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**DEPOSITION OF ARTHUR J. McCULLOUGH, JR., M.D.**

**Belinda Hall, Administratrix, etc. vs. Kaiser Permanente, et al.**

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CONDENSED TRANSCRIPT AND CONCORDANCE

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## Page 1

(1) THE STATE of OHIO, )  
 (2) COUNTY of CUYAHOGA. ) SS:  
 (3) -----  
 (4) IN THE COURT OF COMMON PLEAS  
 (5) -----  
 (6) BELINDA HALL, Administratrix )  
 (7) of the Estate of Delmar Darrell, )  
 (8) plaintiff, ) Case No.  
 (9) vs. ) 363835  
 (10) KAISER PERMANENTE, et al., )  
 (11) defendants. )  
 (12) -----  
 (13) Deposition of ARTHUR J. McCULLOUGH,  
 (14) JR., M.D., a witness herein, called by the  
 (15) Defendant Kaiser Permanente as if upon  
 (16) cross-examination, and taken before David J.  
 (17) Collier, RPR, Notary Public within and for  
 (18) the State of Ohio, pursuant to agreement of  
 (19) counsel, and pursuant to the further  
 (20) stipulations of counsel herein contained, on  
 (21) Thursday, the 16th day of September, 1999,  
 (22) at 8:10 a.m., at the MetroHealth Medical  
 (23) Center, 2500 MetroHealth Drive, City of  
 (24) Cleveland, County of Cuyahoga and the State  
 (25) of Ohio.

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(1) APPEARANCES,  
 (2)  
 (3) ON BEHALF OF THE PLAINTIFF:  
 (4) William Hawal, Esq.  
 (5) Spangenberg, Shibley & Liber  
 (6) 2400 National City Center  
 (7) Cleveland, Ohio 44114  
 (8) (216) 696-3232  
 (9)  
 (10)  
 (11) ON BEHALF OF THE DEFENDANTS KAISER  
 (12) PERMANENTE, RAFAEL BENDEZU, M.D. and  
 (13) JAMES R. BROWN, M.D.:  
 (14)  
 (15) Beverly Sandacz, Esq.  
 (16) Reminger & Reminger  
 (17) The 113 St. Clair Building  
 (18) Cleveland, Ohio 44114  
 (19) (216) 687-1311  
 (20)  
 (21)  
 (22)  
 (23)  
 (24)  
 (25)

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(1) (McCullough Deposition Exhibit 1  
 (2) marked for identification.)  
 (3) -----  
 (4) ARTHUR J. McCULLOUGH, JR., M.D.  
 (5) of lawful age, having been first duly sworn,  
 (6) as hereinafter certified, was examined and  
 (7) testified as follows:  
 (8) -----  
 (9) CROSS-EXAMINATION  
 (10) BY MS. SANDACZ:  
 (11) Q Will you state your full name for the  
 (12) record?  
 (13) A Arthur J. McCullough.  
 (14) Q First name is Arthur?  
 (15) A Yes.  
 (16) Q Doctor, my name is Beverly Sandacz, I'm  
 (17) here on behalf of Kaiser and OPMG  
 (18) physicians. My purpose today is to explore  
 (19) some of your opinions. You have been  
 (20) identified as one of the experts for the  
 (21) plaintiffs, and I want to get an  
 (22) understanding of some of your opinions, so  
 (23) my purpose today is just to explore those  
 (24) and get the basis of those opinions.  
 (25) If at any time you don't

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(1) understand a question that I put to you,  
 (2) please let me know and I will attempt to  
 (3) rephrase it, fair enough?  
 (4) A Yes.  
 (5) Q If you answer a question, I'm going to  
 (6) assume that you answered it truthfully and  
 (7) it was responsive to my question, fair  
 (8) enough?  
 (9) A Yes.  
 (10) Q I'm sure Mr. Hawal has indicated to  
 (11) you -- he told me this is your first  
 (12) deposition, so --  
 (13) A Never done one.  
 (14) Q It is simply just a question and answer  
 (15) session. I'm sure that he told you that you  
 (16) do have to answer verbally because the court  
 (17) reporter is taking down my question and your  
 (18) response and cannot interpret any head nods  
 (19) or um-hum's or some sort of nonverbal  
 (20) gesture, fair enough?  
 (21) A Yes.  
 (22) Q If at any time you need to take a  
 (23) break, that's not a problem. The only other  
 (24) admission I have for you is please allow me  
 (25) to finish my question before you give your

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(1) response, because it makes it difficult for  
 (2) the court reporter to make a clear record of  
 (3) the questions and answers  
 (4) A Understood  
 (5) Q And I will try to do the same for you,  
 (6) because I tend to jump in as well, I think  
 (7) that's just normal conversation, okay?  
 (8) A Fine  
 (9) Q Can you give me your professional  
 (10) address?  
 (11) A MetroHealth Medical Center,  
 (12) 2500 MetroHealth Drive  
 (13) Q Are you employed by MetroHealth?  
 (14) A Yes, full time  
 (15) Q Do you have any other employment  
 (16) outside of MetroHealth?  
 (17) A No  
 (18) Q What is the capacity of your employment  
 (19) here?  
 (20) A I'm the division director of  
 (21) gastroenterology, professor of medicine at  
 (22) Case Western  
 (23) Q As division director of  
 (24) gastroenterology, what does that entail?  
 (25) A It means I have spent about 20 percent

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(1) of my time doing the administrative work of  
 (2) running an academic clinical GI division.  
 (3) Q Okay. Tell me about the GI division.  
 (4) What does it encompass?  
 (5) A We have five full-time physicians,  
 (6) two part-time physicians, and we will be  
 (7) hiring another two part-time physicians very  
 (8) soon. We perform all forms of  
 (9) gastroenterology.  
 (10) Q And is that in-house or does it include  
 (11) outpatient, ambulatory surgery, et cetera?  
 (12) A It's both the in-house service and the  
 (13) outpatient clinics here, both at Metro and  
 (14) at some of our satellite facilities.  
 (15) Q Where are the satellite facilities?  
 (16) A There is one in Strongsville, one in  
 (17) Westlake, one in Brooklyn, and one on  
 (18) West 150th Street.  
 (19) Q And when you say they're satellites,  
 (20) are they still hospital set --  
 (21) A They're owned by Metro.  
 (22) Q And are they governed by the rules and  
 (23) regulations that are governed over Metro?  
 (24) A I believe so.  
 (25) Q So when JCHO comes in and accredits the

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(1) hospital, do they govern those as well?  
 (2) A I think so. I'm not sure of that.  
 (3) Q Do you ever operate yourself under any  
 (4) of these satellites?  
 (5) A No, I do not.  
 (6) Q Do you ever do any patients on the  
 (7) outpatient surgery?  
 (8) A Outpatient surgery?  
 (9) Q Outpatient clinic. Sorry.  
 (10) A Yes, absolutely.  
 (11) Q What kind of procedures do you do in  
 (12) the outpatient clinic?  
 (13) A I perform all gastroenterological  
 (14) procedures.  
 (15) Q Including PEG tube insertion?  
 (16) A Including PEG tube insertion.  
 (17) Q Before we get too far into your  
 (18) practice, let me just ask you some other  
 (19) questions.  
 (20) I have marked as Defendant's  
 (21) Exhibit 1 a curriculum vitae that was given  
 (22) to me. Can you just confirm that that is in  
 (23) fact a current and up-to-date --  
 (24) A Well, it's not current.  
 (25) Q Okay.

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(1) A It's March.  
 (2) Q All right.  
 (3) A It changes at some -- with some  
 (4) regularity.  
 (5) Q Is that your CV?  
 (6) A Yes.  
 (7) Q What, in addition to what's on there,  
 (8) has been changed or needs to be updated?  
 (9) A Probably recent publications.  
 (10) Q Is there any of those publications --  
 (11) A Relevant to this?  
 (12) Q Yes.  
 (13) A I'm sorry. No.  
 (14) Q That's okay. I tried to look through  
 (15) some of these numerous articles that you  
 (16) have here and I did not see any that is  
 (17) directed to PEG tube insertion. Am I  
 (18) correct in that?  
 (19) A No, that's not correct.  
 (20) Q Okay. Tell me which ones you have --  
 (21) A I just have one. The first author's  
 (22) name was Stassen, it's number 8, and I  
 (23) believe if not the first it was one of the  
 (24) first descriptions of pneumoperitoneum  
 (25) described after PEG placement.

(4) Q Yes. The title is "Another cause of  
(5) 'benign' pneumoperitoneum" in  
(6) Gastrointestinal Endoscopy?  
(7) A Yes.  
(8) Q Who is Dr. Stassen?

(4) A Yes.  
(5) Q Here at Metro?  
(6) A Yes.  
(7) Q Any other articles, presentations,  
(8) publications, abstracts, anything, case

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(1) surgery, and when you do PEGs now it's  
(2) realized that you just get air in there and  
(3) it's not a surgical problem, and so this  
(4) prevented people from needlessly going to  
(5) surgery to look for a problem that wasn't  
(6) there.  
(7) Q That conclusion that you just told me,  
(8) that now we believe that air is a common  
(9) finding when this procedure is done, is that  
(10) something that you concluded in that article  
(11) or is that something subsequent to that  
(12) article?  
(13) A Well, we concluded it. I can't  
(14) remember if other people -- if it wasn't the  
(15) first, it was close to the first.  
(16) Q Did this talk about anything about the  
(17) technique?  
(18) A I don't remember.  
(19) Q Okay. Is it fair to say it talked  
(20) about the complication -- a specific  
(21) complication of pneumoperitoneum?  
(22) A Correct.  
(23) Q Did it talk about bowel perforation?  
(24) A I don't remember. Probably it spoke to  
(25) the fact that this pneumoperitoneum was not

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(1) A I don't know what I'm supposed to do  
(2) with that.  
(3) Q You can answer.  
(4) MR. HAWAL: You can answer  
(5) if you can.  
(6) A Yes. I mean, he was recognized as one  
(7) of the first people who did it and he's a  
(8) well-known surgical endoscopist.  
(9) Q And he has a good reputation here in  
(10) the community as it relates to his insights  
(11) as to PEG insertion?  
(12) MR. HAWAL: Objection.  
(13) A As far as I know.  
(14) Q Do you know Dr. Ponsky?  
(15) A Um-hum. Peripherally.  
(16) Q Have you --  
(17) A I don't know him well.  
(18) Q Have you read any of his literature as  
(19) it relates to PEG tube insertion?  
(20) A Just the first one.  
(21) Q Okay. Do you know that he has  
(22) published on PEG tube insertion and/or  
(23) associated issues on numerous occasions?  
(24) A I've heard him talk. I don't know -- I  
(25) assume he's published other articles. I

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(1) don't know that  
 (2) Q You've heard him talk at seminars or  
 (3) CME's --  
 (4) A Yeah  
 (5) Q -- or something on the issue?  
 (6) A Yeah Maybe just once I can't  
 (7) remember  
 (8) Q On PEG tube insertion?  
 (9) A Right  
 (10) Q Do you know he's the expert in this  
 (11) case?  
 (12) A I just heard this morning that he  
 (13) was -- I don't know what -- whose expert he  
 (14) was I heard that he was in the case  
 (15) Q Have you ever reviewed his report?  
 (16) A No  
 (17) Q You are Board certified in internal  
 (18) medicine?  
 (19) A Yes  
 (20) Q And gastroenterology?  
 (21) A Yes  
 (22) Q And it says also medical examiners  
 (23) What is -- is that --  
 (24) A That's national boards, like when you  
 (25) go through medical school

