she --

14 Q. Are you talking about preoperatively?

15 A. Assuming that nothing was done for the wire,
16 that's what I am talking about, and in the next
17 two weeks she makes progress, she -- her white
18 count comes down or fever goes away, she gets off
19 the ventilator, she's up and around, then I say
20 this lady is going to make it.

21 On the other hand, if she stays on
22 the vent another two weeks without any improvement,
23 I'd say the longer she is in I.C.U., the longer on
24 the ventilator, longer she has problems, it's less
25 likely she's going to get out,

1 Q. Specifically if she had received appropriate
2 treatment for this postoperative complication,
3 would she have survived at least that crisis?

4 A. I don't know. If you take her back to
5 the O.R. that just ups the ante, more
6 complications, more problems, more one's chances --
7 we haven't even touched on the risk of general
8 anesthetic in a woman who just had an M.I.

9 You have to put her to sleep again,
10 increases the risk. Obviously the more things that
11 you do to a woman like this, the -- that don't work
12 out well, the greater her risk of not coming out of
13 the hospital is.

14 Q. Could she have been resuscitated from this
15 complication short of surgery?

16 A No, not that I can say. This might be
17 something to ask a vascular surgery expert, but
18 from my knowledge, someone bleeding from an
19 anastomotic site usually you have to go in there
20 and fix it, put more stitches in there, but I'm not
21 an expert on that.

22 Q. Do you have an opinion when she began to
23 bleed postoperatively?

24 A. Probably soon, but that's totally
25 speculation.

1 What happens is you reach a certain
2 level where it's recognized that you lose a certain
3 amount of oxygenation carrying capacity before it
4 perturbs the system. She had tachycardic
5 agitation, she had diaphoresis. I mean, I have no
6 way of knowing.

7 Q. When would Mrs. Weitzel have been a candidate
8 for surgical removal of a wire?

9 A. Again, there is no dogma here, but my own
10 view is that it's not a very high priority
11 situation. The lady had fairly extensive
12 myocardial infarction.

13 I mean, the conventional wisdom --
14 sometimes we deviate from this because of needs --
15 is to wait six months after MI before doing an
16 elective operation. I am not sure this was totally
17 elective. Again, this is judgment, but I would
18 think that if this were my patient, that's all I
19 can say, I would wait until this lady was strong,
20 she is in good shape, you're thinking of sending
21 this lady home, so the risk of general anesthesia
22 would be minimized. That's really the problem.

23 Q. What made the surgery less than totally
24 elective?

25 A. The fact that the wires weren't harming her.

1 There was, as far as I can see, there was no
2 adverse consequence of the wires, nor do I think
3 any were likely in the -- let's take the best case
4 scenario -- in a month she will be ready to go
5 home; my own feeling is in that month the wires are
6 unlikely to do anything.

7 Q. I don't think -- you maybe didn't hear the
8 question.

9 MR. FULTON: Read the
10 question back.

11 - - - - -

12 (Question read as follows: What made the
13 surgery less than totally elective?)

14 - - - - -

15 A. Maybe I shouldn't have said that.

16 In my view it probably is
17 elective. I guess the -- what I am saying is the
18 conventional wisdom of waiting six months before
19 surgery was based on data that was really generated
20 years ago before we knew as much about these
21 people, and so there's really higher risk
22 subgroups, low risk subgroups, and what we've tried
23 to do is define the high risk subgroup, make them
24 wait; Power risk subgroup, you can do in six weeks;
25 because you got to consider this woman, you got

1 two wires in, you -- you got to wait six months to
2 take them out. That's probably not going to sit
3 well with most people.

4 What you might do when she's much
5 better is do a cardiac catheterization, determine
6 her coronary anatomy, her hemodynamics. If she
7 fell into a relatively low risk subgroup, you might
8 say we'll go ahead, do the surgery; if she fell
9 into a higher risk subgroup, you might want to
10 postpone.

11 Q. Was it her MI that put her in the high risk
12 subgroup that started it?

13 A. Assuming that's -- assuming she -- all the
14 A.R.D.S went away, the infection went away, her
15 mental status became completely normal, she still
16 would be a woman who had a massive MI, complicated
17 by recurrent ventricular fibrillations and
18 cardiogenic shock, that usually in and of itself
19 puts people in a pretty high risk subgroup.

20 Q. For patients in the post MI period who are
21 required to undergo surgery, what special
22 precautions are taken to guard against the risk of
23 anesthesia for these patients?

