THE STATE OF OHIO

COUNTY OF CUYAHOGA. - - - - - Doc. 287

IN THE COURT OF COMMON PLEAS

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

vs. : Case no 226946

SAINT VINCENT CHARITY HOSPITAL, et al., :
defendants.

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Deposition of ALAN MARKOWITZ, M.D.

a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at Mount Sinai Hospital, One Mount Sinai Drive, Cleveland, Ohio, on Friday, the 7th day of May, 1992, commencing at 2:30 p.m. pursuant to notice.

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I N D E X

WITNESS: ALAN MARKOWITZ, M.D.

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(NO EXHIBITS MARKED)

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(FOR KEYWORD AND OBJECTION INDEX, SEE APPENDIX)

ALAN MARKOWITZ, M.D.

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

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Doctor, would you state your full name, please.

A. Alan Markowitz.

MR. KAMPINSKI: I'm going to ask you a number of questions. If there are any you don't understand tell me and I will be happy to rephrase any question you don't understand. If at any time you want me to rephrase a question, or repeat it, tell me, all right?

THE WITNESS: Okay.

MR. KAMPINSKI: Respond to my questions orally. She is going to take down everything that is said. She can't take the nod of your head.

Q. Doctor, the CV I have got, is this up-to-date or are there additional articles that aren't on

there yet?

Q. This has been recently revised.

Q. What additions are there then to the CV?

A. Other presentations, several articles in preparation, nothing substantively changed from what it currently is. Slightly different.

Q. Are there additional articles?

A. Things I am currently working on regarding the health care statistics and cardiac surgery statistics.

Q. Any specifically as it would relate to any subject matters involved in this lawsuit?

A. No.

Q. Have you ever been retained as an expert on any prior occasion for Jacobson, Maynard, Tuschman & Kalur?

A. Yes.

Q. How many times, roughly?

A. Probably about a dozen times over the last 10 years.

Q. Do you have a list of the cases?

A. I could compile a list. I don't keep a running tally.

Q. How many of those times have you testified in court?

A. Once.
Q. Do you recall the name of that case?
A. I don't.
Q. How long ago was it?
A. About three or four years ago.
Q. Do you remember the names of the attorneys involved?
A. I remember the name of the defense attorney was Stephen Charms. The plaintiff's attorney I don't recall. It was in Akron.
Q. Which other members of that firm have you worked with previously?
A. Bill Bonezzi, Bob Maynard and a number of others. We worked together several times. Probably about a half dozen attorneys in that firm.
Q. Which plaintiff's attorneys do you recall having taken your deposition in any of those cases?
A. Well, there are some that are very memorable. Paige Martin would be one. Harley Gordon would be another. Other than that, I think Mr. Tracy, Don Tracy.
Q. Any others, any from Mr. Wiseman's firm?
A. No.
Q. Anybody else from Nurenberg's firm other than

Harley Gordon?
A. None that I recall.
Q. Have you done any consulting for Mr. Coyne or anybody in his firm at any previous time?
A. I don't believe so.
Q. How about Mr. Fulton and his firm, Gallagher, Sharp?
A. Yes, several years ago,
Q. How many occasions?
A. I think once or twice.
MR. FULTON: One for me. I think once for Beverly.
Q. Were those Kaiser cases?
MR. FULTON: The one wasn't.
A. I don't believe so.
Q. Do you remember the names of those cases?
A. Again, I don't. I could certainly find out from our files. I don't recall them offhand.
Q. Do you recall who the plaintiff's attorneys were?
A. I don't.
Q. How about for Baker and Hostetler, have you been your retained by them?
A. No.

Q. What have you reviewed in connection with this case prior to preparing your January 28, 1993 report?
A. The hospital records that were sent to me. I believe most of the testimony that had been given in deposition or as letters from the expert witnesses up to that time.
Q. Do you have the materials here?
A. I have materials in my office record, yes.
Q. Do you have all the materials that were provided to you?
A. Yes. I certainly have access to them today.
Q. Where are they?
MR. SEIBEL: I don't know about the depositions. The medical records.
A. The depositions I don't have. I read them and since returned them.
Q. Would you know which deposition you reviewed prior to preparing your report?
A. The deposition that had in fact occurred prior to preparing the report.
Q. In fairness to you, you weren't involved in the litigation, you wouldn't know how many would have been taken? Do you have letters that reflect what was sent to you?

A. I do. That is what I'm going to get. Originally furnished to me November of '92 was the hospital records for Mrs. Weitzel; the autopsy report; the nurse's notes, et cetera; Mr. Moasis' deposition; the chest x-rays and pertinent films and EKG's.

Q. Really only one deposition at that time?

A. Deposition of Dr. Moasis, correct.

Q. Did you review any others then prior to preparing your report, other than his deposition?

A. I read each of the -- what is the last deposition? I don't have a deposition on Dr. Holland. I did review -- if you list the subsequent ones I will tell you which ones I read, which I didn't.

Q. Is what you have in front of you your file as it relates to correspondence in this case?

MR. SEIBEL: Go ahead.

Q. Has anything been removed from here before today?

A. No.

Q. This two page note on the deposition of Dr. Moasis, is this something generated by yourself or provided to you?

A. Generated by me.

MR. FULTON: The light shows up the gray in your hair, Charles.

THE WITNESS: Let me make a quick call while you do that.

MR. KAMPINSKI: Sure.

(Recess had.)

BY MR. KAMPINSKI:

Q. Doctor, it appears to me, at least from looking at all the letters in here, the only deposition that you ever received, at least according to the letters, was Dr. Moasis'; do you recall receiving any others?

A. I don't. It's possible. I may have seen one or two since then. Moasis' deposition is the one I remember.

Q. That is the only reference in any of the writing?

A. Correct.

Q. Was this the only report you generated was the January 28th one?

A. Yes.

Q. There is some mention of your receiving some records last week, hematocrit lab values. Were

those not contained within the original records you received?

A. No, they were contained within the original records. Since there was some question I wanted to be sure about the values. We went back and looked at those again.

Q. They weren't legible or you sent the records back?

A. I sent the records back. I couldn't possibly keep all the records I accumulate in cases.

Q. You wanted those portions back?

A. Correct.

Q. The reason for that was what?

A. It bears directly upon this lady's mode of death.

Q. Which you commented upon in your report, correct?

A. Correct.

Q. Did your going back and looking at them confirm what you originally said or change it in any fashion?

A. It confirmed it.

Q. When you wrote your records you were not aware, I take it, of the fact that Dr. Holland was involved as an expert on behalf of another

defendant in this case?
A. Correct.
Q. His report is dated the same as yours?
A. That could well be,
Q. You received that then subsequent to your report?
A. Yes.
Q. Have you received any either written or verbal reports as to what Dr. Holland said in his deposition?
A. I received a copy of the letter he generated.
Q. The report itself?
A. I have not read his deposition, no.
Q. Who in your practice clears patients for surgery if in fact an attending is a cardiologist, yourself, the cardiologist, or both?
A. Depends upon what kind of background of the patient and for what surgery.
Q. A patient such as Mrs. Weitzel?
A. Who would clear her for a general surgical procedure?
Q. Yes, sir.
A. The attending cardiologists would theoretically be involved.
Q. What would be the extent of their

involvement, would they clear her from a medical standpoint?

A. I would suspect so.

When you say my patient going for cardiac surgery, it is mostly for cardiac disease, they already had an extensive cardiac workup, This lady's operation was not because of cardiac disease but for another unfortunate complication.

If one was to obtain clearance to go to the operating room, one would want to get that not only from the cardiologist, probably from the intensive care physicians who are taking care of her. There is more than just cardiologic influences in this particular case.

