THE STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

Doc. 286

IN THE COURT OF COMMON PLEAS

ALAN DEAN FAZEKAS, etc.,)
)
Plaintiffs)
)
vs.) Case No. 188572
)
AMERITRUST COMPANY, NA,) Richard McMonagle
)
Defendant.)

- - -

DEPOSITION OF ALAN MARKOWITZ, M.D.

TUESDAY, APRIL 2, 1991

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Deposition of ALAN MARKOWITZ, M.D., a witness called for examination by the Defendant under the Ohio Rules of Civil Procedure, taken before me, Richard G. DelMonico, a Professional Reporter and Notary Public within and for the State of Ohio, pursuant to notice at Mt. Sinai Medical Center, Cleveland, Ohio, commencing at 4:35 p.m., the day and date above set forth.

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Richard G. DelMonico
Morse, Gantverg & Hodge

APPEARANCES:

On behalf of the Plaintiffs:

J. MICHAEL MONTELEONE, ESQ.
Jeffries, Kube & Monteleone Co., LPA
1650 Midland Building
Cleveland, Ohio 44115-1027

On behalf of the Defendant:

BURT J. FULTON, ESQ. and
LYNN MOORE, ESQ.
Gallagher, Sharp, Fulton & Norman
7th Floor - Bulkley Building
Cleveland, Ohio 44115

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MR. MONTELEONE: Before we go on the record, let's get this understanding on the record.

Burt is going to do the direct. Examination of Br. Markowitz at this time for use at trial. And because I have a plane that I have to catch at 6:30, the understanding between Burt and myself is that I will cross examine Dr. Markowitz at a later time. And if necessary, if we can't get the doctor sometime between now and April 22nd, we'll have to both move for a continuance. And the secondary or the cross examination will also be at the expense of Burt Fulton.

MR. FULTON: Did you get a copy of my letter that I wrote to you?

MR. MONTELEONE: No, I didn't.

Is that correct what I said?

MR. FULTON: Yes. Did you get a copy of my letter that was hand delivered to you that was sent to

the judge?

MR. MONTELEONE: No. You were going to see me today, what would you hand deliver it to the judge for?

MR. FULTON: so I eould ask him to pass the case so I could take care of your social life.

MR. MONTELEONE: I did, thank you.

ALAN MARKOWITZ, M.D.

of lawful age, called as a witness by the Defendant, pursuant to the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATIQN

BY MR. FULTON:

Q. Doctor, would you please state your name sir?

A. Alan Narkowitz.

Q. And would you give us a little bit of your background, just your premedical education and your medical education?

A. I attended the University of Rochester and

graduated in 1965. I graduated Albany Medical College in 1970, and then trained in general and eardiothoraeie surgery at University Hospitals, Cleveland, finishing in *1978.*

Q. You are Board certified in what areas, doctor?

A. In thoracic surgery,

Q. And also as well as surgery itself? You're first certified in surgery and then thoracic surgery?

A. Yes, it's a --

Q. Combined?

A. -- condition. In other words, for you to sit for your Boards in thoracic surgery you have to be certified in general surgery.

Q. And you have gone through both of those?

A. Yes, including recertification in thoracic surgery.

Q. Would you explain to the court and jury what thoracic surgery is?

A. Surgery of the chest and it's contents.

Q. That includes the chest as well as the heart?

A. It's the heart, lungs, esophagus, diaphragm,

chest wall.

Q. Now we have here a copy of your curriculum vitae, is that it, sir?

A. Yes.

Q. All right. If we could hand that to the court reporter so he can mark it as an exhibit.

Is that current to date?

A. Yes.

MR. FULTON: All right. Would you mark that as Exhibit 1.

(Defendant's Deposition Exhibit 1 was marked for identification by the reporter.)

Q. Now doctor, you may refer to your report.

Did there come a time back in 1990 when I asked you to review certain records regarding the hospital records of Jaquelyn Quaal?

A. Yes.

Q. And certain records were forwarded to you, is that not true?

A. Yes.

Q. And would you tell us what records you reviewed as you -- you can look at your

report there.

A. Sure. I reviewed the hospital record of Jaquelyn Quaal and Dr. Liu's deposition, and the witness, the expert witness's report of I think it was Dr. Kaufer, K-A-U-F-E-R.

Q. And did I ask you to review these records to make a determination as to whether or not the surgery that was undertaken by Dr. Medina was in keeping with the standards of the medical practice?

A. Yes.

Q. And did you come to certain opinions regarding Dr. Medina's conduct in the surgery after reviewing these records?

A. Pes.

Q. And were these opinions based upon reasonable medical certainty and probability?

A. Yes.

Q. And in your report, doctor, you have set forth five numbered paragraphs, have you not?

A. Yes.

Q. Now I would like to ask you -- and again we are asking all these questions through 1, 2,

3, 4, and 5. Each of these opinions was again based upon reasonable medical certainty and probability, is that not true?

A. Yes.

Q. Based upon your expertise in the area of thoracic surgery and your training and participation in this area, right?

A. That's correct.

Q. And doctor, is one hundred percent of your business -- profession, I really should say -- spent in the area of thoracic surgery?

A. Yes.

Q. Now, with respect to opinion Number 1, what conclusion did you come to?

MR. MONTELEONE: Objection to the question.

Q. Go ahead.

MR. MONTELEONE: I object to the form of the question, Mr. Fulton, just to make certain that you have time to correct it.

MR. FULTON: All right.

Q. You came to these conclusion numbered number one through five, did you not?

A. Yes.
Q. And what was your conclusion with respect to to what is set forth in Number 1?
MR. MONTELEONE: Same objection as to the form of the question.
MR. FULTON: Okay. Go ahead.
A. Well, I reiterated that she had a history of aleohol ingestion. She was found to have extensive hepatic cirrhosis at autopsy, in addition to an enlarged spleen. And her admission to Richmond Heights Hospital was for pain on inspiration and palpation in the region of the left anterior and lateral ribs. She also had a history of multiple falls. And that the combination of those makes one seriously wonder about her history as an alcoholic.

I certainly can't deny that having had previous intestinal bypass surgery that that may contribute to her liver status, but it all points to one's concern about her own host resistance and her own ability to make the proper levels of clotting factors.

MR. MONTELEONE: Show a motion to strike the entirety of the

doctor's answer as being irrelevant and prejudicial. And further based upon an improper question by Mr. Fulton.

Q. Okay. And did you make a determination from the records regarding the condition of her spleen?

A. At autopsy it was discovered that she had a significantly enlarged spleen and that's the basis of that conclusion.

Q. And again with respect to your statements, based upon responsible medical certainty as to the condition of her liver and the cirrhosis, was this based upon a review of the records that you had of Mrs. Quaal?

A. Yes, that was described in the autopsy findings.

Q. Now, did you review the records to determine just what her problems were in her lungs or what they were attempting to do there at the hospital?

A. I did.

Q. All right. And what did you find from the records, sir?

A. Well, to try to reconstruct what happened to

Mrs. Quaal, I believe that she had one or more falls at home which resulted in multiple fractured ribs; also resulted in perhaps some underlying lung contusion and/or the accumulation of blood in the plural space. And that this -- the natural tendency is to try and absorb this material and heal any kind of contused lung. And that this became a trapped lung by virtue of a hsmothorax that was not drained.

