IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

ESTATE OF FRANCIS T. COLEN, JR., etc., Plaintiff; -vs- WILLIAM REISINGER, D.O., et al., Defendants.) Case No. 409938

The discovery deposition of DR. FREDERICK LUCHETTE, called by the Plaintiff for examination, taken before NANCY MORAN-BRODERICK, CSR No. 084-002116, a Notary Public within and for the County of Cook, State of Illinois, and a Certified Shorthand Reporter of said State, at the offices of Loyola Hospital, Department of Surgery, 2160 South First Avenue, Maywood, Illinois, on the 20th day of January 2003, at 11:15 a.m.

APPEARANCES:

FRIEDMAN, DOMIANO & SMITH
BY: THOMAS CONWAY, ESQ.
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(216) 621-0070,

On behalf of the Plaintiff,
Estate of Francis T. Colen, Jr.;

BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP
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On behalf of Dr. O'Toole.

REPORTED BY: Nancy Moran-Broderick,
CSR No. 084-002116

I N D E X

E X H I B I T S

(Exhibit Nos. 1 - 4 are attached to this transcript.)

DR. FREDERICK LUCHETTE,

called as a witness, having been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION

BY MR. CONWAY:

Q Good morning, Doctor. My name is Tom Conway. I represent the estate of Francis Colen. We are going to be taking your deposition here this morning. You are aware of that, correct?

A Yes, sir.

Q Would you please, for the record, state your full name spelling your last name for the court reporter?

A Frederick Albert Luchette, L-u-c-h-e-t-t-e.

Q Doctor, this is going to be my only opportunity to ask you questions prior to trial. I'm going to be asking you questions regarding your knowledge of the facts as well as your opinions. I would ask that you don't answer any question that you don't understand.

If you don't understand a question, have me rephrase it, repeat it or in some way

indicate to me you don't understand it, okay?

A Yes, sir.

Q If you do answer a question that I ask, I'm going to assume and rely upon the fact that you understood it, is that fair?

A Yes, sir.

Q If at any time you want to add, subtract, delete, amend, change anything in your deposition which you have testified to, feel free to go back and go on the record and do so, okay?

A Yes, sir.

Q If at any time you want to take a break and speak with Beth, the attorney that's retained you in this case, feel free to do so as well. I would ask that you don't interrupt a question and answer, okay?

A Very good.

Q And you understand that everything you say today is being taken down by the court reporter. It has the same significance as if you were in front of a judge and jury. You understand that?

A Yes, sir.

Q Doctor, would you agree that, when a trauma surgeon is in attendance treating a trauma patient,

the trauma surgeon has the ultimate authority and responsibility for diagnostic and therapeutic decisions including decisions to transfer the patient?

A Yes, sir.

Q You have had an opportunity to read the autopsy in this case, Doctor?

A Yes, sir.

Q Would you agree that the basic mechanism for Francis Colen's death was exsanguination?

A No, sir.

Q You would not. Do you believe that Francis Colen bled to death?

A I think it's difficult for me to discern.

Q Why is it difficult?

A Because the postmortem exam also notes a T7 fracture. As I look through the records, I don't see any documentation about his neurologic status. Although he had significant multiple injuries which led to bleeding, he also had a spine fracture T7 which may have rendered him in neurogenic shock.

Q A T7 spine fracture would have what type of signs and symptoms?

A Typically, the fracture in and of itself

without injury to the spinal cord would have pain. If he had an injury to his spinal cord, then you would look for neurologic signs of that -- decreased motor strength in the lower extremities, decreased rectal tone, decreased cavernosus reflexes, decreased sensation.

Q Is there any evidence in any of the records that you reviewed that Mr. Colen was suffering from any pain that would be associated with a T7 fracture?

A Not that I noted, no, sir.

Q Doctor, in reviewing the records of Francis Colen, is there any evidence in any of the records to point to any neurological defect that would be associated with a T7 fracture?

A I'm very concerned because his failure to resuscitate with the transfusions as well as the crystalloid fluids that Dr. O'Toole administered under his guidance while he was at the bedside and his blood pressure lability would have suggested that there may have been another injury accounting for his hemodynamic instability.

Q Was there any neurological defect that you can specifically point to which you would have

splenic injury?

A From the documents that I have available to review today, yes.

Q You had mentioned before the American College of Surgeons. Are you a member of the American College of Surgeons?

A I am a fellow, yes, sir.

Q Have you ever sat on the Committee On Trauma?

A I am currently a standing member of the central committee, yes, sir.

Q How long have you been -- How long have you had that position?

A I'm starting my second year.

Q Were you in the American College of Surgeons back in February of 1995?

A Yes.

MR. CONWAY: Would you mark these as 2A and 2B?

(Exhibit Nos. 2A and 2B were marked as requested.)

BY MR. CONWAY:

Q Showing you what's been marked for identification as Plaintiff's Exhibit 2A and 2B. It's a two-page exhibit, the front page indicating

don't need to do a DPL and they don't have any other injuries and their blood pressure is labile, you just take them to the operating room. In contrast, when somebody has a whole constellation of injuries basically from their collar bones down to their knees, it's much more difficult to determine when to do the DPL.

Q Other than your statements that ultrasounds are now more commonly used than DPLs, is there anything else on State's Exhibit 2B that you think should be different from the algorithm, which was I guess first generated in February of 1995?

A No, sir.

Q Doctor, have you ever had a patient bleed to death from an injury to the patient's spleen?

A Yes, sir.

Q How many times has that happened?

A I have been practicing trauma surgery for 20 years, so it's impossible for me to give you a definitive answer to that question.

Q The patient or patients that you are referring to or recollecting, did they die of bleeding from the spleen after some type of surgical intervention had been done? Or did they die from

bleeding from the spleen without any type of surgical intervention?

A Well, I have had many more of the latter.

Q Meaning?

A That they die without an operation.

Q Doctor, have you ever misdiagnosed an injury to the spleen?

A When you say misdiagnosed, I'm not sure what you mean by that.

Q Have you ever missed an injury to the spleen? Obviously, you are looking back retrospectively.

A Yes.

Q Do you believe that was below the standard of care?

A No, sir.

Q Why not?

A Because these patients came into the hospital much like Mr. Colen, in extremis with multiple injuries, and they die of a complex nature of all of their injuries totaled up and not just from the spleen.

Q But I guess going back, would it be below the standard of care for you to have a trauma

A Not initially; but after some time, Dr. O'Toole felt it was imperative to intubate the patient.

Q And do you recall how long Mr. Colen had been in the trauma unit prior to being intubated?

A If you'd like, I would review the records for the exact time.

Q Well, I guess you will agree that whatever -- you have no evidence other than what's in the medical records as to a time that Dr. O'Toole intubated Mr. Colen. Would that be correct?

A That is correct.

Q Was there any damage to Francis Colen's pelvic or femoral arteries?

A From the postmortem examination, he had a severe pelvic fracture; but I didn't see any notation of injuries to the femoral artery.

Q And I would take it that you didn't see any notation of any injuries to any of the arteries supplying the pelvic area?

A That is correct.

Q Doctor, in reviewing the medical records, can you cite to any other injury, internal injury, other than the pulpified spleen which would account

for the amount of blood in the peritoneum?

A There was none noted on the postmortem examination, no, sir.

Q Would you agree that, if Francis Colen had been diagnosed with an abdominal bleed by Dr. O'Toole and taken immediately to the OR, more likely than not he would have survived?

A Absolutely not.

Q Why not?

A This man had his chest wall ripped off of his spine. This man had his pelvis ripped off of his spine. He also had a wrist fracture and an extremity fracture. He had multiple sources of bleeding. The 800 cc's of hemoperitoneum is equivalent of two units of blood. He did not die from exsanguinating into his spleen. He died from a constellation of injuries.

I don't know, if he had landed at Metro Health, if I would have gotten him out of the hospital. I don't know, if he had landed at my ER, if I would have gotten him out of the operating room. He had significant injuries.

Q We will get to the specific ones in a little bit.

Q Would you agree that more likely than not the bleeding from the spleen injury was the cause of death?

A Absolutely not. As the postmortem exam says, it's blunt trauma to the head, chest, trunk and pelvis.

Q What head injury did Mr. Colen have that contributed to his death?

A He had contusions around the scalp.

Q Was there any indication of any subdural bleeding?

A Not that I noticed.

Q Was there any indication of any subarachnoid bleeding?

A No, sir.

Q Was there any indication of any bleeding to Mr. Colen's brain?

A No, sir.

Q Would you agree that the pulpified spleen injury occurred at the time of the motor vehicle accident which was approximately 9:47 a.m.?

A Absolutely.

Q You would agree that the motor vehicle

accident itself caused the splenic injury, correct?

A All of his injuries, yes, sir.

Q How do you treat a pulpified spleen, Doctor?

A Well, it depends. Again you have to give me some latitude to describe it. It depends on the patient's total constellation of injuries. If it's an isolated splenic injury and the patient has a CT Scan that shows you the splenic injury, we are very successful with asking radiologists to now embolize or put clotting agents through the vessels to stop the hemorrhage. And splenic injuries alone today, it's rare that we have to actually operate on them, even in complex patients like Mr. Colen.

Q You would agree that Mr. Colen was not a candidate for nonsurgical management? You'd agree with that, correct?

A I would agree, yeah.

Q Going back to your answer to the question regarding how would you treat a pulpified spleen, you gave one type of option?

A Scenario.

Q Can you think of any others that come to mind?

A There would be -- I mean, the definitive way to control bleeding from the spleen, if that's what you think is causing the patient's hemodynamic instability and labile blood pressure, is to remove the spleen and ligate the blood vessels that are bleeding.

Q Should that have been done in this case?

A From my review of the records, it was Dr. O'Toole's opinion and judgment from being at the bedside with the patient that he was more concerned about the nonabdominal injuries in his management than the spleen.

Q But my question is not what Dr. O'Toole was thinking because we have a criticism of his thought process.

A Sure, of course.

Q But do you think that the standard of care in this case for a physician who sees a patient who has a pulpified spleen would be to take the course of surgical action that you just described?

A Well, that depends how you determine that there's a, quote, pulpified spleen. Clearly, this patient was not stable enough for Dr. O'Toole to take into a CT Scan. If his blood pressure had been

stable, then Dr. O'Toole would have taken him to a CT Scan. I think he mentions that in his deposition.

If the patient is unstable and you think or you have evidence that they have a ruptured spleen, then you would take them to the operating room if you think that is the source of their blood loss and their instability.

Q Would you have taken Francis Colen to the -- Strike that. Would you have taken Francis Colen to the operating room in this particular case?

A Again, this is very easy to comment on with a retrospethoscope. Real time I would have been probably focusing more on his pelvic fracture and concerned about that as a bleeding source as well as potential intra-abdominal bleeding sources.

Q My question is though, if you had been the treating trauma surgeon, would you have taken Francis Colen to the operating room to explore his abdomen for potential sources of bleeding?

A I don't know that. I don't know the answer to that.

Q Would you agree that Francis Colen was a level one trauma patient?

A I'm not sure what you mean by level one.

Q Level one trauma patient, I think, by definition of Southwest General Hospital?

A For activation of the trauma team?

Q Correct.

A Yes.

Q Would you agree that, according to the materials you have read, Southwest General Hospital was a level two trauma center?

A Yes, sir.