Q. If such a case were to arise within your hospital, let's say a patient cared for by Dr. Holland, would you rely on him then for clearance of a patient such as Mrs. Weitzel?

A. Yes, theoretically that would have been given if he consults us to do something.

Q. Do you agree that Dr. Steele acted below the standard of care in making a decision to have Mrs. Weitzel undergo surgery on March 14, 1991?

A. No.

Q. Do you agree that Dr. **Moasis** fell below the

standard of care in the decision to have Mrs. Weitzel undergo surgery on March 14, 1991?

A. No.

Q. Do you believe that either of those decisions contributed to cause Mrs. Weitzel's death?

A. Indirectly.

Q. Had those decisions not been made, certainly she wouldn't have had a postoperative death, we can agree on that?

MR. SEIBEL: She is going to die at some point.

MR. KAMPINSKI: So are you and I. Let's talk about the death that she did in fact have, all right?

MR. SEIBEL: Sure.

A. If one accepts the fact if a surgical procedure had not been done would she have the opportunity to die from the surgical procedure, certainly she wouldn't have. Had the surgical procedure been done appropriately, postoperative care given appropriately, I don't know she would have died.

Q. You do in fact criticize the postoperative care in your report?

A. Yes.

Q. That, I take it we agree, fell below the standard of care of the nurses or physicians involved in that postoperative care?

A. Yes.

Q. You don't think however --

MR. FULTON: I have an objection with "physicians." It may be a little bit misleading.

MR. KAMPINSKI: Let me go on. I will clarify.

MR. FULTON: Did you want to say something?

MR. KAMPINSKI: I do. Just object.

MR. FULTON: I learned all this from the way you act.

MR. KAMPINSKI: Are you done?

MR. FULTON: I am. I may start up again, depending upon the question.

BY MR. KAMPINSKI:

Q. I assume, Doctor, you don't believe Mr. Moasis had any significant involvement in the inappropriate conduct postsurgically?

A. I agree with that statement.

Q. **He had a right to rely** on **the nurses and/or**

residents to notify him, or the attending, based upon Mrs. Weitzel's condition?

A. That is correct.

Q. He should have been notified?

A. That's correct.

Q. The failure to do so in your opinion, I take it, contributed to cause her death?

A. That is correct.

Q. There has been some discussion early on in this case regarding the values that were taken off the blood gases, I believe, hemoglobin?

A. Correct.

Q. I think Mr. Fulton initiated that round of discussion in the deposition that you read of Dr. Moasis. Do you believe that those values are something that could have been or should have been relied upon by the nurses or residents?

A. They should have been a signal there was a problem.

Q. Because of the precipitous drop in the values?

A. Yes, should have been a signal something was -- they should have been immediately rechecked.

Q. I take it the other findings relative to her starting at six o'clock -- at eight o'clock that

night also were certainly signs and symptoms of something going wrong postoperatively?

A. Correct.

Q. Dropping blood pressure?

A. Yes.

Q. Remainder of her vital signs deteriorating?

A. Absolutely.

MR. SEIBEL: Let's clarify it was eight o'clock, not six o'clock.

MR. KAMPINSKI: I did change that.

MR. SEIBEL: I want to make sure the record is clear.

Q. It's your belief that the procedure to remove the second wire done by Mr. Moasis on the 14th was a continuation somehow of the procedure that was commenced by Dr. Steele on the 13th?

A. Correct.

Q. Well, Dr. Steele's procedure, Doctor, was not a procedure done under general anesthesia, was it?

A. No.

Q. So Dr. Moasis' procedure was in fact a different procedure?

A. It was a different procedure. It was in the spirit of the same goal., If you accept the fact

that the goal of Dr. Steele was to withdraw two guide wires, which this woman was not born with, which should not have been in her vascular tree, was able to extract one, Dr. Moasis continued the procedure. They are not physically attached.

I'm not sure I understand what or why there is such a tremendous concentration on general anesthesia. It is in fact a very safe form of anesthetic. You can't in any way indict the administration of the general anesthetic as the cause of this lady's death or subsequent instability in the subsequent postoperative period.

Q. Does an anesthetic cause changes within the heart?

A. It may.

Q. Does it make the heart irritable?

A. It may.

Q. Does it depress the function of the heart?

A. It may.

Q. Can that be exacerbated in someone who has had a myocardial infarct one month previous to the surgery?

A. All that can be but let me ask you then, counsel, do you have any evidence that occurred during the conduct of the procedure or immediately

afterwards? There is no evidence the anesthetic here impaired this lady one bit. No evidence this lady had any bit of myocardial instability. She was hemodynamically unstable because of blood loss.

Q. Was she an appropriate candidate for the surgery, pertaining to hemodynamically, prior to surgery?

A. No one would willing do an elective surgery on this woman or anything unless the absolute indication she would sustain something of far worse consequences. If you assemble data, the presence of these two guide wires, to accept these are harmless foreign material, to me is the most naive assumption. To assume these guide wires, because they were in her arterial tree for several weeks, had not caused any damage probably would not cause any complication in the future is groundless. There isn't any basis upon which you can formulate that conclusion.

If you accept the fact those guide wires should not be there, yes, based upon the trend of her care, clinical status in the intensive care unit, based upon vital signs, based upon pulmonary status, which all shows she was progressively improving, there was no reason not to

try to get the second guide wire out.
Q. Everything indicated hemodynamic status was getting better?
A, Correct.
Q. You didn't have an opportunity to review the deposition of Dr. Sopko according to what I looked at in your chart?
A. Correct.
Q. Were you told what he said regarding her pulmonary status?
A. That I don't recall. I was going largely on the basis of her chest x-rays and her blood gases. In fact she was in the coronary care unit.
Q. Those reflected to you her pulmonary status was improving?
A. Yes.
Q. I take it you would not disagree with Dr. Sopko in terms of his belief she be weaned off the ventilator within two weeks?
A. I think that is pretty reasonable,
Q. In terms of her cardiac status, that stabilized shortly after her admission?
A. Correct.
Q. They stopped doing serial EKG's shortly after admission I believe?

A. Correct.

Q. So that the original reason that she was brought to the hospital, why she was hospitalized, that condition had stabilized?

A. Yes.

Q. Is it your testimony that you believe this was an emergency procedure to remove the wires or elective procedure?

A. There are grades, if you stratify the indication for surgery. There is elective, immergent and emergent. Emergent as soon as the problem is recognized. An example would be an acute type A dissection would be made as soon as you make the decision. Elective procedure clearly this was not.

If you accept the fact that the presence of these two guide wires were in fact a noxious stimulus to this woman, if you understand they were inserted through the groin, which carries its own microbiology, the fact that these migrated, since the tip of the guide wires were in the iliac artery, not the femoral artery where inserted, the other tip of the guide wire was protruding in the head vessel off the arch of the aortic left subclavian or left carotid, you also further accept

the fact that these are therefore a danger to this woman, there is nothing to be gained by waiting, if there are no absolute contraindications to take this woman into the operating room. If by the clinical course you postulate she is clinically improving, neurologically getting better, she responds, is able to follow commands, pulmonary picture was clear, I don't see any reason not to take her to the operating room to complete the extrication of those foreign bodies.

Q. You made a lot of assumptions there.

A. Correct.

Q. Those are the assumptions that you made then in reaching your opinion?

A. Correct.

Q. You said that an acute type A dissection would be an example of something that would be what, emergent?

A. As soon as the diagnosis is made you go to the operating room and repair.

Q. Are you talking dissection of an artery for example during angioplasty?

A. No, A dissection of the ascending aorta in patients that are hypertensive, have Morphan's disease, that is an example that carries a 95

percent mortality in 48 hours.

MR. SEIBEL: Why are you smiling?