Q. What in lay terms is a trapped lung? Can you explain that to the court and jury?

A. Sure. A lung normally fills the entire expanse of it's half of a chest. And as you inhale the left diaghragm descends and draws air into the lung and allows its surface to come up and abut against the left chest wall.

If you have some kind of foreign material between the lung and the chest wall it will actually create two problems.

One, it may prevent the full excursion of the diaphragm; and two, it will prevent the full expansion of the lungs, which you can't use the lung properly. If it involves

just a small area of lung, then it is not a particular problem. If it inwolves the entire lung or half of one lung, it can be a significant problem especially in someone that may have compromised pulmonary functions to begin with.

Q. From your review of the records, doctor, and again based upon reasonable medical certainty and probability, what did Dr. Medina believe was her problem, or what were they looking for when they started this surgical procedure?

MR. MONTELEONE: Show an objection to what the doctor believed.

Q. From the records, what you could see from them?

A. Well, they were concerned about what this abnormality in her chest x-ray was in the presence of multiple fractured ribs and something in the plural space. They entertained that there may have been some form of malignancy.

She had an exploration based upon that, but also with the idea that the lung may

have been trapped, and that by freeing up this lung they may well have been able to improve her pulmonary functions.

Q. As part of your review of these records, doctor --

A. Excuse me, could we go off the record?

MR. MONTELEONE: Sure.

(Brief interruption.)

(Off the record.)

Q. You did have a chance in reviewing these records to review the notes made in the chart prior to the operation as well as after the operation, is that not true?

A. Correct.

Q. And you had a chance to review the records to give us an opinion whether you thought the procedures which were undertaken by Dr. Medina were done in keeping with the standards of medicine, is that not true?

A. Yes.

Q. And just tell us what your findings were, based again upon reasonable medical certainty and probability regarding what Dr. Medina did.

MR. MONTELEONE: Object again

to the form of the question so that you have a chance to cure it right here and now.

Q. Go ahead.

A. To try and reconstruct what was done, the left chest was explored, multiple biopsies were sent of areas that were considered to be abnormal looking for a tumor. When it became apparent that this was not a tumor but a trapped lung, the lung was decorticated. And the term decortication means removing a cortex of material that is trapping the underlying lung sandwiched in between the lung and the chest wall. Most of the time this involves the entire lung; it's very rare that it is ever just confined to one small area. And I believe that's what Dr. Medina did.

Q. And did you have an occasion to review the the amount of tissue that had been taken from the lung and reviewed in pathology?

A. Well, as mentioned in the pathology report, 20 grams of pulmonary tissue were submitted. So this was not a major lung resection.

Q. Now, with respect to Mrs. Quaal's condition

immediately after the surgery, what did the hospital records reveal?

A, Revealed that she was extubated, that is taken off the ventilator right after her surgery. That she was maintained without respiratory support for the first four days, at which time she required re-intubation and placement back on the ventilator. And at that point her clinical course began to deteriorate. She ultimately experienced what appeared to be multiple episodes of sepsis and then subsequent sequential multiple organ failure, probably as a result of the sepsis, with her subsequent expiration.

Q. And would you tell the court and jury just exactly what is sepsis?

A. Sepsis is usually uncontrolled infection. That is infection from some source that rather than stay localized has gotten into the blood stream, and by virtue of it's presence in the blood stream has created all sorts of other problems in virtually any organ system. And it can destroy kidney function, it can certainly compromise liver

funetion, brain function, lung function, virtually anything.

Q. Did you come to an opinion, again based on reasonable medical certainty and probability, as to what the cause of Mrs. Quaal's death was?

A. Yes.

Q. And what was that?

A. I believe it was, as I mentioned, multiple organ failure resulting from sepsis in the post-operative period,

Q. Now, you had an occasion to review the report of Dr. Kaufer, did you not?

A. I did.

Q. I don't know if you have that with you?

A. I don't.

Q. You indicated that you had some problems what, locating the file that had been forwarded to you?

A. Yes.

Q. All right. Now Dr. Kaufer, in his report on page 2, indicates that "the surgical procedure certainly was indicated and appears to have been performed properly."

Do you agree with that statement?

A. I do.

MR. MONTELEONE: Are you going to read the rest of that or just take that one statement out of there?

Show an objection then to the last question and motion to strike the last answer.

Q. Now doctor, again, based upon your review of the records provided to you, which you have stated heretofore, based again upon your review of those records, your background and skill as a thoracic surgeon, do you have an opinion, based upon reasonable medical certainty and probability, as to whether Dr. Medina's care of this patient, the operation he performed, was in keeping with the standards of thoracic surgeons?

Do you have an opinion?

A. I do.

MR. MONTELEONE: Show an objection again -- excuse me, once again as to the form of the question so you can correct any error in it.

Q. Okay. Do you have an opinion?

A. I do.

Q. All right. And what is that opinion?

MR. MONTELEONE: Show an objection again and motion to strike the answer.

A. I believe it met the accepted standards of care.

Q. And what, again, are the basis for that opinion?

A. If we accept the fact that Mrs. Quaal had a lung that was trapped by a chronic hemothorax, especially in the presence of very compromised pulmonary functions, the indications for exploration are fairly clear here in the hope that the pulmonary functions would improve once the lung is allowed to fully expand.

This lady presented with pain -- with painful rib fractures and an abnormal chest film, so the exploration was appropriate.

What they found at the time of surgery after they could not prove that she had anything malignant was, in fact, a trapped lung, which they decorticated -- or when I say they I mean Dr. Medina.

And her post-operative course was initially fairly benign in that she was extubated immediately and for four days was able to ventilate herself. She then required re-intubation, placement back on a ventilator, probably as a result of infection that had gotten into her blood stream, and that subsequently took its toll on all the rest of her organ system, in a woman who already was compromised, and compromised by probably poor liver function and an enlarged spleen, which I believe would have severely impaired her own response, her own immunologic response to whatever insult came her way. And as a result of that she ultimately died.

Q. Do you have an opinion, basad upon reasonable medical certainty and probability, as to whether the so called limited procedures referred to by Dr. Kaufer would have dealt with the problems of the left lung that was seen in Mrs. Quaal?

A. I don't know what limited procedure eould have been done here, other than what was done. A lung resection, which was not

appropriate here, is a much bigger operation. I mean, even a lobectomy is a much bigger procedure than what was done.

What was done, in fact, did not remove -- it removed virtually no lung tissue, except minor pieces; did not detract from this lady's pulmonary functions, and in fact expanded her lung. If her pulmonary functions had been that poor she never would have been extubated post-operatively, and this lady was able to maintain herself, and most likely in the onslaught of overwhelming infection she had to reintubated again.

Q. Now doctor, you've had a chance, have you not, to review the consent form of the 11th. I think if we can refer to that, if we can find that.

(Off the record.)

