The State of Ohio,)
) SS:
County of Cuyahoga.)

Doc. 242

IN THE COURT OF COMMON PLEAS

Lester Weitzel, Admr., etc.,)
)
Plaintiff,)
)
vs.) Case No. 226946
)
St. Vincent Charity Hospital, et al.,)
)
Defendants.)

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Deposition of PAUL M. KOHN, M.D., taken by the defendants for the purpose of cross-examination, before Marie L. Larbig, a Notary Public within and for the State of Ohio, at the offices of Paul M. Kohn, M.D., Brainard Place, 29001 Cedar Road, Lyndhurst, Ohio, at 5:50 P.M., Thursday, April 8, 1993, pursuant to notice.

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APPEARANCES:

For the Plaintiff:

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For Defendant St. Vincent Charity Hospital:

William J. Coyne, Esquire
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For Defendant Cleveland Clinic Foundation:

Mary M. Bittence, Esquire
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For Defendant Prem Varma, M.D.:

Burt J. Fulton, Esquire
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APPEARANCES Continued:

For Defendant G. A. Moasis, M.D.:

Robert C. Seibel, Esquire

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For Defendant Central Radiology Consultants:

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The 113 Building

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I N D E X

WITNESS:

EXHIBIT:

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PAUL M. KOHN, M.D., of lawful age, called by defendants for the purpose of cross-examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION OF PAUL M. KOHN, M.D.

BY MR. SEIBEL:

Q Would you state your full name for the record, please?

A It's Paul M. Kohn. K-o-h-n.

Q Doctor, is that your current C.V. in front of you?

A Yes.

Q Could I take a look at it, please?

A Sure.

MR. SEIBEL: Is this a copy that we can attach to the deposition?

THE WITNESS: Well, if you want- Does everybody want a copy of this?

MR. COYNE: Yes.

MR. KAMPINSKI: If we attach it to the deposition, everybody will have it.

THE WITNESS: I can have Debbie make copies.

MR. SEIBEL: I don't care,

as long as there is one attached to the deposition transcript.

THE WITNESS: That's all you need, just the one? All right.

MR. SEIBEL: What I am saying, is this a copy that we can give to the court reporter?

THE WITNESS: Yes, you can, sure.

MR. SEIBEL: Why don't you just go ahead and mark that?

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(Defendant's Exhibit A was marked for the purpose of identification.)

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Q Dr. Kohm, would you identify for the record what we have marked for this deposition as Defendant's Exhibit A?

A This is my C.V.

Q Is it current?

A Yes.

Q Are there changes, modifications, corrections to that C.V.?

No.

Q That would be correct. All right.

Would you describe your current

practice, please?

A Well, I am an internist with special interests in cardiology, and I would say that my practice is probably sixty percent cardiology and forty percent general internal medicine.

Q What do you do in your cardiology practice?

A I operate my own laboratory. It's called 'Brainard Cardiovascular Laboratory' where we do various non-invasive testing, including echocardiography, stress testing, Holter Monitoring, arterial and venous studies.

Q What sort of arterial and venous studies?

A We do, for example, for people who have obstruction in the arteries in the lower extremities. And also we do special studies of carotid, obstruction of carotid arteries, and also do venous studies to rule out such things as deep vein thrombosis.

Q What does the other forty percent of your practice involve?

A General internal medicine.

Q What does that mean?

A That covers the entire gamut of internal medicine which includes all other divisions other than cardiology; such as, coronary disease, neurological disease, endocrinological disease, such things

as respiratory infections. All the things that any general doctor sees.

Most of these people, of course, are people who also have heart disease. I would say most of them do, but they have other medical problems along with it.

Q What specialty training do you have in cardiology?

A Well, my special training is not formal.

When I did my residency program, which was back in 1946, which was the last, there were practically no fellowships available. So I'm basically trained by taking courses, going to meetings.

I developed an interest in it when I was going to medical school. And I did work in the physiology laboratory at Case Western Reserve.

And I did a fair amount of research work at Mount Sinai Hospital after I was there, I worked in the -- in fact, I was the first person to develop a cardiac catherization program. This goes back to about 1950.

I don't do that anymore. That's now a young man's game. I don't do any invasive cardiology anymore.

Q When was the last time you did any sort of

invasive cardiology procedure?

A I suppose probably about 1960.

Q What's your date of birth?

A December 12, 1917.

Q And your Social Security number?

A 283-09-3882.

Q Are these the materials that Mr. Kampinski sent you in this case?

A Yes.

Q Could I take a look at them, please?

A Certainly.

Q Do you recall when you were first contacted in this case?

A I don't remember the date.

THE WITNESS: Do you?

MR. KAMPINSKI: No.

Q In your material there's a letter to you from Mr. Kampinski dated February 3, 1993; was that when you were first contacted by him?

A No, I think it was long before that.

I think if you look at my report that I sent to Mr. Kampinski, undoubtedly that was shortly after I was first contacted by him, I would think.

Q All right. Was that contact by phone?

A Probably.

Q Have you worked with Mr. Kampinski on cases before?

A I think we had one other case. I don't remember when that was.

THE WITNESS: Do you recall?

MR. KAMPINSKI: It might have been two.

THE WITNESS: Two cases you think?

MR. KAMPINSKI: The other one that went to court. The one that went to court.

THE WITNESS: I don't remember how long ago they were either.

So this is the third case I have had with you?

MR. KAMPINSKI: Yes.

Q Do you have a list of the materials you reviewed in this case?

A It's all there.

MR. KAMPINSKI: I think the report sets out the initial materials, Bob.

Q All right, let's go through this.

What I'm curious about is, are there any materials you reviewed in this case other than

are listed in your report?

MR. KAMPINSKI: You mean prior to his doing the report?

MR. SEIBEL: No, at any -- I mean --

A Since then?

Q Yes.

A Yes, I have several things there that I have reviewed.

Q All right. This packet here, Doctor, are these the only medical records that you had to review?

A I originally had the hospital chart to look at. I don't have it now. I gave it to Mr. Kampinski.

Q Did you read that chart cover to cover?

A More or less. Sure, I did.

Q What about these records right here, did you get these separately from the original chart?

A These are extracts from the original chart.

Q Did you copy these?

A No, I didn't.

Q Have you reviewed the deposition of Dr. Moasis?

A I don't think so. No.

Q No?

Have you reviewed a report in this case by

Dr. Markowitz?

A 'Cas.

Q Do you refer patients for cardiovascular surgery in your practice?

A Surely.

Q And to whom do you refer?

A Dr. Markowitz and his associate.

Q Dr. Kaufman?

A Dr. Kaufman.

Q Anybody else?

A No, not since they've been at Mount Sinai.

Q All right. Why do you refer your patients who need surgery to those two physicians?

A Pardon me?

Q Why do you refer your patients who need surgery to those two physicians?

A I personally think they are the best two surgeons in the City of Cleveland.

Q What is your fee for reviewing a case?

A I charge two hundred dollars an hour for reviewing a case.

Q And what about your fee for a deposition?

A Four hundred dollars an hour.

Q And what about your fee for trial testimony?

A Six hundred dollars an hour.

Q Does the term 'medical clearance' mean something to you as a physician?

A Certainly.

Q What does that mean?

A It means as far as I am concerned, before any of my patients are referred to surgery, they are examined by me thoroughly and I have to make a decision whether or not I think this patient is, his medical status is satisfactory so that he could undergo surgery in my opinion.

Q Is your primary concern as an internal medicine physician whether that patient can withstand general anesthesia?

A Yes.

Q Do any other concerns go into your decision to medically clear a patient for surgery besides the ability of that patient to withstand general anesthesia?

A Of course that goes to many problems why he may not be able to.

Of course I'm mainly interested in cardiology, so I have to make sure that their cardiac status is adequate, but there are other problems too. For example, if a person has some electrolyte imbalance. For example, if there's some

endocrinological problem, say diabetes that is not well controlled at the time.