MR. JACKSON: Another case, he's hoping he had a lead there,

MR. KAMPINSKI: I'm just curious. I like to learn things.

MR. FULTON: You are smiling at least.

Q. Have you been told -- do you know who Dr. Smead is?

A. I know of Dr. Smead. I don't know him personally.

Q. I take it you would disagree then with the statement that this was an elective procedure?

A. Yes, to me an elective procedure connotes a patient that can go home and come back or something can be done at any time,

Q. If -- I am sorry, I didn't mean to interrupt.

A. I don't agree it could be done at any time, which is what an elective procedure is.

Q. You started out they can go home and come back. It didn't have to be done then. It could have waited three months, six months, should have

been done before she left the hospital; do you agree or disagree with that?

A. Again, that is not elective. If you have a procedure that has to be done before a patient can go home, it's not considered elective by any criteria by the strictest sense of the word. Since our categories are elective, immergent and emergent it's not safe to send this lady home, I couldn't imagine this lady getting up out of bed walking around with these guide wires in place. I found that most of all no one addressed that issue as almost comical.

Q. To the extent that they would have to be removed, the question becomes when. There are studies, everybody commented upon them, it's almost been a given that the longer you wait post MI for the procedure that doesn't have to be emergent, the better off the person is from the risk standpoint; would you agree with that?

A. I agree with that. The question I raise is who is to know when the guide wires will provide another reason for this lady to die.

The concern about this lady there, they are dealing with problems of sepsis. The likelihood the guide wires could be infected is

enormous. Could migrate into the head vessel in a lady who already sustained an anoxic encephalopathy, which is a tremendous insult to her brain. To have them do anything to interfere with cerebral circulation will kill her more quickly than her heart will.

Q. She had been removed from antibiotics prior to the procedure, are you aware of that?

A. That I don't know.

Q. Then at least it was the belief of the clinicians caring for her, if that be the case, she was not septic at the time of this procedure?

A. Sepsis meaning a reflection she has an ongoing infection.

Q. Sepsis is a blood borne infection?

A. More a sign of systemic infection. Reflecting the fact that infection or product of the infection got into the blood stream, began to infect other organs.

How do you know that these guide wires are not infected? How do you know the guide wires couldn't embolize up to her brain? She could have little tolerated that.

The next step in this lady's recovery would be to wean her off the ventilator,

get her up out of bed. You are not going to get the lady out of bed with a guide wire from the iliac up to the ascending aorta, the the head vessel. They couldn't proceed with this lady's recovery in a meaningful way without getting the guide wires out.

Q. Have you ever removed guide wires from somebody's arterial system?

A. Under circumstances such as this, a guide wire that has been lost?

Q. Yes, sir.

A. No.

Q. I assumed in my question you understood it to mean surgically. I'm going to ask the same question whether or not you ever removed such guide wires percutaneously?

A. No. I witnessed a cardiologist that was involved in removing a guide wire that embolized. We were present in case of complication that required taking the patient to surgery.

Q. They would have done that percutaneously?

A. With the basket or something like that.

Q. I may have asked this, I apologize, were you told at all what Dr. Smead said in his deposition Wednesday?

A. No.
Q. Do you know Dr. Van Aman, the radiologist in Columbus?
A, No,
Q. Were you told what he testified to?
A, No.
Q. Both of them indicated that the second wire should have been removed percutaneously, as opposed to surgically, or that further attempts should have been made to do precisely that.
MR. FULTON: That is a better statement.
MR. SEIBEL: I will object to that mischaracterization.
Q. Assuming that is what they said, do you agree?
MR. FULTON: You said two things.
MR. KAMPINSKI: Let' say it again.
Q. Both the physicians testified attempts should have been made to remove the second wire percutaneously, prior to any thought of doing the surgery; do you disagree with that, Doctor?
A. I do disagree with that because it's based

upon the judgment of the cardiologist at the time who tried to get them out, who spent two hours in the cath lab with a lady on the cath lab table under local anesthetic and fluoroscopy and attached to a ventilator. T's not as though this lady is totally self-contained. She's traveling with a lot of extra baggage. Supported on the ventilator, lying on a hard table for two hours, flouroscopy. He's only able to get one guide wire out.

If Dr. Smead and the other radiologist talked to the cardiologist, said what prevented you from getting the second guide wire out, came to those conclusions, I could understand.

If they weren't really there, didn't really understand if Dr. Steele felt he put this lady through enough, especially since this is being done under a local anesthetic, he felt he could not budge this guide wire, it would be safer to extricate surgically, I can't argue with that., He was there, he was the cardiologist, he knew the patient well. I don't know there were any people that knew the patient better than he did, from what I understand.

Q. Were you aware of the experience that any of

his partners had in removing guide wires percutaneously?
A. No.
Q. Were you aware that Dr. Kitchen attempted to patent a procedure to do precisely this, claims himself as an expert in removal of foreign bodies?
A. I think that is all very well and good, I was not aware. It's no indication he would have been anymore successful than Dr. Steele.
Q. You don't think that an attempt should have been made by him, in light of the fact he wasn't in Columbus like Van Aman and Smead, as you aptly point out, not only was he familiar with Mrs. Weitzel because he covered for Dr. Steele during vacation that Dr. Steele was on -- he was not intimately aware of her condition -- you disagree he should have been consulted and attempted to remove the wire?
A. I think you are asking me to make a judgment for Dr. Steele, You have to ask Dr. Steele questions, not consult his contemporary who has all this expertise. There must have been some reason if Dr. Steele decided to extricate surgically and he consulted Dr. Moasis rather than his colleague.
Q. Whatever his reasoning was or logic was you

defer to that?
A. I do defer. There are complications with continuous manipulation of a catheter in the femoral arteries. Probably he felt if he manipulated, the risk of sepsis is substantial in someone like that, who was probably colonized while in the intensive care unit, he may have felt a more sterile and controlled condition would be better for the patient. Who is to say that is wrong. I don't think so.
Q. Some people may.
A. Some people may.
Q. Is the reason you never had to remove one surgically because to your knowledge any attempt that has ever been made to remove one percutaneously has in fact succeeded?
A. I think that these can migrate into different areas. In the vast majority of these -- it's a rare occurrence when it does occur -- the vast majority are removed by a cardiologist, invasive radiologist.
Since I have been here for 12 years there has not been an incident in that 12 year period we have been called upon to remove them.
Q. I take the answer to my question is yes, it's

always been removed percutaneously rather than surgically?

A. I assume so. I don't know that we have seen 100 percent of the cases. We are the only people that do the surgery so I suspect so.

Q. Did you have any contact with Dr. Varma when he was here at the hospital?

A. No.

Q. I take it you weren't aware of his existence until after he left?

A. That is correct.

Q. Do you have, based upon your review of the record, any opinions as to who was responsible for leaving the guide wires in Mrs. Weitzel?

A. I do.

MR. FULTON: I was going to have an objection.

MR. SEIBEL: You can have an objection,

Q. What is your opinion, Doctor?

MR. FULTON: Did he say yes, he had an opinion?

MR. KAMPINSKI: Yes.

MR. FULTON: Is it set forth in the report?

Q. Go ahead, Doctor.
A. I believe the guide wires were inserted, the femoral arterial lines were attempted to be placed by Dr. Varma.
Q. There were two guide wires?
A. Right.
Q. Apparently Dr. Steele wasn't aware there were two when he originally went into surgery on the 13th; do you know one way or the other?
A. I don't know whether he was aware there were two or not,
Q. Have you had an opportunity to see the guide wires themselves?
A. I have seen the chest x-rays.
Q. From your review of the x-rays, were you able to determine whether or not these were partial guide wires or --
A. A fragment.
Q. That would be partial.
A. Or the whole guide wire?
Q. Yes, or the whole guide wire?
A. I would have to assume they are the whole guide wire. They are both the same length. It would be hard to shear one off at the exact same site the second time.

