

THE STATE OF OHIO

COUNTY OF CUYAHOGA. - - - - -

Doc 287

IN THE COURT OF COMMON PLEAS

- - - - -

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.

- - - - -

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.



## FLOWERS & VERSAGI

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I N D E X

~~WITNESS:-~~ ALAN MARKOWITZ, M.D.

	PAGE
Cross-examination by Mr. Kampinski	6
Cross-examination by Mr. Fulton	42
Cross-examination by Mr. Coyne	59
Recross-examination by Mr. Fulton	76
Recross-examination by Mr. Kampinski	77
Further recross-examination by Mr. Fulton	82

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(NO EXHIBITS MARKED)

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(FOR KEYWORD AND OBJECTION INDEX, SEE APPENDIX)

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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:

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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

1       there yet?

2       Q.       This has been recently revised.

3       Q.       What additions are there then to the CV?

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

7       Q.       Are there additional articles?

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

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

13      A.       No .

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

17      A.       Yes.

18      Q.       How many times, roughly?

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

21      Q.       Do you have a list of the cases?

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

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

1 A. Once.

2 Q. Do you recall the name of that case?

3 A. I don't.

4 Q. How long ago was it?

5 A. About three or four years ago.

6 Q. Do you remember the names of the attorneys  
7 involved?

8 A. I remember the name of the defense attorney  
9 was Stephen Charms. The plaintiff's attorney I  
10 don't recall. It was in Akron.

11 Q. Which other members of that firm have you  
12 worked with previously?

13 A. Bill Bonezzi, Bob Maynard and a number of  
14 others. We worked together several times.  
15 Probably about a half dozen attorneys in that  
16 firm.

17 Q. Which plaintiff's attorneys do you recall  
18 having taken your deposition in any of those cases?

19 A. Well, there are some that are very  
20 memorable. Paige Martin would be one. Harley  
21 Gordon would be another. Other than that, I think  
22 Mr. Tracy, Don Tracy.

23 Q. Any others, any from Mr. Wiseman's firm?

24 A. No.

25 Q. Anybody else from Nurenberg's firm other than



1 Harley Gordon?

2 A. None that I recall.

3 Q. Have you done any consulting for Mr. Coyne or  
4 anybody in his firm at any previous time?

5 A. I don't believe so.

6 Q. How about Mr. Fulton and his firm, Gallagher,  
7 Sharp?

8 A. Yes, several years ago,

9 Q. How many occasions?

10 A. I think once or twice.

11 MR. FULTON: One for me. I  
12 think once for Beverly.

13 Q. Were those Kaiser cases?

14 MR. FULTON: The one  
15 wasn't.

16 A. I don't believe so.

17 Q. Do you remember the names of those cases?

18 A. Again, I don't. I could certainly find out  
19 from our files. I don't recall them offhand.

20 Q. Do you recall who the plaintiff's attorneys  
21 were?

22 A. I don't.

23 Q. How about for Baker and Hostetler, have you  
24 been your retained by them?

25 A. No.

1 Q. What have you reviewed in connection with  
2 this case prior to preparing your January 28, 1993  
3 report?

4 A. The hospital records that were sent to me. I  
5 believe most of the testimony that had been given  
6 in deposition or as letters from the expert  
7 witnesses up to that time.

8 Q. Do you have the materials here?

9 A. I have materials in my office record, yes.

10 Q. Do you have all the materials that were  
11 provided to you?

12 A. Yes. I certainly have access to them today.

13 Q. Where are they?

14 MR. SEIBEL: I don't know  
15 about the depositions. The medical records.

16 A. The depositions I don't have. I read them  
17 and since returned them.

18 Q. Would you know which deposition you reviewed  
19 prior to preparing your report?

20 A. The deposition that had in fact occurred  
21 prior to preparing the report.

22 Q. In fairness to you, you weren't involved in  
23 the litigation, you wouldn't know how many would  
24 have been taken? Do you have letters that reflect  
25 what was sent to you?

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

7 Q. Really only one deposition at that time?

8 A. Deposition of Dr. Moasis, correct.

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

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

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

18 MR. SEIBEL: Go ahead.

19 Q. Has anything been removed from here before  
20 today?

21 A. No.

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

25 A. Generated by me.

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

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

5 MR. KAMPINSKI: Sure.

6 -----

7 (Recess had.)

8 -----

9 BY MR. KAMPINSKI:

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

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

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

20 A. Correct.

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

23 A. Yes .

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

1       those not contained within the original records you  
2       received?

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

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

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

11      Q.       You wanted those portions back?

12      A.       Correct.

13      Q.       The reason for that was what?

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

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

18      A.       Correct.

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

22      A.       It confirmed it.

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

1 defendant in this case?

2 A. Correct.

3 Q. His report is dated the same as yours?

4 A. That could well be,

5 Q. You received that then subsequent to your  
6 report?

7 A. Yes.

8 Q. Have you received any either written or  
9 verbal reports as to what Dr. Holland said in his  
10 deposition?

11 A. I received a copy of the letter he generated.

12 Q. The report itself?

13 A. I have not read his deposition, no.

14 Q. Who in your practice clears patients for  
15 surgery if in fact an attending is a cardiologist,  
16 yourself, the cardiologist, or both?

17 A. Depends upon what kind of background of the  
18 patient and for what surgery.

19 Q. A patient such as Mrs. Weitzel?

20 A. Who would clear her for a general surgical  
21 procedure?

22 Q. Yes, sir.

23 A. The attending cardiologists would  
24 theoretically be involved.

25 Q. What would be the extent of their

1 involvement, would they clear her from a medical  
2 standpoint?

3 A. I would suspect so.

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

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

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

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

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

24 A. No.

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

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

3 A. No.

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

6 A. Indirectly.

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

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

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

15 MR. SEIBEL: Sure.

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

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

25 A. Yes.



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

4 A. Yes.

5 Q. You don't think however --

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

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

11 MR. FULTON: Did you want to  
12 say something?

13 MR. KAMPINSKI: I do. Just  
14 object.

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

17 MR. KAMPINSKI: Are you done?

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

20 BY MR. KAMPINSKI:

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

24 A. I agree with that statement.

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

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

3 A. That is correct.

4 Q. He should have been notified?

5 A. That's correct.

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

8 A. That is correct.

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

12 A. Correct.

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

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

20 Q. Because of the precipitous drop in the  
21 values?

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

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

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

3 A. Correct.

4 Q. Dropping blood pressure?

5 A. Yes.

6 Q. Remainder of her vital signs deteriorating?

7 A. Absolutely.

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

10 MR. KAMPINSKI: I did change  
11 that,

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

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

18 A. Correct.

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

21 A. No.

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

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

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

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

13      Q.       Does an anesthetic cause changes within the  
14      heart?

15      A.       It may.

16      Q.       Does it make the heart irritable?

17      A.       It may.

18      Q.       Does it depress the function of the heart?

19      A.       It may.

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

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

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

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

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

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

1 try to get the second guide wire out.

2 Q. Everything indicated hemodynamic status was  
3 getting better?

4 A. Correct.

5 Q. You didn't have an opportunity to review the  
6 deposition of Dr. Sopko according to what I looked  
7 at in your chart?

8 A. Correct.

9 Q. Were you told what he said regarding her  
10 pulmonary status?

11 A. That I don't recall. I was going largely on  
12 the basis of her chest x-rays and her blood gases.  
13 In fact she was in the coronary care unit.

14 Q. Those reflected to you her pulmonary status  
15 was improving?

16 A. Yes.

17 Q. I take it you would not disagree with  
18 Dr. Sopko in terms of his belief she be weaned off  
19 the ventilator within two weeks?

20 A. I think that is pretty reasonable,

21 Q. In terms of her cardiac status, that  
22 stabilized shortly after her admission?

23 A. Correct.

24 Q. They stopped doing serial EKG's shortly after  
25 admission I believe?

1 A. Correct.

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

5 A. Yes.

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

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

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

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

11 Q. You made a lot of assumptions there.

12 A. Correct.

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

15 A. Correct.

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

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

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

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



1 percent mortality in 48 hours.

2 MR. SEIBEL: Why are you  
3 smiling?

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

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

8 MR. FULTON: You are smiling  
9 at least.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 A. That I don't know.

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

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

15 Q. Sepsis is a blood borne infection?

16 A. More a sign of systemic infection.

17 Reflecting the fact that infection or product of  
18 the infection got into the blood stream, began to  
19 infect other organs.

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

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

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

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

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

11 Q. Yes, sir.

12 A. No.

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

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

21 Q. They would have done that percutaneously?

22 A. With the basket or something like that.

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

1 A. No.

2 Q. Do you know Dr. Van Aman, the radiologist in  
3 Columbus?

4 A, No,

5 Q. Were you told what he testified to?

6 A, No.

7 Q. Both of them indicated that the second wire  
8 should have been removed percutaneously, as opposed  
9 to surgically, or that further attempts should have  
10 been made to do precisely that.

11 MR. FULTON: That is a  
12 better statement.

13 MR. SEIBEL: I will object  
14 to that mischaracterization.

15 Q. Assuming that is what they said, do you  
16 agree?

17 MR. FULTON: You said two  
18 things.

19 MR. KAMPINSKI: Let' say it  
20 again.

21 Q. Both the physicians testified attempts should  
22 have been made to remove the second wire  
23 percutaneously, prior to any thought of doing the  
24 surgery; do you disagree with that, Doctor?

25 A. I do disagree with that because it's based

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

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

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

25 Q. Were you aware of the experience that any of

1 his partners had in removing guide wires  
2 percutaneously?

3 A. No.

4 Q. Were you aware that Dr. Kitchen attempted to  
5 patent a procedure to do precisely this, claims  
6 himself as an expert in removal of foreign bodies?

7 A. I think that is all very well and good, I  
8 was not aware. It's no indication he would have  
9 been anymore successful than Dr. Steele.

10 Q. You don't think that an attempt should have  
11 been made by him, in light of the fact he wasn't in  
12 Columbus like Van Aman and Smead, as you aptly  
13 point out, not only was he familiar with  
14 Mrs. Weitzel because he covered for Dr. Steele  
15 during vacation that Dr. Steele was on -- he was  
16 not intimately aware of her condition -- you  
17 disagree he should have been consulted and  
18 attempted to remove the wire?

19 A. I think you are asking me to make a judgment  
20 for Dr. Steele, You have to ask Dr. Steele  
21 questions, not consult his contemporary who has all  
22 this expertise. There must have been some reason  
23 if Dr. Steele decided to extricate surgically and  
24 he consulted Dr. Moasis rather than his colleague.

25 Q. Whatever his reasoning was or logic was you

1 defer to that?

2 A. I do defer. There are complications with  
3 continuous manipulation of a catheter in the  
4 femoral arteries. Probably he felt if he  
5 manipulated, the risk of sepsis is substantial in  
6 someone like that, who was probably colonized while  
7 in the intensive care unit, he may have felt a more  
8 sterile and controlled condition would be better  
9 for the patient. Who is to say that is wrong. I  
10 don't think so.

11 Q. Some people may.

12 A. Some people may.

13 Q. Is the reason you never had to remove one  
14 surgically because to your knowledge any attempt  
15 that has ever been made to remove one  
16 percutaneously has in fact succeeded?

17 A. I think that these can migrate into different  
18 areas. In the vast majority of these -- it's a  
19 rare occurrence when it does occur -- the vast  
20 majority are removed by a cardiologist, invasive  
21 radiologist.

22 Since I have been here for 12 years  
23 there has not been an incident in that 12 year  
24 period we have been called upon to remove them.

25 Q. I take the answer to my question is yes, it's



1 always been removed percutaneously rather than  
2 surgically?

3 A. I assume so. I don't know that we have seen  
4 100 percent of the cases. We are the only people  
5 that do the surgery so I suspect so.

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

8 A. No.

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

11 A. That is correct.

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

15 A. I do.

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

18 MR. SEIBEL: You can have an  
19 objection,

20 Q. What is your opinion, Doctor?

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

23 MR. KAMPINSKI: Yes.

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

1 Q. Go ahead, Doctor.

2 A. I believe the guide wires were inserted, the  
3 femoral arterial lines were attempted to be placed  
4 by Dr. Varma.

5 Q. There were two guide wires?

6 A. Right.

7 Q. Apparently Dr. Steele wasn't aware there were  
8 two when he originally went into surgery on the  
9 13th; do you know one way or the other?

10 A. I don't know whether he was aware there were  
11 two or not,

12 Q. Have you had an opportunity to see the guide  
13 wires themselves?

14 A. I have seen the chest x-rays.

15 Q. From your review of the x-rays, were you able  
16 to determine whether or not these were partial  
17 guide wires or --

18 A. A fragment.

19 Q. That would be partial.

20 A. Or the whole guide wire?

21 Q. Yes, or the whole guide wire?

22 A. I would have to assume they are the whole  
23 guide wire. They are both the same length. It  
24 would be hard to shear one off at the exact same  
25 site the second time.

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

5 A. Yes.

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

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

13 Q. I follow you.

14 A. The other tip is in the iliac.

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

18 A. Correct.

19 Q. These were J tipped guide wires?

20 A, I believe so.

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

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

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

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

9 MR. FULTON: Objection.

10 A. I do.

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

14 MR. FULTON: Objection.

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

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

1 every cannon of medical ethics I understand.

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

8 Q. That would reflect --

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

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

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

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

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

25 He didn't realize what he had done,

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

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

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

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

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

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

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

1       stopped bleeding on its own?

2       A.       That is possible.

3       Q.       I mean there is no way to tell at this point  
4       I take it?

5       A.       Correct.

6       Q.       In light of her condition, we talked about  
7       this earlier on, prior to surgery, that you  
8       believed allowed both Dr. Steele and Moasis to  
9       appropriately have her undergo surgery, is it your  
10      opinion she probably would have survived had the  
11      postoperative negligence not occurred?

12      A.       I believe she certainly would have survived  
13      the surgery itself. The rest of the question  
14      relates to the severity of her original insult  
15      regarding her heart attack and hypoxic  
16      encephalopathy. The surgical extraction, I believe  
17      she would have survived that.

18      Q.       Hypoxic encephalopathy deals with an insult  
19      that she had at the time of her cardiac arrest,  
20      correct?