Q. Now, I've asked you to address a consent form that's in the hospital records of Mrs. Quaal, right?

A. Yes.

Q. And what is the date on that consent form?

A, January 11th, 1987.

Q. And what does that consent form refer to as

the procedure that was to be undertaken?
A. Left exploratory thoracotomy, possible lobectomy.
Q. And how does a lobectomy itself eompare to the procedure that was undertaken by Dr. Medina?
A. A lobectomy produces a loss of lung tissue. On the left side there are two lobes, and removing one lobe would remove in fact half of the patient's lung tissue on that side. A procedure that Mrs. Quaal probably could not have tolerated very easily. It was a more extensive procedure than what was done.
Q. Other than the sepsis you have referred to and the problems with what came about through the ordinance of Mrs. Quaal, were there any other factors which contributed, in your opinion, to her death at the hospital?
A. No.

MR. MONTELEONE: Show an objection once again as to the form of the question.

A. No, I believe I've discussed them all.
Q. All right. Now, a number of questions were

asked of you on the discovery deposition by Plaintiff's counsel here regarding the discharge summary and the various aspects of that discharge summary. Could you address yourself to that?

MR. FULTON: Could I see your copy?

MR MONTELEONE: Is that what you are look for?

MR. FULTON: Pes.

Q. On that page there is a column marked "final diagnosis" and 11 items are listed there, is that not correct?

A. Pes.

Q. And going through these -- and again I ask You to, in rewiewing these records that your opinions should be based upon reasonable medical certainty and probability.

With respect to Number 1, left lung hematoma. Explain to the jury what that was?

A. Well, hematoma is the same thing as a lung contusion. And that can -- that's basically just like a black and blue mark except sustained by the lung from trauma and often

accompanies fractured ribs.
Q. And Number 2 indicates what, that she did have a left rib fracture, is that not true?
A. I think she had multiple left rib fractures, yes.
Q. Questions were asked of you by Mr. Monteleone regarding acute respiratory distress syndrome, right?
A. *Yes.*
Q. And what is that, as far as a specific diagnosis? Is that a --
A. Well, it's the development of an inability to use your lungs efficiently resulting in difficulties in oxygenation and in getting rid of carbon dioxide, which are the two functions of the lung, caused by either viral infections that may be occult or caused by trauma, or caused or occurring in a post-operative period. And most of the time it's a non-spscific diagnosis that describes that clinical constellation of signs in a setting of a chest x-ray that shows diffuse abnormalities on the chest film of both lungs.
Q. Mr. Monteleone asked you questions regarding

this bronchopleural fistula; and what is that?

A. It's an abnormal connection between the inside of the lung and the outside atmospheric pressure. If you have a tear in a lung it will create a bronchopleural fistula in which when you inspire air it will go out through the surface of the lung rather than just go back out your airway.

Q. Is this something that can occur during any type of an operation that takes place inside of someone's chest?

A. Yes.

Q. And on number 9, it says disseminated intravascular coagulopathy. And what is that?

A. Disseminated intravascular coagulopathy, or DIC, is commonlg over diagnosed in the presence of multiple episodes of bleeding at different sites in a person's body. To make the diagnosis you would have to demonstrate consumption of basic clotting factors as well as the development of fiber and split products, which indicate that you're actually chewing up your clotting factors

which is then allowing you to bleed in almost any part of your body.

Q. And there is also an indication here on number 10 of congestive heart failure; and 11, progressive renal failure; is that correct?

A. Yes.

Q. And that's indicative of what with respect to Mrs. Quaal and her condition? Et- occurred four days after the surgery

A. Well, these -- these --

MR. MONTELEONE: Show an objection as to when those two conditions occurred.

Q. Go ahead.

A. I think these may have occurred later than that. But they probably reflect the sepsis that we were referring to before and it's effect on those different organ systems.

Q. And again, based upon your review of the materials given to you which you have spoken about, based again upon your experience as a Board certified thoracic surgeon, based upon your experience in performing surgery of this type, do you have an opinion as to

whether or not the treatment afforded Mrs. Quaal by Dr. Medina was in any way substandard?

A. I do.

MR. MONTELEONE: Objeet to the form of the question.

Q. And what is that opinion?

A. I believe it met the accepted standards of care.

Q. And that's based upon reasonable medical certainty and probability, is it not?

A. Correct.

MR. MONTELEONE: Object again and motion to strike the last answer.

Q. And doctor, you have performed a number of operations in the chest area, have you not?

A. *Yes.*

Q. How many thoracotomies have you performed, let's say over the last three years?

A. Thoracotomies for lung problems?

Q. For problems similar to what we have here in Mrs. Quaal?

A. Oh, for decortication specifically where we are actually freeing up trapped lung?

A. Yes.
A. We do about 15 to 20 a year. It's, in the overwhelming scheme ob things, it's not a high frequency procedure.
Q. And the reasons for that are what? You don't see trapped lungs in too many individuals?
A. No, most of the type time it can be coped with with intensive pulmonary hygiene and antibiotic coverage.
Q. Now, are there any other opinions that you came to in your letter of December 19 -- December 17, 1990 that we have not covered?
A. I don't believe so.

MR. FULTON: No further questions.

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(Deposition Concluded)

THE STATE OF OHIO,)
) CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Richard G. DelMonico, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named ALAN MARKOWITZ, M.D., was by me, before the giving of his deposition, first duly sworn to testify to the truth, the whole truth and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of stenotype and was later transcribed into typewriting under my direction by computer-aided transcription; that the said deposition was taken pursuant to agreement at the time and place aforesaid; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Gleveland, Ohio, this 5th day of April, 1991.

Richard G. DelMonico, Notary Public
Within and for the State of Ohio

My Commission Expires April 18, 1993.

Richard G. DelMonico
Morse, Cantverg & Hodge

THE STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

IN THE COURT OF COMMON PLEAS

ALAN DEAN FAZEKAS,)
)
Plaintiff,)
)
vs.) Case No. 188572
)
AMERITRUST COMPANY, NA,) RICHARD McMONAGLE
)
)
Defendant,)

- - -

DEPOSITION OF ALAN MARKOWITZ, M.D.

TUESDAY, APRIL 30, 1991

- - -

Deposition of Alan Markowitz. M.D., a witness called for examination by the Defendant under the Ohio Rules of Civil Procedure, taken before me, Richard G. DelMonico, a Professional Reporter and Notary Public within and For the State of Ohio, pursuant to notice at Mt. Sinai Medical Center, Cleveland. Ohio, commencing at 4:15 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff:

J. MICHAEL MONTELEONE, ESQ.
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Cleveland, Ohio 44115-1027

On behalf of the Defendant:

BURT FULTON, ESQ.
Gallagher, Sharp, Fulton & Norman
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MR. MONTELEONE: Mr. Fulton concluded his direct examination as is evidenced by the transcript and now wants to reopen his direct examination as I'm about to begin the cross examination and I don't think it's proper, so I have an objection to it.

MR. FULTON: Well, my position is this was concluded April 2nd, 1991, we were in quite a bit of a hurry this day. It is a discretionary matter to reopen it, we never were able -- it was quite late in the evening and I think I just have these last few questions, and we will let the court decide.