I make sure that their hematologic situation is satisfactory.

Those are the things that have to be checked out.

Q What are the cardiac risks to a patient undergoing general anesthesia thirty days after a myocardial infarction?

A The literature and experience indicates that the chances of problem, particularly death or myocardial infarction -- or recurring myocardial infarction is extremely high the closer the surgery is to the acute myocardial infarction.

As a matter of fact, up until at least three months after a myocardial infarction the mortality rate can be as high as forty percent -- forty, fifty percent. So we try to avoid that if at all possible, unless it's a very crucial situation that cannot be deferred.

Q A good source in the medical literature to understand that issue there is, I think in your report you said Braunwald's text on heart disease?

A Sure.

Q Can you think of any others?

A Well, there's any number of them.

He, of course, gives references himself in his book. And I thought the simplest thing to do is just to mention his which encompasses, I think he said --

THE WITNESS: May I see my report again, please?

MR. KAMPINSKI: Sure.

Here it is.

A I think the numbers were, yes, thirty to sixty percent, according to the various series.

Q In your practice have you ever had a surgeon who declined to do surgery on a patient that you had cleared for surgery medically?

A I can't think of any situation like that, no.

Q Why are patients in the post M.I. period at greater risk for problems surviving general anesthesia?

A It takes many months for the heart to regain its former ability to perform its function.

There is a rehabilitation period that goes to at least three to six months. And during that time until that period is over, the heart function is definitely impaired. There is a marked instability, electrical instability, for

example, that can cause problems and cause rhythm disturbances. And basically it's the left ventricular function that's impaired at that time. It takes that much time for the heart to regain its ability to pump as it should.

Q Is there a relationship to the risk of surgery in a patient post M.I. to the size of the infarct?

A Aside from the infarct?

Q The size of it.

A Oh, the size of the infarct. Yes. Oh, yes, I would think so.

Again, the most important thing is the patient's left ventricular function which in turn depends on how much damage has been done to the myocardium as a result as a result of the myocardial infarction.

Q So the more damage as a result of the M.I., the greater risk; the less damage, the less risk?

A Correct. In general.

Q I understand.

In your review of the records were you able to detect any intraoperative complications from the anesthesia during Mrs. Weitzel's March 14th surgery?

A No.

Q Did Mrs. Weitzel eventually have to have the wires removed?

A Eventually, yes.

Q Why?

A Well, any kind of foreign body, it's wise to remove it if you possibly can. Theoretically there is a possibility of various complications, which I'm sure you are aware of if you were reading all of the various other reports that the doctors have made, but basically it's a question of embolism, thrombo embolism and infection.

Q Would you include perforation in the risks too?

A And perforation, yes,

Q I suppose with embolism there are sub sets?

You have thrombotic embolization and, say, atherosclerosis embolism as risks?

A Yes.

Q Any others in terms of embolism, risks?

A Basically you've covered it.

Q And infection; explain that risk for me.

A Well, there's always a possibility of infection. Although in this particular case apparently there wasn't any at the time that the first wire was removed, and it was checked for infection, none was found.

But anything that goes through the skin and into the vascular system possibly could have some bacteria on it, and bacteria can grow in the bloodstream and cause sepsis.

Q And what are the potential problems with perforation?

A It depends on what's perforated of course. And hemorrhage certainly would be the most important one that you could think about.

Q These risks that you have just identified, embolism, infection and perforation, would those risks diminish as time goes on until those wires were removed?

A No, I don't think that they would diminish.

Q Would they increase?

A I really don't know. I don't have any experience with that situation.

I would think that as long as there isn't any evidence of infection and there isn't any evidence of a perforation at the time that we're talking about, I don't think there is a likelihood of it getting much worse. However, there is a possibility, I'll have to agree, that with time, the more time is involved, there can be some movement of the catheter to a situation

that it can cause more problems.

Q So I guess migration would be another risk?

A Yes.

Q If Mrs. Weitzel would have survived her hospitalization at St. Vincent's Charity Hospital in 1991 and was fortunate enough to begin rehabilitation, would her activities be restricted in any way because of the presence of the wire?

A Oh, I'm sure the wires would have been removed before that time.

Q Why, Doctor?

A Well, for the same good reason that we just mentioned, it's much wiser to get rid of a foreign body than leaving it in because of the possibility of causing difficulty.

But, you know, in this particular case as you well know, the problem was that it was done at the wrong time, the surgery, and everybody feels that she was improving gradually, and most of the data, most of the opinions that I've read and my own experience -- I don't have any for this particular kind of a situation, but most of the people who deposed for you indicated that there was no reason why he couldn't wait a period of time until her general condition

improved to make her a safer prospect for general surgery with anesthesia.

Q In your review of the records did you see any evidence that Mrs. Weitzel had any problem with embolization as a result of the wire?

A No.

Q How about any problems with infection as a result of the wire?

A No.

Q Any problems with perforation as a result of the wire?

A None; no, sir.

Q And any problems with migration of the wire?

A No, there were no problems involved at all at the time.

Q These risks that we have identified in leaving the wire in, were they all life-threatening?

MR. KAMPINSKI: You mean these theoretical risks?

MR. SEIBEL: That's what a risk is, theoretical.

MR. KAMPINSKI: You mean if they occur?

MR. SEIBEL: Right.

MR. KAMPINSKI: Then they

wouldn't be risks, they would be happenings.

MR. SEIBEL: They would be facts.

A It's doubtful.

MR. SEIBEL: I understand. The point's well taken, Chuck.

Q If the wire had caused an embolization, would that have been life-threatening to Mrs. Weitzel?

A Not necessarily. Of course it depends upon where the embolism lies.

The most common place that you would recognize would be in the brain and that, as you know, is not life-threatening although it could cause a stroke.

Interestingly, in my experience emboli usually don't have real severe permanent results as a result of the obstruction of a vessel.

It seems like the embolus seems to gradually, not too long, will in time dissolve and the vascular function continues on as it had been.

So consequently that's -- even though it's a potential risk for an embolus of the brain, I would say that in general if she had one, probably there would be no real permanent residual, in my experience.

I see quite a few of those from, emboli coming from the left atrium in some people who have atrial fibrillation, and they have, it's almost like a transient ischemic attack, it is clear very quickly.

It's not like a thrombosis, a cerebral thrombosis that causes a real scar on the brain and causes permanent damage.

Q If this wire would have perforated her artery, would that have been a life-threatening situation?

A It's conceivable.

Q And if the wire had migrated somewhere, would that have been a life-threatening situation?

A It depends where it had migrated.

Q If it's going to migrate, where is it likely to migrate?

A Any of the major tributaries of the aorta.

Q And if Mrs. Weitzel had an infection because of the wire, is that potentially life-threatening?

A No, not in this day and age.

Q Why not?

A Because of the antibiotics today.

Q How would Mrs. Weitzel's condition have had to change before she would have been a candidate for surgery to remove the wire?

MR. KAMPINSKI: You are talking about surgery with anesthesia as opposed to percutaneous?

MR. SEIBEL: Surgery, yes.

A Like the kind she had?

Q Right.

A Well, I certainly would have preferred had she improved to the extent that she had been extubated, would no longer be on a respirator and that her cardiac status would remain stable and improve, gradually improve as she was already beginning to do. And I certainly would like to see that her mental status would also have cleared to a great extent, which she was beginning to do.

Q What was her cardiac status before the March 14th surgery?

A It was really coming along very nicely. She was no longer in congestive failure and she was not having any significant arrhythmias anymore, so I would say she was coming along reasonably well.

Q And what was her pulmonary status before the March 14th surgery?

A She still had bilateral infiltrates in the lung. And even that was definitely improving. And the pulmonologist just prior to surgery was figuring

on extubating her and weaning her off the respirator within two weeks.

Q What was her mental status, her neurological status before surgery?

A Just before surgery?