Q. You mentioned before about migration. Doctor, your review, did you review the x-rays from the point in time that -- immediately after they were put in until the surgery?

A. Yes.

Q. They had not migrated, had they? They had always been apparently in the iliac artery from the time they were lost, to the carotid, they stayed in the same place?

A* Yes. They appeared in the x-ray -- the inference of migration comes from the fact they were inserted in the femoral radial artery.

Q. I follow you.

A. The other tip is in the iliac.

Q. That is through the point in time they were first observed in the x-ray the day after the insertion?

A. Correct.

Q. These were J tipped guide wires?

A, I believe so.

Q. Is there any significant risk of perforation with those kinds of guide wires?

A. There is a risk of perforation with any vessel with any foreign material, whether it is a wire, whether it's polypropylene, whether it is

plastic, any catheter, any foreign material when present in a blood vessel has a potential to ultimately perforate.

Q. The failure to adhere to the appropriate standard of care by Dr. Varma in putting in or in allowing the guide wires into Mrs. Weitzel's arterial system, do you believe the failure contributed to cause Mr. Weitzel's death?

MR. **FULTON:** Objection.

A. I do.

Q. How would you characterize his failure to apprise any of the attendings or any of his senior residents of what he had done?

MR. **FULTON:** Objection.

Q. It's very difficult to accept that behavior in any way as anything but reprehensible. Obviously there isn't any such thing as a risk free procedure. Any medication carries with it a certain price in terms of the complications, et cetera. If you recognize an untoward result, you deal with it. To not -- I can only look at this one of two ways.

If he did recognize that he lost the guide wires, he did nothing about it subsequently, then he's at fault from virtually

every cannon of medical ethics I understand.

If he didn't recognize he lost the guide wire, he didn't recognize it a second time, then he's at fault because he's clearly demonstrating incompetence. He should not be put in the position he should have been, doing those kinds of procedures.

Q. That would reflect --

MR. FULTON: We move to strike as being outside his report and on the further basis I don't think that violations of ethics is a ground for malpractice action.

Q. I take it, Doctor, that what you just indicated, at least in terms of the second part, would be a reflection of inadequate training on his part, would that be?

MR. FULTON: I would like to have an objection as to outside of his report.

A. You can be well trained and still do something stupid. It's not necessarily an inference his training was at fault for what he subsequently did.

Q. I guess I was trying to follow-up on the way you characterize the two possibilities.

He didn't realize what he had done,

obviously if you are talking about putting a catheter in, doing guide wires, that is something you should know how to do?

A. One would hope so. I don't know you can cite his training.

We all see this, as you probably have colleagues you think are well trained, do silly things in court.

Q. Are you talking about maybe the program of training as opposed to that training of that individual?

I take it in the context of training somebody how to do invasive procedures such as putting in a catheter, putting in a guide wire, that is something that should be observed by someone senior to him to insure he knows how to do it before allowing him to do it on his own?

A. Correct. That is the only way you can learn to do it in the first place.

Q. Dr. Smead testified Wednesday that had the nurses and/or residents postsurgically apprised somebody who would have then done something to address her condition, that it wouldn't necessarily have required any additional surgery, exploratory surgery to correct the problem, it may well have

stopped bleeding on its own?
A. That is possible.
Q. I mean there is no way to tell at this point I take it?
A. Correct.
Q. In light of her condition, we talked about this earlier on, prior to surgery, that you believed allowed both Dr. Steele and Moasis to appropriately have her undergo surgery, is it your opinion she probably would have survived had the postoperative negligence not occurred?
A. I believe she certainly would have survived the surgery itself. The rest of the question relates to the severity of her original insult regarding her heart attack and hypoxic encephalopathy. The surgical extraction, I believe she would have survived that.
Q. Hypoxic encephalopathy deals with an insult that she had at the time of her cardiac arrest, correct?
A. Correct.
Q. It does not automatically equate to brain damage, does it?
A. It is brain damage.
Q. It doesn't necessarily equate to any

permanent brain damage, does it?
A. Not necessarily.
Q. That would have been evaluated based upon her response to stimuli, her neurological evaluation, correct?
A. Correct.
Q. I think you testified earlier that neurologically she seemed to be improving?
A. Yes.
Q. Have you discussed this case with any of the other either physicians involved and/or experts involved in this case?
A. No.
Q. There have been objections interposed, as you heard, by other counsel as to your responding to questions that I addressed to you that weren't necessarily set forth in your report initially. There are any other opinions you have or hold as relates to the responsibility of any parties involved in this case that are not set forth in your report?
A, No, I think we covered it pretty well.
MR. KAMPINSKI: That is all I have.
MR. FULTON: I'm Burt

Fulton. I represent Dr. Varma. Incidently, in your first report --

MR. KAMPINSKI: Can I ask a question?

Do you intend to ask questions, Mr. Coyne?

MR. COYNE: Yes.

MR. KAMPINSKI: 1 object since you represent the same party.

MR. FULTON: I don't see it that way.

MR. KAMPINSKI: There is no argument about that. Dr. Varma was an employee of Charity, you both represent the same party.

MR. FULTON: He hadn't even taken his medical boards.

MR. KAMPINSKI: What does that mean, he shouldn't have been there?

MR. FULTON: He had not taken --

MR. COYNE: Mr. Fulton represents Dr. Varma. I do not represent Dr. Varma. The fact the hospital may be legally responsible for some of Dr. Varma's actions is a separate issue as far as representation is

concerned. The pleadings and everything else clearly reflect Dr. Varma is represented by Mr. Fulton. I represent the hospital.

CROSS-EXAMINATION

BY MR. FULTON:

Q. Incidentally, Doctor, in your report there was never any mention here about your opinions on Dr. Varma, that is true, is it not, your report contains nothing with respect to that?

A. Correct.

Q. In any relationship you ever had with Mr. Kampinski, did he ever talk to you about this case sometime back, perhaps when you were involved with him from a medical standpoint for his family?

A. No.

Q. Although this question is probably improper, was this aspect of the case discussed with Mr. Seibel prior to your testifying here today, regarding Dr. Varma?

A. Which? I am sorry, which aspect?

Q. The opinions you gave with respect to Dr. Varma, did you go over this with Mr. Seibel beforehand?

MR. SEIBEL: We discussed

it.

Go ahead.

A, It's impossible to discuss this case without including the actions of Dr. Varma. One would have to comment on exactly how the guide wires got there.

Q. Do you know a Dr. Keating at Charity Hospital indicated that a guide wire can be in effect lost, the individual not realize it; would you agree with that?

MR. KAMPINSKI: I object. I don't know that she said that.

A. I think that certainly could happen.

Q. With respect to the number of guide wires removed here at Mount Sinai percutaneously, what was the longest period of time between when the wire was first inserted and when it was discovered?

A. I would have to go back and look, Mr. Fulton, it's such a rare event that it happens that we really have not been involved with this for a long time.

It's a rare event because there are basic precautions you can take to keep it from happening. In terms of our cardiologists and radiologists, how often they would see these

procedures, if they see it once every two or three or four years it's a lot. I think your question would be better directed toward that arena because we really don't get involved unless they simply can't get the guide wire out. The last time we were involved was five or six years ago.

Q. That leads to my next question. I take it you have experts here that have been trained to remove these guide wires in the event they do get lost in the vascular system?

A. Their training would involve techniques that would allow them to do that. No one trained specifically to remove foreign bodies because that doesn't occur that often, hopefully.

Q. It occurs often enough to know a means of removal is use of a basket you said?

A. That was originally designed to extract foreign bodies such as bullets in a vascular tree that migrates. You get shot in the leg, migrates to the femoral radial vein. Can go to the heart. They can retrieve those with baskets and other kinds of techniques.