MR. MONTELEONE: It was 4:30 when we left.

MR. FULTON: It was for you to catch an airplane. Let the court know that too.

MR, MONTELEONE: Okay, Burt.

- - -

ALAN MARKOWITZ, M.D.

of lawful age, called as a witness by the Defendant, pursuant to the Ohio Rules of Civil Procedure, being by me first previously sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION (Cont)

BY MR. FULTON:

Q. Doctor, as you know, this is April 30th, 1991, and your deposition commenced on Tuesday, April 2nd, 1991. And I'd like to just reopen up the direct for a few questions.

First of all, you have given us your curriculum vitae which we have marked as an exhibit, but just give us a little bit of background, would you please, with respect to what you have done in the area of lung surgery, cardiovascular surgery, Could you tell the court and jury that, please?

MR. MONTELEONE: Note my objection, continuing objection, so I don't have to interrupt.

A. Well, being a thoracic surgeon means that

you operate on the chest and its contents. We specialize in surgery of the lung and surgery of the heart. The surgery of the lung that we do largely revolves around lung cancer and actually lung infections.. And the lung infections in particular are predominantly either dealing with Bung abscesses or dealing with empyemas, which are infections of the pleural space, such as involved in a case similar to this,

In terms of volumes, is that what -- or in terms of percentages of what we do,

Q. What is your actual position right here at Mt. Sinai?

A. I'm Chief of the Division of Cardiothoracic Surgery.

Q. And of what does that division consist?

A. Well, that means supervising the administration of the division that oversees the surgery of the chest and its contents. So all those people that operate on heart, lung. chest wall, diaphragm, esophagus, et cetera. And then we also have an active part in the general surgery training program.

Q. All right.. Now, you have been Chief of Surgery what length of time?
A. Ten years.,
Q. And you have set forth here a number of the presentations you have made relative to your specialty field, have you not, in this exhibit, your curriculum vitae?
A. Yes, I believe they're listed,
Q. And about how many operations do you do, say, in a time period? Whether it's a month or week?
A. Well, the volume of -- our volume is about 4 to 500 cases a year of which approximately about 350 to 400 are cardiac and about 100 are lung,
Q. Now, doctor, you, back on April 2nd, 1991, gave a number of opinions, did you not?
A. Yes.
Q. With respect to questions I had asked you, is that not true?
A. Correct.
Q. And were these opinions based upon medical certainty and probability within the standards of discipline of physicians who perform thoracic or lung surgery like

yourself?
A. Yes.
Q. All right, And these last few questions,
Since your deposition commenced on April 2nd, 1991, I forwarded you, did I not, the complete deposition of Plaintiff's expert Dr. Kaufer'?
A. Yes.
Q. Did you have a chance to review that?
A. I did,
Q. And this last question,
Had, on the date of surgery of the decedent here, Mrs Quaal, had on that date her chest been closed without further surgical procedure. do you have an opinion, based upon reasonable medical certainty and probability, as to what her prospects would be'? Do you have an opinion?
MR. MONTELEONE: Show an objection.
A. I do,
Q. What is that, sir?
MR. MONTELEONE: Motion to strike,
A. Well, I don't think much would have changed.

The rationale for the surgery was a trapped lung, and with restricted pulmonary function studies and an incision in the chest, if you don't accomplish that and improve the patient's pulmonary functions, then the patient's not going to gel any better,

This woman was actually getting worse.. And to have closed this up and done nothing would not have in any way made her any better, in fact, would have made her substantially worse and might logically have made for litigation in the opposite direction, why didn't they do something.

MR. MONTELEONE: Show a motion to strike.

MR. FULTON: No further questions.

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CROSS EXAMINATION

BY MR. MONTELEONE-

Q. Dr. Markowitz, I am Mike Monteleone and I represent the family of Jacqueline Quaal in this wrongful death case, I guess Mr. Fulton informed you that I would be given an opportunity to ask you some

questions on cross examination?
A. Correct.
Q. So that we can understand your role, your function in this case, if you will, you were not a treating doctor of Jacqueline Quaal, were you?
A. No.
Q. You never saw this lady before she died?
A. No.
Q. And the doctors at Richmond Heights General Hospital never called and asked for your opinion regarding the care and treatment of her while she was alive at Richmond Heights, did they?
A. That's correct.
Q. And the family of of Jacqueline Quaal didn't ask for your professional opinion as to what happened in this case, did they, sir?
A. That's correct.
Q. It was the lawyer who represents the bank, Mr. Fulton, who contacted you and hired you in this case'?
A. I rale at the word hire. If you ask for my opinion, I'll give you that. As much as a patient doesn't hire his surgeon.

Q. Forgive me, it was perhaps just a poor choice of words?

A. Okay, thank you-

MR. FULTON: I do have an objection to the word bank too,

A. I am involved at the request of Mr. Fulton who asked for my opinion, to review the records and give an opinion,

Q. Well, just so the jury is clear, this isn't something you are doing free of service or free of charge, is it?

A. That's correct, I think we established that in the deposition before-

Q. This deposition is the one the jury's going to see. So let me, let me ask you:

Doctor, what is it that you have charged for your professional fee to Mr. Fulton so far in this case?

A. It's an hourly fee of $250 an hour for review and $500 an hour for the deposition, so.

Q. And as of April 2nd, you had told us that you had charged $1250 for the five hours of review and then there was an additional 500 for the deposition?

A. Correct.
Q. All right, Is there another 500 for this deposition today?
A. Depends on how long it takes.
Q. Well, assuming it take takes as long as the last one, an hour or so, is it another $500 then?
A. Yes.
Q. So then we are up to about what, $2250, something around there?
A. I believe that would be about what it would be.
Q. All right.. Dr. Markowitz, have you, sir, testified in other medical/legal cases in the past on behalf of other doctors sued for medical negligence?
A. I have testified in depositions and in court cases in negligence trials both for plaintiff and for defense,
Q. About how many, any idea?
A. In the past 10 years?
Q. That's good enough.
A. I've reviewed, do generally about three or four a year.
Q. All right, So we are talking between 30 and

40 medical negligence cases?
A. Correct.
Q. And would it be fair to say that three-fourths of the time or 75 percent of the time you have come into court you testify on behalf of the doctor who's being sued'?
A. The vast majority of these Rave not gone to court. Of those cases, probably only two or three have gone to court.
And I'd say that's a good guess. Probably 75 percent would be for defense, 25 percent would be for plaintiff, -
Q. All right,
Now, you had an opportunity to look at the records in this case regarding Jacqueline Quaal, true?
A. True.
Q. She went into Richmond Heights Hospital on January 5th, 1987 with a fractured rib or fractured ribs and an abnormal chest x-ray, correct?
A. Correct.
Q. And she came out dead, didn't she, doctor?
A. She died in the hospital, yes.

Q. The doctors who were taking care of her, including Dr. Medina suspected a possible cancer but we can agree that she did not have cancer, did she, doctor?