21      A.       Correct.

22      Q.       It does not automatically equate to brain  
23      damage, does it?

24      A.       It is brain damage.

25      Q.       It doesn't necessarily equate to any

1 permanent brain damage, does it?

2 A. Not necessarily.

3 Q. That would have been evaluated based upon her  
4 response to stimuli, her neurological evaluation,  
5 correct?

6 A. Correct.

7 Q. I think you testified earlier that  
8 neurologically she seemed to be improving?

9 A. Yes.

10 Q. Have you discussed this case with any of the  
11 other either physicians involved and/or experts  
12 involved in this case?

13 A. No.

14 Q. There have been objections interposed, as you  
15 heard, by other counsel as to your responding to  
16 questions that I addressed to you that weren't  
17 necessarily set forth in your report initially.  
18 There are any other opinions you have or hold as  
19 relates to the responsibility of any parties  
20 involved in this case that are not set forth in  
21 your report?

22 A, No, I think we covered it pretty well.

23 MR. KAMPINSKI: That is all I  
24 have.

25 MR. FULTON: I'm Burt



1       Fulton.   I represent Dr. Varma.   Incidentally, in  
2       your first report --

3                   MR. KAMPINSKI:           Can I ask a  
4       question?

5                   Do you intend to ask questions,  
6       Mr. Coyne?

7                   MR. COYNE:            Yes.

8                   MR. KAMPINSKI:        I object since  
9       you represent the same party.

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

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

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

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

19                  MR. FULTON:            He had not  
20       taken --

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

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

4 -----

5 CROSS-EXAMINATION

6 BY MR. FULTON:

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

11 A. Correct.

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

16 A. No.

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

21 A. Which? I am sorry, which aspect?

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

25 MR. SEIBEL: We discussed

1 it.

2 Go ahead.

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

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

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

13 A. I think that certainly could happen.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 Q. Over at University Hospitals, how many there?

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

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

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

1 Q. Incidentally, I know you answered this -- you  
2 mentioned something about a bullet or like  
3 shrapnel. I can speak to that. The fact is  
4 sometimes they leave it in the body, don't they?

5 A. Again, you can leave it in the body if it's  
6 not in a particular cavity or you don't feel it's  
7 at risk of migrating. In that particular case,  
8 shrapnel and bullets can be left in place.

9 Q. As a matter of fact, bullets have been left  
10 in individual's heads as well as around their  
11 hearts; isn't that true, you know that?

12 A. That is correct.

13 Q. I'm interested in something else. You  
14 indicated you were working on something  
15 statistically about health care?

16 A. Correct.

17 Q. I take it you are talking about the chances  
18 of survival depending upon an individual's  
19 condition and the type of procedure undertaken?

20 A. Lightly related to that. There are a number  
21 of state agencies that are not harvesting all the  
22 data for cardiac surgery --

23 Q. Could I --

24 A. -- printing that material in the newspaper  
25 with predicted mortalities for given surgeons and

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

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

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

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

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

21 A. I don't think so.

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

25 A. These are all patients that had a coronary

1 surgery. Specifically coronary bypass and valve  
2 surgery.

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

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

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

11 A. There is.

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

14 A, There is an APACHE 111.

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

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

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

20 A. I'm familiar with APACHE scores.

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

23 A, Yes.

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



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

4       A.       Yes.

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

8       A.       At the time of the initial event?

9       Q.       Yes.

10      A.       Prior to transfer to Saint Vincent?

11      Q.       Yes, initial event in Ashland?

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

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

20                      MR. KAMPINSKI:           I'm going to  
21      object.

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

1 the time? Had to have been.

2 Q. Fortunately I don't have to answer questions  
3 today.

4 A. It had to have been. It's very difficult to  
5 believe this lady would have any recoverable brain  
6 function whatsoever if she was truly without blood  
7 pressure or pulse at normal thermia for 30 minutes,

8 Q. Someone could say there was no blood  
9 pressure, they were unable to get it?

10 A. You may not be able to feel the pulse. There  
11 may be a low blood pressure that may provide enough  
12 perfusion to keep some kind of function in  
13 existence.

14 Q. You used the word brain insult heretofore I  
15 thought?

16 A. Yes.

17 Q. Brain insult is what?

18 A. Any deprivation of the normal physiology,  
19 i.e., blood flow to the brain, head trauma.

20 Q. You get an insult, there are dead tissues, if  
21 there is some insult to the brain, certain tissue  
22 that dies in the brain; isn't that true?

23 MR. KAMPINSKI: Objection.

24 A. Perhaps irreversible, perhaps reversible. If  
25 this lady came in comatose, over a period of time

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

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

8 A. Preoperative, postoperative, intraoperative?

9 Q. Let's try all three.

10 A. We had one defibrillated 104 times.

11 Q. Pre or post?

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

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

19 A. Guide wires, yes.

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

24 A. Yes.

25 Q. You are aware of the fact Dr. **Moasis**

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

3 A. Correct.

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

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

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

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

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

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

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

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

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

11    A.     I don't believe so.

12    Q.     You said you saw certain x-rays?

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

14                     MR. SEIBEL:                 Yes.

15    A.     Returned them,

16    Q.     Mr. Kampinski asked you questions about  
17    migration.

18    A.     Yes.

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

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

1       they were extracted.

2       Q.       You are saying insofar as the percutaneous  
3       removal of the wire or whatever Dr. Steele -- he  
4       indicated a piece of at least what he removed, the  
5       other remained in the same position?

6       A.       Appeared to have, yes.

7       Q.       If it's in the same position, it was down as  
8       far as the wire that was removed?

9       A.       I would assume so.

10      Q.       That would be in a position that would make  
11      it more easily available to someone with expertise  
12      to be able to use a basket or snare or catheter to  
13      remove it percutaneously?

14      A.       Dr. Steele would be an expert in this since  
15      he removed the first one, The question is why  
16      couldn't he remove the second.

17      Q.       I'm not worried about Dr. Steele. Let's talk  
18      about you.

19                   Do you feel that would be in the  
20      position, in the same place that would permit a  
21      second percutaneous removal by someone of expertise  
22      at Mount Sinai?

23      A.       Again, Dr. Steele is an invasive  
24      cardiologist, done many cardiac caths. He knows  
25      the patient. He tried to get the first one out, he

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

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

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

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

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

22    A.     Thank you, Burt.

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

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

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

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

15 A. That is correct.

16 Q. What is hypoxic encephalopathy?

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

20 Q. Not a good thing to have?

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

22 Q. It can shorten your life?

23 A. It certainly can.

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

25 A. Yes, certainly can.



1 Q. Multiple organ failure after myocardial  
2 infarct can shorten your life?

3 A. Yes.

4 Q. They are not good things to have?

5 A. No.

6 Q. If you have a combination A.R.D.S and  
7 myocardial infarct, a two by two inch spot that was  
8 damaged, you have multiple organ failure, you have  
9 your lungs very full, which you saw on those x-rays  
10 almost black at one point in time, isn't that true;  
11 that is not good, is it?

12 A. Without rephrasing, without rephrasing my  
13 observation on the x-ray, it's not good to have any  
14 of those, no.

15 Q. You saw the x-rays?

16 A. I did see x-rays.

17 Q. Those indicate she had a bad pair of lungs?

18 A. She had lungs that were certainly insulted  
19 with A.R.D.S or whatever diagnosis you want to  
20 attach to infiltrated. On the films were  
21 infiltrated. Were improving over the course of her  
22 hospitalization.

23 Q. They still weren't good?

24 A. Good in the sense they were less than they  
25 were before. If before was bad, now they are

1 better. Did she have a normal chest x-ray, no.

2 Q. It was very abnormal? You as a very well  
3 qualified thoracic surgeon can say they were bad,  
4 weren't they?

5 A. I appreciate your endorsement. Looking at  
6 the x-ray, the x-ray showed she had residual  
7 pulmonary infiltrates. They we improving from when  
8 she first showed at the hospital.

9 Q. She showed up dark in the x-ray?

10 A. You have to be careful, Burt, when you say  
11 dark. Dark is the normal appearance of normal  
12 lung.

13 Q. Then it was white?

14 MR. KAMPINSKI: You don't  
15 really care, do you?

16 Q. You wouldn't call them a good set of lungs,  
17 would you?

18 MR. KAMPINSKI: Objection,

19 A. They were not normal.

20 MR. FULTON: No further  
21 questions.

22 MR. COYNE: My name is Bill  
23 Coyne, I represent the hospital in this case. I  
24 have some questions for you.

25 MR. KAMPINSKI: I will object

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

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

5                       -----

6                       CROSS-EXAMINATION

7       BY MR. COYNE:

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

10      A.       Yes.

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

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

17      Q.       She had adult respiratory distress syndrome?

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

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

24      A.       Correct.

25      Q.       When she entered Saint Vincent Charity

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

4 A. Yes.

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

9 MR. KAMPINSKI: Objection.

10 Q. While in the hospital?

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

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

21 MR. KAMPINSKI: Objection.

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

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

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

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

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

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

22 A. Yes.

23 **a.** That is indicative that there is still an  
24 ongoing problem with the lungs certainly?

25 A. Yes.

1 Q. You indicated that you viewed the x-rays and  
2 on x-ray it was not difficult for you to see the  
3 two full length guide wires present February 28th  
4 until March 13th, correct?

5 A. Correct.

6 Q. From your recollection of your viewing the  
7 x-rays, can you tell me by way of x-ray review now  
8 when the adult respiratory distress syndrome we  
9 spoke of began to improve by x-ray?

10 A. It's very difficult to assess by x-ray.  
11 First of all, you have to realize the limitations  
12 of the techniques. You are taking a portable film,  
13 the patient is supine, it's difficult to see detail  
14 you need to.

15 If you want to examine all regions  
16 of the lung, one assessment of improvement or  
17 aggravation of the A.R.D.S picture would really  
18 come clinically. You can have an x-ray that looks  
19 very bad, a patient that clinically improves, your  
20 conclusion would be that patient is continually  
21 improving. The x-ray lags behind the clinical  
22 picture.

23 Q. I understand. Maybe I misunderstood what you  
24 said when you were answering Mr. Fulton's  
25 questions, I thought you said on x-ray you could

1 see the adult respiratory distress syndrome as  
2 improving?

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

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

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

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

16 A. Yes.

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

21 A. Yes.

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

24 A. Absolutely I do.

25 Q. That is your opinion?

1 A. Yes.

2 Q. Are you familiar with the manner in which she  
3 was transferred from the cardiac care intensive  
4 care to the operating suite for the surgical  
5 procedure by Dr. Moasis?

6 A. No, I'm not.

7 Q. Are you familiar with the fact he had to  
8 detach her from the mechanical ventilator, put her  
9 on a gurney, roll her down the hall, by way of ambu  
10 bag, continuous ambu bag monitoring, take her into  
11 the surgical suite and reconnect her to the  
12 ventilator in the surgical suite to do the surgery?

13 A. That I'm familiar with, yes.

14 Q. That in and of itself presents a risk to the  
15 patient of this type, doesn't it?

16 A. As opposed to someone without all those  
17 accouterments, yes.

18 Q. Absolutely. Yes.

19 What was the cause of the elevated  
20 white blood count throughout her hospital stay?

21 A. I think that is anybody's guess. There have  
22 been a lot of opinions offered. An elevated white  
23 count is certainly an indication of ongoing  
24 infection and ongoing acute blood loss, and as I  
25 believe the most recent opinion, prior to surgery



1 was steroid use.

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

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

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

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

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

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

23 A. Correct.

24 Q. Do you agree with that?

25 A. I do.

1 Q. Is that based on the fact you agree with the  
2 consult or independent evaluation you made?

3 A. I agree with the consult. The infectious  
4 disease people are the sleuths. They go over the  
5 patient as thoroughly as anybody can do so. If  
6 they come up with the conclusion such as that, it's  
7 difficult to ignore that.

8 Q. Being the consultants or the sleuths of the  
9 team caring for a patient, would you expect that  
10 the surgeon would discuss the condition of the  
11 patient and the patient's amenability to undergo  
12 surgery prior to commencement of that surgery,  
13 would he look to the sleuths before undertaking  
14 surgery on a patient such as Mrs. Weitzel?

15 A. It's better for all concerned if the  
16 physicians communicate with each other certainly.  
17 I don't know what information Dr. Moasis needed,  
18 how much he knew of Mrs. Weitzel at the time,  
19 presumably he read the consult and interpretation.

20 Q. You wrote Dr. **Moasis** had every right to  
21 consider the patient as stable as she ever would be  
22 to tolerate the procedure that was required?

23 A. Correct.

24 Q. That kind of intrigues me, to say the least,  
25 **when you say she was as stable as she ever would**

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

4 MR. KAMPINSKI: Objection.

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

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

14 Q. Who told you that?

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

18 Q. I'm asking who told you that?

19 A. I looked in the nurse's notes, it's  
20 described.

21 Q. You said you were told by somebody?

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

25 Q. Maybe your semantics threw me off.

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

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

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

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

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

1 A. Correct.

2 Q. Further after the percutaneous removal of the  
3 one guide wire the patient now has one guide wire  
4 left in her?

5 A. Correct.

6 Q. You are aware of the fact, to my knowledge,  
7 that there is nobody questioning the percutaneous  
8 removal of the guide wire on the 13th by  
9 Dr. Steele?

10 A. Correct.

11 Q. So when we go beyond the 13th, we start  
12 talking about one guide wire at that point,  
13 correct?

14 A. Yes.

15 Q. I don't want to pass this over because I'm  
16 still a little bit confused about your statement in  
17 your report where you say Dr. Moasis has every  
18 right to consider this patient as stable as she  
19 ever would be to tolerate the procedure that was  
20 required. You indicated to me when you wrote that  
21 you were thinking of her respiratory and vascular  
22 system primarily?

23 A. True. Other considerations certainly.

24 Q. I am asking you, was her respiratory and  
25 vascular system then as stable at that time as it

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

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

7 Q. You indicate --

8 MR. KAMPINSKI: Let him answer.

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

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

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

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

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

3 A. I'm really trying.

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

9 A. I'm --

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

14 MR. KAMPINSKI: I object.

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

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

25 There is certainly nothing that

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

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

12 MR. COYNE: I read it.

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

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

19 MR. KAMPINSKI: Right.

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

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

25 Q. What was the cause of the blood loss after



1 the surgery?