This is an age of medicine less and less invasive. You can do more and more with catheters. More and more guide wires are being use

for a variety of reasons. The techniques that are developed have been developed because they have better technology that can snare bits of catheter debris or other kind of foreign materials. That is the reason why that expertise exists, but still a guide wire that is lost is a relative rarity.

Q. Who are the experts at Mount Sinai with respect to the retrieval of these?

A. Any one of the invasive radiologists or invasive cardiologists, eight or nine people here.

Q. How many do you believe over at the Cleveland Clinic can do this?

A. I would assume it's a cast of thousands.

Q. Over at University Hospitals, how many there?

A. Again, I don't know since both of those institutions are two and three times the size of ours, I assume a proportionately greater number of people could do that,

Q. Someone out at say a small hospital in Wellington, Ohio ended up with a guide wire in, it would be a good idea to call someone like Mount Sinai or University Hospitals or Cleveland Clinic to retrieve it, wouldn't you think?

A, Unless someone there felt they possessed the expertise to do this.

Q. Incidently, I know you answered this -- you mentioned something about a bullet or like shrapnel. I can speak to that. The fact is sometimes they leave it in the body, don't they?
A. Again, you can leave it in the body if it's not in a particular cavity or you don't feel it's at risk of migrating. In that particular case, shrapnel and bullets can be left in place.
Q. As a matter of fact, bullets have been left in individual's heads as well as around their hearts; isn't that true, you know that?
A. That is correct.
Q. I'm interested in something else. You indicated you were working on something statistically about health care?
A. Correct.
Q. I take it you are talking about the chances of survival depending upon an individual's condition and the type of procedure undertaken?
A. Lightly related to that. There are a number of state agencies that are not harvesting all the data for cardiac surgery --
Q. Could I --
A. -- printing that material in the newspaper with predicted mortalities for given surgeons and

given hospitals. This happened in New York State and Pennsylvania. The predicted mortalities they are deriving are in fact quite at variance with what appears in our literature. There are many surgeons who are being tarred with a very bad paint brush that in fact they don't deserve.

If you look critically at the data in our literature, where it is measured outcomes, you will find that the predicted mortality rates are very erroneous and vastly lower than what really should be. So that is what I'm currently studying.

Q. Obliquely, could I be furnished with that material?

A. Right now it is in the form of a bunch of floppy disks. As soon as it's published I will be happy to give it to you. This is a project that is going to take a year-and-a-half, Burt.

Q. That is not going to help me much by the 18th, is it?

A. I don't think so.

Q. I take it then in this statistical study they deal with individuals depending on myocardial infarct?

A. These are all patients that had a coronary

surgery. Specifically coronary bypass and valve surgery.

Q. Does it deal with people with that type of surgery after the myocardial infarct, as opposed to prior thereto?

A. Yes, Part of the data involved patients that had cardiac surgery, not general surgery.

Q. I understand there are statistics with regard to general surgery. People with myocardial infarct that survive, there is statistical data on that?

A. There is.

Q. I take it that you are familiar with the APACHE II classifications?

A, There is an APACHE 111.

Q. Do you know offhand where could I find it?

A. Probably the Journal of Critical Care or Anesthesia, any one of those.

Q. I wonder if you are familiar with these two articles?

A. I'm familiar with APACHE scores.

Q. You are talking scores as opposed to what may be in this article. Let me show you.

A, Yes.

Q. Whether or not you're familiar with the article, you are familiar with the facts as had

been written with respect to someone who had as you said a brain insult with respect to survivability, et cetera, right?

A. Yes.

Q. Were you advised heretofore of the amount of time that apparently she was without blood pressure or pulse?

A. At the time of the initial event?

Q. Yes.

A. Prior to transfer to Saint Vincent?

Q. Yes, initial event in Ashland?

A. No, I don't know exactly the time frame. Just the profile of the patient when she was admitted to Saint Vincent.

Q. If you were to assume for half an hour at least, according to the findings of the individuals who took her to the hospital, she was without blood pressure, pulse they could determine, that would indicate to you what?

MR. KAMPINSKI: I'm going to object.

A. If we assume she had no blood pressure or pulse for a half an hour, one has to inquire what was going on at that time, was she undergoing closed chest massage, CPR, was that being done at

the time? Had to have been.
Q. Fortunately I don't have to answer questions today.
A. It had to have been. It's very difficult to believe this lady would have any recoverable brain function whatsoever if she was truly without blood pressure or pulse at normal thermia for 30 minutes,
Q. Someone could say there was no blood pressure, they were unable to get it?
A. You may not be able to feel the pulse. There may be a low blood pressure that may provide enough perfusion to keep some kind of function in existence.
Q. You used the word brain insult heretofore I thought?
A. Yes.
Q. Brain insult is what?
A. Any deprivation of the normal physiology, i.e., blood flow to the brain, head trauma.
Q. You get an insult, there are dead tissues, if there is some insult to the brain, certain tissue that dies in the brain; isn't that true?
MR. KAMPINSKI: Objection.
A. Perhaps irreversible, perhaps reversible. If this lady came in comatose, over a period of time

became progressively more responsive, certainly she had some reversible insult to the brain, The key to long-term prognosis was to determine how much is reversible. I don't know we have a way to determine that,

Q. Have you had a patient that you operated on that you defibrillated 17 times?

A. Preoperative, postoperative, intraoperative?

Q. Let's try all three.

A. We had one defibrillated 104 times.

Q. Pre or post?

A. Preoperatively, in the operating room, until we could get the patient on the heart/lung machine.

Q. You indicated here something about the fact of some of the problems that can come about through wires being left in the arterial system or vascular system?

A. Guide wires, yes.

Q. As a matter of fact you recall, do you not, from reading the record at least, the one that was taken out percutaneously was analyzed and revealed no infection, are you aware of that?

A. Yes.

Q. You are aware of the fact Dr. Moasis

indicated he saw no signs of infection with respect to the guide wire he took out?

A. Correct.

Q. Based upon that you would at least, I presume, would have to come to the conclusion at least those two events indicated no infection on the first or second wire?

MR. KAMPINSKI: On the first or second? The second one wasn't cultured.

Q. I'm saying Dr. Moasis indicated there was no infection on the second wire?

A. He doesn't see it grossly. To be sure you have to have a culture, One would assume they weren't.

Q. You indicated something about shearing, you figured they were full size because they weren't sheared. I take it from that statement that some of the problems with respect to guide wires remaining in various patients is the result of sheering by virtue of removal of the needle and sheering the guide wire itself?

A. Correct. If you insert a flexible wire through a sharp needle, then the wire retains its flexibility. If you pull it back to rapidly'the sharp needle will shear off that portion of the

guide wire at the tip. If it completely sheers it off, it migrates into the vascular tree wherever it's going to be carried. If you partially shear it you can get it back out, You have to surgically extract it.

If shear off two catheters or two guide wires, it isn't likely they would be the identical length they appear to be in the x-ray.

Q. Do you have the x-rays or copies of them with you?

A. I don't believe so.

Q. You said you saw certain x-rays?

A. We reviewed the x-rays some months ago.

MR. SEIBEL: Yes.

A. Returned them,

Q. Mr. Kampinski asked you questions about migration.

A. Yes.

Q. Do you remember whether you made any measurement to determine whether there was further migration of what remained in Mrs. Weitzel after the percutaneous attempt?