(1) A My responsibilities to the medical  
 (2) school, every year we teach either the first  
 (3) or second year students on gastroenterology,  
 (4) it's almost always first or second year; and  
 (5) then we rotate on the medicine -- we rotate  
 (6) on the general medicine service once a year  
 (7) for a month, two to four weeks, and we have  
 (8) third year medical students then, and I'm  
 (9) usually the teaching attending in that  
 (10) service; and then I perform subspecialty  
 (11) consultations on rounds in the hospital and  
 (12) we usually have a fourth year student -- or  
 (13) often have a fourth year student on  
 (14) service.  
 (15) Q So you teach classroom to first and  
 (16) second year students on issues of  
 (17) gastroenterology, correct?  
 (18) A Um-hum.  
 (19) Q And do you include in there the  
 (20) insertion of a PEG tube?  
 (21) A (Shaking head.)  
 (22) Q No. Okay.  
 (23) And when you rotate on the service  
 (24) once a year, one month per year, where the  
 (25) third year medical student is with you,

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(1) Q Okay Thank you  
 (2) I didn't know if that was like  
 (3) a --  
 (4) A Nothing special  
 (5) Q No, I was thinking that was more of  
 (6) like an autopsy, person who does --  
 (7) A Oh, no  
 (8) Q Okay Thank you  
 (9) It says you're licensed in the  
 (10) State of Ohio Any other states?  
 (11) A No  
 (12) Q Has your license ever been revoked,  
 (13) suspended or any conditions placed on it?  
 (14) A No  
 (15) Q You have maintained the position of  
 (16) division director of gastroenterology for  
 (17) how long?  
 (18) A I'm not sure I'm -- '91  
 (19) Q I didn't mean to -- this isn't a quiz,  
 (20) I'm just trying to get an understanding  
 (21) You are a full professor at Case  
 (22) Western?  
 (23) A Yes  
 (24) Q What do you teach, any specific class,  
 (25) or --

(1) that's a clinical teaching?  
 (2) A Yes.  
 (3) Q And do you perform, in the course of  
 (4) that, PEG tube insertions in which the third  
 (5) year medical student will be there?  
 (6) A It's possible.  
 (7) Q Okay.  
 (8) A They're -- if a patient is on the  
 (9) service and needs a PEG, then -- when I'm on  
 (10) the service I don't do procedures, but it's  
 (11) likely that --  
 (12) Q I see.  
 (13) A -- if the students -- that patient is  
 (14) the student's patient, the student will go  
 (15) up and observe.  
 (16) Q When you're on the service you just  
 (17) manage the patients within the -- in-house  
 (18) patients; is that --  
 (19) A Correct.  
 (20) Q Okay. So when you're not on service  
 (21) you are doing procedures on a -- whenever  
 (22) they're consulted, either outpatient clinic  
 (23) or inpatient?  
 (24) A Yes. I do procedures once a week on  
 (25) the residents' cases, so they're people

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(1) without their own attendings, and I do cases  
 (2) on my own patients once or two half days a  
 (3) week.  
 (4) Q Where do those patients come from?  
 (5) A My own patients?  
 (6) Q Yes.  
 (7) A Referrals. Patient referrals.  
 (8) Q Okay. And performing subspecialty  
 (9) consultations with the fourth year, what  
 (10) does that entail?  
 (11) A They rotate -- in addition to having to  
 (12) be on the general medicine service two to  
 (13) four weeks a year, each of the attending  
 (14) gastroenterologists here rotate on what's  
 (15) called the consultative GI service, which  
 (16) means that any patient in the hospital who  
 (17) has a GI problem that the primary care  
 (18) physician needs a consult on, we consult,  
 (19) and in that way the students and residents  
 (20) and fellows rotate with the attending, and  
 (21) I'm on this year three months.  
 (22) Q And when you're on that service for the  
 (23) three months, do you do procedures?  
 (24) A Yes.  
 (25) Q Okay. You mentioned that you spend

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(1) ,approximately 20 percent of your time in an  
 (2) (> administrative capacity. Do you spend the  
 (3) remaining 80 percent in the clinical  
 (4) setting?  
 (5) A No, I spend 30 percent of my time doing  
 (6) research and the remaining 50 percent in  
 (7) clinical.  
 (8) Q And this area of research is in  
 (9) hepatics or liver?  
 (10) A Predominantly liver diseases.  
 (11) Q Anything in the area of PEG tube  
 (12) insertion or parenteral nutrition in that  
 (13) manner?  
 (14) A Well, I -- I'm considered a nutrition  
 (15) expert, my grants are on nutrition and liver  
 (16) disease and I've done research on  
 (17) acid-related diseases, stomach things.  
 (18) Q But as it relates to a specific --  
 (19) A PEG?  
 (20) Q Yes.  
 (21) A No.  
 (22) Q As it relates to PEG tube insertions,  
 (23) do you have in your possession any  
 (24) teaching -- any materials that you give to  
 (25) your residents or med students or anybody

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(1) that would help them in learning the  
 (2) particular techniques that are used?  
 (3) A It's not an important thing for medical  
 (4) students to learn, the fellows need to learn  
 (5) it, and we have a director of endoscopy here  
 (6) and we have videos on most things that the  
 (7) trainees watch before they actually watch  
 (8) one being done.  
 (9) Q Who is the director of endoscopy?  
 (10) A His name is Khaled Issa, I-S-S-A.  
 (11) Q What's his first name?  
 (12) A K-H-A-L-E-D, Khaled.  
 (13) Q What does the director of -- how is  
 (14) your position as director of the division of  
 (15) gastroenterology different from the director  
 (16) of endoscopy?  
 (17) A Well, it's -- it's a lot to do. We  
 (18) have a director of research, a director of  
 (19) endoscopy, director of the outpatients, and  
 (20) I sort of try to make them fit together.  
 (21) Q So you oversee all the other particular  
 (22) specialty areas?  
 (23) A Correct.  
 (24) Q You mentioned that you have five  
 (25) full-time staff, two part-time, and possibly

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(1) , hiring two more part-time  
 (2) A Um-hum  
 (3) Q Who in your department does most of the  
 (4) PEG tube insertion?  
 (5) A I think it's pretty even  
 (6) Q And who is that?  
 (7) A I'm sorry?  
 (8) Q And who would that be? You say  
 (9) "even"  
 (10) A Who are the other people?  
 (11) Q I mean, you're including yourself, is  
 (12) that --  
 (13) A Myself, Issa, Cherryan,  
 (14) C-H-E-R-I-Y-A-N, Mullin, and Gadad,  
 (15) G-A-C-A-D. Actually, Mullin is not doing  
 (16) them anymore, so it's probably among the  
 (17) four of us  
 (18) Q And can you give me an approximation of  
 (19) how many PEG tube insertions that you at  
 (20) MetroHealth do over the course of a year?  
 (21) A Me personally?  
 (22) Q No, the whole department  
 (23) A It's a real guess. I'm going to say  
 (24) 75. I could be off significantly  
 (25) Q And are these done mostly in-house or

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(1) in the outpatient clinic?  
 (2) A They are mostly done in-house --well,  
 (3) all the -- whether a patient is an  
 (4) outpatient or an inpatient, they all come to  
 (5) the endoscopy unit.  
 (6) Q Okay.  
 (7) A But we just started doing same day PEG  
 (8) placements, for which I developed the  
 (9) guidelines, and so we've only done maybe two  
 (10) or three of those, but we just developed  
 (11) that, so a patient would come in and then go  
 (12) back out to their home or to a nursing home.  
 (13) Q Okay. Let me just talk about -- the  
 (14) endoscopy unit is located within the  
 (15) hospital itself?  
 (16) A It is located on the 11th floor of the  
 (17) twin towers.  
 (18) Q So in the hospital?  
 (19) A Correct.  
 (20) Q And so patients -- I got the impression  
 (21) when you said you're starting to do same  
 (22) day, patients are admitted or are here  
 (23) in-house --  
 (24) A No, they come directly to the endoscopy  
 (25) unit, we do the procedure, and then they go

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(1) back to wherever they were.  
 (2) Q That's what I meant. I meant they are  
 (3) either in -- in the hospital itself --  
 (4) A Endoscopy unit.  
 (5) Q -- and then they go to the endoscopy  
 (6) unit to get done and then they're returned  
 (7) back to the hospital room where they're at.  
 (8) Do you understand what -- I'm trying to make  
 (9) the distinction.  
 (10) A Correct. But they wouldn't come from  
 (11) another hospital, they would either come  
 (12) from the nursing home or their own home.  
 (13) Q But they're actually admitted into the  
 (14) hospital?  
 (15) A No, they come to the endoscopy unit.  
 (16) Q I'm not talking about now, the same  
 (17) day, I'm talking about --  
 (18) A Oh, the other ones?  
 (19) Q Yeah. So prior to the initiation of  
 (20) the same day PEG placement, the procedures  
 (21) that you and your other colleagues were  
 (22) doing were on patients who were either  
 (23) admitted into the hospital itself --  
 (24) A Correct.  
 (25) Q Correct?

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(1) A Yes.  
 (2) Q When did this same day PEG placement  
 (3) commence?  
 (4) A Three or four months ago. We were  
 (5) reluctant to start it, actually, because we  
 (6) didn't really think it was terribly safe.  
 (7) Q And now you believe that it is safe?  
 (8) A Well, on select patients. I think  
 (9) we've only done two or three.  
 (10) Q You indicated that you were in charge  
 (11) of starting that up and setting up the --  
 (12) A No.  
 (13) Q Okay.  
 (14) A The nutrition service started it up,  
 (15) but they came and helped me devise the  
 (16) guidelines from a physician's standpoint.  
 (17) Q Do you have any of these guidelines?  
 (18) A Um-hum.  
 (19) Q Can you get me a copy of those, please?  
 (20) A Sure.  
 (21) Q And as it relates to these guidelines,  
 (22) what do they talk about? The type of  
 (23) patients that are candidates?  
 (24) A The type of patients, the consults for  
 (25) nutrition, follow-up, outpatient, home care

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(1) nursing, notification of primary care  
 (2) physician, is the patient appropriate.  
 (3) Q Do you consider the nutritional -- or  
 (4) the nutritionist's input as it relates to  
 (5) the patient's nutritional status an  
 (6) important factor in your determination of  
 (7) whether a patient is a candidate for this  
 (8) type of a procedure?  
 (9) A It's a factor. It's more important in  
 (10) the post -- in my opinion, in the post  
 (11) management of the patients, because many  
 (12) patients who get fed by PEG tube get  
 (13) diarrhea and complications.  
 (14) Q But certainly somebody who is either  
 (15) not taking adequate amount of intake for  
 (16) whatever reason, whether it's swallowing or  
 (17) inability to or just refusal to eat, the  
 (18) insight from a nutritionist as to the status  
 (19) of a patient's nutritional level, albumin,  
 (20) protein levels, okay, that is something that  
 (21) you consider in your evaluation of whether a  
 (22) patient needs a PEG tube, fair enough?  
 (23) A Yes.  
 (24) Q These guidelines, do they specifically  
 (25) state a procedure that is followed as far as



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(1) the technique used?  
 (2) A No.  
 (3) Q Is that something that you had -- is it  
 (4) the same technique that you have used in the  
 (5) other in-house patients?  
 (6) A Yes.  
 (7) Q The same day procedure, do you have a  
 (8) pre-op area, the patient then goes to the  
 (9) actual procedure in a procedure room and  
 (10) then goes back to the area where they are  
 (11) recovered and then sent to their --  
 (12) A Yes, but it's all roughly in the same  
 (13) area.  
 (14) Q Okay. Do you have specific forms that  
 (15) you use for the purposes of that same day  
 (16) surgery?  
 (17) A Yes.  
 (18) Q Okay. Are they different than the ones  
 (19) that are used in-house?  
 (20) A Not for the procedure itself.  
 (21) Q Okay. And when you say "the procedure  
 (22) itself," you're talking about the  
 (23) physician's procedure?  
 (24) A Correct.  
 (25) Q Okay. I have been provided with a