Q Right.

A It was difficult of course to assess because she was on Prosed; however, she definitely responded to commands, she moved all four extremities, she seemed to be reasonably alert despite the Prosed, so I would think that in general her neurological status was quite satisfactory.

Q Was her March 14th surgery elective?

A In my opinion, it was.

Q How do you define 'elective surgery'?

A Well, it's a surgery that you can delay more or less indefinitely unless some other problem arises that makes it emergent.

Q When did Mrs. Weitzel become hemodynamically unstable after the surgery?

A Just a few hours later.

Q Can you tell from the records what time that was?

A I would have to look at the records. I don't know exactly.

(Discussion had off the record.)

A Well, at 8:00 o'clock in the morning her blood pressure was 140 over 74. And at 1:30 it was 160 over 88. And then 4:00 o'clock in the afternoon, 130 over 80. It was beginning to drop.

And this is at 8:00 o'clock, right?

MR. FULTON: Two thousand less twelve.

A 8:00 P.M. it had fallen to 112 over 60.

And her pulse rate had risen to 141.

Respiration up to 33.

So I think that we can certainly say at that time her hemodynamic status had very definitely deteriorated.

Q At 8:00 o'clock P.M.?

A Yes.

Q Because she's hypotensive?

A Yes.

Q Tachycardic?

A Right.

Q Tachetic?

A Yes.

Q Would you call her hemodynamically unstable at the 1600 hour reading?

A It was just beginning to be questionable, but I wouldn't challenge anybody about that at that

particular time, at the 8:00 o'clock figures.

Q So to a reasonable medical probability at 8:00 o'clock she became hemodynamically unstable?

A Yes.

Q Do you have an opinion why she became hemodynamically unstable at that time?

A Probably because of the blood loss, the hemorrhage. They found 500 cc's of blood at the operative site.

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

A No. I would imagine within an hour or two after surgery; if not, sooner.

Q Why do you say that?

A Well, why would she all of a sudden bleed at 8:00 o'clock? I'm sure that she started to ooze shortly after surgery because the vessel was not ligated I would presume.

Q All right. In a patient like Mrs. Weitzel, how soon will there be hemodynamic changes as a result of blood loss?

A It depends, of course, how fast the blood is being lost.

In her particular case, I would say it took several hours.

Q Was it appropriate for Dr. Steele to attempt percutaneous removal of the wires on, I think it was March 12th?

A Yes.

MR. COYNE: 13th.

MR. KAMPINSKI: 13th.

Q Why?

A For the reasons that we just mentioned, that if you can remove a foreign body expeditiously and without trauma, without surgery, that is the thing to do.

Q Do you know why it was Dr. Steele was not able to remove the second wire on the 13th?

A I sure don't know why he couldn't do it.

There's some conflicting opinion about that too. I think I remember reading somewhere that he wasn't even aware of the fact that there were two wires there. He thought that two wires must have been superimposed on one another in one of the films that he saw. I think he thought there was only one wire.

That would be one of the reasons. He should have known about it.

Q Maybe stating the obvious, but do you believe that Dr. Varma was negligent for leaving the

two wires in?

A Obviously.

MR. FULTON: Objection.

MR. KAMPINSKI: Why?

MR. FULTON: I don't know.

Q Doctor, do you have an opinion to a reasonable medical probability that Dr. Varma's negligence contributed to cause Mrs. Weitzel's death?

A Absolutely.

Q In what respects and how?

A Well, the whole problem was, there was a series of mishaps that started with Dr. Varma's leaving in the two wires.

Now if he hadn't left in the wires, there would be no need for Dr. Steele to remove the wire, as he did, and there certainly would have been no thought about removing the wire at all at the time that he decided to do it surgically and consequently that surgical procedure would not have been done. And that was the thing that killed her.

So the sequence started with leaving those wires in place.

Q You told me before that you felt that one of the vessels may not have been ligated during the

surgical procedure and led to bleeding afterwards.

MR. KAMPINSKI: Well, you were asking him to speculate on what may have caused the bleeding.

A I'm not a surgeon.

Q I understand. What I really want to find out -- I'm not sure I asked this correctly before -- is whether you have an opinion to a reasonable medical probability as to why she began to bleed postoperatively.

A I would think that's the most obvious reason a person would bleed postoperatively, a small vessel that was not ligated properly or one that let loose let's say and then it started to bleed postoperatively.

Q Can you think of any -- I mean, is that --

A That would be the only reason I could figure out.

Q Is there a relationship to the anesthesia that Mrs. Weitzel received during the surgery and this postoperative bleeding?

A No.

Q And is there any other reason that you have been able to glean from these records to explain Mrs. Weitzel's hemodynamic instability postoperatively other than bleeding?

A Well, I think that she was still in the post myocardial infarction danger period so that, again as I mentioned previously, I'm sure the left ventricular function was still impaired to a significant degree, being only about a month post myocardial infarction, and consequently that heart could not tolerate the stress of the blood loss.

Q Why does a patient's blood pressure go down when they bleed?

We can use Mrs. Weitzel as an example.

I want to confine really to those patients like Mrs. Weitzel or Mrs. Weitzel herself.

A Just loss of blood volume can certainly drop the blood pressure. And that's what happened to her, her blood volume diminished.

You're talking about a person who also had surgery too and who had -- I mean who also had a myocardial infarction.

Q Sure.

A So both of those are contributors.

Q And why does a person's heart rate go up?

A In an attempt of the body to compensate for the drop in the cardiac output.

When the stroke volume is reduced -- there's

an amount of blood squirted out with each beat, and when that becomes inadequate, in order to maintain a cardiac output which would be, let's say, four to five liters per minute, the only way to do it is to increase the number of beats per minute.

Q And why does a person start to breathe quicker?

A Again for the same reason, that there's a difficulty in oxygenation and cardiac output is dropping.

Q All right. In this postoperative period did Mrs. Weitzel receive appropriate care from the hospital nurses?

A Well, I think so.

I don't know if we can really blame the nurses particularly.

I'm trying to recall whether or not the nurse in charge of contacted the resident.

'Dr. Chang notified."

So he was notified at 8:00 o'clock.

Q What should Dr. Chang have done to give Mrs. Weitzel acceptable medical care?

First of all, should he have come to see the patient?

A I didn't see any note about that.

I recall just seeing 'Dr. Chang notified.'

I don't see any notes to the effect that he was there.

Q Should he have come to see the patient?

A Pardon me?

Q Should Dr. Chang have come to see the patient when notified by the nurse?

A There is no evidence that she did in the notes.

Q Should Dr. Chang have come to see the patient when notified by the nurse of these vital signs?

A Should she have come?

Q Yes.

A Sure, she should have come.

Q Why?

A To take care of the situation, do something about it.

Q Was it below or a breach of accepted standard of care for a resident covering a coronary care unit at St. Vincent's Charity Hospital not to come see this patient when apprized of those vital signs?

A I would think so.

Q What treatment should Mrs. Weitzel have received that evening in response to these vital signs?

A Well, had she been seen expeditiously, I think that a decision could have been made to increase --

start fluids, bolus the fluid, try to increase the fluid volume to get the blood pressure back up, make an effort to find out why this happened and get some idea whether or not there was any bleeding. That was one of the first things to think of in a situation like this postoperatively. And of course in time they could have given her transfusions.

Q At what point during this evening did Mrs. Weitzel's death become a probability?

A Well, I would say between 10:00 and 12:00 midnight.

Q Why?

A Because the situation was progressively deteriorating.

She was very diaphoretic, obviously in shock.

Q Would it have been acceptable medical care for someone at the hospital to have called either Dr. Moasis or Dr. Steele?

A Yes.

Q Why?

A They were the people who were most involved as surgeons, they should have been notified as soon as possible that this complication had occurred.

Q And was it a breach of acceptable medical care for them not to call either Dr. Steele or Dr.

Moasis at some point?