A. We can agree that she did not.

Q. There was no evidence that Jacqueline Quaal had a malignancy, is that true?

A. True.

Q. All right. And she did not die from any kind of cancer then?

A. Correct.

Q. All right, Now, is it true doctor, that an autopsy is not done in every single case in which a patient dies?

A. Correct.

Q. Does it usually require some kind of unusual or unexplained death before an autopsy is done?

A. No, it really -- that may be the criteria that the coroner might use, but it's not a criteria for any death that occurs in a hospital, If it was required by law obviously there would be a great deal of autopsy performed. But it's really at the request of the attending physician, and with

the agreement of next of kin that any autopsy is performed, because you learn a great deal from it.

Q. And you know in this case that the family acceded to the request or accepted the request, if you will, of the doctors to do an autopsy on Jacqueline Quaal?

A. Correct.

Q. Now, you wrote a letter to Mr. Fulton in which you indicate that Jacqueline Quaal was obese despite previous intestinal bypass surgery.

You recall that statement that you made, doctor?

A. I do.

Q. How much did she weigh when she was admitted to Richmond Heights General Hospital on January 5, 1987?

A. As I understood it, it was close to 200 pounds.

Q. All right, Where do you get that information from, doctor?

A. Well, when I had reviewed the chart I thought that was the admitting weight.

Q. I'm going to show you a copy of the official

hospital chart. They did an admitting physical examination on her on January 5, 1987.

Would you be nice enough to take a look at that, please?

A. Um-hum, certainly,

Q. They weighed the patient on January 5, 1987, doctor, What was her weight at that time?

A. Is that what's written down here on this?

Q. Look at the top of the page, it's got the vitals, vital signs,

A. Okay, It says 141 pounds,

Q. All right. And that's signed by one of the doctors who examined her, isn't it?

A. Correct.

Q. All right,

A. It's not likely that he weighed the patient, It's likely the nurse weighed the patient on admission.

Q. Well, then why don't we look and see what the nurse wrote down?

A. I don't have any reason to dispute that she weighed 141 pounds instead of 200. It's not really an issue.

Q. Well, that was a mistake then?

A. Yes.
Q. All right.
A. That may have been an impression from what she had been prior to her intestinal bypass or something like that.
Q. But we can agree, however, that when she was admitted to the hospital on January 5, 1987 that she weighed a 140 pounds, thereabouts'?
A. Correct.
Q. All right, And for a woman who was five foot one and a half tall, would you consider that to be obese, doctor?
A. Not particularly obese, no,
The impression most likely stems from the fact she had intestinal bypass for obesity in the past, That's probably where I got the figure of 200 pounds.
Q. That had happened in 1981, and we know that she had had a gastrointestinal bypass and that she had lost an awful lot of weight then?
A. Correct.
Q. And I can understand perhaps you just, you had assumed that she weighed 200 but in fact she only weighed 140 pounds on admission to

the hospital.

A. I think I had seen reference to the number of pounds that she had lost and the number of pounds that she had started from and that's where I believe I got the number 200 but I'll have to go back and check,

Q. Well, perhaps you got the number 200 because at autopsy that was done on February 3rd, 1987, the doctor that did the autopsy noted that she now weighed 200 pounds,

Did you see that?

A. That's possible.

Q. Would you like me to show it to you or would you accept my word for it?

A. I'll accept your word.

Q. Okay, thank you,

Well doctor, Jacqueline Quaal then gained 60 pounds in less than one month's period of time because of the complications that resulted from Dr. Medina's surgery, isn't that true?

MR. FULTON: Objection

A. If you would like to rephrase the question, she developed complications after a surgical procedure, and whether you want to attribute

those complications to what Dr. Medina did I believe is up to the jury, I don't agree with it phrased that way.

This lady developed complications of sepsis, and from those complications yes, she gained substantial amounts of weight.

Q. And the sepsis came on as a result of the surgery that Dr. Medina did, true?

MR. FULTON: Objection.

A. The sepsis occurred in the post-operative period, and sepsis occurs for a number reasons. Sepsis can occur in people who don't even have any surgery whatsoever, So again --

Q. Well, in this particular case --

A. Because they follow temperly doesn't mean that one caused the other. No, I really don't agree with that.

Q. All right, let's do it this way then,

She went into the hospital and she weighed 141 pounds?

A. Correct, I think we all recognize that she gained 60 pounds during that hospitalization.

Q. All right. So her --

A. That was as a result of complications of the diseases that he she had, yes.

Q. And the diseases that she had, doctor, came on after Dr. Medina did his surgery, true?

A. Correct.

Q. All right, Now, we are going to talk about that in a moment, but I just want to clear up this point about the weight gain to get your thoughts on this, if you will.

Less than one month after she's admitted to the hospital she gains 60 pounds or increases her body weight by some 40 percent, correct?

A. Correct.

Q. And that's not a good thing for a patient to have that kind of weight gain in that short of a period of time, is it?

A. No.

Q. We know that she wasn't eating, certainly, to gain all this weight- We can agree on that, can't we?

A. Yes.

MR. FULTON: Objection, I don't think that's what the records show.

Q. Well, did she have an endotracheal tube, doctor, placed on January 16th, 1987?
A. Correct.
Q. And shortly before surgery the anesthesiologist weighed her and wrote a note in the chart that indicated that she at that time weighed -- let me me find it so I can be certain about this.

Here is the anesthesiologist's evaluation on January 12, 1987, doctor, Would you tell the members of the jury how much she weighed the day of surgery, that is the day that Dr. Medina operated on January 12, 1987?

A. 141 pounds.
Q. All right. thank you.

So sometime then between January 12 when he operated and January -- I should say on January 16th, she was now given an endotracheal tube so that she could breathe properly?

A. Correct.
Q. So she couldn't eat with an endotracheal tube in her mouth, could she, Dr. Markowitz?
A. Correct. But she can be fed,

Q. That's what I was going to ask you about now, She was given fluids to the extent that this woman now gained 60 pounds in a period of less than one month, true?

A. Correct.

Q. That's because one of the things that happened to her following the surgery by Dr. Medina was that her kidneys failed?

A. Correct.

Q. So I think we can agree, so that we can move on, she did not gain the 60 pounds from any excessive eating that she did while she was in the hospital?

A. Correct.

Q. All right.

What happens to a person who gains this much weight from the fluids that she was given in this short of period of time, doctor? In your experience, what happens to the organ systems?

A. The fluid gets distributed across all organ systems; that means brain, liver, heart, lungs, kidneys, soft tissue, Patients become swollen and bloated and the function of each one of those organs can be seriously

impaired.

Q. When Jacqueline Quaal was admitted to the hospital on January 5, 1987 they checked her vital signs, didn't they?

A. Yes.

Q. And just so the jury's familiar with this, we're talking about her temperature, her blood pressure, her pulse and her respiration, correct?

A. Correct.

Q. And each one of these vital signs or what the doctors refers to as vital signs were normal, weren't they?

A. Correct.

Q. Including her respiration?

A. Respiratory rate.

Q. Her respiratory rate,

A. Respiration refers to all pulmonary functions.

Q. Her respiratory rate 16 times pel: minute?

A. Correct.

Q. And what's the normal range, doctor?

A. Somewhere between 12 and 20 we accepted as normal.

Q. So she fell right in the middle of the

normal range for the respiratory rate?