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

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

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

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

1 Q. The bleeding stops at death?

2 A. When the blood pressure becomes too low to  
3 cause bleeding.

4 Q. You have no opinion when, how long after the  
5 surgery that she began to bleed?

6 A. I can only assume that it must have been  
7 roughly seven or eight o'clock that evening when  
8 she began to show signs of deterioration of her  
9 vital signs.

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

18 Q. The bleeding was a complication of surgery?

19 A, Certainly.

20 Q. Do you have any opinion as to life expectancy  
21 of this patient, realizing the multiple organ  
22 problems she was having, had there been no wires  
23 introduced, had she not therefore needed surgery to  
24 remove the wires?

25 MR. KAMPINSKI: Objection.

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

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

24                   **MR. COYNE:**                   No further  
25    questions.

1                   MISS BITTENCE:           No questions.

2                   MR. JACKSON:           No questions.

3                   MR. FULTON:           I have two  
4 more.

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

10                  MR. FULTON:           What is so  
11 absurd about that?

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

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

16                  MR. KAMPINSKI:        I object.

17                               -----

18                               RECROSS-EXAMINATION

19                   BY MR. FULTON:

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

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

1 wires.

2 **a.** I understand that. Do you know of any you  
3 could point me to with respect to migrating to the  
4 brain?

5 **A,** No, I don't.

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

8 **A.** She died from blood loss. Unrecognized blood  
9 loss.

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

12 **A.** Yes.

13 **MR. FULTON:** No further  
14 questions,

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

17 -----

18 **RECROSS-EXAMINATION**

19 **BY MR. KAMPINSKI:**

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

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

3 A. Correct.

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

6 A. Yes.

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

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

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

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

1 MR. COYNE: Objection to  
2 possibility.

3 A, It's possible.

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

7 A, Correct.

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

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

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

1 years out or depending upon the mode of treatment?

2 A. If you survive to a certain point are you  
3 likely to survive to another point?

4 Q. Right.

5 A. It's pretty much a linear function. The  
6 further out you get, this lady had pretty advanced  
7 hypertensive heart disease as well, beyond the  
8 coronary disease. Her heart weighed almost **400**  
9 grams, which **is** one-and-a-half times what it should  
10 weigh. She had significant calcific  
11 arteriosclerosis of her coronaries at the age of  
12 46, which is quite early.

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

17 Q. In terms of delineating a certain time frame,  
18 I take it that is nothing you or anybody can do?

19 A. No.

20 MR. FULTON: As to a  
21 specific person?

22 MR. KAMPINSKI: Can I ask my  
23 questions?

24 MR. FULTON: I was trying to  
25 clarify it.



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

3 What was the last question and  
4 answer?

5 -----  
6 (Question and answer read.)

7 -----  
8 MR. COYNE: Show an  
9 objection.

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

13 MR. FULTON: Objection.

14 MR. COYNE: Objection.

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

17 MR. FULTON: Statistics do  
18 bear out --

19 MR. KAMPINSKI: Is this another  
20 question?

21 MR. FULTON: Based on your  
22 question.

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

25 -----

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,)

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ERRATA SHEET

PAGE

LINE

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

---

ALAN MARKOWITZ, M.D.

1 The State of Ohio, .

2 County of Cuyahoga. CERTIFICATE:

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

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

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

21   
22 -----

23 Constance Campbell, Stenographic Reporter,  
24 Notary Public/State of Ohio.

25 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  
 ---  
 EXCLUDES OCCURRENCES IN FIRST 3  
 PAGES  
 ---  
 WORD RANGES@ BOTTOM OF PAGE

## \* \* 1 \* \*

10 [1] 7:19  
 100 [1] 33:4  
 1001 [1] 4:16  
 104 [1] 51:10  
 10th [1] 84:20  
 12 [2] 32:22, 23  
 1240 [1] 47  
 12th [2] 60:1, 77  
 13th [6] 19:17; 34:9; 62:4; 68:23; 69:8, 11  
 14 [3] 15:23; 16:2; 84:25  
 14th [2] 19:15; 63:20  
 15th [1] 60:17  
 17 [1] 51:7  
 18th [1] 47:20  
 1991 [2] 15:23; 16:2  
 1993 [2] 10:2; 84:20  
 1998 [1] 84:25

## \* \* 2 \* \*

20 [1] 81:10  
 20,000 [1] 65:20  
 28 [1] 10:2  
 28th [3] 12:22; 62:3; 68:21

## \* \* 3 \* \*

30 [2] 50:7; 81:10  
 300 [1] 73:20

## \* \* 4 \* \*

40 [1] 81:11  
 40,000 [1] 65:20  
 400 [2] 73:20; 80:8  
 42 [1] 56  
 44113 [1] 4:8  
 44114 [1] 4:17  
 44115 [1] 4:25  
 46 [1] 80:12  
 48 [1] 25:1

## \* \* 5 \* \*

59 [1] 5:7

## \* \* 6 \* \*

6 [1] 55

## \* \* 7 \* \*

76 [1] 58  
 77 [1] 59

## \* \* 8 \* \*

\$2 [1] 5:10

## \* \* 9 \* \*

2 [1] 11:2  
 25 [1] 24:25

## \* \* A \* \*

A.R.D.S [12] 56:24; 57:6, 19; 61:1, 3, 6, 12,  
 13, 76; 62:17; 63:5; 75:6  
 A.R.D.S. [2] 59:18; 60:14  
 ability [1] 68:17  
 able [6] 20:4; 24:7; 30:9; 34:15; 50:10; 54:12  
 abnormal [1] 58:2  
 absolute [2] 21:9; 24:3  
 Absolutely [3] 19:7; 63:24; 64:18  
 absurd [1] 76:11  
 absurdity [1] 76:6  
 accept [7] 19:25; 21:12, 20; 23:16, 25; 36:15;  
 71:17  
 accepts [1] 16:16  
 access [1] 10:12  
 accompanied [1] 74:12  
 according [3] 12:13; 22:6; 49:16  
 account [1] 73:21  
 accoutements [1] 64:17  
 accumulate [1] 13:10  
 accurate [1] 83:22  
 act [1] 17:16  
 acted [1] 15:21  
 action [2] 37:12; 84:17  
 actions [2] 41:24; 43:4  
 actively [3] 61:3, 4; 73:17  
 scute [4] 23:13; 24:16; 61:20; 64:24  
 additional [3] 6:25; 27; 38:24  
 additions [1] 73  
 address [1] 38:23  
 addressed [4] 26:11; 40:16; 71:18, 79  
 adhere [1] 36:4  
 administration [3] 20:10; 65:22; 68:8  
 admission [2] 22:22, 25  
 admitted [2] 49:14; 60:22  
 adult [5] 59:17, 20; 60:7; 62:8; 63:1  
 advanced [1] 80:6  
 advised [1] 49:5  
 affixed [1] 84:19  
 aforesaid [2] 84:7, 12  
 afterwards [1] 21:1  
 age [3] 6:2; 44:23; 80:11  
 agencies [1] 46:21  
 aggravation [1] 62:17  
 agree [14] 15:21, 25; 16:9; 17:1, 24; 25:21;  
 26:2, 19, 20; 29:16; 43:9; 65:24; 66:1, 3  
 Akron [1] 8:10  
 ALAN [4] 5:2; 6:1; 83:25; 84:5  
 Alan [1] 6:12  
 allow [1] 44:12  
 allowed [1] 39:8  
 allowing [2] 36:6; 38:17  
 alone [3] 75:13; 78:8, 13  
 alveolar [1] 61:27  
 Aman [2] 29:2; 31:12  
 ambu [2] 64:9, 10  
 amenability [1] 66:11  
 amount [1] 49:5  
 analyzed [1] 51:22  
 anatomy [1] 75:9  
 Anesthesia [1] 48:17  
 anesthesia [2] 19:20; 20:8  
 anesthetic [6] 20:9, 10, 73; 21:1; 30:4, 18  
 angioplasty [4] 24:22; 75:22; 78:1, 20  
 anoxic [1] 27:2  
 answer [8] 32:25; 50:2; 55:20; 70:8, 10;

77:20; 81:4, 6  
 answered [2] 46:1; 71:2  
 answering [1] 62:24  
 anterior [4] 75:11, 20; 78:11, 77  
 antibiotics [1] 27:7  
 Anybody [1] 8:25  
 anybody [5] 9:4; 61:9; 64:21; 66:5; 80:18  
 anymore [1] 31:9  
 aorta [2] 24:23; 28:3  
 aortic [1] 23:24  
 APACHE [3] 48:13, 14, 20  
 apologize [2] 28:23; 68:1  
 Apparently [1] 34:7  
 apparently [2] 35:7; 49:6  
 appear [1] 53:8  
 appearance [3] 58:11; 63:3, 7  
 APPEARANCES [1] 4:1  
 Appeared [1] 54:6  
 appeared [1] 35:10  
 appears [3] 12:10; 47:4; 65:7  
 APPENDIX [1] 5:18  
 appreciate [2] 58:5; 68:20  
 apprise [1] 36:12  
 apprised [1] 38:21  
 appropriate [3] 21:5; 36:4; 55:7  
 appropriately [4] 16:20, 21; 39:9; 67:13  
 aptly [1] 31:12  
 arch [1] 23:24  
 area [2] 73:10, 12  
 areas [1] 32:18  
 aren't [1] 6:25  
 arena [1] 44:3  
 argue [2] 30:20; 71:1  
 argument [1] 41:13  
 arise [1] 15:15  
 arrest [4] 39:19; 59:9, 20; 60:2  
 arrived [1] 60:5  
 arterial [5] 21:15; 28:8; 34:3; 36:7; 51:17  
 arteries [1] 3:24  
 arteriosclerosis [1] 80:11  
 artery [8] 23:22; 24:21; 35:7, 12; 73:17; 76:22;  
 78:15  
 article [2] 48:22, 25  
 articles [4] 6:25; 7:4, 7; 48:19  
 ascending [2] 24:23; 28:3  
 ascribe [1] 65:8  
 Ashland [1] 49:11  
 asking [6] 31:19; 59:1; 67:18; 69:24; 72:20;  
 76:7  
 aspect [2] 42:18, 21  
 assemble [1] 21:11  
 assess [1] 62:10  
 assessment [2] 62:16; 75:14  
 assume [13] 17:21; 21:14; 33:3; 34:22; 45:13,  
 17; 49:15, 22; 52:13; 54:9; 67:1; 73:18; 74:6  
 assumed [1] 28:13  
 Assuming [1] 29:15  
 assumption [1] 21:14  
 assumptions [2] 24:11, 13  
 attach [1] 57:20  
 attached [2] 20:5; 30:4  
 attack [2] 39:15; 79:19  
 attempt [6] 31:10; 32:14; 53:22; 56:2; 61:8;  
 65:14  
 attempted [3] 31:4, 78; 34:3  
 attempts [3] 29:9, 21; 55:6  
 attended [1] 60:25  
 attending [3] 14:15, 23; 18:1  
 attendings [1] 36:12  
 attorney [3] 8:8, 9, 84:16  
 attorneys [4] 8:6, 75, 17; 9:20

attributed [1] 65:21  
 automatically [1] 39:22  
 autopsy [10] 11:3; 61:11, 14, 17, 18; 73:19;  
 75:14; 78:4, 8, 22  
 available [1] 54:11  
 Avenue [1] 4:16  
 aware [12] 13:24; 27:23 30:25; 31:4, 4 16;  
 33:9; 34:7, 10; 51:23, 25; 69:6

\* \* B \* \*

background [1] 14:17  
 bacteria [1] 61:15  
 bag [2] 64:10  
 baggage [1] 30:7  
 Baker [1] 9:23  
 balanced [1] 71:19  
 balloon [1] 78:1  
 Based [2] 52:4; 81:21  
 based [14] 18:1; 21:21, 23; 29:25; 33:12;  
 40:3; 66:1; 70:24; 73:19; 75:4; 76:7, 8; 79:10  
 basic [1] 43:23  
 basis [4] 21:18; 22:12; 37:11; 65:4  
 basket [3] 28:22; 44:16; 54:12  
 baskets [1] 44:21  
 bear [2] 56:9; 81:18  
 bears [1] 13:14  
 becomes [2] 26:14; 74:2  
 bed [3] 26:9; 28:1, 2  
 beforehand [1] 42:24  
 BEHALF [3] 4:2, 11, 20  
 behalf [1] 13:25  
 behavior [1] 36:15  
 behind [1] 62:21  
 belief [3] 19:14; 22:18; 27:10  
 believe [23] 9:5, 16; 10:5; 16:4; 17:21; 18:11,  
 15; 22:25; 23:6; 34:2; 35:20; 36:7; 39:12, 16;  
 45:11; 50:5; 53:11; 63:17; 64:25; 67:2, 15;  
 74:10; 78:5  
 believed [1] 39:8  
 Beverly [1] 9:12  
 bigger [1] 70:16  
 bilateral [1] 59:13  
 Bill [2] 8:13; 58:22  
 bit [4] 17:8; 21:2, 3; 69:16  
 bits [1] 45:3  
 BITTENCE [1] 76:1  
 black [1] 57:10  
 bleed [1] 74:5  
 bleeding [5] 39:1; 73:24; 74:1, 3, 18  
 blockage [1] 78:4  
 blood [22] 18:11; 19:4; 21:4; 22:12; 27:15,  
 18; 36:2; 49:6, 17, 22; 50:6, 8, 11, 19; 64:20,  
 24; 65:3; 72:4, 25; 74:2; 77:8  
 boards [1] 41:16  
 boat [1] 71:5  
 Bob [1] 8:13  
 bodies [4] 24:10; 31:6; 44:13, 18  
 body [2] 46:4, 5  
 Bonezzi [1] 8:13  
 born [1] 20:2  
 borne [1] 27:15  
 Brain [1] 50:17  
 brain [19] 27:4, 22; 39:22, 24; 40:1; 49:2;  
 50:5, 14, 19, 21, 22; 51:2; 56:17, 19; 60:14,  
 15; 68:14; 76:22; 77:4  
 breathing [1] 75:5  
 broad [1] 79:16  
 bronchopneumonia [1] 61:20  
 brush [1] 47:6  
 budge [1] 30:19

Building [2] 4:7, 24  
 Bulkley [1] 4:24  
 bullet [1] 46:2  
 bullets [3] 44:18; 46:8, 9  
 bunch [2] 47:15; 63:8  
 Butt [4] 40:25; 47:18; 55:22; 58:10  
 Button [1] 4:21  
 bypass [3] 8:1; 77:25; 78:9