Q Would you agree that, whether or not Francis Colen was at a level one trauma center or a level two trauma center, he should have received the same clinical services and the same level of medical expertise?

A I see no evidence to suggest that he did not receive the same level of care that he would have at a level one.

Q But that wasn't my particular question.

A Yes. The clinical capabilities are equivalent at a level one and level two.

Q I'm just doing this because I don't sometimes artfully phrase questions, so it's very difficult for me to restate it, so bear with me.

A Sure.

Q Would you agree that, whether or not Francis Colen was at a level one or a level two trauma center, he should have been given the same clinical services and the same level of medical expertise? Would you agree with that?

A Yes. As I stated, the clinical expertise and services available should be equivalent at a level one and a level two center.

Q What level trauma center is Loyola Medical Center?

A Level one trauma center.

Q Do you ever transfer trauma patients from a level one trauma center here to another level one trauma center?

A No, sir.

Q Have you ever transferred level one -- Excuse me. Have you ever transferred patients from here to a level two trauma center?

A No, sir, but we do have backup plans. In the event that our facility -- our resources are exhausted, then we would transfer the patient. We have transfer agreements with other facilities that would provide the same level of care.

Q There was no evidence whatsoever that Southwest General Hospital's resources were overburdened necessitating Francis Colen to be transferred, correct?

A No, sir.

Q Correct?

A That's correct.

Q And I'm not doing that to -- I've just got to get it answered.

A I appreciate you clarifying for whoever is going to read the depo so there's no question about what the answer was.

Q All right. Did you become familiar with the Southwest General Hospital procedures and protocols for trauma patients and trauma unit and the trauma surgeon?

A Have I personally reviewed their hospital documents?

Q Yes.

A No, sir.

Q Did you ever ask to review the Southwest General protocols and procedures regarding trauma patients, the trauma unit and the duties and responsibilities of the trauma surgeon there?

A No, sir.

Q Would that have been helpful for you in coming to a conclusion as to whether or not Dr. O'Toole complied with Southwest General Hospital's policies and procedures?

A Well, having practiced in the State of Ohio for eight years, I'm fairly familiar with the state trauma system and the regulations -- the requirements for level one, level two trauma center designation. And I took that familiarity and did not specifically review Southwest's internal documents.

Q Did Dr. O'Toole violate the hospital's procedural rule regarding his promptness in responding to this level one trauma activation?

A I don't know that answer. I can tell you that the American College of Surgeons criteria, which is what the State of Ohio had endorsed and adopted, states that, for a level one activation, the trauma surgeon -- the attending trauma surgeon's response time has to be 15 minutes 80 percent of the time.

So in other words, when the bell is rung, we have a trauma patient here. 80 percent of

the time the trauma surgeon needs to be responding within 15 minutes.

Q But you would agree it would certainly be below the standard of care for one of those percentages you are not talking about for the trauma surgeon to take, let's say, three hours to arrive, correct?

MS. NAGEL: Objection.

THE WITNESS: You have to restate that question for me.

BY MR. CONWAY:

Q You are saying that 80 percent of the time the trauma surgeon has to be there within 15 minutes?

A Yes, sir.

Q Certainly, the trauma surgeon could be in violation of that guideline if, during those 20 percent of the time when he isn't there within 15 minutes, he is showing up an hour late for instance, correct?

MS. NAGEL: Objection.

BY MR. CONWAY:

Q And if you can't understand it, I will restate it.

A I understand the question very clearly. Again you would have to refer to Southwest's internal documents to see how they deal with that type of response time. I think that's an internal issue that every hospital would respond to. I can tell you that, in the facilities I have practiced in, it is not a hundred percent.

In other words, the response time within 15 minutes is not a hundred percent. And I know for a fact that the American College of Surgeons, when they were implementing this guideline, they initially wanted it a hundred percent and they realized that that wasn't practical; so they backed off to 80 percent as a threshold for being compliant with the criteria.

BY MR. CONWAY:

Q And that compliance pertains to the hospital, correct?

A Well, that has to be documented and presented to the site surveyors during a visit by the American College of Surgeons.

Q In order to keep their credentialing with the American College of Surgeons, correct?

A To receive their verification, yes, sir.

That being said, if they identify the patient, if Fred Luchette took three hours to respond to a code one but I was 85 percent compliant, they wouldn't even look at that one.

Q But you would agree that, in evaluating Fred Luchette's performance of his medical responsibilities for that particular case where you were three hours late, that gets viewed in and of itself, correct --

A Sure.

Q -- as to whether or not you were negligent in showing up three hours late?

A Sure. Internally within Southwest, they would review that response time and see whether it was justifiable or not. For instance, if it's over triage and the patient didn't have any life threatening injuries -- and, oh, by the way, the nurse didn't document it, but she knows that Luchette called in to the ER and knew what the patient's status was -- well, I'm saving another life in the ICU, I'm not going to be there for a couple hours -- if I was reviewing that, I would say okay.

Q Let's ask a couple questions based upon

that. Number one, you have been an expert witness before, haven't you?

A Multiple times, yes, sir.

Q So you are aware that I have no way of ever getting into viewing any quality assurance information that this hospital may or may not have undertaken in evaluating Dr. O'Toole, correct?

A That's correct.

Q The second question I have is, do you have any evidence whatsoever as to what Dr. O'Toole was doing prior to his arrival to Francis Colen's bedside?

A No, sir.

Q And I think you have pretty much touched on this, but Southwest General Hospital as a level two trauma center should be able to treat a patient such as Francis Colen with his constellation of injuries, correct?

A As I stated a few minutes ago, they should have the resources and the expertise capabilities to take care of the patient that would also be treated at a level one.

Q And the particular patient we are talking about in this case is Francis Colen, correct?

A Yes, sir.

Q From my reading, is the only difference between a level one and a level two trauma center the research and education capabilities?

A Yes, sir. In '99, yes, sir.

Q Would you agree that, upon admission to the emergency room at Southwest General Hospital, Francis Colen was hemodynamically unstable?

A Yes, sir.

Q Would you agree that, during the entire time he remained in the trauma unit at Southwest General Hospital, he remained hemodynamically unstable?

A I'm just going to go back to the record for a second.

Q Sure.

A Yes, sir. From the documents that I'm reviewing, which are labeled Southwest General Health Center Patient Progress record, the vital signs which are documented every five to six minutes to eight minutes, and then there's a half hour -- Well, no, there's a big gap there. These numbers that are documented are what we would describe as hemodynamically unstable.

Q Would you agree that, at the time of Francis Colen's transfer, i.e. when he was taken out of Southwest General Hospital by the Metro Life Flight, he was hemodynamically unstable at that time?

A Yes, sir.

Q So you would agree with that?

A Yes, sir.

Q Can you tell me, based upon your review of the medical records and any depositions you may want to refer to, what steps did Dr. O'Toole take to locate the sources of Mr. Colen's bleeding?

A Well, he followed the protocols as delineated by the ATLS standards in that he focused on the ABCs. And on the Cs, he kept resuscitating the patient. And my interpretation of the records is he knew that the major source of the bleeding was from the chest wall as well as from the pelvic fracture. And he was concerned about intra-abdominal bleeding.

Q I guess my question was, what specific diagnostic steps did Dr. O'Toole take to find these specific sources of potential bleeding?

A He did a chest x-ray.

Q Did that show any bleeding to the chest area or any evidence of bleeding to the chest area?

A Well, it did not show any intrapleural bleeding hemothorax; but it's not going to show you bleeding into the chest wall itself. Here's a gentleman that's five feet nine inches tall, weighs 239 pounds. I think all of us would agree that's a little bit of a stocky gentleman. He has a lot of space between the ribs and skin where he can have contusions which are noted across his entire trunk which associated bleeding between the chest wall and the skin, so you are not going to see that on chest x-ray.

Q Other than the chest x-ray, did Dr. O'Toole undertake any type of diagnostic step to locate the sources of Mr. Colen's bleeding?

A He obtained a pelvis x-ray.

Q Anything else?

A I think he examined the extremities which showed a left -- Was it a left wrist fracture, left upper extremity radius ulna fracture? And that you don't need an x-ray to tell you. The x-ray there just tells you the anatomy, but that classifies it as a long bone fracture.

Q Other than that, any other diagnostic steps he took?

A And he also has a distal tibia and fibula fracture with multiple fractures, meaning it's a severely comminuted fracture, which again would be associated with blood loss.

Q So he observed that obviously with his eyes?

A He examined and felt the patient.

Q Any other diagnostic tests other than what you have described?

A No, sir.

Q I've come across -- There's something called a FAST exam?

A Yes, sir.

Q What's that, Doctor?

A In the previous document, I think it's Exhibit 2 -- Is that what we labeled that?

Q Right.

A That's the ultrasound. That's what they are referencing there.

Q Have you had the occasion to perform a FAST exam, an ultrasound exam on a patient, on a trauma patient and discovered that he had a spleen injury?

A Well, as a member of the American College of Surgeons National Faculty For FAST Instruction, an instructor for them -- FAST is an acronym which stands for focused abdominal sonography for trauma ultrasound. It doesn't tell you that someone has a splenic injury. What it tells you is whether somebody has blood in there or not. You can't really tell the source from the ultrasound.

Q Then you have to go in and surgically explore to find the precise source of the bleeding?

A Right. Then it's a judgment of whether you need to go to CT scan or whether you need to operate. The down side of a FAST -- and again, in the gentleman who's five nine and 240 pounds, you have a large subcutaneous fat, you will not get a real reliable study. That's one of the down sides of the ultrasound in that setting.

Q Would you agree that there was a portable ultrasound machine available to Dr. O'Toole when Mr. Colen came into the trauma unit?

A I didn't note that anywhere in the documents I reviewed; but for discussion, if you say that there's documentation that there was --

Q Well, I think one of the nurses testified

that there was an ultrasound machine that was available. I don't off the top of my head know whether it was in the radiology suite 200 feet down, but it was a portable machine.

A Sure.

Q Should a trauma surgeon at a level two trauma center such as Southwest General Hospital have the competency to use a portable ultrasound machine to do an examination of a trauma patient for abdominal bleeding?

MS. NAGEL: Objection.

THE WITNESS: That is very institutional specific. And now you are talking about practice turf battles between radiology and internal surgeons. I have many friends -- In fact, there are many reports in the literature where trauma patients are managed by the trauma surgeon and a radiologist comes and does the ultrasound for them; whereas, a trauma surgeon is not performing it himself.

BY MR. CONWAY:

Q A level two hospital such as Southwest General Hospital should have a radiologist available to come with an ultrasound machine and do an ultrasound examination if that's what the trauma

surgeon wants, correct?

A They should have ultrasound capability available.

Q And whether it's the trauma surgeon who does the ultrasound examination or the radiologist is up to the institution, is that your point?

A Yes, sir.

Q But getting back to my question, you have been able, I presume in your experience, to diagnose an intra-abdominal bleed by way of doing an ultrasound examination, correct?

A I can diagnose a significant intra-abdominal bleed with ultrasound, yes, sir.

Q Now, a DPL is a diagnostic peritoneal lavage?

A Yes, sir.

Q Should Dr. O'Toole have known how to perform a diagnostic peritoneal lavage --

MS. NAGEL: Objection.

BY MR. CONWAY:

Q -- as a trauma surgeon in 1999 practicing at Southwest General Hospital?

A As a trauma surgeon practicing at a level two trauma center, he should be credentialed to

perform diagnostic peritoneal lavage.