A. Correct.

Q. Is it your opinion, Dr. Markowitz, that Jacqueline Quaal died in the hospital from complications that developed following the surgery by Dr. Medina on January 12, 1987?

A. Yes.

Q. The surgery that was actually done on January 12, 1987 by Dr. Medina was elective surgery, wasn't it?

A, Elective in the sense that it was not emergent,

Q. All right.

A. But this was not the kind of a procedure that you would send someone home for and bring them back on an elective date,

Q. You must agree, however, with Dr. Medina who wrote in the chart that this was an elective surgery that was performed on her on January 12, 1987?

A. Again. it was elective in the sense that they did not have to emergently perform the operation

Q. All right.

A. But they would not likely have been able to send her home.

Q. All right. They had to determine what the source of the pain in the left side of her rib cage was?
A. I think they had a fairly good reason why, given that she had rib fractures,
Q. All right, How long was she actually in surgery on January 12, 1987?
A. I would have to look at the anesthesia record again,
Q. All right, Let me find it for you, doctor.
A. Four to five hours comes to mind.
Q. I'm sorry'?
A. Four to five hours comes to mind, But I don't recall the exact time.

MR. FULTON: What is the time? You probably have it written down there.

MR. MONTELEONE: No, I don't, Mr. Fulton.

MR. FULTON: I thought -- you have a lot of notes.

MR. MONTELEONE: So do you.

MR. FULTON: No.

MR. MONTELEONE: Were you through interrupting now?

MR. FULTON: Just for the time being..

MR. MONTELEONE: Okay. All right.

Q. Dr. Markowitz, is it true that there were a number of very serious complications following the elective surgery that was done by Dr. Medina on January 12, 1987?

MR. FULTON: Objection to the word elective,

A. Yes.

Q. Let's go over some of them, if we can, so the jury has a full appreciation of what actually happened here,

Now, we have already talked about the weight gain, and that certainly was one of the complications that set in following the surgery, wasn't it?

A. The weight gain occurred as a result of therapy that was administered to Mrs. Quaal to treat the complications that she had.

Q. All right,

The discharge summary from Richmond Heights General Hospital indicates, or lists I should say, a number of items that I would

like you to give us the benefit of your explanation on. And we'll take them one at a time, all right?

A. Certainly,

Q. Now, the discharge summary. so the folks understand, is a part of the hospital -- official hospital records in which the attending physician or the operating surgeon in effect summarizes why the person was admitted, what was done, what the lab tests showed, and what the person's condition is on discharge.

Is that basically what happens?

A. That's basically true, it isn't necessarily dictated by the attending physician, It's often dictated by the house officer,

Q. Another doctor in the hospital?

A. Correct.

Q. And then co-signed after review, hopefully, by the admitting or the operating doctor?

A. That's correct.

Q. Now, Cause Number 3 on the discharge diagnosis is acute respiratory distress syndrome, and that's listed on the death certificate also,

Dr. Markowitz, did Jacqueline Quaal have acute respiratory distress syndrome on admission to the hospital?

A. No.

Q. Did that come on following the surgery by Dr. Medina?

A. It developed post-operatively, yes.

Q. Is that a good thing for a patient to have?

A. No.

Q. Why not?

A. Well, respiratory distress is really exactly what it says, the patient has difficulty breathing, Clearly that's a real problem, And if someone has difficulty breathing and it's only minor, there are certain conservative measures that can be taken to treat it. But if those conservative measures aren't adequate, then the patient may have to receive artificial ventilatory support for a certain given period of time until those lungs will function properly again.

So it clearly is a very serious matter.

Q. Is it life threatening?

A. It certainly can be,

Q. I'm sure that in your career you have seen a number of patients who have died from this very disease entity of acute respiratory distress syndrome.

A. It's a diagnosis, I don't know if it's a disease entity because there are many, many things that can cause it.

Q. In any in any event, we know she didn't come into the hospital with it but she got it sometime after the surgery by Dr. Medina?

A, That's correct.

Q. Now also, I think you told us that in your professional opinion Jackie Quaal died of sepsis, which in a general way of speaking, I suppose, is fulminant or rampant infection that's invaded the blood, correct?

A. Correct.

Q. She did not have sepsis on admission to the hospital, did she, doctor?

A, No, she did not,

Q. Is that a good thing for a patient to have, sepsis?

A. No, it's clearly a very bad thing to have.

Q. If there is an infection in the blood, such as occurred in this case, as I understand

it, this can affect also all the organ systems, true?

A. True,

Q. And did this sepsis, where did it come from, in your opinion, doctor? I mean, what was the site of the original infection here?

A. Well, sepsis means uncontrolled infection, and that can occur from one of two ways, Either there is a focus of infection in the body, that is subsequently liberated; or there's a portal of entry somehow either through any particular organ where the organism, the bacteria, if you will, or even a virus, which is harder to characterize, but where the bacteria gets into the blood stream from any given site in the body.

So either a patient may carry it with him or her or it may be introduced in the post-operative period, as it probably occurred in place, in this situation.

As far as Mrs. Quaal is concerned, she may have had an infected plural space or it may have been a portal of entry through her lungs afterwards,

Q. You just said -- I thought I heard you say

the sepsis probably came on after the surgery -- well it did come on after the surgery in this case?

A. Yes.

Q. And was this something that was related in any way to the bronchopleural fistula, do you believe?

A. Whether bronchopleural fistula exist or not, bronchopleural fistula frequently become infected, but you don't have to have bronchopleural fistula existing for sepsis to occur.

And this could have been from an infected area in the pleural space in Mrs. Quaal or it could have been introduced in some other fashion.

Q. Can this sepsis, which in your opinion, took her life, can it affect the liver?

A. Yes.

Q. Can it affect the spleen?

A. Yes.

Q. Can it affect the kidneys?

A. It can affect any organs, per se.

Q. Because the blood circulates throughout the body and has infection in it, now I assume

any organ that it passes through, and of course that's the function that part of the blood is going to cause this infection, isn't it?

A. Correct.

Q. Now on the discharge summary once again, there is reference to a recurrent pneumothorax.

Now what is a pneumothorax, doctor?

A. Pneumo means air, thorax means chest.. So pneumothorax is air in the chest. And this occurred after her surgery, which is a frequent complication of surgery for empyemas.

Q. Did she have this before she went to the hospital, doctor?

A. No, we don't believe so.

Q. It came on sometime after the surgery by Dr. Medina?

A. Correct.

Q. How does one treat this condition? Is it a treatable condition, pneumothorax?

A. Yes.

Q. How does one treat it?

A. Well, you can treat it either with

aspiration or placement of a chest tube. And usually a placement of a chest tube with a one way valve will allow evacuation of the air so that air can escape but not re-enter,

Q. And did they in fact, after the surgery by Dr. Medina, have several more procedures where they inserted that chest tubes into Jacqueline Quaal?

A. I think she required numerous chest tube insertions for isolated localized areas of pneumothorax in the post-operative period.