24 A. That's really a good question.

25 I mean, in question -- general we

1 look to monitor these people hemodynamically, that
2 means putting a Swan-Ganz catheter in to measure
3 the cardiac output, their peripheral vascular
4 resistance, their inter-cardiac pressures, and
5 anesthesiologist can kind of titrate using some
6 certain medications, so if they get out of whack,
7 you kind of bring them back into line using an
8 arterial line.

9 So at least my feeling is high risk
10 cardiac patients who have to have surgical
11 procedures should be done with hemodynamic
12 monitoring.

13 Q. Throughout the operation?

14 A. Throughout the operation, And generally in
15 the intensive care unit, again, that's what we do,
16 that's all I can tell you, we'll do it in the O.R.,
17 then they would be transferred back to the
18 intensive care unit, the lines usually would stay
19 in another day, sometimes things get shaky even
20 after they get out of the operating room.

21 Q. I assume, and correct me if I am wrong, I
22 assume that Mrs. Weitzel's condition made her more
23 sensitive to blood loss?

24 A. Absolutely.

25 Q. Why was that?

1 A. Well, she lost a certain amount of her heart
2 muscle function, and the more you lose, the less
3 you are able to compensate for any kind of
4 instability; and what happens is, some of the
5 mechanisms that are used to help the tachycardia
6 and vasoconstrictions are counterproductive, just
7 puts more stress on the heart,

8 Q. How long would that -- had she been in that
9 kind of condition?

10 A. You mean after the surgery?

11 Q. After her MI.

12 A, For the whole time -- it appeared much of the
13 time she was tachycardic, and that increases
14 myocardial oxygenation consumption. We don't know,
15 at least they didn't know, her myocardial -- her
16 coronary anatomy. You presume there's negative
17 effect from being a persistently tachycardic heart,
18 just had an infarct, but one of the prescriptions
19 is to try to get rid of the tachycardia, if
20 possible.

21 Q. In patients like Mrs. Weitzel, how long does
22 that patient remain sensitive to even small loss,
23 loss of small amounts of blood?

24 A. It's depending on the amount of myocardial
25 damage. It could be the rest of their lives.

1 Q. Was her postoperative bleeding related to the
2 anesthesia?

3 A. I don't know of any connection.

4 Q. I think you said before when Mr. Kampinski
5 was asking you questions that you believe
6 Dr. Steele deviated from the standard of care?

7 A. Yes.

8 Q. In what respects?

9 MR. KAMPINSKI: Are you
10 representing Dr. Steele now?

11 MR. SEIBEL: We might file a
12 crossclaim,

13 MR. KAMPINSKI: Okay.

14 A. In my impression he initiated the operative
15 intervention, and at least tacitly approved her for
16 the surgery.

17 Q. Why would that be below standard of care?

18 A. Well, I think we discussed that,

19 In kind of summation, I felt that
20 the risk of the surgery outweighed any benefit she
21 would receive at that time.

22 Q. What would be the benefits of the surgery
23 assuming it had been successful?

24 A. She wouldn't have the wires in her body
25 anymore.

1 Q. Why would that be beneficial to her?

2 A. It wouldn't really be at that time.

3 Q. So you are saying the surgery had no
4 benefits?

5 A. Not at that time. I can't think of any
6 direct benefits, a short time frame, we're talking
7 about two weeks, a month.

8 Q. Would the surgery at any time in her life had
9 been beneficial?

10 A. Again, we discussed this, There is no -- I
11 can't show you any data that says people who have
12 foreign bodies that the net recommendations is
13 leave them in. The feeling is that you should
14 remove them if the risk of removing them isn't
15 prohibitive. I'll give you an example.

16 If you have a little fragment of
17 guide wire lodged in the lung of somebody, and
18 especially if that somebody is an 80 year old man,
19 everyone would agree the risk of trying to take it
20 out would be prohibitive.

21 On the other hand, if you had a
22 guide wire where you might just cut down a brachial
23 artery, for example, in a 20 year old man, I think
24 everyone would go ahead and take it out. The risks
25 are really minimal, and you know, there are

1 theoretical problems with foreign bodies, although
2 it may not -- if you have a 20 year old man and
3 you're expecting him to live another 60 years and
4 maybe over this period of time this could cause
5 some mischief, the risk of taking it out is quite
6 minimal, say that's the kind of thing that we do,
7 so we go ahead and take it out.

8 Q. When was she hemodynamically unstable
9 preoperatively?

10 A. That's a tough question,

11 Q. In the immediate preoperative?

12 A. She is always hemodynamically unstable.
13 She -- her blood pressure was up, Swan-Ganz in her,
14 pulse going up and down, just look at the flow
15 sheets; but there are thousands of patients that go
16 up and down. There's very many agitations to the
17 nervous system and the nervous system controls the
18 heart in a way, and then the blood pressure and the
19 pulse goes up and stays up for a while.