Q At what point in time did Dr. O'Toole first express an intent to possibly do a diagnostic peritoneal lavage from your review of the medical records and depositions, do you know?

A I don't think we were able to pinpoint a specific time, but he clearly entertained it is my recollection from his deposition.

Q Would that be something reasonable and prudent to do, entertain the idea of doing a diagnostic peritoneal lavage?

A Would it be prudent to entertain it? Yes.

Q Would you agree that the trauma alert was properly called at 9:47 a.m.?

A I don't think --

MS. NAGEL: Can you repeat that?

MR. CONWAY: Yes.

BY MR. CONWAY:

Q Would you agree that the trauma alert was properly called at 9:47 a.m. by the emergency personnel in the field?

A In the field notifying the hospital of Mr. Colen's impending arrival, yes, sir.

Q Would you agree that, according to the

nursing notes, Mr. Colen arrived in the emergency room at 10:15 a.m.?

A Yes, sir.

Q Would you agree that, in reviewing the medical records as well as the depositions, that Mr. Colen was at Southwest General Hospital in the trauma unit for at least one hour and 45 minutes?

A Yes, sir.

Q You indicate that there were -- and I don't want to put words in your mouth -- contusions around the trunk?

A Yes, sir.

Q Those would be indicative of a possible abdominal -- intra-abdominal injury, correct?

A Of a possible intra-abdominal injury, yes, sir.

Q Are spleen injuries common forms of internal injuries that result from motor vehicle accidents?

A Yes, sir.

Q I'd like to show you what's been marked for identification as -- Strike that. I'd like you to mark this for identification as Plaintiff's Exhibit No. 1.

(Exhibit No. 1 marked as requested.)

THE WITNESS: Yes, sir. I have seen this document before.

BY MR. CONWAY:

Q Is there any other charting that you found in your review of the medical records that was generated by Dr. O'Toole other than Plaintiff's Exhibit No. 1 which you are looking at?

A No, sir.

Q Would you agree that Dr. O'Toole's charting in this particular case was deficient?

A I don't know what you mean by deficient.

Q All right. You are aware, based upon the review of the medical records and the different depositions, of the different injuries that Mr. Colen had, correct?

A Yes, sir.

Q And you are aware of, from reading the nursing notes as well as the different hospital records from Southwest General Hospital, that various actions were taken during the time that Mr. Colen was at the hospital, correct?

A Yes, sir.

Q Does this particular chart note generated by Dr. O'Toole presumably at noon on August 10th, 1999 comply with the standard of care for a trauma surgeon in charting his involvement with a trauma patient?

A With the patient in extremis as Mr. Colen, yes.

Q Why?

A Well, because this patient was so critically ill that Dr. O'Toole was tending to the patient and not focusing on having a dictated detailed report of eyes, ears, mouth, et cetera. He described the salient injuries. He's described his resuscitative efforts by documenting despite approximately eight units of packed cells remained hypotensive. He's described his therapeutic interventions, and he's transferring to Metro.

Q Based upon the circumstances of this case, would you have provided more charting than Dr. O'Toole in this particular case --

MS. NAGEL: Objection.

BY MR. CONWAY:

Q -- for his involvement or, if it was you, for your involvement?

A Well, being that I have never transferred a patient, I have always worked at level one, I have never had to document. I can tell you as a recipient of patients transferred from level two trauma centers to facilities I have been working in over the past 20 years that this is sometimes more documentation than I get. So again, I don't see any deficiencies in this documentation.

Q Pursuant to Southwest General Hospital guidelines, was Dr. O'Toole supposed to generate a dictated chart note for this patient?

A I don't know because I haven't reviewed their recommendations, but if we are going to sit here and suggest that Dr. O'Toole deviated from the standard because he did not hold up Mr. Colen's transfer so that the hospital could generate a dictated report to go with him, I think that would be beyond the standard of care.

Q And I'm not suggesting that at all. I'm just asking --

A But for an hour and 45 minutes, this patient had -- I will give you an hour and 30 minutes, this patient had a trauma surgeon at the bedside with a nurse with massive injuries that he's

actively resuscitating doing therapeutics. And this note I think succinctly describes that.

Q In this particular case, was Dr. O'Toole timely in responding to the level one trauma alert?

A Once the patient arrived at the hospital, it's my understanding that the trauma system activation internally was activated at 10:15.

Q Was that your understanding?

A Yes, sir. And I see that -- and I want to say that Dr. O'Toole arrived at -- Was it 10:37? Dr. O'Toole -- 10:38. Again, as I stated earlier, if he's otherwise complying with the response time, that's a reasonable time frame.

Q I don't understand that. I mean, in this particular case, putting aside any other response times he's had with other patients, in this particular case, did Dr. O'Toole timely respond to the trauma activation?

A Well, without knowing what their internal system is that activates -- In other words, do they have an alphanumeric paging system that gives him some description? Had they told him the patient was hypotensive on the original alert? I don't know that detail to render an opinion.

Q If he was notified at or about 9:47 to 9:50 a.m., would his response have been timely?

A With the assumption that he was notified at 9:47?

Q To 9:50 a.m.?

A And he arrives at 10:38?

Q Correct.

A Again, not knowing whether -- I didn't see any documentation that he had talked to the emergency medicine physician and said, would you please get started, I will be there as soon as I can, et cetera. That would probably be outside the norm.

Q Would that be below the standard of care for a trauma surgeon?

A If he knew of Mr. Colen's physiologic status in transport, that would be below the standard.

Q You are a member of the Eastern Association for the Surgery of Trauma?

A Yes, sir.

Q Is that a reputable organization?

A I like to think so, yes.

Q How long have you been a member?

A Since 1989.

Q Do they issue reasonable and prudent guidelines and standards?

A As the Chair of the Guidelines Committee, I hope so.

Q I assume that you would agree with that?

A Yes.

Q You are also obviously a member of the American College of Surgeons, correct?

A Yes, sir.

Q And you would agree that the American College of Surgeons issues reasonable and prudent guidelines and standards for trauma surgeons?

A Yes, sir.

Q And both these groups set guidelines for the evaluation, diagnosis and treatment of abdominal trauma injury, correct?

A Yes.

Q Those guidelines and standards are reasonable and prudent?

A Yes.

Q Obviously, a spleen injury would be considered an abdominal injury, correct?

A Yes, sir.

Q Back in 1999 --

A '95.

Q Right. This was actually -- We are referring for the record to, I think, Plaintiff's Exhibit 2A and 2B. Back in 1999, this would have been an accurate statement of the American College of Surgeons' position regarding evaluation of abdominal trauma, correct?

A Yes.

Q And you'd agree that that's reasonable and prudent?

A Yes.

Q You have had an opportunity to review different medical books over the years, would that be a fair statement?

A Yes, sir.

Q And I assume you would carefully read a book prior to issuing a book review on it?

A Yes, sir.

Q Do you have an opinion as to whether or not -- had Dr. O'Toole performed an ultrasound examination in this particular case, whether or not he would have found abdominal bleeding?

A Again, creating in my mind's eye this

patient's body habitus, as we discussed earlier, five nine, 240 pounds, it would be a limited study. And I don't know whether it would have shown hemoperitoneum or not.

Q Fair enough. Had Dr. O'Toole done a diagnostic peritoneal lavage, is it more likely than not that he would have discovered intra-abdominal bleeding?

A If performed properly, yes. Then on top of that, when we take the pelvic fracture, which gives us a 20 percent incidence of false positive DPLs, it would have been a judgment how to interpret the findings of that DPL.

Q And obviously, there's an algorithm that one can take further when you have a positive DPL in a patient in a case like this, is that correct?

A That's correct.

Q But going back to my question, you would agree that, more likely than not, had a correctly performed diagnostic peritoneal lavage been performed by Dr. O'Toole, he would have discovered intra-abdominal bleeding, correct?

A Yes.

Q Other than the two ways which you earlier

in your deposition described that you would treat a spleen injury like Mr. Colen had -- One was embolization and the other was going in and surgically removing the remnants of the spleen and ligating the blood vessels to the spleen, correct?

A Yes, sir.

Q Are there any other ways of surgically treating this injury?

A You can do a splenorrhagia, which is repairing the spleen. Again, that's a judgment call.

Q Any other type of surgical interventions that would be appropriate for a patient with the extent of injury that Mr. Colen had?

A No, sir.

Q Do you have an opinion as to what time Dr. O'Toole should have been able to diagnose that this patient was suffering from intra-abdominal bleeding?

A Would you restate that, please?

MR. CONWAY: Yes. Would you read that back, please?

(Record read as requested.)

THE WITNESS: I have no reason to believe that

he wasn't entertaining it, as he states in his deposition. And it was his judgment, along with consultation with the orthopaedic surgeon, that the patient would be better served if he was transferred to Metro.

Q Now, going back to your answer, first of all, you'd agree with me that the the physician who bears the responsibility in this particular case for deciding whether or not to transfer Francis Colen is Dr. O'Toole. You'd agree with that, correct?

A Well, the final decision, but that decision is made in consultation with the other specialists that are required to address the patient's injuries, yes, sir.

Q Is there anything in Dr. O'Toole's charting that indicates he was considering intra-abdominal bleeding in this particular case?

A No, sir.

Q At what point in time -- Assuming that intra-abdominal bleeding was suspected, at what point in time should Francis Colen have been surgically explored for the source of that bleeding?

A Not until we definitely had a definitive indication that the intra-abdominal -- there was

intra-abdominal bleeding.

Q Were there indications with regard to Francis Colen's signs and symptoms in the emergency room as well as circumstances surrounding his presentation which would support a diagnosis of intra-abdominal bleeding?

A Not that I have seen in the chart. This is a very difficult patient. As I stated earlier, there's no documentation about his neurological status and there's no reason to believe from the findings postmortem that there wasn't a spinal cord injury also.

Q Should Dr. O'Toole have adequately examined this patient such that he could have charted the neurological status of the patient?

A Again, having practiced medicine and surgery for 20 years, just because it's not charted, it doesn't mean it wasn't done. And I don't know whether he did that or not.

Q Do you have an opinion as to at what point in time, had Mr. Colen's splenic bleeding been stopped, that he more likely than not would have survived?

A As I stated from the beginning, this man

probably would not have made it out of the operating room let alone the hospital. I have no reason to believe that stopping the minor bleeding from his splenic injury would have made any difference in his outcome.

Q It's your characterization of the bleeding that would have resulted from the spleen in this particular case as minor?

A He had 800 cc's of blood at the postmortem examination of hemoperitoneum, 800 cc's. That's the equivalent of two units of blood. He was transfused eight units of blood before he left Southwest Hospital. That doesn't explain where all the bleeding was going on.

Again he had his chest wall ripped off of his spine. He had his pelvis ripped off of his spine. Both are associated with significant venous bleeding.

Q Was there any evidence in this case as to any bleeding into Mr. Colen's chest area?

A Again, I'm not a pathologist or medical examiner. I don't know how diligent they are to look for bleeding into the chest wall. I did not see any evidence that there was -- that they noted

other than the contusions on the trunk that there was bleeding.

Q And we know that a chest tube at one point was inserted, correct?

A Yes, sir.

Q Was there any evidence of any bleeding into the chest area from the insertion of that chest tube?

A It was not what I would call massive bleeding.

Q How much bleeding was it? How would you describe it?