Q. When she got to the hospital on January 5, 1987 she didn't require an endotracheal tube at that time or a chest tube at that time, did she?

A. That's correct.

Q. Incidentally, when she got to the hospital on January 5, 1987, they examined her liver and her spleen, I mean, that's something they do on an admission to the hospital, isn't it?

A. In a very limited fashion.

Q. Well, they feel for it. I mean, the doctor's trained hands palpate or feel, if you will, the abdomen to determine if there

is any enlargement of the spleen --

A. Correct.

Q. -- or the liver, correct?

A. Correct.

Q. Do you know what the result of the examination was in Jacqueline Quaal's case when she was admitted to the hospital for the examination --

A. No, I don't.

Q. _- of the liver and the spleen?

A. I don't recall,

I would only add one word of caution to that. And that is, the most diseased liver is highly contracted, scarred and small and will be impossible to feel,

So the fact that they couldn't feel the liver, if the liver was or was not enlarged really would not give any indication of whether she had liver disease or not.

Q. All right, Well, when the doctors examined her abdomen on admission to the hospital -- let me find the page, if you will, okay?

A. Sure.

Q. This is in the progress notes on January 5, 1987. And the doctor who examined her at

that time, I've highlighted it there, doctor, so that we can -- what did they say about that -- I think the terms they use are hepatosplenomegaly.

A. Correct.

Q. Hepato refers to the liver, right?

A. Yes.

Q. And spleno refers to the?

A. Spleen.

Q. And megaly means?

A. Enlarged.

Q. And what did he find on examination?

A. Well, that's an interesting way of putting it.

Negative palpable hepatosplenomegaly. I gather he means the liver and spleen are not enlarged.

Q. Are not enlarged,

A. Correct.

Q. Thank you, Perhaps you would phrase it differently, but I think we understand it?

A. Yes.

Q. All right.

Is it true also that on admission to the hospital that she had no kidney problems

either, doctor?

A. As nearly as we understand it, at least from our history.

Q. Okay, On the discharge summary, after this lady died they also note that she had hypotension and hypoalbuminemia, Those are two very big words.

What does hypotension mean?

A. Hypotension refers to her blood pressure and it refers to the fact that her blood pressure was low. And blood pressure can be low for a number of reasons in both an acute and chronic setting.

Hypoalbuminemia refers albumin which is a protein that is found in the blood and is generally regarded as a handle on someone's nutritional status, And if your albumin is normal, then it's a fairly good indication, although not always accurate, that your nutritional status is acceptable.

If the albumin is very low, it may be an indication that you've either recently lost a lot of weight, that your nutritional status is poor, or that you have a lot of extra fluid on board.

It can also be low -- well those are the primary reasons,

Q. She did not have any problems with her blood pressure on admission to the hospital, did she?

A. Not as we understand it, no,

Q. Can we agree that too was following the surgery by Dr. Medina as a result of part of the complications that set in following that surgery?

A. Yes.

Q. Now, also listed on the discharge summary is that they found a blood clot in the endotracheal tube,

After the surgery by Dr. Medina they had to put a tube into her a few days after the surgery, didn't they?

A. Four days post-operatively.

Q. And as I understand it, the secretions, either the mucus plugs or the blood can clot and they block the passageway or the airway for the patient, don't they?

A. That's correct.

Q. And the patient can't breathe at all, can they?

A. Not if the endotracheal tube is the only source of airflow in and out of the lung, no.

Q. Was this the only source of the airflow in this lady, as far as you know?

A. Correct.

Q. So in effect what happened, following the surgery by Dr. Medina they had to put this tube down her throat, a clot got in the way and she wasn't able to breathe then?

A. Well, I don't know that exactly temperly occurred like that, She was re-intubated, meaning put back on the ventilator four days after her surgery, And at some point in the the next number of weeks that she was in the hospital, she developed some kind of obstruction of the endotracheal tube, which as I understand it, required the endotracheal tube to be replaced-

But that's one of the things any intensive care unit would be constantly on the lookout for, since you are frequently putting suction catheters down the endotracheal tube to help a patient evacuate secretions, One of things you are always

attuned to is, is there an obstruction in the endotracheal tube.

Q. Certainly one of the things you have to look for if you are in the ICU, correct?

A. Correct.

Q. And in this particular case, if I'm not mistaken, the day before she died is when they found this blood clot in the endotracheal tube?

A. Correct.

Q. Now also listed on the discharge summary is the disease entity known as a disseminated intravascular coagulopathy. And that's another big word, and if I'm not mistaken you sometimes abbreviate it as a DIC, true?

A. Correct.

a. Did this lady have a DIC when she was admitted to the hospital?

A. No.

Q. When did it come on, doctor, do you know?

A, Well, I don't know that they proved that she did have DIC.

As you recall from our previous conversation you need, to prove the diagnosis of DIC, you need to demonstrate

not only decreased levels of clotting factors, but also evidence of fiber and split products. And I don't know that those were ever drawn in her hospital course.

It's possible that she certainly could have started bleeding post-operatively, And sepsis alone can stimulate both DIC and bleeding problems in general. And I don't think that it makes -- I don't know that you have to put a handle on it and necessarily call it DIC. Suffice it to say that she certainly had problems with bleeding afterwards too,

Q. It's not a good thing for a patient to have DIC?

A. No, it's a very bad thing for a patient to have.

Q. They bleed from almost every site where there is an opening in the body, whether it be from a needle or sometimes they bleed from the nose; isn't that true?

A. They can bleed from any site, correct.

Q. Was this also one of the complications, in your judgment, from Dr. Medina's surgery?

MR. FULTQN: Objection,

A. One of the complications of sepsis, yes.
Q. Incidentally, I think you had mentioned in your direct testimony that they had found a cirrhotic or a cirrhosis in this lady's liver after she died?
A. Correct.
Q. Now is it true, doctor. that a gastrointestinal bypass such as this lady had some six years prior to this can cause cirrhosis of the fiver?
A. It can, in a small percentage of patients with intestinal bypasses,
Q. How about hepatitis? If a person's had hepatitis, does that cause cirrhosis of the 1iver?
A. It can go on and become chronic and cause post-hepatitic cirrhosis, That should be detectable by the patient's serologies. You'd know if a patient was positive for hepatitis A, B or C.
Q. There is a way to tell that, isn't there?
A. Yes.
Q. There's a certain test that's done?
A. Yes.
Q. And do *you* know whether or not Jacqueline

Quaal ever had hepatitis?

A. I don't.

Q. All right.

A. Had they been positive it would have been noted in the chart, because that's usually a red flag to any health care worker since it certainly can be contagious if it's serum hepatitis.

Q. Well, if a person's had this hepatitis, this certainly is the kind of think that can result in a cirrhotic or cirrhosis of the liver, is that true?

A. Yes.

Q. I have something from Smith Cline Clinical Laboratories on January 7, 1985 regarding Jacqueline Quaal. And a hepatitis profile was done.

MR. FULTQN: Where was that? Where is this --

MR. MONTELEONE: Do you want to take a look at it, Mr. Fulton?

MR. FULTON: Where is it from?

