THE STATE of OHIO :

COUNTY of CUYAHUGA. :

- - - - -

IN THE COURT OF COMMON PLEAS Doc. 194

- - - - -

LESTER WEITZEL, executrix of the ESTATE of SHARON WEITZEL, deceased, and LESTER WEITZEL,
plaintiffs,

vs.

SAINT VINCENT CHARITY HOSPITAL, et al.,
defendants,

Case no. 226946

- - - - -

Deposition of JOEL B. HOLLAND, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, a Registered Professional Reporter, a Certified Legal Video Specialist, a Notary Public within and for the State of Ohio, at Mount Sinai Hospital, Cleveland, Ohio, on Wednesday, the 7th day of April, 1993, commencing at 4:03 p.m., pursuant to notice.

FLOWERS & VERSAGI
COURT REPORTERS
Computerized Transcription
Computerized Litigation Support
THE 113 SAINT CLAIR BUILDING - SUITE 505
CLEVELAND, OHIO 44114-1273
(216) 771-8018
1-800-837-DEPO

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

Charles Kampinski, Esq.
Donna Kolis, Esq.
Charles Kampinski Co., L.P.A.,
1530 Standard Building
Cleveland, Ohio 44113.

ON BEHALF OF THE DEFENDANTS CENTRAL ANESTHESIA OF CLEVELAND, INC., AND DRS. SOPKO, MOASIS, STEFFEE:

Robert C. Seibel, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114,

ON BEHALF OF THE DEFENDANT CLEVELAND CLINIC FOUNDATION:

Ronald S. Okada, Esq.
Baker & Hostetler
3200 National City Bank Building
Cleveland, Ohio 44114,

APPEARANCES (continued)

ON BEHALF OF THE DEFENDANTS RADIOLOGY CONSULTANTS, INC., AND DRS. J. PORTER, SMITH, WIRTZ:

Robert D. Warner, Esq.
Reminger & Reminger
The 113 Saint Clair Building
Cleveland, Ohio 44114-1273.

ON BEHALF OF THE DEFENDANT SAINT VINCENT CHARITY HOSPITAL:

William J. Coyne, Esq.
William J. Coyne Co., L.P.A.,
1240 Standard Building
Cleveland, Ohio 44113.

ON BEHALF OF THE DEFENDANTS DRS. ROLLINS, KITCHEN, STEELE, KHADDAM:

John V. Jackson, II, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

APPEARANCES (continued)

ON BEHALF OF THE DEFENDANT PREM VARMA, M.D.

Burton J. Fulton, Esq.
Gallagher, Sharp, Fulton & Norman
Seventh Floor - Bulkley Building
Cleveland, Ohio 44115.

ON BEHALF OF THE DEFENDANT PREM VARMA, M.D.

Fred N. Carmen, Esq.
Chattman, Sutula, Friedlander & Paul
6200 Rockside Road
Cleveland, Ohio 44131,

I N D E X

WITNESS: JOEL B. HOLLAND, M.D.

(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.

Q. Doctor, do you have a CV?
A. We're updating it. We can get it to you. I'll give it to Fred. He can get it to you.
MR. FULTON: You're excused,
Q. If you would run me through your educational background starting with high school?
A. Bowne High School in New York City.
Q. B-a-u-m?
A, B-o-w-n-e.
Q. When did you graduate high school?
A, 1969,
Q. What did you do after that?
A. Went to the University of Rochester in Rochester, New York,
Q. What kind of degree did you receive?
A. I received a B.A. Degree in 1973.
Q. What was your major?
A. English,
Q. What did you do then?
A. I went to University of Rochester Medical School.
Q. Graduated?
A. 1977.
Q. Then after that?

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

Q. All at the same institution?

A. University of Chicago.

Q. That brought us up until '82?

A, Yes.

Q. Now, what did you do?

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

Q. In what capacity?

A. Director of the Coronary Care Unit.

Q. Were you an employee of Mount Sinai?

A. Not really, no,

Q. Were you in private practice?

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

Q. Where was your office at that time?

A. At Mount Sinai.

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

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

Q. Were you an employee of the corporation?

A. Yes.
Q. How long did you remain employed by the corporation?
A. I would say five years.
Q. That brings us up to '87?
A, Right,
Q. Then what did you do?
A, I left that corporation because the principals of that corporation left Mount Sinai, and formed a new entity with another cardiologist here,
Q. The name of that entity?
A. Drs. Adler and Holland, Incorporated,
Q. Are you still employed by that corporation?
A, Um-hum.
Q. So that's been your form of employment since '87?
A, That's correct,
Q. Who are the principals in Full-Time Medicine that left?
A, Who were they?
Q. Yes.
A, Joseph Adelstein and Victor Vernes.
Q. Have you had any other position at the Mount Sinai Medical Center other than director of the

coronary?
A. Co-chief of Cardiology with Dr. Adler, he is the other co-chief.
Q. What is the Mount Sinai Heart Institute?
A, That's a good question, It's an umbrella kind of name that encompasses certain physicians, the cardiologists, the cardiovascular surgeons, and the vascular surgeons,
Q. Well, I mean is it a legal entity?
A. No, It's not a corporation. I think it's used mostly for marketing purposes by the hospital.
Q. We're in a building that's separate from the hospital?
A, That's not correct,
Q. This is a part of the hospital?
A, Absolutely,
Q. It's in this building that your offices for private practice are contained?
A. This, and another building in Beachwood.
Q. What is the address there?
A. 26900 Cedar Road,
Q. Do you use this office here for private patients or --
A. Sometimes. Mostly for administrative and teaching purposes.

Q. As relates to your hospital duties?
A. Right.
Q. So you principally see private patients in your Beachwood office?
A, That's correct.
Q. Or if they were inpatients, at the hospital?
A, Absolutely,
Q. Have you authored any articles, sir?
A, I have been co-author on several articles,
Q. Those are on your CV?
A. They would be on my CV somewhere,
a. What's the most recent article, how long ago?
A. Probably five, six years ago.
Q. How many articles are we talking about?
A. Five, six, something like that.
Q. Do you recall the subject matter of the articles?
A, Yes.
Q. Tell me what they are,
A, One was a study in basic cardio-electric physiology, one was a study of survival after myocardial infarction,
Q. What's the name of that article?
A. It was the Save Study.
Q. I'm sorry?

A. It was the called the Save Study.
Q. You said you were co-author there?
A. It's multi-center studies. We were one of the participating centers and I was a participating investigator.

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

Q. What were the years on those two studies, do you know?
A. 1987, 1986. Actually I think these were the year the study took place, but I think the results were published -- I can get that all for you. I have to look that up.
Q. These would be on your CV?
A. They will, will be on the CV.
Q. Do you refer patients to various physicians within your facility; surgeons, for example?

A. Sure.
Q. What surgeons do you use as referral sources?
A. Depends on what the patient's problem is.
Q. Well, for a bypass, for example?
A, Alan Markowitz and Mark Botham are the two surgeons that I generally refer patients to.
Q. Are they together in practice?
A. Yes. You probably know them since I think they operated on your father,
Q. Who else did they operate on?
A, Who else did they operate on?
Q. Yes.
A. Hundreds of people every year,
Q. Give me their names, since you have no difficulty in giving me my father's name,
MR. CARMEN: Objection.
Q. Is that a privilege between my father and Dr. Markowitz, sir?
MR. CARMEN: Objection.
MR. FULTON: I don't think,
MR. CARMEN: You don't have to answer.
MR. KAMPINSKI: Why not?
MR. CARMEN: Because I told him not to,

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

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

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

Q. Is he your attorney?

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

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

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

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

Q. You are the one that brought it up,

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

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

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

A. I can't talk about them with you because he -- they have nothing to do with you.
Q. What does my father have to do with me?
A, I only meant -- you seemed tremendously offended. I was only saying that because you seemed to be not sure who Dr. Markowitz was. I inferred that by the tone of your voice. I was merely pointing out you'd probably remember him as the surgeon who took care of your father. It wasn't meant --
Q. How do you know he took care of my father?
A. Because I know all the patients who come through here at one point or another.
Q. So you know my father?
A. No, I was not his cardiologist, but he was a nice man. That's what I understood, and Dr. Markowitz took care of him. That's all 1 am going to say about it.
Q. You know he was a nice man from whom?
A* From the nurses on the floor said --
Q. What nurse?
MR. CARMEN: You don't have to answer.
MR. FULTON: Tell him not to answer.