A Well, by the -- --

MR. CONWAY: We can mark this while we are waiting. This will be number 3.

(Exhibit No. 3
marked as requested.)

THE WITNESS: I don't see any note from the Metro Health Medical Center Emergency Department note dictated by Dr. Pennington the amount of blood in the left chest when they opened his chest.

Even the Metro Life Flight that placed the chest tube, I don't see any documentation about the amount of blood that returned. So I can't tell

you exactly how much blood was drained from the chest.

BY MR. CONWAY:

Q What areas -- What internal areas of the body would Francis Colen's pelvic injuries bleed into?

A Well, when you have the sacral fractures as described in the postmortem exam, they bleed out into the buttock. And the problem is the clinician can't even see it because they are laying on their buttock and they just keep bleeding out to the muscles and the skin at subcu. And it will dissect down into the peritoneum; and three days later, you will see all this contusion; but initially, on presentation, you can't see it.

Q If you had been the trauma surgeon treating Francis Colen, how would you have treated this patient, Doctor?

MS. NAGEL: Objection.

THE WITNESS: Yeah. It would be pure speculation because this is what we call a contact sport. And until you are there using your hands and your eyes and your diagnostic capabilities, it's pure speculation.

BY MR. CONWAY:

Q Well, if that's your position on this, how can, to a reasonable degree of medical probability, you offer any opinions regarding whether or not this patient received adequate treatment or not?

A Well, because, as we sit here today, we know the list of injuries. And again, that constellation of injuries in my experience over 20 years is associated with at least an 80 percent mortality rate. A patient with a previous CABG that's obese and fat, that's a highly lethal injury combination.

Now, if you want to talk specifically about the judgment on the evaluation of the abdomen, that's a judgment. And as I say, from the records I reviewed, Dr. O'Toole was there for an hour. And although he was concerned, he did not feel that that was the source of bleeding.

Q And I don't mean to beat a dead horse, but I don't want to leave here not knowing something. So I would take it that your answer to my question as to how would you treat this particular patient, Francis Colen, you can't give me an answer at this point had you been his doctor back in 1999?

A Would I have deviated much from what Dr. O'Toole did? Again I don't have the capability to transfer to another facility.

Q Let's put it this way. What would you have done different than Dr. O'Toole?

MS. NAGEL: Objection.

BY MR. CONWAY:

Q If anything?

A What I would have done differently is I would have evaluated his abdomen for intra-abdominal injuries.

Q And Dr. O'Toole did not do that, did he?

A No, sir, he didn't; but that's because I know this patient had a ruptured spleen. I can sit here and say that convincingly; but at the time, he didn't know he had a ruptured spleen.

Q I want you to put yourself back in time because you have been an expert witness before and you know the difference between a retrospective analysis and trying to put yourself without that retrospective knowledge back in the shoes of the clinician, okay?

A Right.

Q I want you to go back into the shoes of the

clinician. And without having looked at the autopsy and the postmortem which shows the significance of the different injuries that Francis Colen had, and this patient rolls into your trauma unit, you would have evaluated him for intra-abdominal bleeding, correct?

A Probably.

Q And Dr. O'Toole did not, correct?

A Right.

Q Anything else you would have done differently?

A Not that would have made a difference in the outcome, no, sir.

Q But we are dealing with proximate cause once again. I just want to know -- Forget the issue of whether it would have made a difference or not because we will delve into that in a moment. I'm just saying, as the trauma surgeon with a patient like Mr. Colen, what else in addition to evaluating him for intra-abdominal bleeding would you have done in this case?

A No. To be quite honest with you, as I stated earlier, it's Dr. O'Toole and a nurse. And the fact that they kept this critically injured

patient alive for an hour and a half I think is a credit to the practitioners that are caring for him.

Q So I guess other than -- Strike that. Other than evaluating Mr. Colen for intra-abdominal bleeding, you would not have done anything different than Dr. O'Toole did?

A No, sir.

Q How would you have evaluated Francis Colen from intra-abdominal -- Strike that. How would you have examined Mr. Colen for intra-abdominal bleeding back in 1999?

A At that time in the hospital I was practicing, I probably would have attempted an ultrasound, but very reluctantly because of the concern over his body habitus and whether it's sensitive or not. So if I got a negative ultrasound, I don't know whether that would have been accurate or not. It could have been a false negative. And then again, there's the option of the DPL. Those are the two options I think you have.

Q So back in 1999, if you went to do an ultrasound and at the time you were not convinced as to the reliability of the ultrasound, you would have proceeded to a diagnostic peritoneal lavage?

A No, sir, I didn't say that at all. What I would do then is I would repeat the ultrasound. Again it's your comfort level and your expertise. And do I think that I have now two negative ultrasounds in a 45-minute time frame? If I thought I had good images, it's that judgment issue in the experience, then I would not have looked in his belly with a DPL.

Q You would have surgically explored him?

A No, sir, not at all. If I had two ultrasound exams that I thought were technically adequate, two ultrasound exams that did not show any blood, I would not have explored his belly -- 45 minutes apart. He would not have been exsanguinating into his belly. That doesn't mean he wouldn't have had a splenic injury, but he would not have been bleeding to death in his belly.

Q What would you have done had you gotten a positive ultrasound on the first attempt?

A Then I'd have to weigh that into the initial evaluation. I mean, we have 800 cc's at postmortem exam. I don't know how much blood he had in his belly when he first came into Southwest. I don't know how much blood he had in his belly after

an hour there. What we do know, as we sit here and talk today, we noted exactly the postmortem exam showed 800 cc's of hemoperitoneum, which is a postmortem finding.

Q Doctor, if you, back in 1999, were not comfortable doing ultrasounds but were comfortable doing diagnostic peritoneal lavages, would you have performed a diagnostic peritoneal lavage on this patient?

A Working in a level one trauma center, yes, sir.

Q If you had been working in a level two trauma center, would you have done the same thing?

A Not having worked in level twos, I don't know.

Q But level one and level two are supposed to have the same clinical capabilities and expertise available to a patient such as Mr. Colen, correct?

A Exactly.

Q You have had an opportunity to read Dr. Hickey's discovery deposition?

A Yes, sir.

Q Do you know Dr. Hickey?

A No, sir.

Q Have you ever met him?

A Not that I recall.

Q I'm just going to go through because this is the only way I know how to find out what you plan on testifying to at trial. I'm just starting with since he was the first author of an expert report going to go through his criticisms. I presume that you may disagree with some of his criticisms and if you could tell me why and we will go through it that way?

A I may have a different opinion or two, yes, sir.

Q That's fine. I want to know it before I leave here today.

A I understand.

Q The first criticism Dr. Hickey had was that Dr. O'Toole was late responding to the trauma alert and violated hospital rules and procedures. You don't have an opinion on that because you have not looked at the rules and procedures issued by Southwest General Hospital, correct?

A That's correct. I have no reason to believe that he was not notified until 10:15. As I stated earlier, if he was notified at 10:15,

arriving at the time this is documented as 10:38, knowing that could be within two or three minutes by the way ER nurses document, I don't think that's an unreasonable response time.

Q Dr. Hickey then issues a criticism that Dr. O'Toole did not immediately do proper labs, including an eye stat, to determine the hematocrit. Do you disagree with that?

A Absolutely. Hematocrit does not impact on how you manage the patient.

Q Would a hematocrit tell a trauma surgeon whether or not the patient was bleeding?

A No, sir. On arrival, no, sir, because he's bleeding whole blood. So if he's down 70 percent of his blood volume, we put a needle in the vein and pull some blood out, the hematocrit is going to be what it's normally. It's not until we start the active process of resuscitation that we get an index from a subsequent hemoglobin or hematocrit on whether this patient has ongoing blood loss. There's no question in this case that the patient was bleeding.

Q So that's your answer to his criticism?

A I don't think it was a deviation from the

standard of care.

Q Do you agree that it's the trauma surgeon's responsibility to make sure there's blood products available in the trauma unit?

A I'm not sure what you mean by blood products.

Q Well, Dr. Hickey had a criticism that Dr. O'Toole did not have or order adequate blood products to adequately resuscitate Mr. Colen in the trauma unit?

A Well, again, knowing how hospital blood banks and transfusion criteria varied and not seeing the documents for Southwest, I'm going to default to the man got eight units of packed cells in an hour and a half, and that's pretty darn aggressive resuscitation. And that to me reflects a blood bank that was able to answer his needs for blood.

Q Do you believe the resuscitation was adequate in this particular case?

A No.

Q Do you believe the resuscitative effort was adequate in this case?

A I think Dr. O'Toole did as best as he could, yes, sir.

Q Do you think it met the standard of care for what a trauma surgeon should have been able to do in this particular case?

A I think he placed the appropriate lines and he ordered blood and crystalloid in a timely fashion, yes, sir.

Q So you believe his efforts at resuscitation complied with the standard of care in this particular case?

A I see no deviation from the standard of care.

Q Do you have any criticisms that don't rise to the level of a deviation from the standard of care in how Dr. O'Toole resuscitated or attempted to resuscitate this patient?

A No, sir.

Q Dr. Hickey criticizes Dr. O'Toole for failing to diagnostically consider intra-abdominal bleeding by doing a peritoneal lavage or an ultrasound?

A As we have discussed for the last few minutes, I strongly disagree with that criticism for the reasons previously stated.

Q In that it wouldn't have made any

difference?

A Well, again, it's a judgment. Dr. O'Toole was sitting right there. He was concerned about intra-abdominal bleeding, but not to the point that he wanted to do any diagnostic studies.

Q Would there have been any type of drawback in Dr. O'Toole doing a diagnostic study to either rule in or rule out intra-abdominal bleeding?

A Only in that, if it -- as we discussed about the documentation issue, if that would have held him up from getting the patient to the next level of care that he wanted him to get to, yeah, I would have been fearful of that. That would have been the reason not to do it. If he felt it would hold up transfer of the patient to do the DPL, then that would be a deviation from the standard of care.

Q Is there any indication in this particular case that doing a DPL would have held up the transfer of this patient?

A Depends on when we would have done the DPL. If we did the DPL at 11:50, I think it would have held up the transfer.

Q How about if we did the DPL about 10:52 to 11:30?

A No, it would not have held up the transfer, although it may have interrupted Dr. O'Toole's resuscitative efforts.

Q I think we may have partially addressed this, that Dr. Hickey was critical of Dr. O'Toole's inadequate fluid resuscitation regarding the insufficiency of crystalloid as well as the insufficiency of blood products. Do you agree or disagree with that criticism?

A I disagree. Eight units in an hour and a half.

Q Was there adequate crystalloid given?

A To my recollection, it was approximately a couple liters. And depending on the resources available to him, he had a level one. And it's not detailed enough reporting here which lines were used for what. Three liters of lactated Ringers were given. In their documentation at Southwest, it says nine units of blood and three liters of lactated Ringers documented at 12:12 on the patient progress record. What we teach residents is, when patients are bleeding, you give them blood.

Now, textbook, could you be critical? Sure. Am I critical of Dr. O'Toole's resuscitation

in his crystalloid and blood products? No.

Q What would the textbook criticism of Dr. O'Toole be for the level of fluid resuscitation he offered this patient?

MS. NAGEL: Objection. Go ahead.

THE WITNESS: Well, the textbook would say you should give three liters of crystalloid to every unit of packed cells. That's ideal. When it's all said and done, once you have the patient have their bleeding controlled, then you can go ahead and give the crystalloid.