\* \* C \* \*

calcific [1] 80:10  
 call [3] 12:4; 45:21; 58:16  
 Campbell [2] 84:3, 23  
 candidate [1] 21:5  
 cannon [1] 37:1  
 caption [1] 84:15  
 Cardiac [1] 59:20  
 cardiac [20] 7:9; 15:5, 6, 7; 22:21; 39:19;  
 46:22; 48:7; 54:24; 59:9; 60:2; 64:3; 65:14;  
 67:6; 68:9; 72:3; 75:8; 77:23  
 cardiologic [1] 15:13  
 cardiologist [9] 14:15, 16; 15:11; 28:17; 30:1,  
 11, 21; 32:20; 54:24  
 cardiologists [3] 14:23; 43:24; 45:10  
 cardiology [1] 56:2  
 cardiovascular [1] 71:11  
 Care [1] 48:16  
 care [22] 7:9; 15:12, 22; 16:1, 21, 24; 17:2, 3;  
 21:22, 23; 22:73; 32:7; 36:5; 46:15; 58:15;  
 59:23; 60:20; 64:3, 4; 65:5; 74:13  
 cared [1] 15:16  
 careful [1] 58:10  
 caring [2] 27:11; 66:9  
 carotid [2] 23:25; 35:8  
 carried [1] 53:3  
 carries [3] 23:19; 24:25; 36:18  
 carry [1] 61:1  
 case [19] 8:2; 10:2; 11:17; 14:1; 15:14, 15;  
 18:10; 25:4; 27:11; 28:19; 40:10, 12, 20;  
 42:14, 18; 43:3; 46:7; 58:23; 65:17  
 cases [6] 7:21; 8:18; 9:13, 77; 13:10; 33:4  
 cast [1] 45:13  
 categories [1] 26:7  
 cath [4] 30:3; 55:1, 11  
 catheter [6] 32:3; 36:1; 38:2, 14; 45:3; 54:12  
 catheterization [1] 75:8  
 catheters [2] 44:25; 53:6  
 caths [1] 54:24  
 caused [4] 21:16; 56:18; 59:22; 65:3  
 cavity [1] 46:6  
 cc [1] 73:20  
 cease [1] 60:25  
 cerebral [2] 27:5; 60:12  
 CERTIFICATE [1] 84:2  
 certified [1] 6:5  
 certify [2] 84:4, 13  
 cetera [4] 11:4; 36:20; 49:3; 73:8  
 challenge [1] 75:19  
 chances [1] 46:17  
 change [3] 13:20; 19:10; 79:25  
 changed [1] 7:5  
 changes [1] 20:13  
 characterize [2] 36:11; 37:24  
 CHARITY [1] 4:3  
 Charity [3] 41:14; 43:7; 59:25  
 Charles [1] 12:2  
 Charms [1] 8:9  
 chart [1] 22:7  
 chest [5] 11:5; 22:12; 34:14; 49:25; 58:1  
 circulation [2] 27:5; 56:19

circumstances [4] 28:9; 67:8; 68:6; 71:24  
 cite [1] 38:4  
 Civil [1] 6:4  
 claims [1] 31:5  
 clarification [1] 81:2  
 clarify [3] 17:10; 19:8; 80:25  
 classifications [1] 48:13  
 clear [5] 14:20; 15:1; 19:13; 24:8; 65:18  
 clearance [2] 15:9, 18  
 clears [1] 14:14  
 Cleveland [6] 4:8, 17, 25; 45:11, 22; 84:19  
 Clinic [3] 45:12, 22; 79:17  
 clinical [4] 21:22; 24:5; 62:21; 65:9  
 Clinically [1] 61:10  
 clinically [4] 24:5; 62:18, 79; 65:6  
 clinicians [1] 27:11  
 closed [1] 49:25  
 clotting [2] 73:6, 7  
 Co [1] 4:6  
 colleague [1] 31:24  
 colleagues [1] 38:7  
 colonized [1] 32:6  
 Columbus [2] 29:3; 31:12  
 comatose [1] 50:25  
 combination [1] 57:6  
 comical [1] 26:12  
 commands [2] 24:7; 67:13  
 commenced [1] 19:17  
 commencement [1] 66:12  
 comment [1] 43:5  
 commented [2] 13:16; 26:15  
 Commission [1] 84:25  
 communicate [1] 66:16  
 compile [1] 7:22  
 complete [1] 24:9  
 completely [1] 53:1  
 complication [4] 15:8; 21:17; 28:19; 74:18  
 complications [3] 32:2; 36:19; 76:25  
 compromise [1] 79:18  
 compromised [3] 61:4, 5; 79:21  
 computer [1] 84:9  
 concentration [1] 20:7  
 concern [2] 26:23; 56:11  
 concerned [3] 42:1; 66:15; 68:7  
 concluded [1] 82:15  
 conclusion [4] 21:19; 52:5; 62:20; 66:6  
 conclusions [1] 30:13  
 condition [8] 18:2; 23:4; 31:16; 32:8; 38:23;  
 39:6; 46:19; 66:10  
 conduct [3] 17:23; 20:25; 72:1  
 confirm [1] 13:20  
 confirmed [1] 13:22  
 confused [1] 69:16  
 confusion [1] 72:20  
 conglomeration [1] 59:18  
 connection [1] 10:1  
 connotes [1] 25:16  
 consequences [2] 21:11; 60:12  
 consider [3] 66:21; 69:18; 72:16  
 consideration [1] 80:16  
 considerations [2] 56:9; 69:23  
 considered [1] 26:5  
 consolidated [1] 61:16  
 Constance [2] 84:3, 23  
 constant [1] 55:12  
 consult [5] 31:21; 65:22; 66:2, 3, 19  
 consultants [1] 66:8  
 consulted [2] 31:17, 24  
 consulting [1] 9:3  
 consults [1] 15:20  
 contact [1] 33:6

contained [2] 13:1, 3  
 contains [1] 42:10  
 contemporary [1] 31:21  
 context [2] 38:12; 72:8  
 contingencies [1] 75:23  
 continually [1] 62:20  
 continuation [1] 19:16  
 continue [1] 61:6  
 continued [2] 4:1; 20:4  
 continuous [2] 32:3; 64:10  
 contraindications [1] 24:3  
 contributed [3] 16:5; 18:7; 36:8  
 controlled [2] 32:8; 71:24  
**copies [1] 53:9**  
 copy [1] 14:11  
 coronaries [1] 80:11  
 coronary [6] 22:13; 47:25; 48:1; 74:13; 79:15; 80:8  
 correspondence [1] 11:17  
 counsel [3] 20:24; 40:15; 84:16  
 count [6] 64:20; 23; 65:3, 8, 15; 68:7  
 County [1] 84:2  
 couple [1] 77:16  
 course [4] 24:5; 57:21; 65:9; 70:6  
 court [2] 7:25; 38:8  
 cover [1] 59:11  
 covered [3] 31:14; 40:22; 82:6  
 COYNE [11] 41:7, 21; 58:22; 59:7; 70:9; 72:12; 75:24; 79:1; 81:8, 14, 23  
 Coyne [10] 4:5, 6; 57:9; 3; 41:6; 58:23; 76:7; 77:16, 20; 79:8  
 CPR [1] 49:25  
 criteria [1] 26:6  
 Critical [1] 48:16  
 critically [1] 47:7  
 criticize [1] 16:23  
 CROSS-EXAMINATION [3] 6:8; 42:5; 59:6  
 Cross-examination [3] 5:5, 6, 7  
 cross-examination [1] 6:3  
 culture [2] 52:13; 61:15  
 cultured [1] 52:9  
 curious [1] 25:7  
 currently [3] 7:6, 8; 47:11  
 Cuyahoga [1] 84:2  
 CV [2] 624; 73

## \* \* D \*

damage [5] 21:16; 39:23, 24; 40:1; 79:12  
 damaged [2] 57:8; 75:16  
 danger [1] 24:1  
 Dark [1] 58:11  
 dark [2] 58:9, 11  
 data [5] 21:11; 46:22; 47:7; 48:6, 10  
 date [1] 63:8  
 dated [1] 14:3  
 day [3] 35:16; 68:13; 84:20  
 dead [1] 50:20  
 deal [5] 36:21; 47:23; 48:3; 67:24; 76:25  
 dealing [2] 26:24; 67:7  
 deals [1] 39:18  
 death [10] 13:15; 16:5, 8, 13; 18:7; 20:11; 36:8; 61:12; 74:1; 77:11  
 debris [1] 45:4  
 decided [1] 31:23  
 decidedly [1] 79:20  
 decision [4] 15:22; 16:1; 23:14; 56:10  
 decisions [2] 16:4, 7  
 deemed [1] 78:16  
 DEFENDANT [2] 4:2, 20  
 defendant [1] 14:1

DEFENDANTS [1] 4:11  
 defense [1] 8:8  
 defer [2] 32:1, 2  
 defibrillated [2] 51:7, 10  
 define [1] 75:9  
 defined [1] 75:4  
 delineating [1] 80:17  
 demise [1] 73:21  
 demonstrated [2] 78:12  
 demonstrating [1] 37:5  
 department [1] 56:1  
 depending [4] 17:19; 46:18; 47:23; 80:1  
 Depends [1] 14:17  
 Deposition [2] 11:8; 82:15  
 deposition [18] 8:18; 10:6, 18, 20; 11:5, 7, 10, 12, 22; 12:12, 16; 14:10, 13; 18:14; 22:6; 28:24; 84:13  
 depositions [2] 10:15, 16  
 depress [1] 20:18  
 deprivation [2] 50:18; 56:18  
 deriving [1] 47:3  
 descending [1] 75:12  
 describe [2] 61:14; 78:21  
 described [2] 67:16, 20  
 description [2] 61:19; 73:19  
 deserve [1] 47:6  
 designed [1] 44:17  
 detach [1] 64:8  
**detail [1] 62:13**  
 detect [1] 65:14  
 deteriorating [2] 19:6; 70:11  
 deterioration [2] 70:6; 74:8  
 determine [9] 34:16; 49:18; 51:3, 5; 53:20; 75:19; 77:22; 78:7; 79:10  
 develop [1] 73:9  
 developed [4] 45:2; 60:6, 24  
 diagnoses [1] 59:19  
 diagnosis [5] 24:19; 57:19; 60:23; 61:1, 5  
 de [5] 16:11, 18; 26:22; 68:15; 77:7  
 died [2] 16:22; 77:8  
 des [1] 50:22  
 difficult [10] 36:15; 50:4; 55:19; 62:2, 10, 13; 65:7; 66:7; 68:11; 75:14  
 diffuse [1] 73:19  
 direct [2] 60:19; 77:7  
 directed [1] 44:3  
 direction [1] 84:10  
 disagree [6] 22:17; 25:14; 26:2; 29:24, 25; 31:17  
 discharged [1] 77:24  
 discovered [1] 43:17  
 discuss [2] 43:3; 66:10  
 discussed [3] 40:10; 42:18, 25  
 discussion [2] 18:9, 14  
 disease [9] 15:5, 7; 24:25; 65:21; 66:4; 68:9; 79:15; 80:7, 8  
 disks [1] 47:16  
 display [1] 53:25  
 dissection [4] 23:13; 24:16, 21, 23  
 distress [5] 59:17, 21; 60:8; 62:8; 63:1  
 Dobutamine [2] 75:18; 78:17  
 Doctor [14] 6:10, 24; 12:10; 17:21; 19:19; 29:24; 33:20; 34:1; 35:2; 37:13; 42:7; 59:2, 72:7, 11  
 doesn't [5] 26:17; 39:25; 44:14; 52:12; 64:15  
 Don [1] 8:22  
 dozen [2] 7:19; 8:15  
 Dr [65] 11:8, 13, 23; 12:13; 13:24; 14:9; 15:17, 21, 25; 18:15; 19:17, 19, 22; 20:1, 4; 22:6, 18; 25:11, 12; 28:24; 29:2; 30:10, 16; 31:4, 9, 14, 15, 20, 23, 24; 33:6; 34:4, 7; 36:5;

38:20; 39:8; 41:1, 13, 22, 23, 24; 42:2, 9, 20, 23; 43:4, 7; 51:25; 52:10; 54:3, 14, 17, 23; 55:4, 17, 18; 58:12; 64:5; 66:17, 20; 69:9, 17; 72:16; 74:10  
 drastic [1] 70:16  
 drop [1] 18:20  
 Dropping [1] 19:4  
 DRS [1] 4:11  
 due [1] 59:23  
 duly [2] 6:5; 84:6  
 dynamic [1] 75:16

## \* \* E \*

early [2] 18:9; 80:12  
 easily [2] 54:11; 73:11  
 effect [1] 43:8  
 eight [4] 18:25; 19:9; 45:10; 74:7  
 EKG [2] 1:6; 22:24  
**Elective [1] 23:14**  
 elective [9] 21:8; 23:8, 10; 25:15, 16, 22; 26:3, 5, 7  
 elevated [5] 64:19, 22; 65:3, 8; 68:7  
 elevation [1] 65:21  
 embolism [1] 68:15  
 embolize [1] 27:22  
 embolized [1] 28:18  
 emergency [1] 23:7  
 Emergent [1] 23:11  
 emergent [4] 23:11; 24:18; 26:7, 17  
 employee [1] 41:13  
 encephalopathy [8] 27:3; 39:16, 18; 56:16; 59:8, 22; 60:3, 24  
 ended [1] 45:20  
 endorsement [1] 58:5  
 enormous [2] 27:1; 68:16  
 entered [1] 59:25  
 equate [2] 39:22, 25  
 ERRATA [1] 83:1  
 erroneous [1] 47:10  
 Esq [4] 4:5, 14, 21, 22  
 et [4] 11:4; 36:19; 49:3; 73:8  
 ethics [2] 37:1, 12  
 evaluated [1] 40:3  
 evaluation [2] 40:4; 66:2  
 evening [1] 74:7  
 event [6] 43:19, 22; 44:9; 49:8, 11; 63:20  
 events [1] 52:6  
 everybody [2] 26:15; 68:7  
 evidence [4] 20:24; 21:1, 2; 67:15  
 exacerbated [1] 20:20  
 exact [1] 34:24  
 exactly [2] 43:5; 49:12  
 examine [2] 55:20; 62:15  
 examined [1] 6:6  
 example [4] 23:12; 24:17, 22, 25  
 EXHIBITS [1] 5:14  
 existence [2] 33:9; 50:13  
 exists [1] 45:5  
 expect [1] 66:9  
 expectancy [2] 74:20; 79:9  
 experience [2] 30:25; 56:12  
 expert [5] 7:14; 10:6; 13:25; 31:6; 54:14  
 expertise [5] 31:22; 45:5, 25; 54:11, 21  
 experts [3] 40:11; 44:8; 45:7  
 expiration [1] 84:25  
 exploratory [1] 38:24  
 exposure [1] 55:12  
 exposures [1] 55:14  
 extensive [1] 15:6  
 extent [2] 14:25; 26:13

extra [1] 30:7  
 extract [4] 20:4; 44:17; 53:5; 68:12  
 extracted [2] 54:1; 56:10  
 extracting [1] 71:23  
 extraction [1] 39:16  
 extricate [2] 30:20; 31:23  
 extrication [2] 24:10; 55:6