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

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

Q. Do you find this humorous, Doctor?

MR. CARMEN: Don't answer that.

Q. Do you have a father?

MR. CARMEN: Don't answer.

Q. Do you?

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

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

MR. CARMEN: He is --

MR. FULTQN: Nobody talked about medical background, Charles.

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

MR. CARMEN: He is not going to answer,

MR. KAMPINSKI: Why not?

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

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

MR. CARMEN: He already explained.

MR. KAMPINSKI: No, he hasn't.

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

Q. Is your father still alive, Doctor?

MR. FULTON: Don't answer,

MR. CARMEN: Don't answer,

Q. How about your mother?

MR. FULTON: Don't answer,

Q. Do you have any siblings?

MR. CARMEN: Don't answer,

Q. Are you married?

MR. CARMEN: You can answer.

A, Yes, I am married.

Q. Do you have children?

A. No.

Q. Who is your wife's doctor?

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

THE WITNESS: I am relaxed.

Q. Answer the question,

MR. CARMEN: He is not going to answer.

Q. Do you know who treated my mother?

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

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

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

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

MR. KAMPINSKI: So he is your counsel.

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

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

MR. CARMEN: Don't respond to him.

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

MR. CARMEN: He gave you the reason,

MR. KAMPINSKI: We didn't give

me the --

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

BY MR. KAMPINSKI:

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

MR. CARMEN: That, you can answer.

A, Good. I reviewed many documents,

Q. Where are they?

A, They're sitting in my office.

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

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

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

THE WITNESS: I'll ask my secretary

(Recess had.)

BY MR. KAMPINSKI:

Q. How long have you lived on Shelburne?

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

Q. Where did you live before that?
A, Calverton Road.
Q. The address?
A, 22000 Calverton Road.
Q. Where is that at?
A, Shaker Heights, Ohio.
Q. How long did you live there?
A, About a year and a half, I think.
Q. Where did you live before that?
A, 19501 VanAken, also in Shaker Heights.
Q. How long did you live there?
A. Two years,
Q. Before that?
A. 2687 Rockland Road, Shaker Heights, Ohio,
Q. How long did you live there?
A, Five years.
Q. And before that?
A. Something, something Blackstone Road, Chicago, Illinois, 53525 or -- I can get that for you.
Q. The two reports you referred to, the CAST report, the last one, that's set forth on your GV?
A, Yes.
Q. And the other one, is that on there?
A. No.

Q. Where would that be found, the Save Study?
A. I said it was published in the New England Journal. We were one of the participating centers,
Q. Is there a reason it's not on your CV?
A, Yeah, because it hasn't been updated. It was published in the last few years.
Q. Have you been sued, sir?
A, Yes.
Q. When?
A, 1983.
Q. Here in Cleveland?
A. Yeah,
Q. For what?
A. Patient who Dr. Markowitz operated on when -- who unfortunately died after the surgery, and the physicians here at the hospital taking care of her were sued.
Q. What was the result of that lawsuit?
A. Settled out of court,
Q. Who were you represented by?
A. Jacobson, Maynard.
Q. Which attorney?
A, Steven Charms,
Q. Were you deposed in that case?

A, Yes, I think so.
Q. Who was the plaintiff's attorney?
A. I don't even remember,
Q. Any others?
A, Another similar case, probably 1984.
Q. Dr. Markowitz operated on that person too?
A. Yes.
Q. This would have been a patient of yours that you had referred to him?
A, Yes, both were. Yes.
Q. What firm represented you in that case?
A. Same firm.
Q. What attorney?
A. Steve Charms.
Q. What was the result of that case?
A. It was dropped.
Q. Were you deposed in that case?
A, I think so, as well.
Q. Who was the attorney that represented the plaintiff?
A, A Weisman, is that a familiar name.
Q. Any other cases?
A. No, that would be it.
Q. Have you testified in any cases?
A, In what manner?

Q. Any capacity.
A. Yes.
Q. Expert, witness?
A. Yes.
Q. How many times have you testified as an expert?
A. I would say five times or less,
Q. Who did you testify for on those occasions, who were the attorneys?
A. Charms, and I'm trying to think of the other guy. Gary --
Q. Goldwasser?
A. Right.
Q. Anybody else?
A. Yes, there's another person at Jacobson, but I don't think -- I haven't given a deposition, so in terms of depositions, those are the two,
Q. I don't want to be confused,
Are you saying you're including in the five or less, deposition testimony --
A. Right.
Q. -- and courtroom?
A. As opposed to reviewing a ease, for example.
Q. How many times would it have been in court?
A. I never testified in court,

Q. So all five of these times, as I understand at least, the attorney that you are telling me about would have been for the defendant then?
A. Right.
Q. Do you review cases often for Jacobson, Maynard?
A. Couple times a year they ask me to look at something.
Q. How about for Reminger's firm?
A. Reminger's, occasionally.
Q. Any others?
A, No.
Q. How many times a year would you say for Reminger's firm?
A. I'd say I've done it probably twice.
Q. Do you have a list of the cases that you have been an expert in --
A. No.
Q. -- for these firms?
A. No,
Q. Are some of them still pending?
A. Yes.
Q. How many?
A, Probably just one.
Q. Do you remember the names of the attorneys

that would have taken your depositions in these five cases?
A. No.
Q. Within what time frame are we talking, last year, last two years, five years?
A. This -- these five cases would be in the last ten years.
Q. Would you have any record that would reflect who the attorneys would have been in those cases for the plaintiffs?
A, No. Usually after the case is concluded in one way or another I just depose of all the documents, so if you gave me a list I might be able to recognize say a name. I can't come up with them off the top of my head.
Q. Do you recall the subject matter that you were asked to testify in these five cases?
A. Usually someone who had some kind of heart surgery or had a heart attack, had a bad outcome, That's generally what they are about.
Q. You are not a surgeon?
A. No.
Q. So that would not be something you render your expert advice on?
A. No.

Q. It would be the medical aspect surrounding the surgery?
A. Yes.
Q. Either before, during, or after?
A. Absolutely.
Q. Have you done work for Mr. Carmen or his firm or Mr. Fulton or his firm or Mr. Coyne or his firm in the past?
A. Never.
Q. How is it you got involved in this case?
A. I think Mr. Carmen called me.
Q. Do you know how he obtained your name?
A. Probably from his client, Dr. Varma,
Q. How do you know Dr. Varma?
A. Dr. Varma was a resident here for a year or so.
Q. When was that?
A. Let's see, Prem finished about this time last year, so that would be '91, '92, something like that.
Q. Was he someone you trained?
A. Well, to the extent that he was here for a year, we worked together, I guess you would say that.
Q. Did you have anything to do with his coming

here as a resident?
A. Absolutely nothing.
Q. When he was here as a resident, did he work in the cardiology department?
A, I think for several months, so I worked with him personally for some of that time.
Q. Were you aware of this case when he was a resident here?
A, I was aware there were problems. I didn't know it was a case.
Q. What were you aware of?
A, I was aware there was an incident at Saint Vincent that caused a problem for him and led to his leaving the Cleveland Clinic residency program and seeking a position somewhere else, I was not aware that it was a case, per se.
Q. Well, how did you become aware of this?
A, He told me,
Q. What did he tell you?
A, He told me -- this may be a little foggy -- I think he asked me for a letter of recommendation so he can pursue further training, he felt he needed to explain why he left the Cleveland Clinic and so he told me there had been a problem and they -- there had been some problems with his continuing

there, and things of that nature.