20 In a sense these kinds of patients
21 are always relatively hemodynamically unstable.

22 Q. How long would she have been in that kind of
23 state?

24 A. Probably until she came off the ventilator,
25 and the ventilator is a very noxious instrument to

1 people, especially as they do improve
2 neurologically. become more and more awake they
3 don't like being in that setting; sometimes that's
4 enough to get their -- just like being
5 cross-examined, it's a stress for some people and
6 their blood pressure and pulse go up -- for those
7 people being in I.C.U. is a stress, sometimes just
8 being there; or family member comes by and they
9 want to talk to the family member, want to tell
10 them something and they can't, blood pressure goes
11 up. There's always some degree of instability.

12 Q. What was her cardiac status preoperatively?

13 A. She had had a major infarct. It's hard to
14 determine that preoperatively, They couldn't do a
15 Swan -- I mean they couldn't do a cardiac
16 catheterization, she was too unstable for that,

17 I think they probably attempted an
18 echocardiogram, probably was not of much quality
19 given the fact she was intubated say everything, I
20 think the autopsy report showed a moderate amount
21 of myocardial damage.

22 a. Preoperatively was her cardiac status
23 improving, stabilized, or getting worse?

24 A. I think it really had stabilized after the
25 few first days at Charity Hospital. I can't say

1 that it was getting worse in any way.

2 Q. Was her pulmonary status worsening,
3 improving, or stabilized?

4 A. Again, I am not a Pulmonary expert, I'll
5 defer, but my feeling from reading the chart, I
6 didn't concentrate on that, but is that it
7 stabilized; and many of this could be days when she
8 looked a little bit better, then one could be more
9 optimistic maybe about extubating her; but on
10 another day the blood gasses were deteriorating and
11 you're a little more pessimistic. That's how it
12 is: one step forward, two-quarters of a step back,
13 that's how these patients really are.

14 Q. Would Mrs. Weitzel's cardiac status have
15 restricted her activity assuming she had lived?

16 A. I think so.

17 Q. In what respects?

18 A. I think that she would have had some
19 limitation of her activity, assuming that whatever
20 was appropriate was done, she made a full recovery,
21 she was treated by a cardiologist and got good
22 treatment, I think she would have had a reasonably
23 functional status.

24 She didn't have a massive MI where
25 you think about sending her for a heart transplant

1 or something. There clearly **would** have been
2 limitations on her functional status.

3 Q. In the post MI period I take it the risk of
4 general anesthesia decreases with time, in the post
5 MI period?

6 A. Yes.

7 Q. Is there a recognized curve, or what is the
8 rate of the reduction of the risk post MI?

9 A. Nobody has that data, okay. It's felt that
10 any intervention within the first few days is not
11 advisable, and certainly the longer one can wait,
12 the better it is; and the key factor is the
13 patient: the patient who has a tiny little MI, we
14 can probably send home that afternoon, they
15 wouldn't notice it and they would be fine; there's
16 patients who have pretty large MIs and they remain
17 in kind of danger for the rest of their lives.

18 One has to approach any procedure
19 with lots of care, So it really depends more on
20 the patient than it does on time.

21 Q. Is there anything magical with the 30-day
22 period post MI?

23 A. Not in my opinion.

24 Q. Are you familiar with any literature that
25 discusses that?

1 A. There's a lot of old literature where they go
2 over periods, that was all done before patients
3 were really stratified. The real emphasis anymore
4 is stratifying the risk after MI,

5 The stratification is done based
6 on data from cardiac catheterization and treadmill
7 exercising, often with thallium, or echos; and
8 based on patients, how well they do the stress
9 test, what the cath looks like. You stratify them
10 as high risk, low risk, medium risk, that seems to
11 be much more important than any kind of 30-day
12 this, 30-day that,

13 Q. Where did Mrs. Weitzel fall into that
14 stratification in modern cardiology thinking?

15 A. She couldn't be stratified, She wasn't
16 cathed, she certainly couldn't have a stress test,
17 so she hadn't been stratified; but my gut feeling
18 based on the presentation, the -- and you know,
19 reports, is that she would have been at least
20 medium risk, if not high risk,

21 Q. What led you to believe she would have been
22 medium risk?

23 A. Not low risk, is why.

24 Q. She wouldn't be low risk, is that what you
25 are saying?

1 A. You'd either be medium or high, she wouldn't,
2 you know, be low, I don't know which one.

3 Q. What tells you she would have been at least a
4 medium risk?

5 A. The location of her infarct, the size of her
6 infarct, and the problem with ventricular
7 arrhythmias. The ventricular arrhythmias may have
8 been the least compelling reason why your risk
9 could be high,

10 Q. And what factor would have led you to
11 conclude that she would have been a high risk?

12 A. Well, the need for multiple defibrillations
13 on the onset and the continuing ventricular ectopic
14 activities during the hospitalization, that often
15 places people in a high risk category.