A Well, the way it works ordinarily in a hospital is that the nurse calls the resident or intern who is on call and then in turn the resident would call the attending surgeon and attending physician.

So those people were never involved because Dr. Chang never saw the patient.

Q And as a result Mrs. Weitzel didn't get the treatment that she needed for her condition?

A Correct.

Q If Mrs. Weitzel had received the appropriate car from either the hospital nurse or the hospital resident the evening of her surgery, would she have survived?

MR. COYNE: Objection.

A It is possible, certainly very likely.

Q But for the wires being left in Mrs. Weitzel during this arterial line placement, would she have died prematurely?

MR. FULTON: Objection to the form of the question.

MS BITTENCE: Same objection.

MR. KAMPINSKI: I am going to object.

MR. SEIBEL: Do you want to make it unanimous?

THE WITNESS: Would you please repeat the question? I want to see why everybody objected.

(Question read.)

MR. KAMPINSKI: And in addition to it not being, I mean just technically not being a legal standard, it's been asked and answered. The doctor already told you he believes that was a contributing proximate cause.

MR. SEIBEL: Yes, the doctor said she wouldn't have died -- I want to know overall if she would have died prematurely.

A What do you mean by 'prematurely'?

Q Before a normal, healthy person would have died.

A In other words, you want to know whether she would have died while in the hospital, for example, shortly after the myocardial infarction or at the time that surgery was done?

She was certainly alive at that point.

What in your opinion would be premature, that's what I don't quite understand.

Right. Sure. That's fair.

What was her life expectancy on February 25, 1991, the day before the wires were left in?

A I would say expectancy would be no less than five years less than a normal individual or even less than that.

We know nowadays that if a person goes for five years post myocardial infarction, they have standard insurance.

Q Did anything happen in between the time that the wires were inserted and until she went to surgery that caused you to think that, you know, her condition was worsening?

A No.

Q And in that time between the insertion of the wires and her surgery did her condition stabilize?

A Improve; it began to improve somewhat, yes.

Q Do you hold an opinion to a reasonable medical probability that Dr. Moasis breached accepted standards of care in his involvement with Mrs. Weitzel?

A I would have to say 'yes'.

Q In what respects?

A Because his patient was only one month post myocardial infarction and consequently the dangers of having postoperative complications and

death are much greater than the probability of getting the problems by leaving the wire in.

Q In assessing the risks versus benefits of surgery, were there benefits to the surgery?

I mean in the preoperative evaluation.

A Only to the extent that it's always nice to get rid of the foreign body.

I think that before -- again this doesn't reflect on Dr. Moasis, it's his business to operate, but I think it was up to Dr. Steele to see if he couldn't remove the wire himself, there are other ways, other people who are qualified to remove it in a much less traumatic form.

And if there was really a problem in anybody's mind how dangerous it was to get that wire out, they certainly should have tried to do it in a manner other than a two-hour open surgery procedure.

Q Was Dr. Moasis entitled to rely upon Dr. Steele's clearance for surgery?

A Well, he's entitled to, yes.

Q Do you also feel that Dr. Steele breached standards of care to a reasonable medical probability?

A Yes.

Q How?
A By clearing her for surgery.
Q And what's the basis for your opinion?
MR. KAMPINSKI: Other than what he has already told you a few times?
MR. SEIBEL: Well, if it's what he's already told me, fine.
A The dangers of complications and surgery shortly after acute myocardial infarction.
Q What injuries to Mrs. Weitzel were directly and proximally caused by Dr. Moasis's negligence?
A Just having surgery, plus the fact that she bled after surgery.
MR. FULTON: When you use the word 'injury' .....
Could I have that question read back?
MR. KAMPINSKI: I mean it's obvious, she died.
Are you asking something different?
MR. SEIBEL: I am asking for the answer.
MR. FULTON: Could you read that question back?
(Question read.)
A I didn't hear the word 'negligence'.

Q Well, you know, I'm equating 'negligence' with breaches of the standard of care.

Is that your understanding of those terms?

A Yes, but I think the main negligence was in doing the surgery.

Q Right.

A As far as the technical aspects of the surgery, as far as I can understand it, it was certainly adequate except that there was bleeding.

This is certainly a complication that occurs even in the best of hands, so that's something I can't blame him for particularly. I don't think that's a matter of negligence.

MR. KAMPINSKI: And I don't think that's what you are trying to do at all.

MR. SEIBEL: No, it wasn't.

You're going to ask him that question at trial, that's why I asked.

MR. KAMPINSKI: Well, it's obvious that the doctor perceives what you are asking him had to do with the actual surgery, okay?

He's already told you he thinks Dr. Moasis was negligent in doing the surgery at all and that led to her death.

MR. SEIBEL: Yes.

MR. KAMPINSKI: So, I mean, obviously there's a confusion in terms of the question that you are asking him.

THE WITNESS: Did I answer the question satisfactorily about the surgery, the technical aspects and so on?

MR. SEIBEL: I think so.

Q Are you going to come to trial and criticize anything that Dr. Moasis did during the surgery?

A No.

Q Are you going to come to trial and criticize anything that Dr. Steele did actually during the attempted removal percutaneously on the 13th?

A Yes.

Q All right. What are you going to criticize?

A I'm going to criticize for not removing the second wire.

Q Do you know why he didn't remove the second wire?

A I do not know why. It's not clear to me.

Q Do you feel it was below the standard of care for Dr. Steele not to remove the second wire during his percutaneous attempt?

MR. KAMPINSKI: Are you now asking this question on behalf of Dr. Steele

or in what capacity are you asking this?

MR. SEIBEL: Evidence; same firm.

MR. KAMPINSKI: As Mr. Jackson. Mr. Jackson isn't here. He represents Dr. Steele.

I just wondered what you are asking as.

MR. SEIBEL: As Dr. Moasis's lawyer.

Give me the question back.

(Question read.)

A I answered 'yes'.

Q Why do you feel that it was below the standard of care for Dr. Steele not to have removed the second wire during the March 13th percutaneous procedure?

A Again the question arises why he didn't do it.

Now if he didn't do it because he felt that he couldn't do it, it was too difficult for him, then he could have had another cardiologist, invasive cardiologist or one of the invasive radiologists to attempt to remove it percutaneously.

If he was not aware of the fact that he

didn't remove the second wire, he should have known that there was another wire there that was left in place.

I could not understand why he didn't do it. There isn't any clear explanation for that.

Q Do you have any personal experience in removing these kinds of foreign bodies?

A No.

Q If you assume for purposes of this question that Mrs. Weitzel survived her St. Vincent's Charity hospitalization --

A Yes.

Q -- what would her quality of life have been?

A I think it would have been back to normal eventually.

Q How long?

A Well, the rehabilitation period would be at least another six months in her case.

Q And when do you feel that she could have safely undergone surgery to remove the remaining wire?

A As long as possible after the three months' period. I would prefer actually after six months.

Q Do you have any opinion that Dr. Moasis was negligent in the postoperative period?

A I really can't blame him as long as he wasn't

notified of what the situation was.

Q Do you have any opinion that Dr. Steele was negligent in the postoperative period?

A The same reason.

Q No?

A No.

Q Do you have any other opinions other than what we have discussed already about Dr. Moasis being negligent in his involvement with Mrs. Weitzel?

A No.

Q And how about any other opinions with respect to Dr. Steele and his negligence and his involvement with Mrs. Weitzel other than what we have discussed already in the deposition?

A No, nothing else.

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

MR. WARNER: I want to go about three minutes and we will get out of here.

CROSS-EXAMINATION OF PAUL M. KOHN, M.D.

BY MR. WARNER:

Q Doctor, I represent the radiologist.

In your report, on Page 2, you said that the first chest x-ray that noted two guide wires was

March the 1st. The last paragraph of your second page.

And then you go on to say that apparently the attendings actually become physically aware of this on or about March the 8th.