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(1) A Yes.  
 (2) Q Now, as I reviewed those, it appears  
 (3) that they speak more toward pre-op  
 (4) anesthesia, anesthesia checking them, and  
 (5) post-anesthesia evaluation, fair enough?  
 (6) A Yes.  
 (7) Q Are those documentations that you as a  
 (8) physician use to document the actual  
 (9) procedure performed, et cetera?  
 (10) A No, those are computer derived, we type  
 (11) them up.  
 (12) Q And when you say "computer derived,"  
 (13) what does that mean?  
 (14) A Well, we type in every procedure that  
 (15) we do, we make a note of it, we type in the  
 (16) procedure, what we've done, and print it  
 (17) out.  
 (18) Q Just so we're talking about the same  
 (19) thing, same procedure that you do in-house  
 (20) versus now in the same day --  
 (21) A Um-hum.  
 (22) Q Okay. And when you type it up, is that  
 (23) something that you physically type up?  
 (24) A Usually the trainee types it up.  
 (25) Q And that being somebody -- a resident

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(1) number of forms that I believe came from  
 (2) you  
 (3) A These look like ours  
 (4) Q Okay Those are forms that have been  
 (5) used in the inpatient MetroHealth --  
 (6) A Yes  
 (7) Q -- endoscopy procedure? Okay  
 (8) A Um-hum  
 (9) Q The forms that you now utilize in the  
 (10) same day surgery, are those different or  
 (11) similar to that?  
 (12) A No, this -- these are forms that are  
 (13) done in the endoscopy unit around the  
 (14) procedure itself, the other ones are done to  
 (15) coordinate the different people managing the  
 (16) patient when they go home  
 (17) Q Okay. I guess I'm not following I'm  
 (18) not understanding  
 (19) A You're asking me about -- I'm sorry  
 (20) Q That's okay I'm just not  
 (21) understanding, if you can help me with  
 (22) that Are those forms that are used for  
 (23) patients who undergo PEG tube insertion?  
 (24) A Yes  
 (25) Q And those are in-house forms, correct?

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(1) or somebody that's assisting in the  
 (2) procedure?  
 (3) A Right.  
 (4) Q This is not something that you would  
 (5) actually dictate an operative note?  
 (6) A No.  
 (7) Q Okay. And the operative or the  
 (8) procedure note that you would utilize is  
 (9) something that maybe has a heading and then  
 (10) you put in the procedure, then you type it  
 (11) in; is that correct?  
 (12) A Correct. But there's a large -- there  
 (13) is a large open space that the specifics of  
 (14) each procedure are typed in.  
 (15) Q Okay. And when you put in there -- do  
 (16) you put in exactly what you did -- you know  
 (17) how -- strike that.  
 (18) This large open space, do you  
 (19) actually type in specifically each step that  
 (20) you have undergone in that procedure?  
 (21) A We try to.  
 (22) Q You try to?  
 (23) A (Nodding head.)  
 (24) Q Is that a requirement?  
 (25) A Yes.

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(1) Q And who makes that requirement?  
 (2) A We have -- each person would have  
 (3) specifics written up with -- every attending  
 (4) tries to make the fellow describe it as  
 (5) detailed as possible.  
 (6) Q Is that something that's pre -- I mean,  
 (7) I would assume that you do the procedure  
 (8) pretty much the same way every time, fair  
 (9) enough?  
 (10) A Urn-hum.  
 (11) Q And is that something that is  
 (12) preprinted for you underneath "specifics"  
 (13) and then you may alter if there are any  
 (14) differences?  
 (15) A Just the top, and then the procedure  
 (16) itself actually each one is typed in  
 (17) specifically, we don't have a pro forma.  
 (18) Q Could you also do me a favor and  
 (19) provide me with a copy of the documentation  
 (20) that you use with an example -- and you can  
 (21) take the patient's name off, I'm certainly  
 (22) not interested in that, but show me what you  
 (23) actually type in for the purposes of that  
 (24) procedure? Fair enough?  
 (25) A All right. So you need two things now,

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(1) go in and type these?  
 (2) A Some attendings type. I'm not a great  
 (3) typist.  
 (4) Q I'm just impressed that you do that,  
 (5) so -- okay.  
 (6) In your practice, are there any  
 (7) texts or publications or journals that in  
 (8) your mind set forth the particular technique  
 (9) for the PEG tube insertion?  
 (10) A Could you repeat the question again?  
 (11) Q Sure. Is there any textbook,  
 (12) publication, journals, or any type of  
 (13) guidelines from anywhere that you believe  
 (14) sets forth the technique that should be used  
 (15) for PEG tube insertion?  
 (16) A There are articles that describe the  
 (17) technique. I can't remember which journals  
 (18) they're from.  
 (19) Q Is there anything that you rely on or  
 (20) have relied on in forming the same day  
 (21) surgery procedure that you developed about  
 (22) three or four months ago?  
 (23) A No, it's probably been a compendium of  
 (24) resources. I can't quote a specific --  
 (25) Q You can't quote a specific journal --

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(1) right? What's the --  
 (2) MR. HAWAL: And that you do  
 (3) with me, Doctor, on those things.  
 (4) Q Yeah. I'm sorry. If you'll give it to  
 (5) him and then he'll provide it to me.  
 (6) The forms that I had shown you  
 (7) earlier that you've identified as inpatient  
 (8) forms, the ones that you used at the  
 (9) hospital, you use different forms for the  
 (10) same day surgery as it relates to the  
 (11) nurse's evaluation post-op?  
 (12) A Urn-hum.  
 (13) Q Can you provide me with those, a copy  
 (14) of those as well?  
 (15) A Yeah.  
 (16) Q And I think you said it's the  
 (17) responsibility of the resident or the person  
 (18) that you're teaching --  
 (19) A It's always the attending's  
 (20) responsibility.  
 (21) Q Okay. But he has the resident -- in  
 (22) reality the resident will do it, you then  
 (23) sign the form after he has completed it?  
 (24) A Yes.  
 (25) Q So you as the attending don't actually

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(1) A -- paper or article that led us to --  
 (2) Q -- or textbook?  
 (3) A Correct.  
 (4) Q So this is something that the technique  
 (5) has evolved over time; is that a fair  
 (6) statement?  
 (7) A Yes.  
 (8) Q And the technique has evolved based  
 (9) upon complications or maybe experienced  
 (10) individuals performing it may have found  
 (11) that this way is a little bit better?  
 (12) A I can't say -- I don't think it's  
 (13) because of complications. It's probably  
 (14) just people get more comfortable with doing  
 (15) the procedure.  
 (16) Q So you don't think techniques have been  
 (17) added to counter any complications that have  
 (18) been experienced?  
 (19) A I don't know the answer to that.  
 (20) Q In your practice, have you made any  
 (21) alterations to your technique based upon  
 (22) complications you've experienced?  
 (23) A The only thing I can remember is we no  
 (24) longer put a button in. A button is  
 (25) something that when you replace a PEG,

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(1) someone's had a PEG in, you remove it,  
 (2) usually when it's been in there longer than  
 (3) six or 12 months, something came out called  
 (4) a button where you didn't have to perform  
 (5) endoscopy, and we were never comfortable  
 (6) with that so we now make it mandatory that  
 (7) we do a repeat endoscopy when we reinsert  
 (8) this.  
 (9) Q Mr. Hawal has indicated to me this is  
 (10) your first deposition that you have given.  
 (11) A Yes.  
 (12) Q Have you ever served as an expert in  
 (13) any other cases before?  
 (14) A Yes.  
 (15) Q Tell me what those cases involved, or  
 (16) let me -- let's start with this. How many  
 (17) times have you served as an expert?  
 (18) A Probably three.  
 (19) Q Three or--  
 (20) A Less than five for sure.  
 (21) Q Over the course of how long?  
 (22) A Since 1980. 19 years.  
 (23) Q Any of those times when you served as  
 (24) an expert, either three or less than five,  
 (25) did you address the issue of PEG tube

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(1) insertion?  
 (2) A No.  
 (3) Q So this is the first time in your  
 (4) experience as an expert this issue has come  
 (5) up where you've been asked to --  
 (6) A Yes.  
 (7) Q -- render an opinion?  
 (8) I take it with those three or less  
 (9) than five times you have not -- it's not  
 (10) gone beyond writing a report?  
 (11) A Correct.  
 (12) Q Have you ever done any work for  
 (13) Mr. John Martin before?  
 (14) A On this case.  
 (15) Q Excuse me. Other than this case.  
 (16) A No.  
 (17) Q How about Mr. Hawal?  
 (18) A No.  
 (19) Q I know he kind of came in afterwards,  
 (20) The cases that you reviewed, were  
 (21) those in Ohio?  
 (22) A Yes.  
 (23) Q And do you know the lawyers that asked  
 (24) you to review stuff for them?  
 (25) A I could probably -- I keep files.

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(1) There was one in Akron, Roetzel maybe.  
 (2) Q Roetzel & Andress?  
 (3) A There was someone named Crist who was  
 (4) the lawyer, but -- I can't remember.  
 (5) Q When you've reviewed those cases, how  
 (6) many times did you do it for plaintiffs?  
 (7) A None.  
 (8) Q The three reviews or less than five  
 (9) have been for defendants?  
 (10) A Um-hum.  
 (11) Q Local defendants?  
 (12) A Ohio. I mean, in Akron.  
 (13) Q Okay. Northeast Ohio?  
 (14) A Um-hum.  
 (15) Q Do you have any idea what you're going  
 (16) to charge for this deposition?  
 (17) A No. I charge 250 an hour. I don't  
 (18) know if depositions get more or less.  
 (19) Q Okay. You charge 250 an hour to review  
 (20) medical records?  
 (21) A Um-hum.  
 (22) Q How long did it take you to review the  
 (23) medical records before you rendered your  
 (24) opinion in your report -- opinions, excuse  
 (25) me, in the report dated July 19th, 1998?

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(1) A Probably two or three hours with Martin  
 (2) and another four or five hours subsequent to  
 (3) Martin.  
 (4) Q How is it that Mr. Martin called you or  
 (5) you were initially contacted?  
 (6) A I have no idea.  
 (7) Q Did he give you any type of summary or  
 (8) tell you what the case was about or what  
 (9) happened, or --  
 (10) A I think -- all I have in my file is  
 (11) what I gave you.  
 (12) Q Okay. Right there?  
 (13) A So I suspect he must have given me some  
 (14) of that I don't remember the specifics of  
 (15) our phone conversation.  
 (16) Q Was there ever any letters that  
 (17) accompanied any of the materials that you  
 (18) have in your file?  
 (19) A Not that I remember.  
 (20) Q So you would just get an envelope with  
 (21) materials in it and there would be nothing  
 (22) else?  
 (23) A I got a letter from Bill about this  
 (24) meeting and did I want to get involved. I  
 (25) can't remember any -- I don't have any

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(1) letter from Martin that I -- no, that's not  
 (2) true I may have some letters I do have  
 (3) letters  
 (4) Q If you can just give me some idea of  
 (5) what those letters say Do they say  
 (6) enclosures, please find, or --  
 (7) A I don't remember I can get them for  
 (8) you  
 (9) Q Okay  
 (10) A This was a while ago  
 (11) Q I understand Why don't you -- can you  
 (12) get them for me?  
 (13) MR HAWAL Also, just make  
 (14) sure that you are aware, the doctor has to  
 (15) be at ten o'clock with patients, so --  
 (16) A I can get the letters though if you  
 (17) want  
 (18) Q Yeah, if you could  
 (19) MR HAWAL And I'll see  
 (20) them first Doctor  
 (21) -----  
 (22) (Recess had)  
 (23) -----  
 (24) BY MS SANDACZ  
 (25) Q While Mr Hawal is looking at those

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(1) letters, I want to go through -- this is  
 (2) your entire file that is before you here  
 (3) that you have received and reviewed?  
 (4) A Um-hum.  
 (5) Q First of all, you have the deposition  
 (6) of James Brown, Dr. James Brown, correct?  
 (7) A Um-hum.  
 (8) Q Deposition of Arnold Vogten?  
 (9) A (Nodding head.)  
 (10) Q You have what appears to be progress  
 (11) sheets dated March 27th, 1997 and enclosures  
 (12) of the endoscopy procedure and the nurse's  
 (13) notes, et cetera, correct?  
 (14) A Um-hum.  
 (15) Q You also have what appears to be a  
 (16) front page of the Cleveland Clinic  
 (17) Foundation patient data sheet with maybe  
 (18) some more demographic information regarding  
 (19) the admission of Mr. Darrell up until the  
 (20) point of discharge on 4-21-97, correct?  
 (21) A Um-hum. Yes. I'm sorry. Yes.  
 (22) Q That's okay. Discharge summary, dining  
 (23) services form, Cleveland Clinic Hospital,  
 (24) dated March 28th, 1997, operative note of  
 (25) Dr. Harry Reynolds for Mr. Delmar Darrell.