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

A. I'll do the best I can.

Q. Fine.

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

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

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

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

coming here as a resident to begin with?
A. No.
Q. As part of the rotation through cardiology, that would have been the normal rotation of a resident?
A. Sure.
Q. That's how you came into contact with him?
A, Absolutely.
Q. How many residents would rotate through your department at any given time?
A. In any month there could be four, five in the CCU, two or three on another service; could be a busy month and you have a lot of residents, anywhere from five to seven a month come through.
Q. How long did the rotation last?
A, One month.
Q. How many rotations did he do with you?
A. My recollection is he did probably two. The program is small enough they rotate on the weekends and change the coverage so you wind up spending a fair amount of time with these people anyway; my recollection is I spent -- Prem was interested in cardiology,, and so during the time he was here I wound up spending a fair amount of time with him.
Q. The box that you brought in here, Doctor,, are

these all of the records you reviewed?
A. Yes.
Q. Has anything been removed from the records, that you removed?
A. No, these are all the records.
Q. Is the first time that you received these, would that be January 22, I am looking at the letter here signed by Lynn Moore?
A. Yes,
Q. It's sent by messenger to you, that's when you would have received these materials?
A. Let me see,
Q. Sure.
A. I think so. I think I had a brief meeting with Lynn and maybe Fred, and then they -- we talked about it briefly. They said they will send the records, and then the next day they came in that box.
Q. Did you receive any additional records after these that are set forth in this January 22nd letter?
A. Not that I am aware of, no,
MR. FULTON: What are you looking at?
MR. KAMPINSKI: Records that

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

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

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

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

MR. KAMPINSKI: My spirit.

MR. FULTON: Your spirit was there

- - - - -

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

- - - - -

BY MR. HAMPINSKI:

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

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

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

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

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

we I don't remember ever seeing that. I don't know what would be in that letter. I mean, I don't. know what it is, I mean, if someone could tell me what the contents were, I can tell them whether I've seen it or not. I don't know what the letter is,

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

A, No.

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

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

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

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

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

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

Ashland Hospital, hospitalization.

I don't think it's in here.

Q. Can you tell me what happened to it?

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

Q. Did you remove it from your file?

A. No.

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

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

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

A. Okay.

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

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

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

MR. KAMPINSKI: Yes, it is.

MR. CARMEN: Do you want to go see.

THE WITNESS: I don't know

what it is but I'll look for it.

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

MR. COYNE: Either way, come back,

(Recess had.)

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

BY MR. KAMPINSKI:

Q. Is there anything else there under the desk?

A. Well, there's one other case,

Q. Pertaining to this case, Doctor?

A, No.

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

A. I did not look at it, no.

- - - - -

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

- - - - -

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

the record, please?
A. This is a letter to Mr. Michael Meehan, who is at the Cleveland Clinic, and from Fred Carmen.
Q. That's the May 14th letter referred to --
A. Yes.
Q. -- in Exhibit 2 --
A. Yes.
Q. -- the letter from Gallagher, Sharp, sending you the materials they wanted you to review for purposes of preparing a report?
A. Right.
Q. You received another letter prior to that, Doctor, that I marked as Exhibit 1, would you identify that, please?
A. This is a letter to me from Sanjay Varma from December 24, 1992.
Q. Apparently he provided you with various materials as well?
A. Correct.
Q. And the purpose of that was what?
A. I believe this was right after I was contacted by telephone to see whether I would assist in this case, and then following a conversation he sent me these materials.
Q. In looking at the two letters apparently you

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

A. That's probably the case.

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

A. Yes.

Q. -- for your review a number of internal memoranda, and some journal articles, right?

A, Yes.

Q. Then asked you a number of questions?

A. That's correct,

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

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

Q. I'm sorry?

A. I would agree with that,

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

procedures during which the wires were removed"?
A, Yes.
Q. What is the answer to the first part of that question, what precisely occurred during the February 26, 1991 --
A. I have to say I don't know for sure. I don't know
Q. Well, what is your opinion based on your careful review of all, the records as to what occurred on February 26, 1991 during Dr. Varma placing the arterial line?
A. Well., I can say that an arterial, line was attempted and the end result was that there were two full intact guide wires left in the patient.
Q. Did you understand my question? That's the result. I'm asking what occurred,
Who put them in --
MR. FULTON: Objection.
Q. -- in your opinion?
MR. CARMEN: Same.
A, I don't know.
Q. Did you review Dr. Steele's deposition?
A. I have reviewed all of the depositions. I have to say I don't know after reviewing all the information.

Q. Don't have a clue?

MR. CARMEN. Objection. Asked and answered.

A. I don't know.

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

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

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

Q. It's a mystery to you then?

A. It really is, yes.

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

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

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

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

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

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

A. Other physicians who participated in that procedure.

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

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

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

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

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

A. It may take a while.

Q. Whatever.

A. Okay.

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

MR. CARMEN: No.

THE WITNESS: This is it, is not going anywhere.

MR. CARMEN: Okay. Take your time.

THE WITNESS: Yes.

MR. JACKSON: We have a tabulated chart, Doctor.

THE WITNESS: That will help.

MR. SEIBEL: It's not full.

THE WITNESS: What day is this?

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

THE WITNESS: Mr. Jayne, here.

BY MR. KAMPINSKI:

Q. Did she attempt to insert a femoral line?

A. The nurse note, 4:00 p.m., Dr. Varma and Dr. Jayne her to insert femoral something.

Q. Did you read Dr. Varma's testimony about Mr. Jayne's involvement?

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

Q. Well, I mean, as someone trying to figure out what happened on February 26, wouldn't the details be somewhat important?

A. Absolutely.

Q. But you don't recall?

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

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

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

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

A, Fine,

MR. JACKSON: May I see that, please?

MR. FULTQN: I think this is attached to the Complaint. Where is that other exhibit, the letter?

MR. OKADA: This is it.

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

MR. KAMPINSKI: Keep everything on the record,

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

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

THE WITNESS: I still don't

see where that says who did what.

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

MR. CARMEN: Flip here.

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

MR. CARMEN: There is one other.

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

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

BY MR. KAMPINSKI:

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

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

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

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

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

do, that's correct,

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

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

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

A, You mean arterial wires?

Q. Yes. Guide wire?

A, Yes.

Q. Anybody else?

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

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

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

Q. Is that what it said3

A, That's what it said,

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

Am Femoral, right, that's correct,

Q. So then why is he potentially a culprit?

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

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

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

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

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

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

A, No.

Q. Were you aware that he was deposed?

A, No.

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

A, No.

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

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

MR. CARMEN: Objection.

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

MR. KAMPINSKI: Absolutely.

MR. FULTQN: He doesn't have to speculate.

A. It's not a medical question.

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

A. Right. And 1 said I do not know,

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

A. I don't know.

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

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

A. Yes.

Q. Yes, you have an opinion?

A, Yes.

Q. What is your opinion?

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

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

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

A. Let's say ten or let's say he never told anybody --

MR. FULTON: That isn't so.

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

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

Q. Criminal?

MR. CARMEN Objection. IS

he a lawyer?

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

Q. How about unethical from a medical standpoint?

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

MR. CARMEN: Objection. You can answer,

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

Q. Have you put guide wires into patients?

A. Yes,

Q. For the purpose of putting catheters in?

A. Yes.

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

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

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

Ae I guess so.

Q. So your qualification as to that answer

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

A, That would be correct. Yes.

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

A. Yes.

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

A, Yes.

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

A, No.

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

A, Yes.

Q. When was that?

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

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

A, Certainly,

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

MR. FULTON: Objection.

MR. CARMEN: Same.

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

Q. Who did you write letters to?

A. Number of hospitals in the United States.

Q. Who?

A. I couldn't tell you.

Q. Why not?

A, Because I don't recall.