So it's that seven-day delay period that I'm talking about. Did that seven-day delay in which the attending physician finally becomes aware that two guide wires result in damage to Mrs. Weitzel?

A No.

Q Did not.

And in fact you've already stated that those wires or that wire could have been left for several months?

A That's correct.

Q And that none of the complications, that is the embolism, infection, perforation that you talked about as possibilities, none of those possibilitie occurred,at least during that seven-day period?

A That's true.

MR. WARNER: Thank you. Nothing else.

MR. SEIBEL: Doctor, before I leave, remember, when he asked you those

questions, he's representing Dr. Varma in this case.

THE WITNESS: Okay, I'll remember that.

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(Mr. Seibel and Mr. Warner left the deposition room.)

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CROSS-EXAMINATION OF PAUL M. KOHN, M.D.

BY MR. COYNE:

Q Doctor, relative to the designation in a hospital chart of a patient being critical, what does that mean?

A As the word itself implies, her general condition is extremely poor and there's always a possibility of further deterioration and death.

Q Mrs. Weitzel's condition as chronicled in the chart from the time she was admitted to Charity until the time she passed away remained critical, correct?

A Yes.

Q From the time that she was admitted into Charity and in fact even at the Samaritan Hospital before her admission, she eras on a ventilator, correct?

A Yes.

Q And a ventilator is needed for what?

A To ensure that there is proper oxygenation.

Q In other words, she couldn't breathe on her own, correct?

A I know it was felt that she couldn't breathe on her own adequately to oxygenate herself.

Q And to remove her from the ventilator would have been a life-threatening situation for her?

A Yes.

Q Are you familiar with the survival rate for patients who suffer cardiac arrests secondary to ventricular fibrillation when bystanders do not initiate cardiopulmonary resuscitation?

MR. KAMPINSKI: Who subsequently survive and are in a hospital setting or other hospital patients who don't survive? Because obviously he doesn't understand.

MR. COYNE: What's the difference?

I'd like him to answer it first.

MR. KAMPINSKI: Well, I want him to understand. Because he nodded his head 'yes'.

The important thing is if he understands it.

A Yes. I would say if the statistics include prior to hospitalization and the hospitalizations, of course the figures are going to be much higher. If the patient is able to get to a hospital and proper methods of resuscitation are produced, then the probabilities of course for death are much less. In any event, it would probably be fifty percent.

Q In your opinion, it would be fifty percent?

A Yes.

Q That's assuming they get to the hospital too?

A Yes.

Q Obviously if they don't get to the hospital in very good time, you're in --

A I say that's included. It would even be higher.

Q This patient was defibrillated approximately seventeen times. You are aware of that, Doctor?

A Yes.

Q What was the need for defibrillation, why was that done?

A Because she had persistent recurrent ventricular fibrillation and ventricular tachycardia.

Q Was that necessitated because the heart stops beating?

A It doesn't stop beating. The heart goes very, very

fast so that it is no longer able to efficiently provide adequate cardiac output. So it is not necessarily in cardiac standstill. That is one possibility.

In her particular case it wasn't cardiac standstill, it was fibrillation and tachycardia.

Q What if there is no pulse?

A You can still have heart activity without a pulse if there is such poor rejection from the heart.

Q You did see in the records where she was first treated by the EMS squad, that she had no pulse when they arrived?

A Yes.

Q What did that indicate to you?

A Just as I said, there was not any significant cardiac output getting to the radial artery where you could feel the pulse.

Q Are you familiar with the statistics regarding survivorship of a patient with adult respiratory distress syndrome for a period of one week or over in a hospital?

A Yes.

Q And what is that statistic?

A I'd say that also would be about sixty percent mortality.

Q Are you familiar with the survival rate for patients with adult respiratory distress and three or more organ systems are involved over a one-week period of time?

A It would certainly be more than sixty percent.

Q This patient -- we're talking about Mrs. Weitzel-- she had a pacemaker installed, didn't she?

A Yes, I think so, a temporary pacemaker.

Q Okay. And what was the need for the pacemaker to be installed?

A In case she would develop cardiac standstill, very, very mild tachycardia, slow pulse.

Q And it would assist in rhythmatic beating of the heart, a pacemaker, at a proper rate?

A Yes, of course.

Basically the only time a pacemaker would be involved is if the -- where you set the rate at.

Let's assume that rate is set at least eighty beats per minute and the patient's heart rate falls spontaneously below that figure, then the pacemaker kicks in and prevents the heart rate from getting any lower than the setting.

Q Was the pacemaker removed prior to her demise?

A I don't recall.

Q I believe on February 28th of 1991 she had a tracheostomy. You are familiar with that also?

A Yes.

Q And the need for the tracheostomy was what?

A To continue with using the respirator to prevent any further damage to the pharynx and larynx produced by the tube the patient had intubated.

Q Are you familiar also that prior to the surgery of March 14th, I believe it was on March 13th, she had been tested and cultured positive for Pseudomonas?

a Yes.

Q And I believe there was a positive culture in her urine at the tracheostomy site, at the area of the swan-ganz line; do you recall that?

A Yes.

Q And Pseudomonas is what?

A It's a bad germ, bacteria.

Q And that in and of itself can be fatal if not properly treated?

A If not properly treated, yes.

Fortunately we do have effective antibiotics for Pseudomonas.

Q Did the treatment of steroids here cause any medical complications in your professional medical opinion?

A No. I think the only thing it did really is to confuse the doctors, because one of the things that they were concerned about, the question of sepsis was a high white count.

And one of the things you find with sepsis of course is a high white count.

But on the other hand, if a person is getting steroids, that alone can cause the white blood count to be high.

So, as I say, that would just sort of mislead the doctors who are not familiar with that particular background of steroids.

Q Based on your review of the chart, Doctor, and prior to the surgery of March 14th, was she hemodynamically stable?

A Just prior to surgery?

Q Yes, prior to the surgery of March 14th.

A I would say so.

Q Over the few days preceding that, on your review of the chart, do you believe she was hemodynamically stable?

A As I recall, yes.

Q Have you reviewed the x-rays in this case by the way?

A I did not review the x-rays per se, however I have reviewed all the x-ray reports.

Q But as far as the actual --

A Not the actual films, no.

Q In regard to the decision to go ahead with the surgery on March 14th, that was a decision to be made primarily by the attending physician; is that true?

A Yes.

Q That would be Dr. Steele?

A Yes.

Q When one considers a surgical procedure requiring general anesthesia as in this particular case, is it encumbent upon the attending physician to evaluate all of the patient's symptoms and systems before deciding to go ahead with the procedure?

A Yes.

Q And you have indicated -- and I believe quite accurately so -- that one of the things you would consider would be the fact that this was a postmyocardial infarction just approximately thirty days after the event, correct?

A Yes.

Q And that would be one of the criteria or symptoms that you believe would contraindicate elective surgery such as this, correct?

A Yes.

Q Now would an attending physician also in a patient that had adult respiratory distress syndrome discuss the pulmonary aspects of the patient with the attending pulmonologist?

A Yes, he should have.

Q Should have, okay.

Would the attending physician who is dutiful and concerned about his client or patient also discuss the infection with the infectious disease specialist?

A Yes.

Q And that should have been done, is that correct?

A Yes.

Q Is it then the attending physician's responsibility to take into consideration the post myocardial event, the adult respiratory distress syndrome, the Pseudomonas, and package all of those together in evaluating the patient as to whether or not that patient would be acceptable for surgery?

MR. KAMPINSKI: I just want to interject one thing, Mr. Coyne.

You might be right in that characterization, however I just don't recall precisely when the culture was reported in terms of the Pseudomonas, whether that was prior to or after the surgery.

But it is clear that it was drawn before. I just, I don't recall when it was reported.

MR. COYNE: I may be wrong, but my recollection is that it was diagnosed on March 13th.