BY MR. CONWAY:

Q Were there any steps taken by Dr. O'Toole to control any bleeding in this patient?

A Well, the only way we control the bleeding from the chest wall is to just keep transfusing the patient. We really don't have any therapeutic interventions there unless they're bleeding into the pleural space.

As we discussed earlier, there was no evidence that he was exsanguinating into the pleural space. It was into the chest wall. With the pelvic fracture, that's a major source of bleeding and there are different measures to take to address the

pelvic bleeding.

Q Did Dr. O'Toole take any of those measures?

A I didn't see, other than transfusion for the ongoing bleeding, that there was any measures taken.

Q Should he have taken some steps to stop the pelvic bleeding?

A Again that will depend on the resources available to him. Should he have put an external fixator on? They may not have the capability at Southwest. That won't prevent them from being a level two trauma center.

Did they have mass triages available? Most hospitals don't have those available in the emergency room. Depending on the resources available to him, it depends on what he could have done to stop the bleeding.

Q Do you have an opinion as to how much -- and I want this quantified if you can. Do you have an opinion as to how much Mr. Colen bled from his pelvic fracture?

A And you want that quantified?

Q If you are able to, Doctor.

A I can't quantify that for you. What I was

doing was reviewing the Medical Examiner's report to see if there was a CBC drawn at the time of the postmortem, which would have shed some light on that question. Recognize that serious pelvic fractures that Mr. Colen sustained are significant cause of death.

Q As to this particular pelvic fracture here, you can't offer an opinion as to the quantity of bleeding that Mr. Colen had from that injury, correct?

A Well, I can quantify it to this degree. If we say that two units of blood were in the pelvis at the time of the medical examiner's review and the patient got nine units, that leaves seven units that were divided between the chest and the pelvis. And that wasn't adequate because he continued to have ongoing hemorrhage. We presume, although we still do not know about the T7 fracture, whether he had an an element of neurogenic shock.

Q So you can't offer an opinion to a reasonable degree of medical probability that he did have neurogenic shock, correct?

A Yes, sir.

Q So your answer would be correct?

A Correct. Keep me honest here.

Q I want you, if you would, to look at Dr. O'Toole's transfer note. There's no indication in that charting by Dr. O'Toole that he considered any internal bleeding, correct?

A No.

Q Correct?

A Correct.

Q Did he note Mr. Colen's rib fractures?

A Yes -- Oh, now, you are going to make me take that back, aren't you?

Q Kind of.

A As he smiles.

Q I'm not smiling.

A No, it does not; but it's clearly documented on the nursing notes.

Q But we are dealing with --

A Dr. O'Toole's note, yes, sir.

Q Right. Would rib fractures be a type of injury that should be able to be diagnosed on a patient like Francis Colen?

A That's an interesting question. And it's going to depend on the patient's body habitus again. The best way to diagnose a rib fracture is point

tenderness along the rib on physical exam. If this man's ribs were grossly displaced, he should be able to palpate that and feel that.

Q How about a chest x-ray?

A We don't get the chest x-rays for the rib fractures. We actually get that for injuries from the rib fractures.

Q Should a trauma surgeon be able to read a chest film, a chest x-ray?

A For acute traumatic injuries, yes.

Q Should the trauma surgeon be able to read a chest x-ray to determine whether or not there's rib fractures?

A Again, the definitive diagnosis of rib fractures made on physical exam. If there's displaced rib fractures, you should be able to see some of them on chest x-ray.

Q Have you looked at any of the x-rays in this case?

A No, sir.

Q Would that have been helpful to you in your review?

A No, sir.

Q Is it the standard of care for a trauma

surgeon to do a history and physical on his patient if at all possible?

A Yes, sir, absolutely.

Q Meaning, if the patient can verbalize responses, the trauma surgeon should take a history and physical from that patient, correct?

A Yes, sir, as well as the nursing staff.

Q Shouldn't the trauma -- after he takes that history and physical, chart the responses to his history and physical of the patient?

A Again, in trauma, it depends on who is charting. When I walk downstairs in this institution and I have a trauma patient, I or my residents are getting a history. They are verbalizing that to the nurse, who is documenting it in their note. So if a patient is stable and I go back and write an H&P, I incorporate those findings into my H&P. If the patient is unstable and you don't have the time to do all of this documentation, I do not feel it's a deviation from the standard of care.

Q Is there any indication in this chart at all as to a history and physical?

A This was the transfer note? To me, this is

the history and physical that Dr. O'Toole put together.

Q Other than that, is there any history and physical by any medical practitioner taken in this case?

A No. The only documentation I have seen is the nursing flow sheets.

Q So there was no -- There's no indication whatsoever that a history and physical was charted by any nurses, correct?

A No, sir.

Q Correct?

A Correct. You have to bear with me. I have been conditioned to yes, sir and no, sir.

Q I gotcha. Dr. O'Toole did not chart any of his procedural notes either, did he?

A No, sir.

Q Do you make sure that different procedures you have done or had done at your direction are charted?

A Ideally, yes, sir. In a purely elective situation, yes, sir.

Q Going to another criticism that Dr. Hickey had, giving sodium bicarbonate IV and starting

vasopressors were an inappropriate way to treat a patient who is hypotensive from volume loss and hemorrhagic shock?

A Again, maybe Dr. O'Toole thought the patient did have an element -- I interpreted it that he thought he did have neurogenic shock and that would be the treatment. Again, if the patient's acid base status pH is below 72, you don't use the bicarb- -- I'm sure this is what Dr. Hickey is critical of. You don't use that to replace the resuscitation, but you do that in addition to the resuscitation to correct a patient's pH so all the catecholamines and enzymes work normally.

Q Let's assume that Dr. O'Toole was not considering the possibility that Francis Colen had any type of neurogenic injury. Given that assumption, would him having given sodium bicarbonate IV and starting vasopressors have been inappropriate in treating Francis Colen?

A For blood pressures as low as 60 and 40? While he's giving blood and crystalloid, I don't think so. What would have been a worse outcome for Mr. Colen is if he infarcted his brain and woke up comatose so we had to harden the lungs preserved and

his brain is not dead because he is hypotensive and he had a massive stroke. That's why you give those vasopressors while you are resuscitating because you can maintain profusion to the vital organs.

Q Is there any indication whatsoever in any of the medical records that Francis Colen was suffering from a deceased mental status at any time while he was at Southwest General Hospital?

A Yes.

Q Why don't you give me the time and your interpretation of his mental status at that time?

A I mean, one of the earliest signs of shock is confusion and agitation. And that's -- There's at least one notation. Here, Glasgow -- At 10:25 -- Forget that. It looks to me like a GCS of 14, but I can't be certain of that. Here's a GCS at 10:45, GCS of 14. That's not normal. That's abnormal.

Q Let me just back up, and then we will go ahead with your next one. What was that time, 10:25?

A 10:45, sir.

Q I'm sorry, I wanted to make certain. We are saying 10:45, he has a Glasgow coma scale of --

A 14.

Q Could that be an indication of hemorrhagic shock?

A That could be an indication of hemorrhagic shock. It could be an indication of drugs. It could be -- Most commonly, it will be an indication of shock. It could also be an indication of an expanding head injury.

Q I'm sorry for cutting in. Go to the next one you see.

A Here's what I would interpret at 10:50: Denies pain, wants rebreather off. He's confused and agitated, which goes along with the shock state. 10:55, alert to time and person but not to place. Again that's an indication that he has compromised profusion to his brain.

And then here at 11:00, they document, continues alert and oriented GCS of 15, which means now we have -- and depending on what the blood pressure is, now we have got profusion to the brain reestablished, that he's cognizant and interacting in a much more reasonable fashion. And 11:20 GCS of 3, those are all standard indications that he's got compromised profusion of his brain.

Q Was Mr. Colen conscious at the time of this

transfer from Southwest General to the Metro Life Flight?

A I'm trying to find out the exact time when the intubation occurred. So at 11:36, approximately one hour after the patient arrives -- well, one hour at the worst that Dr. O'Toole arrives, Life Flight per phone to O'Toole. So there was a conversation had there.

To recognize this constellation of injuries in an hour can get things moving. To transfer him I don't think is below the standard of care. And I'm sure that he was intubated and paralyzed at the time of transfer. So I can't tell you whether he was conscious at the time of transfer.

Q What do you mean by paralyzed?

A Typically, with a patient this critically injured, the flight teams would like to use a paralytic agent so the patient doesn't become combative and possibly injurious to themselves as well as the flight team while transporting the patient by helicopter.

Q Who is supposed to administer that paralytic agent?

A That's typically at the discretion of the flight team.

Q Was there a delay in intubating Francis Colen in this case?

A That's a judgment call. And I don't see any evidence that there was a delay.

Q Would you have intubated him sooner than Dr. O'Toole did?

A Maybe.

Q Should Dr. O'Toole have put in a chest tube?

A Give me one second. I'm still looking for paralytics. It looks to me on the Metro Life Flight at 12:10 a chemical paralysis was given. Okay? Your next question was, should Dr. O'Toole have placed a chest tube?

Q Should Dr. O'Toole have placed a chest tube? Yes.

A Again, if it was not going to hold up the transfer of the patient, yes. Once you intubate and you know you have rib fractures, you are better off to place a chest tube. I don't know the detail of the conversation between the Metro Flight team and Dr. O'Toole, whether they said don't worry about

that, Doc, we will do that in the back of the helicopter.

Q Doctor, if you were treating Francis Colen in this particular case, would you have placed a chest tube?

A I don't know.

Q Going back to a question -- And if you don't know the answer, that's fine, Doctor. Was Mr. Colen conscious at the time that he left the care and treatment of Dr. O'Toole and was turned over to Metro Life Flight?

A I don't see any documentation at Southwest Hospital that will easily answer that question. It looks like he was alert by Metro Life Flight's GCS that they gave him of 9T, which would be indicative that he was responsive and moving around. Can't talk because he has a breathing tube in his mouth.

Q Dr. Hickey was critical of Dr. O'Toole for having this patient transferred from -- Excuse me, strike that. Dr. Hickey was critical of Dr. O'Toole for having this particular patient in this case transferred while he was hemodynamically unstable. What's your reaction to that criticism?

A That's a short and simple criticism. I'm

not that critical because this patient had a tremendous constellation of injuries that Dr. O'Toole was weighing, whether he could address them for this patient or not and whether or not the patient was better served after consultation with the orthopaedic surgeon being transferred five minutes away.

Q If you were the trauma surgeon in this particular case for Francis Colen, would you have transferred Francis Colen while he was hemodynamically unstable?

MS. NAGEL: Objection.

THE WITNESS: Again, having only worked on a level one trauma center, no, I do know not know the way the cycle worked in a level two trauma center.

BY MR. CONWAY:

Q If Francis Colen had come into your level one trauma center and you were his treating physician, you would not have transferred him as Dr. O'Toole did in this case, correct?

A I wouldn't -- There would be no place to transfer him, so I would not transfer him.

Q And you wouldn't transfer a hemodynamically unstable patient like Mr. Colen, correct?

A Depending on the constellation of injuries and what I think is going on with the patient. Sometimes you just don't have an option.

Q There were some open wounds, open fractures in this particular case, correct?

A Yes.

Q You don't have any indication from review of the medical records or depositions as to the quantity of bleeding that took place from those open fractures, correct?