16 Q. Is there anything else that you would go to
17 to assess her risk at the time she underwent her
18 surgery?

19 A. Myocardial function, Swan-Ganz, hemodynamics,
20 cardiac catheterization,

21 Q. I'm talking about actual data in this case?

22 A. That we have?

23 Q. Right.

24 A. That was available at the time when they did
25 the surgery or subsequent to that? I'm talking

1 about the autopsy report.

2 Q. Well, anything that you have that you can
3 even look in retrospect that would say she was high
4 risk?

5 A, She had a fairly significant infarct, she had
6 tremendous, tremendous ventricular ectopy, she had
7 significant coronary disease. I'd put her at high
8 risk, and then she had other problems, her
9 pulmonary problems.

10 I'm not saying she wouldn't get
11 better, but at the time the surgery was done, I
12 mean, she was still on a ventilator.

13 Q. Are you going to venture an opinion from a
14 pulmonary standpoint whether she would be clear for
15 the surgery?

16 A. No. Can't do that,

17 Q. Do you have training as a surgeon?

18 A, None.

19 Q. What sort of issues in your practice do you
20 defer to cardiac surgeons or vascular surgeons?

21 A, Things that I have -- I don't know much
22 about. In a general way, if there is a -- I'll
23 give you an example that would help you.

24 Catheterizations that we do and if
25 there is a problem with a pulse, we'll as a

1 vascular surgeon to give us a hand, cardiac
2 surgeons, will ask them. There's certain cases
3 that are very straightforward we think ought to be
4 operated on and we can't imagine why they would
5 object sometimes, and there's cases where it's a
6 risky case and we're concerned about the patient
7 making it through and we'll ask the surgeon to see
8 what do you think the indications are of getting --
9 helping this patient, getting them through the
10 operation, those sorts of things.

11 MR. FULTON: You are talking
12 about losing a pulse after cath?

13 A, We -- usually when I consult a vascular,,yes,
14 surgeon, They might see someone else in my office,
15 I think the internists take care of that here, who
16 has a vascular problem, comes in with claudication,
17 and I might refer them to a vascular surgeon; but
18 generally that is something the internists who work
19 here do,

20 Q. When you refer a patient for a surgical
21 evaluation, what role is played by the surgeon in
22 the medical clearance issues for one of your
23 patients?

24 A, Usually none. Usually -- see, I don't know
25 about the word "clearance." I want to say it on

1 the record. Clearance is --

2 Q. If there's a better term.

3 A. -- when your plane leaves the airport, you
4 get clearance from the control tower.

5 What I want everyone to understand,
6 the surgeon, the internist, the family, the
7 patient, that there are risks and benefits;
8 everyone has a clear understanding of what the
9 risks are and everyone has a strategy how they are
10 going to deal with those risks in the operating
11 room and in the perioperative period.

12 The surgeon always wants the
13 patient cleared. I even have a reputation around
14 here, I do not clear patients. We kind of
15 determine -- determine what the cardiac risk of
16 doing a certain procedure is, we either proceed or
17 don't proceed with the procedure based on the
18 patient, people's feelings, the patient's family,
19 the surgeon, the internist, anyone else who is
20 involved in the case.

21 There is no such thing as medical
22 clearance for a procedure.

23 Q So what role did the surgeon play when you
24 refer patients for surgery, in evaluating the
25 cardiac risks of surgery for any particular

1 patient?

2 A. It's really the surgeon's decision. He may
3 say if you really think there's a chance of a
4 complication, I'd rather not do the case, I think
5 there's other ways of handling this problem. I'll
6 give you an example.

7 Somebody might have severe
8 claudication, and I have patients like that, I just
9 tell the surgeon you can operate on this guy but
10 you are going to have complications, he may not
11 make it. The surgeon is very likely to say he is
12 going to have to live with his claudication, that's
13 the sort of thing.

14 I don't feel it's justified to take
15 his life so he can walk a hundred meters longer.

16 Q. What about the converse, have you had
17 situations in referring patients to surgery where
18 you feel that there is -- there are minimal or
19 reduced cardiac risks for surgery, yet the surgeon
20 refuses to operate because of those risks?

21 A. That's a very unlikely scenario, and you
22 always -- I have the option of referring to another
23 surgeon. This town has lots of surgeons.

24 If the surgeon says I'm not
25 comfortable, the patient still feels they want the

1 operation, then we'll send them to someone else for
2 another opinion.