A. No. We felt that the wires where we saw the wires initially on the very first x-ray that display these, is the same place they were when

they were extracted.
Q. You are saying insofar as the percutaneous removal of the wire or whatever Dr. Steele -- he indicated a piece of at least what he removed, the other remained in the same position?
A. Appeared to have, yes.
Q. If it's in the same position, it was down as far as the wire that was removed?
A. I would assume so.
Q. That would be in a position that would make it more easily available to someone with expertise to be able to use a basket or snare or catheter to remove it percutaneously?
A. Dr. Steele would be an expert in this since he removed the first one, The question is why couldn't he remove the second.
Q. I'm not worried about Dr. Steele. Let's talk about you.

Do you feel that would be in the position, in the same place that would permit a second percutaneous removal by someone of expertise at Mount Sinai?
A. Again, Dr. Steele is an invasive cardiologist, done many cardiac caths. He knows the patient. He tried to get the first one out, he

spent two hours in the cath lab trying to get these wires out. So if he stopped, he stopped for a reason.

One would have to ask Dr. Steele questions why he stopped, why he didn't feel any further attempts at percutaneous extrication would have been appropriate. I can't tell you that for sure.

He may have run into something. The patient may have been in tremendous pain, moving all over the cath lab table. He may have felt the radiation exposure from the constant fluorscopy didn't justify proceeding in a lady that already had numerous x-ray exposures. There are probably a number of reasons.

I think if that really is an issue, that should be taken up with Dr. Steele.

Q. Unfortunately I don't have Dr. Steele here. I have you and you are a very difficult witness to examine. All I would like to have you answer is with respect --

A. Thank you, Burt.

Q. If the wire were in the same place, didn't migrate at least after the first percutaneous removal, it would be in a position that perhaps you

would have brought in someone from your department here, cardiology or radiology, who would attempt a second percutaneous removal? I'm talking about you.

A. I can't tell you that. If you ask me why can one surgeon do a procedure and another surgeon can't on any given patient, I can't tell you that, I was not there. There may have been technical considerations in this woman that came to bear on the decision to have it operatively extracted.

Q. At least you will say as far as concern here at Mount Sinai, over your long experience, you have never heard of one that had to be surgically removed?

A. That is correct.

Q. What is hypoxic encephalopathy?

A. That is insult to the brain function because of deprivation of oxygen. Usually caused by an interruption of circulation to the brain.

Q. Not a good thing to have?

A. No, it's a very bad thing.

Q. It can shorten your life?

A. It certainly can.

Q. So can A.R.D.S shorten your life?

A. Yes, certainly can.

Q. Multiple organ failure after myocardial infarct can shorten your life?
A. Yes.
Q. They are not good things to have?
A. No.
Q. If you have a combination A.R.D.S and myocardial infarct, a two by two inch spot that was damaged, you have multiple organ failure, you have your lungs very full, which you saw on those x-rays almost black at one point in time, isn't that true; that is not good, is it?
A. Without rephrasing, without rephrasing my observation on the x-ray, it's not good to have any of those, no.
Q. You saw the x-rays?
A. I did see x-rays.
Q. Those indicate she had a bad pair of lungs?
A. She had lungs that were certainly insulted with A.R.D.S or whatever diagnosis you want to attach to infiltrated. On the films were infiltrated. Were improving over the course of her hospitalization.
Q. They still weren't good?
A. Good in the sense they were less than they were before. If before was bad, now they are

better. Did she have a normal chest x-ray, no.
Q. It was very abnormal? You as a very well qualified thoracic surgeon can say they were bad, weren't they?
A. I appreciate your endorsement. Looking at the x-ray, the x-ray showed she had residual pulmonary infiltrates. They we improving from when she first showed at the hospital.
Q. She showed up dark in the x-ray?
A. You have to be careful, Burt, when you say dark. Dark is the normal appearance of normal lung.
Q. Then it was white?
MR. KAMPINSKI: You don't really care, do you?
Q. You wouldn't call them a good set of lungs, would you?
MR. KAMPINSKI: Objection,
A. They were not normal.
MR. FULTON: No further questions.
MR. COYNE: My name is Bill Coyne, I represent the hospital in this case. I have some questions for you.
MR. KAMPINSKI: I will object

once again, for the record, to both of you asking questions of the Doctor.

MR. FULTON: Hope he does better than I did.

CROSS-EXAMINATION

BY MR. COYNE:

Q. The hypoxic encephalopathy was a result of her cardiac arrest, correct?

A. Yes.

Q. To cover a few more things you observed both in your review of the records and now that I know you looked at the x-rays, she had bilateral pneumonia too, correct?

A. Pneumonia reflected she was infiltrated in both lungs, yes.

Q. She had adult respiratory distress syndrome?

A. A.R.D.S. is a loose conglomeration of diagnoses. They fit the picture.

Q. Cardiac arrest, the pneumonia, the adult respiratory distress syndrome, hypoxic encephalopathy, none of those illnesses were caused by anyone negligent or lack of due care, correct?

A. Correct.

Q. When she entered Saint Vincent Charity

Hospital on February 12th she came in with the history and the symptoms of the cardiac arrest and the recent hypoxic encephalopathy; is that correct?

A. Yes.

Q. Then after she arrived, while she was a patient in the hospital, she developed these other illnesses such as pneumonia, adult respiratory distress syndrome and sepsis, correct?

MR. KAMPINSKI: Objection.

Q. While in the hospital?

A. They occurred while in the hospital. Whether they were natural consequences of the cerebral insult is hard to say. You can have insult to the brain and subsequently see a picture of **A.R.D.S.** just because of brain insult. That is well known.

Q. My point is they were obvious while she was a patient in the hospital from the 12th to the 15th when she passed away, none of those illnesses were a direct and proximate result of any substandard care, correct?

MR. KAMPINSKI: Objection.

A. If we can back up a minute, she was admitted to the hospital, she had a diagnosis of hypoxic encephalopathy, developed infiltrates on the x-rays while being attended to. When does someone cease

to carry a diagnosis of A.R.D.S if in fact they are getting better, I don't know. When you say someone has A.R.D.S, it means they are actively compromised. This woman, while actively compromised, was in fact recovering.

Did she continue to have A.R.D.S, was she manifesting the x-ray picture of her attempt to recover, i.e., reshaping her lungs, replacing tissue, that is anybody's guess. Clinically she was getting better.

Q. Didn't it show on autopsy she still had A.R.D.S at death?

A. Again A.R.D.S is only an x-ray picture, not an autopsy finding. You can describe lungs that weigh more, culture out bacteria, viruses that are consolidated, you can't make a diagnosis of A.R.D.S in the autopsy itself.

Q. You did observe on the autopsy that in the microscopic description of the lungs she had organizing acute bronchopneumonia wide spread widening of alveolar septae?

A. Yes.

Q. That is indicative that there is still an ongoing problem with the lungs certainly?

A. Yes.

Q. You indicated that you viewed the x-rays and on x-ray it was not difficult for you to see the two full length guide wires present February 28th until March 13th, correct?
A. Correct.
Q. From your recollection of your viewing the x-rays, can you tell me by way of x-ray review now when the adult respiratory distress syndrome we spoke of began to improve by x-ray?
A. It's very difficult to assess by x-ray. First of all, you have to realize the limitations of the techniques. You are taking a portable film, the patient is supine, it's difficult to see detail you need to.

If you want to examine all regions of the lung, one assessment of improvement or aggravation of the A.R.D.S picture would really come clinically. You can have an x-ray that looks very bad, a patient that clinically improves, your conclusion would be that patient is continually improving. The x-ray lags behind the clinical picture.
Q. I understand. Maybe I misunderstood what you said when you were answering Mr. Fulton's questions, I thought you said on x-ray you could

see the adult respiratory distress syndrome as improving?

A. The appearance of her later films were certainly better than the earlier films were when the A.R.D.S was at its worse.