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

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

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

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

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

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

MR. FULTON: Objection,

MR. CARMEN: Objection,

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

Q. So you don't believe that occurred?
A. I guess my feeling is people are innocence until we prove them guilty, and we haven't proven anybody guilty here.
Q. Who is it that proves them guilty, is it people in the medical community that review the record to determine what happened?
A. Those would be some of the people, yes,
Q. Did you read Dr. Steele's deposition?
A. Yes.
MR. CARMEN: Objection. Asked and answered.
MR. KAMPINSKI: You are right.
A. I did.
MR. KAMPINSKI: You are right.
Q. What did Dr. Steele say about what happened?
A. My recollection is that he felt Dr. Varma put them in.
Q. Do you not believe him?
A. It's not a question of belief. It comes back to the same answer, do I feel that you can conclude unequivocally that Dr. Varma put them there, and I can't, and --
Q. Is that what's necessary in your mind, an unequivocal determination?

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

Q. And what percent is unequivocal?

MR. CARMEN: Objection.

Q. 100 percent?

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

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

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

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

A. Yes.

Q. -- I assume you are including him?

A. Certainly.

Q. Would you include the consults in that?

A. Depends on what their -- if their consult was relevant to the surgery being performed.

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

A, I would say certainly the cardiologist.

Q. Dr. Steele?

A, Yes.

Q. Who else?

A, There was a pulmonologist, a chest physician,

Q. Dr. Sopko?

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

Q. Okay.

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

Q. Dr. Chmielewski?

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

Q. Dr. Moasis?

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

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

Q. In this particular case Dr. Steele didn't speak to assistance of either Dr. Sopko or Dr. Chmielewski, was he wrong in not seeking their assistance?

MR. JACKSON: Objection. I'm objecting for the record.

THE WITNESS: You are not silencing me?

A. I don't know. I was the worst wrong. I certainly would in that case.

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

MR. JACKSON: Objection.

Q. -- in your terminology?

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

Q. Of course not.

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

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

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

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

There's certainly room for different physicians to behave differently and still fall above the standard of medical care,

Q. So you don't believe that he deviated from the acceptable standard of care in not consulting with Dr. Chmielewski and Dr. Sopko prior to allowing Dr. Moasis to perform surgery?

A. I think that's correct,

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

A, I am kind of speaking for myself.

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

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

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

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

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

MR. **CARMEN**: Answer the way that you answered,,

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

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

Q. Why don't you straighten me out.

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

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

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

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

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

MR. FULTON: He didn't say that.

MR. CARMEN: Do you know?

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

Q. You don't know?

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

Q. The question is: Did you feel in your

opinion that he did?

MR. CARMEN: Objection. He already --

MR. FULTON: He already answered.

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

Q. Well, did he?

MR. CARMEN: If you know.

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

Q. Whatever he did is okay with you?

MR. CARMEN: Objection.

A. That's not what I said.

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

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

Q. Wasn't the correct decision in your opinion --

A. No.
Q. -- to a reasonable degree of medical certainty?
A. No.
Q. You believe he fell below the standard of care in making that decision then?
A, I believe so.
Q. Did that failure contribute to cause Mrs. Weitzel's death?
A, I believe so.
Q. Did Dr. Moasis' input in a collaborative effort, I guess with Dr. Steele, in deciding to do the surgery fall below the standard of care in Mrs. Weitzel's case?
A, I believe so. I would qualify that with I am not a vascular surgeon, so I mean -- but I think between the two of them, I think the fact that she underwent surgery under those circumstances fell below the standard of care.
Q. Did that contribute to cause her death?
A. Yes,
Q. Did Dr. Varma in his -- assuming he put the wires into Mrs, Weitzel -- contribute to cause Mrs. Weitzel's death?
A. I don't believe so,

Q. Do you believe that the --

MR. FULTON: Your own expert says that.

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

MR. FULTQN: Thank you, I'll abide by your --

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

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

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

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

MR. KAMPINSKI: I'd like to,

MR. CARMEN: Good.

BY MR. KAMPINSKI:

Q. How about the hospital personnel subsequent

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

MR. CARMEN: Objection. What hospital personnel?

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

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

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

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

Q. You will say what, so I understand?

A. That they fell below the standard of care.

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

A. Probably to an extent it did, yes.

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

A. I'll try.

Moves arms in her --

Q. Just refer to the date.

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

Q. That was the admit note?

A. Coldness of both feet, no plantar reflex, VTR's, three plus; hyperactive reflex and decerebrate posturing.

Q. That was on the day of admission?

A. Yes.

Q. Anything else?

A. Another note continues, unresponsive --

Q. Please tell me the dates.

A. 2-11.

Q. Same day?

A. Later in the same day.

Q. Later or at the same time?

A. No, that was later.

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

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

Continues unresponsive.

Q. Okay.

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

MR. SEIBEL: You may not find the earlier records in those notes, Doctor.

A, Patient on 2-23 lethargic, sleepy.

Q. I'm sorry, What was the date?

A, February 23rd.

Q. Lethargic and sleeping?

A. Yes.

Q. Wait a minute. I mean, is that evidence of abnormal mental status related to anoxic brain damage?

A, It is definitely related to an abnormal mental status,

Q. And was she on any medication at that time, sir?

A. On lots of medication,

Q. Was she on any medication that would account for her being lethargic?

A, I can't tell you from this note.

Q. Well, I mean, what part of the chart would assist you in telling whether or not she was on any medication?

A. Here are the medications, actually,

At that point she was on s.cut. Heparin, Unisom, aspirin, Nitro paste, Digoxin, Vancomycin, Erythromycin, Tobramycin, Amantadine,

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

Here we got Flagyl, Lopressor, Peri-Colace.

Q. Anything else?

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

Q. Versed?

A. Versed is certainly one of them.

Q. Was she getting it?

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

Q. What does Versed do to a patient?

A. It depresses their mental status.

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

A. It would be an explanation, yes.

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

A. Yes.

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

A. No.

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

A. I saw many.

Q. Let me finish.

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

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

A. They don't write notes like that.

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

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

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

Q. Please do.

A. Okay. Thank you. I appreciate it.

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

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

It would -- may I finish?

Q. Absolutely.

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

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

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

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

MRe FULTON: Objection.

MR. CARMEN: Objection.

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

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

MR. CARMEN: Objection.

That's not what he's saying.

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

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

Q. Why don't you answer my question.

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

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

Q. I want to make sure you're done with your answer; are you?

A. Yes.

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

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

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

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

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

A. That's also correct,

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

A. That is correct,

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

A. I don't believe so.

Q. Did you ask for it?

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

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

A. Okay. It's a deal.
Q. -- in terms of what his interplay with her was, in light of the fact that he was there day and night every day?
A. No.
Q. Does that matter?
A. May I answer?
Q. Please,
A, No. I think since he has the closest relationship with the woman, obviously he might gain some insight by her expressions that some of the other people might not; but often families are often seeing things that aren't there as well, It's sort of a double-edged sword.
Q. And you're not a neurologist?
A, No, not at all,
Q. But that doesn't mean you can't assess and analyze someone's neurological status as part of your duties as a cardiologist, because you can, I take it?
A. As a general physician I think it's probably as good as most general physicians, but not certainly the level that a neurologist would be.
Q. You go on in your report to say, ''However, the most life-threatening problem was the patient's

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

A. Yes.

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

A. No.

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

MR. FULTON: Just an extra COPY.

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

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

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

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

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

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

Q. Time out, sire Time out,

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

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

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

A, Okay.

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

Ae You are mot wrong, and I am not wrong8 There's different ways to approach it.

I was asked to review the hospital

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

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

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

A. No.

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

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

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

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

A. No. No.

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

A. Yes.

Q. -- of your report.

What is superinfection as opposed to just infection?

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

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

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

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

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

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

A, Yes.