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(1) We have the Cleveland Clinic  
 (2) Foundation Department of General Internal  
 (3) Medicine hospital exploration summary dated  
 (4) 4-21-97. Chart and physician record of  
 (5) Kaiser Permanente, looks like an emergency  
 (6) room presentation dated 3-28-97. Admission  
 (7) assessment, I guess it's nursing admission  
 (8) assessment for Cleveland Clinic Foundation.  
 (9) Preoperative assessment inclusive of general  
 (10) anesthesia, anesthesia record. Post  
 (11) anesthesia care record of Cleveland Clinic  
 (12) dated 3-28-97. Cleveland Clinic Hospital  
 (13) exploratory laparotomy operative report of  
 (14) Harry Reynolds and Roland Phipps, 4-20-97.  
 (15) Cleveland Clinic Hospital, Harry Reynolds,  
 (16) tracheostomy and preoperative assessment.  
 (17) Cleveland Clinic general anesthesia sheet  
 (18) and anesthesia record, 4-18-97. Is that  
 (19) the -- is that all-inclusive of the file  
 (20) that you have reviewed in this matter?  
 (21) A To the best of my knowledge.  
 (22) Q Okay. Obviously your report was  
 (23) generated prior to the depositions of both  
 (24) Dr. Brown and Dr. Vogten, correct?  
 (25) A I believe everything I got except the

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(1) two depositions I received from Martin.  
 (2) Q Okay. Did you ever receive any of the  
 (3) Judson Park records that -- and I don't know  
 (4) if you're familiar with -- Judson Park is  
 (5) the nursing home where Mr. --  
 (6) A Yeah, I must have, because I -- there  
 (7) was that weight loss, because he lost a lot  
 (8) of weight before this procedure.  
 (9) Q Okay. What is your recollection of how  
 (10) much weight he lost?  
 (11) A A lot. Over 30 percent of his body  
 (12) weight, I remember that, which is where the  
 (13) rate of death increases.  
 (14) Q Okay. And when you say "before this  
 (15) procedure," at what point in time? From  
 (16) what point in time did he lose that weight?  
 (17) A I don't remember.  
 (18) Q Okay. Was it at the point in time  
 (19) after his obvious intracranial bleed and  
 (20) then he was discharged to the nursing home,  
 (21) from that point until his -- to the  
 (22) procedure that you believe he suffered that  
 (23) 30 percent drop in body weight --  
 (24) A It was while he was in the nursing  
 (25) home, but then I believe there was an

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(1) inaccurate weight in the nursing home, so he  
(2) really hadn't lost all that much weight, as  
(3) I remember.

(4) Q So when you say he lost 30 percent of  
(5) his body weight, that in fact did not  
(6) happen?

(7) A Right.

(8) Q So when you say that increases his risk  
(9) of mortality or morbidity, that is not in  
(10) fact a fact; is that correct?

(11) A Weight loss?

(12) Q No, I'm talking about the 30 percent  
(13) loss of body weight that you described.

(14) A I don't want to comment too  
(15) specifically because I don't remember -- I  
(16) don't remember actually what that is. I do  
(17) remember looking at the nursing home  
(18) reports, and I do remember the weights that  
(19) I saw was a 30 percent weight loss, and then  
(20) I was told that one of the weights was  
(21) incorrect and that he had actually not lost  
(22) 30 percent. I don't remember how much  
(23) weight he lost, so I'm uncomfortable saying  
(24) whether that was a risk factor or not.

(25) Q Okay. So for the basis of your

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(1) opinions that you're going to tell me today,  
(2) you just don't know what the amount of  
(3) weight loss was that Mr. Darrell suffered at  
(4) the nursing home?

(5) A Correct. But I do know that the state  
(6) of malnutrition influences the outcome of  
(7) the procedure.

(8) Q Sure, and a lot of times patients who  
(9) need PEG tube insertions, it's because of a  
(10) nutritional state?

(11) A Absolutely.

(12) Q Before we get too far as to the  
(13) letters, there are several notations on the  
(14) deposition of Dr. Brown, specific page  
(15) numbers. Did you make those?

(16) A Yeah. Yes.

(17) Q And what reason did you make those  
(18) notations?

(19) A I usually make those things when I --  
(20) when I'm reading through something and it  
(21) doesn't make sense and I want to read back  
(22) over it or something didn't gel or I thought  
(23) something was not right.

(24) Q I see several notations or at least  
(25) brackets around testimony. There is one

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(1) section, and I'll show it to you, it's got a  
(2) little bracket and it says "No" next to it,  
(3) and it says -- it's right around the area,  
(4) it says, "He would then start pressing  
(5) against the anterior abdominal wall while  
(6) we're both watching the monitor to see if he  
(7) can indent the stomach with his finger.  
(8) That tells us whether or not there's  
(9) something intervening between the wall of  
(10) the stomach and the abdominal wall." Can  
(11) you tell me why you put a bracket around  
(12) there and it says "No"?

(13) A Because it doesn't tell you if there's  
(14) something between the stomach or not, it  
(15) just tells you you can see light -- I mean,  
(16) you can see the finger.

(17) Q Okay. So you were objecting to what he  
(18) was concluding based upon the indentation  
(19) or --

(20) A I think it's an incomplete statement.

(21) Q Okay. And what would be needed to  
(22) complete that statement?

(23) A What would be needed would be to -- and  
(24) Dr. Vogten mentioned this,  
(25) transillumination, indentation and

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(1) aspiration.

(2) Q Those are three things that Dr. Vogten  
(3) used or described --

(4) A In his deposition, I noticed.

(5) Q Okay. He described that they use those  
(6) particular things?

(7) A Correct. Which was not done here,  
(8) stated here.

(9) Q Okay. Was there anywhere in that  
(10) deposition of Dr. Brown that you saw him  
(11) indicate that transillumination was in fact  
(12) utilized in his --

(13) A I would have to -- transillumination --  
(14) I don't remember. I'd have to look through  
(15) this.

(16) Q Okay. So you don't remember whether or  
(17) not Dr. Brown indicated in his deposition  
(18) that transillumination was used?

(19) A Correct. But I did not reread this  
(20) prior to today.

(21) Q If in fact he did use  
(22) transillumination, that is one of the  
(23) techniques used to identify the location for  
(24) the PEG tube placement?

(25) A Correct,

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(1) Q When you put the endoscopy scope down,  
 (2) does that necessarily have a light on it?  
 (3) A It better have, yes.  
 (4) Q So you use this light that's on the  
 (5) endoscope to, number one, get your way down  
 (6) to the area that you're looking in, and then  
 (7) also it can be utilized to shine against the  
 (8) wall of the stomach and transilluminate the  
 (9) light out to the skin area?  
 (10) A Yes.  
 (11) Q Okay. Just let me look at these  
 (12) letters real quick.  
 (13) Any other letters than these ones  
 (14) that appear to be written to and from  
 (15) yourself regarding the payment or fee  
 (16) structure for your review?  
 (17) A No, I don't think so.  
 (18) Q Has anything been removed out of your  
 (19) file?  
 (20) A Not that I know of.  
 (21) Q Okay.  
 (22) A And I do notice here that right under  
 (23) here transillumination is stated.  
 (24) Q So your notation about "No" was for the  
 (25) purpose of --

(1) expectancy had he survived this procedure?  
 (2) A I've not been asked that.  
 (3) Q And you indicated to me you have not  
 (4) seen the report of Dr. Ponsky; is that  
 (5) right?  
 (6) A Correct.  
 (7) Q Do you know any of the physicians in  
 (8) this case, either Dr. Brown or Dr. Vogten?  
 (9) A No, I don't know Dr. Brown. That was  
 (10) the first time I had ever seen the name,  
 (11) which surprised me, because he's a  
 (12) gastroenterologist and Cleveland is not that  
 (13) big. Dr. Vogten I know peripherally.  
 (14) Q And how do you know him peripherally?  
 (15) A I know him from when he came to  
 (16) Cleveland, he would come to some of the  
 (17) city-wide conferences, and I had heard his  
 (18) name as a former trainee up at the Mayo  
 (19) Clinic.  
 (20) Q Do you have any understanding as to his  
 (21) reputation here in the community?  
 (22) A No.  
 (23) Q Do you know anything about his  
 (24) background as it relates to internal  
 (25) medicine or endoscopy issues?

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(1) A The top portion  
 (2) Q Okay As it relates to the remainder  
 (3) of your notations I see some similar kinds  
 (4) of brackets Is that just to -- tell me  
 (5) what those are made for  
 (6) A As I mentioned, they're things that  
 (7) either don't make sense to me or I need more  
 (8) information on  
 (9) Q Okay Do you know Jack Conomy?  
 (10) A Yes  
 (11) Q Did you --  
 (12) A I know Jack Conomy very peripherally  
 (13) Q Okay  
 (14) A I was an intern at the Cleveland Clinic  
 (15) and he was I believe, the chairman of  
 (16) neurology at the time  
 (17) Q Have you seen any type of report from  
 (18) Dr. Conomy?  
 (19) A No  
 (20) Q Are you going to be rendering any  
 (21) opinions as it relates to Mr. Darrell's  
 (22) potential recovery from his CVA?  
 (23) A I've not been asked to do that  
 (24) Q Okay Are you going to render any  
 (25) opinions as it relates to his life

(1) A No I mean, just that he came from the  
 (2) Netherlands and he did some training at the  
 (3) Mayo Clinic, and I was surprised when he --  
 (4) I saw him in Cleveland I had not seen him  
 (5) or heard anything from him in many years  
 (6) Q I asked you earlier about the number of  
 (7) PEG tubes that are done in a year by your  
 (8) group and you indicated about 75 or gave me  
 (9) an estimate  
 (10) A That's a -- that's a guess  
 (11) Q And I'm not asking -- I just want to  
 (12) get an understanding  
 (13) Of those 75, how many do you do  
 (14) per year?  
 (15) A Probably 15 to 20  
 (16) Q Are you involved at all in the decision  
 (17) as it relates to allowing -- or decision as  
 (18) it relates to the need for the PEG tube?  
 (19) A Yes  
 (20) Q Okay And is that something that's  
 (21) shared with the patient's attending  
 (22) physician?  
 (23) A His primary care physician?  
 (24) Q Thank you That's what I mean  
 (25) A There's two layers that happen The

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(1) in-house patients, which until just the last  
 (2) few months would be all the patients, would  
 (3) be seen by the consulting gastroenterologist  
 (4) on the team and a decision regarding the  
 (5) appropriateness of it, the anatomy of --  
 (6) there are certain questions you need to  
 (7) know, is there reflux, are there scars, is  
 (8) there gastromotility problems, certain  
 (9) decisions that go into that, how recent,  
 (10) what's the cause, is there weight loss, is  
 (11) he expected to recover from his stroke  
 (12) within a reasonable amount of time so we  
 (13) could feed him with, you know, nasogastric  
 (14) tubes and things, that decision is made  
 (15) independent of the endoscopist, okay? That  
 (16) patient then would be referred to the  
 (17) endoscopy center, at which time a second  
 (18) evaluation is performed, albeit more briefly  
 (19) at that time by the attending physician.