3 Q. Doctor, at trial are you going to offer an
4 opinion that Dr. Moasis, my client the surgeon, was
5 negligent in his care and treatment of
6 Mrs. Weitzel?

7 MR. KAMPINSKI: Objection.

8 MR. FULTON: Objection.

9 MR. KAMPINSKI: He already
10 stated that opinion. Are you suggesting he's going
11 to suggest something at trial other than he did
12 here?

13 MR. SEIBEL: I want to know.

14 MR. FULTON: I don't think
15 that's a fair question the way you phrased it.

16 MR. SEIBEL: Are you having
17 trouble with "negligence," do you want me to say
18 breach of standard of care.

19 MR. KAMPINSKI: I'm going to
20 object, It was asked and answered, I don't know
21 if you're asking him if he's going to testify
22 differently at trial than he did here,

23 MR. SEIBEL: I don't think
24 the question and answer before was as clear as I
25 just asked it.

1 MR. KAMPINSKI: We don't think
2 it's clear now. Nobody objected when I asked it.
3 It must have been clear before.

4 MR. FULTON: Here is my
5 objection,

6 It well could be that I would be
7 asking some questions of this doctor at trial and I
8 have yet to determine just exactly what I might ask
9 him, he might not -- he may not -- I haven't even
10 conferred with him, so it -- put your question
11 differently to him so he can answer,

12 MR. KAMPINSKI: What did you
13 just say? What in the world did you just say?

14 THE WITNESS: I'm happy to --

15 MR. COYNE: Let's get on
16 with this.

17 THE WITNESS: You sort it out
18 and tell me.

19 BY MR. SEIBEL:

20 & I want you to answer the question. You can
21 go ahead.

22 A- Again, I am not going to -- my feeling is
23 that the combined decision to send this lady for
24 surgery was a mistake. That's what this gentleman
25 **referred to, that's what.** I answered; and I am not

1 in the business of apportioning how much blame.

2 It seems to be Dr. Steele and
3 Dr. Moasis, who were the two people who were
4 involved in, did get this lady to the operating
5 room, which I feel was not the best thing for her;
6 that's what I will testify to if I am asked to
7 testify.

8 Q. Do you feel in any other way Dr. Moasis may
9 have had a mistake in the care and treatment of
10 Mrs. Weitzel?

11 A. No. I think that -- I am not sure what you
12 are getting at, some of -- it's something and I am
13 not sure what you are getting at.

14 Q. I'm trying to wrap it up.

15 I don't want to be at trial and you
16 say something that I haven't asked you about and
17 you --

18 A. I am not going to render any opinion about
19 his skill or the practice. I am not qualified to
20 do that. The only thing that I feel is something
21 that I do, so I -- I feel somewhat qualified to do,
22 and that is the decision whether this lady was
23 stable enough to undergo surgery considering what
24 the problem was, that's something I do every day.

25 Q. In terms of mistakes you feel were made by

1 Dr. Steele, are there any others besides what you
2 already described in the deposition?

3 A. None .

4 MR. SEIBEL: I'm done at
5 this point.

6 MR. WARNER: No questions.

7 MR. COYNE: I have just a
8 few questions.

9 MR. KAMPINSKI: I'm going to
10 object to you asking him any questions because I
11 believe your interests are the same as Dr. Varma's,
12 but go ahead.

13 MR. COYNE: Well, I have
14 others who are not identified exactly with
15 Dr. Varma, that's why we have separate counsel for
16 Dr. Varma.

17 MR. KAMPINSKI: Well, I object.

18 MR. FULTON: We have two
19 separate counsel.

20 MR. COYNE: Objection is
21 noted.

22 MR. KAMPINSKI: There's a lot
23 of people representing Dr. Varma, apparently.

24

25

CROSS-EXAMINATION

BY MR. COYNE:

Q. Just if I understand, you are not going to render any opinion as to how the wires got into this patient; is that correct, or who put them in?

A. Well, they got there in the course of a procedure. I mean, they didn't walk in there, but I don't know how they got there. I'm going -- I am confused by the medical record and I don't know how they got there.

a. Relative to -- you just mentioned a name -- relative to Dr. Jayne, one of the other residents?

A. Before, yes.

Q. Have you reviewed any document or any evidence whatsoever that she ever laid a hand on the patient during the time of this --

A. No.

Q. -- February 26th procedure?

A. Not -- no, I have no evidence that she did anything.

Q. Other than what she was --

A. Her name appears as being there.

MR. KAMPINSKI: I will withdraw my objection to your asking that question. I'll do it question by question.