Q. Can you remember when the x-rays began to improve by appearance?

A. I don't recall the date. There was a bunch of serial films we looked at months ago. I would have to go back.

Q. In your report, you indicate that following the surgical procedure, if notified, Dr. Moasis could have come back to the hospital and intervened with immediate reexploration and repair. Do you remember saying that in your report?

A. Yes.

Q. Do you believe, knowing this patient's history, knowing her multiple illness, that she would have withstood a reexploration by way of surgery after the surgical event of March 14th?

A. Yes.

Q. You think she could have been operated on again and survived it?

A. Absolutely I do.

Q. That is your opinion?

A. Yes.
Q. Are you familiar with the manner in which she was transferred from the cardiac care intensive care to the operating suite for the surgical procedure by Dr. Moasis?
A. No, I'm not.
Q. Are you familiar with the fact he had to detach her from the mechanical ventilator, put her on a gurney, roll her down the hall, by way of ambu bag, continuous ambu bag monitoring, take her into the surgical suite and reconnect her to the ventilator in the surgical suite to do the surgery?
A. That I'm familiar with, yes.
Q. That in and of itself presents a risk to the patient of this type, doesn't it?
A. As opposed to someone without all those accouterments, yes.
Q. Absolutely. Yes.
What was the cause of the elevated white blood count throughout her hospital stay?
A. I think that is anybody's guess. There have been a lot of opinions offered. An elevated white count is certainly an indication of ongoing infection and ongoing acute blood loss, and as I believe the most recent opinion, prior to surgery

was steroid use.

Q. Is that an opinion you hold, it was the steroids caused the elevated white blood count?

A. Again, I would have to go on the basis of the specialists taking care of her.

In this woman who clinically appears to be getting better, it's difficult to ascribe an elevated white count to undiscovered or ongoing infection. Her clinical course would not be improving.

Q. You are relying upon others for that opinion then?

A. Also the fact in studies in our own field, cardiac surgery, in an attempt to detect the source of infection the white count is a notoriously unreliable figure.

Q. Your opinion in this case, I want to get clear, did you mention in your report that is why you said she had a number of measurements between 20,000 and 40,000 and in fact her most recent elevation was attributed by the infectious disease consult to steroid administration?

A. Correct.

Q. Do you agree with that?

A. I do.

Q. Is that based on the fact you agree with the consult or independent evaluation you made?
A. I agree with the consult. The infectious disease people are the sleuths. They go over the patient as thoroughly as anybody can do so. If they come up with the conclusion such as that, it's difficult to ignore that.
Q. Being the consultants or the sleuths of the team caring for a patient, would you expect that the surgeon would discuss the condition of the patient and the patient's amenability to undergo surgery prior to commencement of that surgery, would he look to the sleuths before undertaking surgery on a patient such as Mrs. Weitzel?
A. It's better for all concerned if the physicians communicate with each other certainly. I don't know what information Dr. Moasis needed, how much he knew of Mrs. Weitzel at the time, presumably he read the consult and interpretation.
Q. You wrote Dr. **Moasis** had every right to consider the patient as stable as she ever would be to tolerate the procedure that was required?
A. Correct.
Q. That kind of intrigues me, to say the least, **when you say she was** as stable as **she ever would**

be. I assume from that statement that you don't believe she was going to get any better while she was in the hospital?

MR. KAMPINSKI: Objection.

A. No, when I used the term stability, I mean both from a respiratory and cardiac status we are dealing with invasion of the vascular system. This woman came in under rather hard circumstances, actually began to recover.

Initially I was under the impression neurologically she was pretty impaired, was told that no, in fact she was actually responding appropriately, could follow commands.

Q. Who told you that?

A. I believe that we had evidence of that as described in the nurse's notes. Specifically that is what we looked for.

Q. I'm asking who told you that?

A. 1 looked in the nurse's notes, it's described.

Q. You said you were told by somebody?

A. When I say I was told, observation I made. As you well know nurse's notes are a source of a great deal of information.

Q. Maybe your semantics threw me off.

A. I am sorry. I apologize for the indiscretion.

Q. You could have been told by somebody. I wouldn't know.

A. No, these were nurse's notes. Under those circumstances, neurologically she is improving, if an elevated white count everybody is concerned about is from the steroid administration or infectious disease manifested by the cardiac instability in the weeks she's been in the hospital, it's difficult to say we should still wait to extract this guide wire when in fact if you postulate the scenario the next day the guide wire could migrate into her brain, she could throw a final embolist, die of a massive stroke. The neurologic threat of those guide wires is enormous, not to mention the ability to slowly perforate through a major vessel.

Q. Let's back up. You said a lot there. I appreciate all the input.

Between February 28th when you first observed the two guide wires on the x-rays, March 13th, the last time the x-ray showed two guide wires before one is removed, they had not migrated on x-ray as you observed them, correct?

A. Correct.
Q. Further after the percutaneous removal of the one guide wire the patient now has one guide wire left in her?
A. Correct.
Q. You are aware of the fact, to my knowledge, that there is nobody questioning the percutaneous removal of the guide wire on the 13th by Dr. Steele?
A. Correct.
Q. So when we go beyond the 13th, we start talking about one guide wire at that point, correct?
A. Yes.
Q. I don't want to pass this over because I'm still a little bit confused about your statement in your report where you say Dr. Moasis has every right to consider this patient as stable as she ever would be to tolerate the procedure that was required. You indicated to me when you wrote that you were thinking of her respiratory and vascular system primarily?
A. True. Other considerations certainly.
Q. I am asking you, was her respiratory and vascular system then as stable at that time as it

was ever going to be in this patient, it was not going to get any better in your professional opinion?

A. It's not a matter of -- the improving stability means she maintained the same level course without subsequent deterioration.

Q. You indicate --

MR. KAMPINSKI: Let him answer.

MR. COYNE: I am trying to get to his answer rather than yours.

A. If the patient is deteriorating you can't do anything to the patient. If the patient is stable or improving, the likelihood is you can intervene and intervene safely.

We operate on patients with a bigger procedure and more drastic surgery, for massive sepsis, infected heart valves, we take those patients to the operating room, do all sorts of major intervention.

This procedure on a scale of one to ten is about a three or four in terms of overall invasiveness. She did not manifest instability that would have suggested they not go to the operating room based upon the risk of the guide wires to her.

Q. I'm not going to argue with you. I don't think you answered the question.

A. I'm really trying.

Q. You may be. I think you are missing the whole boat. If you said she was stable, he could operate, I could understand what you are saying, You say in your report that she was as stable as she ever would be. You get my point?

A. I'm --

Q. Presumably as far as the stability of her respiratory and cardiovascular system, which you said you were thinking of, it wasn't going to get any better?

MR. KAMPINSKI: I object.

A, I'm not saying -- you are putting words in my mouth. I'm not saying not get any better. I'm saying the lady is stable. If you accept the fact she has something which needs to be addressed and addressed soon, then life is a series of balanced risks.

The risk to the lady from the guide wires, to me, is greater than the risk of taking her to the operating room and extracting them under controlled circumstances.

There is certainly nothing that

occurred during or immediately after the conduct of this procedure that suggests that pulmonary, cardiac infectionwise she had any problem whatsoever. It was a matter of blood loss that went unrecognized.

MR. KAMPINSKI: Because you now asked this question to the Doctor, the same question three times, you took it out of context in the report. You took out four words out of an entire sentence. The entire sentence says precisely what the Doctor just said.

MR. COYNE: I read it.

MR. KAMPINSKI: You didn't read the whole sentence,

Q. I'm going to read the whole sentence. I said, "Dr. Moasis had every right to consider this patient as stable as she ever would be to tolerate the procedure that was required."

MR. KAMPINSKI: Right.