A No, sir.

Q Correct?

A Correct. Off the record for a second.

(Discussion off the record.)

BY MR. CONWAY:

Q Doctor, would you have given antibiotics to Mr. Colen if you had been his treating physician in this case considering his open wounds?

A I only give antibiotics if I think there's an open fracture. We will give Ancef generically; but with a patient as critically injured as Mr. Colen, am I going to be critical that he didn't get a dose of antibiotics when there's a physician and one nurse taking care of him? I would not be

critical of that.

Q But my question was, would you have given antibiotics to Francis Colen had you been his trauma surgeon?

A Probably somewhere along the line, he would have gotten some antibiotics.

Q It's your understanding that, in this particular case, there was only Dr. O'Toole and one nurse rendering care and treatment to this patient?

A Maybe two.

Q Maybe two what?

A Nurses.

Q Isn't it the trauma surgeon's responsibility to ask for assistance if he needs it in treating a trauma patient such as Francis Colen?

A It depends on what his resources are for assistance, yes, sir.

Q If there were anesthesiologists, radiologists, emergency room physicians available as well as additional nurses, should Dr. O'Toole have requested those individuals' assistance?

A In fact, he did. He asked the anesthesiologist to come down and intubate the patient. We already discussed the expertise and the

ability to read the chest x-ray for acute traumatic injuries. So I don't see the need, unless you are really not clear on an issue, to call a radiologist to come help you.

Q Again maybe I'm just misinterpreting your answer. It seemed like you were stating that, in light of the fact that there was only Dr. O'Toole and one nurse working on this patient --

A -- I would not be critical of him.

Q For not doing some of the procedures and steps that Dr. Hickey is critical of him for, right?

A Right.

Q My next question though is, if you in fact think that a trauma surgeon is working shorthanded and he does, in fact, have assistance available, it's that trauma surgeon's responsibility to ask for that assistance, correct?

A Yes, but that doesn't mean he's going to get it. It depends on how busy the emergency room is, if there's another code in a bay next to him, et cetera. It doesn't mean you are going to get the assistance.

Q But you have got to at least ask, right? If you feel shorthanded, you have got to ask for it,

correct?

A Sure, you have got to ask for it.

Q Marked for identification as Exhibit No. 3 --

A Yes, sir.

Q That is your report?

A Yes, sir.

Q And that's the report you issued to Dirk, Riemenschneider, correct?

A Yes.

Q And you have issued these expert witness reports before, correct?

A Yes, sir.

Q And that's a true and fair and accurate copy of your report, correct?

A Exactly.

Q Have you issued any type of supplemental report following your issuing of this report of March 19, 2002?

A A written report? No, sir.

Q I assume you have spoken with Defendant's counsel prior to this deposition, correct?

A Yes, sir.

Q You had an opportunity to prepare for this

deposition with defense counsel, correct?

A Yes.

Q And you have not issued any type of written supplement to this report, right?

A No, sir, that is correct.

Q So I take it it's your opinion that there's no way that Mr. Colen ever would have survived these injuries regardless of what treatment he received, is that your opinion?

A My opinion is as stated. He had a probability of death with his total constellation of injuries and previous cardiac history in excess of 51 percent.

Q Can you define for me better what in excess of 51 percent is?

A As I stated earlier, with his significant chest wall injuries, with his pelvic fracture and the possibility of a T7 fracture, his mortality and coming in in shock, his mortality with the previous CABG is in excess of 80 percent.

Q How did that previous CABG, which is a coronary artery bypass graft, affect his survivability in this particular case?

A Well, he doesn't have a healthy heart. He

has a diseased heart.

Q At least the blood vessels were diseased at one point, correct?

A The blood vessels are, which typically leads to underlying myocardial issues.

Q Are there any of those underlying myocardial issues in this particular case?

A Other than that very history puts him at an increased risk, no.

Q But you are looking at the autopsy protocol. And from the autopsy protocol, is there any indication of any other type of cardiac type condition?

A No, sir, but there is an area of fibrosis, which is -- that is transmural consistent with a previous heart attack.

Q Which probably was what led to him having the coronary artery bypass graft, right?

A Right, but that in and of itself supports the interpretation that he is at increased risk because he's had a previous heart attack.

Q You have treated trauma patients who come through your trauma unit who have had coronary artery bypass grafts following heart attacks,

correct?

A Yes, sir.

Q And those kind of patients do, on occasion, survive, correct, the trauma?

A On occasion, yes, sir. And just as frequently, they expire.

Q You have had an opportunity to read Dr. O'Toole's depo?

A Yes, sir.

Q Dr. Panigutti's depo?

A Beth and I were talking about that this morning. Let me just make sure for the record. Dr. Panigutti was the orthopaedic surgeon?

Q Correct.

A I'm not sure that I read through that since I'm not an orthopaedic surgeon.

Q Were you asked not to read through that?

A No, sir, not at all. That was my choice.

Q Can I see real quick your file?

A Absolutely.

Q I will just go through and list what I see that's contained in your file. It will probably be quicker to do it this way.

Theresa Murphy's deposition. There is

no writing or highlighting in it.

Carol Lee Mone, M-o-n-e, RN's deposition. There is no writing or highlighting in it.

The deposition of Elizabeth Colen, no writing or highlighting in it.

Office records of Dr. O'Toole, which I think are basically the Southwest General Hospital chart, correct, Doctor?

A I know I didn't look at that.

Q You did not look at --

A Dr. O'Toole's office records, no, sir.

Q Well, I think by office records --

A But that document labeled Office Records I did not look at. There's a separate copy of the Southwest Medical records as there's a separate binder of Metro Health.

Q Okay.

A This was compiled by Mr. Riemenschneider's office and sent to you, right? There's a cover letter, March 5th, 2002, which was sent to you by Dirk Riemenschneider in which there's some writing on that.

A Yes, sir.

Q And what does the writing at the top say?

A You can't read my writing, sir? It has 3-16, which would have been March 16th, meaning that I spent three hours reviewing these documents. Directly below that is Dr. Riemenschneider's E-Mail address.

Q Dirk Riemenschneider's, not doctor.

A Thank you. I'm promoting him as the morning goes on.

And I don't recall sending any E-Mails. It doesn't mean I haven't, but I don't recall it. And then at the very bottom of the letter I have in quotes, "More likely than not, he would succumb to his injuries."

Q Do you know when you did all this writing on this particular letter?

A The exact date, no, sir.

MR. CONWAY: Can we have this marked as number 4?

(Exhibit No. 4
marked as requested.)

BY MR. CONWAY:

Q Then we have a deposition from Dr. Reisinger, D.O. And there is some highlighting

in this one.

MS. NAGEL: Can I just clarify, he was the Life Flight doctor?

MR. CONWAY: Right, right.

BY MR. CONWAY:

Q There is highlighting. And I will run through this real quick because we are not going to make copies of your stuff for you. Transcript page 30, lines 2, 6, 7, 8, 15, 16, 17, 18, 19; highlighting page 31, lines 2, 3, 4, 9, 15, 16, 17, 18; page 32, highlighted lines 1 through 7; page 49, highlighted lines 12 through 22; highlighted lines on page 52 are 3 through 5; highlighted lines on page 55 are 20, 21, 22 and 25.

And page 58, highlighted lines are 4 through 7. On page 61, highlighted lines are 12 through 16. On page 72, highlighted lines are -- page 72, highlighted lines are lines 5 through 8 and 11; page 75, lines 14 through 16.

Did I accurately state them?

A Yes. I can't see that far away.

Q You can go back and review it if you want. We have the deposition of Dr. O'Toole, in which highlighting wasn't done but various items were

circled. And I will just read the pages and lines of the circled items.

Page 11, lines 23 through 25; Page 12, lines 15 through 16; 20 through 22 -- excuse me, 20 through 21 and 23; page 14, 17 through 20; Page 15, 12 through 13 and 16 through 19; page 16, 1 through 4; page 20, 6 through 11 and 24 through 25; page 22, 18 through 23.

And I correctly stated those, right, Doctor?

A Yes.

Q By the way, was there a delay in starting -- was there a delay in starting to administer blood products to Mr. Colen?

A Not that I could detect from the record.

Q Would you have started giving him blood products quicker than he was in this case?

A Again, that's a judgment issue where you have to be at the patient's bedside evaluating the patient and their responses to the therapeutic interventions you are doing. So I can't render an opinion.

Q How about starting crystalloid infusion for Mr. Colen? Should it have been started sooner than

it was in this case?

A I don't know.

Q Now we have got also part of your file is your report of March 19th. We also have a deposition from Dr. Hickey in which page 30 is dog eared. And you have a note written by lines 19 and 22. "Did he respond any other way? By phone?" Correct?

A Right.

Q We have no indication that he responded to the trauma alert by phone, correct?

A Not that I have seen today, no, sir.

Q Dr. Panigutti's deposition is here. And it's your testimony that you did not review Dr. Panigutti's --

A I don't recall looking at it.

Q This was sent to you by Dirk Riemenschneider's paralegal on July 8, 2002, correct?

A Yes, sir.

Q Dr. Bruce Janiak's deposition, did you have an opportunity to review his discovery deposition? He's the emergency medicine expert from Toledo?

A Off the top of my head, I don't recall.

Q Do you know Dr. Janiak?
A No, sir.
Q Have you ever heard of Dr. Janiak?
A No, sir.
Q We have got the autopsy protocol --
A Yes, sir.
Q -- in which you have highlighted on page 2 of the autopsy protocol numbers 8, 9, part of 10 and 3.
A Is that a new paragraph?
Q Let's start this over. It will never make sense.

Doctor, I'm reading the autopsy protocol that's been submitted to you. And you have highlighted on page 2 the section in the autopsy protocol that pertains to the rib fractures, the fracture of the body of the seventh thoracic vertebrae and the multiple pelvic fractures, correct?

A Right. It's under section Trunk paragraphs 8, 9 and 10.
Q And then going down the left, upper extremity, you have number 3 highlighted, fracture of the proximal radius and ulna?

A Correct.

Q Then on page 3, you have right lower extremity highlighted open laceration exposing the subcutaneous tissue with fracture of the distal femur and, number 3, multiple fracture of the distal tibia and fibula, correct?

A Yes.

Q And then on page 4, you have the myocardium is of normal consistency and appearance except for an area of fibrosis 1.5 by 1.5 by 1.0 centimeters that is transmural, correct?

A Yes.

Q And then under microscopic description, adrenal gland, you have periadrenal hemorrhage?

A Highlighted, yes, sir.

Q What's the significance of that to you, Doctor?

A Just another sign of the intense truncal forces that his body sustained.

Q Is the adrenal gland located close to the spleen?

A On the left side, yes. It sits right on top of the left kidney up under the ribs.

Q Then we have the Southwest General Hospital

notes, correct, the chart? And I don't see any highlighting in this, correct?

A Correct.

Q And then we have the Metro Health records including the Life Flight records. And I don't see any highlighting in those, correct?

A Right. That's just confirming the deposition today.

Q I don't see any written notes -- I don't see any written notes you have made in this case, am I correct in that?

A Other than my report of March 5th -- I'm sorry, when was my report? The 19th? March 19th.

Q Doctor, did you make notes in connection with your exhaustive review of this matter and discard those notes at any time?

A No, sir.

Q You didn't find it necessary to make any notes in connection with your review of this case?