1 Q. If I understood you during the questions by
2 Mr. Kampinski, it's your opinion that this patient
3 probably would have needed surgery postoperatively
4 to stop the internal bleeding; is that correct?

5 A, That's an opinion with --

6 | P. Probability?

7 A, -- with the realization that I am not a
8 vascular surgeon, I do not deal routinely -- as a
9 general physician, that would seem appropriate to
10 me.

11 Q. When a person dies, the bleeding stops,
12 correct?

13 A. Yes, that is correct.

14 Q. From the autopsy you found evidence that
15 there was internal bleeding?

16 A. That's what the autopsy report suggests,
17 yes.

18 Q. Relative to the decision on the surgery on
19 March the 14th, if I understand you, is it your
20 professional opinion that when the decision is made
21 to go forward with the patient such as
22 Mrs. Weitzel, in this particular case with the
23 history of a recent myocardial infarction, with
24 ARDS present, with some immediate history of
25 sepsis, **that** when that decision is made, the

1 attending cardiologist should consult with a
2 pulmonologist concerning the pulmonary stability or
3 lack thereof relative to undergoing the surgery,
4 was that --

5 A. I think you're stating what I said -- and I
6 may be confusing you guys -- I think that's stating
7 it too strongly.

8 I think in a complicated patient
9 like this woman --

10 Q. We're dealing with this one. That's all I'm
11 going to deal with.

12 A. -- that the care of her, the patient, has to
13 be by committee, and different physicians work
14 differently with other people, and I've never been
15 in this building, Saint Vincent Hospital. I don't
16 know these doctors -- I don't know how they work,
17 so I can't really say.

18 The doctor may have talked to
19 Dr. Steele, he may have said Mike, or whatever it
20 is, is that his name, Mike Sopko, that what do you
21 think of Mrs. Weitzel going to surgery, in the
22 course of seeing him in the hallway. I don't
23 think -- I don't know. I don't want to make a
24 strong point that he had to request a written
25 consultation in the chart.

1 Q. I didn't mean to infer that.

2 A. Okay.

3 Q. All I am saying, should the attending have
4 consulted with the pulmonologist in some fashion,
5 or orally, written, to get an evaluation of the
6 present status, for instance, of the ARDS
7 condition?

8 A. I think that would be appropriate. I think
9 if you're going to call in a consult, okay, and
10 there's a big decision coming up that that
11 consultant's area is relative to what is coming up,
12 I personally think it's a good idea to get
13 everyone's point of view, that's my opinion.

14 MR. COYNE: I have no
15 further questions.

16 MR. KAMPINSKI: Just a couple
17 things to follow up. I want to make sure I
18 understood.

19 -----

20 RECROSS-EXAMINATION

21 BY MR. KAMPINSKI:

22 Q. Does a vascular or cardiovascular surgeon
23 rely on a cardiologist, and I won't now use the
24 word "clearance," but rely on a cardiologist, for
25 your: opinion, regarding the medical. suitability of

1 a patient such as Mrs. Weitzel to undergo surgery?

2 A. This would be something in the domain of a
3 vascular surgeon.

4 Q. Fine.

5 A. I would think so, yes.

6 Q. It was pointed out during questioning
7 apparently that there another report of yours that
8 you authored; can I have that, please?

9 A. I don't have that, but I mean, it's not a big
10 deal. I'd be happy to tell --

11 MR. CARMEN: There is no
12 other report. There is one report which was given
13 to us in a rough form to look at. You are welcome
14 to see the draft. I have a copy of the draft.

15 MR. KAMPINSKI: Well, I want to
16 see whatever it is the doctor authored before it
17 was changed, after it was changed, however many
18 drafts there were, and then I want to ask him why
19 it was changed.

20 THE WITNESS: You can go
21 ahead. You can ask me that question.

22 MR. KAMPINSKI: Good. Let me
23 see it, then I will ask.

24 MR. CARMEN: We don't have
25 the draft here,

1 MR. KAMPINSKI: Mr. Fulton was
2 just looking at it.

3 MR. CARMEN: Do you have one
4 that isn't marked up?

5 MISS KOLIS: I don't have
6 it, Nine is like that one.

7 MR. CARMEN: Let me see the
8 one if --

9 MR. KAMPINSKI: Do you have a
10 xerox machine here?

11 THE WITNESS: Yes,

12 MR. KAMPINSKI: So Mr. Fulton
13 can xerox it,

14 MR. CARMEN: Mr. Fulton has
15 marks on it. Can I have see what you have?

16 MR. FULTON: I have one that
17 everyone else has,

18 MR. KAMPINSKI: In looking at
19 that, yours is different, too,

20 MR. CARMEN: That's what I
21 am saying6 I think this is the --

22 MR. KAMPINSKI: Can I see the
23 one you have?

24 MR. CARNEN: Sure, you can,
25 Make sure there is no marks on it.

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(Dr. Holland Deposition Exhibit 4
marked for identification.)