(20) Q And the same day surgery that you now  
 (21) utilize, tell me how that procedure is done.

(22) A That is done in an ideal situation as a  
 (23) primary care physician identifies the  
 (24) problem, the patient's problem, they contact  
 (25) one of the gastroenterology attendings,

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(1) discussions are had with the nutrition  
 (2) department that handles almost all of the  
 (3) logistics of post-procedure, and then the  
 (4) patient is brought to the endoscopy unit

(5) Q You talked a little bit about  
 (6) indications. You mentioned whether or not  
 (7) the patient has had weight loss, that is  
 (8) obviously an indication for consideration  
 (9) for a PEG tube insertion?

(10) A It's one factor, yes

(11) Q Okay. And inability to eat or maintain  
 (12) nutritional status, correct?

(13) A Yes

(14) Q Difficulty swallowing?

(15) A Yes

(16) Q Stroke type event that interferes with  
 (17) the ability of a patient to swallow --

(18) A Yes

(19) Q -- or to take in adequate nutrition?

(20) A Yes

(21) Q Dehydration may be one? Not in and of  
 (22) itself, but along --

(23) A Not in and of itself, yes

(24) Q Do you have any reason to believe that  
 (25) Mr. Darrell was not a candidate or did not

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(1) have indications for PEG tube insertion?

(2) not a candidate. Have no reason to believe that he was

(4) Q So in fact in this type -- this would  
 (5) be the type of patient that you would follow  
 (6) through with a primary care's request to  
 (7) have a PEG tube inserted: is that fair?

(8) A From the information I have, yes.

(9) Q Okay. So you're not critical of any  
 (10) decision for the PEG tube insertion?

(11) A No, other than it may have been delayed  
 (12) too long.

(13) Q Okay. We'll talk about that.

(14) You would agree that a PEG tube is  
 (15) generally accepted as a safe procedure?

(16) A Yes.

(17) Q Okay. And I think you even now use the  
 (18) same day surgery, you believe that route or  
 (19) method of procedure is also an effective and  
 (20) safe --

(21) A For a very specific type patient..

(22) Q What specific type patient?

(23) A Basically someone who has no other  
 (24) medical conditions other than perhaps  
 (25) inability to swallow, for example, someone

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(1) with Lou Gehrig's disease who is functioning

(2) at home and just can't swallow.

(3) that same day surgery setting? nursing home patients in

(5) A I think we've only done two or three.

(6) Q So you haven't made any conclusions --

(7) A No.

(8) Q -- as it relates to whether a nursing  
 (9) home patient may be a candidate for your  
 (10) same day surgery?

(11) A No, I don't think that number of  
 (12) patients is enough to make any conclusions.

(13) Q You would agree with me that the --

(15) Contraindications for the

(16) procedure, any, just on a general basis?

(17) A Anatomy, gastroesophageal reflux  
 (18) disease, poor life expectancy, ascites,  
 (19) morbid obesity.

(20) Q Any reason to believe that Mr. Darrell  
 (21) suffered from any of those  
 (22) contraindications?

(23) A No.

(24) Q What is a pull-through technique?

(25) A A pull-through technique is the one

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(1) that was developed by Gauderer and Ponsky  
 (2) where -- do you want me to describe it in  
 (3) detail?  
 (4) Q Absolutely.  
 (5) A Okay. The patient -- once the decision  
 (6) to do the procedure is made, the patient is  
 (7) brought to the endoscopy unit, the abdominal  
 (8) wall is sterilized, the patient is given  
 (9) sedation. The back of the mouth is sprayed  
 (10) with topical Novocaine. An endoscope is  
 (11) then advanced under direct vision into the  
 (12) stomach. The standard endoscopic procedure  
 (13) is performed, that is, to evaluate all the  
 (14) areas, the postbulbar and bulbar duodenum,  
 (15) the anterior, the proximal and distal  
 (16) stomach with retrograde views and the  
 (17) esophagus.  
 (18) After that is performed and there  
 (19) is no reason not to perform the PEG, such as  
 (20) an ulcer or a pyloric narrowing or free  
 (21) reflux of material in which a PEJ would be  
 (22) performed instead of a PEG, the stomach is  
 (23) blown up, insufflated, and the endoscopy  
 (24) operator then starts to move the tip towards  
 (25) the anterior abdominal wall.

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(1) At that time the other person --  
 (2) it's a two person procedure. After he has  
 (3) anest -- cleaned the area, he puts a drape  
 (4) on and you look for a light, and once you  
 (5) see the light -- and it's very important,  
 (6) you have to make sure there's no scar area  
 (7) around it, you palpate with the finger  
 (8) against the abdominal wall. The  
 (9) endoscopist -- and now with the video  
 (10) cameras both the endoscopist and the other  
 (11) operator look for where you have an optimal  
 (12) point of indentation. Once that is obtained  
 (13) you then start to anesthetize with Xylocaine  
 (14) and you do -- you start to inject and you  
 (15) inject and aspirate all the time.  
 (16) Q Injecting what?  
 (17) A Initially Xylocaine.  
 (18) Q Okay.  
 (19) A And then once you're comfortable, the  
 (20) idea with the aspiration is to make sure  
 (21) that you don't get anything back, air, you  
 (22) know, black material, intestinal material,  
 (23) discolored material before -- or air before  
 (24) the needle is into the -- in the stomach.  
 (25) Once that's done a small three or

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(1) five millimeter nick is made in the skin  
 (2) where you want to go. You then introduce  
 (3) the trocar with the intracath over it, and  
 (4) once again, usually with a little saline,  
 (5) you advance and aspirate, advance and  
 (6) aspirate, once again to make sure that the  
 (7) only time you get air is when the needle is  
 (8) in the stomach.  
 (9) Once you're comfortable with that  
 (10) you then advance a thread.  
 (11) Q Guide wire?  
 (12) A Guide wire.  
 (13) Q What do you guys use? I'm sorry.  
 (14) A Athread.  
 (15) Q An actual piece of --  
 (16) A Yeah, it's surgical suture.  
 (17) Q Okay.  
 (18) A Through the trocar. The endoscopist  
 (19) grabs it with a biopsy forceps through it,  
 (20) takes it out. Then the PEG tube is tied to  
 (21) this and then the person on the outside  
 (22) pulls it back through the abdominal wall so  
 (23) that the bumper is inside the stomach. Then  
 (24) we put an outer sheath to maintain it in  
 (25) place. The endoscopist then goes back in to

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(1) make sure that it's in place, that it's not  
 (2) too tight, we inject some fluid to make sure  
 (3) there's free flow and no resistance, and if  
 (4) all those things happen we put, you know,  
 (5) Betadine and things locally, we tie it up,  
 (6) we give the patient antibiotics, and we make  
 (7) them NPO for 24 hours, and that's the  
 (8) procedure.  
 (9) Q So when I said to you a pull-through,  
 (10) you were able to give me all of those  
 (11) techniques?  
 (12) A Um-hum.  
 (13) Q So you knew what I was talking about  
 (14) when I said a pull-through?  
 (15) A Yes.  
 (16) Q Okay. In your review of both  
 (17) Dr. Vogten and Dr. Brown's deposition  
 (18) testimony, did they describe the procedure  
 (19) in a manner in which you did right there?  
 (20) A Brown did not.  
 (21) Q Okay.  
 (22) A Brown did not discuss aspiration,  
 (23) Vogten did.  
 (24) Q Who was in charge of doing the  
 (25) aspiration?



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(1) A The non-endoscopist.  
 (2) Q So if Dr. Brown is up at the head of  
 (3) the bed, that's not his role --  
 (4) A Correct.  
 (5) Q --to do the aspiration?  
 (6) So when Dr. Vogten says, I was  
 (7) aspirating, that would be his role?  
 (8) A Yes.  
 (9) Q So your review of Dr. Vogten's  
 (10) testimony is that he followed the technique  
 (11) that you've just described?  
 (12) A Regarding those three things about the  
 (13) transillumination thing and --  
 (14) Q Aspiration?  
 (15) A And then palpation.  
 (16) Q How about insufflation?  
 (17) A Insufflation, yes.  
 (18) Q Do you elevate the head to displace the  
 (19) colon?  
 (20) A We elevate the head of the bed for two  
 (21) reasons, to displace the colon and to  
 (22) minimize aspiration.  
 (23) Q So if Dr. Brown and Dr. Vogten used  
 (24) those five things that we've just talked  
 (25) about, elevate the head of the bed,

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(1) insufflation, transillumination, palpation  
 (2) and aspiration, you would agree with me that  
 (3) they met the standard of care in performing  
 (4) this procedure?  
 (5) A Probably  
 (6) Q As the endoscopist doing the procedure,  
 (7) do you have any contact with the family  
 (8) about obtaining consent?  
 (9) A Yes  
 (10) Q And tell me how that comes about  
 (11) A If the patient can't give consent,  
 (12) which is often the case, you get the nearest  
 (13) relative or someone who has power and you go  
 (14) over the necessity for the procedure, you go  
 (15) over the stated risks and hopefully the  
 (16) expected outcomes  
 (17) Q Necessity of procedure we've talked  
 (18) about, the indications, is that fair?  
 (19) A Um-hum  
 (20) Q Okay As it relates to risks, what do  
 (21) you tell them?  
 (22) A We tell them that people can  
 (23) hemorrhage, you can have leaks, you can have  
 (24) perforation, and you can have infection  
 (25) Q When you have given that discussion or

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(1) had that discussion with the family where  
 (2) you have said hemorrhage, leaks,  
 (3) perforation, infection, have you ever had  
 (4) anyone say, I don't want the procedure?  
 (5) A Yes, probably.  
 (6) Q You have? On how many occasions?  
 (7) A Not many.  
 (8) Q Okay. And did they give you a reason  
 (9) why they didn't want the procedure?  
 (10) A Usually it's because they think the  
 (11) quality of life is so bad that they don't  
 (12) want to prolong life.  
 (13) Q So this is a patient who obviously has  
 (14) multiple other medical problems that this is  
 (15) just not going to correct those problems?  
 (16) A Um-hum.  
 (17) Q Yes?  
 (18) A Yes.  
 (19) Q Okay. So the majority of your contact  
 (20) with and discussions with families, other  
 (21) than the times when the patient has very  
 (22) poor quality of life, you have never had  
 (23) anyone refuse the procedure?  
 (24) A Not to my --the best of my knowledge.  
 (25) Q Do you ever tell them that death could

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(1) be a complication as well?  
 (2) A Yes.  
 (3) Q And even with that, they still agree to  
 (4) the procedure?  
 (5) A Yes.  
 (6) Q Would you agree with me -- strike that.  
 (7) I'm getting ahead of myself.  
 (8) Sorry.  
 (9) What is the percentage of  
 (10) complications for perforation, do you know?  
 (11) A When I reviewed it, it's estimated  
 (12) somewhere around one percent.  
 (13) Q And I didn't ask you this, and I  
 (14) apologize: What did you do in preparation  
 (15) for your depo today other than talk to  
 (16) Mr. Hawal?  
 (17) A Well, actually, I didn't talk to  
 (18) Mr. Hawal very much about this deposition.  
 (19) Q I apologize. I just assumed.  
 (20) A I did not review Brown's. I reviewed  
 (21) Vogten's because I just received that not  
 (22) that long ago.  
 (23) Q Okay.  
 (24) A I re-reviewed my articles.  
 (25) Q What articles?