MR. KAMPINSKI: You might be right. I'm not arguing with you, I just don't recall.

a In other words, the evaluation of the patient would include not only the post myocardial infarction, but the presence of the adult respiratory distress syndrome and pneumonia and the Pseudomonas had it been at least diagnosed and found prior to the surgery of March 14th, correct?

A Absolutely.

Q And it's when you package all these things

together apparently that you believe that this patient was not a candidate for elective surgery such as removing the wire; is that true?

A Undoubtedly.

Q And the decision -- by the way, that decision to go ahead with the surgery by Dr. Steele and the symptoms that were present in this patient is something that the surgeon should also consider and evaluate before he agrees to go ahead with it; isn't that true?

A I agree.

Q So if I understand you correctly then, the decision by Dr. Steele and Dr. Moasis to go ahead with the surgery was substandard care in this case?

A Yes, sir.

Q And it's your professional opinion that the surgery directly and proximally contributed to the ultimate demise of Mrs. Weitzel, correct?

A Absolutely.

Q I am looking at the second page of your report, in the second paragraph, Dr. Kohn, directing your attention to the second sentence there in your report, you say, "Another factor increasing the risk of surgery in Mrs. Weitzel's case was

the preoperative electrocardiogram dated March 14th which showed ST segment depression in the inferior leads."

That apparently was another risk over and above these other things that we talked about as far as contraindicating surgery at this time?

A Well, yes and no. I mean, I think that it was there because of the fact that she had a myocardial infarction and that close to the acute episode, and that was just one of the clearer manifestations of her recent myocardial infarction.

Q You go on and you say at the beginning of the next paragraph, "As if this electrocardiographic change indicative of hemodynamic instability --" in that paragraph, if I understand you, there is a question in your mind as to whether or not she was hemodynamically stable to go ahead with the surgery on the 14th.

A She was not hemodynamically stable enough to go to surgery, but her hemodynamic stability had definitely improved up to that time but still was not at the point where she was a good candidate for surgery.

Q All right, that clarifies those.

On Page 3 of your report, about the fifth

line down, you make the observation apparently on a review of the Coroner's Report or Autopsy Report in this case that,"Examination of the coronary arteries revealed stenosing calcific atherosclerosis with near complete occlusion of the anterior descending branch of the left coronary artery."

That was one of the things that was found on autopsy,right?

A Yes.

Q Would that have required surgery in the near future had Mrs. Weitzel survived the event at the hospital?

A Not necessarily.

The reason I say that is because there were circumflexed and the right coronary arteries were essentially normal, and consequently there was obviously some covering that covered the remainder of the heart muscle.

The reason I say that, because the actual infarct itself, area of the infarct was relatively small.

So I believe that the other arteries that were completely normal could have perfused enough myocardium so that only a small, relatively small

area, two by one inch, was the result.

So consequently, that being the case, it's entirely possible that she could have been managed afterwards with medication, or even without medication, depending on the situation.

But I also said that in the event that she would have any problem such as post myocardial infarction angina which could not be completely covered by medication and controlled by medication, or if she developed some kind of a problem with the rhythm that could not be controlled by medication, and if in deed it was determined that the reason she had the rhythm disturbance was due to the blockage of the left coronary artery, then and only then would surgery be required.

Q Bypass of the left anterior coronary artery?

A Yes. So consequently I would say that, in my opinion I would say that the necessity for post myocardial infarction, coronary bypass surgery would be very, very low, the probability would be very, very low for that requirement.

Q Doctor, have you any opinion regarding whether or not another surgery after the 14th would have been reasonably necessary to correct the

internal bleeding that was going on following the surgical procedure by Dr. Moasis had it been discovered?

A I would think so.

Q You've indicated you believe that the internal bleeding started probably within a few hours after the surgery, correct?

A Yes.

Q And we know of course it stops at death, correct?

A Yes.

Q Presumably had she survived that internal bleeding would have to be corrected by some further surgery following exploratory or whatever, correct?

A Very likely.

Q She certainly wouldn't have been a good candidate for yet another surgery to correct the bleeding postoperatively, would she?

A That's true.

Q The chances are to a reasonable degree of medical certainty that had they discovered the internal bleeding postoperatively, say at 10:00, 11:00 or midnight of that same evening and had to go back in, she probably wouldn't have survived another surgery, would she?

A That's very probable.

Q Do you have any criticisms of the resident, Dr. Brooks-James' care and treatment of this patient?
A I don't really know how much she was involved with the care of the patient.
Q I'm just wondering if you reached any professional opinion regarding her care and treatment of this patient.
A I haven't, no.
Q Have you rendered or reached any opinion regarding the care and treatment rendered to this patient by a resident by the name of Dr. Milah?
A Not that I know of.
Q Are you going to testify regarding any professional opinion regarding a cover-up of these particular wires by anyone other than Dr. Varma in this case?
A No.
Q And what is your professional opinion regarding the cause of death of Mrs. Weitzel?
A A combination of the bleed and the cardiac status, post myocardial infarction.
Q Did her cardiac arrest then of February 11th contribute to her demise partially?
A Well, only insofar as it was a result of the myocardial infarction. I would think it probably,

there was a further effect on the heart function by having been defibrillated seventeen times. So that just added insult to injury.

Q By the way, on autopsy I believe it indicated the heart of Mrs. Weitzel was enlarged; did you observe that?

A I didn't -- yes, that's what it said, but there was no actual weight.

THE WITNESS: Do you have her autopsy report there?

Let me see what the heart weighed.

(Examining report.)

A 396. Yes, that's an enlargement.

Q That is an abnormal condition of the heart, correct?

A Yes.

Q And does an enlarged heart such as she had impose any risk to her health and well-being even had she come out of the hospital and say that the wires were never even in her?

A No. There's remodeling that takes place after myocardial infarction, but with proper medication, if necessary, these kinds of people can actually get their heart muscles back to normal and also the weight of the heart and the size of the heart can also get smaller again, back towards normal.

Now the only question in my mind is about her blood pressure reading prior to surgery.

I don't think we have any evidence of it, do we?

In other words, the question is, why did she have the enlarged heart in the first place.

That's one of the questions you are asking.

I don't remember seeing any data of having been examined prior or been treated for hypertension. I don't think she was.

Q Prior to her --

A Was she treated for hypertension?

Q Yes. She was on medication prior to her heart attack for high blood pressure.

A If that's the case, that was also probably the reason that she had an enlarged heart.

Q Do you have an opinion whether or not the adult respiratory distress syndrome that she had for several weeks prior to her demise contributed to her death?

MR. KAMPINSKI: Now, look, I'm going to object at this point.

She obviously had conditions, and you're asking if the conditions contributed to her death. He's already answered that

had the negligence not occurred, she would have survived and been fine.

MR. COYNE: I understand, but I'm asking whether or not in his professional opinion the adult respiratory distress syndrome that she had which we know can be fatal in some patients contributed.

A Yes, I think it contributed.

MR. COYNE: All right. Thank you.

I have no further questions.

CROSS-EXAMINATION OF PAUL M. KOHN, M.D.

BY MS BITTENCE:

Q Doctor, at the trial do you intend to offer an opinion with respect to Dr. Varma's training?

A If I'm asked, I suppose I'll have to respond.

MS BITTENCE: Then my question goes to you because I don't want to go into it if you don't.

MR. KAMPINSKI: Sure. Go ahead. I am going to go into it.

Q Doctor, do you have an opinion with respect to the training that Dr. Varma received at the Cleveland Clinic?

A Well, as it applies to this particular case,

as you probably know, that he never had any training in inserting a femoral line or any experience with it by the time he got to St. Vincent's Charity, so in that respect, there was certainly a deficit in his training.

Q And what is the basis for your opinion on that?

A Well, I looked over his log, training log, and there was no entry while he was at the Cleveland Clinic that he was trained at all or had experience at all in obtaining a line in a femoral artery.