- - - - -

BY MR. KAMPINSKI:

Q. Doctor, I'm going to hand you what's been
marked Exhibit 4 and I will ask you, sir, if you
can identify that?

A. It's a letter from me to Fred Carmen
concerning this case.

Q. What's the date of that?

A. February 28, 1993.

Q. What's the date of your -- February 28 or
January?

A. January. I'm sorry. January. My mistake.

MR. CARMEN: That would have
made it really interesting.

Q. This apparently was faxed to Mr. Carmen on
January 29, right?

A. Well --

Q. According to the fax?

A, The fax -- if the fax date is correct, then
that's correct,

Q. The other version of your report is also
dated the 28th?

1 A. Right.

2 Q. Explain to me why there were two versions?

3 A. Okay. There was one sentence where I said
4 something about the presence of several wires, and
5 Mr. Carmen felt that he wanted me to be more
6 specific since there are only two wires, and since
7 I didn't see that as being any material change in
8 the contents of my report, I said I have no
9 problem; and my secretary took out her floppy and
10 changed the word and didn't change the date and
11 there we have it. That's the mystery.

12 Q. So in other words, you sent this to
13 Mr. Carmen by fax for his approval?

14 MR. CARMEN: Objection.

15 A. I sent it to Mr. Carmen, period.

16 Q. Well, when he wasn't happy with the wording,
17 you changed it to comply with what he wanted?

18 MR. CARMEN: Objection.

19 Asked and answered. He just explained it.

20 A. I already said he wanted it to be more
21 precise.

22 Q. Is that correct?

23 A. Yes. Had I felt it would have changed the
24 content, I wouldn't have done it. I felt it merely
25 improved it, made it more precise.

1 Since you were getting on my case
2 earlier about --

3 MR. CARMEN: Don't argue.

4 A. -- for not being Precise, I certainly don't
5 object to someone pointing something out to me.

6 MR. KAMPINSKI: The marked
7 exhibits I'd like left with the court reporter to
8 be attached to the Doctor's deposition, and if you
9 would, Frank, get the originals then back to the
10 Doctor and attach copies; if that's agreeable with
11 everybody.

12 MR. SEIBEL: I need a copy
13 of the exhibits with the transcript.

14 MR. KAMPINSRI: That's what I
15 just said. The original should be like all the
16 copies.

17 That's all the questions I have.

18 MR. SEIBEL: I have a few
19 more. Not too many.

20 MR. KAMPINSKI: Just so we
21 don't have to keep going back and forth, you will
22 provide me with an updated CV of yours or give it.
23 to Mr. Carmen and he'll provide it to me.

24 MR. CARMEN: That's fine.

25 MR. SEIBEL: Dr. Holland --

1 THE WITNESS: Can I have that
2 back to help me update it? That's the only copy.

3 MR. KAMPINSKI: Can you make a
4 copy of this before we leave here today?

5 MR. FULTON: He'll send it
6 to you,

7 THE WITNESS: I'll see if I
8 can figure out how to turn the machine on, It's
9 seven o'clock.

10 MR. KAMPINSKI: I'll tell you
11 what, this is easier,

12 THE WITNESS: You tell me.

13 MR. CARMEN: What do you
14 want to do?

15 MR. KAMPINSKI: I'm going to
16 mark it as an exhibit, I'm going to attach it to
17 your deposition and he'll get this back to you like
18 the other exhibits,,

19 MR. CARMEN: Is that the one
20 and only copy?

21 THE WITNESS: I want my
22 secretary to type this up and --

23 MR. CARMEN: Okay.

24 THE WITNESS: He's going
25 to -- when is he going to physically return it?

1 -----
2 (Dr. Holland Deposition Exhibit 5

3 marked for identification,)

4 -----
5 MR. KAMPINSKI: So the record
6 is clear, Exhibit 5 is the Doctor's CV, which we
7 have acknowledged is not an updated one and this
8 will be returned to you tomorrow so you can update
9 it.

10 -----
11 RECROSS-EXAMINATION

12 BY MR. SEIBEL:

13 Q. On the issue of medical suitability, not
14 medical clearing, but medical suitability for
15 Mrs. Weitzel, is the primary concern with the
16 patient such as her, her ability to withstand
17 anesthesia for this procedure?

18 A, It is one of the big ones. The two big ones
19 are the hemodynamic effects of anesthesia, which
20 are considerable, the hemodynamic effects and
21 coagulation effects of any kind of surgery.