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

A. That's absolutely correct,

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

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

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

A. That's correct.

Q. So --

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

A. I believe you said the progress notes.

Q. Yes.

A. That's what I'm talking.

MR. FULTON: So we understand that.

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

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

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

MR. FULTON: What does "coaching" mean?

MR. KAMPINSKI: I don't know.

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

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

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

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

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

A. I just want to clarify what I said.

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

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

Q. The percutaneous removal?

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

Q. Have you removed wires such as this percutaneously?

A. On one occasion.
Q. Is that a difficult procedure?
A. I did it with a radiologist who had extensive experience in doing the procedure. I had had really minimal experience previously and asked him to help and kind of assisted him, I will say, would be most appropriate. He kind of showed me. Fortunately I have not had occasion to have to do it.
Q. Was that here at this hospital?
A. Yes.
Q. Bow long ago was that?
A. I'd say that was seven or eight years ago.
Q. Prior to Dr. Varma being here?
A. Yes.

MR. KAMPINSKI: Just curious.

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

THE WITNESS: Sorry.

MR. FULTON: I meant Mr. Kampinski being fair.

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

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

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

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

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

Q. I didn't,

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

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

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

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

Q. That's what you meant?

A, Yes.

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

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

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

MR. CARMEN: Kitchen.

Q. -- Kitchen?

A. I know Dr. Rollins.

Q. How do you know him?

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

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

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

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

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

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

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

Dr. Pitluk, didn't you?
A. And Paul Kohn.
Q. Were you provided with Dr. Mazal; do you recall?
A. I don't think so. If I was, I don't recall that.
MR. FULTON: What's the date on that letter?
MR. KAMPINSKI: This one is your January 22nd, the one you sent, of '93; and one that Mr. Varma sent was December of '92.
Q. Have you received subsequent --
A. This is it.
Q. -- reports or records?
A. This is it.
I don't know if those depositions came with this. They may have come separately. I don't remember.
Q. I think they did.
A. Did they? You know better.
Q. According to these letters they did.
A. Okay, I don't remember. I don't keep track of these things.
Q. Neither of these referred to Dr. Pitluk's report?

A, Well, it was there, I read it.
Q. Do you know how you got it?
A. Somebody sent it, either this firm or what --
Q. "This firm," the record won't get that.
A, Chattman, Sutula, et cetera, et cetera.
Q. Or?
A. Gallagher, Sharp sent it to me. That's the only way I've gotten any records on this case.
Q. Are there other correspondence that you removed then from your file?
MR. JACKSON: Those reports you are referring to are attached.
MR. KAMPINSKI: To the December letter?
MR. JACKSON: To the thick one, I believe they are.
MR. KAMPINSKI: Okay,
Q. Mr. Jackson's correct, They're not referred to in the letter but apparently it's attached to the letter that you received from Mr. Varma?
A, That must be where I saw it,
Q. Did you receive any other expert reports subsequently?
A, No.
MR. KAMPINSKI: If you need

to make a call.

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

(Recess had.)

(Record read.)

BY MR. KAMPINSKI:

Q. Do you agree with the following statement: That the removal of the guide wire by Dr. Moasis was merely a completion of the procedure that had been initiated by Dr. Steele; do you agree with that?

A. No.

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

A. Not at all.

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

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

Q. Do you agree with that?
A. That the -- they were basically one procedure; is that what you are saying?
Q. That's right.
A. No, they were two completely different procedures.
Q. Do you believe that her hemodynamic problems that occurred subsequent to Dr. Moasis' surgery was due to blood loss or cardiac irritability?
A. A combination of factors, probably both were important.
Q. So anyone that said it was due to bhod loss as opposed to cardiac irritability you would disagree with?
A. I would agree with them in the sense that we're kind of splitting hairs, but I mean, I would agree with them to the extent blood loss was a factor, but if we did that to you, for example, and you hemorrhaged after that kind of procedure, you were otherwise healthy, I don't think you would have died, you would have survived.

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

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

A. I'm confused.
Q. The following statement was made and I want to know if you agree with it, referring to her developing hemodynamic problems: This was due to blood loss, not cardiac irritability; do you agree or disagree with that?
A, To an extent, yes, blood loss sets off the chain of events probably; but what I am saying is that you could -- to set off the chain of events -- I hope I am not being too complicated here -- but you cannot set off that chain of events in someone who was -- did not have the problems that this woman had.
Q. I understand.
A, Okay.
Q. But I am not sure you answered me whether you agree with that statement or disagree.
MR. FULTON: Maybe he can't,
A, I partially agree,
Q. Does that mean you partially disagree with it?
A. Right.
Q. You agree with the part that the hemodynamic problems were due to the blood loss, you disagree with. the part that says the hemodynamic problem

were caused or when he said they were not caused by cardiac irritability?

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

Q. I understand.

Her white count throughout the hospital stay was elevated --

A. That's my recollection.

Q. -- was it not?

A, Yes.

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

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

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

A. Go ahead,

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

A. Absolutely not. Let me just clarify that,

I mean "stability" is a relative team. For a life-threatening problem, then you

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

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

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

A. Very strongly.

MR. FULTQN: It's tough,

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

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

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

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

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

Q. You didn't get his report?

A. Right,

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

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

Q. I'm talking about Dr. Pitluk.

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

Q. So did you receive any kind of --

A. No.

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

MR. CARMEL: Wait until he finishes.

Q. What he testified to in deposition?

A. No.

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

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

MR. KAMPINSKI: That's all I have.

Anybody else have any questions?

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

MR. COYNE: Do you have

any?

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

CROSS-EXAMINATION

BY MR. SEIBEL:

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

A. Yes.

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

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

What's the time frame for those comments?

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

Q. Until surgery and the postoperative?

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

had problems.

Q. On the second page of your letter?

A, Sure.

Q* Second paragraph on page 2 you say that -- you say, "Although the surgery appeared to go uneventfully" --

MR. FULTON: Hold on.

MR. SEIBEL: You have a different type.

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

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

MR. KAMPINSKI: Right here, Where is that?

THE WITNESS: Third paragraph.

MR. SEIBEL: Second paragraph on my version.

MR. COYNE: Here.

MR. KAMPINSKI: Okay.

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

MR. KAMPINSKI: Yes.

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

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

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

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

BY MR. SEIBEL:

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

A. None.

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

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

Q. When after the surgery did this start?

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

I can refer to the record.

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

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

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

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

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

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

A. so --

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

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

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

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

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

THE WITNESS: Nursing progress notes.

MR. KAMPINSKI: We started --

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

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

THE WITNESS: Down at the bottom.

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

MR. COYNE: You mean 9:30.

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

MR. KAMPIMSKI: Have you reviewed the eight o'clock note in answer to his question.

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

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

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

MR. KAMPINSKI: That one is 10:00.

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

By this, is this ten o'clock?

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

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

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

MR. SEIBEL: You can,

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

She has persistent tachycardia.

MR. SEIBEL: From what time?

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

MR. CARMEN: 4:00.

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

BY MR. SEIBEL:

Q. At what time would you become concerned?

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

Q. What **is the least likely** cause **for her**

hemodynamic instability postoperatively?
A. That's a tough one,
Q. Do you have an opinion one way or the other?
A. I have a number of opinions. I will tell you what my thinking would be.
She lost blood, obviously she had surgery, One would have to look at blood loss as a factor. She developed a new infection related to going into her retroperitoneal space, she's septic, she's hypoxic, which she is, but not alarming so, but some hypoxic; the surgery and these particular fluid shifts have caused a myocardial dysfunction, I think all of these need to be considered,
Q. Do you have an opinion as to the most likely cause of her hemodynamic instability which begins at eight o'clock?
A. I have an opinion based on what I know about the case; is that what you want?
Q. Sure.
A. She was bleeding, she had serious retroperitoneal bleed. It's not obvious to a resident coming on a floor.
Q. I didn't ask that,,
A, That's not what you meant?
Q. I didn't ask that.