Q Do you recall what his logbook said with respect to his experience with inserting swan-ganz catheters?

A As I recall, I think he did have some experience with it at the Clinic.

Q And do you recall what his logbook said with respect to his experience with placing central venous pressure lines?

A I think it would be much easier of course if we had his log in front of us so I could answer specifically.

Q I think it was in the material that was sent to you.

A I'm going from my memory.

(Examining record.)

A He started at the Clinic, I think it was in December of 1990 -- no. September, 1990.

December the 10th he had placed a subclavian central venous pressure line.

And then he had another one. No date there. So he did that again.

You asked about -- that's one of the things you asked me about.

Q One of the questions, and I might as well start with that one, was what your understanding was of his experience with placing central venous pressure lines.

A Okay. December 10th he had placed one. And another one subsequently, there was no date for that one. And then nothing until January 15th. That of course was already at St. Vincent's.

So at the Clinic, he was there until probably December 31, I would imagine. He went to St. Vincent's on January 1st I would imagine. That's the usual ....

So he only had two entries for putting in a subclavian central venous pressure line at the Cleveland Clinic.

Q And does the logbook reflect that he has had

additional experience with placing central venous pressure lines during his training at St. Vincent's prior to any procedure on Mrs. Weitzel?

A January 15th he put in a line. And then again December 25th he put in a central venous pressure line. Then he put in a swan-ganz January 5th. Another right subclavian January 5th. And a swan-ganz January 10th. C.V.P. line January 23rd. And femoral arterial line January 27th. Radial arterial line January 27th.

And then the next swan-ganz was with Mrs. Weitzel on February 13th.

Q Doctor, do you have an opinion to a reasonable degree of medical probability whether the Cleveland Clinic was negligent in its training of Dr. Varma?

A The only thing I can focus on to answer your question is the fact that he did not have any experience at all in putting in a femoral line and I think that he probably should have had. And that's one of the procedures that a resident should be trained in.

Q Does your opinion rise to a reasonable degree of medical probability?

Do you understand what I am asking?

A I don't know what medical probability has to do with it. That's something that should have been done by the Cleveland Clinic in training him.

Q Are guide wires used in placing the swan-ganz catheters?

A Ordinarily I don't think they have to be in because that's the venous side and it's not necessary, just drain in a catheter.

Q Can they be?

A Sure.

Q And that would be within medical standards to use guide wires to place swan-ganz catheters?

A I don't think it's necessary in most cases.

Q I understand. But what I'm asking --

A The time when it's necessary, yes.

If there is some reason they can't do it just with the soft catheter alone, they have to use a guide wire.

Q Are guide wires used with placement of central venous pressure lines?

A They can be, yes.

Q Doctor, is your criticism of the Cleveland Clinic in this case limited to your understanding that he did not do any femoral arterial lines prior to Mrs. Weitzel's?

A Basically, yes.

Q If in fact -- and this is just a hypothetical -- if in fact Dr. Varma is just not a good logkeeper, but he did do femoral arterial lines prior to Mrs. Weitzel's, would that change your opinion?

A If he had previous experience at the Cleveland Clinic you are talking about?

Q Correct.

A Sure, I would change my opinion.

Q Doctor, are you familiar with the training at the Cleveland Clinic?

A Not really.

MS BITTENCE: That's all I have.

CROSS-EXAMINATION OF PAUL M. KOHN, M.D.

BY MR. FULTON:

Q Well, Doctor, as I indicated before, I am counsel for Dr. Moasis.

I was going to ask you that in the event you had a patient the condition that Mrs. Weitzel was in, who had to undergo an operation, and you were the consulting attending cardiologist, would you not normally call back after the surgery and make some inquiry into her condition?

A Well, usually what happens is that the surgeon

will call me after he finishes his surgery and tells me what he did and how she got along in the surgery and if there were any problems or not.

And so that is my own experience with surgeons.

And if everything went well during the surgery, that I presume it did here, then Dr. Moasis left for the day and she was -- he must have seen her just before he left, and she was okay, I wouldn't expect him to tell Dr. Steele, you better come to see her.

I don't think Dr. Steele would have come unless it was necessary for him to use some medical input into the situation.

Q I am going to hand you these records.

(Discussion had off the record.)

Q Now, look, I am going to have Mr. Kampinski read along with me because I have a typed version of a note by Dr. Varma.

And this is a note of Dr. Varma right here, from here to here.

MR. COYNE: Do you want to put the date on it?

Q 3/8/91. And it says down here, I think it says '9:00 P.M.'

And you may disagree. You know, I am trying to read all of the typed version. I want to be sure that's what it says.

A Go ahead.

Q It says, 'Above events noted. Patient has on CXR persistent wire which is not explainable.

'After reviewing CXR, this wire was not present on CXR on the date of 2/26,' is it?

A 2/24.

Q 2/26. 2/24, but there is some question.

MR. KAMPINSKI: I can't tell. I don't remember what he said.

Q But on 2/28/91 the wire was present?

A Yes.

Q It says, 'On 2/26/91 femoral arterial line was placed and subsequent to that wire was present'.

MR. KAMPINSKI: It's hard to tell what it says. I don't see a 'Q' in there.

Well, there's a word there that we don't necessarily agree with, but we'll say that around that word is an 'and' and a 'to'.

Q All right. It also says, 'Possibilities include guide wire remains in which I felt because I did procedure myself. It is possible the sheath was left in, which I doubt. Will discuss with

staff. Will need removal --'

MR. KAMPINSKI: Well, you missed a word.

MR. FULTON: 'It's possible the sheath was left in, which I doubt.'

MR. KAMPINSKI: No. After 'staff' there's a word here. 'Possible --'

THE WITNESS: Probable?

MR. KAMPINSKI: It may be that a word is crossed out there.

MR. FULTON: There is a word crossed out and there may be a word underneath it.

Q But it says, 'Will need --'

A Removal.

Q ' via fluoroscopy.'

A Fluoroscopy.

Q All right. And it says, 'Discuss with doctor --'

A Fluoroscopy.

Q But that will indicate that at least as of that date that Dr. Varma made a note on March the 8th, 1991 that there is a possibility that a guide wire could remain in there.

MR. KAMPINSKI: Well, it's not a possibility. It was there. The guide

wire was there, right?

THE WITNESS: Yes.

Q Now on that date, on the 9th, there is a note here, 'Kitchen and Rollins.' And that does say, 'Reviewed x-rays. Guide wire prolapsed on itself from left iliac up to base of neck'. There's a question mark. And then it says, what?

A Intervertebral.

MR. KAMPINSKI: I.C. or vertebral.

A Intercarotic or vertebral. I.C. or intercarotic.

Q All right.

A 'and has apparently been in place ten days.'

Q And then it says, 'wire snapped in two in neck. Dr. Rollins aware yesterday and because of --'

Is that 'the patient's condition'?

A Yes, right.

Q 'discussed --'

A 'decision not to attempt removal at this time and will discuss again with him today.'

Q 'Discussed options with Dr. Khaddam.'

Now on 3/13, we will get to that.

All right. on 3/13, over here, there is a note, and what does it state?

A 'Wire retrieved.'

MR. KAMPINSKI: Retrieval.

Q Retrieval.

A Wire retrieval, yes.

Q And it says, 'No. 8 --'

A Sheath.

Q 'inserted in left femoral --'

A 'artery. Snare using --'

Q 'Snare using N.I.H. catheter'?

A In area of wire.

Q 'One --' isn't that 'One'? 'One wire --'

A 'One wire was successfully snared and removed, but the other piece could not be snared -- could not be snagged.'

Q Then he goes on to the next page and says what?

A 'Will ask vascular surgeon to see to make sure femoral artery is okay and to discuss options for removal of other piece of wire.'

Q 'other piece of wire.'

So there was some discussion back then among the cardiologists that one wire had broken and that there had been another piece left in there, is that not true? According to the records.

A That's what it sounds like, yes.