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(1) A I-- I have a file of articles on PEG.  
 (2) Q Are any of those articles written by  
 (3) Dr. Ponsky?  
 (4) A The original one.  
 (5) Q That's the one in 1980 or 19 --  
 (6) A '80, '81. The first author was  
 (7) Gauderer.  
 (8) Q Right. What else did you do?  
 (9) A That was pretty much it.  
 (10) Q Did you do any MEDLINE search or look  
 (11) in any textbooks?  
 (12) A Yeah, I looked in some textbooks. I  
 (13) have a pretty big file though on PEGs.  
 (14) Q Did you rely on anything to render your  
 (15) opinions that you have articulated in your  
 (16) July, 1998 report?  
 (17) A I probably talked to some  
 (18) gastroenterologists for their opinion, if  
 (19) they had ever seen this particular  
 (20) complication.  
 (21) Q And those are gastroenterologists that  
 (22) you deal with here at Metro?  
 (23) A Yeah.  
 (24) Q Have you ever in your practice had a  
 (25) complication of a perforation?

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(1) A No.  
 (2) Q Have any of your colleagues had one?  
 (3) A Yes.  
 (4) Q Have you ever heard of it happening?  
 (5) A Yes.  
 (6) Q Would you agree with me that that  
 (7) complication can occur even with the best  
 (8) technique?  
 (9) A What complication?  
 (10) Q Perforation.  
 (11) A Of what?  
 (12) Q Perforation of the colon.  
 (13) A No.  
 (14) Q Why not?  
 (15) A When people talk about perforations,  
 (16) the one percent is talking -- they're almost  
 (17) always from the stomach, they're gastric  
 (18) perforations almost always, and then when I  
 (19) reviewed the literature about gastrocolic  
 (20) fistulas, that happens rarely, two or three  
 (21) per thousand, but gastrocolic fistula is not  
 (22) what this gentleman had.  
 (23) Q What did he have?  
 (24) A This person had a transection of the  
 (25) colon with peritonitis from that.

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(1) Q Transection of the colon --  
 (2) A Transverse colon.  
 (3) Q Transverse colon.  
 (4) A According to the Cleveland Clinic's  
 (5) note.  
 (6) Q And you are of the opinion that that  
 (7) could not occur even with the best  
 (8) technique?  
 (9) A It's probable that it would not occur.  
 (10) Q And that's based upon the percentage  
 (11) of --  
 (12) A The literature.  
 (13) Q Okay. And why is it that that  
 (14) transverse colon is not in a position to  
 (15) cause -- to be perforated with this type of  
 (16) procedure?  
 (17) A Because with the techniques -- if you  
 (18) avoid scars -- and I don't know if this  
 (19) gentleman had an abdominal scar, from review  
 (20) of the records I was not able to ascertain  
 (21) that.  
 (22) Q Would that be something that would be  
 (23) important for you to know?  
 (24) A It would be something important for the  
 (25) endoscopist to know.

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(1) Q Well, if you're rendering opinions --  
 (2) A Yes, it would be  
 (3) Q Okay.  
 (4) A But then it's not stated in the  
 (5) endoscopy report about a scar, and I don't  
 (6) know -- there's no report that they avoided  
 (7) a scar or didn't avoid a scar I don't  
 (8) know  
 (9) Q Let me ask you this You're talking  
 (10) about an actual surgical scar?  
 (11) A Previous surgical scar  
 (12) Q Can a patient have scar tissue or  
 (13) adhesions for whatever reason either from  
 (14) alcohol abuse --  
 (15) A Rarely.  
 (16) Q Okay Any other -- pancreatitis,  
 (17) anything that they can develop --  
 (18) A Endometriosis, and very rare, very rare  
 (19) diseases of fibrosis  
 (20) Q If the transverse colon is transected,  
 (21) as in this case, how does that occur?  
 (22) A The transverse colon was between the  
 (23) abdominal wall and the stomach where the  
 (24) tube was placed  
 (25) Q Is there any explanation of why if

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(1) you've done the insufflation,  
 (2) transillumination, palpation and the  
 (3) aspiration, that this can still occur?

(4) A Not that I know of.

(5) Q What about the colon being so empty  
 (6) that it collapses on itself and gives you  
 (7) the impression that it is -- there is  
 (8) nothing in between the stomach and the  
 (9) abdominal wall?

(10) A That would be very rare. The colon  
 (11) almost always has air, and when the  
 (12) patient's in the supine position the  
 (13) transverse colon is where the air goes to,  
 (14) the air floats, it's the highest portion, so  
 (15) if there's going to be air anywhere in the  
 (16) colon, and there is always air in the colon,  
 (17) it's going to be in the transverse colon,

(18) Q Is there any explanation of why the  
 (19) transverse colon may not drop when you do  
 (20) the head of the bed elevated, the  
 (21) insufflation, all of those techniques?

(22) A Any reason why it would not drop?

(23) Q Yeah, why it wouldn't displace.

(24) A No, other than scar tissue.

(25) Q Okay. Am I correct in stating that

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(1) your opinion is based upon the fact that  
 (2) this -- your opinion that the technique  
 (3) completed by Dr. Vogten and Dr. Brown in  
 (4) performing this PEG tube insertion on  
 (5) Mr. Darrell was below the standard of care  
 (6) is based upon the mere fact that the  
 (7) perforation of the transverse colon  
 (8) occurred?

(9) A No, that's not correct.

(10) Q Okay. What is --

(11) A That's one factor.

(12) Q Okay. What else?

(13) A The other factor is that there's the  
 (14) note, there's no documentation on the note,  
 (15) it's just stated "pull-through";

(16) Q Well, Doctor, you just gave me a whole  
 (17) technique of what the pull-through meant,  
 (18) and if in fact they followed that, your  
 (19) conclusion is based merely upon the fact  
 (20) that the perforation occurred?

(21) A No, because not everyone has the same  
 (22) opinion of a pull-through. I mean, if you  
 (23) look -- I look to see the different  
 (24) techniques. Pull-through techniques are not  
 (25) described the same way in the literature.

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(1) Gauderer and Ponsky's original technique did  
 (2) not even talk about transillumination,  
 (3) finger palpation and aspiration, even the  
 (4) Mayo Clinic description doesn't, so I don't  
 (5) know what a standard pull-through is. I  
 (6) told you what my opinion is --

(7) Q Sure.

(8) A -- and I didn't know from their report,  
 (9) their endoscopy report, what that was.

(10) Q Well, certainly a pull-through means --  
 (11) the pull-through means basically instead of  
 (12) inserting it from outside the stomach you're  
 (13) pulling it through from the inside out.

(14) A Um-hum.

(15) Q And I think what you said is that  
 (16) Dr. Ponsky and this other author did not  
 (17) include transillumination initially but have  
 (18) subsequently added that, that's something  
 (19) that's in the literature?

(20) A Not -- it's not described all the same  
 (21) in different parts of the literature.

(22) Q Okay. But you indicated to me that if  
 (23) those -- strike that.

(24) You talked about five things, head  
 (25) of the bed elevated, insufflation,

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(1) transillumination, palpation and  
 (2) aspiration.

(3) A Um-hum.

(4) Q If any one of those were not completed,  
 (5) in your opinion does that mean that they  
 (6) breached the standard of care in the  
 (7) performance of a pull-through technique?

(8) A It's probable that they did or this  
 (9) complication would not have happened. This  
 (10) is an extremely rare -- in my opinion, an  
 (11) extremely rare --

(12) Q But you have heard it happening,  
 (13) correct?

(14) A I'm not sure.

(15) Q Not personally, but through the  
 (16) literature?

(17) A No, I'm not sure.

(18) Q Okay.

(19) A Because these review articles, when  
 (20) I -- I reviewed them, they talk about  
 (21) peritonitis and then they say almost all are  
 (22) from the stomach, okay? Well, "almost all,"  
 (23) I'm not sure where the others are, okay?  
 (24) And the gastrocolic fistula happens, but  
 (25) that's not -- gastrocolic fistula is when a

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(1) tract develops from the stomach to the  
 (2) colon, there's no peritonitis, and the  
 (3) problem the patient has there is when you  
 (4) put the food in the stomach or the enteral  
 (5) feeding, it goes right out his rear end.  
 (6) Q So your review of the literature is  
 (7) you're not convinced by your review of the  
 (8) literature that transverse colon perforation  
 (9) was included as part of the perforation that  
 (10) they speak about?  
 (11) A Correct.  
 (12) Q Anything else on which you base your  
 (13) opinion that Dr. Vogten and Dr. Brown  
 (14) breached the standard of care in performance  
 (15) of this procedure other than lack of  
 (16) documentation as to what they did and  
 (17) perforation of the bowel?  
 (18) A Yes.  
 (19) Q Okay:  
 (20) A And there seemed to be poor  
 (21) documentation of post-procedure, which  
 (22) seemed to be more nursing than physician.  
 (23) Q That didn't cause any injury to  
 (24) Mr. Brown -- or Mr. Darrell, correct?  
 (25) A I don't know that. I mean, it's --

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(1) perhaps he may have been able to -- may have  
 (2) been able to diagnose the peritonitis  
 (3) earlier. I don't know.  
 (4) Q When in your mind can a peritonitis  
 (5) be -- when would you anticipate the signs  
 (6) and symptoms of a peritonitis to demonstrate  
 (7) themselves when a patient has a perforation  
 (8) of his bowel?  
 (9) A When I read the post-procedure note,  
 (10) this guy's blood pressure dropped a lot,  
 (11) okay? Now, blood pressure drops, but this  
 (12) was a lot. I don't remember the specifics,  
 (13) but it would make me very concerned.  
 (14) Q Do you have any recollection or  
 (15) understanding of what the explanation is for  
 (16) the blood pressure dropping?  
 (17) A I -- Narcan was given, so I presume the  
 (18) thought was because of the sedation that he  
 (19) received.  
 (20) Q And, Doctor, that can happen in a  
 (21) patient who is nutritionally depleted or has  
 (22) less reserves, they --  
 (23) A Yes.  
 (24) Q -- can be more sensitive to sedative  
 (25) medications, correct?

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(1) A Yes.  
 (2) Q And so in your practice you have  
 (3) experienced patients decreasing their blood  
 (4) pressure as a result of anesthetic or  
 (5) sedating medications, correct?  
 (6) A Yes, but not to this extent.  
 (7) Q Okay. Do you have an understanding as  
 (8) to any other explanation of why the blood  
 (9) pressure was noted to be low?  
 (10) A No.  
 (11) Q Okay. Other than that reporting of  
 (12) that one blood pressure, do you have any  
 (13) opinions whether or not he showed any other  
 (14) signs or symptoms that this gentleman --  
 (15) (~ ~) that his bowel was perforated?  
 (16) A Well, he was agitated, which is often a  
 (17) sign of infection or hypoxia, but it's not  
 (18) clearly stated what his mental status was  
 (19) before, so I'm not sure if that was  
 (20) different or not.  
 (21) Q Well, let me represent to you that  
 (22) Mr. Darrell pulled out his NG tube a number  
 (23) of times. That would be consistent with  
 (24) somebody who was somewhat agitated, fair  
 (25) enough?