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

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

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

A. Sure.

Q. -- due to blood loss?

A. Yes.

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

A. Short term, long term?

Q. Let's include them all.

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

THE WITNESS: No. Here you go.

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

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

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

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

A. Three to four months.

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

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

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

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

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

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

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

Q. Was there risk of perforation?

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

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

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

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

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

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

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

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

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

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

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

percentages and I can't give you percentages.

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

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

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

Q. Are you talking about preoperatively?

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. What made the surgery less than totally elective?

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

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

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

MR. FULTON: Read the question back.

- - - - -

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

- - - - -

A. Maybe I shouldn't have said that.

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

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

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

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

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

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

A. That's really a good question.

I mean, in question -- general we

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

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

Q. Throughout the operation?

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

Q. 1 assume, and correct me if I am wrong, I assume that Mrs. Weitzel's condition made her more sensitive to blood loss?

A, Absolutely.

Q. Why was that?

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

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

A. You mean after the surgery?

Q. After her MI.

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

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

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

Q. Was her postoperative bleeding related to the anesthesia?
A. I don't know of any connection.
Q. I think you said before when Mr. Kampinski was asking you questions that you believe Dr. Steele deviated from the standard of care?
A. Yes.
Q. In what respects?
MR. KAMPINSKI: Are you representing Dr. Steele now?
MR. SEIBEL: We might file a crossclaim,
MR. KAMPINSKI: Okay.
A. In my impression he initiated the operative intervention, and at least tacitly approved her for the surgery.
Q. Why would that be below standard of care?
A. Well, I think we discussed that,
In kind of summation, I felt that the risk of the surgery outweighed any benefit she would receive at that time.
Q. What would be the benefits of the surgery assuming it had been successful?
A. She wouldn't have the wires in her body anymore.

Q. Why would that beneficial to her?
A. It wouldn't really be at that time.
Q. So you are saying the surgery had no benefits?
A. Not at that time. I can't think of any direct benefits, a short time frame, we're talking about two weeks, a month.
Q. Would the surgery at any time in her life had been beneficial?
A. Again, we discussed this, There is no -- I can't show you any data that says people who have foreign bodies that the net recommendations is leave them in. The feeling is that you should remove them if the risk of removing them isn't prohibitive. I'll give you an example.

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

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

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

Q. When was she hemodynamically unstable preoperatively?

A. That's a tough question,

Q. In the immediate preoperative?

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

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

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

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

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

Q. What was her cardiac status preoperatively?

A. She had had a major infarct. It's hard to determine that preoperatively, They couldn't do a Swan -- I mean they couldn't do a cardiac catheterization, she was too unstable for that, I think they probably attempted an echocardiogram, probably was not of much quality given the fact she was intubated say everything, I think the autopsy report showed a moderate amount of myocardial damage.

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

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

that it was getting worse in any way.
Q. Was her pulmonary status worsening, improving, or stabilized?
A. Again, I am not a pulmonary expert, I'll defer, but my feeling from reading the chart, I didn't concentrate on that, but is that it stabilized; and many of this could be days when she looked a little bit better, then one could be more optimistic maybe about extubating her; but on another day the blood gasses were deteriorating and you're a little more pessimistic. That's how it is: one step forward, two-quarters of a step back, that's how these patients really are.
Q. Would Mrs. Weitzel's cardiac status have restricted her activity assuming she had lived?
A. I think so.
Q. In what respects?
A. I think that she would have had some limitation of her activity, assuming that whatever was appropriate was done, she made a full recovery, she was treated by a cardiologist and got good treatment, I think she would have had a reasonably functional status.
She didn't have a massive MI where you think about sending her for a heart transplant

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

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

A. Yes.

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

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

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

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

A. Not in my opinion.

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

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

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

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

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

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

A. Not low risk, is why.

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

A. You'd either be medium or high, she wouldn't, you know, be low, I don't know which one.
Q. What tells you she would have been at least a medium risk?
A. The location of her infarct, the size of her infarct, and the problem with ventricular arrhythmias. The ventricular arrhythmias may have been the least compelling reason why your risk could be high,
Q. And what factor would have led you to conclude that she would have been a high risk?
A. Well, the need for multiple defibrillations on the onset and the continuing ventricular ectopic activities during the hospitalization, that often places people in a high risk category.
Q. Is there anything else that you would go to to assess her risk at the time she underwent her surgery?
A. Myocardial function, Swan-Ganz, hemodynamics, cardiac catheterization.
Q. I'm talking about actual data in this case?
A. That we have?
Q. Right.
A. That was available at the time when they did the surgery or subsequent to that? I'm talking

about the autopsy report.

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

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

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

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

A. No. Can't do that,

Q. Do you have training as a surgeon?

A, None.

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

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

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

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

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

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

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

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

the record. Clearance is --

Q. If there's a better term.

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

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

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

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

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

patient?

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

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

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

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

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

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

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

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

MR. KAMPINSKI: Objection.

MR. FULTON: Objection.

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

MR. SEIBEL: I want to know.

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

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

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

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

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

MR. FULTQN: Here is my objection,

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

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

THE WITNESS: I'm happy to --

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

THE WITNESS: You sort it out and tell me.

BY MR. SEIBEL:

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

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

in the business of apportioning how much blame.

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

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

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

Q. I'm trying to wrap it up.

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

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

Q. In terms of mistakes you feel were made by

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

A. None.

MR. SEIBEL: I'm done at this point.

MR. WARNER: No questions.

MR. COYNE: I have just a few questions.

MR. KAMPINSKI: I'm going to object to you asking him any questions because I believe your interests are the same as Dr. Varma's, but go ahead.

MR. CQYNE: Well, I have others who are not identified exactly with Dr. Varma, that's why we have separate counsel for Dr. Varma.

MR. KAMPINSKI: Well, I object.

MR. FULTQN: We have two separate counsel.

MR. COYNE: Objection is noted.

MR. KAMPINSKI: There's a lot of people representing Dr. Varma, apparently.

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.

Q. 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.

Q. If I understood you during the questions by Mr. Kampinski, it's your opinion that this patient probably would have needed surgery postoperatively to stop the internal bleeding; is that correct?

A, That's an opinion with --

Q. Probability?

A, -- with the realization that I am not a vascular surgeon, I do not deal routinely -- as a general physician, that would seem appropriate to me.

Q. When a person dies, the bleeding stops, correct?

A. Yes, that is correct.

Q. From the autopsy you found evidence that there was internal bleeding?

A. That's what the autopsy report suggests, yes.

Q. Relative to the decision on the surgery on March the 14th, if I understand you, is it your professional opinion that when the decision is made to go forward with the patient such as Mrs. Weitzel, in this particular case with the history of a recent myocardial infarction, with ARDS present, with some immediate history of sepsis, **that** when that decision is made, the

attending cardiologist should consult with a pulmonologist concerning the pulmonary stability or lack thereof relative to undergoing the surgery, was that --

A. I think you're stating what I said -- and I may be confusing you guys -- I think that's stating it too strongly.

I think in a complicated patient like this woman --

Q. We're dealing with this one. That's all I'm going to deal with.

A. -- that the care of her, the patient, has to be by committee, and different physicians work differently with other people, and I've never been in this building, Saint Vincent Hospital. I don't know these doctors -- I don't know how they work, so I can't really say.

The doctor may have talked to Dr. Steele, he may have said Mike, or whatever it is, is that his name, Mike Sopko, that what do you think of Mrs. Weitzel going to surgery, in the course of seeing him in the hallway. I don't think -- I don't know. I don't want to make a strong point that he had to request a written consultation in the chart.

Q. I didn't mean to infer that.
A. Okay.
Q. All I am saying, should the attending have consulted with the pulmonologist in some fashion, or orally, written, to get an evaluation of the present status, for instance, of the ARDS condition?
A. I think that would be appropriate. I think if you're going to call in a consult, okay, and there's a big decision coming up that that consultant's area is relative to what is coming up, I personally think it's a good idea to get everyone's point of view, that's my opinion.