Q Did you get Dr. Smead's report?

A No.

Q Well, this is a report from Dr. Smead addressed to me on March 30, 1993.

Now I've underlined in it in red just certain portions.

And I'd like you to read this.

MR. KAMPINSKI: To himself?

MR. FULTON: The last time I asked him to read to himself, I'd like to have it read on the record.

MR. KAMPINSKI: Well, do you just want him to read something. If we knew what your purpose of doing it --

MR. FULTON: First he's going to read this and I'm going to ask if he agrees with that.

MR. KAMPINSKI: Then he doesn't have to read it out loud, does he?

I mean, is it an attempt by you to somehow interject your expert's testimony into Dr. Kohn's deposition?

MR. FULTON: I wouldn't do that.

MR. KAMPINSKI: No, of course not.

MR. KAMPINSKI: Just ask him a question.

MR. FULTON: I am going to ask him a question.

Q I want to know if you agree with Dr. Smead's statement here.

MR. KAMPINSKI: I object.

Q Okay, so I go along....

"Her hospital course was marked by multi-system organ failure and sepsis. Organ systems involved included heart (congestive failure), lungs (ARDS), liver (hepatosplenomegaly with abnormal liver function studies), and brain (obtundation, abnormal brain stem reflexes, and motor deficits). She developed septic complications early in her hospitalization and required prolonged antibiotic therapy until her death. She required tracheostomy for long term ventilatory support."

Do you agree with that statement?

A Yes.

Q And on Page 2 he states, "In most cases these intraluminal foreign bodies can be safely removed by percutaneous techniques utilizing a snare device."

Do you agree with that?

A Yes.

Q And he says, "This was indeed successful in removing one of the two wires. In my opinion additional attempts, perhaps by an interventionalist with greater experience, would have been preferable to any surgical attempt at retrieval in this critically ill woman. "

Do you agree with that?

A Yes.

Q And "The operative mortality rate in patients with recent myocardial infarction (less than three to six months) is markedly increased and should not be undertaken without urgent indications and in circumstances in which no alternative methods of treatment are available."

Do you agree with that?

A Yes.

Q And do you agree with, "Postoperatively, the patient sustained another cardiac arrest from which she could not be resuscitated."?

A Yes.

Q Okay. And on the autopsy, I just want to be sure I understand it, here they're talking about the cardiovascular. And they answered it, the heart

was enlarged and answered various questions about that. And there was a severe stenosing calcific atherosclerosis.

That was probably true, was that not?

A In the left anterior descending coronary artery.

Q Now down here the statement is, 'The affected area --' Read above that. They talk about a one-inch to two-inch affected area. Is that the size of the myocardial infarct?

A Yes.

Q I thought you said it was rather small.

Isn't that pretty large, one by two inches?

A That's pretty small.

Q One by two inches?

A Yes.

Q Are they describing like a, as a physician, does that mean like a square or one to two inches of a circular?

A. I would say it is -- I don't know whether it's a circle or square. It probably was more like a circle or elipse or something like that.

But in any event, this is a relatively small area.

Q What's a whole heart measure?

Four to six inches?

A Well, at least.

Probably six or seven inches by maybe -- it's probably more than that -- four or five inches.

Q These last couple of questions I think I may be repeating something Mr. Coyne asked you, but I'll make it quick.

CPR means what?

A Cardiac pulmonary resuscitation.

Q ACLS is what? Assisted cardiac something?

Does that mean anything to you?

ACLS, is that assisted cardiac --

A That's probably the technique authorized.

Q Assisted cardiac life-saving technique or something like that?

A I don't know the answer.

Q Well, let me ask you this: If indeed you got between eight to twelve minutes before you get CPR, would you agree that there's a --

MR. KAMPINSKI: Eight to ten minutes of what?

MR. FULTON: Before you get to CPR.

Q For eight to twelve minutes a person doesn't get any CPR, their survival rate is probably no

greater than six percent.

Would you agree with that?

A No. Their survival rate can be, as far as being alive is concerned, much more than that, but there can be certainly damage to the brain.

Q And if you have unattended ventricular fibrillation, that can lead to some brain damage?

MR. KAMPINSKI: You're asking hypothetically?

Q Yes, hypothetically.

A Yes.

Q And signs of this, say, irreversible brain damage, can that be shown by convulsions? Is that one of the signs?

A No, that wouldn't necessarily indicate -- no.

Q I didn't mean indicate, but if a person did have, say, irreversible brain damage, could a sign --

A Could there be a sign?

Q Convulsion?

A Yes, there could be convulsion.

Q How about a positive Babinski?

A That shows there is an effect on the brain, yes.

Q How about a dilation of the pupils?

A The same.

Q If a person is in a state of coma for a couple

of days and then awakes, is there usually some loss of motor ability?

A She was seen --

Q I'm talking hypothetically.

MR. KAMPINSKI: Let him answer the question.

MR. FULTON: I will. I'm now talking hypothetically.

A What is your hypothetical question again now?

Q Well, I'm saying --

MR. FULTON: Let him answer.

Q -- if, you know, a person's in a coma for two days, say, just not awake --

A Yes.

Q -- is there a good probability that such a person will have some motor deficiencies?

A Again, not necessarily.

Q How about cognitive deficiencies? Nada

A What?

Q Cognitive.

A Cognitive?

Q Yes; two days' coma.

A I say again, may or may not be, depending upon how much damage is done to the brain.

Q How about if after defibrillation the heartbeat

goes below sixty; does that indicate there's a very slight chance of survival?

A Below sixty. Say fifty-nine. No, no problem.

Q Where do you say the problem exists if a person has been defibrillated, at what point the heartbeat goes below which?

Below forty I would say.

Q You indeed indicated on your direct examination that of course if the lines hadn't been in there, you wouldn't have had the surgery.

A That's true.

Q I'm just going to ask you these last couple hypotheticals. But before I ask that, you did say that, "But the surgery is what killed her."

Those are my notes.

A Yes.

Q And that it should not have been undertaken and the cardiologist and the surgeon should have come to that conclusion based on reasonable probability.

A Yes.

Q Now we do know that one wire was retrieved?

A Yes.

A If indeed that was the only wire that Dr. Varma put in -- and this is a hypothetical -- then you would have to change your opinion about the

proximate cause, would you not?

A Yes, I would have to.

MR. FULTON: That's the only question I have.

MR. COYNE: Do you want to read this, Doctor, or do you want to waive signature?

THE WITNESS: I'll waive signature.

I wouldn't mind having a copy, though.

MR. KAMPINSKI: Why don't you read it?

Submit it. I will take a copy. I will get it to the Doctor for his review.

Okay? Is there any problem with that?

MR. COYNE: No.

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(It was stipulated by and between counsel that a letter concerning signature of the witness is waived.)

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ERRATA SHEET

I, Paul M. Kohn, M.D., do hereby certify that I have read the foregoing transcript of my deposition this _____day of _____, 19__, and believe the same to be true and correct (or, except as follows, noting the page and line number of the change or addition as desired and the reason why):

PAGE	LINE	CHANGE

Dated this _____day of _____, 19__.

Paul M. Kohn, M.D.

CERTIFICATE

The State of Ohio,)
) SS:
County of Cuyahoga.)

I, Marie L. Larbig, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named PAUL M. KOHN, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotypy, and was later transcribed into typewriting by me, and is a true record of the testimony given by the witness; that said deposition was taken on Thursday, the 8th day of April, A.D. 1993, in the City of Cleveland, County of Cuyahoga, and State of Ohio, pursuant to notice, and was completed without adjournment; that I am not a relative or attorney of any of the parties or otherwise interested in this action.

IN WITNESS WHEREOF, I hereunto set my hand and affix my seal of office at Cleveland, Ohio, this 15th day of April, A.D. 1993.

Marie L. Larbig, Notary Public
within and for the State of Ohio

My Commission expires
July 22, 1993.