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(1) A Yes.  
 (2) Q All right. Other than the blood  
 (3) pressure, did you see an elevation in his  
 (4) pulse rate?  
 (5) A I don't remember that.  
 (6) Q Okay. You can look if you'd like.  
 (7) A I'm sorry. Here it is.  
 (8) No, his heart rate was 86.  
 (9) Q Would you expect if there is an actual  
 (10) decrease in blood pressure that you would  
 (11) see an inverse increase in someone's pulse  
 (12) rate?  
 (13) A In someone who is healthy, not in  
 (14) someone who is sick. Not in someone who  
 (15) is -- people with -- old people can have  
 (16) florid peritonitis and have -- really not  
 (17) look very bad.  
 (18) Q Okay. What was his blood pressure upon  
 (19) discharge?  
 (20) Let me help you if I can. DO you  
 (21) see it on the top there? It's right there.  
 (22) A Oh. Discharge. 129 over 89. 159.  
 (23) Q And in your opinion that would be --  
 (24) A That's acceptable blood pressure.  
 (25) Q And so if those vital signs are

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(1) accurate, 129 over 39, pulse 88,  
 (2) respirations 18, you would agree with me  
 (3) that that patient is stable regarding his  
 (4) vital signs?  
 (5) A Regarding his vital signs, yes.  
 (6) Q There was also noted decrease in his  
 (7) oxygen saturation; that can occur as well as  
 (8) a result of his sedation?  
 (9) A Correct.  
 (10) Q Any indication that his oxygen  
 (11) saturation decreased as a result of anything  
 (12) other than the sedation medications?  
 (13) A No.  
 (14) Q Do you have any opinion as to whether  
 (15) or not it was a breach of the standard of  
 (16) care to release him back to the nursing home  
 (17) with those vital signs as we've stated?  
 (18) A I'm uncomfortable answering that.  
 (19) Q Okay.  
 (20) A I don't know. This is exactly why we  
 (21) don't do many patients same day. I don't --  
 (22) I don't -- I can't sit and look at what  
 (23) their decision process is at that time.  
 (24) It's highly likely that we would have  
 (25) admitted this patient to the hospital simply

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(1) because of -- for observation simply because  
 (2) of his deteriorated state and that degree of  
 (3) hypotension. That's -- that's an unusual  
 (4) degree of hypotension.  
 (5) Q You mean the hypotension that's  
 (6) recorded this one time here?  
 (7) A Correct. Well, it drops further. It's  
 (8) not just the one time. There's blood  
 (9) pressure of 53 over 26 and then 26 over 8,  
 (10) this is an unobtainable number. Also, I  
 (11) mean, you can't -- that blood pressure of 26  
 (12) over 8, I mean, I don't know how they got  
 (13) that. I mean, I don't know how they  
 (14) measured that.  
 (15) Q Okay. So probably these -- these  
 (16) values are probably incorrect, correct?  
 (17) MR. HAWAL: Objection.  
 (18) A All I know is that I don't know how  
 (19) they got that degree of --  
 (20) Q Okay. If you were a physician and you  
 (21) saw those and you walked over to the  
 (22) patient, what would you look for?  
 (23) A I would look for his mental status, I  
 (24) would examine his abdomen, but sometimes  
 (25) those things don't -- they can't come up

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(1) because they're older people.  
 (2) Q Assuming this to be the case where his  
 (3) blood pressure was 26 over 8, would in this  
 (4) case you see the change in his pulse rate?  
 (5) A Not necessarily.  
 (6) Q Okay. Now, when a nurse comes to you  
 (7) and says --  
 (8) A I want to say --  
 (9) Q Sure.  
 (10) A I want to step back. I am  
 (11) uncomfortable at this point because I don't  
 (12) want to project -- I wasn't there, okay?  
 (13) All I'm saying is that you asked me if it  
 (14) would be standard of care, and I'm  
 (15) uncomfortable saying that it is standard of  
 (16) care. That's all I'm saying.  
 (17) Q When you say you're uncomfortable,  
 (18) you're uncomfortable --  
 (19) A That would be not -- I'm sorry.  
 (20) Q You would be uncomfortable rendering an  
 (21) opinion either way, whether it breached or  
 (22) met the standard of care?  
 (23) A I would be comfortable saying that  
 (24) would not be my standard of care.  
 (25) Q Okay. Just so I understand what

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(1) opinion you're putting here, you're saying  
 (2) that this is the type of patient that should  
 (3) have been admitted to the hospital based  
 (4) upon his blood pressures?  
 (5) A I don't -- I don't know how to answer  
 (6) that question.  
 (7) Q I guess I'm --  
 (8) A I don't want to criticize them too much  
 (9) or not because I don't know. I don't want  
 (10) to -- you asked me if this was standard of  
 (11) care to discharge him based on his vital  
 (12) signs, and all I'm saying is I'm  
 (13) uncomfortable saying yes or no to that  
 (14) question.  
 (15) Q That's fine. As long as you're not  
 (16) going to render an opinion, that's all I  
 (17) need to know. You don't have enough  
 (18) information and you weren't there to render  
 (19) an opinion --  
 (20) A Correct.  
 (21) Q Okay. That's fine.  
 (22) MR. HAWAL: However, he did  
 (23) say that he would have evaluated -- a  
 (24) physician should have seen him based on that  
 (25) kind of information.

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(1) A Yes, I agree with that  
 (2) Q If a -- let me give you a hypothetical  
 (3) situation  
 (4) A patient comes -- or a nurse  
 (5) comes up to you and says patient X has a  
 (6) blood pressure of 53 over 28 and 26 over 8,  
 (7) your practice would be to go over and  
 (8) evaluate that patient, correct?  
 (9) A Yes  
 (10) Q And if in your evaluation this person  
 (11) appears to be normal mentation for him,  
 (12) normal status in other manners, you would  
 (13) suspect or think that these blood pressure  
 (14) readings were inaccurate, is that a fair  
 (15) statement?  
 (16) A I would be concerned that his blood  
 (17) pressure -- I would be -- I would be  
 (18) concerned that the latter blood pressure  
 (19) measurements were actually made up  
 (20) 23. Q Or maybe not -- maybe there's something  
 (21) wrong with the machinery --  
 (22) A Correct  
 (23) Q -- or something?  
 (24) A That's possible  
 (25) Q And that has happened?

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(1) A Yes, absolutely.  
 (2) Q And if that happens, that would  
 (3) indicate that maybe perhaps these blood  
 (4) pressure readings are not the true and  
 (5) accurate blood pressures for Mr. Darrell?  
 (6) MR. HAWAL: Objection.  
 (7) A Yes, assuming that you're not --  
 (8) assuming you're using machinery that works.  
 (9) Q Let's talk a little bit about the  
 (10) documentation, because that seemed to be  
 (11) part of your opinion as it relates to  
 (12) standard of care.  
 (13) You indicate that the  
 (14) documentation of this operative procedure or  
 (15) the PEG tube insertion procedure performed  
 (16) by Dr. Vogten and Dr. Brown is insufficient  
 (17) to give you an understanding of what in fact  
 (18) transpired.  
 (19) A Correct.  
 (20) Q But I've asked you to assume that they  
 (21) did what they said they did in their  
 (22) deposition; you would agree with me that  
 (23) they met the standard of care as it relates  
 (24) to the pull-through technique?  
 (25) A Probably. Dr. Vogten's.

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(1) Q Well, we talked about that. Dr. Brown  
 (2) doesn't do the aspiration.  
 (3) A Correct. I agreed with Dr. Vogten's --  
 (4) Q And if in fact the procedure was done  
 (5) in the manner in which Dr. Vogten said it  
 (6) was done, you would agree he met the  
 (7) standard of care?  
 (8) MR. HAWAL: Objection,  
 (9) because you're -- I want to object to the  
 (10) foundation of your hypothetical because both  
 (11) doctors testified that they didn't remember  
 (12) this procedure, so --  
 (13) Q Okay. If they did the procedure in the  
 (14) normal course that they described in their  
 (15) depositions, you would agree with me that  
 (16) they met the acceptable standards of care?  
 (17) A Yes.  
 (18) Q What is it about the documentation that  
 (19) you are critical of?  
 (20) A They don't describe it, and everyone's  
 (21) pull-through is not the same.  
 (22) Q And what is it that you need to --  
 (23) A There *is* no description of the  
 (24) abdominal wall.  
 (25) Q As it relates to the endoscopy

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(1) findings?  
 (2) A As it relates to whether the scar *is*  
 (3) done, the way they chose the spot.  
 (4) Q There has been some reference that JCHO  
 (5) has requirements as it relates to operative  
 (6) notes procedures  
 (7) A Um-hum  
 (8) Q Are you aware of what those  
 (9) requirements are?  
 (10) A When they came by -- not the specifics,  
 (11) but when they came by the last time they --  
 (12) we had to have all -- the last time being  
 (13) probably a year ago, all the operative  
 (14) procedures, whether they were done in  
 (15) endoscopy or in the OR, had to have the same  
 (16) material and they had to have basically -- I  
 (17) think I gave you the one --  
 (18) Q Oh, those forms?  
 (19) A Right They had to have a lot of these  
 (20) things Each specific detail, I don't  
 (21) remember --  
 (22) Q Okay  
 (23) A -- which --  
 (24) Q And we already talked about -- the  
 (25) forms that you're referencing are anesthesia

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(1) records, correct?  
 (2) A No.  
 (3) Q Preanesthesia evaluation --  
 (4) A And post, and nursing.  
 (5) Q Right.  
 (6) A And physician. Physician evaluation,  
 (7) anesthesia, which is conscious sedation.  
 (8) Q Where in here is anything about what  
 (9) you, Doctor, do?  
 (10) A The -- all this is done, first two  
 (11) pages.  
 (12) Q That's not anesthesia doing that?  
 (13) A No. This is not -- the reason is  
 (14) because this is conscious sedation.  
 (15) Q Okay.  
 (16) A So --  
 (17) Q There's no anesthesiologist.  
 (18) A Right.  
 (19) Q You are them. Got you.  
 (20) Do you know whether JCHO governs  
 (21) freestanding endoscopy --  
 (22) A I don't know that.  
 (23) Q Do you have any understanding of  
 (24) whether there is another governing body that  
 (25) operates over freestanding --

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(1) A I don't know  
 (2) Q You're not in a position to render any  
 (3) opinions as to what JCHO requires as it  
 (4) relates to operative procedures in the  
 (5) procedure that was performed by Dr. Brown  
 (6) and Dr. Vogten?  
 (7) A Correct  
 (8) Q So your criticism as to documentation  
 (9) is based upon what you at MetroHealth use --  
 (10) A What we're required -- yes  
 (11) Q -- and what you're required --  
 (12) A Yes  
 (13) Q --based upon your understanding of  
 (14) what JCHO requires?  
 (15) A Yes  
 (16) Q Other than the fact that they don't  
 (17) describe the technique, is there anything  
 (18) else that should be included in this report  
 (19) that is not?  
 (20) A As I remember, I thought there might  
 (21) have been a little bit more description of  
 (22) the patient before the surgery, but my major  
 (23) concern was the lack of documentation of the  
 (24) procedure itself  
 (25) Q Okay

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(1) A I think as well that there wasn't  
 (2) enough about the patient evaluation before.  
 (3) Q Okay. Do you have any understanding of  
 (4) any conversations that Dr. Vogten had with  
 (5) any of the primary care physicians for  
 (6) Mr. Darrell?  
 (7) A No.  
 (8) Q So you don't know whether or not they  
 (9) did anything preoperatively to assess his  
 (10) need for -- indication for the PEG tube  
 (11) placement, his ability to undergo that and  
 (12) evaluating any additional data?  
 (13) A Correct. I don't know.  
 (14) Q Anything else about this reporting, or  
 (15) documentation that you are critical of?  
 (16) A No.  
 (17) Q So you are assuming based upon the  
 (18) absence of documentation and the existence  
 (19) of the perforation that the procedure was  
 (20) done incorrectly; is that fair?  
 (21) A Yes.  
 (22) Q I want to turn to your July 9th, 1998  
 (23) report. Is that the only report that you  
 (24) have rendered in this case?  
 (25) A That one?