MR. COYNE: I have no further questions.

MR. KAMPINSKI: Just a couple things to follow up. I want to make sure I understood.

RECROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Does a vascular or cardiovascular surgeon rely on a cardiologist, and I won't now use the word "clearance," but rely on a cardiologist, for your opinion, regarding the medical suitability of

a patient such as Mrs. Weitzel to undergo surgery?
A. This would be something in the domain of a vascular surgeon.
Q. Fine.
A. I would think so, yes.
Q. It was pointed out during questioning apparently that there another report of yours that you authored; can I have that, please?
A. I don't have that, but I mean, it's not a big deal. I'd be happy to tell --
MR. CARMEN: There is no other report. There is one report which was given to us in a rough form to look at. You are welcome to see the draft. I have a copy of the draft.
MR. KAMPINSKI: Well, I want to see whatever it is the doctor authored before it was changed, after it was changed, however many drafts there were, and then I want to ask him why it was changed.
THE WITNESS: You can go ahead. You can ask me that question.
MR. KAMPINSKI: Good. Let me see it, then I will ask.
MR. CARMEN: We don't have the draft here,

MR. KAMPINSKI: Mr. Fulton was just looking at it.

MR. CARMEN: Do you have one that isn't marked up?

MISS KOLIS: I don't have it, Nine is like that one.

MR. CARMEN: Let me see the one if --

MR. KAMPINSKI: Do you have a xerox machine here?

THE WITNESS: Yes,

MR. KAMPINSKI: So Mr. Fulton can xerox it,

MR. CARMEN: Mr. Fulton has marks on it. Can I have see what you have?

MR. FULTON: I have one that everyone else has,

MR. KAMPINSKI: In looking at that, yours is different, too,

MR. CARMEN: That's what I am saying6 I think this is the --

MR. KAMPINSKI: Can I see the one you have?

MR. CARNEN: Sure, you can, Make sure there is no marks on it.

- - - - -

(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?

A. Right.
Q. Explain to me why there were two versions?
A. Okay. There was one sentence where I said something about the presence of several wires, and Mr. Carmen felt that be wanted me to be more specific since there are only two wires, and since I didn't see that as being any material change in the contents of my report, I said I have no problem; and my secretary took out her floppy and changed the word and didn't change the date and there we have it. That's the mystery.
Q. So in other words, you sent this to Mr. Carmen by fax for his approval?
MR. CARMEN: Objection.
A. I sent it to Mr. Carmen, period.
Q. Well, when he wasn't happy with the wording, you changed it to comply with what he wanted?
MR. CARMEN: Objection. Asked and answered. He just explained it.
A. I already said he wanted it to be more precise.
Q. Is that correct?
A. Yes. Mad I felt it would have changed the content, I wouldn't have done it. I felt it merely improved it, made it more precise.

Since you were getting on my case earlier about --

MR. CARMEN: Don't argue.

A. -- for not being precise, I certainly don't object to someone pointing something out to me.

MR. KAMPINSKI: The marked exhibits I'd like left with the court reporter to be attached to the Doctor's deposition, and if you would, Frank, get the originals then back to the Doctor and attach copies; if that's agreeable with everybody.

MR. SEIBEL: I need a copy of the exhibits with the transcript.

MR. KAMPINSRI: That's what I just said. The original should be like all the copies.

That's all the questions I have.

MR. SEIBEL: I have a few more. Not too many.

MR. KAMPINSKI: Just so we don't have to keep going back and forth, you will provide me with an updated CV of yours or give it to Mr. Carmen and he'll provide it to me.

MR. CARMEN: That's fine.

MR. SEIBEL: Dr. Holland --

THE WITNESS: Can I have that back to help me update it? That's the only copy.

MR. KAMPINSKI: Can you make a copy of this before we leave here today?

MR. FULTON: He'll send it to you,

THE WITNESS: I'll see if I can figure out how to turn the machine on, It's seven o'clock.

MR. KAMPINSKI: I'll tell you what, this is easier,

THE WITNESS: You tell me.

MR. CARMEN: What do you want to do?

MR. KAMPINSKI: I'm going to mark it as an exhibit, I'm going to attach it to your deposition and he'll get this back to you like the other exhibits,,

MR. CARMEN: Is that the one and only copy?

THE WITNESS: I want my secretary to type this up and --

MR. CARMEN: Okay.

THE WITNESS: He's going to -- when is he going to physically return it?

(Dr. Holland Deposition Exhibit 5 marked for identification,)

MR. KAMPINSKI: So the record is clear, Exhibit 5 is the Doctor's CV, which we have acknowledged is not an updated one and this will be returned to you tomorrow so you can update it.

RECROSS-EXAMINATION

BY MR. SEIBEL:

Q. On the issue of medical suitability, not medical clearing, but medical suitability for Mrs. Weitzel, is the primary concern with the patient such as her, her ability to withstand anesthesia for this procedure?

A, It is one of the big ones. The two big ones are the hemodynamic effects of anesthesia, which are considerable, the hemodynamic effects and coagulation effects of any kind of surgery.

So the anesthetic is a large one, it causes change with the heart, makes the heart irritable, depresses function of the heart.

Whenever you make an incision you

create a situation where the platelets tend to adhere more to each other. The platelets are the sticky things in the blood, right; so in anyone who had an infarct, it can cause a second infarct, okay.

So you rev up the coagulation system, because again, any blood loss is going to create hemodynamic instability. So you have multiple problems which kind of again, always interact with each other which otherwise can destabilize a quasi-stable patient.

Q. How long is the cardiac irritability following the cessation of anesthesia?

A, Until the anesthetic wears off. Et depends on the anesthetic they use.

Again, I am not an expert in the field. I think someone -- I can offer my feeling that a high risk patient like this that they will use anesthetic agents which were relatively low risk, that had short half-lives, i.e., the effect would be relatively shortened.

I know they like to use one called Fentanyl, that seems to be a favorite in these cases; but I am not an expert in Fentanyl or anesthesias.

Q. How long after the anesthesia stops would you --

A. How many hours?

Q. How long would you expect as a cardiologist for there to be cardiac irritability following cessation of anesthesia, if it's in fact a short acting anesthesia?

A. Related to the anesthetic device, a couple of hours, This lady also has an ongoing condition which predisposes her to ventricular irritability.

Same old problem, you take someone like you, you get a general anesthetic, you will sail through it, you won't have any irritability; you take the same anesthetic and give it to someone one who had a recent MI, has a big scar in the substrate or ventricular irritability, and it's unpredictable.

Q. Did her ventricular irritability cause her to bleed postoperatively?

A. No,

Q. Do you know what caused her to bleed postoperatively?

MR. CARMEN: Objection, Asked and answered,

A, She hemorrhaged. Statistically the most

likely thing is that anastomosis, there was a leak in the anastomosis, that's usually the case. I don't know. I don't think the autopsy report commented on that specifically.

MR. SEIBEL: I don't have anything further.

MR. COYNE: No more questions.

MR. SEIBEL: Are you going to read and sign it?

MR. CARMEN: You have the right to read this. You can't change anything you said. You have the right to determine whether the court reporter has accurately transcribed this.

What you want to say if you want to read it is, "I don't waive"; what you want to say if you don't want to read it is, you say "I'll waive."

THE WITNESS: This sounds like the Miranda rights.

What do you suggest?

MR. CARMEN: I'd suggest you read it.

THE WITNESS: Okay. Fine,

(Deposition concluded; signature not waived.)

ERRATA SHEET

PAGE LINE

I have read the foregoing transcript and the same is true and accurate,

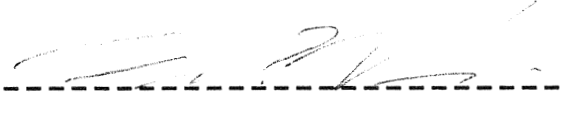
_____

JOEL B. HOLLAND, M.D.