\* F \*

fact [40] 10:20; 13:24; 14:15; 16:13; 16, 23;  
 19:22; 25; 20:8; 21:20; 22:13; 23:16; 17, 20;  
 24:1; 27:17; 31:11; 32:16; 35:11; 41:23; 46:3;  
 9; 47:3; 6; 51:15; 20, 25; 61:1, 5; 64:7; 65:13;  
 20; 66:1; 67:12; 68:12; 69:6; 71:17; 74:12;  
 78:9, 17  
 factor [1] 80:15  
 facts [1] 48:25  
 failure [6] 18:6; 36:4, 7, 11; 57:1, 8  
 fa i i [1] 10:22  
 familiar [9] 31:13; 48:12; 18, 20, 24, 25; 64:2,  
 7, 13  
 family [1] 42:15  
 fashion [1] 13:21  
 fault [3] 36:25; 37:4, 21  
 February [3] 30:1; 62:3; 68:21  
 feel [4] 46:6; 50:10; 54:19; 55:5  
 fell [2] 15:25; 17:1  
 felt [7] 30:16; 18; 32:4, 7; 45:24; 53:23; 55:12  
 femoral [6] 23:22; 32:4; 34:3; 35:12; 44:20;  
 76:22  
 fibers [1] 78:19  
 field [2] 65:13; 73:5  
 figure [1] 65:16  
 figured [1] 52:16  
 file [1] 11:16  
 files [1] 9:19  
 film [1] 62:12  
 films [5] 11:5; 57:20; 63:3, 4, 9  
 final [1] 68:15  
 find [3] 9:18; 47:9; 48:15  
 finding [1] 61:14  
 findings [2] 18:24; 49:16  
 firm [6] 8:11, 16, 23, 25; 9:4, 6  
 First [1] 62:11  
 first [14] 6:5; 35:16; 38:19; 41:2; 43:17; 52:7,  
 8; 53:24; 54:15, 25; 55:24; 58:8; 68:22; 84:6  
 fit [2] 59:19; 79:16  
 five [1] 44:6  
 flexibility [1] 52:24  
 flexible [1] 52:22  
 Floor [1] 4:24  
 floppy [1] 47:16  
 fluoroscopy [1] 30:8  
 flow [1] 50:19  
 fluoroscopy [1] 30:4  
 fluorscopy [1] 55:13  
 follow [5] 24:7; 35:13; 67:13; 77:16; 79:14  
 follow-up [1] 37:23  
 followed [1] 75:22  
 following [1] 63:11  
 follows [1] 6:6  
 foregoing [3] 83:21; 84:10, 15  
 foreign [8] 21:13; 24:10; 31:6; 35:24; 36:1;  
 44:13, 18; 45:4  
 form [2] 20:8; 47:15  
 formulate [1] 21:18  
 forth [3] 33:24; 40:17, 20  
 Fortunately [1] 50:2  
 found [1] 26:10  
 four [4] 8:5; 44:2; 70:21; 72:9

fragment [1] 34:18  
 frame [2] 49:12; 80:17  
 free [1] 36:17  
 front [1] 11:16  
 full [4] 6:10; 52:16; 57:9; 62:3  
 FULTON [35] 9:11, 14; 12:1; 17:6, 11, 15, 18;  
 25:8; 29:11, 17; 33:16, 21, 24; 36:9, 14; 37:9,  
 17; 40:25; 41:10, 15, 19; 42:6; 58:20; 59:3;  
 76:3, 10, 14, 19; 77:13; 80:20, 24; 81:13, 17,  
 21; 82:2  
 Fulton [12] 4:21, 23; 5:6, 8, 10; 9:6; 18:13;  
 41:1, 21; 42:3; 43:18; 62:24  
 function [6] 20:18; 50:6, 12; 56:17; 75:4; 80:5  
 functional [4] 75:7, 10; 78:16, 23  
 functionally [1] 75:16  
 functioning [1] 75:21  
 furnished [2] 11:2; 47:13  
 future [1] 21:17

\* \* G \* \*

gain [1] 78:19  
 gained [1] 24:2  
 Gallagher [2] 4:23; 9:6  
 gases [2] 18:11; 22:12  
 gave [1] 42:22  
 Generated [1] 11:25  
 generated [3] 11:23; 122:1; 14:11  
 give [1] 47:17  
 given [9] 10:5; 15:19; 16:21; 26:16; 46:25;  
 47:1; 56:7; 84:7, 12  
 goal [2] 19:25; 20:1  
 Gordon [2] 8:21; 9:1  
 grade [1] 75:11  
 grades [1] 23:9  
 grams [1] 80:9  
 gray [1] 12:2  
 great [1] 67:24  
 greater [2] 45:17; 71:22  
 groin [1] 23:19  
 grossly [1] 52:12  
 ground [1] 37:12  
 groundless [1] 21:17  
 guess [4] 37:23; 61:9; 64:21; 77:10  
 Guide [1] 51:19  
 guide [65] 20:2; 21:12, 14, 20; 22:1; 23:17,  
 21, 23; 26:10, 21, 25; 27:20, 21; 28:2, 6, 7, 9,  
 15, 18; 30:9, 12, 19; 31:1; 33:14; 34:2, 5, 12,  
 17, 20, 21, 23; 35:19, 22; 36:6, 24; 37:3; 38:2,  
 14; 43:5, 4, 14; 44:5, 9, 25; 45: 20; 52:2, 18,  
 21; 53:1, 7; 62:3; 68:12, 13, 16, 22, 24; 69:3,  
 8, 12; 70:24; 71:21; 76:21, 25  
 gurney [1] 64:9

\* \* H \* \*

hadn't [1] 41:15  
 hair [1] 12:2  
 half [3] 8:15; 49:15, 23  
 hall [1] 64:9  
 hand [1] 84:19  
 happening [1] 43:24  
 happens [1] 43:19  
 happy [3] 6:15; 47:17; 76:15  
 hard [4] 30:8; 34:24; 60:13; 67:8  
 Harley [2] 8:20; 9:1  
 harmless [1] 21:13  
 harvesting [1] 46:21  
 head [5] 6:23; 23:24; 27:1; 28:3; 50:19  
 heads [1] 46:10  
 health [2] 7:9; 46:15  
 heard [2] 40:15; 56:13

heart [13] 20:14, 16, 78; 27:6; 39:15; 44:20;  
 51:13; 70:17; 79:18; 80:7, 8, 15  
 hearts [1] 46:11  
 help [1] 47:19  
 hematocrit [1] 12:25  
 hematoma [2] 73:20, 22  
 hemodynamic [2] 22:2; 74:16  
 hemodynamically [2] 21:4, 6  
 hemoglobin [1] 18:11  
 hereby [1] 84:4  
 herein [1] 6:2  
 hereinafter [1] 6:5  
 heretofore [2] 49:5; 50:14  
 hereunto [1] 84:18  
 high [1] 75:11  
 history [3] 60:2; 63:18; 79:14  
 hold [2] 40:18; 65:2  
 Holland [4] 11:13; 13:24; 14:9; 15:17  
 home [4] 25:17, 23; 26:5, 8  
 Hope [1] 59:3  
 hope [1] 38:4  
 hopefully [1] 44:14  
 hoping [1] 25:5  
 HOSPITAL [1] 4:3  
 Hospital [2] 43:7; 60:1  
 hospital [23] 10:4; 11:3; 15:16; 23:3; 26:1;  
 33:7; 41:23; 42:3; 45:19; 49:17; 58:8, 23; 60:6,  
 10, 11, 17, 23; 63:13; 64:20; 67:3; 68:11; 73:8;  
 77:25  
 hospitalization [1] 57:22  
 hospitalized [1] 23:3  
 Hospitals [2] 45:14, 22  
 hospitals [1] 47:1  
 Hostetler [1] 9:23  
 hour [2] 49:15, 23  
 hours [4] 25:1; 30:2, 8; 55:1  
 hypertensive [2] 24:24; 80:7  
 hypertrophic [1] 80:15  
 Hypoxic [1] 39:18  
 hypoxic [6] 39:15; 56:16; 59:8, 21; 60:3, 23

\* I \* \*

i.e. [2] 50:19; 61:8  
 idea [1] 45:21  
 identical [1] 53:8  
 ignore [1] 66:7  
 II [2] 4:14; 48:13  
 III [1] 48:14  
 iliac [4] 23:21; 28:3; 35:7, 14  
 illness [1] 63:18  
 illnesses [3] 59:22; 60:7, 18  
 imagine [1] 26:9  
 immediate [1] 63:14  
 immediately [4] 18:23; 20:25; 35:3; 72:1  
 immergent [2] 23:11; 26:7  
 impaired [3] 21:2; 67:11; 75:16  
 impairment [1] 75:5  
 impossible [1] 43:3  
 impression [1] 67:11  
 improper [1] 42:17  
 improve [2] 62:9; 63:7  
 improvement [1] 62:16  
 improves [1] 62:19  
 improving [12] 21:25; 22:15; 24:6; 40:8;  
 57:21; 58:7; 62:21; 63:2; 65:10; 68:6; 70:4, 13  
 inability [1] 79:10  
 inadequate [1] 37:15  
 inappropriate [1] 17:23  
 inch [1] 57:7  
 incident [1] 32:23



Incidentally [1] 427  
 Incidentally [2] 41:1; 46:1  
 incision [1] 73:16  
 incompetence [1] 37:5  
 independent [1] 66:2  
 INDEX [1] 5:18  
 indicate [4] 49:19; 57:17; 63:11; 70:7  
 indicated [13] 22:2; 29:7; 37:14; 43:8; 46:14;  
 51:15; 52:1, 6, 10, 15; 54:4; 62:1; 69:20  
 indicates [1] 78:22  
 indication [5] 21:10; 23:10; 31:8; 64:23; 74:15  
 indicative [1] 61:23  
 indict [1] 20:9  
 Indirectly [1] 16:6  
 indiscretion [1] 68:2  
 individual [4] 38:11; 43:9; 46:10, 18  
 individuals [2] 47:23; 49:16  
 infarct [10] 20:21; 47:24; 48:4, 9; 57:2, 7;  
 75:13; 79:13, 21, 23  
 infect [1] 27:19  
 infected [4] 26:25; 27:21; 70:17; 73:8  
 infection [12] 27:14, 15, 16, 17, 18; 51:23;  
 52:1, 6, 11; 64:24; 65:9, 15  
 infectionwise [1] 72:3  
 infectious [3] 65:21; 66:3; 68:9  
 inference [2] 35:11; 37:21  
 infiltrated [3] 57:20, 21; 59:15  
 infiltrates [2] 58:7; 60:24  
 influences [1] 15:14  
 information [2] 66:17; 67:24  
 initial [2] & 11  
 Initially [1] 67:10  
 initially [2] 40:17; 53:24  
 initiated [1] 18:13  
 input [1] 68:20  
 inquire [1] 49:23  
 insert [1] 52:22  
 inserted [6] 23:19, 22; 34:2; 35:12; 43:17;  
 76:21  
 insertion [1] 35:17  
 insofar [1] 54:2  
 instability [5] 20:12; 21:3; 68:10; 70:22; 74:16  
 institutions [1] 45:16  
 insufficiency [1] 74:17  
 insult [14] 27:3; 39:14, 18; 49:2; 50:14, 17,  
 20, 21; 51:2; 56:17; 60:13, 15; 75:3  
 insulted [1] 57:18  
 insure [1] 38:16  
 intend [1] 41:5  
 intensive [4] 15:12; 21:22; 32:7; 64:3  
 interested [2] 46:13; 84:17  
 interfere [1] 27:4  
 interposed [1] 40:14  
 interpretation [1] 66:19  
 interrupt [1] 25:20  
 interruption [1] 56:19  
 intervene [2] 70:13, 14  
 intervened [1] 63:13  
 intervention [1] 70:19  
 intimately [1] 31:16  
 intraoperative [1] 51:8  
 intrigues [1] 66:24  
 introduced [1] 74:23  
 invasion [1] 67:7  
 invasive [6] 32:20; 38:13; 44:24;  
 54:23  
 invasiveness [1] 70:22  
 involve [1] 44:11  
 involved [15] 7:12; 8:7; 10:22; 13:25; 14:24;  
 17:3; 28:18; 40:11, 12; 42:14; 43:20; 44:4,  
 6; 48:6

involvement [2] 15:1; 17:22  
 irreversible [1] 50:24  
 irreversibly [1] 75:16  
 irritable [1] 20:16  
 issue [3] 26:11; 41:25; 55:16

\* \* J \* \*

JACKSON [2] 25:4; 76:2  
 Jackson [1] 4:14  
 Jacobson [2] 4:15; 21:5  
 January [3] 10:2; 12:22; 84:25  
 John [1] 4:14  
 Journal [1] 48:16  
 judgment [2] 30:1; 31:19  
 justify [1] 55:13