A No, sir.

Q Did you know Dirk Riemenschneider prior to this case? Strike that, let me go back. Have I described for the record your entire file?

A Yes, sir.

Q What we can do on this one is she can make a copy of that and we can get it back to you. That's Exhibit No. 4, I think?

A Yes, sir, correct.

Q Did you know Dirk Riemenschneider prior to this case, your review of this case?

A I'm not sure. I'm going to say maybe there may be another case that I'm helping him on, but I'm not certain.

Q And that other case may be going on right now?

A I don't recall off the top of my head. I can't stay up with the legal court system. All I know is they drag on and on and on.

Q Is there a case that you have reviewed for Dirk in addition to this case that you don't know the status of? Is that a better way of putting it?

A There may be.

Q How would you find that out?

A I'd have to go through my office files.

Q But that's something you could find out?

A Or I could call counsel and ask him directly.

Q Because if you are doing something, there

may be a report deadline?

A Right.

Q But that's something you could find out?

A Yes, sir.

Q Prior to this case and this other possible case, had you done any expert review work for Dirk Riemenschneider?

A No, sir.

Q For the law firm of Buckingham, Doolittle?

A Not that I'm aware of, no, sir.

Q For Ron Wilt?

A No, sir.

Q For the law firm of Jacobson, Menard, Tuschman & Kalur?

A Where are they based out of?

Q They were -- Were you ever -- Strike that. Were you ever insured by PIE Insurance?

A Not to my knowledge. Cincinnati had their own malpractice insurance company.

Q Where you were at?

A Yes, sir.

Q Did you ever do any expert witness work then for the law firm of Jacobsen, Menard, Tuschman & Kalur which was located in Cincinnati or

with their office located in Kentucky?

A I don't recall off the top of my head; but you have to understand that I don't pay real close attention to the overall law firm and the members of that law firm. And I apologize for not being so diligent to that detail, but I just don't.

Q What about Ron Wilt?

A I don't know that name.

Q You do expert witness reviews, correct?

A Yes, sir.

Q Could you give me a breakdown of the percentage you do for hospitals and doctors?

A Beth and I were talking about it earlier this morning, and I don't have accurate counting of who the legal firm was representing. I do -- I'm involved with a legal firm from Dayton, Ohio on a couple of cases where they were representing hospitals and residents. I have been involved with litigation for defendants as well as plaintiffs.

Q What's the ratio? What's the breakdown?

A I can't tell you an exact number.

Q Can you give me an approximation?

A You got a coin? It's fifty/fifty.

Q How many cases right now do you have --

A Active? There's probably five or six.

Q In those particular cases, how many are for the plaintiff and how many are for a doctor or hospital?

A I'd have to say the majority, with the clear definition of majority over fifty percent, for the defendant or a hospital.

Q Would all six of them be for the defendant or hospital?

A There's maybe one for plaintiff, but I don't even think that.

Q So it's probably six for the defense?

A Right.

Q Which would be the hospital or the doctor, correct?

A Right.

Q How much do you charge per hour for review?

A At the time this contract was made, it was 350 an hour for record review, $500 an hour for depos with a $1500 retainer in advance. And the same I think --

Q Which our office is responsible for paying or reimbursing?

A Right. And the same is for trial

deposition or trial testimony.

Q What is your rate going to be for trial?

A It will be the same, whatever we agreed to back in the spring.

Q Is that 350?

MS. NAGEL: Same as for depo.

THE WITNESS: Right.

MR. CONWAY: $500 an hour.

THE WITNESS: And $1500 retainer in advance. And the time starts typically if I have got to come to Cleveland.

BY MR. CONWAY:

Q You have indicated you don't know Dr. Bruce Janiak; nor do you know Dr. Michael Hickey, correct?

A Not to my knowledge.

Q Do you know Dr. Bruce Browner?

A Not to my knowledge.

Q Did you read any of the expert witness reports in this case?

A Other than what we just covered?

Q Well, yeah. I covered some things here, but those were depositions. Were you ever able to review Dr. Hickey's expert witness report?

A I think it's attached to the deposition.

Q But prior to the deposition?
A No, sir, no, sir.
Q You weren't furnished with that?
A No, sir.
Q How about Dr. Janiak's expert witness report?
A No, sir.
Q How about Dr. Browner's?
A No, sir.
Q So I take it you reviewed no expert witness reports other than Dr. Hickey's or Janiak's as they may have been attached to their deposition?
A Precisely.
Q I take it you have no criticism of the nurses at Southwest General Hospital, am I correct?
A No, sir.
Q Correct?
A Correct.
Q You don't have any criticisms of Dr. Panigutti?
A Not at this point, right.
Q Well, you have had an opportunity to read the whole file basically. You have had that opportunity, and you do not have a criticism of him,

correct?

A As of this time, I haven't reviewed his deposition. If I'm asked to review it in the future, my opinion might change.

Q You have had expert witness depositions taken before, right, Doctor?

A Yes, sir.

Q Approximately how many times have you been deposed?

A I'd say a dozen.

Q Have you testified live in trial?

A A few times, three or four.

Q Have you testified in Ohio at all?

A No, sir.

Q Well, as I indicated when we started this depo, as I'm sure you are familiar with, this is my only time that I get an opportunity to find out what your opinions are on everything.

A And I have stated my opinions true to fact today.

Q But I have a bit of a problem with Dr. Panigutti's deposition not having been read by you and you kind of holding back as to whether or not you have a criticism or not?

A He was the orthopaedic consultant.

Q Correct.

A I will not have an opinion.

Q So you will obviously not be critical of Dr. Panigutti, correct?

A No, sir.

Q Correct?

A Correct.

Q Do you have a criticism of any of the Metro Health physicians, whether at their Emergency Department or the Life Flight physicians?

A No, sir.

Q Do you have any criticism of the EMS technicians who took --

A No, sir.

Q Do you have any -- Let me just finish this sentence. Do you have any criticism of the EMS physicians who took Mr. Colen from the accident to the hospital?

A No, sir.

Q And I take it you don't have any criticism of any of the hospital employees and/or technicians, correct?

A No, sir.

Q Correct?

A Correct. Can we go off the record for a second so I can answer a page?

Q Sure, go ahead, Doctor.

(Discussion off the record.)

BY MR. CONWAY:

Q Approximately how many hours of work did you put in on this case reviewing, reviewing it, formulating your report, preparing for the deposition just approximately?

A Six.

MR. CONWAY: We can go off the record for a minute.

(Discussion off the record.)

MR. CONWAY: Back on the record.

BY MR. CONWAY:

Q So how many hours?

A About six, six or seven.

Q Doctor, have you ever had your license suspended or revoked?

A No, sir.

Q Have you ever had any type of disciplinary action taken against you by a hospital or a licensing board?

A No, sir.

Q Have you ever had hospital privileges suspended or revoked?

A No, sir.

Q Were you board certified on your first attempt?

A Yes, sir.

Q Have you ever been sued?

A Yes, sir.

Q Approximately how many times have you been sued for medical practice?

MS. NAGEL: Objection.

THE WITNESS: That I really don't keep track of. It's got to be around 12, 15.

BY MR. CONWAY:

Q Have there ever been occasions where money has been paid out on behalf of cases which you have been involved in?

A There was one settlement for $2500 with no liability.

Q Any other cases where you have had money paid out on behalf of you or your group?

MS. NAGEL: Continuing objection to all of this.

THE WITNESS: No, sir.

BY MR. CONWAY:

Q Do you have any outstanding medical malpractice cases?

A Active litigation? Yes.

Q How many?

A You got to have a score card to keep track of it. I really couldn't tell you exactly. Seems like there must be around six floating around. The courts, when they get dismissed, they never notify you. You call in a couple years to find out, oh, yeah, that was dismissed. So I can't give you an accurate number.

Q It could be six currently outstanding against you?

A Could be, sure.

Q Are we in Cook County?

A I think we are technically in DuPage.

Q And the hospital where you practice is right here at Loyola, correct?

A Yes, sir.

Q Do you ever go downtown?

A No, sir.

Q So any cases that would be filed against you would be in DuPage County, correct?

A Yes, sir. And to answer the question, I don't have any pending litigation in DuPage County. I have only been here a year. I used to be in Cincinnati.

Q So you could have pending cases back in Hamilton County?

A Yes, sir.

Q Why did you leave Cincinnati and come here?

A This was a great professional opportunity in a great Department of Surgery and I couldn't get my professional needs met at Cincinnati, so I decided to relocate to Loyola.

Q At Cincinnati, was that a level one or a level two trauma center?

A Level one.

Q Have you ever worked in a level two trauma center?

A No, sir.

Q Have you ever testified before in a case involving a level two trauma center?

A I testified in a case in Ohio where there was a transfer from a level one to a level one at the family's request. I don't recall -- There may be other level twos, but I don't recall.

Q So you can't --

A I can't say with certainty.

Q That you have ever been involved in a case that involved a level two trauma center, correct?

A That is correct.

MR. CONWAY: Doctor, thank you very much. I have no further questions. You obviously have the right to read this transcript and review the stenography that took place if you want to avail yourself of that right.

MS. NAGEL: Sure, if you will, that be would would be great.

MR. CONWAY: That's it.

(Whereupon, at 1:30 p.m., signature having been reserved, the deposition ceased.)

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)

I, NANCY MORAN-BRODERICK, Certified Shorthand Reporter No. 84-002116, Registered Professional Reporter and Notary Public in and for the County of Cook, State of Illinois, do hereby certify that previous to the commencement of the examination, said witness was duly sworn by me to testify the truth; that the said deposition was taken at the time and place aforesaid; that the testimony given by said witness was reduced to writing by means of shorthand and thereafter transcribed into typewritten form; and that the foregoing is a true, correct, and complete transcript of my shorthand notes so taken as aforesaid.

I further certify that there were present at the taking of the said deposition the persons and parties as indicated on the appearance page made a part of this deposition.

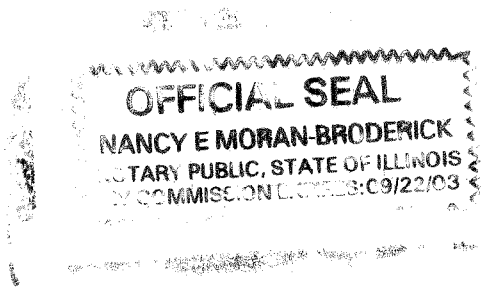
I further certify that I am not counsel for nor in any way related to any of the parties to this suit, nor am I in any way interested

in the outcome thereof.

I further certify that this certificate applies to the original signed IN BLUE and certified transcripts only. I assume no responsibility for the accuracy of any reproduced copies not made under my control or direction.

IN TESTIMONY WHEREOF I have hereunto set my hand and affixed my notarial seal this 24th day of January, A.D., 2003.

Nancy Moran-Broderick, CSR, RPR, CRR



My Commission Expires
May 31, 2003.