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(1) Q Yes.  
 (2) A Yes. Is that to Mr. Martin?  
 (3) Q That is correct.  
 (4) A Yes.  
 (5) Q Any drafts of this report?  
 (6) A No, I don't think so.  
 (7) Q And what I mean by that, is there  
 (8) something that you may have given to  
 (9) Mr. Martin or anyone else, what do you think  
 (10) about this?  
 (11) A Oh, no.  
 (12) Q Take this out -- okay.  
 (13) Anything taken out at the request  
 (14) of anybody?  
 (15) A No.  
 (16) Q Do you keep any notes or anything that  
 (17) helps you prepare this report?  
 (18) A If I did, I threw them out. You know,  
 (19) I write it in draft first.  
 (20) Q There are three opinions set forth in  
 (21) this particular report. Are these all the  
 (22) opinions that you are going to espouse in  
 (23) the event that a trial goes forward in this  
 (24) case?  
 (25) A Yes.

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(1) MR. HAWAL: Well, he's  
 (2) already corrected you, Bev, that he's not  
 (3) giving the third one about the weight loss.  
 (4) Q Well, that's -- I'll explore that,  
 (5) because I think we did talk a little bit  
 (6) about that but I think you seemed to  
 (7) indicate that there was a delay in getting  
 (8) the procedure done and I don't know if it's  
 (9) related to that -- yeah, there is reference  
 (10) to the delay in that third one.  
 (11) A Um-hum.  
 (12) Q So let's talk about the first one.  
 (13) Again, you talk about extremely  
 (14) poor documentation of the patient's status  
 (15) and ability to undergo the PEG placement  
 (16) prior to the procedure. Now, I think we  
 (17) just talked about you don't know what  
 (18) transpired prior to the procedure actually  
 (19) being done.  
 (20) A Correct.  
 (21) Q If I'm correct, you don't have any  
 (22) understanding as to the consent or the  
 (23) discussions had with the daughter or  
 (24) Mr. Darrell as it relates to the need for  
 (25) the procedure?

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(1) A Correct.  
 (2) Q All right. You're not going to offer  
 (3) any opinions as to whether or not  
 (4) Mr. Darrell or his family members obtained  
 (5) informed consent as it --  
 (6) A No.  
 (7) Q -- relates to the procedure?  
 (8) There is also an inadequate  
 (9) description of the actual procedure itself  
 (10) regarding, most importantly, the basis of  
 (11) the site selection and confirmation of  
 (12) placement of the PEG tube in the appropriate  
 (13) place. There is also poor documentation and  
 (14) description of the post-procedure monitoring  
 (15) and pre-discharge evaluation of the patient  
 (16) by the nursing and physician staff. Let's  
 (17) take the first part first.  
 (18) Site selection and Confirmation of  
 (19) placement all relate to the -- what you  
 (20) believe should be a little bit more  
 (21) descriptive or -- descriptive technique?  
 (22) A Correct.  
 (23) Q As it relates to the post-procedure  
 (24) monitoring and pre-discharge evaluation, I  
 (25) think you indicated you don't have an

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(1) opinion whether this patient should have  
 (2) been discharged back to the nursing home; is  
 (3) that fair?  
 (4) A Yes.  
 (5) Q We talked at length about the blood  
 (6) pressure monitoring, and I think you  
 (7) indicated you don't know anything else other  
 (8) than those two values?  
 (9) A Correct.  
 (10) Q Okay. You made a statement, I have  
 (11) included copies of standard pre and post  
 (12) patient evaluation sheets for your review  
 (13) and comparison to those provided in  
 (14) Mr. Darrell's case. Those are the forms  
 (15) that we looked at?  
 (16) A Yes.  
 (17) Q Anything else as it relates to this  
 (18) opinion you've espoused?  
 (19) A No.  
 (20) Q We've exhausted it. Okay.  
 (21) I'll keep it on time.  
 (22) A That's okay.  
 (23) Q Second opinion, the complication which  
 (24) occurred is extremely rare. My review of  
 (25) the literature and nonspecific survey of

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(1) physicians in this field indicate that it  
 (2) would have been a preventable complication.  
 (3) Survey of physicians, these are the  
 (4) colleagues you talked about?  
 (5) A Yes.  
 (6) Q Talked to.  
 (7) And who were they specifically?  
 (8) A Issa, Cheriyan, I think that was it.  
 (9) Q Did you have an opinion prior to  
 (10) talking to those individuals or is that  
 (11) something that you formed with them?  
 (12) A Oh, no, I had an opinion. Oh, no, I  
 (13) had an opinion.  
 (14) Q In light of this and the very poor  
 (15) documentation before, during and after,  
 (16) lends credence to the probability of errors;  
 (17) and I think we talked about those two  
 (18) factors being in your opinion.  
 (19) A Yes.  
 (20) Q Forming the basis.  
 (21) Now, let's talk about the third  
 (22) opinion. We talked about that you've  
 (23) indicated 30 percent -- 37 percent of his  
 (24) body weight was lost during a one month  
 (25) stay.



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(1) A Is that what I wrote, 37?  
 (2) Q I think you've already indicated that  
 (3) there was a -- it was an incorrect weight  
 (4) preadmission.  
 (5) A Someone told me that the weight was  
 (6) incorrect and so that it was not that much  
 (7) of a weight loss.  
 (8) Q So you are no longer of that opinion,  
 (9) that he suffered this extensive 30 percent  
 (10) loss of his body weight?  
 (11) A Yes.  
 (12) Q All right. Now, you do talk about the  
 (13) delay in getting a consultation. Tell me  
 (14) what -- are you critical of the time frame?  
 (15) A It must have been -- and I don't  
 (16) remember -- because I don't actually know  
 (17) where my -- I must have -- must have had  
 (18) them, but I don't remember where they are  
 (19) and I don't remember how long ago. I don't  
 (20) remember the time frame, I don't remember  
 (21) the specifics of it, so I don't know.  
 (22) Q Okay.  
 (23) A I'd have to look that over again.  
 (24) Q Okay. So as we sit here today, you  
 (25) don't have an understanding of what delay

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(1) took place?  
 (2) A I don't remember the basis upon which I  
 (3) wrote that  
 (4) Q Okay And as I look at your file  
 (5) materials, it doesn't appear that you have  
 (6) any of the nursing home notes, certainly in  
 (7) the file that you've presented to me  
 (8) A Correct  
 (9) Q Do you think that you have some of the  
 (10) Judson?  
 (11) A I don't know where they are I mean, I  
 (12) know I read them  
 (13) Q Okay Are you going to be rendering an  
 (14) opinion that there was a delay here that  
 (15) caused --  
 (16) MR HAWAL No  
 (17) Q Okay.  
 (18) MR. HAWAL I mean, the --  
 (19) A Especially because I think one of the  
 (20) factors that made me concerned is the weight  
 (21) loss, and so if that's not --  
 (22) Q That's fair enough  
 (23) MR HAWAL Not an issue  
 (24) Q So this whole third opinion you have in  
 (25) your report is a non-issue?

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(1) A Correct.  
 (2) Q And it was based upon misinformation  
 (3) that you reviewed in the records?  
 (4) A Correct.  
 (5) Q Doctor, you would agree with me that  
 (6) there was an indication for a PEG tube  
 (7) insertion in Mr. Darrell?  
 (8) A Yes.  
 (9) MR. HAWAL: Objection.  
 (10) Asked and answered.  
 (11) Q Doctor, you would agree with me that  
 (12) there was no contraindications that you're  
 (13) aware of for the insertion of a PEG tube in  
 (14) Mr. Darrell?  
 (15) MR. HAWAL: Asked and  
 (16) answered.  
 (17) Q You can answer.  
 (18) A Yes.  
 (19) Q Okay. Would you agree with me, Doctor,  
 (20) that even if those steps are taken during  
 (21) the procedure, insufflation,  
 (22) transillumination, palpation, aspiration,  
 (23) head of the bed elevated, that it is not  
 (24) 100 percent unavoidable for a bowel  
 (25) perforation?

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(1) MR. HAWAL: Objection,  
 (2) Asked and answered.  
 (3) A What? Could you repeat the question?  
 (4) THE WITNESS: And do I have to  
 (5) answer that? Should I answer this?  
 (6) MR. HAWAL: You can answer  
 (7) it. I'm objecting because it's already been  
 (8) something gone over in the deposition,  
 (9) you've answered it before.  
 (10) Q Mr. Hawal doesn't like when I ask  
 (11) questions twice.  
 (12) MR. HAWAL: I don't like  
 (13) repetitive questions.  
 (14) A If you can just repeat the question  
 (15) Q That's all right.  
 (16) Doctor, would you agree with me  
 (17) that even if the safety maneuvers that we  
 (18) talked about, the five, were performed, that  
 (19) the bowel perforation is not 100 percent  
 (20) unavoidable?  
 (21) A No, I don't agree that nothing's -- I  
 (22) don't believe that everything is possible, I  
 (23) don't believe that, if you do standard of  
 (24) care.  
 (25) Q Okay.

BSA

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(1) A I mean, I hear that all the time. I  
 (2) don't believe it.  
 (3) Q Do you ever read the Gastrointestinal  
 (4) Endoscopy Clinics of North America?  
 (5) A Occasionally, yeah.  
 (6) Q Is that the same journal that you  
 (7) printed your article in in 1994? 1984,  
 (8) excuse me.  
 (9) A What was the journal again?  
 (10) Q Gastrointestinal Endoscopy Clinics of  
 (11) North America.  
 (12) A You know, I don't remember. There's a  
 (13) couple endoscopy journals. I'm not sure.  
 (14) Q Is that a book maybe?  
 (15) A It's a --there's Gastroenterology  
 (16) Clinics of North America, which is a book  
 (17) that comes out every other month, and then  
 (18) there's journals, endoscopy journals, and I  
 (19) published mine in a journal. The difference  
 (20) is that the journal articles are peer  
 (21) reviewed, those articles are reviews that  
 (22) are opinions of the author.  
 (23) MS. SANDACZ: Okay. I'm  
 (24) done. Thank you very much.  
 (25) (Deposition concluded at 9:39 a.m.)

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(1) I do further certify that I am not a  
 (2) relative, counsel or attorney for either  
 (3) party, or otherwise interested in the  
 (4) outcome of this action.  
 (5)  
 (6) IN WITNESS WHEREOF, I have  
 (7) hereunto set my hand and affixed my seal of  
 (8) office at Cleveland, Ohio, this 23rd day of  
 (9) September, 1999.  
 (10)  
 (11) \_\_\_\_\_  
 (12) David J. Collier, RPR,  
 (13) Notary Public/State of Ohio.  
 (14) Commission expiration: April 26, 2001  
 (15)  
 (16)  
 (17)  
 (18)  
 (19)  
 (20)  
 (21)  
 (22)  
 (23)  
 (24)  
 (25)

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(1) C E R T I F I C A T E  
 (2)  
 (3) The State of Ohio, )  
 (4) County of Cuyahoga. ) SS:  
 (5)  
 (6) I, David J. Collier, Registered  
 (7) Professional Reporter, Notary Public within  
 (8) and for the State of Ohio, duly commissioned  
 (9) and qualified, do hereby certify that the  
 (10) within named witness, ARTHUR J. McCULLOUGH,  
 (11) JR., M.D., was by me first duly sworn to  
 (12) testify the truth, the whole truth and  
 (13) nothing but the truth in the cause  
 (14) aforesaid; that the testimony then given by  
 (15) the above-referenced witness was by me  
 (16) reduced to stenotypy in the presence of said  
 (17) witness; afterwards transcribed, and that  
 (18) the foregoing is a true and correct  
 (19) transcription of the testimony so given by  
 (20) the above-referenced witness.  
 (21)  
 (22) I do further certify that this  
 (23) deposition was taken at the time and place  
 (24) as in the foregoing caption specified, and  
 (25) was completed without adjournment.

**Concordance Report**Unique Words: **1,473**Total Occurrences: **4,505**Noise Words: **384**Total Words In File: **13,745**

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