MR. MONTELEONE: It's from one of the hospital records.

MR. FULTON: You tell me it's

out of the hospital record?

MR. MONTELEONE: What does it say on it?

MR. FULTON: I don't know what it says.

MR. MONTELEONE: Well, read it.

MR. FULTON: I know what it says here, but I just want to ask you if it's in the hospital record. I don't see a punch in there or hole like the rest of your records. You know what I'm saying.

MR. MONTELEONE: Are you through?

MR. FULTON: It doesn't have this on here,

MR. MONTELEONE: I'm going to ask the doctor a question.

MR. FULTON: I understand. I just wanted to know where it came from.

Are you going to mark it as an exhibit?

MR. MONTELEONE: Sure.

(Off the record.)

Q. Dr. Markowitz, I appreciate you may not have been given that by Mr. Fulton, maybe you haven't seen it before?

A. No, I haven't,

Q. It does in fact indicate that this lady in 1985 had -- in the past had hepatitis, correct?

A. Yes. It says hepatitis C antibodies present, which would mean that she came in contact with it. It doesn't necessarily mean that she had hepatitis per se.

Q. Somehow she came in contact with it?

A. Correct.

MR. FULTON: Are we going to mark that as an exhibit?

MR. MONTELEONE: Sure, we can do that.

MR. FULTON: Can we do that now?

MR. MONTELEONE: Well, we can do it when I'm through with my direct examination,

MR. FULTON: I just want to be sure it's marked as an exhibit so the court knows it.

Q. Doctor, the last two items on the discharge summary indicate that Mrs, Quaal had congestive heart failure, She did not have congestive heart failure when she was admitted to the hospital, did she?
A. Not from any evidence we see in the chart, no.
Q. And they examined her heart and the indications were that her heart was apparently normal, did you see that?
A. She had a normal cardiac exam on the history -- on the physical exam, yes,
Q. On January 5, 1987?
A. Yes.
Q. And then as a result of these complications that set in following the surgery by Dr. Medina, the congestive heart failure came on?
A. Yes, I think that's a reflection -- it's hard to know whether she had true congestive heart failure or just heart failure from sepsis, It's really the same, basically the same thing,
Q. Would the sepsis or the blood infection, would that affect the heart itself?

A. It can destroy the heart.
Q. Finally they list on the discharge summary that she had progressive renal failure. Renal refers to her kidneys?
A. Yes.
Q. All right. She, on admission to the hospital, didn't have kidney failure, did she, doctor?
A. No.
Q. And after the surgery by Dr. Medina is when it came on?
MR. FULTON: Objection.
A. Once she developed her sepsis, yes,
Q. All these items, as I understand what you are telling us, are somewhat inter-related?
A. Yes.
Q. The infection, the blood or the sepsis contributed to the DIC, the congestive heart failure, the progressive renal failure, they're all bound together, aren't they, in some --
A. I think they're triggered by the same stimulus.
Q. Which was?
A. Sepsis.

Q. I omitted one item because I wanted to have you explain this in just a little bit more detail.

Is the fact that she had a bronchopleural fistula -- now a fistula is an abnormal connection between two organs or two parts of a body, true?

A. True.

Q. It's not normally a good thing for a patient to have, is it?

A. No, it's a bad thing,

Q. She didn't have this fistula when she came into the hospital, did she?

A. No.

Q. And when you say bronchopleural, we are referring to that part of the chest in which an opening somehow had been created into the lung, And now when she would breathe in air, instead of the air going out as it does for you or for me, it was being trapped under the skin, if you will, wasn't it?

A. Well, bronchopleural fistula refers to a connection between the bronchus, which is the airway inside the lung, and the plura, which is the surface of the lung. Rather

than having the air travel out to the functional unit of the lung, which is the alveolus, whose integrity is intact, there is somehow a rupture of that and the air fritters out into the -- through the plura into the space between the lung and the chest wall.

It doesn't necessarily get into the skin per se, unless you make an incision into the skin, So a bronchopleural fistula means an abnormal connection between the inside of the airway and the surface of the Bung, And this can occur after the surgery for empyema,

Q. Did this, in this lady's case, result from the surgery that was performed by Dr. Medina?

A. Yes.

Q. All in all, this surgery that was done by Dr. Medina on January 12, 1987, did not turn out very well for Mrs. Quaal, did it?

MR. FULTON: Objection.

A. Well, I think a mortality following an operation would allow one to conclude that the results were not particularly good, no.

Q. It didn't turn out very well for her, did it, doctor?

MR. FULTON: Objection.

A, No, I don't think it did,

MR. MONTELEONE: That's all I have right now. Thank you, Dr. Markowitz.

MR. FULTON: Just these couple of questions, Dr. Markowitz,

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REDIRECT EXAMINATION

BY MR. FULTON:

Q. You have answered many questions asked of you today by Mr. Monteleone. have you not?

A. Yes.

Q. You Rave also had the occasion, have you not, to review the testimony of Dr. Kaufer, which I had sent to you, is that not true?

A. That is true-

Q. Do any of these questions, and your answers by Mr. Monteleone, or the review of the testimony of Dr. Kaufer in any way change your opinion based on reasonable medical certainty and probability as to whether Dr. Medina, in operating on Mrs. Quaal, met the

standard of care of physicians in the discipline of and operating on the lungs and in the thoracic area?

MR. MONTELEONE: Objection to the form of the question,

A. No, I don't feel what he did was substandard.

Q. And again, based on reasonable medical certainty and probability, what, in your opinion, was the proximate cause of the death of Mrs. Quaal?

MR. MONTELEONE: I object again. Outside the scope of redirect.

A. Mrs. Quaal, I believe, died from the effects of sepsis, and the sepsis developed after a decortication of a trapped lung. The decortication is basically the only procedure you can do under those circumstances to free up the lung to allow it to function,

Sepsis occurred in this woman most likey because she was immunocompromised, but for whatever reason, it subsequently destroyed most of her organs, She had a

very rapid downhill course with loss of function of most of the organ systems.

Q. And can these problems of sepsis which you just discussed occur after surgery, be that surgery a great length of time or a limited length of time?

MR. MONTELEONE: Objection.

A. That's correct.

MR. FULTON: No further questions.

MR. MONTELEONE: Thank you.

VIDEO TECHNICIAN: Doctor, you have the right to review this tape or you may waive that right.

THE WITNESS: I would like to review it.

VIDEO TECHNICIAN: And will counsel waive filing of the tape?

MR. FULTON: Yes.

MR. MONTELEONE: Sure.

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(Deposition Concluded.)

THE STATE OF OHIO,)
) CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Richard G. DelMonico, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named ALAN MARKOWITZ, M.D., was by me, before the giving of his deposition, first duly sworn to testify to the truth, the whole truth and nothing but the truth; that the deposition as above set Forth was reduced to writing by me by means of stenotype and was later transcribed into typewriting under my direction by computer-aided transcription; that the said deposition was taken pursuant to agreement at the time and place aforesaid; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 3rd day of May, 1991.

Richard G. DelMonico, Notary Public
Within and for the State of Ohio

My Commission Expires April 18, 1993.