22 So the anesthetic is a large one,
23 it causes change with the heart, makes the heart
24 irritable, depresses function of the heart.

25 **Whenever you make an incision you**

1 Create a situation where the platelets tend to
2 adhere more to each other. The platelets are the
3 sticky things in the blood, right; so in anyone who
4 had an infarct, it can cause a second infarct,
5 okay.

6 So you rev up the coagulation
7 system, because again, any blood loss is going to
8 create hemodynamic instability. So you have
9 multiple problems which kind of again, always
10 interact with each other which otherwise can
11 destabilize a quasi-stable patient.

12 Q. How long is the cardiac irritability
13 following the cessation of anesthesia?

14 A. Until the anesthetic wears off. Et depends
15 on the anesthetic they use.

16 Again, I am not an expert in the
17 field. I think someone -- I can offer my feeling
18 that a high risk patient like this that they will
19 use anesthetic agents which were relatively low
20 risk, that had short half-lives, i.e., the effect
21 would be relatively shortened.

22 I know they like to use one called
23 Fentanyl, that seems to be a favorite in these
24 cases; but I am not an expert in Fentanyl or
25 anesthetics.

|

1 Q. How long after the anesthesia stops would
2 you --

3 A. How many hours?

4 Q. How long would you expect as a cardiologist
5 for there to be cardiac irritability following
6 cessation of anesthesia, if it's in fact a short
7 acting anesthesia?

8 A. Related to the anesthetic device, a couple of
9 hours, This lady also has an ongoing condition
10 which predisposes her to ventricular irritability.

11 Same old problem, you take someone
12 like you, you get a general anesthetic, you will
13 sail through it, you won't have any irritability;
14 you take the same anesthetic and give it to someone
15 one who had a recent MI, has a big scar in the
16 substrate or ventricular irritability, and it's
17 unpredictable.

18 Q. Did her ventricular irritability cause her to
19 bleed postoperatively?

20 A. No,

21 Q. Do you know what caused her to bleed
22 postoperatively?

23 MR. CARMEN: Objection,
24 Asked and answered,

25 A, She hemorrhaged. Statistically the most

1 likely thing is that anastomosis, there was a leak
2 in the anastomosis, that's usually the case. I
3 don't know. I don't think the autopsy report
4 commented on that specifically.

5 MR. SEIBEL: I don't have
6 anything further.

7 MR. COYNE: No more
8 questions.

9 MR. SEIBEL: Are you going
10 to read and sign it?

11 MR. CARMEN: You have the
12 right to read this. You can't change anything you
13 said. You have the right to determine whether the
14 court reporter has accurately transcribed this.

15 What you want to say if you want to
16 read it is, "I don't waive"; what you want to say
17 if you don't want to read it is, you say "I'll
18 waive."

19 THE WITNESS: This sounds
20 like the Miranda rights.

21 What do you suggest?

22 MR. CARMEN: I'd suggest you
23 read it.

24 THE WITNESS: Okay. Fine,
25 (Deposition concluded; signature not waived.)

ERRATA SHEET

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I have read the foregoing transcript and the
same is true and accurate,

JOEL B. HOLLAND, M.D.

1 The State of Ohio, -

County of Cuyahoga. : CERTIFICATE:

3 I, Frank P. Versagi, Registered Professional
 4 Reporter, Certified Legal Video Specialist, Notary
 5 Public within and for the State of Ohio, do hereby
 6 certify that the within named witness, JOEL B.
 7 HOLLAND M D was by me first duly sworn to testify
 8 the truth in the cause aforesaid; that the
 9 testimony then given was reduced by me to stenotypy
 10 in the presence of said witness, subsequently
 11 transcribed onto a computer under my direction, and
 12 that the foregoing is a true and correct transcript
 13 of the testimony so given as aforesaid, I do
 14 further certify that this deposition was taken at
 15 the time and place as specified in the foregoing
 16 caption, and that I am not a relative, counsel, or
 17 attorney of either party, or otherwise interested
 18 in the outcome of this action. IN WITNESS WHEREOF,
 19 I have hereunto set my hand and affixed my seal of
 20 office at Cleveland, Ohio, this 12th day of April,
 21 1993.

22
 23 
 24 Frank P. Versagi, RPR, CLVS, Notary Public/State of
 25 Ohio. Commission expiration: 2-24-98.

Look-See Concordance Report

1,955 UNIQUE WORDS
386 NOISE WORDS
21,302 TOTAL WORDS

SINGLE FILE CONCORDANCE

CASE SENSITIVE

EXCLUDES OCCURRENCES IN FIRST 3 PAGES

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