Q. That is all I'm asking, My confusion perhaps was the words she was as stable as she ever would be.

A. I understand. Perhaps it would be better to say this lady is stable to tolerate a procedure.

Q. What was the cause of the blood loss after

the surgery?

A. Well, again, one can postulate a leak from the suture line. One could postulate an ooze which is a slow leak from the surgical surfaces in the operative field, especially if this woman was not clotting properly. It's possible this woman might have had some clotting problems. Long time in the hospital, previously infected, et cetera. These patients notoriously can develop those kinds of problems. When you operate in the area of the retroperitoneum, it's a big space. You can easily leak into the area over a period of time, not recognize it.

One could postulate it leaked from the suture line. It started late. Clearly no one would close an incision if the suture line in an artery was actively leaking.

I have to assume there was a slow, diffuse ooze based on the description from autopsy of a 300 to 400 cc hematoma which in and of itself would not be enough to account for her demise.

Then a hematoma that runs the length of the entire retroperitoneum, which sounds like she is slowly bleeding into the soft tissue. It takes some time for that to happen.

Q. The bleeding stops at death?
A. When the blood pressure becomes too low to cause bleeding.
Q. You have no opinion when, how long after the surgery that she began to bleed?
A. I can only assume that it must have been roughly seven or eight o'clock that evening when she began to show signs of deterioration of her vital signs.

I believe when Dr. Moasis saw the patient before he left, at that time she was stable. In fact, he accompanied her from the operating room to the coronary care unit, went back to see her before he left. In those two observations there was no indication at that point she had any hemodynamic instability or pulmonary insufficiency.

Q. The bleeding was a complication of surgery?
A, Certainly.
Q. Do you have any opinion as to life expectancy of this patient, realizing the multiple organ problems she was having, had there been no wires introduced, had she not therefore needed surgery to remove the wires?

MR. KAMPINSKI: Objection.

A. In terms of would her life span be normal, I don't think she would have had a normal life span. The pulmonary insult would have to be further defined based upon the pulmonary function study, breathing study, to show us what kind of impairment the A.R.D.S, for want of a better term, has left her with. She would have to have functional cardiac studies, cardiac catheterization, perhaps a stress test, to see, further define the anatomy, see how much functional muscle she has at risk from the high grade obstruction, the left anterior descending.

The size of the infarct alone measured at autopsy is a difficult assessment to make because you don't know how much muscle was functionally impaired, is irreversibly damaged. The only way you can tell that would be with a dynamic study such as a thallium stress, Dobutamine challenge to determine if the lateral wall, anterior wall would have recruitable back to normal functioning if revascularized with surgery, angioplasty or followed medically. There are a lot of contingencies.

MR. COYNE: No further questions.

MISS BITTENCE: No questions.

MR. JACKSON: No questions.

MR. FULTON: I have two more.

MR. KAMPINSKI: Objection. Just to further point out the absurdity of this, you are asking questions based upon Mr. Coyne's questions; he asked questions based upon your questions.

MR. FULTON: What is so absurd about that?

MR. KAMPINSKI: Because you represent the same party. Go ahead.

MR. FULTON: We are not doing very well. You ought to be happy.

MR. KAMPINSKI: I object.

RECROSS-EXAMINATION

BY MR. FULTON:

Q. Can you point me to any literature or study that ever revealed a guide wire inserted in the femoral radial artery migrating to the brain?

A. I don't know that I recall that specifically. There are certainly papers and literature that deal with complications of guide

wires.

Q. I understand that. Do you know of any you could point me to with respect to migrating to the brain?

A, No, I don't.

Q. The last question, in simplistic terms, which I have to direct myself, what did she die from?

A. She died from blood loss. Unrecognized blood loss.

Q. I guess in the vernacular of medicine this is called a postoperative death?

A. Yes.

MR. FULTON: No further questions,

MR. KAMPINSKI: I have just a couple to follow up on Mr. Coyne.

RECROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. In terms of your answer to Mrs. Coyne's last question, I take it there are multiple things you just can't determine or can't tell with respect to the cardiac status, how she would have been treated once she would have been discharged from the hospital, whether revascularized by bypass,

angioplasty, which is use of a balloon, or medication?

A. Correct.

Q. The autopsy did reveal a blockage of the -- I believe the LAD; is that correct?

A. Yes.

Q. Is there any way that you can determine by the autopsy alone whether that was a treatable lesion by virtue of bypass if in fact the other modes were not or could not be used?

A. You can if the anterior wall would be demonstrated, would be demonstrated to be all scarred, narrowing of the LAD alone that supplies it would be of questionable value to operate on that particular artery.

If it's deemed to be functional, in fact the anterior wall by thallium or Dobutamine stress test, you see shortening, thickening of the fibers in that region, you have everything to gain by angioplasty or operating on the vessels. They describe some thickening of muscle in the region on autopsy, which indicates a lot of that is pretty permanent scarring of the functional muscle.

Q. It's possible she would have been treated medically as opposed to surgically?

MR. COYNE: Objection to possibility.

A, It's possible.

Q. The reason I didn't ask probable, you can't tell one way or the other what mode of treatment she would have undergone?

A, Correct.

Q. Your response to Mr. Coyne you don't think she would have had a normal life expectancy is once again based upon your inability to determine what mode of treatment would have been provided and what damage there was done as a result of the myocardial infarct?

A. Yes. If you follow the natural history study of patients with coronary disease that have had an operative procedure, by broad fit and number of other people from the Clinic, if you look at people with heart muscle compromise from a previous heart attack in the year before surgery, the long-term survival is decidedly different than if the ventricle isn't compromised by previous infarct, She was not going to live as long statistically as if she didn't have the infarct.

Q. When you say not as long, if somebody -- do those statistics then change a year out or three

years out or depending upon the mode of treatment?
A. If you survive to a certain point are you likely to survive to another point?
Q. Right.
A. It's pretty much a linear function. The further out you get, this lady had pretty advanced hypertensive heart disease as well, beyond the coronary disease. Her heart weighed almost 400 grams, which is one-and-a-half times what it should weigh. She had significant calcific arteriosclerosis of her coronaries at the age of 46, which is quite early.

To postulate this lady who have a normal life span is unlikely. She had a big, thick hypertrophic heart muscle. That is a risk factor that has to be taken into consideration.

Q. In terms of delineating a certain time frame, I take it that is nothing you or anybody can do?
A. No.

MR. FULTON: As to a specific person?

MR. KAMPINSKI: Can I ask my questions?

MR. FULTON: I was trying to clarify it.

MR. KAMPINSKI: If I need clarification, I will ask for it.

What was the last question and answer?

(Question and answer read.)

MR. COYNE: Show an objection.

Q. She might have lived another 30 years, 20 years, 40 years. There is no way as we sit here we can tell?

MR. FULTON: Objection.

MR. COYNE: Objection.

A. No way we can tell how long she would have lived,

MR. FULTON: Statistics do bear out --

MR. KAMPINSKI: Is this another question?

MR. FULTON: Based on your question.

MR. COYNE: Let's get out of here.

FURTHER RECROSS-EXAMINATION

BY MR. FULTON:

Q. There are statistics with regard to longevity with problems such as Mrs. Weitzel's?

A. I think we have seen it.

Q. It's covered there?

A. Yes.

Q. That is these records we asked you to look at?

A. Yes.

(Deposition concluded; signature not waived,)

ERRATA SHEET

PAGE LINE

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

_____

ALAN MARKOWITZ, M.D.

The State of Ohio, .

County of Cuyahoga. CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, ALAN MARKOWITZ, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 10th day of May, 1993.

Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 1998.

Look-See Concordance Report

1,618 UNIQUE WORDS
386 NOISE WORDS
13,064 TOTAL WORDS

SINGLE FILE CONCORDANCE

CASE SENSITIVE

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