\* \* K \* \*

Kaiser [1] 9:13  
 Kalur [2] 4:15; 21:6  
 KAMPINSKI [43] 6:9, 13, 20; 12:5, 9; 16:12;  
 17:9, 13, 17, 20; 19:10; 25:6; 29:19; 33:23;  
 40:23; 41:3, 8, 12, 17; 43:11; 49:20; 50:23;  
 52:8; 58:14, 18, 25; 60:9, 21; 67:4; 70:8;  
 71:14; 72:6, 13, 19; 74:5; 76:5, 12, 16; 77:15,  
 19; 80:22; 81:1,  
 19  
 Kampinski [4] 5:5, 9; 42:13; 53:16  
 Keating [1] 43:7  
 keep [4] 7:22; 13:10; 43:23; 50:12  
 key [1] 51:2  
 KEYWORD [1] 5:18  
 KHADDAM [1] 4:12  
 kill [1] 27:5  
 kinds [4] 35:22; 37:7; 44:22; 73:9  
 KITCHEN [1] 4:12  
 Kitchen [1] 31:4  
 knowing [2] 63:17, 18  
 knowledge [2] 32:14; 69:6

\* \* L \* \*

L.P.A. [1] 4:6  
 lab [5] 12:25; 30:3; 55:1, 11  
 lack [1] 59:23  
 LAD [2] 78:5, 13  
 lady [24] 13:14; 15:7; 20:11; 21:2, 3; 26:8, 9,  
 22, 23; 27:2, 24; 28:2, 4; 30:3, 5, 17; 50:5, 25;  
 55:13; 71:17, 21; 72:24; 80:6, 13  
 lags [1] 62:21  
 Lakeside [1] 4:16  
 largely [1] 22:11  
 last [8] 7:19; 11:11; 12:25; 44:5; 68:23; 77:6,  
 20; 81:3  
 late [1] 73:15  
 lateral [1] 75:19  
 lawful [1] 6:2  
 lawsuit [1] 7:12  
 lead [1] 25:5  
 leads [1] 44:7  
 leak [3] 73:2, 4, 12  
 leaked [1] 73:14  
 leaking [1] 73:17  
 learn [2] 25:7; 38:18  
 learned [1] 17:15  
 leave [2] 46:4, 5  
 leaving [1] 33:14  
 leg [1] 44:19  
 legally [1] 41:23  
 legible [1] 13:7  
 length [4] 34:23; 53:8; 62:3; 73:23  
 lesion [1] 78:9

letter [1] 14:11  
 letters [4] 10:6, 24; 12:11, 13  
 level [1] 70:5  
 fe[9] 56:22, 24; 57:2; 71:19; 74:20; 75:1, 2;  
 9:9; 80:14  
 light [3] 12:1; 31:11; 39:6  
 lightly [1] 46:20  
 likelihood [2] 26:25; 70:15  
 imitations [1] 62:11  
 JINE [1] 83:2  
 ne [3] 73:3, 15, 16  
 near [1] 80:5  
 nes [1] 34:3  
 ist [3] 7:21, 22; 11:13  
 literature [4] 47:4, 8; 76:20, 25  
 litigation [1] 10:23  
 ive [1] 79:22  
 ived [2] 81:10, 16  
 ocal [2] 30:4, 18  
 ogic [1] 31:25  
 ong-term [2] 51:3; 79:19  
 ongest [1] 43:16  
 ongevity [1] 82:3  
 ooks [1] 62:18  
 oose [1] 59:18  
 oss [6] 21:4; 64:24; 72:4, 25; 77:8, 9  
 ost [7] 28:10; 35:8; 36:23; 37:2; 43:8; 44:10;  
 15:6  
 ot [7] 24:11; 30:6; 44:2; 64:22; 68:19; 75:22;  
 78-22  
 ow [2] 50:11; 74:2  
 ower [1] 47:10  
 ung [3] 51:13; 58:12; 62:16  
 ungs [9] 57:9, 17, 18; 58:16; 59:16; 61:8, 14,  
 19, 24  
 ying [1] 30:8  
 Lynn [1] 4:22

\* \* M \* \*

M.D. [5] 4:20; 5:2 6:1; 83:25; 84:5  
 machine [1] 51:14  
 maintained [1] 70:5  
 major [2] 68:18; 70:19  
 majority [2] 32:18, 20  
 malpractice [1] 37:12  
 manifest [1] 70:22  
 manifested [1] 68:9  
 manifesting [1] 61:7  
 manipulated [1] 32:5  
 manipulation [1] 32:3  
 manner [1] 64:2  
 March [5] 15:23; 16:2; 62:4; 63:20; 68:23  
 MARKED [1] 5:14  
 MARKOWITZ [4] 5:2; 6:1; 83:25; 84:5  
 Markowitz [1] 6:12  
 Martin [1] 8:20  
 massage [1] 49:25  
 massive [2] 68:15; 70:17  
 material [5] 21:13; 35:24; 36:1; 46:24; 47:14  
 materials [4] 10:8, 9, 10; 45:4  
 matter [4] 46:9; 51:20; 70:4; 72:4  
 matters [1] 7:12  
 Maynard [3] 4:15; 7:15; 8:13  
 mean [5] 25:19; 28:14; 39:3; 41:18; 67:5  
 meaning [1] 27:13  
 meaningful [1] 28:5  
 means [3] 44:15; 61:3; 70:5  
 measured [2] 47:8; 75:14  
 measurement [1] 53:20  
 measurements [1] 65:19

mechanical [1] 64:8  
 medical [5] 10:15; 15:1; 37:1; 41:16; 42:15  
 medically [2] 75:22; 78:25  
 medication [2] 36:18; 78:2  
 medicine [2] 44:23; 77:10  
 members [1] 8:11  
 memorable [1] 8:20  
 mention [4] 12:24; 42:8; 65:18; 68:17  
 mentioned [2] 35:1; 46:2  
 ME [1] 26:16  
 microbiology [1] 23:20  
 microscopic [1] 61:19  
 migrate [4] 27:1; 32:17; 55:24; 68:14  
 migrated [3] 23:20; 35:6; 68:25  
 migrates [3] 44:19; 53:2  
 migrating [3] 46:7; 76:22; 77:3  
 migration [4] 35:1, 11; 53:17, 21  
 minute [1] 60:22  
 minutes [1] 50:7  
 mischaracterization [1] 29:14  
 misleading [1] 17:8  
 MISS [1] 76:1  
 missing [1] 71:4  
 misunderstood [1] 62:23  
 Moasis [22] 11:4, 8, 23; 12:13, 16; 15:25;  
 17:22; 18:15; 19:15; 22; 20:4; 31:24; 39:8;  
 51:25; 52:10; 63:12; 64:5; 66:17, 20; 69:17;  
 72:16; 74:10  
 mode [4] 13:14; 79:5, 11; 80:1  
 modes [1] 78:10  
 monitoring [1] 64:10  
 month [1] 20:21  
 months [4] 25:25; 53:13; 63:9  
 Moore [1] 4:22  
 Morphan [1] 24:24  
 mortalities [2] 46:25; 47:2  
 mortality [2] 25:1; 47:9  
 mostly [1] 15:5  
 Mount [5] 43:15; 45:7, 21; 54:22; 56:12  
 mouth [1] 71:16  
 move [1] 37:9  
 moving [1] 55:11  
 Mrs [15] 11:3; 14:19; 15:18, 23; 16:2, 5; 18:2;  
 31:14; 33:14; 36:6; 53:21; 66:14, 18; 77:20;  
 82:4  
 Multiple [1] 57:1  
 multiple [4] 57:8; 63:18; 74:21; 77:21  
 muscle [6] 75:10, 15; 78:21, 23; 79:18; 80:15  
 myocardial [8] 20:21, 21:3; 47:23; 48:4, 9;  
 57:1, 7; 79:12  
 myself [1] 77:7

\* \* N \*

naïve [1] 21:13  
 name [4] 6:10; 8:2, 8; 58:22  
 named [1] 84:5  
 names [2] 8:6; 9:17  
 narrowing [1] 78:13  
 natural [2] 60:12; 79:14  
 needle [3] 52:20, 23, 25  
 needs [1] 71:18  
 negligence [1] 39:11  
 negligent [1] 59:23  
 neurologic [1] 68:16  
 neurological [1] 40:4  
 neurologically [4] 24:6; 40:8; 67:11; 68:6  
 newspaper [1] 46:24  
 night [1] 19:1  
 nine [1] 45:10  
 nobody [1] 69:7

nod [1] 6:22  
 normal [11] 50:7, 18; 58:1, 11, 19; 75:1, 2,  
 20; 79:9; 80:14  
 Norman [1] 4:23  
 Notary [2] 34:3, 24  
 note [1] 11:22  
 notes [5] 11:4; 67:16, 19, 23; 68-5  
 notified [2] 18:4; 63:12  
 notify [1] 18:1  
 notoriously [2] 65:15; 73:9  
 November [1] 11:2  
 noxious [1] 23:18  
 number [8] 6:14; 8:13; 43:14; 45:17; 46:20;  
 55:15; 65:19; 79:16  
 numerous [1] 55:14  
 Nuremberg [1] 8:25  
 nurse [5] 11:4; 67:16, 19, 23; 68:5  
 nurses [4] 17:2, 25; 18:17; 38:21

\* \* O \*

o'clock [5] 18:25; 19:9; 74:7  
 object [8] 7:14; 29:13; 41:8; 43:11; 49:21;  
 58:25; 71:14; 76:16  
 OBJECTION [1] 5:18  
 Objection [12] 36:9, 14; 50:23; 58:18; 60:9,  
 21; 67:4; 74:25; 76:5; 79:1; 81:13, 14  
 objection [5] 17:7; 33:17, 19; 37:18; 81:9  
 objections [1] 40:14  
 Obliquely [1] 47:13  
 observation [2] 57:13; 67:22  
 observations [1] 74:15  
 observe [1] 61:18  
 observed [5] 35:16; 38:15; 59:11; 68:22, 25  
 obstruction [1] 75:11  
 obtain [1] 15:9  
 obvious [1] 60:16  
 Obviously [1] 36:17  
 obviously [1] 38:1  
 occasion [1] 7:15  
 occasions [1] 9:9  
 occur [2] 32:19; 44:14  
 occurred [5] 10:20; 20:24; 39:11; 60:11; 72:1  
 occurrence [1] 32:19  
 occurs [1] 44:15  
 offered [1] 64:22  
 offhand [2] 9:19; 48:15  
 office [2] 10:9; 84:19  
 Ohio [9] 4:8, 17, 25; 6:4; 45:20; 84:1, 4, 20,  
 24  
 Okay [1] 6:19  
 one-and-a-half [1] 80:9  
 ones [2] 11:14  
 ongoing [5] 27:14; 61:24; 64:23, 24; 65:9  
 ooze [2] 73:3, 19  
 operate [4] 70:15; 71:6; 73:10; 78:14  
 operated [2] 51:6; 63:22  
 operating [11] 15:10; 24:4, 9, 20; 51:12; 64:4;  
 70:18, 24; 71:23; 74:13; 78:20  
 operation [1] 15:7  
 operative [2] 73:5; 79:16  
 operatively [1] 56:10  
 opinion [13] 18:6; 24:14; 33:20, 22; 39:10;  
 63:25; 64:25; 65:2, 11, 17; 70:3; 74:4, 20  
 opinions [5] 33:13; 40:18; 42:8, 22; 64:22  
 opportunity [3] 16:18; 22:5; 34:12  
 opposed [6] 29:8; 38:10; 48:4, 21; 64:16;  
 78:25  
 orally [1] 6:21  
 organ [3] 57:1, 8; 74:21  
 organizing [1] 61:20

organs [1] 27:19  
 original [4] 13:1, 3; 23:2; 39:14  
 Originally [1] 11:2  
 originally [3] 13:20; 34:8; 44:17  
 ought [1] 76:15  
 ours [1] 45:17  
 outcome [1] 84:17  
 outcomes [1] 47:8  
 outside [2] 37:10, 18  
 overall [1] 70:21  
 oxygen [1] 56:18

\* \* P \*

PAGE [2] 5:4; 83:2  
 page [1] 11:22  
 Paige [1] 8:20  
 pain [1] 55:10  
 paint [1] 42:5  
 pair [1] 57:17  
 papers [1] 76:24  
 Part [1] 48:6  
 part [2] 37:14, 76  
 partial [2] 34:16, 19  
 partially [1] 53:3  
 parties [1] 40:19  
 partners [1] 31:1  
 party [4] 41:9, 14; 76:13; 84:16  
 pass [1] 69:15  
 passed [1] 60:18  
 patent [1] 31:5  
 patient [39] 14:18, 19; 15:4, 16, 18; 25:17;  
 26:4; 28:20; 30:22, 23; 32:9; 49:13; 51:6, 13;  
 54:25; 55:10; 56:7; 60:6, 17; 62:13, 19, 20;  
 63:17; 64:15; 66:5, 9, 11, 14, 21; 69:3, 18;  
 70:1, 11, 12; 72:17; 74:11, 21  
 patients [9] 14:14; 24:24; 47:25; 48:6; 52:19;  
 70:15, 18; 73:9; 79:15  
 Pennsylvania [1] 47:2  
 People [1] 48:9  
 people [10] 30:22, 32:11, 12; 33:4; 45:10, 18;  
 48:3; 66:4; 79:17  
 percent [2] 25:1; 33:4  
 percutaneous [8] 53:22; 54:2, 21; 55:6, 24;  
 56:3; 69:2, 7  
 percutaneously [10] 28:16, 21; 29:8, 23;  
 31:2; 32:16; 33:1; 43:15; 51:22; 54:13  
 perforate [2] 36:3; 68:17  
 perforation [2] 35:21, 23  
 perfusion [1] 50:12  
 period [5] 20:12; 32:24; 43:16; 50:25; 73:12  
 permanent [2] 40:1; 78:23  
 permit [1] 54:20  
 person [2] 26:18; 80:21  
 personally [1] 25:13  
 pertaining [1] 21:6  
 pertinent [1] 11:5  
 physically [1] 20:5  
 physicians [6] 15:12; 17:2, 7; 29:21; 40:11;  
 66:16  
 physiology [1] 50:18  
 picture [7] 24:8; 59:19; 60:14; 61:7, 13; 62:17,  
 22  
 piece [1] 54:4  
 place [8] 26:10; 35:9; 38:19; 46:8; 53:25;  
 54:20; 55:23; 84:14  
 placed [1] 34:3  
 plaintiff [4] 6:3; 8:9, 17; 9:20  
 plastic [1] 36:1  
 pleadings [1] 42:1  
 please [1] 6:11