SOUTHWEST GENERAL HEALTH CENTER

PROGRESS NOTES

COLEN, FRANCIS T
1363322 EMER 729834
M W . 04/14/34 64Y
GRABER, THOMAS W
GRABER, THOMAS W

Date	Each Note to be Signed by Physician
8/10/98 noon	Trauma Staff 70 yo ♂ Emergency trauma multiple pelvic fx open ① elbow fx ② tib/fib fx remains hypotensive despite ≥ 8 units PRBC intubated art line / CVP & Foley introduced placed Pt. transfer to metro - ortho surgery here & recommend transfer to metro GTR

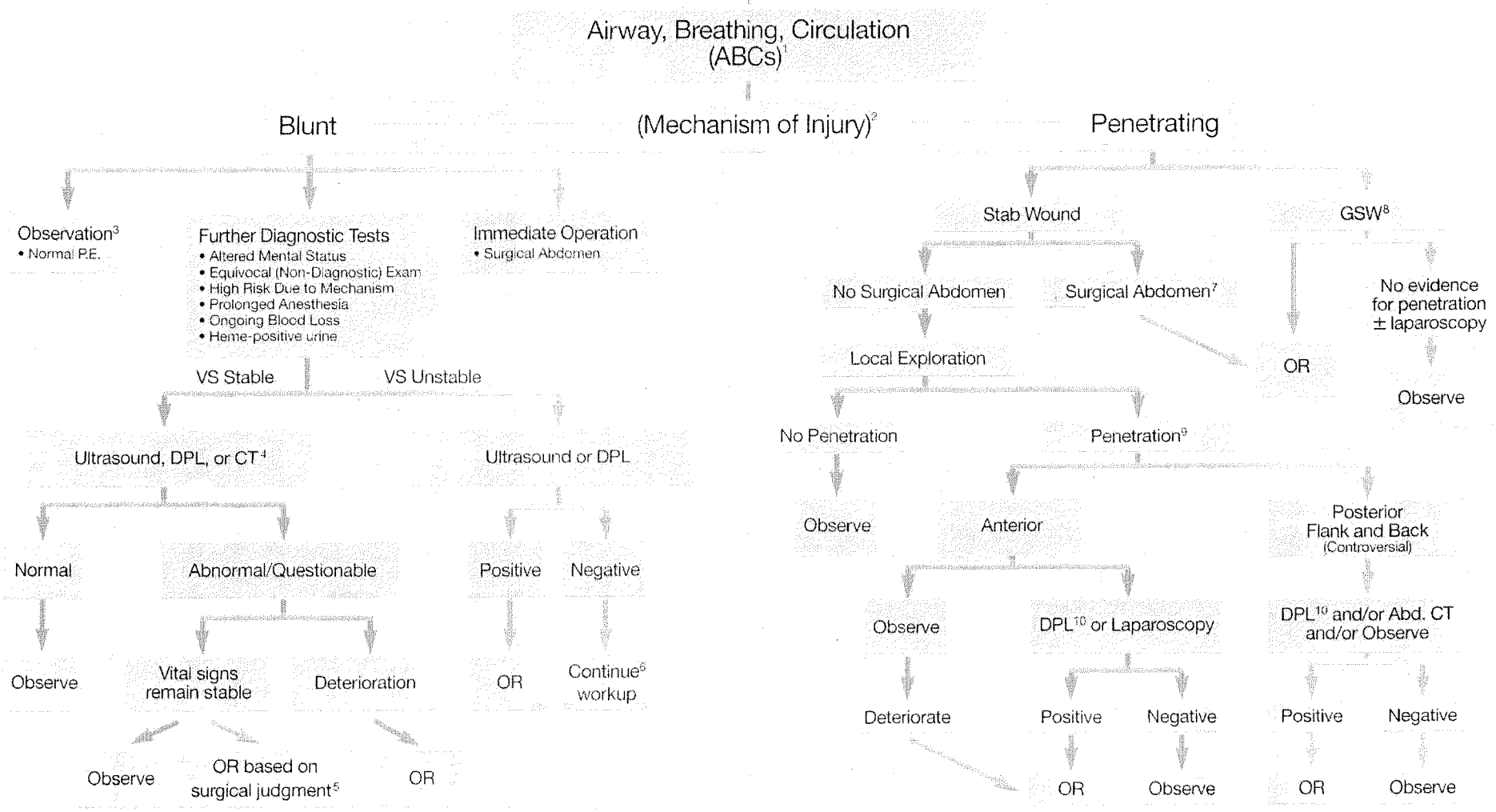
EXHIBIT 16
Lid.
1-20-03

Evaluation of Abdominal Trauma

American College of Surgeons
Committee on Trauma
February 1995

Evaluation of Abdominal Trauma

Ronald V. Maier, MD, FACS



1. ABCs as defined by ATLS®
2. Utilize prehospital EMS history and assessment.
3. No other injuries or drugs that confuse or cloud physical exam.
4. CT with GI and IV contrast. CT preferred to IVP to evaluate hematuria.
5. Intra-abdominal fluid (not blood density), bowel wall thickening, peripancreatic fluid, or blood without solid organ injury.
6. Emergent angiography, particularly with pelvic fracture.
7. Peritonitis, hypotension, evisceration, and so on.
8. Low-velocity superficial tangential wounds without fascial penetration may be observed.
9. Penetration includes either peritoneum and/or fascia; decision controversial.
10. Debate over level of positive RBC count (>1,000 to >100,000). Laparoscopy or ultrasound may be used in selected cases.

EXHIBIT 11
2B
1-20-23

Chicago's Jesuit University

LOYOLA UNIVERSITY CHICAGO

Fred A. Luchette, M.D., FACS, FCCM
Professor of Surgery
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LOYOLA UNIVERSITY MEDICAL CENTER

March 19, 2002

EXHIBIT 13
3/id.
1-30-03

Dirk Riemenschneider
Attorney at Law
Buckingham, Doolittle & Burroughs, LLP
1375 E. 9th Street, Suite 1700
Cleveland, OH 44114

Re: E/O Francis T. Colen, Jr. vs. William Reisinger, D.O., et al.
File: #42568-0049

Dear Mr. Riemenschneider,

I am responding to your correspondence dated March 5, 2002 regarding the above litigation. I have had the opportunity to review the following records:

1. Office records of John M. O'Toole, M.D.
2. Medical Records of Southwest General Hospital
3. Medical Records of MetroHealth Medical Center
4. Seven (7) x-rays from Southwest General Hospital
5. Deposition Transcript of John O'Toole, M.D.
6. Autopsy Report, Coroner's Verdict and Toxicology Results from The Cuyahoga County Coroner's office.

I have also enclosed with this report a copy of my fee schedule and CV.

Let me briefly summarize the documents you asked me to review and then render an opinion.

On August 10, 1999 at approximately 10:30 a.m. Mr. Frank Colen was involved in a motor vehicle crash. He was a 62 year old driver in a frontal impact. The emergency medical documents state that he was unrestrained and required a prolonged extrication time. He was subsequently transported by the Brook Park Fire Department to Southwest General Hospital and admitted to the Emergency Room. On arrival, he was hypotensive and the trauma staff notification system was activated.
Dr. John O'Toole was the trauma surgeon on call and arrived at approximately 10:30 a.m. Mr. Colen sustained multiple injuries including long bone fractures, bilateral rib fractures and a pelvic fracture. His past medical history was significant for previous CABG. Despite aggressive resuscitation by Dr. O'Toole, including transfusion of seven units of packed cells and 3 liters of crystalloid, the patient remained hemodynamically

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unstable and at approximately Noon he was transported to MetroHealth Hospital by helicopter for further care.

On arrival at Metrohealth, the patient was in extremis and arrested. Despite open cardiac massage and pharmacologic therapy, he expired at approximately 12:30 p.m.

The autopsy report identified the above noted injuries as well as a T-7 vertebral body fracture and a ruptured spleen with approximately 800 ccs of hemoperitoneum. The cause of death is listed as blunt impact to head, trunk and extremities with skeletal and visceral injuries following a pickup truck vs. auto accident.

This gentleman received excellent care at Southwest General Hospital. Dr. O'Toole was clearly concerned about an intra-abdominal injury and because of the overall constellation of injuries, he elected not to do a DPL but rather transfer the patient to a Level I Center for further management. It was Dr. O'Toole's opinion that the patient was hemodynamically stable enough to tolerate a brief air transport to the receiving facility. I see nothing in the medical records to suggest that Dr. O'Toole was in error. Although the patient was hemodynamically labile, it was Dr. O'Toole's opinion that the patient was stable. This is a clinical judgment that can only be rendered at the time of caring for the patient at the bedside.

The patient's multiple injuries, and his previous cardiac history would place him in a significantly high risk group for succumbing to his injuries. I would predict his probability of death with his total constellation of injuries and previous cardiac history, as in excess of 51%.

Thank you for the opportunity to render an opinion on this patient's care. Please do not hesitate to contact me if you should have any further questions.

Sincerely,

Fred A. Luchette, MD

FAL/ck
Enclosures

BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP
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Canton
Cleveland
Columbus

VIA OVERNIGHT MAIL

March 5, 2002

3/16 3 hours

Driemenschneider@bdblaw.com

Fred Luchette, M.D.
Loyola University Medical Center
Department of Surgery
2160 South First Avenue
Maywood, IL 60153

RE: ***E/O Francis T. Colen, Jr. v. William Reisinger, D.O., et al.***
Our File No.: 42568-0049

Dear Dr. Luchette:

On behalf of my client, John M. O'Toole M.D., I appreciate your willingness to review this case. Enclosed for your review are the following:

a) Office records of John M. O'Toole, M.D.;
b) Medical Records of Southwest General Hospital;
c) Medical Records of MetroHealth Medical Center;
d) Seven (7) x-rays from Southwest General Hospital;
e) Deposition Transcript of John O'Toole, M.D.; and
f) The Autopsy Report, Coroner's Verdict and Toxicology Results from the Cuyahoga County Coroner's office.

Should you find that you require additional medical records, or have any questions, please do not hesitate to contact me.

When you have had a chance to complete your analysis, please telephone me so that we can discuss your findings. I will need a written report by **March 21, 2002.**

Additionally, please provide to me, at your earliest convenience, a copy of your Curriculum Vitae as well as your fee schedule.

Thank you for your assistance in this matter. I look forward to hearing from you in the not too distant future.

Very truly yours,

Dirk E. Riemenschneider /kc

Dirk E. Riemenschneider
DER/kc
Encls.
«CL2:142773_1»

"more likely than not he would succumb to his injuries"

EXHIBIT 13
1-2003

STATE OF ILLINOIS)

COUNTY OF C O O K)

Judith Munnich, on behalf of VICTORIA COURT REPORTING SERVICE, INC.; being first duly sworn, deposes and says that she is an employee othe appropriate f VICTORIA COURT REPORTING SERVICE, INC.;

That the deposition of Frederick Luchette (hereinafter referred to as "The Witness") was taken on January 20, 2003, in the matter of Estate of Francis T. Colen, Jr., et al., vs. William Reisinger, D.O., et al.,;

That on January 29, 2003, a notice was sent requesting that The Witness come to our office to review the transcript and sign the signature pages and errata sheets within thirty days (see attached);

That by the expiration of said thirty days, The Witness had failed to appear or make alternate arrangements for signature of the transcribed deposition;

That due to the above-mentioned circumstances, the attached deposition of Frederick Luchette is hereby completed under the provisions of the appropriate Rule of Court pertaining to the taking of depositions, and is deemed completed and "used as fully as though signed".

VICTORIA COURT REPORTING SERVICE, INC.

Judith Munnich, Production Manager

SUBSCRIBED AND SWORN TO

by me this 7 day

of November 2003.

NOTARY PUBLIC

OFFICIAL SEAL
PAMELA S. ZALLIS
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 4-23-2005