The State of Ohio, :

County of Cuyahoga. : CERTIFICATE:

I, Frank P. Versagi, Registered Professional Reporter, Certified Legal Video Specialist, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, JOEL B. HOLLAND, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid, I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel, or attorney of either party, or otherwise interested in the outcome of this action. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 12th day of April, 1993.



Frank P. Versagi, RPR, CLVS, Notary Public/State of 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

WORD RANGES @ BOTTOM OF PAGE

* 1 *

1 [3] *5:14; 31:13; 35:13*
1-22-93 [1] *5:16*
1-28-92 [1] *5:20*
100 *[2] 51:5; 66:22*
10:00 [4] *93:11, 74,23, 24*
11:00 [1] *93:11*
11th [1] *63:22*
12-24-92 [1] *5:14*
122 [1] *5:7*
126 [1] *5:8*
128 [1] *5:21*
12th [1] *138:20*
132 *[2] 5:9,* 22
14 [1] *52:5*
140 [1] *94:16*
141 [1] *94:15*
14th [5] *31:25; 35:4; 85:22; 91:17; 124:18*
15th [1] *91:16*
1600 [1] *94:10*
19501 [1] *20:10*
1969 [1] *7:12*
1973 [1] *7:17*
1977 [1] *7:24*
1983 *[1] 21:11*
1984 [1] *22:5*
1986 [1] *12:18*
1987 [1] *12:18*
1991 [3] *36:23; 37:5, 10*
1992 [1] *35:16*
1993 [2] *129:11; 138:21*

* 2 *

2 *[6] 5:16; 31:13, 20, 24; 35:6; 89:4*
2-11 [1] *61:15*
2-11-91 [1] *61:3*
2-23 [1] *62:3*
2-24-98 [1] *138:25*
2-26 [1] *40:10*
20 [2] *108:23; 109:2*
22 [1] *30:7*
22000 [1] *20:4*
22nd *[2] 30:20; 80:10*
23rd *[2] 05; 63:22*
24 [1] *35:16*
26 [5] *36:23; 37:5, 10; 40:22; 74:10*
2687 [1] *20:14*
26900 [1] *10:21*
26th [2] *45:4; 123:17*
28 [3] *89:14; 129:11, 12*
28th [2] *40:10; 129:24*
29 [1] *129:18*

* 3 *

3 [5] *5:18; 31:24; 34:22, 25; 38:22*
30-day [3] *112:21; 113:11, 12*
31 [2] *5:15, 17*
34 [1] *5:19*
3914 [1] *92:19*

* 4 *

4 [3] *5:20; 129:1,* 6
44106 [1] *6:14*
44115 [1] *4:8*
44131 [1] *4:16*
4:00 [2] *40:16; 94:12*

* 5 *

5 *[3] 5:22; 133:1, 4*
5-14-92 [1] *5:18*
53525 [1] *20:19*

* 6 *

6 [1] *5:5*
60 [1] *109:3*
6200 [1] *4:15*
6:00 [1] *61:21*

* 8 *

8 [1] *47:7*
80 [1] *108:18*
82 [1] *8:7*
87 [2] *9:5, 17*
88 [1] *5:6*
8th [1] *75:1*

* 9 *

9-1 [1] *91:23*
9-14 [3] *92:10, 12; 93:9*
91 [1] *26:19*
92 *[2] 26:19; 80:11*
93 [1] *80:10*
9:00 [1] *94:22*
9:30 [1] *9277*

* A *

A.R.D.S [1] *104:14*
A.R.D.S. *[4] 72:20, 24; 73:13; 74:2*
abide *[2] 14:4; 59:11*
abiding [1] *59:13*
ability *[2] 58:1; 133:14*
able *[4] 25:13; 65:11; 90:11; 106:3*
abnormal *[6] 60:22; 62:9, 11; 63:24; 64:7, 77*
Absolutely [11] *10:16; 11:7; 26:5; 27:2; 29:8; 40:24; 45:9; 65:8; 70:15; 85:23; 105:24*
absolutely [1] *74:18*
accept [1] *86:1*
acceptable [1] *54:15*
accordance [1] *54:24*
According [2] *80:21; 129:20*
account [1] *62:16*
accrued [1] *86:8*
accurate [1] *137:22*
accurately [1] *136:12*
acknowledged [1] *133:5*
acting [1] *135:5*
action *[2] 46:2; 138:18*
activities [1] *114:14*
activity [3] *98:18; 111:15, 79*
actual [1] *114:21*
Adapin [1] *63:7*
additional *[2] 30:19; 44:19*
address [3] *6:12; 10:20; 20:3*
Adelstein [1] *9:23*
adhere [2] *60:1; 133:25*
Adler [2] *9:13; 10:2*
administration [2] *85:12, 15*
administrative [1] *10:24*
admission [3] *61:10; 65:18; 67:14*
admit *[2] 61:3, 6*
adult [1] *70:1*
adverse [1] *103:2*
advice [2] *14:4; 25:24*
advisable [1] *112:11*
advise [2] *31:8; 98:21*
affixed [1] *138:19*
aforesaid [2] *138:8, 73*
afternoon *[2] 6:16; 112:14*
age [1] *6:2*
agents [1] *134:17*
agitated [1] *93:3*
agitation [1] *102:5*
agitations [1] *109:16*
agree [14] *36:19, 27; 82:10, 13, 76; 83:1, 75, 77; 84:3, 5, 17, 19, 23; 108:19*
agreeable [1] *131:9*
airport [1] *117:3*
Alan [1] *13:5*
alarming [1] *95:10*
alert [1] *64:19*
alive [1] *17:6*
allowing [1] *54:17*
alone [1] *93:8*
Amantadine [1] *62:25*
amends [1] *54:19*
American [2] *79:14, 78*
amount [7] *29:21, 24; 96:7; 102:3; 106:1, 24; 110:20*
amounts [1] *106:23*
analyze [3] *66:2; 69:18; 70:9*
anastomosis *[2] 135:24, 25*
anastomotic [1] *101:19*
anatomy *[2] 104:6; 106:16*
anesthesia [10] *102:21; 104:23; 107:2; 112:4; 133:15, 77; 134:11, 24; 135:4, 5*
anesthesias [1] *134:23*
anesthesiologist *[2] 52:23; 105:5*
anesthetic *[8] 101:8; 133:20; 134:12, 73, 77; 135:6, 10, 72*
anoxic [9] *60:23; 62:9; 63:24; 64:8, 11, 18; 65:19, 24; 67:20*
Answer *[2] 17:23; 55:14*
answer [45] *13:22; 14:3, 75, 79, 21; 15:23, 25; 16:3, 5, 8, 11, 20; 17:7, 8, 10, 12, 15, 27, 25; 18:3; 19:7; 37:3; 38:10, 17, 27; 41:3, 8; 45:16; 47:10, 25; 50:21; 54:19; 56:20, 24; 64:20; 66:19; 67:10; 68:8; 69:7; 91:8; 9226; 94:2; 119:24;* 120:11, 20
answered [10] *38:3; 50:12; 55:15; 57:5; 84:16; 85:17; 119:20; 120:25; 130:18; 135:22*
ante [1] *101:5*
antibiotics *[2] 74:5,* 8
anticipated [1] *72:15*
Anybody *[3] 23:14; 43:11; 87:22*
anybody [5] *46:11, 78; 48:1; 49:20; 50:4*
anymore [5] *12:14; 14:19; 96:19; 107:25; 113:3*
anyway [1] *29:21*
anywhere *[2] 29:14; 39:25*
apologize [4] *28:25; 74:24; 85:17; 92:12*
Apparently [1] *35:17*
apparently *[8] 35:25; 36:4; 57:20; 81:19;*

* * B * *

* * C * *

* * D * *

* * E * *

* * F *

* I *

* * J * *

* * K * *

* * L * *

* * Q * *

* * R * *

* * T * *

* * U * *

* * V * *