Pneumonia [1] 59:15  
 pneumonia [3] 59:14, 20; 60:7  
 point [15] 16:11; 31:13; 35:3, 15; 39:3; 57:10;  
 60:16; 69:12; 71:8; 74:15; 76:6, 20; 77:3; 80:2,  
 3  
 polypropylene [1] 35:25  
 portable [1] 62:12  
 portion [1] 52:25  
 portions [1] 13:11  
 position [6] 37:6; 54:5, 7, 10, 20; 55:25  
 possessed [1] 45:24  
 possibilities [1] 37:24  
 possibility [1] 79:2  
 post [2] 26:16; 51:11  
 postoperative [8] 16:8, 20, 23; 17:3; 20:12;  
 39:11; 51:8; 77:11  
 postoperatively [1] 19:2  
 postsurgically [2] 17:23; 38:21  
 postulate [6] 24:5; 68:13; 73:2, 3, 14; 80:13  
 potential [1] 36:2  
 practice [1] 14:14  
 Pre [1] 51:11  
 precautions [1] 43:23  
 precipitous [1] 18:20  
 precisely [3] 29:10; 31:5; 72:11  
 predicted [3] 46:25; 47:2, 9  
 PREM [1] 4:20  
 Preoperative [1] 51:8  
 Preoperatively [1] 51:12  
 preparation [1] 7:5  
 preparing [4] 10:2, 19, 21; 11:10  
 presence [3] 21:11; 23:17; 84:8  
 present [3] 28:19; 36:2; 62:3  
 presentations [1] 7:4  
 presents [1] 64:14  
 pressure [8] 19:4; 49:6, 18, 22; 50:7, 9, 11;  
 74:2  
 Presumably [1] 71:10  
 presumably [1] 68:19  
 presume [1] 52:5  
 pretty [6] 22:20; 40:22; 67:11; 78:22; 80:5, 6  
 prevented [1] 30:12  
 previous [4] 9:4; 20:21; 79:18, 21  
 previously [2] 8:12; 73:8  
 price [1] 36:19  
 primarity [1] 69:22  
 printing [1] 46:24  
 Prior [1] 49:10  
 prior [13] 7:15; 10:2, 19, 21; 11:9; 21:6; 27:7;  
 29:23; 39:7; 42:19; 48:5; 64:25; 66:12  
 probable [1] 79:4  
 problem [5] 18:19; 23:12; 38:25; 61:24; 72:3  
 problems [7] 26:24; 51:16; 52:18; 73:7, 10;  
 74:22; 82:4  
 Procedure [1] 6:4  
 procedure [37] 14:21; 16:17, 18, 20; 19:14,  
 16, 19, 20, 22, 23, 24; 20:5, 25; 23:7, 8, 14;  
 25:15, 16, 22; 26:4, 17; 27:8, 12; 31:5; 36:18;  
 46:19; 56:6; 63:12; 64:5; 66:22; 69:19; 70:16,  
 20; 72:2, 18, 24; 79:16  
 procedures [3] 37:7; 38:13; 44:1  
 proceed [1] 28:4  
 proceeding [1] 55:13  
 product [1] 27:17  
 professional [1] 70:2  
 profile [1] 49:13  
 prognosis [1] 51:3  
 program [1] 38:9  
 progressively [2] 21:25; 51:1  
 project [1] 47:17  
 property [1] 73:6

roportionately [1] 45:17  
 rotruding [1] 23:23  
 rovide [2] 26:21; 50:11  
 rovided [3] 10:11; 11:24; 79:11  
 roximate [1] 160:19  
 ublic [2] 84:3, 24  
 ublished [1] 47:16  
 ull [1] 5224  
 ulmonary [9] 21:24; 22:10, 14; 24:7; 58:7;  
 2:2; 74:16; 75:3, 4  
 ulse [5] 49:7, 1423; 50:7, 10  
 urpose [1] 6:3  
 ursuant [1] 6:4  
 utting [5] 36:5; 38:1, 14; 71:15

## \* \* Q \* \*

qualified [1] 58:3  
 Question [1] 81:6  
 question [23] 6:16, 17; 13:4; 17:19; 26:14,  
 30; 28:13, 15; 32:25; 39:13; 41:4; 42:17; 44:2,  
 7; 54:15; 71:2; 72:7, 8; 77:6, 21; 81:3, 20, 22  
 Questionable [1] 78:14  
 questioning [1] 69:7  
 Questions [21] 6:14, 21; 31:21; 40:16; 41:5;  
 50:2; 53:16; 55:5; 58:21, 24; 59:2; 62:25;  
 75:25; 76:1, 2, 7, 8, 9; 77:14; 80:23  
 quick [1] 124  
 quickly [1] 27:5

## \* \* R \* \*

radial [3] 35:12; 44:20; 76:22  
 adiation [1] 55:12  
 radiologist [3] 29:2; 30:11; 32:21  
 radiologists [2] 43:25; 45:9  
 radiology [1] 56:2  
 raise [1] 26:20  
 rapidly [1] 52:24  
 rare [3] 32:19; 43:19, 22  
 rarity [1] 45:6  
 rates [1] 47:9  
 read [11] 10:16; 11:11, 14; 14:13; 18:14;  
 66:19; 72:12, 13, 15; 81:6; 83:21  
 reading [1] 51:21  
 realize [3] 37:25; 43:9; 62:11  
 realizing [1] 74:21  
 reason [10] 13:13; 21:25; 23:2; 24:8; 26:22;  
 31:22; 32:13; 45:5; 55:3; 79:4  
 reasonable [1] 22:20  
 reasoning [1] 31:25  
 reasons [2] 45:1; 55:15  
 recall [11] 8:2, 10, 17; 9:2, 19, 20; 12:14;  
 22:11; 51:20; 63:8; 76:23  
 received [5] 12:12; 13:2; 14:5, 8, 11  
 receiving [2] 12:14, 24  
 recent [3] 60:3; 64:25; 65:20  
 recently [1] 7:2  
 Recess [1] 12:7  
 rechecked [1] 18:23  
 recognize [5] 36:20, 23; 37:2, 3; 73:13  
 recognized [1] 23:12  
 recollection [1] 62:6  
 reconnect [1] 64:11  
 record [5] 10:9; 19:13; 33:13; 51:21; 59:1  
 records [12] 10:4, 15; 11:3; 12:25; 13:1, 4, 7,  
 9, 10, 23; 59:12; 82:8  
 recover [2] 61:8; 67:9  
 recoverable [1] 50:5  
 recovering [1] 61:5  
 recovery [2] 27:25; 28:5  
 RECROSS-EXAMINATION [3] 76:18; 77:18;

2:7  
 recross-examination [2] 5:8, 9  
 ecross-examination [1] 5:10  
 recruitable [1] 75:20  
 educed [1] 84:8  
 eexploration [2] 63:14, 19  
 eference [1] 12:18  
 effect [3] 10:24; 37:8; 42:2  
 effected [2] 22:14; 59:15  
 reflecting [1] 27:17  
 eflection [2] 27:13; 37:15  
 egard [2] 48:8; 82:3  
 egarding [5] 7:8; 18:10; 22:9; 39:15; 42:20  
 egion [2] 78:19, 21  
 egions [1] 62:15  
 elate [1] 7:11  
 elated [1] 46:20  
 elates [3] 11:17; 39:14; 40:19  
 elationship [1] 42:12  
 elative [3] 18:24; 45:6; 84:15  
 elied [1] 18:17  
 ely [2] 15:17; 17:25  
 elying [1] 65:11  
 elmainder [1] 19:6  
 emained [2] 53:21; 54:5  
 emaining [1] 52:19  
 emember [7] 8:6, 8; 9:17; 12:17; 53:19;  
 53:6, 15  
 removal [9] 31:6; 44:16; 52:20; 54:3, 21;  
 55:25; 56:3; 69:2, 8  
 remove [12] 19:14; 23:7; 29:22; 31:18; 32:13,  
 15, 24; 4-93; 54:13, 16; 74:24  
 removed [14] 11:19; 26:14; 27:7; 28:7, 15;  
 29:8; 32:20; 33:1; 43:15; 54:4, 8, 15; 56:14;  
 68:24  
 removing [2] 28:18; 31:1  
 repair [2] 24:20; 63:14  
 repeat [1] 6:18  
 rephrase [2] 6:16, 17  
 rephrasing [2] 57:12  
 replacing [1] 61:9  
 report [25] 10:3, 19, 21; 11:4, 10; 12:21;  
 13:16; 14:3, 6, 12; 16:24; 33:25; 37:10, 18;  
 40:17, 21; 41:2; 42:7, 9; 63:11, 75; 65:18;  
 69:17; 71:7; 72:9  
 Reporter [1] 84:23  
 reports [1] 14:9  
 reprehensible [1] 36:16  
 represent [7] 41:1, 9, 14, 22; 42:3; 58:23;  
 76:13  
 representation [1] 41:25  
 represented [1] 42:2  
 represents [1] 41:22  
 required [5] 28:20; 38:24; 66:22; 69:20; 72:18  
 reshaping [1] 61:8  
 residents [4] 18:1, 17; 36:13; 38:21  
 residual [1] 58:6  
 respect [11] 42:10, 22; 43:14; 45:8; 49:1, 2;  
 52:1, 18; 55:21; 77:3, 22  
 respiratory [9] 59:17, 21; 60:7; 62:8; 63:1;  
 67:6; 69:21, 24; 71:11  
 Respond [1] 6:20  
 responding [2] 40:15; 67:13  
 responds [1] 24:7  
 response [2] 40:4; 79:8  
 responsibility [1] 40:19  
 responsible [2] 33:13; 41:24  
 responsive [1] 51:1  
 rest [1] 39:13  
 result [5] 36:20; 52:19; 59:8; 60:19; 79:12  
 retained [2] 7:14; 9:24

retains [1] 52:23  
 retrieval [1] 45:8  
 retrieve [2] 44:21; 45:23  
 retroperitoneum [2] 73:11, 23  
 Returned [1] 53:15  
 returned [1] 10:17  
 revascularized [2] 75:21; 77:25  
 reveal [1] 78:4  
 revealed [2] 51:22; 76:21  
 reversible [3] 50:24; 51:2, 4  
 review [9] 11:9, 13; 22:5; 33:12; 34:15; 35:2; 59:12; 62:7  
 reviewed [3] 10:1, 18; 53:13  
 revised [1] 7:2  
 Right [4] 34:6; 47:15; 72:19; 80:4  
 right [7] 6:18; 16:14; 17:25; 49:3; 66:20; 69:18; 72:16  
 risk [12] 26:18; 32:5; 35:21, 23; 36:17; 46:7; 64:14; 70:24; 71:21, 22; 75:10; 80:15  
 risks [1] 71:20  
 roll [1] 64:9  
 ROLLINS [1] 4:11  
 room [9] 15:10; 24:4, 9, 20; 51:12; 70:18, 24; 71:23; 74:13  
 roughly [2] 7:18; 74:7  
 round [1] 18:13  
 Rules [1] 6:4  
 run [1] 55:9  
 running [1] 7:23  
 runs [1] 73:22

\* \* S \*

safe [2] 20:8; 26:8  
 safely [1] 70:14  
 safer [1] 30:19  
 SAINT [1] 4:3  
 Saint [3] 49:10, 14; 59:25  
 saying [7] 52:10; 54:2; 63:15; 71:6, 15, 16, 17  
 scale [1] 70:20  
 scarred [1] 78:13  
 scarring [1] 78:23  
 scenario [1] 68:13  
 scores [2] 48:20, 21  
 seal [1] 84:19  
 second [15] 19:15; 22:1; 29:7, 22; 30:12; 34:25; 37:3, 14; 52:7, 9, 11; 54:16, 21; 56:3  
 SEIBEL [11] 10:14; 11:18; 16:10, 15; 19:8, 12; 25:2; 29:13; 33:18; 42:25; 53:14  
 Seibel [2] 42:19, 23  
 self-contained [1] 30:6  
 semantics [1] 67:25  
 send [1] 26:8  
 senior [2] 36:12; 38:16  
 sense [2] 26:6; 57:24  
 sentence [4] 72:10, 14, 15  
 separate [1] 41:25  
 Sepsis [2] 27:13, 15  
 sepsis [4] 26:24; 32:5; 60:8; 70:17  
 septae [1] 61:21  
 septic [1] 27:12  
 serial [2] 22:24; 63:9  
 series [1] 71:19  
 seven [1] 74:7  
 severity [1] 39:14  
 Sharp [2] 4:23; 9:7  
 sharp [2] 52:23, 25  
 shear [4] 34:24; 52:25; 53:3, 6  
 sheared [1] 52:17  
 shearing [1] 52:15  
 sheering [2] 52:20, 21

sheers [1] 53:1  
 SHEET [1] 83:1  
 shorten [3] 56:22, 24; 57:2  
 shortening [1] 78:18  
 shot [1] 44:19  
 Show [1] 81:8  
 show [4] 48:22; 61:11; 74:8; 75:5  
 shows [2] 12:1; 21:24  
 shrapnel [2] 46:3, 8  
 sign [1] 27:16  
 signal [2] 18:18, 22  
 signature [1] 82:15  
 significant [3] 17:22; 35:21; 80:10  
 signs [6] 19:1, 6; 21:23; 52:1; 74:8, 9  
 silly [1] 38:8  
 simplistic [1] 77:6  
 Sinai [5] 43:15; 45:7, 22; 54:22; 56:12  
 sir [2] 14:22; 28:11  
 sit [1] 81:11  
 site [1] 34:25  
 six [4] 18:25; 19:9; 25:25; 44:6  
 Sixth [1] 4:24  
 size [3] 45:16; 52:16; 75:13  
 sleuths [3] 66:4, 8, 13  
 Slightly [1] 7:6  
 slow [2] 73:4, 18  
 slowly [2] 68:17; 73:24  
 Smead [6] 25:11, 12; 28:24; 30:10; 31:12; 38:20  
 smiling [2] 25:3, 8  
 snare [2] 45:3; 54:12  
 soft [1] 73:24  
 somebody [6] 28:8; 38:13, 22; 67:21; 68:3; 79:24  
 somehow [1] 19:16  
 Someone [2] 45:19; 50:8  
 someone [12] 20:20, 32:6; 38:16; 45:21, 24; 49:1; 54:11, 21; 56:1; 60:25; 61:2; 64:16  
 Sopko [2] 22:6, 18  
 sorry [3] 25:19; 42:21; 68:1  
 sorts [1] 70:18  
 sounds [1] 73:23  
 source [2] 65:14; 67:23  
 space [1] 73:11  
 span [3] 75:1, 2; 80:14  
 speak [1] 46:3  
 specialists [1] 65:5  
 specific [1] 80:21  
 Specifically [2] 48:1; 67:16  
 specifically [3] 7:11; 44:13; 76:24  
 specified [1] 84:14  
 spent [2] 30:2; 55:1  
 spirit [1] 19:25  
 spoke [1] 62:9  
 spot [1] 57:7  
 spread [1] 61:20  
 stability [3] 67:5; 70:5; 71:10  
 stabilized [2] 22:22; 23:4  
 stable [12] 66:21, 25; 69:18, 25; 70:12; 71:5, 7, 17; 72:17, 21, 24; 74:12  
 Standard [1] 4:7  
 standard [4] 15:22; 16:1; 17:2; 36:5  
 standpoint [3] 15:2; 26:18; 42:15  
 start [2] 17:19; 69:11  
 started [2] 25:23; 73:15  
 starting [1] 18:25  
 State [4] 47:1; 84:1, 4, 24  
 state [2] 6:10; 46:21  
 statement [6] 17:24; 25:15; 29:12; 52:17; 67:1; 69:16  
 statistical [2] 47:22; 48:10

statistically [2] 46:15; 79:22  
 Statistics [1] 81:17  
 statistics [5] 7:9, 10; 48:8; 79:25; 82:3  
 status [8] 21:22, 24; 22:2, 10, 14, 21; 67:6; 77:23  
 stay [1] 64:20  
 stayed [1] 35:8  
 STEELE [1] 4:12  
 Steele [21] 15:21; 19:17, 19; 20:1; 30:16; 31:9, 14, 15, 20, 23; 34:7; 39:8; 54:3, 14, 17, 23; 55:4, 17, 18; 69:9  
 Stenographic [1] 84:23  
 stenotypy [1] 84:8  
 step [1] 27:24  
 Stephen [1] 8:9  
 sterile [1] 32:8  
 steroid [3] 65:1, 22; 68:8  
 steroids [1] 65:3  
 stimuli [1] 40:4  
 stimulus [1] 23:18  
 stopped [5] 22:24; 39:1; 55:2, 5  
 stops [1] 74:1  
 stratify [1] 23:9  
 stream [1] 27:18  
 stress [3] 75:9, 18; 78:18  
 strictest [1] 26:6  
 strike [1] 37:10  
 stroke [1] 68:15  
 studies [3] 26:15; 65:13; 75:8  
 study [6] 47:22; 75:4, 5, 18; 76:20; 79:14  
 studying [1] 47:12  
 stupid [1] 37:20  
 subclavian [1] 23:25  
 subject [1] 7:12  
 subsequent [5] 11:14; 14:5; 20:11, 12; 70:6  
 subsequently [4] 36:25; 37:22; 60:14; 84:9  
 substandard [1] 60:19  
 substantial [1] 32:5  
 substantively [1] 7:5  
 succeeded [1] 32:16  
 successful [1] 31:9  
 suggested [1] 70:23  
 suggests [1] 72:2  
 suite [3] 64:4, 11, 12  
 supine [1] 62:13  
 supplies [1] 78:13  
 Supported [1] 30:7  
 surfaces [1] 73:4  
 surgeon [4] 56:6; 58:3; 66:10  
 surgeons [2] 46:25; 47:5  
 surgery [42] 7:9; 14:15, 18; 15:5, 23; 16:2; 20:22; 21:6, 7, 8; 23:10; 28:20; 29:24; 33:5; 34:8; 35:4; 38:24, 25; 39:7, 9, 13; 46:22; 48:1, 2, 4, 7, 9; 63:20; 64:12, 25; 65:14; 66:12, 14; 70:16; 73:1; 74:5, 18, 23; 75:21; 79:19  
 surgical [11] 14:20; 16:16, 18, 19; 39:16; 63:12, 20; 64:4, 11, 12; 73:4  
 surgically [9] 28:14; 29:9; 30:20; 31:23; 32:14; 33:2; 53:4; 56:13; 78:25  
 survivability [1] 49:2  
 survival [2] 46:18; 79:20  
 survive [3] 48:10; 80:2, 3  
 survived [4] 39:10, 12, 17; 63:23  
 suspect [2] 15:3; 33:5  
 sustain [1] 21:10  
 sustained [1] 27:2  
 suture [3] 73:3, 15, 16  
 sworn [2] 6:5; 84:6  
 symptoms [2] 19:1; 60:2  
 syndrome [5] 59:17, 21; 60:8; 62:8; 63:1  
 system [9] 28:8; 36:7; 44:10; 51:17, 18; 67:7;

69:22, 25; 71:11  
systemic [1] 27:16

\* \* T \* \*

**tabb** [3] 30:3, 8; 55:11  
takes [1] 73:25  
**talk** [3] 16:13; 42:13; 54:17  
**talked** [2] 30:11; 3:6  
**talking** [7] 24:21; 38:1, 9; 46:17; 48:21; 56:3; 69:12  
**tally** [1] 7:23  
**tarred** [1] 47:5  
**team** [1] 65:9  
**technical** [1] 56:8  
**techniques** [4] 44:11, 22; 45:1; 62:12  
**technology** [1] 45:3  
**ten** [1] 70:21  
**term** [2] 67:5; 75:6  
**terms** [10] 22:18, 21; 36:19; 37:14; 43:24; 70:21; 75:1; 77:6, 20; 80:17  
**test** [2] 75:9; 78:18  
**testified** [6] 6:6; 7:24; 29:5, 21; 38:20; 40:7  
**testify** [1] 84:6  
**testifying** [1] 42:19  
**testimony** [4] 10:5; 23:6; 84:7, 11  
**thallium** [2] 75:18; 78:17  
**Thank** [1] 55:22  
**theoretically** [2] 142:4; 15:19  
**thereto** [1] 48:5  
**thermia** [1] 50:7  
**thickening** [2] 78:18, 21  
**thinking** [2] 69:21; 71:12  
**thoracic** [1] 58:3  
**thoroughly** [1] 66:5  
**thousands** [1] 45:13  
**threat** [1] 68:16  
**three** [8] 8:5; 25:25; 44:1; 45:16; 51:9; 70:21; 72:8; 79:25  
**threw** [1] 67:25  
**throw** [1] 68:14  
**times** [9] 7:18, 19, 24; 8:14; 45:16; 51:7, 10; 72:8; 80:9  
**tip** [4] 23:21, 23; 35:14; 53:1  
**tipped** [1] 35:19  
**tissue** [3] 50:21; 61:9; 73:24  
**tissues** [1] 50:20  
**tolerate** [4] 66:22; 69:19; 72:17, 24  
**tolerated** [1] 27:23  
**totally** [1] 30:6  
**Tracy** [2] 8:22  
**trained** [4] 37:19; 38:7; 44:8, 12  
**training** [7] 37:15, 21; 38:5, 10, 13; 44:11  
**transcribed** [1] 84:9  
**transcript** [2] 83:21; 84:11  
**transfer** [1] 49:10  
**transferred** [1] 64:3  
**trauma** [1] 50:19  
**traveling** [1] 30:6  
**treatable** [1] 78:8  
**treated** [2] 77:23; 78:24  
**treatment** [3] 79:5, 11; 80:1  
**tree** [4] 20:3; 21:15; 44:18; 53:2  
**tremendous** [3] 20:7; 27:3; 55:10  
**trend** [1] 21:22  
**True** [1] 69:23  
**true** [6] 42:9; 46:11; 50:22; 57:10; 83:22; 84:11  
**truly** [1] 50:6  
**truth** [1] 84:6

**Tuschman** [2] 4:15; 7:16  
**twice** [1] 9:10  
**type** [5] 23:13; 24:16; 46:19; 48:3; 64:15

\* \* U \*

**ultimately** [1] 36:3  
**unable** [1] 50:9  
**undergo** [4] 15:23; 16:2; 39:9; 66:11  
**undergoing** [1] 49:24  
**undergone** [1] 79:6  
**understand** [13] 6:15, 16; 20:6; 23:18; 30:14, 16, 24; 37:1; 48:8; 62:23; 71:6; 72:23; 77:2  
**understood** [1] 28:13  
**undertaken** [1] 46:19  
**undertaking** [1] 66:13  
**undiscovered** [1] 65:8  
**unfortunate** [1] 15:8  
**Unfortunately** [1] 55:18  
**unit** [4] 21:23; 22:13; 32:7; 74:13  
**University** [2] 45:14, 22  
**unlikely** [1] 80:14  
**Unrecognized** [1] 77:8  
**unrecognized** [1] 72:5  
**unreliable** [1] 65:16  
**unstable** [1] 21:4  
**untoward** [1] 36:20  
**up-to-date** [1] 6:24

\* \* V \*

**vacation** [1] 31:15  
**value** [1] 78:14  
**values** [5] 122:5; 13:5; 18:10, 15, 21  
**valve** [1] 48:1  
**valves** [1] 70:17  
**Van** [2] 29:2; 31:12  
**variance** [1] 47:3  
**variety** [1] 45:1  
**VARMA** [1] 4:20  
**Varma** [13] 33:6; 34:4; 36:5; 41:1, 13, 22, 23, 24; 42:2, 9, 20, 23; 43:4  
**vascular** [8] 20:3; 44:10, 18; 51:17; 53:2; 67:7; 69:21, 25  
**vast** [2] 82:18, 19  
**vastly** [1] 47:10  
**vein** [1] 44:20  
**ventilator** [6] 22:19; 27:25; 30:5, 7; 64:8, 12  
**ventricle** [1] 79:21  
**verbal** [1] 14:9  
**vernacular** [1] 77:10  
**vessel** [6] 23:24; 27:7; 28:4; 35:24; 36:2; 68:18  
**vessels** [1] 78:20  
**viewed** [1] 62:1  
**viewing** [1] 62:6  
**VINCENT** [1] 4:3  
**Vincent** [3] 49:10, 14; 59:25  
**violations** [1] 37:11  
**virtually** [1] 36:25  
**virtue** [2] 52:20; 78:9  
**viruses** [1] 61:15  
**vital** [3] 19:6; 21:23; 74:9

\* \* W \*

**wait** [2] 26:16; 68:12  
**waited** [1] 25:25  
**waiting** [1] 24:2  
**waived** [1] 82:15  
**walking** [1] 26:9  
**wall** [4] 75:19, 20; 78:11, 17  
**wanted** [2] 13:4, 11

**ways** [1] 36:22  
**wean** [1] 27:25  
**weaned** [1] 22:18  
**Wednesday** [2] 28:25; 38:20  
**week** [1] 12:25  
**weeks** [3] 21:15; 22:19; 68:10  
**weigh** [2] 61:15; 80:10  
**weighed** [1] 80:8  
**Weitzel** [15] 11:3; 14:19; 15:18, 23; 16:2, 5; 18:2; 31:14; 33:14; 36:6, 8; 53:21; 66:14, 18; 82:4  
**Wellington** [1] 45:20  
**weren't** [9] 10:22; 13:7; 30:15; 33:9; 40:16; 52:14, 16; 57:23; 58:4  
**whatsoever** [2] 50:6; 72:4  
**WHEREOF** [1] 84:18  
**wherever** [1] 53:2  
**white** [7] 58:13; 64:20, 22; 65:3, 8, 15; 68:7  
**wide** [1] 61:20  
**widening** [1] 61:21  
**William** [2] 4:5, 6  
**willing** [1] 21:8  
**wire** [40] 19:15; 22:1; 23:23; 28:2, 10, 18; 29:7, 22; 30:9, 12, 19; 31:18; 34:20, 21, 23; 35:25; 37:3; 38:15; 43:8, 17; 44:5; 45:6, 20; 52:2, 7, 11, 21, 22, 23; 53:1; 54:3, 8; 55:23; 68:12, 13; 69:3, 8, 12; 76:21  
**wires** [46] 20:2; 21:12, 14, 21; 23:7, 17, 21; 26:10, 21, 25; 27:21, 22; 28:6, 7, 16; 31:1; 33:14; 34:2, 5, 13, 17; 35:19, 22; 36:6, 24; 38:2; 43:5, 14; 44:9, 25; 51:17, 19; 52:18; 53:7, 23, 24; 55:2; 62:3; 68:16, 22, 24; 70:25; 71:22; 74:22, 24; 77:1  
**Wiseman** [1] 8:23  
**withdraw** [1] 20:1  
**withstood** [1] 63:19  
**WITNESS** [4] 5:2; 6:19; 12:3; 84:18  
**witness** [4] 6:2; 55:19; 84:5, 9  
**witnessed** [1] 28:17  
**witnesses** [1] 10:7  
**woman** [11] 20:2; 21:9; 23:18; 24:2, 4; 56:9; 61:4; 65:6; 67:8; 73:5, 6  
**wonder** [1] 48:18  
**word** [2] 26:6; 50:14  
**words** [3] 71:15; 72:9, 21  
**worked** [2] 8:12, 14  
**working** [2] 7:8; 46:14  
**workup** [1] 15:6  
**worried** [1] 54:17  
**worse** [2] 21:10; 63:5  
**wouldn't** [7] 10:23; 16:8, 19; 38:23; 45:23; 58:16; 68:4  
**writing** [1] 12:19  
**written** [2] 14:8; 49:1  
**wrong** [2] 19:2; 32:9  
**wrote** [3] 13:23; 66:20; 69:20

\* \* X \* a

**x-ray** [21] 35:10, 16; 53:8, 24; 55:14; 57:13; 58:1, 6, 9; 61:7, 13; 62:2, 7, 9, 10, 18, 21, 25; 68:23, 25  
**x-rays** [17] 11:5; 22:12; 34:14, 15; 35:2; 53:9, 12, 13; 57:9, 15, 16; 59:13; 60:24; 62:1, 7; 63:6; 68:22

\* \* Y \* \*

**year** [3] 32:23; 79:19, 25  
**year-and-a-half** [1] 47:18  
**years** [10] 7:20; 8:5; 9:8; 32:22; 44:2, 6; 80:1;

81:10, 11

York [1] 47:1

yours [2]14:3; 70:10

yourself [2]11:23; 14:16